

Veille scientifique en économie de la santé

Watch on Health Economics Literature

Juillet-août 2020 / July-August 2020

Assurance maladie	<i>Health Insurance</i>
E-santé – Technologies médicales	<i>E-health – Medical Technologies</i>
Économie de la santé	<i>Health Economics</i>
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Health Insurance**► The Past, Present, and Possible Future of Public Opinion on the ACA**

BRODIE M., HAMEL E. C., KIRZINGER A., *et al.*
2020

Health Affairs 39(3): 462-470.

<https://doi.org/10.1377/hlthaff.2019.01420>

When the Affordable Care Act (ACA) became law in 2010, public opinion of it was narrowly divided and deeply partisan. Our review of 102 nationally representative public opinion polls in the period 2010-2019 reveals that opinion remains divided and has shifted in a sustained way at only two points in time: in a negative direction following technical problems in the first enrollment period, and in a positive direction after President Donald Trump's election and subsequent Republican repeal efforts. In late 2019 the ACA was more popular than ever, yet partisan divisions have gotten larger rather than smaller. Many core elements of the law remain popular across partisan groups, even as fewer people recognize the ACA as the source of some of these provisions. While Republicans may never embrace the law that is seen as President Barack Obama's legacy, the public's reluctance to see certain benefits taken away will continue to be a roadblock for people who would seek to repeal or dismantle it.

► Did the ACA Lower Americans' Financial Barriers to Health Care?

GLIED S. A., COLLINS S. R. ET LIN S.
2020

Health Affairs 39(3): 379-386.

<https://doi.org/10.1377/hlthaff.2019.01448>

The Affordable Care Act was designed to provide financial protection to Americans in their use of the health care system. This required addressing two intertwined problems: cost barriers to accessing coverage and care, and barriers to comprehensive risk protection provided by insurance. We reviewed the evidence on whether the law was effective in achieving these goals. We found that the Affordable Care Act generated substantial, widespread improvements in protecting Americans against the financial risks of illness. The coverage expansions reduced uninsurance rates, especially relative to earlier forecasts; improved

access to care; and lowered out-of-pocket spending. The insurance market reforms also made it easier for people to get and stay enrolled in coverage and ensured that those who were insured had true financial risk protection. But subsequent court decisions and congressional and executive branch actions have left millions uninsured and allowed the risk of inadequate insurance to resurface.

► Women's Coverage, Utilization, Affordability, and Health After the ACA: A Review of the Literature

LEE L. K., CHIEN A., STEWART A., *et al.*
2020

Health Affairs 39(3): 387-394.

<https://doi.org/10.1377/hlthaff.2019.01361>

Women of working age (ages 19-64) faced specific challenges in obtaining health insurance coverage and health care before the Affordable Care Act. Multiple factors contributed to women's experiencing uninsurance, underinsurance, and increased financial burdens related to obtaining health care. This literature review summarizes evidence on the law's effects on women's health care and health and finds improvements in overall coverage, access to health care, affordability, preventive care use, mental health care, use of contraceptives, and perinatal outcomes. Despite major progress after the Affordable Care Act's implementation, barriers to coverage, access, and affordability remain, and serious threats to women's health still exist. Highlighting the law's effects on women's health is critical for informing future policies directed toward the continuing improvement of women's health care and health.

► The Political Economy of Universal Health Coverage: A Systematic Narrative Review

RIZVI S. S., DOUGLAS R., WILLIAMS O. D., *et al.*
2020

Health Policy and Planning 35(3): 364-372.

<https://doi.org/10.1093/heapol/czz171>

The uptake and implementation of universal health coverage (UHC) is primarily a political, rather than a

technical, exercise, with contested ideas and diverse stakeholders capable of facilitation or resistance—even veto—of the policy uptake. This narrative systematic review, undertaken in 2018, sought to identify all peer-reviewed publications dealing with concepts relating to UHC through a political economy framing. Of the 627 papers originally identified, 55 papers were directly relevant, with an additional eight papers added manually on referral from colleagues. The thematic analysis adapted Fox and Reich's framework of ideas and ideologies, interests and institutions to organize the analysis. The results identified a literature strong in its exploration of the ideologies and ideas that underpin UHC, but with an apparent bias in authorship towards more rights-based, left-leaning perspectives. Despite this, political economy analyses of country case studies suggested a more diverse political framing for UHC, with the interests and institutions engaged in implementation drawing on pragmatic and market-based mechanisms to achieve outcomes. Case studies offered limited detail on the role played by specific interests, though the influence of global development trends was evident, as was the role of donor organizations. Most country case studies, however, framed the development of UHC within a narrative of national ownership, with steps in implementation often critical political milestones. The development of institutions for UHC implementation was predicated largely on available infrastructure, with elements of that infrastructure—federal systems, user fees, pre-existing insurance schemes—needing to be accommodated in the incremental progress towards UHC. The need for technical competence to deliver ideological promises was underlined. The review concludes that, despite the disparate sources for the analyses, there is an emerging shared narrative in the growing literature around the political economy of UHC that offers an increasing awareness of the political dimensions to UHC uptake and implementation.

► **How Have ACA Insurance Expansions Affected Health Outcomes? Findings from the Literature**

SONI A., WHERRY L. R. ET SIMON K. I.
2020

[Health Affairs 39\(3\): 371-378.](#)

<https://doi.org/10.1377/hlthaff.2019.01436>

A growing body of literature examining the effects of the Affordable Care Act (ACA) on nonelderly adults provides promising evidence of improvements in

health outcomes through insurance expansions. Our review of forty-three studies that employed a quasi-experimental research design found encouraging evidence of improvements in health status, chronic disease, maternal and neonatal health, and mortality, with some findings corroborated by multiple studies. Some studies further suggested that the beneficial effects have grown over time and thus may continue to grow if the ACA insurance expansions remain in force. However, not all studies reported a significant positive relationship between ACA provisions that expanded insurance coverage and health status. We highlight the challenges facing researchers, including the importance of nonmedical factors in determining individual health and the use of outcome data predominantly drawn from self-reports. In closing, we identify opportunities to enhance researchers' understanding of the relationship between the ACA insurance expansions and health outcomes using new data sources, including electronic health records.

► **Equal Long-Term Care for Equal Needs with Universal and Comprehensive Coverage? An Assessment Using Dutch Administrative Data**

TENAND M., BAKX P. ET VAN DOORSLAER E.
2020

[Health Economics 29\(4\): 435-451.](#)

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3994>

Abstract The Netherlands is one of the few countries that offer generous universal public coverage of long-term care (LTC). Does this ensure that the Dutch elderly with similar care needs receive similar LTC, irrespective of their income? In contrast with previous studies of inequity in care use that relied on a statistically derived variable of needs, our paper exploits a readily available, administrative measure of LTC needs stemming from the eligibility assessment organized by the Dutch LTC assessment agency. Using exhaustive administrative register data on 616,934 individuals aged 60 and older eligible for public LTC, we find a substantial pro-poor concentration of LTC use that is only partially explained by poorer individuals' greater needs. Among those eligible for institutional care, higher-income individuals are more likely to use—less costly—home care. This pattern may be explained by differences in preferences, but also by their higher copayments for nursing homes and by greater feasibility of home-based LTC arrangements for richer elderly. At face value, our findings suggest that the Dutch LTC insurance “overshoots”

its target to ensure that LTC is accessible to poorer elderly. Yet, the implications depend on the origins of the difference and one's normative stance.

► **Delisting Eye Examinations from Public Health Insurance: Empirical Evidence from Canada Regarding Impacts on Patients and Providers**

WANG C. ET SWEETMAN A.

2020

Health Policy 124 (5) : 540-548

<https://doi.org/10.1016/j.healthpol.2020.03.006>

This paper examines the impacts of delisting routine eye exam services on patient eye care utilization and on providers' labour market outcomes in a public healthcare system. Provincial governments in Canada

started to de-insure routine eye examinations from the basket of publicly insured healthcare services in the early 1990s. We explore these policy changes across Canadian provinces to estimate the impacts of delisting from the supply- and demand-sides. Demand side analysis suggests that, on average, for the working age population delisting decreased the probability of using eye care. However, the number of visits among those who continued to use eye care services did not change. Additionally, the delisting may have had unintended consequences by causing a large negative impact among low-income individuals, and there is suggestive evidence of a positive spillover on utilization by publicly-funded patients over age 64. On the supply side, using Canadian census data we find that delisting eye exams decreased optometrists' weekly work hours, raised their annual work weeks and had little effect on their income.

E-santé – Technologies médicales

E-health – Medical Technologies

► **Enjeux, répercussions et cadre éthique relatifs à l'Intelligence Artificielle en santé. Vers une Intelligence Artificielle éthique en médecine**

DUGUET J., CHASSANG G. ET BÉRANGER J.

2019

Droit, Santé et Société 3(3): 30-39.

<https://www.cairn.info/revue-droit-sante-et-societe-2019-3-page-30.htm>

Un climat alternant le chaud et le froid, s'est installé suscitant engouement et suspicion, envers le numérique et les développements de l'Intelligence Artificielle (IA). Cela a pour conséquence de rendre plus fragile la relation de confiance entre les professionnels notamment dans le domaine de la santé et les citoyens. Face aux enjeux grandissants qui entourent l'IA en santé, une vision éthique apparaît nécessaire afin de retrouver de la cohérence et du sens dans l'approche de cette nouvelle technologie. Cette réflexion éthique renvoie à un système de valeurs pour lesquelles sont associées quatre principes éthiques universels notamment en biomédical : l'autonomie des personnes, la bienfaisance, la non-malfaisance et la justice. Par conséquent, les machines intelligentes doivent être

éthiques dès leur conception, jusqu'à leur usage. La responsabilité attachée à la machine appartient à la fois aux concepteurs et aux propriétaires. Ainsi, il est essentiel d'apporter une « personnalité morale » à ces IA par le biais d'une conscience éthique algorithmique. En définitive, la notion de responsabilité doit être au centre de la relation médecin-IA-patient.

► **Quantifying SARS-Cov-2 Transmission Suggests Epidemic Control with Digital Contact Tracing**

FERRETTI L., WYMANT C., KENDALL M., *et al.*

2020

Science : 368(6491) : eabb6936

<https://doi.org/10.1126/science.abb6936>

The newly emergent human virus SARS-CoV-2 is resulting in high fatality rates and incapacitated health systems. Preventing further transmission is a priority. We analyzed key parameters of epidemic spread to estimate the contribution of different transmission routes and determine requirements for case isolation and contact-tracing needed to stop the epidemic. We conclude that viral spread is too fast to be contained

by manual contact tracing, but could be controlled if this process was faster, more efficient and happened at scale. A contact-tracing App which builds a memory of proximity contacts and immediately notifies contacts of positive cases can achieve epidemic control if used by enough people. By targeting recommendations to only those at risk, epidemics could be contained without need for mass quarantines ('lock-downs') that are harmful to society. We discuss the ethical requirements for an intervention of this kind.

► **What Place for French Morbidity Registries in the Era of Big Data?**

FRANCIS F., TERROBA C., PERSOZ C., *et al.*
2020

[Rev Epidemiol Sante Publique 68\(2\): 117-123.](#)

The recent opening of massive health databases, as well as the development of methods and tools adapted to their data processing, questions the French model of «morbidity registry». In France in 2019, nearly 61 health registries were operating. As defined by law, these registries identify exhaustively all patients with a given disease in a given territory. Established several decades ago, these registries are part of the French surveillance system that is used for research and evaluation purposes. Since the advent of recent technological progress, large-scale databases are made available to researchers and it is possible with these databases to answer questions initially assigned to the

registries. What is the place of such registries in this new context: are they obsolete or still useful? Should they be opposed to the new tools or are they complementary to them, and if so, what is their place in the new French public health ecosystem? The objective of this work was to assess the roles and missions of existing registries and to reflect on their positioning in this new environment. The French model of registry is sometimes questioned because of the complexity of its circuits, requiring a significant amount of human resources. However, the data that constitute them, validated by cross-checking information from several sources, are of very high quality, and make it possible to validate the data in the new databases (National Health Data System (NSDS) or Hospital Data Warehouses). Registries and new databases are in fact complementary, and far from jeopardizing this model, the recent opening of these databases represents an opportunity for registries to modernize their operations and respond to new missions.

► **Machine Learning and Medical Appointment Scheduling: Creating and Perpetuating Inequalities in Access to Health Care**

SAMORANI M. ET BLOUNT L. G.
2020

[American Journal of Public Health 110\(4\): 440-441.](#)
<https://doi.org/10.2105/AJPH.2020.305570>

Économie de la santé

Health Economics

► **Exploring Variations In Health-Care Expenditures—What Is The Role Of Practice Styles?**

AHAMMER A. ET SCHOBERT T.
2020

[Health Economics 29\(6\) : 683-699](#)
<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4011>

Variations in medical resource usage, both across and within geographical regions, have been widely documented. In this paper, we explore physician practice styles as a possible determinant of these variations. In particular, we exploit patient mobility between physicians to identify practice styles among general practi-

tioners (GPs) in Austria. We use a large administrative data set containing detailed information on a battery of different health-care services and implement a model with additive patient and GP fixed effects that allows flexibly for systematic differences in patients' health states. We find that, although GPs explain only a small part of the overall variation in medical expenses, heterogeneities in spending patterns among GPs are substantial. Conditional on patient characteristics, we document a difference of € 751.47 per patient per year in total medical expenses (which amounts to roughly 45% of the sample mean) between high- and low-spending GPs.

► **Exploring Differences Between Private and Public Prices in the English Care Homes Market**

ALLAN S., GOUSIA K. ET FORDER J.
2020

Health Economics, Policy and Law: 1-16.
<https://DOI.org/10.1017/S1744133120000018>

This work quantitatively assesses the potential reasons behind the difference in prices paid by care home residents in England. Evidence suggests that the price paid by private payers is higher than that paid for publicly supported residents, and this is often attributed to the market power wielded by local authorities as the dominant purchaser in local markets. Estimations of private prices at the local authority level are used to assess the difference in price paid between private and public prices, the fees gap, using data from 2008 to 2010. Controlling for local area and average care home characteristics, the results indicate that both care home and local authority market power play a role in the price determination of the market.

► **Lack of Medical or Dental Care: Impact on Health Expenditures for People with Chronic Disease**

BAS A. C. ET AZOGUI-LEVY S.
2020

Rev Epidemiol Sante Publique 68(2): 91-98.

BACKGROUND: People with chronic disease often have dental (especially periodontal) disorders. Nevertheless, people with chronic disease seek dental care less often than others. We wanted to know if there is a relationship between the consumption of medical care and the consumption of dental care, and if so if the relationship is especially strong for people with chronic disease. **METHODS:** We conducted a longitudinal study that combined two data-sets: consumption data from the French National Health Insurance Fund and health and socioeconomic welfare data collected with a dedicated national survey. We studied healthcare expenditure and analyzed the association between healthcare consumption, health status and healthcare expenditure over a four-year period (2010-2013). **RESULTS:** People who did not seek medical or dental care in 2010 exhibited irregular consumer behavior thereafter. This pattern was particularly evident among those with chronic disease whose healthcare expenditures did not stabilize during the study period compared with the rest of the study population. Among people who did not

seek medical care in 2010, variation in average dental care expenditure was 91% in people with chronic disease versus 42% for those without chronic disease. Lack of medical care during the first year of the study was also associated with greater expenditure-delay in people with chronic disease (77%) compared with 15% in people without chronic disease. **CONCLUSION:** The lack of medical or dental care in 2010 for people with chronic disease did not lead to an increase in medical and dental consumption in the following years. The catch-up delay was longer than four years. This highlights a problem of monitoring and identifies a marginalized population within the healthcare system.

► **The Medical Care Costs of Obesity and Severe Obesity in Youth: An Instrumental Variables Approach**

BIENER A. I., CAWLEY J. ET MEYERHOEFER C.
2020

Health Economics 29(5): 624-639.
<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4007>

Abstract This paper is the first to use the method of instrumental variables to estimate the impact of obesity and severe obesity in youth on U.S. medical care costs. We examine data from the Medical Expenditure Panel Survey for 2001–2015 and instrument for child BMI using the BMI of the child’s biological mother. Instrumental variables estimates indicate that obesity in youth raises annual medical care costs by \$907 (in 2015 dollars) or 92%, which is considerably higher than previous estimates of the association of youth obesity with medical costs. We find that obesity in youth significantly raises costs in all major categories of medical care: outpatient doctor visits, inpatient hospital stays, and prescription drugs. The costs of youth obesity are borne almost entirely by third-party payers, which is consistent with substantial externalities of youth obesity, which in turn represents an economic rationale for government intervention.

► **L'impact de la protection sociale et de son financement sur la distribution territoriale des revenus**

CAUSSAT L.

2019

Regards 56(2): 23-40.

<https://www.cairn.info/revue-regards-2019-2-page-23.htm>

Les dispositifs de protection sociale ont pour vocation de soutenir le revenu de personnes ou familles qui sont affectées par certains risques (vieillesse, invalidité, accidents du travail, chômage, maladie...) ou par certaines situations sociales (charges d'éducation des enfants, coût élevé du logement locatif, handicap, pauvreté ou précarité...). Ils ont également pour caractéristique saillante d'être financés au moyen de ressources essentiellement affectées et dont les assiettes se composent pour une part décisive des revenus d'activité, sous l'effet du poids important des cotisations sociales et de la contribution sociale généralisée (CSG). Par conséquent, en sus des transferts de revenus qu'elle induit entre les personnes préservées des risques et des situations précédentes et celles qui sont affectées par eux (« redistribution horizontale »), et en complément de la contribution qu'elle réalise à la réduction des inégalités de revenu du fait de la distribution des prestations et des prélèvements sociaux selon les caractéristiques socio-économiques des allocataires et des cotisants (« redistribution verticale »), la protection sociale opère une réallocation des revenus entre les territoires. En effet, elle verse des prestations sociales au lieu de résidence des bénéficiaires, et elle prélève les cotisations et contributions sociales au lieu d'emploi des cotisants : or il n'y a aucune raison que les lieux géographiques coïncident, et au contraire on observe une polarisation croissante des emplois dans un nombre limité de lieux concentrant la main-d'œuvre, des infrastructures et des centres de formation et de recherche.

► **Prospective Study on Chronic Diseases and Healthcare Costs for the South of France Region, 2016-2028**

DAVIN B., CORTAREDONA S., GUAGLIARDO V., *et al.*

2019

European Journal of Public Health 29(Supplement_4).

<https://doi.org/10.1093/eurpub/ckz185.029>

In France, Health Regional Agencies (HRA) have to elaborate a Public Health Plan for the 5 coming

years. For estimating future population health needs and associated costs to adapt the health services on the regional territory, the HRA in southeastern France requested a prospective analysis, based on demographic and epidemiologic scenarios about major chronic diseases, to evaluate future trends. Six chronic diseases were selected: diabetes (1 or 2), cardiovascular diseases, respiratory diseases, cancers, neurological diseases and dementia. We used medico-administrative data from the National health insurance fund, and adapted algorithms to identify people with these diseases. We calculated prevalence rates according to gender and age and used two alternative scenarios (a constant one, and a trend-based one) to estimate the number of people with chronic diseases in 2023 and 2028, starting in 2016. We also estimated future healthcare costs according a constant and a trend-based scenario. The algorithms detect reasonable rates of disease compared to official rates available for 2016. Due to demographic (ageing) and/or epidemiologic trends, the number of people with chronic diseases will highly increase during the next ten years in the South of France region. For instance, between 2016 and 2028, there will be from 15% to 20% more people with diabetes. Associated costs will also be higher (+33% between 2016 and 2028), especially those granted to nursing care (+40%). Burden of diseases and health expenditures are going to increase in the future. Projections are needed to help policymakers anticipating the required health services adaptation. Medico-administrative database are an invaluable source of data to do so. The next step of this project will consist in estimating those trends for smaller geographical areas. Data of the French Health Insurance fund can be used to predict future prevalence of chronic diseases and healthcare costs. South of France will face a main increase of people with chronic diseases.

► **Paiement à l'acte et régulation du système de soins : une analyse de longue période (1803-2013)**

DOMIN J.-P.

2020

Revue Française de Socio-Économie Hors-série(en lutte): 241-260.

<https://www.cairn.info/revue-francaise-de-socio-economie-2020-en-lutte-page-241.htm>

Ce travail propose une lecture rétrospective du système de santé et notamment de l'évolution du mode de rémunération. La profession s'est constituée autour

de certains principes gravés dans le marbre en 1927 dans la Charte médicale. Paradoxalement, ces principes issus de la guérilla menée par les médecins contre les assurances sociales dans les années 1930 vont accompagner le développement de la socialisation de la médecine. Aujourd'hui, la socialisation recule progressivement et les pouvoirs publics tentent de mettre en place de nouvelles formes de rémunération qui vont à l'encontre de certains principes de la Charte (notamment la liberté de thérapeutique). Les praticiens seraient ainsi prêts à abandonner certains principes pour maintenir leur niveau de revenu.

► **Fair Allocation of Scarce Medical Resources in the Time of Covid-19**

EMANUEL E. J., PERSAD G., UPSHUR R., *et al.*
2020

New England Journal of Medicine 382 :2049-2055
<https://www.nejm.org/doi/full/10.1056/NEJMs2005114>

Covid-19 is officially a pandemic. It is a novel infection with serious clinical manifestations, including death, and it has reached at least 124 countries and territories. Although the ultimate course and impact of Covid-19 are uncertain, it is not merely possible but likely that the disease will produce enough severe illness to overwhelm health care infrastructure. Emerging viral pandemics “can place extraordinary and sustained demands on public health and health systems and on providers of essential community services. Such demands will create the need to ration medical equipment and interventions.

► **Financing the Infrastructure of Accountable Communities for Health Is Key to Long-Term Sustainability**

HUGHES D. L. ET MANN C.
2020

Health Affairs 39(4): 670-678.
<https://doi.org/10.1377/hlthaff.2019.01581>

Accountable Communities for Health (ACHs) are collaborative partnerships spanning health, public health, and social services that seek to improve the health of individuals and communities by addressing social determinants of health such as housing, food security, employment, and transportation. ACHs require funding not only for programs and services but also for core infrastructure functions. We conducted a legal and policy review to identify potential funding streams

specifically for ACH infrastructure activities. We found multiple and credible options at the federal and state levels and in the public health, health insurance, and philanthropic and private sectors. Such options could support ACH infrastructure directly or through reimbursement for administrative costs associated with programmatic work. Yet we also found that there is no dedicated or explicit source of funding for these critical functions. For sustainable and long-term ACH support, policy makers and program administrators should clarify and define ACH infrastructure functions and, where appropriate, explicitly recognize supporting these functions as an allowable use of funds and facilitate their coordination across program funding streams.

► **National Health Expenditure Projections, 2019–28: Expected Rebound in Prices Drives Rising Spending Growth**

KEEHAN S. P., CUCKLER G. A., POISAL J. A., *et al.*
2020

Health Affairs 39(4): 704-714.
<https://doi.org/10.1377/hlthaff.2020.00094>

National health expenditures are projected to grow at an average annual rate of 5.4 percent for 2019-28 and to represent 19.7 percent of gross domestic product by the end of the period. Price growth for medical goods and services is projected to accelerate, averaging 2.4 percent per year for 2019-28, which partly reflects faster expected growth in health-sector wages. Among all major payers, Medicare is expected to experience the fastest spending growth (7.6 percent per year), largely as a result of having the highest projected enrollment growth. The insured share of the population is expected to fall from 90.6 percent in 2018 to 89.4 percent by 2028.

► **Containing or Shifting? Health Expenditure Decomposition for the Aging Dutch Population After a Major Reform**

KRABBE-ALKEMADE Y., MAKAI P., SHESTALOVA V., *et al.*
2020

Health Policy 124(3): 268-274.
<http://www.sciencedirect.com/science/article/pii/S0168851020300014>

Aging populations add to pressure on health budgets, notably in long-term care (LTC). This development is particularly significant in the Netherlands, because

of its relatively large, publicly financed LTC sector. The recent LTC reform aimed to substitute institutional care with aging-in-place, and thus reduce LTC expenditure. We investigate whether the reform actually went beyond shifting institutional care expenditure to other healthcare domains. We use individual health insurance and social care claims for the entire Dutch population aged 65 years and above over the period 2012–2016 to gain an insight into total healthcare utilization by individuals. Based on this information, individuals are allocated into subgroups – care steps – according to their dependence on assistance and nursing care. We analyze the changes within and between these steps over time in order to demonstrate the substitution of care provision after the reform was implemented. The results show that as the population share in institutional care decreased, the average health expenditure on the individuals receiving this care increased. By contrast, the average expenditure in the district nursing care steps fell, partly due to reallocation of individuals between care steps. Due to the reallocation from the institutional care to aging-in-place, the reform has contributed to a slowdown in the growth of total health expenditure on those aged 65 years and over, at least in the short term.

► **Additional Reimbursement for Outpatient Physicians Treating Nursing Home Residents Reduces Avoidable Hospital Admissions: Results of a Reimbursement Change in Germany**

KÜMPEL C. ET SCHNEIDER U.

2020

Health Policy 124(4) : 470-477

<https://doi.org/10.1016/j.healthpol.2020.02.009>

Potentially avoidable hospitalizations of nursing home residents are costly and may even be harmful for the residents concerned. This study analyzes whether the introduction, in Germany in 2016, of an additional reimbursement for outpatient care physicians treating nursing home residents has led to a reduction in hospital admissions. This analysis exploits the introduction of the additional reimbursement in a difference-in-difference approach, using recipients of professional home care as a control. The analysis is based on claims data from the largest German sickness fund, which provide complete information on health care and long-term care utilization for each insured person. Our analysis highlights a 5-percent reduction in overall hospital stays and an 8-percent reduction

in ambulatory care-sensitive admissions as a result of the additional reimbursements. However, we found no effect for short-term hospital admissions or for admissions at night or at the weekend. We conclude that the overall health care utilization for nursing home patients seems to have improved due to an increased presence of physicians in nursing homes during daytime working hours. Thus, an additional reimbursement for outpatient care physicians seems to be an effective tool to reduce potentially avoidable hospital admissions in the nursing home sector. However, it does not appear to improve emergency care utilization, especially out-of-hour.

► **Article 51 : expérimenter pour innover mais aussi innover dans la façon d'expérimenter**

LEMAIRE N., POLTON D. ET TAJAHMADY A.

2020

Les Tribunes de la santé 63(1): 35-42.

<https://www.cairn.info/revue-les-tribunes-de-la-sante-2020-1-page-35.htm>

Il y a déjà eu, dans le passé, de nombreux dispositifs visant à expérimenter de nouvelles organisations ou de nouveaux modèles de financement dans le système de santé : réseaux de soins, nouveaux modes de rémunération des maisons de santé, télé médecine, coordination du parcours de santé des personnes âgées en risque de perte d'autonomie (PAERPA)... pour n'en citer que quelques-uns. Mais l'article 51 de la loi de financement de la Sécurité sociale pour 2018 diffère des expériences précédentes en ce sens qu'il porte une nouvelle approche dans la conduite des expérimentations, pour en faire réellement des leviers de changement à grande échelle des organisations et des pratiques. Les projets qui sont aujourd'hui mis en œuvre au titre de ce dispositif, ou qui vont l'être dans les prochains mois, témoignent de ce changement de conception et de posture ; l'avenir dira si le pari de la transformation du système de santé dont ils sont porteurs est tenu.

► **Cost-Effectiveness of Dementia Care Mapping in Care-Home Settings: Evaluation of a Randomised Controlled Trial**

MEADS D. M., MARTIN A., GRIFFITHS A., *et al.*

2020

Applied Health Economics and Health Policy 18(2): 237-247.

<https://doi.org/10.1007/s40258-019-00531-1>

Behaviours such as agitation impact on the quality of life of care-home residents with dementia and increase healthcare use. Interventions to prevent these behaviours have little evidence supporting their effectiveness or cost-effectiveness. We conducted an economic evaluation alongside a trial assessing Dementia Care Mapping™ (DCM) versus usual care for reducing agitation, and highlight methodological challenges of conducting evaluations in this population and setting.

► **The Distributive Fairness of Out-Of-Pocket Healthcare Expenditure in the Russian Federation**

PAUL P.

2020

International Journal of Health Economics and Management 20(1): 13-40.

<https://doi.org/10.1007/s10754-019-09268-9>

This article examines the effects of socioeconomic position and urban–rural settlement on the distribution of out-of-pocket expenditure (OPE) for health in the Russian Federation. Data comes from 2005 to 2016 waves of the Russian Longitudinal Monitoring Survey. Concentration index reflects changes in the distribution of OPE between the worse-off and the better-off Russians over a 12-year period. Finally, unconditional quantile regression—a recent influence function approach estimates differential impacts of covariates along the distribution of OPE. OPE is concentrated amongst the better-off Russians in 2016. Urban settlements contribute to top end OPE distribution for the richest and town settlements, at the median for the richest and the poorest. Our model for the analysis is unique in the context of study population, as it marginalises the effect over the distributions of other covariates used in the model.

► **Impact of Payment Model on the Behaviour of Specialist Physicians: A Systematic Review**

QUINN A. E., TRACHTENBERG A. J., MCBRIEN K. A., *et al.*

2020

Health Policy : 124(4) : 345-358

<https://doi.org/10.1016/j.healthpol.2020.02.007>

Physician payment models are perceived to be an important strategy for improving health, access, quality, and the value of health care. Evidence is predominantly from primary care, and little is known regarding whether specialists respond similarly. We conducted a systematic review to synthesize evidence on the impact of specialist physician payment models across the domains of health care quality; clinical outcomes; utilization, access, and costs; and patient and physician satisfaction. We searched Medline, Embase, and six other databases from their inception through October 2018. Eligible articles addressed specialist physicians, payment models, outcomes of interest, and used an experimental or quasi-experimental design.

► **Health Expenditure and Gross Domestic Product: Causality Analysis by Income Level**

RANA R. H., ALAM K. ET GOW J.

2020

International Journal of Health Economics and Management 20(1): 55-77.

<https://doi.org/10.1007/s10754-019-09270-1>

The empirical findings on the relationship between gross domestic product (GDP) and health expenditure are diverse. The influence of income levels on this causal relationship is unclear. This study examines if the direction of causality and income elasticity of health expenditure varies with income level. It uses the 1995–2014 panel data of 161 countries divided into four income groups. Unit root, cointegration and causality tests were employed to examine the relationship between GDP and health expenditure. Impulse-response functions and forecast-error variance decomposition tests were conducted to measure the responsiveness of health expenditure to changes in GDP. Finally, the common correlated effects mean group method was used to examine the income elasticity of health expenditure. Findings show that no long-term cointegration exists, and the growth in health expenditure and GDP across income levels has

a different causal relationship when cross-sectional dependence in the panel is accounted for. About 43% of the variation in global health expenditure growth can be explained by economic growth. Income shocks affect health expenditure of high-income countries more than lower-income countries. Lastly, the income elasticity of health expenditure is less than one for all income levels. Therefore, healthcare is a necessity. In comparison with markets, governments have greater obligation to provide essential health care services. Such results have noticeable policy implications, especially for low-income countries where GDP growth does not cause increased health expenditure.

► **Déterminants des dépenses de santé post-phase aiguë de l'accident vasculaire cérébral en France**

SIKA-KOSSI D. ET BRICARD D.

2020

Revue d'Épidémiologie et de Santé Publique 68: S34.

<https://doi.org/10.1016/j.respe.2020.01.075>

En France, 75 % des victimes d'accident vasculaire cérébral (AVC) gardent des séquelles importantes nécessitant des soins de longue durée dont le montant a été estimé à 2,4 milliards d'euros en 2013. Les objectifs de cette étude sont d'estimer les dépenses de soins post-AVC et d'identifier leurs déterminants. Méthodes Un modèle de panel « poolé » des dépenses de soins par trimestre sur les 12 mois suivant la sortie de l'hospitalisation pour AVC est construit. La population étudiée correspond à un échantillon représentatif des victimes d'un primo-AVC survenu en 2012. Les dépenses, comprenant les dépenses ambulatoires et les dépenses en soins de suite et de réadaptation (SSR), sur 12 mois avant et 12 mois après AVC, sont extraites du Système national des données de santé (SNDS). Deux modèles expliquant la survenue du décès, d'une part, et d'une réhospitalisation, d'autre part, sont réalisés pour en connaître les déterminants. Résultats L'échantillon comprend 6452 patients dont 80 % avec AVC ischémique, 52 % d'hommes, âge moyen 71 ans. La dépense de soins post-AVC, tout motif confondu (hors dépenses de réhospitalisation), est estimée à 10 417 € en moyenne la première année, dont 4381 € (42 %) en soins ambulatoires et 6036 € (58 %) en SSR. Elle dépend du parcours-type post-MCO et augmente avec l'intensité de la rééducation. Elle est plus élevée chez les patients pris en charge en unité neurovasculaire (UNV). Le passage en UNV favorise la réduction des réhospitalisations et des décès respectivement de

2 % et 0,5 %. Nos résultats mettent en évidence une forte hétérogénéité des dépenses selon le type de parcours de rééducation. Pour les patients les moins graves, le niveau de dépense revient plus rapidement au niveau initial. Le passage en UNV est associé à une dépense plus élevée en rééducation en SSR au premier trimestre mais permet de diminuer les décès et les réhospitalisations dont l'impact sur les dépenses pourra être valorisé pour compléter les analyses.

► **Do Payor-Based Outreach Programs Reduce Medical Cost And Utilization?**

UKERT B., DAVID G., SMITH-MCLALLEN A., *et al.*

2020

Health Economics 29(6) : 671-682

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4010>

There is growing interest in using predictive analytics to drive interventions that reduce avoidable health-care utilization. This study evaluates the impact of such an intervention utilizing claims from 2013 to 2017 for high-risk Medicare Advantage patients with congestive heart failure. A predictive algorithm using clinical and nonclinical information produced a risk score ranking for health plan members in 10 separate waves between July 2013 and May 2015. Each wave was followed by an outreach intervention. The varying capacity for outreach across waves created a set of arbitrary intervention treatment cutoff points, separating treated and untreated members with very similar predicted risk scores. We estimate a difference-in-differences model to identify the effects of the intervention program among patients with a high score on care utilization. We find that enrollment in the intervention decreased the probability and number of hospitalizations (by 43% and 50%, respectively) and emergency room visits (10% and 14%, respectively), reduced the time until a primary care visit (8.2 days), and reduced total medical cost by \$716 per month in the first 6 months following outreach.

► **Mapping Variability in Allocation of Long-Term Care Funds Across Payer Agencies in OECD Countries**

WAITZBERG R., SCHMIDT A. E., BLÜMEL M., *et al.*

2020

Health Policy 124 (5): 491-500

<https://doi.org/10.1016/j.healthpol.2020.02.013>

Long-term care (LTC) is organized in a fragmented manner. Payer agencies (PA) receive LTC funds from the agency collecting funds, and commission services. Yet, distributional equity (DE) across PAs, a precondition to geographical equity of access to LTC, has

received limited attention. We conceptualize that LTC systems promote DE when they are designed to set eligibility criteria nationally (vs. locally); and to distribute funds among PAs based on needs-formula (vs. past-budgets or government decisions).

État de santé

Health Status

► **Mortality Convergence in the Enlarged European Union: A Systematic Literature Review**

HRZIC R., VOGT T., JANSSEN F., *et al.*

2020

European Journal of Public Health : Ahead of pub.

<https://doi.org/10.1093/eurpub/ckaa038>

The high mortality rates in the European Union (EU) Member States that acceded in 2004 sparked political interest in mortality convergence. Whether mortality is converging in the EU remains unclear. We reviewed the literature on mortality convergence in the post-2004 EU territory as a whole. We also explored whether the study designs influenced the results and whether any determinants of mortality convergence had been empirically examined. A systematic literature review was performed. Our search included scientific databases and the websites of international governmental institutions and European demographic research institutes. We uncovered 94 unique records and included seven studies that reported on 36 analyses. There was marked methodological heterogeneity, including in the convergence measures (beta and sigma convergence). All of the beta convergence analyses found narrowing mortality differentials, whereas most of the sigma convergence analyses found widening mortality differentials. The results are robust to the units of analysis and mortality and dispersion measures. Our results also suggest that there is a lack of evidence on the determinants of mortality convergence in the EU. There is general agreement that the EU regions and the Member States with high initial mortality rates improved the fastest, but this trend did not lead to overall mortality convergence in the EU. The harmonization of mortality convergence measures and research into determinants of mortality convergence are needed to support future EU cohesion policy.

Policy-makers should consider supporting areas that have moderate but stagnant mortality rates, in addition to those with high mortality rates.

► **Assessing the Quality of Cause of Death Data in Six High-Income Countries: Australia, Canada, Denmark, Germany, Japan and Switzerland**

MIKKELSEN L., IBURG K. M., ADAIR T., *et al.*

2020

International Journal of Public Health 65(1): 17-28.

<https://doi.org/10.1007/s00038-019-01325-x>

This paper assesses the policy utility of national cause of death (COD) data of six high-income countries with highly developed health information systems.

► **European Union State of Health from 1990 to 2017: Time Trends and Its Enlargements' Effects**

SANTOS J. V., LOBO M., NEIVA R. M., *et al.*

2020

International Journal of Public Health 65(2): 175-186.

<https://doi.org/10.1007/s00038-020-01335-0>

We aimed to study health status' time trends in the European Union (EU) during 1990–2017 and its enlargements' impact.

Geography of Health

► Territoires et innovations dans les services de santé, une illustration à partir des expérimentations de l'article 51

BOUSQUET F.
2019

Regards 56(2): 117-137.

<https://www.cairn.info/revue-regards-2019-2-page-117.htm>

L'article 51 de la loi de financement de la sécurité sociale pour 2018 a introduit un dispositif permettant d'expérimenter de nouvelles organisations en santé; elles reposent sur des modes de financement inédits, la loi ouvrant la possibilité de déroger à un certain nombre de dispositions. Ces organisations doivent contribuer à améliorer le parcours des patients, l'efficacité du système de santé, l'accès aux soins ou encore la pertinence de la prescription des produits de santé. L'originalité du dispositif tient au fait que l'initiative du projet expérimental échoit, principalement, aux acteurs non institutionnels (professionnels de santé, associations de patients, industriels, start-up). Ainsi que l'a souligné la ministre des Solidarités et de la Santé lors du lancement du dispositif, aujourd'hui communément appelé « article 51 », celui-ci doit « permettre d'amorcer une démarche de transformation, en faisant « sauter les verrous » pour que la coordination des parcours de santé et les coopérations interprofessionnelles puissent devenir une réalité au quotidien dans les territoires. » À la fin de l'année 2019, une quarantaine de projets expérimentaux étaient autorisés et une dizaine avait commencé à inclure des patients, les autres travaillant à la mise en œuvre opérationnelle du dispositif de prise en charge.

► 10 ans d'ARS : quel bilan d'une forme de déconcentration régionale ?

EVIN C.
2019

Regards 56(2): 105-116.

<https://www.cairn.info/revue-regards-2019-2-page-105.htm>

La qualité et la pérennité de notre système de santé sont au cœur des préoccupations des Français. Ce système apporte-t-il aujourd'hui une réponse satisfaisante à ces attentes? Les comparaisons internationales montrent que nos indicateurs de santé ne

sont pas si favorables, alors même que les dépenses de santé sont parmi les plus importantes du monde. Des progrès importants sont donc à accomplir pour améliorer la santé publique, tout en maîtrisant mieux les dépenses. À l'heure où l'échelon régional s'affirme comme le niveau pertinent de pilotage du système de santé, un pilotage territorial unifié et responsabilisé constitue un levier majeur pour relever ce défi. Ce pilotage, actuellement réparti entre les services de l'État, de l'Assurance maladie et les agences régionales d'hospitalisations (ARH), n'est en effet pas satisfaisant. Enchevêtrement des compétences, éclatement institutionnel, cloisonnement des acteurs (notamment entre le secteur ambulatoire et le secteur hospitalier) : le diagnostic sur le pilotage actuel met en évidence la nécessité d'un pilotage unifié du système territorial de santé. L'excessive centralisation du système de santé, la trop faible adaptation des politiques de santé aux spécificités territoriales et les limites des actions menées en matière de dépenses plaident par ailleurs pour un pilotage territorial responsabilisé, tant en matière de politiques de santé que de maîtrise des dépenses. Un pilotage unifié et responsabilisé du système territorial de santé, c'est la définition des agences régionales de santé (ARS).

► Retour d'expérience : la Communauté professionnelle territoriale de santé (CPTS) du 13^e arrondissement de Paris

FALCOFF H., GASSE A.-L., BERRAHO-BUNDHOO Y.,
et al.
2019

Regards 56(2): 93-104.

<https://www.cairn.info/revue-regards-2019-2-page-93.htm>

Depuis 20 ans, les soins primaires, et tout particulièrement la médecine générale ont connu de profonds changements : informatisation, filière universitaire de médecine générale, parcours de soins coordonnés avec incitation des patients à déclarer un médecin traitant, rétribution sur objectifs de santé publique (rétribution individuelle des médecins), apparition des premières maisons de santé pluriprofessionnelles (MSP). En 2010, le programme « Expérimentation de Nouveaux Modes de Rémunération (ENMR) » a ouvert la possibilité aux professionnels de soins primaires

de bénéficier de quelques moyens pour développer des innovations organisationnelles. À l'initiative d'un cabinet de médecine générale du 13^e arrondissement de Paris, une trentaine de professionnels de santé se regroupent autour d'un « Acte de bonne foi », puis créent l'Association pour le Développement du Pôle de Santé Paris 13^e Sud-Est, rapidement désignée « Pôle santé Paris 13 ». L'association dépose auprès de l'ARS Île-de-France une demande de participation à l'ENMR. Une convention est signée avec l'ARS Île-de-France et la Cnam de Paris en mars 2011.

► CPTS et territoire

LEICHER C.

2019

Regards 56(2): 81-92.

<https://www.cairn.info/revue-regards-2019-2-page-81.htm>

Avec la création des communautés professionnelles territoriales de santé (CPTS), se met en place une organisation territoriale de proximité du secteur ambulatoire. Généralisant le principe de la coordination pluri professionnelle autour des besoins de santé des patients, permettant de répondre aux services attendus par la population, organisée autour des équipes de soins primaires, sur un territoire qu'elle définit, la CPTS est un outil qui crée un interlocuteur visible pour les autres acteurs, et qui en rééquilibrant l'organisation du système de santé, permettra à terme d'aider le secteur de l'hospitalisation à surmonter la crise liée à son utilisation inadéquate. Les Communautés Professionnelles territoriales de santé ont été créées par la loi n° 2016-41 du 26 janvier 2016 de modernisation de notre système de santé. Elles sont composées de professionnels de santé, regroupés éventuellement en équipe de soins primaires, d'acteurs de premier ou de second recours, d'acteurs médico-sociaux et sociaux, concourant à la réalisation des objectifs du projet régional de santé. Ces membres déterminent dans un projet de santé notamment le territoire de leur intervention.

► Les CPTS : de l'ambition politique à la réalité territoriale

RIST S. ET ROGEZ R.

2020

Les Tribunes de la santé 63(1): 51-55.

<https://www.cairn.info/revue-les-tribunes-de-la-sante-2020-1-page-51.htm>

Les communautés professionnelles territoriales de santé (CPTS) ont été créées par la loi de modernisation de notre système de santé du 26 janvier 2016 pour participer à l'amélioration de l'accès aux soins. Pivots de la stratégie de réorganisation du système de santé présentée dans le cadre du plan « Ma santé 2022 », ces CPTS devraient être au nombre de 1 000 en 2022. Les CPTS ont vocation à devenir un outil indispensable à la réorganisation du soin autour du patient, incitant à la coopération interprofessionnelle, au dialogue et laissant place à l'initiative de terrain. Elles sont le reflet d'un changement de paradigme dans la construction de la politique de santé et dans l'organisation des professionnels. Pour autant, l'ambition de ce vaste déploiement de 1 000 CPTS se heurte à certains obstacles.

► Impact of Nonphysician Providers on Spatial Accessibility to Primary Care in Iowa

YOUNG S. G., GRUCA T. S. ET NELSON G. C.

2020

Health Services Research : 55(3) :476-485

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13280>

This aim of this paper is to assess the impact of non-physician providers on measures of spatial access to primary care in Iowa, a state where physician assistants and advanced practice registered nurses are considered primary care providers. Data Sources 2017 Iowa Health Professions Inventory (Carver College of Medicine), and minor civil division (MCD) level population data for Iowa from the American Community Survey. Study Design :We used a constrained optimization model to probabilistically allocate patient populations to nearby (within a 30-minute drive) primary care providers. We compared the results (across 10 000 scenarios) using only primary care physicians with those including nonphysician providers (NPPs). We analyze results by rurality and compare findings with current health professional shortage areas. Data Collection/Extraction Methods :Physicians and NPPs practicing in primary care in 2017 were extracted from the Iowa Health Professions Inventory. Principal Findings Considering only primary care physicians, the average unallocated population for primary care was 222 109 (7 percent of Iowa's population). Most of the unallocated population (86 percent) was in rural areas with low population density (< 50/square mile). The addition of NPPs to the primary care workforce reduced unallo-

cated population by 65 percent to 78 252 (2.5 percent of Iowa's population). Despite the majority of NPPs being located in urban areas, most of the improvement in spatial accessibility (78 percent) is associated

with sparsely populated rural areas. Conclusions :The inclusion of nonphysician providers greatly reduces but does not eliminate all areas of inadequate spatial access to primary care.

Handicap

Disability

► **Pathologies et recours aux soins des personnes ayant un handicap repérable dans le Système national des données de santé**

VERBOUX D., COLINOT N., THOMAS M., *et al.*
2020

Revue d'Épidémiologie et de Santé Publique 68: S7-S8.

<http://www.sciencedirect.com/science/article/pii/S0398762020300225>

Des études, basées sur des données déclaratives, ont décrit le difficile accès aux soins des personnes handicapées. Nous avons décrit les pathologies et les recours aux soins des bénéficiaires d'une allocation adulte handicapée (AAH) sans activité professionnelle ou d'une pension d'invalidité (PI) dans le SNDS. Méthodes Les bénéficiaires du régime général (y compris sections locales mutualistes) âgés de 20 à 64 ans en 2016 ont été inclus. Les prévalences de pathologies (identifiées à partir de la Cartographie des pathologies) et les taux de recours aux soins (professionnels de santé, médicaments, hospitalisations) des bénéficiaires d'une AAH sans activité professionnelle (sans PI) ou d'une PI ont été décrits et comparés à la population « générale » (sans AAH ni PI) après standardisation sur l'âge et le sexe de cette population. Résultats Parmi 32,5 millions de personnes incluses, 2,3 % bénéficiaient de l'AAH (âge moyen 46 ans, 48 % de femmes, CMU-c 17 %) et 2,3 % d'une PI (âge moyen 53 ans, 55 % de femmes, CMU-c 5 %). Toutes les pathologies étaient plus fréquentes chez les bénéficiaires d'une AAH ou PI que dans la population générale, notamment les pathologies psychiatriques (AAH : 44 %, PI : 31 %, population générale : 3 %) et neurologiques (AAH : 14 %, PI : 13 %, population générale : 0,8 %), mais également les cancers, le diabète et les maladies cardiovasculaires. Les bénéficiaires d'une AAH ou PI avaient des taux de recours aux soins supérieurs à ceux de la popula-

tion générale, à l'exception des taux de recours aux spécialistes et aux soins dentaires, inférieurs chez les bénéficiaires de l'AAH (62 % et 36 % respectivement) par rapport à ceux de la population générale (68 % et 45 % respectivement) et aux bénéficiaires de PI (76 % et 46 % respectivement). Discussion/Conclusion Ces résultats suggèrent des difficultés d'accès aux soins dentaires et de spécialistes chez les bénéficiaires de l'AAH sans activité professionnelle (précaires), alors que les pathologies sont plus fréquentes dans cette population. La précarité de ces personnes n'explique probablement qu'en partie ces résultats.

Hospital**► Access To Palliative Care During A Terminal Hospitalization**SEOW H., QURESHI D., ISENBERG S.R.
2020**Journal of Palliative Medicine : Ahead of pub.**<https://www.liebertpub.com/doi/abs/10.1089/jpm.2019.0416>

Background: Research shows that access to palliative care can help patients avoid dying in hospital. However, access to palliative care services during the terminal hospitalization, specifically, has not been well studied. Objective: To determine whether access to palliative care varied by disease trajectory among terminal hospitalizations. Design, Setting, Subjects: We conducted a population-based retrospective cohort study of decedents who died in hospital in Ontario, Canada between 2012 and 2015 by using linked administrative databases. Measurements: Using hospital and physician billing codes, we classified access to palliative care in three mutually exclusive groups of patients with terminal hospitalization: (1) main diagnosis for admission was palliative care; (2) main diagnosis was not palliative care, but the patient received palliative care specialist consultation; and (3) the patient did not receive any specialist palliative care. We conducted a logistic regression on odds of never receiving palliative care. Results: We identified 140,475 decedents who died in an inpatient hospital unit, which represents 42% of deaths. Among inpatient hospital deaths, 23% (n = 32,168) had palliative care listed as the main diagnosis for admission, 41% (n = 58,210) received specialist palliative care consultation, and 36% (n = 50,097) never had access to specialist palliative care. In our regression, dying of organ failure or frailty compared with cancer increased the odds of never receiving palliative care by 4.07 (95% confidence interval [CI]: 3.95–4.20) and 4.51 (95% CI: 4.35–4.68) times, respectively. Conclusions: A third of hospital deaths had no palliative care involvement. Access to specialist palliative care is particularly lower for noncancer decedents. Inpatient units play an important role in providing end-of-life care.

► La Réhabilitation améliorée après chirurgie (RAAC) : analyse de l'impact au CHRU de Tours, FranceAESCH B., CASTEL S., CAPSEC J., *et al.*
2020**Revue d'Épidémiologie et de Santé Publique 68: S20.**<https://doi.org/10.1016/j.respe.2020.01.043>

La réhabilitation améliorée après chirurgie (RAAC) est une démarche d'amélioration des pratiques. Pour la campagne tarifaire 2019, une mesure de soutien à l'activité RAAC a été mise en place. Afin d'estimer les recettes potentielles de cette mesure, le DIM du CHRU de Tours a souhaité effectuer une simulation financière sur les séjours éligibles à la RAAC. Méthode L'analyse rétrospective des séjours groupant dans les 17 racines de GHM concernées sélectionnés dans le logiciel PMSI (CORA) a été menée sur deux mois en 2019. Ont été exclus les séjours dépassant la borne basse et ceux ne répondant pas aux critères de mode d'entrée-sortie RAAC. Les séjours ont été revus en qualité (éventuelle modification de DP et/ou ajout de DAS) pour rechercher des niveaux de sévérité indépendamment de leur durée. Résultats : Sur 396 séjours éligibles, 263 ont été retenus. Le gain spécifique à la variable RAAC sur la période était de 16 244 € (7547+ 8697). Parallèlement, l'analyse en qualité a généré un gain de 33 400 € (40 400–7000). Discussion Le codage des séjours était initialement pour deux-tiers des cas effectués par les cliniciens et pour un tiers par le DIM, expliquant les écarts de valorisation sur cet échantillon restreint. Le résultat financier spécifique à la RAAC est décevant au regard des dépenses induites par les moyens humains nécessaires au programme dans le respect des critères HAS. Les perspectives d'évolution en 2020 se limiteraient à une extension à d'autres GHM. Cependant l'organisation mise en place pour la RAAC s'avèrera utile lors du passage au financement à l'épisode de soins (expérimentations en cours). L'incitation financière liée à l'association RAAC- épisode de soins s'avèrera plus prometteuse.

► **Rapid Viral Diagnosis and Ambulatory Management of Suspected COVID-19 Cases Presenting at the Infectious Diseases Referral Hospital in Marseille, France, - January 31st to March 1st, 2020: A Respiratory Virus Snapshot**

AMRANE S., TISSOT-DUPONT H., DOUDIER B., *et al.*
2020

Travel Med Infect Dis : Ahead of pub.

BACKGROUND: Rapid virological diagnosis is needed to limit the length of isolation for suspected COVID-19 cases. METHOD: We managed the first 280 patients suspected to have COVID-19 through a rapid care circuit and virological diagnosis in our infectious disease reference hospital in Marseille, France. Rapid viral detection was performed on sputum and nasopharyngeal samples. RESULTS: Over our study period, no SARS-CoV-2 was detected. Results were obtained within approximately 3 h of the arrival of patient samples at the laboratory. Other viral infections were identified in 49% of the patients, with most common pathogens being influenza A and B viruses, rhinovirus, metapneumovirus and common coronaviruses, notably HKU1 and NL63. CONCLUSION: Early recognition of COVID-19 is critical to isolate confirmed cases and prevent further transmission. Early rule-out of COVID-19 allows public health containment measures to be adjusted by reducing the time spent in isolation.

► **Mesurer la qualité pour transformer l'hôpital ? Analyse sociotechnique d'une discrète quantification**

BERTILLOT H.
2020

Revue Française de Socio-Économie Hors-série(en lutte): 149-170.

<https://www.cairn.info/revue-francaise-de-socio-economie-2020-en-lutte-page-149.htm>

Depuis le début des années 2000, les pouvoirs publics français déploient des instruments d'évaluation de la qualité dans les établissements de santé. En procédant à la déconstruction sociotechnique des « indicateurs de qualité », cet article analyse une discrète entreprise de quantification. Mesurant des dimensions peu conflictuelles de la qualité, nourris de savoirs pluriels, équivoques dans leurs usages, les indicateurs de qualité sont suffisamment doux pour ne pas brusquer les professionnels, tout en étant suffisamment robustes pour instiller discipline et audibilité. Au nom de la

qualité, cette technologie de gouvernement est ainsi équipée pour rationaliser l'hôpital en douceur.

► **Adherence to Medical Follow-Up Recommendations Reduces Hospital Admissions: Evidence from Diabetic Patients in France**

BUSSIÈRE C., SIRVEN N., RAPP T., *et al.*
2020

Health Economics 29(4): 508-522.

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3999>

The aim of this study was to document the extent to which diabetic patients who adhered to required medical follow-ups in France experienced reduced hospital admissions over time. The main assumption was that enhanced monitoring and follow-up of diabetic patients in the primary care setting could be a substitute for hospital use. Using longitudinal claim data of diabetic patients between 2010 and 2015 from MGEN, a leading mutuelle insurance company in France, we estimated a dynamic logit model with lagged measures of the quality of adherence to eight medical follow-up recommendations. This model allowed us to disentangle follow-up care in hospitals from other forms of inpatient care that could occur simultaneously. We found that a higher adherence to medical guidance is associated with a lower probability of hospitalization and that the take-up of each of the eight recommendations may help reduce the rates of hospital admission. The reasons for the variation in patient adherence and implications for health policy are discussed.

► **Payments for Outpatient Joint Replacement Surgery: A Comparison of Hospital Outpatient Departments and Ambulatory Surgery Centers**

CAREY K. ET MORGAN J. R.
2020

Health Services Research 55(2): 218-223.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13262>

The aim of this study is to compare commercial insurance payments for outpatient total knee and hip replacement surgeries performed in hospital outpatient departments (HOPDs) and in ambulatory surgery centers (ASCs). Data Sources :A large national claims database that contains information on actual prices paid to providers over the period 2014-2017.

Data Collection We identified all patients receiving total knee replacement surgery and total hip replacement surgery in HOPDs and in ASCs for each of the 4 years. **Study Design:** For each year, we conducted descriptive and statistical patient-level analyses of the facility component of payments to HOPDs and to ASCs. **Principal Findings** For each procedure and for each year, ASC payments exceeded HOPD payments by a wide margin; however, the gap across settings declined over time. In 2014, knee replacement payments to HOPDs (n = 67) were \$6016 compared to \$23 244 in ASCs (n = 68). By 2017, payments to HOPDs (n = 223) had grown to \$10 060 compared to \$18 234 in ASCs (n = 602). Similarly, for hip replacements, HOPD payments (n = 43) rose from \$6980 in 2014 to \$11 139 in 2017 (n = 206) and in ASCs fell from \$28 485 in 2014 (n = 82) to \$18 595 in 2017 (n = 465). **Conclusions:** Results suggest that for total joint replacement, common perceptions of cost savings from transition of services from hospitals to ASCs may be misguided.

► **Care Continuity and Care Coordination: A Preliminary Examination of Their Effects on Hospitalization**

CHEN, C.-C. ET CHENG, S.-H.

Medical Care Research and Review 0(0): 1077558720903882.

<https://journals.sagepub.com/doi/abs/10.1177/1077558720903882>

Both care continuity and care coordination are important features of the health care system. However, little is known about the relationship between care continuity and care coordination, their effects on hospitalizations, and whether these effects vary across patients with various levels of comorbidity. This study employed a panel study design with a 3-year follow-up from 2007 to 2011 in Taiwan's universal health coverage system. Patients aged 18 years or older who were newly diagnosed with diabetes in 2007 were included in the study. We found that the correlation between care continuity and care coordination was low. Patients with higher levels of care continuity or care coordination were less likely to experience hospitalization for diabetes-related conditions. Furthermore, both care continuity and care coordination showed stronger effects for patients with higher comorbidity scores. Improving care continuity and coordination for patients with multiple chronic conditions is the right direction for policymakers.

► **Hospital Reforms in 11 Central and Eastern European Countries Between 2008 and 2019: A Comparative Analysis**

DUBAS-JAKÓBCZYK K., ALBREHT T., BEHMANE D., *et al.*

2020

Health Policy 124(4) : 368-379

<https://doi.org/10.1016/j.healthpol.2020.02.003>

This paper aims to: (1) provide a brief overview of hospital sector characteristics in 11 Central and Eastern European countries (Bulgaria, Czech Republic, Estonia, Croatia, Latvia, Lithuania, Hungary, Poland, Romania, Slovakia, Slovenia); (2) compare recent (2008 – 2019) hospital reforms in these countries; and (3) identify common trends, success factors and challenges for reforms. Methods applied involved five stages: (1) a theoretical framework of hospital sector reforms was developed; (2) basic quantitative data characterizing hospital sectors were compared; (3) a scoping review was performed to identify an initial list of reforms per country; (4) the list was sent to national researchers who described the top three reforms based on a standardized questionnaire; (5) received questionnaires were analysed and validated with available literature. Results indicate that the scope of conducted reforms is very broad. Yet, reforms related to hospital sector governance and changes in purchasing and payment systems are much more frequent than reforms concerning relations with other providers. Most governance reforms aimed at transforming hospital infrastructure, improving financial management and/or improving quality of care, while purchasing and payment reforms focused on limiting hospital activities and/or on incentivising a shift to ambulatory/day care. Three common challenges included the lack of a comprehensive approach; unclear outcomes; and political influence. Given similar reform areas across countries, there is considerable potential for shared learning.

► **Prevalence and Characteristics of Surprise Out-Of-Network Bills from Professionals in Ambulatory Surgery Centers**

DUFFY E. L., ADLER L., GINSBURG P. B., *et al.*

2020

Health Affairs : 39(5)

<https://doi.org/10.1377/hlthaff.2019.01138>

Patients treated at in-network facilities can involuntarily receive services from out-of-network providers, which may result in « surprise bills ». While several

studies report the surprise billing prevalence in emergency department and inpatient settings, none document the prevalence in ambulatory surgery centers (ASCs). The extent to which health plans pay a portion or all of out-of-network providers' bills in these situations is also unexplored. We analyzed 4.2 million ASC-based episodes of care in 2014-17, involving 3.3 million patients enrolled in UnitedHealth Group, Humana, and Aetna commercial plans. One in ten ASC episodes involved out-of-network ancillary providers at in-network ASC facilities. Insurers paid providers' full billed charges in 24 percent of the cases, leaving no balance to bill patients. After we accounted for insurer payment, we found that there were potential surprise bills in 8 percent of the episodes at in-network ASCs. The average balance per episode increased by 81 percent, from \$819 in 2014 to \$1,483 in 2017. Anesthesiologists (44 percent), certified registered nurse anesthetists (25 percent), and independent laboratories (10 percent) generated most potential surprise bills. There is a need for federal policy to expand protection from surprise bills to patients enrolled in all commercial insurance plans.

► **Why Are There Long Waits at English Emergency Departments?**

GAUGHAN J., KASTERIDIS P., MASON A., *et al.*
2020

The European Journal of Health Economics 21(2): 209-218.

<https://doi.org/10.1007/s10198-019-01121-7>

A core performance target for the English National Health Service (NHS) concerns waiting times at Emergency Departments (EDs), with the aim of minimising long waits. We investigate the drivers of long waits. We analyse weekly data for all major EDs in England from April 2011 to March 2016. A Poisson model with ED fixed effects is used to explore the impact on long (> 4 h) waits of variations in demand (population need and patient case-mix) and supply (emergency physicians, introduction of a Minor Injury Unit (MIU), inpatient bed occupancy, delayed discharges and long-term care). We assess overall ED waits and waits on a trolley (gurney) before admission. We also investigate variation in performance among EDs. The rate of long overall waits is higher in EDs serving older patients (4.2%), where a higher proportion of attendees leave without being treated (15.1%), in EDs with a higher death rate (3.3%) and in those located in hospitals

with greater bed occupancy (1.5%). These factors are also significantly associated with higher rates of long trolley waits. The introduction of a co-located MIU is significantly and positively associated with long overall waits, but not with trolley waits. There is substantial variation in waits among EDs that cannot be explained by observed demand and supply characteristics. The drivers of long waits are only partially understood but addressing them is likely to require a multi-faceted approach. EDs with high rates of unexplained long waits would repay further investigation to ascertain how they might improve.

► **Who Knows Best? Older People's and Practitioner Contributions to Understanding and Preventing Avoidable Hospital Admissions**

GLASBY J., LITTLECHILD R., LE MESURIER N., *et al.*
2019

Health Economics, Policy and Law 15(2): 225-246.

<https://DOI.Org/10.1017/S1744133118000518>

Whenever there are well-publicised pressures on acute care, there is a tendency for policy makers and the media to imply that a significant number of older people may be taking up hospital beds when they do not really need the services provided there. However, evidence to back up such claims is often lacking, and existing research tends to fail to engage meaningfully with older people themselves. In contrast, this research explores the emergency hospital admissions of older people in three English case study sites, drawing on the lived experience of older people and the practice wisdom of front-line staff to explore the appropriateness of each admission and scope for alternatives to hospital. Contrary to popular opinion, the study did not find evidence of large numbers of older people being admitted to hospital inappropriately. Indeed, some of the older people concerned delayed seeking help and only ended up at hospital as a very last resort, possibly due to concerns about being seen as a burden on scarce public resources. While older people and front-line staff identified a number of suggestions to improve services in future, there seemed few clear cut, easy answers to the longstanding dilemma of how best to reduce emergency admissions. Seeking to understand and potentially reduce emergency hospital admissions is complex, and it is important to consider the experiences and expertise of older people and front-line staff.

► **Interventions to Decrease Use in Prehospital and Emergency Care Settings Among Super-Utilizers in the United States: A Systematic Review**

IOVAN S., LANTZ P. M., ALLAN K., *et al.*

2020

Medical Care Research and Review 77(2): 99-111.

<https://journals.sagepub.com/doi/abs/10.1177/1077558719845722>

Interest in high users of acute care continues to grow as health care organizations look to deliver cost-effective and high-quality care to patients. Since “super-utilizers” of acute care are responsible for disproportionately high health care spending, many programs and interventions have been implemented to reduce medical care use and costs in this population. This article presents a systematic review of the peer-reviewed and grey literature on evaluations of interventions to decrease prehospital and emergency care use among U.S. super-utilizers. Forty-six distinct evaluations were included in the review. The most commonly evaluated intervention was case management. Although a number of interventions reported reductions in prehospital and emergency care utilization and costs, methodological and study design weaknesses—especially regression to the mean—were widespread and call into question reported positive findings. More high-quality research is needed to accurately assess the impact of interventions to reduce prehospital and emergency care use in the super-utilizer population.

► **The Impact of Hospital-Acquired Infections on the Patient-Level Reimbursement-Cost Relationship in a DRG-Based Hospital Payment System**

KAIER K., WOLKEWITZ M., HEHN P., *et al.*

2020

International Journal of Health Economics and Management 20(1): 1-11.

<https://doi.org/10.1007/s10754-019-09267-w>

Hospital-acquired infections (HAIs) are a common complication in inpatient care. We investigate the incentives to prevent HAIs under the German DRG-based reimbursement system. We analyze the relationship between resource use and reimbursements for HAI in 188,731 patient records from the University Medical Center Freiburg (2011–2014), comparing cases to appropriate non-HAI controls. Resource use is approximated using national standardized costing

system data. Reimbursements are the actual payments to hospitals under the G-DRG system. Timing of HAI exposure, cost-clustering within main diagnoses and risk-adjustment are considered. The reimbursement-cost difference of HAI patients is negative (approximately –€4000). While controls on average also have a negative reimbursement-cost difference (approximately –€2000), HAI significantly increase this difference after controlling for confounding and timing of infection (–1500, $p < 0.01$). HAIs caused by vancomycin-resistant Enterococci have the most unfavorable reimbursement-cost difference (–€10,800), significantly higher (–€9100, $p < 0.05$) than controls. Among infection types, pneumonia is associated with highest losses (–€8400 and –€5700 compared with controls, $p < 0.05$), while cost-reimbursement relationship for Clostridium difficile-associated diarrhea is comparatively balanced (–€3200 and –€500 compared to controls, $p = 0.198$). From the hospital administration’s perspective, it is not the additional costs of HAIs, but rather the cost-reimbursement relationship which guides decisions. Costs exceeding reimbursements for HAI may increase infection prevention and control efforts and can be used to show their cost-effectiveness from the hospital perspective.

► **Speeding up the Clinical Pathways by Accessing Emergency Departments**

LEVAGGI R., MONTEFIORI M. ET PERSICO L.

2020

The European Journal of Health Economics 21(1): 37-44.

<https://doi.org/10.1007/s10198-019-01107-5>

Inappropriate emergency admissions create overcrowding and may reduce the quality of emergency care. In Italy, overcrowding is further exacerbated by patients who use emergency admissions as a shortcut to avoid the general practitioner (GP) gateway. In this paper, we investigate access to emergency departments (EDs) by patients with non-severe medical conditions and their willingness to wait. Population data for ED accesses in Liguria (an Italian administrative region) in 2016 were used to estimate the number of strategic accesses and waiting time elasticities of low-severity patients. Our results show that the practice of using EDs to skip gatekeeping is a serious problem. The percentage of patients who engage in such practice vary from 8.7 to 9.9% of non-urgent patients; they generally prefer to access more specialized hospitals, especially during weekdays, when GPs are available, but hospi-

tals run at full capacity. Strategic patients are usually much younger than average. From a policy point of view, our results show that long waits may discourage “genuine” patients rather than strategic ones. It is necessary to develop a system to improve access to patients mainly requiring specialist care, along with enhancing the management of diagnostic examinations through primary care.

► **The Effects of DRGs-Based Payment Compared with Cost-Based Payment on Inpatient Healthcare Utilization: A Systematic Review and Meta-Analysis**

MENG Z., HUI W., CAI Y., *et al.*

2020

Health Policy 124(4): 359-367.

<https://doi.org/10.1016/j.healthpol.2020.01.007>

Diagnosis related groups (DRGs)-based payment is increasingly used worldwide to control hospital costs instead of pre-existing cost-based payment, but the results of evaluations vary. A systematic analysis of the effects of DRGs-based payment is needed. This study aims to conduct a systematic review and meta-analysis to compare the effects of DRGs-based payment and cost-based payment on inpatient health utilization in terms of length of stay (LOS), total inpatient spending per admission and readmission rates. We included studies undertaken with designs approved by the Cochrane Effective Practice and Organisation of Care that reported associations between DRGs-based payment and one or more inpatient healthcare utilization outcomes. After a systematic search of eight electronic databases through October 2018, 18 studies were identified and included in the review. We extracted data and conducted quality assessment, systematic synthesis and meta-analyses on the included studies. Random-effects models were used to handle substantial heterogeneity between studies. Meta-analysis showed that DRGs-based payment was associated with lower LOS (pooled effect: -8.07% [95%CI -13.05 to -3.10], $p = 0.001$), and higher readmission rates (pooled effect: 1.36% [95%CI 0.45–2.27], $p = 0.003$). This meta-analysis revealed that DRGs-based payment may have cost-saving implications by lowering LOS, whereas hardly reduce the readmission rates. Policy-makers considering adopting DRGs-based payment should pay more attention to the hospital readmission rates compared with cost-based payment.

► **Elder Abuse in the Out-Of-Hospital and Emergency Department Settings: A Scoping Review**

MERCIER E., NADEAU A., BROUSSEAU A. A., *et al.*

2020

Ann Emerg Med 75(2): 181-191.

This scoping review aimed to synthesize the available evidence on the epidemiology, patient- and caregiver-associated factors, clinical characteristics, screening tools, prevention, interventions, and perspectives of health care professionals in regard to elder abuse in the out-of-hospital or emergency department (ED) setting. Literature search was performed with MEDLINE, EMBASE, the Cumulative Index of Nursing and Allied Health, PsycINFO, and the Cochrane Library. Studies were eligible if they were observational or experimental and reported on elder abuse in the out-of-hospital or ED setting. A qualitative approach, performed independently by 2 reviewers, was used to synthesize and report the findings. A total of 413 citations were retrieved, from which 55 studies published between 1988 and 2019 were included. The prevalence of elder abuse reported during the ED visit was lower than reported in the community. The most commonly detected type of elder abuse was neglect, and then physical abuse. The following factors were more common in identified cases of elder abuse: female sex, cognitive impairment, functional disability, frailty, social isolation, and lower socioeconomic status. Psychiatric and substance use disorders were more common among victims and their caregivers. Screening tools have been proposed, but multicenter validation and influence of screening on patient-important outcomes were lacking. Health care professionals reported being poorly trained and acknowledged numerous barriers when caring for potential victims. There is insufficient knowledge, limited training, and a poorly organized system in place for elder abuse in the out-of-hospital and ED settings. Studies on the processes and effects of screening and interventions are required to improve care of this vulnerable population.

► **The Effect of Rural Hospital Closures on Emergency Medical Service Response and Transport Times**

MILLER K. E. M., JAMES H. J., HOLMES G. M., *et al.*
2020

Health Services Research 55(2): 288-300.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13254>

Objective :To examine the effect of rural hospital closures on EMS response time (minutes between dispatch notifying unit and arriving at scene); transport time (minutes between unit leaving the scene and arriving at destination); and total activation time (minutes between 9-1-1 call to responding unit returning to service), as longer EMS times are associated with worse patient outcomes. **Data Sources/Study Setting :**We use secondary data from the National EMS Information System, Area Health Resource, and Center for Medicare & Medicaid Provider of Service files (2010-2016). **Study Design** We examined the effects of rural hospital closures on EMS transport times for emergent 9-1-1 calls in rural areas using a pre-post, retrospective cohort study with the matched comparison group using difference-in-difference and quantile regression models. **Principal Findings :** Closures increased mean EMS transport times by 2.6 minutes ($P = .09$) and total activation time by 7.2 minutes ($P = .02$), but had no effect on mean response times. We also found closures had heterogeneous effects across the distribution of EMS times, with shorter response times, longer transport times, and median total activation times experiencing larger effects. **Conclusions** Rural hospital closures increased mean transport and total activation times with varying effects across the distribution of EMS response, transport, and total times. These findings illuminate potential barriers to accessing timely emergency services due to closures.

► **Is Mortality Readmissions Bias a Concern for Readmission Rates Under the Hospital Readmissions Reduction Program?**

PAPANICOLAS I., ORAV E. J. ET JHA A. K.
2020

Health Services Research 55(2): 249-258.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13268>

Objective :To determine whether the exclusion of patients who die from adjusted 30-day readmission rates influences readmission rate measures and pen-

alties under the Hospital Readmission Reduction Program (HRRP). **Data Sources/Study Setting :**100% Medicare fee-for-service claims over the period July 1, 2012, until June 30, 2015. **Study Design:** We examine the 30-day readmission risk across the three conditions targeted by the HRRP: acute myocardial infarction (AMI), congestive heart failure (CHF), and pneumonia. Using logistic regression, we estimate the readmission risk for three samples of patients: those who survived the 30-day period after their index admission, those who died over the 30-day period, and all patients who were admitted to see how they differ. **Data Collection/Extraction Methods** We identified and extracted data for Medicare fee-for-service beneficiaries admitted with primary diagnoses of AMI ($N = 497\,931$), CHF ($N = 1\,047\,552$), and pneumonia ($N = 850\,552$). **Results :**The estimated hospital readmission rates for the survived and nonsurvived patients differed by 5%-8%, on average. Incorporating these estimates into overall readmission risk for all admitted patients changes the likely penalty status for 9% of hospitals. However, this change is randomly distributed across hospitals and is not concentrated amongst any one type of hospital. **Conclusions :**Not accounting for variations in mortality may result in inappropriate penalties for some hospitals. However, the effect of this bias is low due to low mortality rates amongst incentivized conditions and appears to be randomly distributed across hospital types.

► **The Variability of Critical Care Bed Numbers in Europe**

RHODES A., FERDINANDE P., FLAATTEN H., *et al.*
2012

Intensive Care Med 38(10): 1647-1653.

PURPOSE: To quantify the numbers of critical care beds in Europe and to understand the differences in these numbers between countries when corrected for population size and gross domestic product. **METHODS:** Prospective data collection of critical care bed numbers for each country in Europe from July 2010 to July 2011. Sources were identified in each country that could provide data on numbers of critical care beds (intensive care and intermediate care). These data were then cross-referenced with data from international databases describing population size and age, gross domestic product (GDP), expenditure on health-care and numbers of acute care beds. **RESULTS:** We identified 2,068,892 acute care beds and 73,585 (2.8%) critical care beds. Due to the heterogeneous descrip-

tions of these beds in the individual countries it was not possible to discriminate between intensive care and intermediate care in most cases. On average there were 11.5 critical care beds per 100,000 head of population, with marked differences between countries (Germany 29.2, Portugal 4.2). The numbers of critical care beds per country corrected for population size were positively correlated with GDP ($r(2) = 0.16$, $p = 0.05$), numbers of acute care beds corrected for population ($r(2) = 0.12$, $p = 0.05$) and the percentage of acute care beds designated as critical care ($r(2) = 0.59$, $p < 0.0001$). They were not correlated with the proportion of GDP expended on healthcare. **CONCLUSIONS:** Critical care bed numbers vary considerably between countries in Europe. Better understanding of these numbers should facilitate improved planning for critical care capacity and utilization in the future.

► **Impact de la durée moyenne de séjour sur les réadmissions, analyse préliminaire des pratiques dans le cadre des expérimentations article 51 de la Loi de financement de la sécurité sociale, projet Épisode de soins**

SANCHEZ M. A.

2020

Revue d'Épidémiologie et de Santé Publique 68: S16.

<https://doi.org/10.1016/j.respe.2020.01.034>

Introduction : La mise en place des paiements au parcours de type épisode de soins (EDS), dans le cadre de l'article 51 de la loi de financement de la sécurité sociale (LFSS) 2018 est susceptible d'impacter la qualité des soins, et notamment le taux de réadmissions des établissements de santé. L'objectif est d'étudier le lien entre durée moyenne séjour (DMS) et réadmissions permettant d'estimer l'impact sur le coût global du parcours. Méthodes : Une étude observationnelle a été réalisée à partir des données du Système national des données de santé (SNDS) sur la période de 2014–2016 ayant servi à la définition des parcours et au calcul des forfaits par l'agence technique de l'information sur l'hospitalisation (ATIH). Nos analyses portent sur l'ensemble des séjours composant le parcours EDS colectomie. L'analyse comporte deux volets. Le premier représente la relation entre la DMS et le taux de réadmission, à l'aide d'une régression segmentée. Le second permet de calculer le ratio coût marginal du séjour de réadmission sur coût marginal du séjour inaugural. Résultats : La durée moyenne de séjour était de 12,5 jours (valeurs comprises entre 0 et

321jours). Nous traduisons l'effet d'une journée d'hospitalisation supplémentaire lors du séjour inaugural, sur la diminution de la probabilité de réadmission et sur le coût total du parcours. L'effet compensatoire varie de 8,15 % dans la base complète à 12,29 % dans le sous-échantillon. Pour des durées de séjours très courtes (entre 1 et 5 jours), l'effet est majoré, allant de 7,7 à 30,5 %. Discussion/Conclusion : Ce travail s'inscrit dans l'évaluation des modes de tarification innovants des expérimentations EDS. Il donne un éclairage de l'impact de la DMS sur les réadmissions, ainsi que sur la dépense globale du parcours. Ce nouveau mode de paiement pourrait permettre une modification des pratiques visant à diminuer les réadmissions.

► **Opening the Black Box of Diagnosis-Related Groups (DRGs): Unpacking the Technical Remuneration Structure of the Dutch DRG System**

VAN HERWAARDEN S., WALLENBURG I., MESSELINK J., *et al.*

2018

Health Economics, Policy and Law 15(2): 196-209.

<https://doi.org/10.1017/S1744133118000324>

While we know that upcoding of diagnosis-related groups (DRGs) regularly occurs, we have little knowledge of the role of the technical features of coding systems in inducing coding behaviour. This paper presents methods for investigating the financial structure of the Dutch DRG system, and more in particular the grouper software, to gain such insight. The paper describes a system for investigating the robustness of the reward structure, by simulating the response of the DRG system to small changes in individual coding. The results from these analyses are used to visualise some data on coding behaviour, and to investigate how this behaviour is affected by incentives in the technical features of the DRG system. A number of technical weaknesses in the system are also identified.

► **Impact de nouvelles cliniques sur les fréquentations des urgences : une étude avant après basée sur un « clustering » de flux patients**

WARTELLE A., MOURAD-CHEHADE F., YALAOUJ F.,
et al.

2020

Revue d'Épidémiologie et de Santé Publique 68: S6.

<https://DOI.org/10.1016/j.respe.2020.01.010>

En France, le nombre d'admissions aux urgences a doublé entre 1996 et 2016 avec une croissance moyenne de 3,5 % par an. Face aux problèmes de saturation engendrés, la redirection des flux de patients vers de nouvelles structures est l'une des solutions proposées afin de mieux répartir la demande et de rendre l'offre plus efficiente. L'étude de l'évolution des passages aux urgences pourrait permettre d'évaluer l'impact de ces nouvelles structures. L'objectif de cette étude est d'évaluer l'impact de l'ouverture de structures de soins non programmés sur les consommations de soins au service des urgences à partir des variations de profils patients dans le temps. Méthodes : Nous avons mené une étude avant-après portant sur l'ensemble de la consommation de soins au sein du département de l'Aube (Grand Est, France) et en particulier celle du service d'urgence du Centre hospitalier de Troyes à partir de sa base de données ResUrgences. Nous avons proposé une méthode de « clustering » hiérarchique pour segmenter la population selon leurs différents diagnostics CIM-10. Cette méthode utilise une nouvelle mesure de distance, entre diagnostics CIM-10, fondée sur un lien statistique de comorbidité et une similarité lexicale. Un modèle multivarié de régression logistique, modélisant la probabilité pour un passage d'appartenir à un des clusters en baisse, a été évalué pour ajuster l'effet de période sur différents facteurs de confusion. Résultats : Au total, 126 061 passages aux urgences ont été observés sur une période de 24 mois (2017–2019). Les 20 clusters les plus volumineux, représentant 68,95 % de la population, ont été sélectionnés. L'analyse avant-après montrait une baisse moyenne de 45,9 passages (3,8 % du volume total) par semaine pour ces 20 clusters. La probabilité d'appartenance à ces clusters a diminué après l'ouverture avec un OR de 0,90 (IC95 % [0,84, 0,95]) traduisant l'impact des nouvelles structures de soins non programmés. Discussion/Conclusion : Cette méthode pourrait être généralisée pour évaluer la mise en place de structures concurrentielles aux services d'urgences et de soins non programmés.

► **Hospital Staff Shortages: Environmental and Organizational Determinants and Implications for Patient Satisfaction**

WINTER V., SCHREYÖGG J. ET THIEL A.

2020

Health Policy 124(4): 380-388.

<https://doi.org/10.1016/j.healthpol.2020.01.001>

Recent discussions and previous research often indicate that German hospitals are affected by a shortage of healthcare personnel on the labor market. However, until now, research has provided only limited insights into how environmental and organizational factors explain variations in staff shortages, how staff shortage measures relate to staffing ratios, and what relevance staff shortages have for patients. Regression analyses based on survey data of 104 German hospitals from 2015 to 2016, combined with labor market and patient satisfaction data, show that several environmental and organizational factors are significantly related to hospital staff shortages, measured by self-reports, vacancies, and turnover. These three measures of staff shortage do not correlate to the same degree for physicians and nurses, and none of the three significantly relate to nursing ratios, which indicates that the latter is a distinct concept rather than a direct consequence of staff shortage. The analyses further show that hospital staff shortages relate significantly to patient satisfaction with physician and nursing care. The findings suggest that hospitals are, to a certain extent, able to influence the degree to which they are affected by staff shortages and that hospitals' decisions about staffing levels depend on more than staff availability.

Health Inequalities

► **Reasons for Unmet Needs for Health Care: The Role of Social Capital and Social Support in Some Western EU Countries**

FIORILLO D.
2020

International Journal of Health Economics and Management 20(1): 79-98.

<https://doi.org/10.1007/s10754-019-09271-0>

This paper focuses on the demand side factors that determine access to health care and analyses the issues of unmet needs for health care and the reasons thereof in western EU countries. A probit model is estimated from a sample of the whole population, accounting for the possibility of individual selection in unmet needs for health care (UN) (selection equation). Expanded probit models (including the inverse Mills ratio) are then used on the reasons for unmet needs (RUN) with social capital and social support as determinants and using the European Union Statistics on Income and Living Conditions dataset from 2006. In the RUN equations, the findings show that females, large households, people with low income and financial constraints, the unemployed and those in poor health have a higher probability of declaring unmet needs due to economic costs. Additionally, people in tertiary education, those with high income and the employed have a higher probability of not visiting a doctor when needed due to time constraints. Furthermore, the frequency of contact with friends and the ability to ask for help are correlated with a lower probability of unmet needs due to economic costs, while the frequency of contact with relatives is correlated with a lower probability of unmet needs due to time constraints and distance. However, the ability to ask for help is also correlated with a higher probability of not having medical care due to time constraints and the wait-and-see approach.

► **Social Inequalities in Medical Rehabilitation Outcomes—A Registry-Based Study on 219 584 Insured Persons in Germany**

GÖTZ S., WAHRENDORF M., SIEGRIST J., *et al.*
2020

European Journal of Public Health 30(3) : 498-503

<https://doi.org/10.1093/eurpub/ckaa024>

Given limited knowledge on the extent of social inequalities in longer-term work ability of people with a chronic disease, this study analyzes social inequalities of three consecutive indicators of work ability following medical rehabilitation in a large sample of insured employees. Based on data from the German statutory pension insurance, a representative 20% random sample of all employed persons undergoing medical rehabilitation between 2006 and 2008 was included in a longitudinal analysis (n = 219 584 persons). Three measures of consecutive work-related outcomes (physicians' assessment of work ability at discharge; return to work in the year thereafter; disability pension during follow-up) and socioeconomic position (SEP) (education, occupational position and income) were assessed. Adjusted relative risks (RRs) for each outcome were calculated according to SEP, applying Poisson regression analysis. The measures of SEP were associated with all three outcomes of work ability in the fully adjusted models. Relatively strongest relationships were observed for education as SEP measure, and they were particularly pronounced for 'low work ability' (RR = 2.38 for lower secondary education compared to tertiary education; 95% CI: 2.26–2.51). Based on average marginal effects, absolute differences of work ability by SEP indicate a socially graded pattern, with only few exceptions. Despite Germany's universal access to medical and vocational rehabilitation social inequalities in longer-term work ability following chronic disease persist, thus calling for targeted programmes of prevention and occupational health promotion.

► **Undocumented U.S. Immigrants and Covid-19**

PAGE K. R., VENKATARAMANI M., BEYRER C., *et al.*
2020

New England Journal of Medicine. 382(21):e62.

<https://www.nejm.org/doi/full/10.1056/NEJMp2005953>

Covid-19 has exposed weaknesses in the U.S. health system. The country faces shortages of personal protective equipment, tests, and ventilators. As emergency departments (EDs) and intensive care units brace for surges in volume, public health officials urge people

with symptoms to stay home and call their doctor before seeking in-person medical care. Unfortunately, for many undocumented immigrants, calling their doctor is not an option. The Affordable Care Act excludes undocumented immigrants from eligibility for coverage, and an estimated 7.1 million undocumented immigrants lack health insurance. As a result, many undocumented immigrants do not have primary care providers (PCPs) and have had to rely on EDs for years. Telling people now to avoid EDs and call their doctors leaves those without PCPs in limbo. The Covid-19 epidemic has exposed the risk of limiting access to primary care for segments of the population, including undocumented immigrants.

► **Health for All? A Qualitative Study of NGO Support to Migrants Affected by Structural Violence in Northern France**

PURSCH B., TATE A., LEGIDO-QUIGLEY H., *et al.*
2020

Social Science & Medicine 248: 112838.

<https://doi.org/10.1016/j.socscimed.2020.112838>

France hosts approximately 368,000 ‘persons of concern’ (e.g. refugees, stateless, people in refugee-like situations, asylum-seekers). Northern France has become a focal area, due to its proximity to the Dover entry-point to the UK and larger numbers of migrants. This study used a structural violence lens to explore the provision of health services to migrants in Calais and La Linière in northern France, to contribute to discourse on the effects of structural violence on non-state service providers and migrants in precarious conditions and inform service provision policies. Our qualitative study design used semi-structured key-informant interviews, conducted in summer 2017 with 20 non-governmental service-providers, 13 who had worked in Calais and 7 in La Linière migrant camp. We analysed interviews thematically, using inductive coding. Themes from analysis were : (i) power dynamics between NGOs and the state; (ii) resource allocation and barriers to accessing services; and (iii) effects of structural violence on social determinants of health. NGO service provision varied due to tense power dynamics between state and NGOs, shifting state requirements, and expanding roles. Interviewees described ongoing uncertainties, and inherent disempowerment associated with humanitarian aid, as negatively affecting migrant health and wellbeing, increasing illness risks, and providing unequal life chances. Structural realities including violence appeared to negatively

affect migrant social determinants of health, reducing healthcare access, social inclusion, and sense of empowerment. The role of NGOs in providing migrant health services in northern France was complex and contested. Structural violence negatively affected migrant wellbeing through restricted services, intentional chaos, and related disempowerment. The violence exerted on migrants appeared to diminish their life chances while being an ineffective deterrent, indicating better approaches are needed.

► **Child Health Research and Planning in Europe Disadvantaged by Major Gaps and Disparities in Published Statistics**

RIGBY M. J., DESHPANDE S. ET BLAIR M. E.
2020

European Journal of Public Health : Ahead of pub.

<https://doi.org/10.1093/eurpub/ckaa052>

Population data, such as mortality and morbidity statistics, are essential for many reasons, including giving context for research, supporting action on health determinants, formulation of evidence-based policy for health care and outcome evaluation. However, when considering children, it is difficult to find such data, despite children comprising one-fifth of the European population and being in a key formative life stage and dependent on societal support. Moreover, it would be expected that there should be confidence in the key child health data available, with little to no discrepancy between recognized health statistic databases. This study explored the main health databases in or including Europe to collate child mortality data, for both all-cause and specific-cause mortality. Tables were constructed for comparison of values and rankings. The results show that there are major differences in reported mortality data between two prominent health statistic databases, difference in coding systems, and unannounced changes within one of the databases. The lack of health data for children seems compounded by challenges to the trust and credibility, which are vital if these data are to have utility. Children and society are the losers, and resolution is needed as a priority.

Pharmaceuticals

► **Do Pharmaceutical Budgets Deliver Financial Sustainability in Healthcare? Evidence from Europe**

MILLS M. ET KANAVOS P.

2020

Health Policy 124(3): 239-251.

<https://doi.org/10.1016/j.healthpol.2019.12.002>

Payers have increasingly implemented a variety of cost-containment measures to promote sustainability in the pharmaceutical sector. This paper provides an assessment of a range of different applications of pharmaceutical budgets and assesses their impact in the context of health financing goals. A comprehensive literature review was carried out in order to identify evidence on the presence and impact of pharmaceutical budget-setting and capping mechanisms and an analytical framework was developed outlining relevant tradeoffs between macroeconomic and microeconomic efficiency. Evidence from the literature was validated by expert opinion through a round-table meeting followed by a series of semi-structured interviews. Five broad types of pharmaceutical budgets were identified as relevant : global, regional, disease-specific, product-specific, and prescribing. Fixed global budgets on total pharmaceutical expenditure are used primarily to promote cost-containment; however, their use often restricts flexibility in terms of total health budget allocation. Disease-specific budgets without consequences for exceeding the budget are unlikely to promote fiscal sustainability as these budgets are frequently exceeded. Product-specific budgets and prescribing budgets can play an important role in contributing to microeconomic efficiency; however, evidence on their impact is mixed. Overall, pharmaceutical budgets are present at both macroeconomic and microeconomic levels. While they are important tools for promoting fiscal sustainability, additional policy measures are needed to further enhance value for money in the pharmaceutical sector.

► **Variation in the Prescription Drugs Covered by Health Systems Across High-Income Countries: A Review of and Recommendations for the Academic Literature**

MORGAN S. G., DAW J. R., GREYSON D., *et al.*

2020

Health Policy 124(3): 231-238.

<https://doi.org/10.1016/j.healthpol.2019.12.010>

Background: Because not all medicines are equally safe, effective, and affordable, health systems often use formularies to define explicitly which medicines will be included and excluded from coverage. Objective :We sought to synthesize methods and findings from published studies of formulary variation across health systems in high-income countries. Methods: We conducted a systematic review of peer-reviewed research papers published from 2000 to 2017, inclusively. Because of the heterogeneous nature of the literature, we used an inductive approach to summarize methods and findings. Results Nine studies met our study inclusion criteria. Included studies used a variety of methods for selecting medicines for analysis, for measuring coverage levels, and for measuring concordance between formularies. Studies assessing variations in coverage of all licensed medicines and found lower rates of cross-national coverage variation than studies of coverage for selected specialty drugs and indications. The one study that focused on coverage of high-volume medicines found the most complete and consistent levels of formulary listings across countries. Conclusion: Although published studies contain interesting findings that likely have prompted discussions about their policy implications, the literature can be improved with greater transparency concerning the overarching objective of work in this area and more rigor concerning the selection, analysis, and reporting of data.

► **The Impact of Reducing Pharmaceutical Industry Payments on Physician Prescribing**

PARKER-LUE S.

2020

Health Economics 29(3): 382-390.

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3993>

Policymakers in the U.S. have expressed the hope that reducing payments from pharmaceutical companies to physicians will result in lower drug expenditures by reducing branded prescribing. This paper analyzes how the overall use and charges for generic and branded prescriptions change in an inpatient setting after a physician has had a payment from a pharmaceutical company reduced or cut off entirely. This research analyzes the impact of a pharmaceutical company cutting speaking payments to physicians in order to use fewer physicians more often, so the removal of payments is unrelated to a change in the company's product offering. Using hospital discharge data from New Jersey, this research employs a within-physician differences-in-differences design and finds that physicians who have payments reduced do not alter the number of or charges for prescriptions relative to unpaid physicians, neither do physicians who have their payments cut off but are still being paid by other pharmaceutical companies. Physicians who have their payments cut but who are not being paid by other companies, however, increase in the charges for and number of prescriptions written (both branded and generic) relative to their unpaid peers.

► **Potentially Inappropriate Medications in Older Adults: A Population-Based Cohort Study**

ROUX B., SIROIS C., SIMARD M., *et al.*

2019

Family Practice 37(2): 173-179.

<https://doi.org/10.1093/fampra/cmz060>

Non-optimal medication use among older adults is a public health concern. A concrete picture of potentially inappropriate medication (PIM) use is imperative to ensure optimal medication use. To assess the prevalence of PIMs in community-dwelling older adults and identify associated factors, a retrospective population-based cohort study was conducted using the Quebec Integrated Chronic Disease Surveillance System (QICDSS). The QICDSS includes data on drug claims for community-dwelling older adults with

chronic diseases or at risk of developing chronic diseases aged ≥ 65 years who are insured by the public drug insurance plan. Individuals aged ≥ 66 years who were continuously insured with the public drug plan between 1 April 2014 and 31 March 2016 were included. PIMs were defined using the 2015 Beers criteria. We conducted multivariate robust Poisson regression analyses to explore factors associated with PIM use. A total of 1 105 295 individuals were included. Of these, 48.3% were prescribed at least one PIM. The most prevalent PIMs were benzodiazepines (25.7%), proton-pump inhibitors (21.3%), antipsychotics (5.6%), antidepressants (5.0%) and long-duration sulfonamides (3.3%). Factors associated with PIM exposure included being a woman [rate ratio (RR): 1.20; 95% confidence interval (CI): 1.20–1.21], increased number of medications and having a high number of chronic diseases, especially mental disorders (RR: 1.50; 95% CI: 1.49–1.51). Almost one out of two community-dwelling older adults use a PIM. It is imperative to reduce the use of PIMs, by limiting their prescription and by promoting their deprescribing, which necessitates not only the active involvement of prescribers but also patients.

Methodology - Statistics

► **Comparing Web-Based Versus Face-To-Face and Paper-And-Pencil Questionnaire Data Collected Through Two Belgian Health Surveys**

BRAEKMAN E., CHARAFEDDINE R., DEMAREST S., *et al.*

2020

International Journal of Public Health 65(1): 5-16.

<https://doi.org/10.1007/s00038-019-01327-9>

Using the European Health Interview Survey (EHIS) questionnaire, a web-based survey was organized alongside a face-to-face (F2F) survey including a paper-and-pencil (P&P) questionnaire for sensitive topics. Associated with these different modes, other design features varied too (e.g., recruitment, incentives, sampling). We assessed whether these whole data collection systems developed around the modes produced equivalent health estimates.

► **Place and Quantitative Methods: Critical Directions in Quantitative Approaches to Health and Place**

MCLAFFERTY S.

2020

Health & Place 61: 102232.

<https://doi.org/10.1016/j.healthplace.2019.102232>

Health and Place has played a key role in “placing” quantitative methods in health research. Ongoing trends include use of big geospatial data, dynamic and longitudinal approaches, and person-based contextual measures. Critical approaches are important in harnessing new types of quantitative data and methodologies.

► **Use of Electronic Medical Records in Development and Validation of Risk Prediction Models of Hospital Readmission: Systematic Review**

MAHMOUDI E., KAMDAR N., KIM N., *et al.*

2020

BMJ 369: m958.

<https://doi.org/10.1136/bmj.m958>

The aim of this study is to predict 30 day hospital readmission. Design Systematic review .Data source Ovid Medline, Ovid Embase, CINAHL, Web of Science, and Scopus from January 2015 to January 2019. Eligibility criteria for selecting studies All studies of predictive models for 28 day or 30 day hospital readmission that used EMR data. Outcome measures Characteristics of included studies, methods of prediction, predictive features, and performance of predictive models. Results :Of 4442 citations reviewed, 41 studies met the inclusion criteria. Seventeen models predicted risk of readmission for all patients and 24 developed predictions for patient specific populations, with 13 of those being developed for patients with heart conditions. Except for two studies from the UK and Israel, all were from the US. The total sample size for each model ranged between 349 and 1195640. Twenty five models used a split sample validation technique. Seventeen of 41 studies reported C statistics of 0.75 or greater. Fifteen models used calibration techniques to further refine the model. Using EMR data enabled final predictive models to use a wide variety of clinical measures such as laboratory results and vital signs; however, use of socioeconomic features or functional status was rare. Using natural language processing, three models were able to extract relevant psychosocial features, which substantially improved their predictions. Twenty six studies used logistic or Cox regression models, and the rest used machine learning methods. No statistically significant difference (difference 0.03, 95% confidence interval -0.0 to 0.07) was found between average C statistics of models developed using regression methods (0.71, 0.68 to 0.73) and machine learning (0.74, 0.71 to 0.77). Conclusions :On average, prediction models using EMR data have better predictive performance than those using administrative data. However, this improvement remains modest. Most of the studies examined lacked inclusion of socioeconomic features, failed to calibrate the models, neglected to conduct rigorous diagnostic testing, and did not discuss clinical impact.

► **Plateformes numériques, algorithmes et discrimination**

MARTY F.
 2019

Revue de l'OFCE 164(4): 47-86.

<https://www.cairn.info/revue-de-l-ofce-2019-4-page-47.htm>

L'accroissement des données disponibles sur les caractéristiques et les comportements des consommateurs ainsi que le renforcement des capacités de traitement de ces dernières par des algorithmes ouvrent la voie au développement de stratégies de discrimination tarifaire de troisième degré avec une granularité extrêmement fine. Si les effets de cette discrimination de quasi-premier degré sur le surplus total sont ambigus, ils induisent aussi un transfert de bien-être entre agents économiques. Cet article analyse la possibilité de mettre en œuvre de telles stratégies dans l'économie numérique et envisage les possibles réponses venant des règles de concurrence ou des consommateurs eux-mêmes.

► **Random Parameters and Spatial Heterogeneity Using Rchoice in R**

MAURICIO S.
 2020

Region 7(1) 1-19.

<https://openjournals.wu.ac.at/ojs/index.php/region/article/view/279>

This study focus on models with spatially varying coefficients using simulations. As shown by Sarrias (2019), this modeling strategy is intended to complement the existing approaches by using variables at micro level and by adding flexibility and realism to the potential domain of the coefficient on the geographical space. Spatial heterogeneity is modelled by allowing the parameters associated with each observed variable to vary "randomly" across space according to some distribution. To show the main advantages of this modeling strategy, theRchoice package in R is used.

► **Data Envelopment Analysis Applications in Primary Health Care: A Systematic Review**

ZAKOWSKA I. ET GODYCKI-CWIRKO M.
 2019

Family Practice 37(2): 147-153.

<https://doi.org/10.1093/fampra/cmz057>

Strategic management of primary health care centres is necessary for creating an efficient global health care system that delivers good care. To perform a systematic literature review of the use of data envelopment analysis in estimating the relative technical efficiency of primary health care centres, and to identify the inputs, outputs and models used. PubMed, MEDLINE Complete, Embase and Web of Science were searched for papers published before the 25 March 2019. Of a total of 4231 search results, 54 studies met the inclusion criteria. The identified inputs included personnel costs, gross expenditures, referrals and days of hospitalization, as well as prescriptions and investigations. Outputs included consultations or visits, registered patients, procedures, treatments and services, prescriptions and investigations. A variety of data envelopment analysis models used was identified, with no standard approach. Data envelopment analysis extends the scope of tools used to analyse primary care functioning. It can support health economic analyses when assessing primary care efficiency. The main issues are setting outputs and inputs and selecting a model best suited for the range of products and services in the primary health care sector. This article serves as a step forward in the standardization of data envelopment analysis, but further research is needed.

Health Policy

► **Opportunities For, and Implications Of, Skill Mix Changes in Health Care Pathways: Pay, Productivity and Practice Variations in a Needs-Based Planning Framework**

BIRCH S., GIBSON J. ET MCBRIDE A.
2020

Social Science & Medicine 250: 112863.

<https://doi.org/10.1016/j.socscimed.2020.112863>

Health workforce planning is traditionally based on demographically-driven 'silo-based' models in which future requirements for particular health professions are determined by applying estimates of the future population to the existing population-based level of workforce supply. Estimates of future workforce requirements are focused on, and constrained by population size and requirements increase monotonically. Key failures of existing models include (1) lack of integration between planning the health care workforce, health care services and health care funding and (2) lack of integration between planning different health care inputs and the potential for substitution between inputs. Hence planning models fail to incorporate emerging developments in healthcare delivery and workforce change. We present an integrated needs-based framework for health workforce planning and apply the framework using data from nine European countries to explore the workforce and financial implications of re-configuring the delivery of care through changes in the allocation of treatment tasks between health care professions (skill mix). We show that cost consequences depend not only on pay differences. Instead, workforce planning in rapidly changing workforce environments must consider and incorporate between-provider group differences in productivity (the number of patients that are served per fixed period of time) and practice style (the number and mix of tasks used in providing care to the same type of patient).

► **Self-Isolation Compliance in the COVID-19 Era Influenced by Compensation: Findings from a Recent Survey in Israel**

BODAS M. ET PELEG K.
2020

Health Affairs: 10.1377/hlthaff.2020.00382.

<https://doi.org/10.1377/hlthaff.2020.00382>

A new Coronavirus disease (COVID-19) outbreak is spreading since December 2019. In an attempt to contain the disease, health authorities call for self-quarantine of individuals suspected as exposures. Health officials assume the public will comply in high rates; however, studies suggest that a major obstacle to compliance for household quarantine is concern over loss of income. A cross sectional study of the adult population of Israel was conducted in the last week of February 2020 to assess public attitudes toward the COVID-19 outbreak. In particular, public compliance rates with self-quarantine were assessed depending on compensation for lost wages. The results suggest that when compensation was assumed, the compliance rate was 94%; yet, when compensation was removed, the compliance rate dropped to less than 57%. This study demonstrates that providing people with assurances for their livelihood during self-quarantine is an important component in compliance with public health regulations.

► **Interventions to Enhance Patient and Family Engagement Among Adults with Multiple Chronic Conditions: A Systematic Scoping Review**

DANIEL O., DEST A., MUNSON A., *et al.*
2020

Medical Care 58(4): 407-416.

<https://doi.org/10.1097/mlr.0000000000001274>

Purpose: In the United States, 42% of adults, and 81% of adults over 65 years of age live with multiple chronic condition (MCC). Current interventions to facilitate engagement in care focus primarily on the patient; however, many individuals with MCC manage and live with their conditions within the context of their family. This review sought to identify interventions used to facilitate patient and/or family engagement among

adults with MCC. Methods: We adhered as closely as possible to PRISMA guidelines and conducted a systematic scoping review using a modified approach by Arksey and O'Malley. We searched PubMed, Web of Science, and Scopus using terms related to MCC, patient and family engagement, and intervention. We included articles that: (1) were published in English; (2) were peer-reviewed; (3) described an engagement intervention (with or without a comparator); and (4) targeted individuals with MCC. We abstracted data from included articles and classified them using the Multidimensional Framework for Patient and Family Engagement in Health and Health Care, and the Classification Model of Patient Engagement. Results: We identified 21 discrete interventions. Six (29%) were classified as having the highest degree of engagement. Eighteen (85%) focused on engagement at the direct care level. Only one was specifically designed to engage families. Conclusions: Many engagement interventions currently exist for adults with MCC. Few of these interventions foster the highest degree of engagement; most focus on engagement at the level of direct care and do not specifically target family member involvement.

► **Commonalities and Differences in Legal Euthanasia and Physician-Assisted Suicide in Three Countries: A Population-Level Comparison**

DIERICKX S., ONWUTEAKA-PHILIPSEN B., PENDERS Y., *et al.*
2020

[International Journal of Public Health 65\(1\): 65-73.](https://doi.org/10.1007/s00038-019-01281-6)
<https://doi.org/10.1007/s00038-019-01281-6>

To describe and compare euthanasia and physician-assisted suicide (EAS) practice in Flanders, Belgium (BE), the Netherlands (NL) and Switzerland (CH).

► **Le promoteur de parcours inclusif : coordonner la logique de parcours dans le médico-social sur un territoire**

DUBRUC N. ET VIALETTE L.
2019

[Management & Avenir Santé 5\(1\): 53-80.](https://www.cairn.info/revue-management-et-avenir-sante-2019-1-page-53.htm)
<https://www.cairn.info/revue-management-et-avenir-sante-2019-1-page-53.htm>

La logique de parcours instituée par les lois de 2002 et 2005 vise à changer l'accompagnement des personnes

en situation de handicap pour favoriser leur pouvoir d'agir et l'inclusion (Bauduret, 2017). Et, cela passe nécessairement par un travail de coopération entre professionnels à l'échelle d'un territoire. (Loubat, 2017; Bloch et Hénaut, 2014). Dans cet article, après avoir interrogé les notions de coordination et coopération, (Moine, 2006; Paquot, 2011; Bartoli et Gozlan, 2014; Jaeger, 2010; Dollet, 2014), nous proposons la définition d'un nouveau métier « le promoteur de parcours inclusif » (PPI) issue d'une immersion auprès de professionnels du secteur sur plus d'un an et demi d'accompagnement autour de la logique de parcours. Cette recherche met en évidence l'importance d'un acteur interface sur un territoire. Le PPI est celui qui va assurer une relation pertinente et adaptée avec le public accompagné, mettre en place la réponse accompagnée, suivre et accompagner le parcours et concevoir l'accompagnement en complémentarité avec les partenaires du territoire et travailler en réseau. À l'interface de différentes structures, au service de la réalisation du projet de vie de la personne en situation de handicap, le PPI sera un acteur-clé de l'inclusion et de la continuité du parcours de vie.

► **Novel Coronavirus and Old Lessons — Preparing the Health System for the Pandemic**

HICK J. L. ET BIDDINGER P. D.
2020

[New England Journal of Medicine. 382:e55](https://www.nejm.org/doi/full/10.1056/NEJMp2005118)
<https://www.nejm.org/doi/full/10.1056/NEJMp2005118>

How sad that the people who remember the last major pandemic — influenza in 1968 — are the primary victims of today's. How sad that despite the many medical advances that have been made since then — critical care, extracorporeal membrane oxygenation (ECMO), emergency medicine, and emergency medical services, to name a few — the treatments offered to many patients in areas where Covid-19 has exploded are the same ones they might have received in that era. Perhaps the lessons they remember, those of quarantine, isolation, and social distancing, are the ones that will save us again.

► **Covid-19 and the Need for Health Care Reform**

KING J. S.
2020

New England Journal of Medicine 382:e104.
<https://www.nejm.org/doi/full/10.1056/NEJMp2000821>

The Covid-19 pandemic has brought into sharp focus the need for health care reforms that promote universal access to affordable care. Although all aspects of U.S. health care will face incredible challenges in the coming months, the patchwork way we govern and pay for health care is unraveling in this time of crisis, leaving millions of people vulnerable and requiring swift, coordinated political action to ensure access to affordable care.

► **Covid-19: What Is the Evidence for Cloth Masks?**

MAHASE E.
2020

BMJ 369: m1422.
<https://www.bmj.com/content/bmj/369/bmj.m1422.full.pdf>

People should wear cloth face coverings in public places where social distancing measures are “difficult to maintain,” such as supermarkets and pharmacies, the CDC advises. It said the masks can be “fashioned

from household items or made at home from common materials at low cost.” It also warned that surgical masks and N-95 respirators should not be used by the public, as these were “critical supplies that must continue to be reserved for healthcare workers and other medical first responders.”

► **Quarantine Alone or in Combination with Other Public Health Measures to Control COVID-19: A Rapid Review**

NUSSBAUMER-STREIT B., MAYR V., DOBRESCU A. I.,
et al.
2020

Cochrane Database of Systematic Reviews(4).
<https://doi.org/10.1002/14651858.CD013574>

Coronavirus disease 2019 (COVID-19) is a rapidly emerging disease that has been classified a pandemic by the World Health Organization (WHO). To support WHO with their recommendations on quarantine, we conducted a rapid review on the effectiveness of quarantine during severe coronavirus outbreaks. The objective of this study is to conduct a rapid review to assess the effects of quarantine (alone or in combination with other measures) of individuals who had contact with confirmed cases of COVID-19, who travelled from countries with a declared outbreak, or who live in regions with high transmission of the disease.

Prévention santé

Health Prevention

► **Predictive Factors for Non-Participation or Partial Participation in Breast, Cervical and Colorectal Cancer Screening Programmes**

DAWIDOWICZ S., LE BRETON J., MOSCOVA L., *et al.*
2019

Family Practice 37(1): 15-24.
<https://doi.org/10.1093/fampra/cmz031>

No study has investigated factors associated with non-participation or partial participation in the different combination patterns of screening programmes for all three cancers, that is, breast, colorectal and cervical cancer. In a retrospective cohort study, we

sought to describe combinations of cancer screening participation rates among women in the Val-de-Marne area of France and to identify individual and contextual factors associated with non-participation or partial participation. Women aged between 50 and 65 and who were eligible for all three screening programmes (n = 102 219) were analysed in multilevel logistic models, with the individual as the Level 1 variable and the place of residence as the Level 2 variable. The women who did not participate in any of the screening programmes were 34.4%, whereas 30.1%, 24% and 11.5% participated in one, two or all three screening programmes, respectively. Age below 55, a previous false-positive mammography, prior opportu-

istic mammography only, no previous mammography, membership of certain health insurance schemes (all < 0.05) and residence in a deprived area ($P < 0.001$) were independently associated with non-participation or partial participation. We observed a stronger effect of deprivation on non-participation in all three cancers than in combinations of screening programmes. Our findings suggest that the health authorities should focus on improving cancer screenings in general rather than screenings for specific types of cancer, especially among younger women and those living in the most socially deprived areas.

► **Le dépistage par mammographie en France dans la théorie du comportement planifié : bénéfice collatéral, confiance, valeur perçue et comportements périphériques**

PERNIN J.-L.
2020

[Sciences sociales et santé 38\(1\): 39-66.](#)

<https://www.cairn.info/revue-sciences-sociales-et-sante-2020-1-page-39.htm>

Cet article propose d'utiliser une version étendue de la théorie du comportement planifié pour étudier les déterminants psychosociologiques de la participation des femmes aux campagnes de dépistage du cancer du sein par mammographie en France. Les modifications théoriques concernent : l'intégration d'un bénéfice collatéral, le test du rôle de la confiance et de la valeur perçue dans la formation de l'intention et l'intégration de comportements périphériques. Une enquête par questionnaire ($n = 135$) a été menée auprès de femmes de 40 à 75 ans. Les analyses sont réalisées à l'aide de modélisations par équations structurelles. Les principaux résultats concernent l'importance du bénéfice collatéral dans la formation de l'attitude et le lien entre l'acceptation de faire des analyses de sang et le dépistage par mammographie. Le temps est le principal frein pour se faire dépister. Ni la confiance ni la valeur perçue ne sont prédictifs de l'intention comportementale.

Prévision – Evaluation

Prevision -Evaluation

► **Partenariat autour de l'évaluation des cas complexes : ce qui ne va pas de soi**

DUJARDIN V. ET GUÉZENEC P.
2019

[Pratiques en santé mentale 65e année\(4\): 6-12.](#)
<https://www.cairn.info/revue-pratique-en-sante-mentale-2019-4-page-6.htm>

Les conseils locaux de santé mentale sont largement plébiscités dans notre pays et font désormais partie de son paysage social. Parmi ceux-ci, 85 % ont souhaité mettre en place des instances collectives d'analyse de situations complexes, c'est-à-dire de réflexion et d'action concernant des habitants qui posent question ou problème aux acteurs sociaux locaux. Cet article soulève les difficultés que pose ce type de pratique tant sur le plan éthique que juridique et appelle à la plus grande prudence quant à la création de telles pratiques en particulier dans le cadre des CLSM.

► **Cost–Utility Analyses of Interventions for Informal Carers: A Systematic and Critical Review**

GUETS W., AL-JANABI H. ET PERRIER L.
2020

[PharmacoEconomics 38\(4\): 341-356.](#)
<https://doi.org/10.1007/s40273-019-00874-6>

Demographic and epidemiological changes place an increasing reliance on informal carers. Some support programmes exist, but funding is often limited. There is a need for economic evaluation of interventions for carers to assist policymakers in prioritizing carer support.

► **Challenges of Systematic Reviews of Economic Evaluations: A Review of Recent Reviews and an Obesity Case Study**

JACOBSEN E., BOYERS D. ET AVENELL A.

2020

PharmacoEconomics 38(3): 259-267.

<https://doi.org/10.1007/s40273-019-00878-2>

Decision makers increasingly require cost-effectiveness evidence to inform resource allocation and the need for systematic reviews of economic evaluations (SREEs) has grown accordingly. The objective of this article is to describe current practice and identify unique challenges in conducting and reporting SREEs. Current guideline documents for SREEs were consulted and summarised. A rapid review of English-language SREEs, using MEDLINE and EMBASE, published in 2017/2018, containing at least 20 studies was undertaken to describe current practice. Information on data extraction methods, quality assessment (QA) tools and reporting methods were narratively summarised. Lessons learned from a recently conducted SREE of weight loss interventions for severely obese adults were discussed. Sixty-three publications were included

in the rapid review. Substantial heterogeneity in review methods, reporting standards and QA approaches was evident. Our recently conducted SREE on weight loss interventions identified scope to improve process efficiency, opportunity for more transparent and succinct reporting, and potential to improve consistency of QA. Practical solutions may include (1) using pre-piloted data extraction forms linked explicitly to results tables; (2) consistently reporting on key assumptions and sensitivity analyses that drive results; and (3) using checklists that include topic-specific items where relevant and allow reviewers to distinguish between reporting, justification and QA. The lack of a mutually agreed, standardised set of best practice guidelines has led to substantial heterogeneity in the conduct and reporting of SREEs. Future work is required to standardise the approach to conducting SREEs so that they can generate efficient, timely and relevant evidence to support decision-making. We suggest only data extracting information that will be reported, focusing discussion around the key drivers of cost-effectiveness, and improving consistency in QA by distinguishing between what is reported, justified by authors and deemed appropriate by the reviewer.

Psychiatrie

Psychiatry

► **Consentement et dignité : deux concepts fondateurs de la médiation dans le domaine de la santé**

AZOUX BACRIE L.

2019

Droit, Santé et Société 3(3): 8-15.

<https://www.cairn.info/revue-droit-sante-et-societe-2019-3-page-8.htm>

La dignité et le consentement sont étroitement imbriqués. Ils parlent à notre conscience, et doivent faire partie du respect de la personne, nous donnons le consentement et notre dignité à notre médecin qui en est responsable. Ces deux maîtres mots de la bioéthique font partie intégrante de la substance des droits fondamentaux sous l'angle éthique, juridique et médical.

► **Un RESAD au risque de l'éthique**

BOBOT M.-L.

2019

Pratiques en santé mentale 65e année(4): 59-63.

<https://www.cairn.info/revue-pratique-en-sante-mentale-2019-4-page-59.htm>

Les RESAD (Réseaux d'Évaluation, de Situations d'Adultes en Difficulté) se donnent pour mission de réunir des membres du conseil local de santé mentale. Retour d'expérience sur deux années de fonctionnement du RESAD Val d'Oise Est et certains risques de dérives auquel il a été confronté l'éloignant des projets tels que formulés par la charte de départ et son éthique.

► **The Psychological Impact of Quarantine and How to Reduce It: Rapid Review of the Evidence**

BROOKS S. K., WEBSTER R. K., SMITH L. E., *et al.*
2020

[The Lancet 395\(10227\): 912-920.](#)

[https://doi.org/10.1016/S0140-6736\(20\)30460-8](https://doi.org/10.1016/S0140-6736(20)30460-8)

The December, 2019 coronavirus disease outbreak has seen many countries ask people who have potentially come into contact with the infection to isolate themselves at home or in a dedicated quarantine facility. Decisions on how to apply quarantine should be based on the best available evidence. We did a Review of the psychological impact of quarantine using three electronic databases. Of 3166 papers found, 24 are included in this Review. Most reviewed studies reported negative psychological effects including post-traumatic stress symptoms, confusion, and anger. Stressors included longer quarantine duration, infection fears, frustration, boredom, inadequate supplies, inadequate information, financial loss, and stigma. Some researchers have suggested long-lasting effects. In situations where quarantine is deemed necessary, officials should quarantine individuals for no longer than required, provide clear rationale for quarantine and information about protocols, and ensure sufficient supplies are provided. Appeals to altruism by reminding the public about the benefits of quarantine to wider society can be favourable.

► **Sans programme de soins mais avec des projets de soins**

CANTERO A.
2020

[L'information psychiatrique 96\(3\): 185-189.](#)

<https://www.cairn.info/revue-l-information-psychiatrique-2020-3-page-185.htm>

La loi permet désormais de contraindre les citoyens souffrant de maladie psychiatrique de se soigner. Ce qui pourrait passer pour une avancée avec des soins en ambulatoire nous paraît être un non-respect des droits des personnes. Les programmes de soins vont à l'encontre de la mouvance actuelle d'empowerment et de réhabilitation. Il est possible de faire sans les programmes de soins en favorisant démocratie sanitaire et psychiatrie humaniste.

► **Assurer les soins aux patients souffrant de troubles psychiques en France pendant l'épidémie à SARS-CoV-2**

CHEVANCE A., GOURION D., HOERTEL N., *et al.*
2020

[L'Encephale.](#)

<http://www.sciencedirect.com/science/article/pii/S0013700620300646>

L'absence de préparation du système de soins psychiatriques à l'épidémie de virus SARS-CoV-2 fait redouter un scénario pessimiste pour la santé physique et mentale des patients suivis en psychiatrie. L'objectif de cet article est de proposer des éléments de guidance pour réorganiser les soins psychiatriques dans le contexte de pandémie COVID-19. Méthode : Les auteurs ont réalisé une synthèse de la littérature internationale combinée au partage des expériences locales françaises. Résultats : Les patients souffrant de troubles psychiques semblent particulièrement vulnérables à ce virus et à la pandémie : vulnérabilités liées aux comorbidités médicales, à l'âge, aux troubles cognitifs qui peuvent entraver le respect des consignes de confinement, et aux complications psychosociales. Plusieurs initiatives ont été prises pour assurer la continuité des soins et contenir l'épidémie : création en psychiatrie d'unité COVID+ co-supervisée par des médecins généralistes ou internistes, restriction des consultations aux cas sévères et redéploiement des soins en téléconsultation, accompagnements spécifiques pour les complications psychiques du confinement. Les populations suivies en pédopsychiatrie, en psychiatrie du sujet âgé, en addictologie ou détenues en prison doivent bénéficier d'une attention particulière. Plusieurs questions restent en suspens : la question de l'interaction négative ou positive des traitements sur l'infection SARS-CoV-2, l'épidémiologie de l'infection chez les personnes souffrant de troubles psychiques, leur adaptation à un confinement long. Discussion : Une prise de conscience par les décideurs politiques de la grande vulnérabilité de ces populations et des institutions psychiatriques dans cette situation de catastrophe sanitaire est urgente.

► **Singularité du sujet, singularités des pratiques**

CONRATH P. ET OUAZZANI M.

2020

Le Journal des psychologues 376(4): 14-14.

<https://www.cairn.info/revue-le-journal-des-psychologues-2020-4-page-14.htm>

On a pu lire ou dire, çà et là, que le psychologue avait l'esprit de contradiction, adepte du « pourquoi pas », du « peut-être » ou du « peut-être pas ». L'art du contre-pied serait une de ses déformations professionnelles, comme d'ailleurs, celui de l'objection. Même si ces petits défauts peuvent se retrouver chez certains d'entre nous, ils ont, tout du moins, le mérite de mettre en mouvement la pensée, et pas forcément comme un pur artifice théorique. Il permet surtout au psychologue d'avoir l'esprit en mobilité, bref, d'être l'empêcheur de penser en rond, pour plagier le titre d'une célèbre collection d'ouvrages. C'est cette mobilité intellectuelle et soignante qui pousse beaucoup de psychologues, aujourd'hui, à réinventer les lieux, les espaces, parfois les méthodes cliniques. Aussi, le psychologue peut-il faire preuve d'inventivité lorsqu'il s'agit d'approcher la singularité du sujet. Aller vers des terrains peu habituels, utiliser un médiateur peu conventionnel, favoriser la rencontre de cette subjectivité qui l'amène parfois à sortir du cadre classique de l'entretien, rendant compte d'une certaine manière de la richesse des apports et applications de la clinique, de la créativité et parfois de l'audace du professionnel. Dans ce dossier, il sera question de quelques-unes de ces cliniques. Sans être néanmoins exhaustif, il ouvre une fenêtre sur certaines pratiques parfois atypiques, originales, peu reconnues ou peu répandues.

► **La profession inspectée par l'Igas**

DARMON L.

2020

Le Journal des psychologues 376(4): 7-7.

<https://www.cairn.info/revue-le-journal-des-psychologues-2020-4-page-7.htm>

Rendu public en février, le rapport de Julien Emmanuelli et François Schechter, membres de l'Inspection générale des affaires sociales (Igas), avait pour objectif initial d'évaluer plusieurs expérimentations de remboursement de l'accès aux psychologues en libéral. Comme il s'est avéré qu'il était trop tôt pour le faire, l'étude a été recentrée sur « la question de la formation et des conditions d'exercice des psycho-

logues cliniciens », afin de garantir « la qualité des soins ainsi délivrés » si les expérimentations devaient se généraliser.

► **Economics of Mental Health: Providing a Platform for Efficient Mental Health Policy**

DORAN C. M. ET KINCHIN I.

2020

Applied Health Economics and Health Policy 18(2): 143-145.

<https://doi.org/10.1007/s40258-020-00569-6>

According to the World Health Organization (WHO), mental health is a state of wellbeing in which every individual realizes their potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to the community [1]. Unfortunately, problems associated with mental health are common in all regions of the world, affecting every community and age group across all-income countries. Mental-health-related disorders account for an estimated 7% of all global disease as measured in disability-adjusted life-years, 19% of all years lived with disability [2], and 16% of the global burden of disease and injury in people aged 10–19 years [3]. Almost three quarters of the global burden is in low- and lower middle-income countries. Mental ill-health also weighs heavily on societies and economies, with the annual cost of mental illness to developed countries estimated at 4% of gross domestic product and results in around 12 million days of reduced productivity each year [4]. There are significant social and economic benefits of improving individuals' mental health [5], yet mental-health-related disorders account for <1% of most countries' healthcare budget.

► **Le programme de soins : quelles responsabilités ?**

DUJARDIN-LASCAUX V. ET PECHILLON É.

2020

L'information psychiatrique 96(3): 195-200.

<https://www.cairn.info/revue-l-information-psychiatrique-2020-3-page-195.htm>

Le programme de soins constituant une modalité de prise en charge en soins sans consentement ambulatoire fut introduit dans le dispositif des soins psychiatriques par la loi 2011-803 du 05 juillet 2011, apparaissant dès lors pour les juristes comme un OJNI (objet

juridique non identifié). Sa qualification juridique complexe conduit à un enchevêtrement de risques contentieux en termes de responsabilité. Quelles responsabilités ? Pour qui ? La décision légale de mettre en place – ou non – un programme de soins peut être à l'origine de conséquences dommageables et aboutir à rechercher, à déterminer la part de responsabilité imputable à chacun des acteurs : l'autorité administrative signataire de la mesure, le patient, le psychiatre, voire comme certains l'espère parfois le législateur lui-même.

► **Disparities in the Use of General Somatic Care Among Individuals Treated for Severe Mental Disorders and the General Population in France**

GANDRÉ C. ET COLDEFY M.

2020

[Int J Environ Res Public Health 17\(10\).](https://doi.org/10.3390/ijerph17103367)

<https://www.doi.org/10.3390/ijerph17103367>

Individuals with severe mental illnesses (SMI) face a striking excess and premature mortality which has been demonstrated in several national contexts. This phenomenon, which constitutes a red-flag indicator of public health inequities, can be hypothesized to result from healthcare access issues which have been insufficiently documented so far. In this context, our objective was to explore patterns of general somatic healthcare use of individuals treated for SMI in comparison to those of the general population in France using national health administrative data and a matched case-control study. Differences in the use of general and specific somatic preventive care services, primary care, routine specialized somatic care and admissions to non-psychiatric hospital departments for somatic causes were described between cases and controls after adjustment on differing clinical needs, socio-economic status, and living environment. Our results show a lower use of general preventive care services and of routine specialized somatic care in the SMI population, despite more frequent comorbidities, and a higher occurrence of avoidable hospitalizations, despite higher contacts with primary care physicians. These findings suggest that the health system fails to address the specific needs of this vulnerable population and support the development of measures aimed at reducing this gap.

► **Le recours aux soins somatiques des personnes suivies pour des troubles psychiques sévères en France : comparaison avec la population générale**

GANDRÉ C. ET COLDEFY M.

2020

[Revue d'Épidémiologie et de Santé Publique 68: S31.](https://doi.org/10.1016/j.respe.2020.01.069)

<https://doi.org/10.1016/j.respe.2020.01.069>

La surmortalité des individus suivis pour des troubles psychiques a été récemment objectivée en France, appelant des éléments explicatifs et suggérant que cette population est confrontée à des inégalités de santé. Dans ce contexte, notre objectif est d'identifier d'éventuels défauts dans les parcours de soins somatiques des personnes suivies pour des troubles psychiques sévères. Méthodes : Nous mobilisons le Système national des données de santé (SNDS) pour décrire et comparer le recours aux soins somatiques entre les individus suivis pour des troubles psychiques sévères (identifiés via la cartographie médicalisée de la Caisse nationale d'assurance maladie pour l'année 2014) et la population générale. Plusieurs aspects des parcours de soins sont étudiés sur une période allant jusqu'à deux ans (2015 et 2016) : notamment le recours aux soins préventifs, aux soins somatiques courants, aux soins en urgence et aux hospitalisations évitables. Résultats : La part des personnes ayant recours à la vaccination et au dépistage du cancer du sein et/ou de l'utérus est moindre chez les personnes suivies pour des troubles psychiques en comparaison avec la population générale (ratios de 0,91 et 0,76 respectivement). Ce moindre recours est également observé pour les soins dentaires, gynécologiques et ophtalmologiques (ratios compris entre 0,66 et 0,94). Les individus suivis pour des troubles psychiques présentent un nombre moyen de passage aux urgences annuelles 2,4 fois plus élevé que la population générale. Les disparités sont particulièrement marquées pour les hospitalisations évitables qui sont 3,4 fois plus fréquentes chez les personnes avec des troubles psychiques. Discussion/ Conclusion : Ces premiers résultats mettent en évidence des disparités dans le recours aux soins somatiques courants des individus suivis pour des troubles psychiques sévères, dont la persistance après ajustement sur les caractéristiques individuelles (notamment socio-économiques) devra être explorée. Ils soutiennent le développement d'approches qualitatives visant à mieux comprendre les difficultés et obstacles dans les parcours de soins somatiques des patients suivis pour des troubles psychiques.

► **Les programmes de soins (PDS) : une double revue de la littérature systématique mixte en France et à l'international**

LEFEBVRE A., ROELANDT J.-L. ET SEBBANE D.
2020

L'information psychiatrique 96(1): 13-20.
<https://www.cairn.info/revue-l-information-psychiatrique-2020-1-page-13.htm>

Libertés et contraintes sont des concepts débattus dans le champ de la psychiatrie depuis son origine et qui restent d'actualité. Les pays industrialisés qui ont développé un système de soin en santé mentale ont connu un virage ambulatoire pour des raisons humaniste, économique et dans un contexte de découverte des neuroleptiques. En France, le PDS est apparu dans la loi du 5 juillet 2011 révisée en 2013. Cet article présente le résultat d'une double revue de la littérature systématique mixte en France et à l'international. Elle explore sur le plan qualitatif et quantitatif les contenus des écrits relatifs aux PDS dans la littérature française et les thématiques traitées par les chercheurs concernant l'équivalent des PDS à l'étranger. Ce travail s'inscrit dans une réflexion plus large, initiée par le GCS-CCOMS (Groupement de coopération sanitaire-Centre collaborateur de l'OMS) pour la Recherche et la Formation en Santé Mentale de Lille. Cet état de l'art sur le sujet réaffirme sa complexité, située à l'interface d'enjeux juridiques, éthiques, sociétaux et sanitaires.

► **Santé mentale : les vraies voies d'un avenir à construire**

LEGUAY D.
2019

Pratiques en santé mentale 65e année(4): 1-2.
<https://www.cairn.info/revue-pratique-en-sante-mentale-2019-4-page-1.htm>

► **Programmes de soins : quand la contrainte se déploie hors des murs de l'hôpital**

MOREAU D. ET MARQUES A.
2020

L'information psychiatrique 96(3): 177-184.
<https://www.cairn.info/revue-l-information-psychiatrique-2020-3-page-177.htm>

Instaurés par la loi du 5 juillet 2011, les « programmes de soins » ont été défendus comme des mesures moins restrictives de liberté que les hospitalisations sans consentement, permettant d'articuler soins dans le milieu de vie de la personne et continuité de la prise en charge. La question se pose cependant de savoir s'ils constituent une « moindre contrainte » ou une extension de la contrainte, dans le temps, dans l'espace et quant au nombre de personnes concernées. Cet article revient sur l'émergence de la contrainte ambulatoire dans une économie du soin psychiatrique qui se déplace vers l'extra-hospitalier, et sur les raisons pour lesquelles celles-ci font moins l'objet de controverses que d'autres dispositifs de contrainte dans le contexte français; il proposera enfin un cadre d'analyse de la nature de la contrainte qui s'y exerce, ou plutôt des formes de contraintes qui peuvent s'introduire dans le soin et l'accompagnement, dans et par-delà les dispositifs légaux.

► **Les programmes de soins en psychiatrie : quelles évaluations pour quelles évolutions ?**

PASTOUR N., MOREAU D. ET HAZO J.-B.
2020

L'information psychiatrique 96(3): 171-172.
<https://www.cairn.info/revue-l-information-psychiatrique-2020-3-page-171.htm>

Les modalités de soins sans consentement ambulatoires soulèvent des enjeux tant cliniques que juridiques, éthiques et sociaux. Quels bénéfices attend-on de ces dispositifs, pour la personne, sur le plan clinique, mais aussi sur le plan de sa trajectoire de soins ou de son insertion sociale? S'y ajoute-t-il des attentes pour la société, en termes de réduction de conduites jugées « problématiques »? Au regard de ces bénéfices escomptés, on peut se demander quels dispositifs peuvent être considérés comme acceptables.

► **Mental Health and the Covid-19 Pandemic**

PFEFFERBAUM B. ET NORTH C. S.
2020

New England Journal of Medicine.
<https://www.nejm.org/doi/full/10.1056/NEJMp2008017>

Uncertain prognoses, looming severe shortages of resources for testing and treatment and for protecting responders and health care providers from infection, imposition of unfamiliar public health measures

that infringe on personal freedoms, large and growing financial losses, and conflicting messages from authorities are among the major stressors that undoubtedly will contribute to widespread emotional distress and increased risk for psychiatric illness associated with Covid-19. Health care providers have an important role in addressing these emotional outcomes as part of the pandemic response.

► **Psychothérapie, quelle formation possible via la simulation en santé ? Retour d'expérience sur la formation en psychothérapie au Centre universitaire d'enseignement par la simulation (CUESim), université de Lorraine**

PHAM-DINH C., HAMI H., AÏM P., *et al.*

2020

L'information psychiatrique 96(2): 123-128.

<https://www.cairn.info/revue-l-information-psychiatrique-2020-2-page-123.htm>

Depuis 2013, les internes du DES de psychiatrie de la faculté de médecine de Nancy bénéficient d'enseignement via la simulation en santé dès leur prérentrée. Le bon déroulement de ces séances a inspiré la mise en place, à la rentrée 2017, de séances de simulation au sein de deux séminaires de psychothérapie du DES de psychiatrie : thérapies cognitivo-comportementales (TCC) et hypnose-thérapies brèves. Ces séances de simulations reposaient sur la collaboration entre un expert de la psychothérapie enseignée et un formateur aguerri à la pédagogie par la simulation en santé. La simulation permettait une mise en pratique des techniques de psychothérapies auprès d'un patient simulé. L'efficacité des séances de simulation nous encourage à développer encore cette modalité d'enseignement, y compris en psychothérapie. Cette observation encourage également à des recherches plus poussées pour valider l'efficacité de cette technique, notamment concernant le transfert de compétence en vie réelle.

► **Des situations complexes**

QUINTIN A.

2019

Pratiques en santé mentale 65e année(4): 3-4.

<https://www.cairn.info/revue-pratique-en-sante-mentale-2019-4-page-3.htm>

► **Le « cas » des personnes souffrant de troubles psychiques à leur domicile : réflexion sur le travail psychosocial**

QUINTIN A.

2019

Pratiques en santé mentale 65e année(4): 30-38.

<https://www.cairn.info/revue-pratique-en-sante-mentale-2019-4-page-30.htm>

Les cas ou situations complexes, c'est-à-dire des situations dans lesquelles des problématiques psychiques, sociales et physiques sont intriquées, nécessitent des accompagnements pluridisciplinaires mais également un travail particulier permettant à chaque institution impliquée de dépasser ses missions spécifiques. De ce travail doit naître un objectif commun permettant l'accompagnement de la personne dont la situation est complexe.

► **Formal Social Participation Protects Physical Health Through Enhanced Mental Health: A Longitudinal Mediation Analysis Using Three Consecutive Waves of the Survey of Health, Ageing and Retirement in Europe (SHARE)**

SANTINI Z. I., JOSE P. E., KOYANAGI A., *et al.*

2020

Social Science & Medicine 251: 112906.

<https://doi.org/10.1016/j.socscimed.2020.112906>

Previous studies have shown that formal social participation may reduce the risk of developing chronic conditions. Yet, the underlying mechanisms are largely unknown. In this study, we assessed the potential mediating roles of quality of life and depressive symptoms using longitudinal data. Method: We analyzed nationally representative data from three consecutive waves (2011, 2013, 2015) of the SHARE survey, including 28,982 adults from 12 European countries aged 50 years and above at baseline. Measures were self-reported and included formal social participation (i.e. active participation within volunteer organizations, educational institutions, clubs, religious organizations, or political/civic groups), quality of life (CASP-12), depressive symptoms (EURO-D), and chronic conditions. Structural equation modeling was used to construct a focused longitudinal path model. Results Formal social participation at baseline was inversely associated with the number of chronic conditions at 4-year follow-up. We identified two significant longitudinal mediation patterns: 1) formal social participation predicted higher

levels of quality of life, which in turn, predicted lower levels of chronic conditions; and 2) formal social participation predicted lower levels of depressive symptoms, which, in turn, also predicted lower levels of chronic conditions. Conclusions :Formal social participation functions as a protective factor against the onset or development of chronic conditions. This association is partially explained by enhanced quality of life and diminished depressive symptoms.

► **Universal Mental Health Interventions for Children and Adolescents: A Systematic Review of Health Economic Evaluations**

SCHMIDT M., WERBROUCK A., VERHAEGHE N., *et al.*
2020

Applied Health Economics and Health Policy 18(2): 155-175.

<https://doi.org/10.1007/s40258-019-00524-0>

Effective mental health interventions may reduce the impact that mental health problems have on young people's well-being. Nevertheless, little is known about the cost effectiveness of such interventions for children and adolescents.

► **Prise en charge de patients dans des lieux atypiques : psychologue au sein d'une Équipe mobile psychiatrie précarité**

SEIN L.
2020

Le Journal des psychologues 376(4): 22-27.

<https://www.cairn.info/revue-le-journal-des-psychologues-2020-4-page-22.htm>

Un des préceptes qui régit le travail du psychologue clinicien, qui lui est enseigné lors de son cursus universitaire, mais aussi lors de sa formation continue, est l'importance du cadre dans lequel il exerce. Le cadre est « une notion issue de la pratique psychanalytique appliquée ensuite à tous les développements de la psychothérapie » (Martin, 2001). Il se définit alors par différents critères, dans lesquels on retrouve notamment la position des personnes (setting), la confidentialité, la règle de neutralité, la fréquence, la durée et le lieu de l'intervention. Qu'il s'agisse d'une pratique en cabinet libéral ou en institution, le psychologue clinicien se doit donc de proposer au patient un lieu suffisamment contenant et protecteur, propice à l'émergence de sa parole, et à l'intérieur duquel la mise en mots de

sa souffrance puisse se faire en sécurité. De manière générale, il s'entend tacitement (tant pour les professionnels que pour les patients) que ce lieu prenne la forme d'une pièce confortable avec un bureau (des fauteuils, un divan...), quelles que soient l'approche et les références théoriques auxquelles le thérapeute ait décidé de s'adosser. Une telle définition du cadre nous amène à nous questionner. Comment mener à bien une thérapie lorsque le psychologue ne dispose pas de bureau ou de lieu suffisamment contenant ? Comment créer un espace sécurisant là où les notions mêmes de confidentialité, fréquence ou durée, ne peuvent être garanties ?

► **Predictors of Personal Continuity of Care of Patients with Severe Mental Illness: A Comparison Across Five European Countries**

SMITH P., NICAISE P., GIACCO D., *et al.*
2019

European Psychiatry 56: 69-74.

<https://doi.org/10.1007/s40258-019-00524-0>

In Europe, at discharge from a psychiatric hospital, patients with severe mental illness may be exposed to one of two main care approaches: personal continuity, where one clinician is responsible for in- and outpatient care, and specialisation, where various clinicians are. Such exposure is decided through patient-clinician agreement or at the organisational level, depending on the country's health system. Since personal continuity would be more suitable for patients with complex psychosocial needs, the aim of this study was to identify predictors of patients' exposure to care approaches in different European countries. Methods :Data were collected on 7302 psychiatric hospitalised patients in 2015 in Germany, Poland, and Belgium (patient-level exposure); and in the UK and Italy (organisational-level exposure). At discharge, patients were exposed to one of the care approaches according to usual practice. Putative predictors of exposure at patients' discharge were assessed in both groups of countries. Results :Socially disadvantaged patients were significantly more exposed to personal continuity. In all countries, the main predictor of exposure was the admission hospital, except in Germany, where having a diagnosis of psychosis and a higher education status were predictors of exposure to personal continuity. In the UK, hospitals practising personal continuity had a more socially disadvantaged patient population. Conclusion :Even in countries where exposure is

decided through patient-clinician agreement, it was the admission hospital, not patient characteristics, that predicted exposure to care approaches. Nevertheless, organisational decisions in hospitals tend to expose socially disadvantaged patients to personal continuity.

► **Leveraging Implementation Science to Reduce Inequities in Children’s Mental Health Care: Highlights from a Multidisciplinary International Colloquium**

STADNICK N. A., AARONS G. A., BLAKE L., *et al.*
2020

BMC Proceedings 14(2): 2.

<https://doi.org/10.1186/s12919-020-00184-2>

Access to evidence-based mental health care for children is an international priority. However, there are significant challenges to advancing this public health priority in an efficient and equitable manner. The purpose of this international colloquium was to convene a multidisciplinary group of health researchers to build an agenda for addressing disparities in mental health care access and treatment for children and families through collaboration among scholars from the United States and Europe engaged in innovative implementation science and mental health services research.

► **The Evolution of Mental Health in the Context of Transitory Economic Changes**

STOYANOVA A. ET PINILLA J.
2020

Applied Health Economics and Health Policy 18(2): 203-221.

<https://doi.org/10.1007/s40258-019-00537-9>

Mental health disorders are highly prevalent across countries. They increase over time and impose a severe burden on individuals and societies.

► **Social Distancing in Covid-19: What Are the Mental Health Implications?**

VENKATESH A. ET EDIRAPPULI S.
2020

BMJ 369: m1379.

<https://www.bmj.com/content/bmj/369/bmj.m1379.full.pdf>

As of 1 April 2020, there have been 29 474 confirmed cases of covid-19 in the UK. As discussed by Mahase, the UK government has enforced “social distancing” measures to curb transmission, protect the vulnerable, and prevent saturation of the NHS. Social distancing has potential mental health implications—how can we mitigate these to bolster this essential public health effort?

► **Arguments en faveur des soins sans consentement en ambulatoire**

VIDON G.
2020

L’information psychiatrique 96(3): 191-194.

<https://www.cairn.info/revue-l-information-psychiatrique-2020-3-page-191.htm>

La sectorisation – organisation des soins exemplaires pour un territoire – consiste néanmoins à s’occuper de tous les patients de ce territoire... y compris ceux qui refusent les soins ou qui sont dans le déni de leur maladie. Pour ces derniers, et surtout s’ils présentent des troubles répétés des conduites ou du comportement, il ne saurait être question de les « abandonner » sans se préoccuper de leur devenir. Les soins sans consentement constituent pour nous une étape rendue nécessaire vers l’alliance thérapeutique. Nous rassemblons dans ce court article l’argumentaire pour des soins sans consentement en ambulatoire, notamment en décrivant les principaux résultats de l’étude île-de-France sur le sujet (1111 dossiers).

► **A New Approach to Mental Health Care, Imported from Abroad**

WATERS R.
2020

Health Affairs 39(3): 362-366.

<https://doi.org/10.1377/hlthaff.2020.00047>

Can a transformative care strategy, tested and proven in Trieste, Italy, work in Los Angeles, California?

► **Mental Health: A Particular Challenge Confronting Policy Makers and Economists**

ZWEIFEL P.

2020

Applied Health Economics and Health Policy 18(2): 147-153.

<https://doi.org/10.1007/s40258-019-00479-2>

The first objective of this paper is to expound the particular challenge posed by the occurrence of inconsis-

ency in the expression of preferences by mental health patients to both economists and policy makers. Since this difficulty cannot be resolved, the second aim of the paper is to identify agents who may be counted upon to identify the true patient preferences. A decision rule is developed to help identify these agents who may be family members or judges in court, who have the ability and incentive to make these decisions. No single agent is found to dominate with respect to the five dimensions of preference distinguished, constituting a major challenge to policy makers.

Sociologie de la santé

Sociology of Health

► **Covid-19 Pandemic: A Public and Global Mental Health Opportunity for Social Transformation?**

AHMAD A., MUELLER C. ET TSAMAKIS K.

2020

BMJ 369: m1383.

<https://www.bmj.com/content/bmj/369/bmj.m1383.full.pdf>

Covid-19 is challenging our position in the world because we realise our connectedness to those around us regardless of geographic distance, yet we are deeply aware of our individuality because the illness is a threat to our physical—and mental—wellbeing. Our concepts, language, and understandings of our self and the world are merely semantics. We become our bodies through our experiences of illness. Covid-19 is as much a challenge of how we are going to frame it from a psychiatric perspective as it is a public health crisis. By merging public health with mental health, the ways that covid-19 are changing the world could be for better rather than worse. Our responsibility as mental healthcare professionals is to ensure that the ways we prescribe the meaning and representation of covid-19 to our own selves and the world enhances our mental health rather than limits what we can transform individually and globally.

► **Les parcours de soins des enfants en rechute de cancer. Un objet multi-situé au croisement de la sociologie et de la médecine**

BESLE S., CAROF S. ET SCHULTZ É.

2019

Espaces et sociétés 178(3): 73-88.

<https://www.cairn.info/revue-espaces-et-societes-2019-3-page-73.htm>

Pour les enfants, adolescents et jeunes adultes atteints de cancers avancés, l'accès à l'innovation thérapeutique par les essais cliniques de phases précoces est un enjeu important. Du fait de la rareté des centres menant ces recherches, une coordination est nécessaire entre les différents hôpitaux et le quotidien des familles, amenant de nouvelles contraintes dans les parcours de soins. Cet article présente la construction du projet sociologique accé à la rencontre des réflexions portées par le monde médical et associatif. Il vise à rendre compte de la dimension multi-située de l'accès aux essais précoces caractérisée par la mise en relation d'espaces différents à partir d'une méthodologie dédiée. Après avoir décrit dans une première partie l'importance de mobiliser des méthodologies complémentaires pour saisir la dimension multi-située, notre article met en exergue dans une deuxième partie son importance pour rendre compte de la structuration de l'accès de la recherche, ainsi que de l'expérience des familles.

► **Respect de la volonté en fin de vie :
une étude qualitative**

CROYERE N. ET BIRMELE B.
2020

Éthique & Santé 17(1): 37-43.

<http://www.sciencedirect.com/science/article/pii/S1765462920300039>

La loi française préconise l'autodétermination de la personne, en particulier en fin de vie. Mais est-ce que les souhaits et volontés du patient sont respectés ? Le but de cette étude est de déterminer comment est entendue, recueillie et respectée la volonté du patient en fin de vie. Des données sont recueillies dans 6 unités prenant en charge des patients ayant des pathologies sévères et/ou en fin de vie. La méthodologie est une étude qualitative collaborative : (1) étude des dossiers des patients; (2) réunions pluridisciplinaires pour évoquer les situations et les difficultés rencontrées; (3) recherche de la conformité avec les recommandations des bonnes pratiques. Déterminer et respecter la volonté du patient sont une priorité, mais leur mise en œuvre est complexe. L'information doit être donnée et comprise. Des difficultés sont l'état fluctuant du patient, son ambivalence, parfois l'attitude de la famille, la temporalité. Des échanges entre professionnels, informels et en réunion pluridisciplinaire, permettent d'interpréter et décoder cette volonté. L'incertitude sur l'interprétation des paroles rend la transcription dans le dossier délicate. Pour les professionnels, il est essentiel d'accompagner le patient à son rythme, d'écouter ses choix et ses refus. Les professionnels ont le souci de respecter la volonté de la personne, de l'accompagner selon ses souhaits, ses choix, ses refus, conformément aux recommandations. Ils soulignent l'importance de la communication, des échanges pluridisciplinaires d'une organisation adaptée à cette dynamique pour discerner cette volonté, pour la respecter, même si peu d'éléments sont retranscrits dans le dossier du patient.

► **European Adult Smokers' Perceptions
of the Harmfulness of E-Cigarettes
Relative to Combustible Cigarettes: Cohort
Findings from the 2016 and 2018 EUREST-
PLUS ITC Europe Surveys**

GRAVELY S., DRIEZEN P., KYRIAKOS C. N., *et al.*
2020

European Journal of Public Health.

<https://doi.org/10.1093/eurpub/ckz215>

This study presents perceptions of the harmfulness of electronic cigarettes (e-cigarettes) relative to combustible cigarettes among smokers from six European Union (EU) countries, prior to the implementation of the EU Tobacco Products Directive (TPD), and 2 years post-TPD. Data were drawn from the EUREST-PLUS ITC Europe Surveys, a cohort study of adult smokers (≥ 18 years) from Germany, Greece, Hungary, Poland, Romania and Spain. Data were collected in 2016 (pre-TPD: N = 6011) and 2018 (post-TPD: N = 6027). Weighted generalized estimating equations were used to estimate perceptions of the harmfulness of e-cigarettes compared to combustible cigarettes (less harmful, equally harmful, more harmful or 'don't know'). In 2016, among respondents who were aware of e-cigarettes (72.2%), 28.6% reported that they perceived e-cigarettes to be less harmful than cigarettes (range 22.0% in Spain to 34.1% in Hungary). In 2018, 72.2% of respondents were aware of e-cigarettes, of whom 28.4% reported perceiving that e-cigarettes are less harmful. The majority of respondents perceived e-cigarettes to be equally or more harmful than cigarettes in both 2016 (58.5%) and 2018 (61.8%, $P > 0.05$). Overall, there were no significant changes in the perceptions that e-cigarettes are less, equally or more harmful than cigarettes, but 'don't know' responses significantly decreased from 12.9% to 9.8% ($P = 0.036$). The only significant change within countries was a decrease in 'don't know' responses in Spain (19.3–9.4%, $P = .001$). The majority of respondents in these six EU countries perceived e-cigarettes to be equally or more harmful than combustible cigarettes.

► **Community Involvement
in the Development and Implementation
of Chronic Condition Programmes
Across the Continuum of Care in High-
and Upper-Middle Income Countries:
A Systematic Review**

HALDANE V., SINGH S. R., SRIVASTAVA A., *et al.*
2020

Health Policy 124(4): 419-437.

<https://doi.org/10.1016/j.healthpol.2019.11.012>

Background Community involvement is an important component of health programme development and implementation, including those focused on chronic condition treatment and management. Yet, few studies explore the manifestations of community involvement in chronic care programmes. Our review aims to examine the evidence on how communities are involved in

planning and implementing chronic condition programmes in high and upper-middle income countries. Methods Eligible studies included those that involved the community in the planning, implementation, monitoring and evaluation of health services, policy or health interventions. We searched Medline, Embase, Global Health, Scopus, and LILACs from 2000 to 2016, independently screened articles for inclusion, conducted data extraction, and assessed studies for risk of bias. Results 27,232 records were identified and after screening, 32 met inclusion criteria. We conducted a narrative synthesis to report on the forms and processes of community involvement used across mental health programmes and contrast this with the paucity of evidence on comparable programmes addressing other chronic conditions. Challenges reported included user factors, organisational factors, and social challenges such as stigma. Conclusion :Our review adds to the evidence supporting community involvement in chronic condition management and the processes that contribute to successful and sustainable involvement. We report on a model, derived from inductive analysis, that considers social and cultural components, organisational factors and stakeholder relationships as underpinning the development of community interventions across the care continuum.

► **Physician Adherence to Clinical Guidelines in Euthanasia and Assisted Suicide in the Netherlands: A Qualitative Study**

RILEY S. R., OVERBEEK A. ET VAN DER HEIDE A.
2019

Family Practice 37(2): 269-275.

<https://doi.org/10.1093/fampra/cmz069>

Euthanasia and assisted suicide laws in the Netherlands require physicians meet clinical guidelines when performing the practice to ensure death is peaceful and painless. Despite oversight by the regional review committees over each case, little research exists into the frequency of guideline deviation and the reasons for nonadherence. Cases reported and reviewed between 2012 and 2017 that did not meet due medical care were analysed for thematic content. Semistructured interviews were conducted with 11 Dutch physicians on their experience with the clinical and pharmacological elements of euthanasia and assisted suicide, their interaction and comportment with the recommended guidelines, and reasons why guideline deviation might occur. Reported case reviews and interviews were used

to obtain themes and subthemes to understand how and why deviations from clinical guidelines happened. Violations of due medical care were found in 42 (0.07%) of reported cases. The regional review committees found physicians in violation of due medical care mostly for inadequate confirmation of coma-induction and deviations from recommended drug dosages. Physicians reported that they rarely deviated from the guidelines, with the most common reasons being concern for the patient's family, concern over the drug efficacy, mistrust in the provided guidelines, or relying on the poor advice of pharmacists or hospital administrators. Deviations from the guidelines and violations of due medical care are rare, but should nonetheless be monitored and prevented. A few areas for improvement include skills training for physicians, consistency between review committee rulings, and further clarity on dosage recommendations.

► **Des « symptômes médicalement inexpliqués » aux « maladies d'une époque ». Les difficultés de la prise en charge des patients. Commentaire**

THOMAS M.

2020

Sciences sociales et santé 38(1): 31-38.

<https://www.cairn.info/revue-sciences-sociales-et-sante-2020-1-page-31.htm>

De tout temps, la souffrance des individus a été reconnue comme liée à des causes physiques, des maladies ou des accidents, à l'environnement familial, social ou professionnel, ou à des causes psychologiques. Mais elle a également été fréquemment non comprise. Toute vie humaine entraîne bien-être et... mal-être. Lorsque ce dernier survient, dans nos sociétés modernes et développées, l'individu en souffrance s'adresse bien souvent, mais non exclusivement, au médecin. Il lui présente alors des plaintes qui peinent à entrer dans les cadres classiques des maladies. Ce sont des symptômes médicalement inexpliqués (SMI). Les patients qui en souffrent en revendiquent souvent la reconnaissance en tant que « vraie » maladie. Dans le travail de Sarradon-Eck, Dias et Pouchain, une des jeunes médecins interviewés déclare à propos des SMI : « Mais je sais que probablement ils n'ont pas rien ces gens, et qu'ils souffrent réellement. Je pense qu'ils ont une vraie douleur, mais avec la médecine que l'on connaît, on n'a pas de cadre pour les prendre en charge. »

Primary Health Care

► **Development of a Novel Metric of Timely Care Access to Primary Care Services**

BATTEN A. J., AUGUSTINE M. R., NELSON K. M., *et al.*
2020

Health Services Research 55(2): 301-309.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13255>

This aim of this paper is to develop a model for identifying clinic performance at fulfilling next-day and walk-in requests after adjusting for patient demographics and risk. Data Source :Using Department of Veterans Affairs (VA) administrative data from 160 VA primary care clinics from 2014 to 2017. Study Design :Using a retrospective cohort design, we applied Bayesian hierarchical regression models to predict provision of timely care, with clinic-level random intercept and slope while adjusting for patient demographics and risk status. Timely care was defined as the provision of an appointment within 48 hours of any patient requesting the clinic's next available appointment or walking in to receive care. Data Collection/Extraction Methods :We extracted 1 841 210 timely care requests from 613 263 patients. Principal Findings Across 160 primary care clinics, requests for timely care were fulfilled 86 percent of the time (range 83 percent-88 percent). Our model of timely care fit the data well, with a Bayesian R2 of .8. Over the four years of observation, we identified 25 clinics (16 percent) that were either struggling or excelling at providing timely care. Conclusion :Statistical models of timely care allow for identification of clinics in need of improvement after adjusting for patient demographics and risk status. VA primary care clinics fulfilled 86 percent of timely care requests.

► **A New Model of Patient-Centred Care for General Practitioners: Results of an Integrative Review**

BRICKLEY B., SLADDIN I., WILLIAMS L. T., *et al.*
2019

Family Practice 37(2): 154-172.

<https://doi.org/10.1093/fampra/cmz063>

GPs providing patient-centred care (PCC) is embedded in international health care policies due to its

positive impact on patients and potential to lower health care costs. However, what is currently known about GP-delivered PCC is unknown. To synthesize literature investigating GP-delivered PCC and address 'what is currently known about GP-delivered PCC?' A systematic literature search was conducted between June and July 2018. Eligible articles were empirical, full-text studies published in English between January 2003 and July 2018, related to at least three of the four dimensions of PCC described by Hudon et al. (2011), and related to preventative, acute, and/or chronic care by GPs. Following screening, full-text articles were independently assessed for inclusion by two investigators. Data were extracted and quality assessed by two researchers. Findings on PCC were analysed thematically (meta-synthesis). Thirty medium- to high-quality studies met the inclusions criteria. Included studies utilized varied designs, with the most frequent being quantitative, cross-sectional. A theoretical model of PCC was synthesized from included studies and contained four major components: (i) understanding the whole person, (ii) finding common ground, (iii) experiencing time and (iv) aiming for positive outcomes. Harms of PCC were rarely reported. Four overarching theoretical components of PCC relate to elements of the consultation and experience of time. These components can be used to inform the development of toolkits to support GPs and general practice organizations in pursuit of PCC as well as tools to measure patient-centredness.

► **Embedding Social Workers in Veterans Health Administration Primary Care Teams Reduces Emergency Department Visits**

CORNELL P. Y., HALLADAY C. W., ADER J., *et al.*
2020

Health Affairs 39(4): 603-612.

<https://doi.org/10.1377/hlthaff.2019.01589>

While an emerging body of evidence suggests that medical homes may yield more benefits than traditional care models do, the role of social workers within medical homes has yet to be evaluated separately. We assessed the impact of an initiative to add social workers to rural primary care teams in the Veterans Health

Administration on patients' use of social work services, hospital admissions, and emergency department visits. We found that introducing a social worker increased social work encounters by 33 percent among all veterans who received care. Among high-risk patients, we observed a 4.4 percent decrease in the number of veterans who had any acute hospital admission and a 3.0 percent decrease in veterans who had any emergency department visit, after the introduction of a social worker. Investing in social workers is a key strategy for addressing the social determinants of health and managing care coordination for high-risk, high-need populations.

► **Quantifier la qualité des soins.
Une critique de la rationalisation de la
médecine libérale française**

DA SILVA N.
2020

**Revue Française de Socio-Économie Hors-série(en
lutte): 261-280.**

<https://www.cairn.info/revue-francaise-de-socio-economie-2020-en-lutte-page-261.htm>

Avec la logique de quantification de la qualité du travail médical, les patients sont invités à faire confiance aux normes chiffrées déterminées par les agences de santé indépendantes – plutôt que de se fier à la relation personnelle avec leur médecin. Si cette nouvelle régulation ressemble à une rationalisation des pratiques, nous proposons de montrer en quoi il est utile de revenir sur la méthode de production de ces normes du travail médical et de questionner l'usage politique des essais cliniques randomisés. Après avoir rappelé les justifications théoriques et empiriques de la « rationalisation », nous défendons l'idée que la politique de quantification de la qualité des soins repose sur une épistémologie de la maladie arbitraire et une épistémologie des statistiques réductrice. Or cela n'est pas sans conséquences négatives, tant pour les professionnels que pour les patients.

► **Patient Choice, Entry, and the Quality
of Primary Care: Evidence from Swedish
Reforms**

DIETRICHSON J., ELLEGÅRD L. M. ET KJELLSSON G.
2020

Health Economics 29(6): 716-730.

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4015>

Abstract :Policies aiming to spur quality competition among health care providers are ubiquitous, but their impact on quality is ex ante ambiguous, and credible empirical evidence is lacking in many contexts. This study contributes to the sparse literature on competition and primary care quality by examining recent competition enhancing reforms in Sweden. The reforms aimed to stimulate patient choice and entry of private providers across the country but affected markets differently depending on the initial market structure. We exploit the heterogeneous impact of the reforms in a difference-in-differences strategy, contrasting more and less exposed markets over the period 2005–2013. Although the reforms led to substantially more entry of new providers in more exposed markets, the effects on primary care quality were modest: We find small improvements of patients' overall satisfaction with care, but no consistently significant effects on avoidable hospitalisation rates or satisfaction with access to care. We find no evidence of economically meaningful quality reductions on any outcome measure.

► **Effect of a National Primary Care Reform
on Avoidable Hospital Admissions (2000–
2015): A Difference-In-Difference Analysis**

DIMITROVOVÁ K., PERELMAN J. ET SERRANO-
ALARCÓN M.

2020

Social Science & Medicine 252: 112908.

<https://doi.org/10.1016/j.socscimed.2020.112908>

In 2006 a major primary care reform was initiated in Portugal. The most significant aspect of this reform was the creation of a new organizational model of primary care provision: Family Health Units (FHUs), consisting of small voluntarily constituted multidisciplinary teams that have functional autonomy and are partly financed through capitation and pay-for-performance. The creation of FHUs sought to increase access to care and to chronic disease management by improving the long-term relationship between health professionals and patients. The objectives of this study are to evaluate the impact of the FHUs implementation on population health outcomes, measured by the rate of hospitalizations for ambulatory care sensitive conditions (ACSC), i.e. avoidable hospital inpatient admissions, and to explore the effectiveness of the pay-for-performance in primary care by analysing the subset of disease specific hospitalizations for ACSC related to the financial incentives. Using data from 276 Portuguese municipalities from 2000 to 2015 (n = 4416) and exploiting

the gradual introduction of the FHUs over time, we used a difference-in-differences approach contrasting the evolution of the hospitalization rate for ACSC in municipalities that implemented or not the FHUs. We then explored heterogeneous effects by incentivized (diabetes and hypertension) and non-incentivized disease-specific rates of hospitalizations for ACSC. During the period under analysis, 448 FHUs were created in 126 municipalities. No significant impact of the FHUs implementation on the reduction of the hospitalization rate for ACSC was found. This result also held for the incentivized hospitalizations for ACSC. We only found a statistically significant effect of the FHUs implementation in the reduction of one non-incentivized area (the rate of urinary tract infection ACSC). Our results question the capacity of this payment mechanism to achieve better health outcomes, and invites a more careful and evidence-based action toward its wider diffusion.

► **Communication Between Primary and Secondary Care: Deficits and Danger**

DINSDALE E., HANNIGAN A., O'CONNOR R., *et al.*

2019

Family Practice 37(1): 63-68.

<https://doi.org/10.1093/fampra/cmz037>

Timely and accurate communication between primary and secondary care is essential for delivering high-quality patient care. The aim of this study is to evaluate the content contained in both referral and response letters between primary and secondary care and measure this against the recommended national guidelines. Using an observational design, senior medical students and their general practice supervisors applied practice management software to identify 100 randomly selected adults, aged greater than 50 years, from a generated list of consults over a 2-year period (2013–2015). All data included in referral and response letters for these adults were examined and compared with the gold standard templates that were informed by international guidelines. Data from 3293 referral letters and 2468 response letters from 68 general practices and 17 hospitals were analysed. The median time that had elapsed between a patient being referred and receiving a response letter was 4 weeks, ranging from 1 week for Emergency Department referral letters to 7 weeks for orthopaedic surgery referral letters. Referral letters included the reason for referral (98%), history of complaint (90%) and current medications (82%). Less commonly included were management prior to refer-

ral (65%) and medication allergies (57%). The majority of response letters included information on investigations (73%), results (70%) and follow-up plan (85%). Less commonly, response letters included medication changes (30%), medication lists (33%) and secondary diagnoses (13%). Future research should be aimed at developing robust strategies to addressing communication gaps reported in this study.

► **When Do People Choose to Be Informed? Predictors of Information-Seeking in the Choice of Primary Care Provider in Sweden**

HOFFSTEDT C., FREDRIKSSON M., LENHOFF H., *et al.*
2018

Health Economics, Policy and Law 15(2): 210-224.

<https://doi.org/10.1017/S1744133118000373>

Improving the ability of patients to make informed choices of health care provider can give providers more incentive to compete based on quality. Still, it is not evident to what extent and when people search for information when choosing a provider. The aim of this study is to identify under what circumstances individuals seek information when choosing a primary care provider. Research to date has mostly focused on individuals' demographic and socio-economic characteristics and the poor availability of information as barriers to information-seeking and use. Our results highlight the importance of taking individuals' personal motivations and situational context into account when studying information-seeking behavior. Overall, these results suggest that not even individuals who are likely to search for information since they switched or considered switching primary care provider, do so to any greater extent. However, those motivated to change providers by internal factors such as dissatisfaction or a belief that other providers may provide superior services actively sought out information to a greater extent than those motivated by external factors such as the closure of their current provider, or by moving house. Gender, employment status, place of residence and education level was also significantly associated with information-seeking.

► **Professional, Practical and Political Opportunities: Optimizing the Role of Ontario Physician Assistants in Family Medicine**

BURROWS K., ABELSON J., MILLER P., *et al.*

2020

[Journal of Canada's Physician Assistants 1\(4\).](#)

<https://ojs.lib.umanitoba.ca/index.php/jcpa/article/view/855>

The objectives of this study are to identify that facilitators and barriers that influence Physician Assistant (PA) role optimization and success in family practice setting. Setting: Rural and urban family practice settings in Ontario that had employed a PA for a minimum of two consecutive years. Participants: Six family medicine clinics in Ontario represented by seven family medicine Physician Assistants, eight Family Physicians (seven supervising physicians, one physician/administrator), and one clinic manager. Method: To identify the factors that influence role success and barriers which prevent PA role optimization, we conducted an exploratory single case study with embedded subunits of analysis. Data consisted of semi-structured interviews with 15 participants and analysis of documents (medical directives, job announcements, and communications). Main findings: Barriers and facilitators to PA integration and role success can be categorized into professional, practice-based, and political factors. Professional factors that facilitate role optimization include the professional relationship between the PA and physician, level of comfort with autonomy, trust, rapport and PA competencies. Practice factors that optimize the role include appropriate administrative support/organization, investment in PA training and patient satisfaction. Barriers include employer knowledge of medical-legal risks, communication around the PA role and accessibility of funding. Political factors that limit role optimization and success include billing practices, absence of consistent funding models and lack of regulatory oversight. Conclusion: Most of the barriers identified relate to enduring policy legacies, which continue to limit the sustainability and stability of PAs in Ontario. Successful Family Physician-PA teams have created individualized solutions to these barriers, and describe their partnership as increasing patient access to care, improving work-life balance, expanding comprehensiveness of services, and advancing team-based collaborative care.

► **Le ressenti de médecins généralistes face au refus de soins des patients : une étude qualitative**

LELIEVRE C., LASSERRE C., JARDE O., *et al.*

2020

[Éthique & Santé 17\(1\): 44-51.](#)

<https://doi.org/10.1016/j.etiqe.2019.12.001>

En demandant le consentement au patient, le médecin s'attend à entendre un « oui ». Il se retrouve alors démuné quand le patient répond par la négation. La relation de soin s'en trouve déséquilibrée et cela peut alors créer des tensions, menaçant la confiance soignant-soigné normalement nécessaire à une bonne alliance thérapeutique. L'objectif de cette étude est d'évaluer le ressenti du médecin généraliste face à un refus de soins d'un patient. Une étude qualitative a été réalisée à partir de l'analyse thématique de 18 entretiens semi-dirigés de médecins généralistes entre le mois d'octobre 2017 et février 2018. Pour la plupart des médecins, le refus de soins des patients était avant tout le signe d'une incompréhension ou de représentation négative du soin. La compréhension reposait avant tout sur une bonne communication entre le médecin et le malade. Afin d'obtenir une adhésion au soin, la stratégie la plus pertinente était une approche centrée sur le patient afin d'aboutir à un compromis entre le projet de soin du soignant et le projet de vie du patient. Mais en cas de persistance du refus, les médecins s'accordaient à dire qu'ils respectaient ce choix. Conclusion Généralement les médecins ne vivaient pas le refus de soins comme une atteinte personnelle et ne souffraient pas de cette situation. Toutefois, ce refus pouvait entraîner une rupture de la relation thérapeutique. Cependant, quelques-uns voyaient le refus de soins comme une manière de renforcer le lien médecin-malade et de favoriser le dialogue.

► **Outcomes of Primary Care Delivery by Nurse Practitioners: Utilization, Cost, and Quality of Care**

LIU C.-F., HEBERT P. L., DOUGLAS J. H., *et al.*

2020

[Health Services Research 55\(2\): 178-189.](#)

This aim of this paper is to examine whether nurse practitioner (NP)-assigned patients exhibited differences in utilization, costs, and clinical outcomes compared to medical doctor (MD)-assigned patients. Data Sources Veterans Affairs (VA) administrative data capturing characteristics, outcomes, and provider assignments

of 806 434 VA patients assigned to an MD primary care provider (PCP) who left VA practice between 2010 and 2012. Study Design We applied a difference-in-difference approach comparing outcomes between patients reassigned to MD and NP PCPs, respectively. We examined measures of outpatient (primary care, specialty care, and mental health) and inpatient (total and ambulatory care sensitive hospitalizations) utilization, costs (outpatient, inpatient and total), and clinical outcomes (control of hemoglobin A1c, LDL, and blood pressure) in the year following reassignment. Principal Findings Compared to MD-assigned patients, NP-assigned patients were less likely to use primary care and specialty care services and incurred fewer total and ambulatory care sensitive hospitalizations. Differences in costs, clinical outcomes, and receipt of diagnostic tests between groups were not statistically significant. Conclusions Patients reassigned to NPs experienced similar outcomes and incurred less utilization at comparable cost relative to MD patients. NPs may offer a cost-effective approach to addressing anticipated shortages of primary care physicians.

► **The Changing Landscape of Primary Care: Effects of the ACA and Other Efforts over the Past Decade**

PEIKES D., TAYLOR E. F., O'MALLEY A. S., *et al.*

2020

Health Affairs 39(3): 421-428.

<https://doi.org/10.1377/hlthaff.2019.01430>

Providing high-quality primary care is key to improving health care in the United States. The Affordable Care Act sharpened the emerging focus on primary care as a critical lever to use in improving health care delivery, lowering costs, and improving the quality of care. We describe primary care delivery system reform models that were developed and tested over the past decade by the Center for Medicare and Medicaid Innovation which was created by the Affordable Care Act and reflect on key lessons and remaining challenges. Considerable progress has been made in understanding how to implement and support different approaches to improving primary care delivery in that decade, though evaluations showed little progress in spending or quality outcomes. This may be because none of the models was able to test substantial increases in primary care payment or strong incentives for other providers to coordinate with primary care to reduce costs and improve quality.

► **Ces patients « particuliers ». Comment les jeunes médecins (dé)médicalisent les symptômes médicalement inexplicables ?**

SARRADON-ECK A., DIAS M. ET POUCHAIN R.

2020

Sciences sociales et santé 38(1): 5-30.

<https://www.cairn.info/revue-sciences-sociales-et-sante-2020-1-page-5.htm>

À partir d'entretiens de groupe et individuels avec de jeunes médecins généralistes (internes ou récemment diplômés), l'article examine la catégorisation des personnes présentant des symptômes médicalement inexplicables en patients « particuliers » ou « difficiles ». Il analyse les ressorts de ce processus de catégorisation par les médecins qui se produit lorsqu'ils ont des difficultés à atteindre les idéaux médicaux incorporés lors de leur socialisation professionnelle. La mise en échec de ces idéaux les amène à reconfigurer leur savoir et leur expertise, et les conduit à re-conceptualiser les situations cliniques pour les inclure dans un cadre de pensée qui démédicalise une partie des demandes de soins afin de renforcer leur identité professionnelle. Cette démédicalisation de facto suit plusieurs voies. La première consiste à refuser ou à minimiser la gravité des troubles ressentis, et/ou les situer en dehors d'une prise en charge ordinaire en médecine générale. La seconde requalifie les troubles et le comportement de la personne dans le registre de la déviance morale et/ou médicale.

► **Changes in General Practitioners' Consultation Frequency over Time for Patients with Hypertension or Anxiety/Depression Symptoms: A 10-Year Follow-Up of the Norwegian HUNT Study**

SKARSHAUG L. J., KASPERSEN S. L., BJØRNGAARD J. H., *et al.*

2019

Family Practice 37(2): 248-254.

<https://doi.org/10.1093/fampra/cmz070>

General Practitioners' (GPs') workload has been suggested to increase in many countries; how does this impact patient follow-up? To investigate trends in GP consultation patterns for adults according to baseline hypertension and anxiety/depression symptoms and attribution of the GP to trend differences. Prospective cohort study, linking survey data and clinical measurements from the Norwegian HUNT3 study (2006–08)

with national administrative data on GP list assignment and consultations with GP services. We grouped participants aged 40–59 years according to sex and their baseline status regarding hypertension and anxiety/depression symptoms. We registered GP consultations in 2007–16 and used general estimation equation models to estimate the level of GP consultations per month per year during follow-up. We used multilevel models with participants nested in their assigned regular GP to calculate GP-level intra-class correlation coefficients, reflecting to what extent patients' consultation patterns could be attributed to the individual GP. In total, 47 550 HUNT3 participants were registered with 102 different GPs in Nord-Trøndelag County, Norway, in 2007. Adjusted for age, we observed an overall increase in GP consultations in 2007–16, particularly in those with a better health status at baseline. About 2% of the variance of patient consultations could be attributed to differences between GPs and 10% to the use of lengthy consultations. Out-of-hours consultations did not change much in the study period 2007–16. Increased use of GP consultations, mainly among the healthiest participants, encourage further research into whether these patients displace patients with heavier and more complex needs.

► **Integration and Retention of American Physician Assistants/Associates Working in English Hospitals: A Qualitative Study**

TAYLOR F., DRENNAN V. M., HALTER M., *et al.*
2020

Health Policy.

<https://doi.org/10.1016/j.healthpol.2020.03.001>

Health workforce planners in many high-income countries are considering policy strategies to retain home and overseas-trained health professionals. There is a lack of evidence on how hospitals can successfully integrate and retain skilled overseas professionals in relevant work roles. This study aimed to explore the integration and retention experiences of skilled American physician assistants/associates working in English hospitals.

► **Covid-19: How Coronavirus Will Change the Face of General Practice Forever**

THORNTON J.
2020

BMJ 368: m1279.

<https://www.bmj.com/content/bmj/368/bmj.m1279.full.pdf>

At practice level, primary care has altered dramatically in the past few weeks, with staff—clinical and administrative—adapting to new ways of working. At some practices, entrance doors are locked shut and prescriptions given out from a window. Red tape, appraisals, and routine work has been relaxed, and home visits hugely reduced. At the end of phone and video consultations, many patients are saying “thank you and good luck.”

Health Systems

► **Steering by Their Own Lights: Why Regulators Across Europe Use Different Indicators to Measure Healthcare Quality**

BEAUSSIER A.-L., DEMERITT D., GRIFFITHS A., *et al.*
2020

Health Policy 124(5) : 501-510

<https://doi.org/10.1016/j.healthpol.2020.02.012>

Despite widespread faith that quality indicators are key to healthcare improvement and regulation, surpris-

ingly little is known about what is actually measured in different countries, nor how, nor why. To address that gap, this article compares the official indicator sets—comprising some 1100 quality measures—used by statutory hospital regulators in England, Germany, France, and the Netherlands. The findings demonstrate that those countries' regulators strike very different balances in: the dimensions of quality they assess (e.g. between safety, effectiveness, and patient-centredness); the hospital activities they target (e.g. between clinical and non-clinical activities and management);

Systèmes de santé

and the ‘Donabedian’ measurement style of their indicators (between structure, process and outcome indicators). We argue that these contrasts reflect: i) how the distinctive problems facing each country’s healthcare system create different ‘demand-side’ pressures on what national indicator sets measure; and ii) how the configuration of national healthcare systems and governance traditions create ‘supply-side’ constraints on the kinds of data that regulators can use for indicator construction. Our analysis suggests fundamental differences in the meaning of quality and its measurement across countries that are likely to impede international efforts to benchmark quality and identify best practice.

► **Innovative Integrated Health and Social Care Programs in Eleven High-Income Countries**

BHATTACHARYYA O., SHAW J., SINHA S., *et al.*
2020

Health Affairs 39(4): 689-696.

<https://doi.org/10.1377/hlthaff.2019.00826>

High-income countries face the challenge of providing effective and efficient care to the relatively small proportion of their populations with high health and social care needs. Recent reports suggest that integrated health and social care programs target specific high-needs population segments, coordinate health and social care services to meet their clients’ needs, and engage clients and their caregivers. We identified thirty health and social care programs in eleven high-income countries that delivered care in new ways. We used a structured survey to characterize the strategies and activities used by these programs to identify and recruit clients, coordinate care, and engage clients and caregivers. We found that there were some common features in the implementation of these innovations across the eleven countries and some variation related to local context or the clients served by these programs. Researchers could use this structured approach to better characterize the core components of innovative integrated care programs. Policy makers could use this approach to provide a common language for international policy exchange, and this structured characterization of successful programs could play an important role in spreading them and scaling them up.

► **Realizing Policy Aspirations of Voluntary Sector Involvement in Integrated Care Provision: Insights from the English National Health Service**

CROFT C. ET CURRIE G.

2020

Health Policy 124(5) : 549-555

<https://doi.org/10.1016/j.healthpol.2020.03.008>

Integrating voluntary sector organizations (VSOs) into complex health and social care provision is a priority in global healthcare policy. However, realization of these policy aspirations in practice is limited, as VSOs struggle to collaborate with health and social care professionals, or influence the wider healthcare system, undermining their potential involvement in care provision. This paper aims to increase understandings of how the policy implementation gap could be addressed, by asking: how do new workforce roles support VSO involvement in delivering integrated care? Drawing on 40 interviews with VSO workers, healthcare commissioners, and healthcare professionals, conducted over 18 months in the English NHS, we outline how workforce capacity development through the introduction of coordinating roles, coupled with increasing regulatory control of VSO involvement, resulted in enhanced VSO integration in service provision. However, we also warn against the potential for exploitation of VSOs whereby they become replacements for health and social care provision, rather than a complementary service within an integrated team, resulting in patient harm. Our findings have important implications for policy makers, practitioners, VSO leaders and healthcare commissioners. We conclude that policy realization is dependent on the development of coordinating roles, coupled with levels of regulation which protect against exploitation without becoming normatively restrictive, thereby losing the important flexibility of VSOs.

► **Provision of Health Care Services and Regional Diversity in Germany: Insights from a Bayesian Health Frontier Analysis with Spatial Dependencies**

HASCHKA R. E., SCHLEY K. ET HERWARTZ H.

2020

The European Journal of Health Economics 21(1): 55-71.

<https://doi.org/10.1007/s10198-019-01111-9>

The German health care system is among the most patient-oriented systems in Europe. Nevertheless,

distinct utilisation patterns, access barriers due to socio-economic profiles, and potentials of misallocation of medical resources lead to disparities in the provision of health care services. We analyse how a possible over- and undersupply of services and the utilisation of and the access to the health care system relate to regional variations in the population's well-being. For this purpose, we employ a recent Bayesian stochastic frontier approach that allows for spatial dependence structures. Our results indicate that patient migration plays an important role in contributing to regional differences in the utilisation of the medical infrastructure. As a consequence, policy should take spatial patterns of health care utilisation into account to improve the allocation of medical resources.

► **Integration of Patient-Reported Outcomes (PROs) for Personalized Symptom Management in “Real-World” Oncology Practices: A Population-Based Cohort Comparison Study of Impact on Healthcare Utilization**

HOWELL D., LI M., SUTRADHAR R., *et al.*

2020

Supportive Care in Cancer.

<https://doi.org/10.1007/s00520-020-05313-3>

The use of patient-reported outcomes (PROs) for routine cancer distress screening is endorsed globally as a quality-care standard. However, there is little research on the integration of PROs in “real-world” oncology practices using implementation science methods. The Improving Patient Experience and Health Outcome Collaborative (IPEHOC) intervention was established at multisite disease clinics to facilitate the use of PRO data by clinicians for precision symptom care. The aim of this study was to examine if patients exposed to the intervention differed in their healthcare utilization compared with contemporaneous controls in the same time frame.

► **Is Canada Ready to Partner for Value-Based Healthcare?**

JASON V. ET GABRIELA P.

2020

HealthcarePapers 19(1): 40-47.

<https://www.longwoods.com/content/26156/is-canada-ready-to-partner-for-value-based-healthcare->

Global experience demonstrates that the transition of healthcare systems towards better value requires the collaboration of multiple actors, including health industry. Globally, several initiatives are already demonstrating the power of value-based partnerships between public and private sectors. This paper will explore how international healthcare systems are evolving to adapt to a new value-based framework and will highlight the role of the private sector. The paper will also provide some examples of successful projects in Canada and abroad. Health systems in Canada are strained. Is Canada's healthcare system ready for these innovative collaborative approaches with industry?

► **Prédiction du parcours de soins des patients en vue d'un modèle de financement intégré : exemple de la prothèse de hanche**

KANKEU-TCHEWONPI H., ELEGBEDE C. F., RIGOLLOT N., *et al.*

2020

Revue d'Épidémiologie et de Santé Publique 68: S21.

<https://doi.org/10.1016/j.respe.2020.01.045>

À la suite de la LFSS 2018 (Art. 51) qui prévoyait la mise en place de financements innovants à l'épisode de soins (EDS), l'ATIH, en lien avec la Direction générale de l'offre de soins (DGOS), la Cnam et les acteurs de terrain a mené des travaux pour comprendre le parcours de soins (PdS) des patients avec une pose de prothèse de hanche (PTH), afin de le prédire pour un patient donné et de financer l'EDS. Une méthodologie en trois temps a été élaborée : définir le périmètre de l'EDS et identifier les PdS ; prédire le PdS attendu pour un patient selon ses caractéristiques ; déterminer le forfait associé à l'EDS. Cette présentation décrit les deux premières étapes. Les données du Système national des données de santé (SNDS) 2013–2017 ont été utilisées (DCIR ; table bénéficiaire ; PMSI-MCO, SSR et HAD ; ACE). Tous les patients avec un séjour MCO pour pose de PTH (séjour initial) entre 2014 et 2016 ont été inclus. Premièrement, le périmètre de l'EDS a été défini : séjours hospitaliers MCO, SSR, HAD et soins de ville (SDV, infirmier, kiné, MPR) en lien avec la PTH. Des périodes pré (45 j) et post (90 j) séjour initial ont été considérées. Les principaux PdS ont ensuite été décrits. Deuxièmement, les facteurs prédictifs des PdS ont été recherchés parmi les caractéristiques des patients (âge, sexe, niveau socio-économique, comorbidités, etc.) par régression logistique et des méthodes de sélection de variables. Huit PdS principaux ont été

identifiés selon : SDV avant intervention, passage en SSR et SDV après intervention. La modélisation des PdS a montré, par exemple, que le passage en SSR est plus fréquent chez les femmes. Discussion/Conclusion Ces premières étapes ont permis de définir les PdS des patients avec une pose de PTH et d'en identifier les facteurs prédictifs. Les facteurs prédictifs retenus étaient cohérents avec les recommandations de la SOFMER. Le modèle développé permet de prédire le PdS pour un patient afin de financer l'entièreté de la consommation de soins au cours de l'EDS.

► **Inefficiencies in a Healthcare System with a Regulatory Split of Power: A Spatial Panel Data Analysis of Avoidable Hospitalisations in Austria**

RENNER A.-T.

2020

The European Journal of Health Economics 21(1): 85-104.

<https://doi.org/10.1007/s10198-019-01113-7>

Despite generous universal social health insurance with little formal restrictions of outpatient utilisation, Austria exhibits high rates of avoidable hospitalisations, which indicate the inefficient provision of primary healthcare and might be a consequence of the strict regulatory split between the Austrian inpatient and outpatient sector. This paper exploits the considerable regional variations in acute and chronic avoidable hospitalisations in Austria to investigate whether those inefficiencies in primary care are rather related to regional healthcare supply or to population characteristics. To explicitly account for inter-regional dependencies, spatial panel data methods are applied to a comprehensive administrative dataset of all hospitalisations from 2008 to 2013 in the 117 Austrian districts. The initial selection of relevant covariates is based on Bayesian model averaging. The results of the analysis show that supply-side variables, such as the number of general practitioners, are significantly associated with decreased chronic and acute avoidable hospitalisations, whereas characteristics of the regional population, such as the share of population with university education or long-term unemployed, are less relevant. Furthermore, the spatial error term indicates that there are significant spatial dependencies between unobserved characteristics, such as practice style or patients' utilization behaviour. Not accounting for those would result in omitted variable bias.

► **Value in Healthcare: Designing an Integrated Value-Based Healthcare System**

RICHARD LEWANCZUK A. C. K. T. ET VERNA Y.

2020

HealthcarePapers 19(1): 59-64.

<https://www.longwoods.com/content/26154>

Value-based healthcare (VBHC) can be interpreted in many ways depending on one's jurisdiction. Often it is used synonymously with cost-effectiveness. In Alberta, VBHC might more appropriately be termed "values-based healthcare." This reflects our belief that a healthcare system should meet the needs and desires of its population and contribute to overall wellness. We therefore developed a framework based on the dimensions of quality, the Quadruple Aim and feasibility considerations, which enables us to assess and measure our system activities and initiatives to determine if they are in keeping with VBHC in the Alberta context.

► **Towards Value in an Integrated Care Environment: Early Lessons from an Ontario Health Team**

SARAH DOWNEY S. M. ET PATRICK F.

2020

HealthcarePapers 19(1): 11-18.

<https://www.longwoods.com/content/26159>

Integrated healthcare models are being experimented with in many jurisdictions as a way to improve patient care and lower system costs. This commentary presents early lessons from one Ontario Health Team as it works towards new models of care. The authors recount early discussions on developing an integrated health services network, how funding for « winter surge initiatives »; became an opportunity to test ideas and how these experiences are informing current planning. Some of the early lessons learned include the value of trusted relationships, moving care upstream and framing problems as collective challenges.

► **Characterizing Patients with High Use of the Primary and Tertiary Care Systems: A Retrospective Cohort Study**

SINGER A., KOSOWAN L., KATZ A., *et al.*

2020

[Health Policy 124\(3\): 291-297.](#)

<https://doi.org/10.1016/j.healthpol.2020.01.011>

The aim of this study is to utilize complementary data from primary care and administrative health and social services to describe the clinical, social and demographic characteristics of high users of health care services. **Methods** We conducted a retrospective cohort study using data from the Manitoba Primary Care Research Network (MaPCReN) and the Manitoba Centre for Health Policy Research Data Repository in Canada. We assessed data from 193,760 patients with at least one visit to a primary care provider between 2011 and 2016. We defined HU within the following areas: primary care, hospital discharges, length of stay and emergency department visits. **Descriptive statistics and logistic regression** was used to identify key demographic, social, and medical complexities associated with HU. **Results** Between 2011 and 2016, 30.8% of patients had HU during at least one year within at least one area. Among patients with HU, 5% had persistent HU (HU for ≥ 2 years) and 359 (0.6%) had HU across all four definitions. **Medical complexity** was associated with HU for patients with hospital discharges, ED visits and primary care visits, whereas socially complex patients were more likely to have a longer LOS, and visit the ED. **Conclusions** There were unique characteristics in the various HU cohorts including medical, social, and demographic features that can inform strategies aimed at improving health system efficiency in managing patients with HU.

► **Integration Vs Separation in the Provision of Health Care: 24 OECD Countries Compared**

TOTH F.

2018

[Health Economics, Policy and Law 15\(2\): 160-172.](#)

<https://doi.org/10.1017/S1744133118000476>

This article proposes a classification of the different national health care systems based on the way the network of health care providers is organised. To this end, we present two rivaling models: on the one hand, the integrated model and, on the other, the separated model. These two models are defined based on five dimensions: (1) integration of insurer and provider; (2) integration of primary and secondary care; (3) presence of gatekeeping mechanisms; (4) patient's freedom of choice; and (5) solo or group practice of general practitioners. Each of these dimensions is applied to the health care systems of 24 OECD countries. If we combine the five dimensions, we can arrange the 24 national cases along a continuum that has the integrated model and the separated model at the two opposite poles. Portugal, Spain, New Zealand, the UK, Denmark, Ireland and Israel are to be considered highly integrated, while Italy, Norway, Australia, Greece and Sweden have moderately integrated provision systems. At the opposite end, Austria, Belgium, France, Germany, the Republic of Korea, Japan, Switzerland and Turkey have highly separated provision systems. Canada, The Netherlands and the United States can be categorised as moderately separated.

Travail et santé

Occupational Health

► **Paid Sick Leave in Washington State: Evidence on Employee Outcomes, 2016–2018**

SCHNEIDER D.

2020

[American Journal of Public Health 110\(4\): 499-504.](#)

<https://doi.org/10.2105/AJPH.2019.305481>

The aim of this study is to estimate if Washington State's paid sick leave law increased access to paid sick leave, reduced employees' working while sick, and relieved care burdens. **Methods.** I drew on new data from 12772 service workers collected before and after the law took effect in January 2018 in Washington State

and over the same time period in comparison states that did not have paid sick leave requirements. I used difference-in-difference models to estimate the effects of the law. Results. The law expanded workers' access to paid sick leave by 28 percentage points ($P < .001$). The law reduced the share of workers who reported working while sick by 8 percentage points ($P < .05$). Finally,

there was little evidence that the law served to reduce worklife conflict for Washington workers. Conclusions. Mandated paid sick leave increased access to paid sick leave benefits and led to reductions in employees working while sick. However, covered workers did not experience reductions in worklife conflict in the period immediately following passage.

Vieillesse

Ageing

► **Health Promotion Policies for Elderly—Some Comparisons Across Germany, Italy, The Netherlands and Poland**

ARSENIJEVIC J. ET GROOT W.
 2020

Health Policy : Ahead of pub.

<https://doi.org/10.1016/j.healthpol.2020.01.013>

The aim of this study is to compare health promotion policies (HPP) for older adults in four European countries: Germany, Italy, the Netherlands and Poland. We focus on the design, regulations and implementation of policies in these countries. Method :As policy relevant information is mostly available in national languages we have approached experts in each country. They filled in a specially designed questionnaire on the design, regulation and implementation of health promotion policies. To analyze the data collected via questionnaires, we use framework analyses. For each subject we define several themes. Results :Regarding regulations, Poland and Italy have a top-down regulation system for health promotion policy. Germany and Netherlands have a mixed system of regulation. Regarding the scope of the policy, in all four countries both health promotion and prevention are included. Activities include promotion of a healthy life style and social inclusion measures. In Poland and Italy the implementation plans for policy measures are not clearly defined. Clear implementation plans and budgeting are available in Germany and the Netherlands. Conclusions :In all four countries there is no document that exclusively addresses health promotion policies for older adults. We also found that HPP for older adults appears to be gradually disappearing from the national agenda in all four countries.

► **Les personnes âgées en France : où et dans quel logement vivent-elles ?**

BLANCHET M.
 2020

Population & Avenir 747(2): 4-7.

<https://www.cairn.info/revue-population-et-avenir-2020-2-page-4.htm>

► **Chronic Disease Management Models in Nursing Homes: A Scoping Review**

BOSCART V., CRUTCHLOW L. E., SHEIBAN TAUCAR L., *et al.*
 2020

BMJ Open 10(2): e032316.

<https://bmjopen.bmj.com/content/bmjopen/10/2/e032316.full.pdf>

Nursing home (NH) residents experience a high burden of chronic disease. Chronic disease management (CDM) can be a challenge, as the context of care provision and the way care is provided impact care delivery. This scoping review aimed to identify types of chronic diseases studied in intervention studies in NHs, influential contextual factors addressed by interventions and future CDM research considerations. The scoping review followed guidelines by Arksey and O'Malley (2005) and Levac, Colquhoun and O'Brien. (2010). Six reviewers screened citations for inclusion. Data extraction was performed by one reviewer and verified by a second reviewer. We searched four databases: CINAHL, EMBASE, PubMed and Scopus, in March 2018. Eligibility criteria Studies were included if (1) aim of intervention was to improve CDM, (2) intervention incorporated the chronic care model (CCM), (3) included NH residents, (4) analysed the efficacy of the intervention and (5)

sample included adults over age 65 years. Studies were limited to English or French language and to those published after 1996, when the CCM was first conceptualised. Extracted information included the type of chronic disease, the type and number of CCM model components used in the intervention, the method of delivery of the intervention, and outcomes. Results On completion of the review of 11 917 citations, 13 studies were included. Most interventions targeted residents living with dementia. There was significant heterogeneity noted among designs, outcomes, and type and complexity of intervention components. There was little evaluation of the sustainability of interventions, including feasibility. Research was heavily focused on management of dementia. The most commonly included CCM components were multidisciplinary care, evidence-based care, coordinated care and clinical information systems. Future research should include subjective and objective outcomes, which are meaningful for NH residents, for common chronic diseases.

► **Linking Health and Social Services Through Area Agencies on Aging Is Associated with Lower Health Care Use and Spending**

BREWSTER A. L., WILSON T. L., FREHN J., *et al.*
2020

Health Affairs 39(4): 587-594.

<https://doi.org/10.1377/hlthaff.2019.01515>

Area Agencies on Aging are increasingly partnering with health care organizations to address the health-related social needs of older adults and contribute to multisector coalitions that promote community health. Using survey data for the period 2008-13, we examined the potential health impacts of establishing such partnerships. Partnerships with hospitals located in an agency's service county were associated with a reduction of \$136 in average annual Medicare spending per beneficiary, while partnerships with mental health organizations in an agency's service county saw potentially avoidable nursing home use fall by 0.5 percentage points. When agencies were funded participants in livable community initiatives? multisector coalitions to promote the well-being and health of older adults potentially avoidable nursing home use fell by nearly 1 percentage point. Our results suggest that investments in health and human services partnerships through Area Agencies on Aging can yield health returns among older adults, in the form of reduced health care use and spending.

► **Lorsqu'un outil de coordination gérontologique territoriale suscite des tensions dans un service de soins**

CECCATO M.

2019

Management & Avenir Santé 5(1): 81-101.

<https://www.cairn.info/revue-management-et-avenir-sante-2019-1-page-81.htm>

L'article relate les perceptions de professionnels de santé officiant dans un hôpital public français suite à l'introduction d'un outil de coordination, le COGERT (Coordination Gérontologique par Télémédecine) à l'intérieur d'un service de soins. Les recherches portant sur l'introduction de la Télémédecine se sont focalisées sur ses bienfaits en matière médicale ou économique, mettant de côté les aspects organisationnels, du point de vue des pratiques des agents (David et al., 2003). Nous contribuons aux recherches portant sur ces pratiques en recueillant les perceptions de 7 professionnels de santé vis-à-vis de l'usage de cet outil, en s'intéressant aux tensions ressenties spécialement artefactuelles (Katz et Kahn, 1967; Smith et Lewis, 2011; Mazouz, Rousseau et Sponem, 2015). Le cas révèle des différences de perceptions entre les médecins et les cadres de santé (CS) autour de l'outil, complexifiant la prise en charge des patients chez les CS et nuisant à la coordination entre ces deux acteurs. Il souligne aussi la nécessité d'éclaircir les rôles et les missions des managers de proximité (MP).

► **Trajectoires d'aide au fil du temps. Articuler, désarticuler, réarticuler**

CHARLAP C., CARADEC V., CHAMAHIAN A., *et al.*

2020

Gérontologie et société 42 / 161(1): 147-170.

<https://www.cairn.info/revue-gerontologie-et-societe-2020-1-page-147.htm>

Apporter de l'aide à un proche âgé malade lorsqu'on travaille demande non seulement d'articuler l'activité d'aide et l'activité professionnelle, mais également les activités conjugales, parentales, grand-parentales, personnelles, et ce sur la durée. Dans cet article, fondé sur une enquête auprès de 35 proches en activité professionnelle prenant soin d'un parent atteint de troubles cognitifs et/ou moteurs, nous nous attachons à saisir de manière dynamique le travail d'articulation opéré par les aidants entre ces différentes activités. Notre propos est structuré en deux temps. Dans une première partie, nous présentons les deux dimensions à partir

desquelles se fonde le travail d'articulation : d'une part, le degré d'investissement dans l'aide, que nous appelons « registre d'aide » et qui renvoie à ce que l'aidant souhaite faire et, d'autre part, les éléments de contexte, qui constituent ce que nous nommons les « conditions pratiques » de l'aide et qui déterminent ce qu'il est possible de faire. Dans une seconde partie, nous présentons une typologie de trajectoires d'aide, entre continuité et discontinuité des registres d'aide, éclairant, dans le temps, le travail d'articulation, de désarticulation et de réarticulation.

► **The Relationship Between Physical Activity and Out-Of-Pocket Health Care Costs of the Elderly in Europe**

DALLMEYER S., WICKER P. ET BREUER C.

2020

European Journal of Public Health.

<https://doi.org/10.1093/eurpub/ckaa045>

Increasing health care costs represent an economic burden placed on individuals across many European countries. Against this backdrop, the aim of this study was to examine the relationship between participation in physical activity and out-of-pocket health care costs in Europe. Individual data from the cross-national Survey of Health, Ageing and Retirement (n = 94267) including 16 European countries were utilized. Two-part models were estimated to investigate how different levels of participation frequency in physical activity are related to out-of-pocket costs (OOPC) for people aged 50 years and older. Only participation in physical activity more than once a week significantly decreases the probability of incurring any OOPC. However, all frequencies of physical activity significantly reduce the level of costs, with the highest savings being generated by participation once a week. The results reveal higher savings for men compared to women. Physical activity can be a useful policy instrument to reduce the economic burden of out-of-pocket health care costs for an aging population in Europe. Public officials should primarily promote physical activity interventions targeting older people who are not active at all.

► **Covid-19 and Long Term Conditions: What if You Have Cancer, Diabetes, or Chronic Kidney Disease?**

EXTANCE A.

2020

BMJ 368: m1174.

<https://www.bmj.com/content/bmj/368/bmj.m1174.full.pdf>

When the UK prime minister, live on national TV with the chief medical officer Chris Whitty, advised vulnerable patients—including those with chronic kidney disease—to minimise their social contact, it should have been a welcome surprise for Tess Harris, chief executive of the Polycystic Kidney Disease (PKD) charity. But recognition of this often unseen group provided no pleasure. Instead, it led to confusion.

► **Expectations and Needs of Families in Nursing Homes: An Integrative Review**

HAVRENG-THÉRY C., GINER-PEROT J., ZAWIEJA P., *et al.*

2020

Medical Care Research and Review Ahead of pub.

<https://journals.sagepub.com/doi/abs/10.1177/1077558720907183>

A better understanding of the expectations and needs of the families of nursing home residents is needed for a constructive and sustainable relationship of mutual trust. The objective of this study was to understand the expectations of families of nursing home residents described in the literature. A systematic integrative review of the literature was conducted. After a rigorous selection made by two researchers, independently, 53 articles were selected out of 1,094 results. The expectations of families are quality care, consideration complying with human dignity of the resident, collaboration, honesty, and mutual confidence that ties together families, staff, and physicians. This study reveals that families consider themselves as a strength for a resident's support services, in line with Gottlieb's strength-based approach. This approach offers promising implications for practice and for a new type of management in nursing homes based on strong values.

► **Use of Long-Term Care Services in a Universal Welfare State - on the Importance of Age at Migration**

INNES H. M.

2020

Social Science & Medicine 252: 112923.

<https://doi.org/10.1016/j.socscimed.2020.112923>

There is broad agreement in the international literature that there are significant barriers to the use of long-term care services (LTCS) by older migrants in various contexts. However, there is a lack of comprehensive study in this area, and particularly concerning the diversity of migrants from different sending countries and the heterogeneity of their migration trajectories concerning the age at migration. Barriers to the use of care might be intensified for persons migrating at an older age, resulting in lower use of care. However, it is still unknown whether late-in-life migrants are under-represented as users of LTCS in comparison to Swedish born and migrants arriving at younger ages. We study the likelihood of using any (1) LTCS, (2) residential care, and (3) personal and domestic care among older foreign-born, compared to Swedish-born older persons. Secondly, we study the likelihood of care across different birth countries compared to older persons born in Sweden. Thirdly, we investigate the likelihood of LTCS among migrants arriving at different ages. The total population of all persons 65 years and over in Sweden, is studied using register data with almost two million observations. The central findings of this study show that there is substantial heterogeneity across and within different birth countries regarding utilization of LTCS, residential care and personal and domestic care. The results from this study also suggest that late in life migration does not have to imply lower utilization of LTCS, residential care and personal, and domestic care. However, results show a slight over-representation of personal and domestic care among those who have migrated later in life. Further, there is an under-representation of residential care among late-in-life migrants. Our findings thus suggest that caution is needed when generalizing about levels of formal care use in migrant populations.

► **Multimorbidity and Intention to Retire: A Cross-Sectional Study on 14 European Countries**

LAIRES P. A., SERRANO-ALARCÓN M., CANHÃO H., *et al.*

2020

International Journal of Public Health 65(2): 187-195.

<https://doi.org/10.1007/s00038-019-01322-0>

To describe the association between multimorbidity and intention of retirement in Europe and to understand whether this relationship is modified by the working environment and disability integration policies.

► **Retraites : une réforme mal préparée et peu urgente**

LE BRAS H.

2020

Études (3): 31-43.

<https://www.cairn.info/revue-etudes-2020-3-page-31.htm>

En France, de nombreux aspects des retraites peuvent être améliorés et beaucoup de petites injustices existent. Un chauffeur de bus à Bordeaux n'a pas les mêmes avantages qu'à Paris. Ce n'est pas une raison pour tout chambouler, ni pour crier au loup et à l'urgence d'une réforme comme s'il fallait prévenir une prochaine catastrophe dont on va montrer qu'elle ne s'annonce pas.

► **Les proches aidants en France. De l'invisibilité à l'inscription dans les politiques publiques ?**

LEDUC F.

2020

Gérontologie et société 42 / 161(1): 31-35.

<https://www.cairn.info/revue-gerontologie-et-societe-2020-1-page-31.htm>

Faire reconnaître le rôle central des aidants profanes et rappeler le caractère indispensable de leur contribution fait aujourd'hui partie des principaux besoins que les aidants revendiquent explicitement, tant vis-à-vis des professionnels avec qui ils collaborent, que vis-à-vis des pouvoirs publics. Dans un contexte de plus forte sensibilisation à leur égard, c'est aussi l'ambition de ce numéro de *Gérontologie et société*, qui se propose à la fois de définir et de renseigner ce que recouvre la notion de proches aidants auprès de

personnes âgées mais également de comprendre la nature de leurs engagements et de leurs expériences. Comment ces aidants pensent-ils leur rôle et envisagent-ils leur situation ? Quels sont les ressorts et les logiques sociales qui déterminent leurs investissements et leurs manières d'aider ? Dans quelle mesure sont-ils épaulés et comment s'accommodent-ils des services qui leur sont proposés ? Sur la base d'une sélection de 9 articles, retenus pour leur diversité d'approche disciplinaire et territoriale, les contributions présentes dans ce numéro offrent un témoignage concret du profil hétérogène de ces aidants, de l'extrême diversité des tâches qu'ils accomplissent mais aussi des difficultés qu'ils sont susceptibles de rencontrer au quotidien. Plus fondamentalement encore, ils interrogent la situation d'aide, l'intimité des relations entre aidants et aidés et démontrent l'impérieuse nécessité à poursuivre les efforts pour soutenir ces proches aidants dans leur travail quotidien d'accompagnement.

► **La réception de l'aide informelle au grand âge : entre solidarité et ambivalence**

MASOTTI B. ET HUGENTOBLER V.

2020

Gérontologie et société 42 / 161(1): 71-86.

<https://www.cairn.info/revue-gerontologie-et-societe-2020-1-page-71.htm>

L'objectif de cet article est de s'interroger sur la place qu'ont les solidarités informelles dans le dispositif d'aide à la vieillesse qui, en Suisse, est fortement ancré autour du maintien à domicile. La réflexion se construit en partant du point de vue, encore peu exploré, de l'aidé. Les données sont à la fois quantitatives et qualitatives et portent sur un échantillon de personnes âgées de 80 ans et plus vivant à domicile dans le canton du Tessin. Une large majorité bénéficie du soutien d'un ou de plusieurs proches ; un support qui s'exprime avant tout dans la présence et dans des tâches plus pratiques et ponctuelles telles que les courses, le transport et les aides administratives. Plus présente chez les aînés insérés dans un réseau filial, cette aide reste pourtant déterminée non pas par l'existence d'une descendance, mais par celle de contacts directs d'une certaine fréquence et, par conséquent, d'une proximité géographique entre aidant et aidé. Si elle suscite généralement des vécus positifs, l'aide intergénérationnelle peut aussi générer des contradictions : d'une part du fait que, face à des besoins majeurs, on souhaiterait compter sur la présence de ses enfants, d'autre part en raison de la volonté de respecter l'autonomie de

ceux-ci. Une reconnaissance institutionnelle majeure de l'aide des proches – par l'introduction d'aides financières et de congés universels – pourrait contribuer à réduire ce sentiment d'ambivalence, tant chez l'aidant que chez l'aidé.

► **Vieillir en couple, rôle du conjoint aidant et (non-)recours aux professionnels**

RENAUT S.

2020

Gérontologie et société 42 / 161(1): 117-132.

<https://www.cairn.info/revue-gerontologie-et-societe-2020-1-page-117.htm>

Avec l'allongement de la vie des hommes et des femmes, le vieillissement ordinaire repose plus longtemps sur la vie en couple : en 2015 en France métropolitaine, six personnes sur dix vivent à deux avec leur conjoint après 60 ans à domicile. Croisant deux types d'analyses quantitative et qualitative issues de l'enquête CARE (Capacités, Aides et REssources des seniors), l'article observe la fréquence de l'aide des conjoints, le (non-)recours aux professionnels et la capacité du couple à renforcer ou restreindre la disposition à se faire aider par l'extérieur. Trois fois sur quatre, les personnes vivant à deux en couple, aidées par leur entourage ou un professionnel pour les activités quotidiennes, désignent leur conjoint comme aidant. Au-delà du niveau de dépendance et de l'aide d'autres proches que le conjoint, la demande d'aide professionnelle des femmes est toujours plus fréquente que celle des hommes. Des entretiens semi-directifs auprès de 25 couples permettent d'expliquer le (non-)recours aux professionnels selon quatre logiques impliquant le conjoint aidant : la valorisation de l'entraide dans le couple comme rempart vis-à-vis de l'extérieur, le refus de déléguer des activités assumées par les femmes, le (non-)recours comme enjeu de pouvoir dans les relations de couple conflictuelles et enfin, le recours aux professionnels justifié par l'implication du conjoint aidant.

► **Decentralized Home Care Sector Regulation and the Demand for Formal Care**

ROQUEBERT Q., KABORÉ R. ET WITTEWER J.

2019

Revue d'économie politique 129(6): 1031-1054.

<https://www.cairn.info/revue-d-economie-politique-2019-6-page-1031.htm>

Face au vieillissement de la population dans les pays de l'OCDE, une grande partie des politiques publiques encouragent le recours à l'aide professionnelle à domicile pour les personnes âgées résidant à domicile. En France, ces politiques financent la demande d'aide dite formelle sous la forme de subventions mais régulent également, du côté de l'offre, une partie des producteurs dans le secteur de l'aide à domicile. Cet article étudie le lien entre la régulation de l'offre et le recours à l'aide à domicile des personnes âgées à domicile. Dans le contexte d'une régulation décentralisée au niveau des conseils départementaux, nous utilisons les variations territoriales du niveau de régulation pour estimer les déterminants du recours à l'aide formelle. Nous exploitons une enquête départementale originale pour enrichir l'enquête nationale Handicap Santé Ménages. Lorsque les producteurs non régulés — dont la qualité est peu contrôlée et le prix n'est pas régulé — dominant le marché, le recours à l'aide formelle est plus faible. Cet effet est toutefois concentré sur les personnes âgées de 60 à 70 ans et n'est pas observé pour les populations plus âgées. Ces résultats contribuent à discuter les questions soulevées par la décentralisation d'une politique nationale ainsi que les effets de la récente réforme du secteur de l'aide à domicile augmentant le niveau de régulation du marché.

► **Important Oral Care Needs of Older French People: A Cross-Sectional Study**

ROSA R. W., SAMOT J., HELMER C., *et al.*

2020

Revue d'Épidémiologie et de Santé Publique 68(2): 83-90.

<https://doi.org/10.1016/j.respe.2020.01.135>

Les personnes âgées constituent une proportion croissante de la population européenne mais leur profil épidémiologique bucco-dentaire est mal documenté. Les objectifs de cette étude étaient d'évaluer l'état bucco-dentaire des personnes âgées de 90 ans et plus en France, de comparer leurs besoins en soins

bucco-dentaires perçus et observés, et d'identifier les problèmes bucco-dentaires associés à une faible qualité de vie liée à la santé bucco-dentaire (QdVSBD).

► **The Dynamics of Frailty and Change in Socio-Economic Conditions: Evidence for the 65+ in Europe**

SIRVEN N., DUMONTET M. ET RAPP T.

2020

Eur J Public Health : Ahead of pub.

The frailty phenotype for older people is defined as an increased vulnerability to stressors, leading to adverse health outcomes. It is acknowledged as a specific precursor of disability besides chronic diseases that allows for some reversibility in the loss of autonomy. Although the literature on the socio-economic determinants of frailty is emerging in cross-sectional settings, little is known about the dynamics of this relationship over time. This article examines the joint evolution of frailty and change in economic conditions for the 65+ in Europe. METHODS: Individual and longitudinal data from SHARE (Survey on Health, Ageing and Retirement in Europe) over the period 2004-12 has been used. The sample contains 31 044 observations from 12 002 respondents aged 65 or more. A fixed effect Poisson model is estimated in order to control for unobserved individual heterogeneity. Three types of explanative economic variables have been considered in turn: income, wealth and a subjective variable of deprivation. RESULTS: Our results indicate that individuals with worsening economic conditions (wealth and subjective deprivation) over time simultaneously experience a rapid increase in the frailty symptoms. Results also show that the nature of economic variable does not affect the frailty process in the same way. Subjective measure of deprivation seems to better evaluate the household's financial difficulties than objective measure. CONCLUSION: From a public policy perspective, these results show that policies fostering economic conditions of the elderly could have a significant impact on frailty and henceforth, could reduce the risks of disability.

► **Conjoint-e comme avant : genre et frontières des aides conjugale et filiale**

THOMAS J. ET BANENS M.

2020

Gérontologie et société 42 / 161(1): 55-69.

<https://www.cairn.info/revue-gerontologie-et-societe-2020-1-page-55.htm>

La question des « frontières de genre », proposée par Toni Calasanti et Mary Elizabeth Bowen (2006) pour analyser l'aide conjugale, est approfondie ici pour étudier les délimitations de l'aide à une personne âgée avec des incapacités grandissantes encore en couple à domicile. Dans le cadre d'une enquête par entretiens, étudier les frontières de l'aide et les positions dans les relations familiales nous ont permis de mieux comprendre l'expérience des aidés et des aidants, conjugaux et familiaux. La définition familiale de ces frontières paraît liée à celle du genre, mais avant tout à celle du maintien des équilibres familiaux et conjugaux antérieurs. Nous verrons ainsi d'une part que les frontières les plus importantes sont conjugales, arrangées par le couple autour de lui-même dans le but de maintenir l'unité domestique « comme avant », en déléguant certaines tâches aux enfants de manière genrée. D'autre part, la continuation de la relation conjugale : la manière de « faire couple », telle qu'elle existait avant les incapacités, semble prioritaire, et peut signifier, dans les pratiques, traverser les « frontières du genre » à l'encontre des habitudes passées. Le genre pèse en revanche fortement sur les vécus de l'aide, et les manières d'en parler – plutôt en défaveur des femmes.

► **Proche aidance et conjugalité aux âges avancés : motivations et postures**

VAN PEVENAGE I., DAUPHINAIS C., DUPONT D., *et al.*

2020

Gérontologie et société 42 / 161(1): 37-54.

<https://www.cairn.info/revue-gerontologie-et-societe-2020-1-page-37.htm>

Cet article s'intéresse aux motifs avancés par des personnes âgées pour expliquer le soin apporté à leur conjoint au Québec. Les expériences de l'aide explorées ici se situent au prisme de la conjugalité et de la prise en charge d'un conjoint nécessitant du soutien au quotidien. Nos analyses visent à approfondir les motifs de l'aide, en les inscrivant dans leurs contextes particuliers dont celui de la relation conjugale. Cela nous apparaît d'autant plus important que les recherches

sur la proche aidance se sont principalement concentrées sur les relations filiales. Basés sur l'analyse de 27 entretiens menés auprès de personnes âgées de 65 ans et plus qui offrent un soutien quotidien à leur conjoint malade, les résultats montrent que les motivations des proches aidantes s'inscrivent pour une grande part dans une logique de préservation des continuités conjugales et identitaires. En outre, les participantes présentent, au moment de l'entretien, différentes postures face à leur situation : des personnes assument complètement leur engagement, d'autres se montrent davantage résignées et d'autres encore présentent un profil davantage subi. Ces postures ne peuvent toutefois être appréhendées sans considérer le rôle déterminant des facteurs contextuels que sont le type et la trajectoire de la maladie, l'état de santé physique et psychologique de la proche aidante, ainsi que l'accès, l'organisation et la qualité des services formels.

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