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

Veille scientifique
en économie de la santé

Watch on Health Economics Literature

Mai 2024 / May 2024

Assurance maladie	*Health Insurance*
E-santé	*E-Health*
Économie de la santé	*Health Economics*
Environnement et santé	*Environnemental Health*
État de santé	*Health status*
Géographie de la santé	*Geography of Health*
Handicap	*Disability*
Hôpital	*Hospital*
Inégalités de santé	*Health Inequalities*
Médicaments	*Pharmaceuticals*
Méthodologie – Statistique	*Methodology-Statistics*
Politique de santé	*Health Policy*
Prévention	*Prevention*
Psychiatrie	*Psychiatry*
Sociologie de la santé	*Sociology of Health*
Soins primaires	*Primary Health Care*
Systèmes de santé	*Health Systems*
Travail et santé	*Occupational Health*
Vieillissement	*Aging*

Centre de documentation de l'Irdes / IRDES Information Center

Présentation

Cette publication mensuelle, réalisée par les documentalistes de l'Irdes, rassemble de façon thématique les résultats de la veille documentaire sur les systèmes et les politiques de santé ainsi que sur l'économie de la santé : articles, littérature grise, ouvrages, rapports…

Certaines publications recensées sont disponibles gratuitement en ligne. D'autres, payantes, peuvent être consultées sur rendez-vous au Centre de documentation de l'Irdes ou être commandées auprès des éditeurs concernés. Des copies d'articles peuvent aussi être obtenues auprès des bibliothèques universitaires (Sudoc) ou de la British Library. En revanche, aucune photocopie par courrier n'est délivrée par le Centre de documentation.

La collection des numéros de Veille scientifique en économie de la santé (anciennement intitulé Doc Veille) est consultable sur le site internet de l'Irdes :
www.irdes.fr/documentation/veille-bibliographique-en-economie-de-la-sante.html

Presentation

Produced by the IRDES Information Centre, this publication presents each month a theme-sorted selection of recently published peer-reviewed journal articles, grey literature, books and reports related to Health Policy, Health Systems and Health Economics.

Some documents are available online for free. Paid documents can be consulted at the IRDES Information centre or be ordered from their respective publishers. Copies of journal articles can also be obtained from university libraries (see Sudoc) or the British Library.

Please note that requests for photocopies or scans of documents will not be answered.

All past issues of Watch on Health Economics Literature (previously titled Doc Veille) are available online for consultation or download:

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

Veille scientifique en économie de la santé

Watch on Health Economics Literature

Directeur de la publication	Denis Raynaud	**Publication Director**
Documentalistes	Véronique Suhard Rouguiyatou Ndoye	**Information specialists**
Maquette & Mise en pages	Franck-S. Clérembault	**Design & Layout**

ISSN : 2556-2827

Institut de recherche et documentation en économie de la santé
21-23, rue des Ardennes - 75019 Paris • Tél. : 01 53 93 43 00 • www.irdes.fr

Sommaire
Contents

Assurance maladie
Health Insurance

E-santé
E-Health

Économie de la santé
Health Economics

Environnement et santé
Environnemental Health

État de santé
Health status

Géographie de la santé
Geography of Health

Handicap
Disability

Hôpital
Hospital

Inégalités de santé
Health Inequalities

Médicaments
Pharmaceuticals

Méthodologie – Statistique
Methodology-Statistics

Politique de santé
Health Policy

Prévention
Prevention

Psychiatrie
Psychiatry

Sociologie de la santé
Sociology of Health

Soins primaires
Primary Health Care

Systèmes de santé
Health Systems

Travail et santé
Occupational Health

Vieillissement
Aging

Assurance maladie

Health Insurance

Joint Effects of Medicaid Eligibility and Fees on Recession-Linked Declines in Healthcare Access and Health Status

BENITEZ J., CALLISON K. ET ADAMS E. K.

2024

Health Economics: 1-28.

https://doi.org/10.1002/hec.4823

Whether Medicaid can function as a safety net to offset health risks created by health insurance coverage losses due to job loss is conditional on (1) the eligibility guidelines shaping the pathway for households to access the program for temporary relief, and (2) Medicaid reimbursement policies affecting the value of the program for both the newly and previously enrolled. We find states with more expansive eligibility guidelines lowered the healthcare access and health risk of coverage loss associated with rising unemployment during the 2007–2009 Great Recession. Rises in cost-related barriers to care associated with unemployment were smallest in states with expansive eligibility guidelines and higher Medicaid-to-Medicare fee ratios. Similarly, states whose Medicaid programs had expansive eligibility guidelines and higher fees saw the smallest recession-linked declines in self-reported good health. Medicaid can work to stabilize access to health care during periods of joblessness. Our findings yield important insights into the alignment of at least two Medicaid policies (i.e., eligibility and payment) shaping Medicaid's viability as a safety net.

The Association Between Allostatic Load and Guaranteed Annual Income Using the Canadian Longitudinal Study on Aging: A Cross-Sectional Analysis of the Benefits of Guaranteed Public Pensions

DUIGNAN L. ET DUTTON D. D.

2024

Health Policy 143: 105054.

https://doi.org/10.1016/j.healthpol.2024.105054

Background Old Age Security (OAS) represents an public policy through which income-related inequalities in health may be improved. The goal of this cross-sectional study was to investigate the health benefits of receiving OAS in financially insecure older Canadians. Methods Using data from the Canadian Longitudinal Study on Aging (CLSA) (n = 15,691), ordered logistic regression was used to measure associations between financial insecurity and allostatic load. Results Receiving OAS as highest personal income source appeared to remove the health penalty of being financially insecure. While financial insecurity was associated with worse allostatic load in both males and females not receiving OAS, those receiving OAS as highest personal income source had better allostatic load compared to other financially insecure older adults (ORM: 0.398, 95% CI: 0.227, 0.696; ORF: 0.677, 95% CI: 0.483, 0.949). Discussion While longitudinal data would be needed to draw causal inferences, these results suggest OAS may play a role improving health outcomes and narrowing income-related health inequalities. Such findings may have important implications on older adults, other vulnerable populations, and future directions of Canadian health and public policy.

The French Medical Community United Against Cuts to State Medical Aid

FÉRAL PIERSSENS A. L., CASTAN B., CORDEL H., *et al.*

2024

Health Policy 143: 105037.

https://doi.org/10.1016/j.healthpol.2024.105037

State medical aid was created in France in 2000. It guarantees free access to healthcare for undocumented migrants. It has improved their access to health care and contributed to the preservation of public health. Politically presented as a factor of France's attractiveness, it is under political threat. There is no scientific data to support this association with migratory flows.

Out-Of-Pocket Expenditure, Need, Utilization, and Private Health Insurance in the Australian Healthcare System

LUDLOW T., FOKIN J., ROSE C., *et al.*
2024
International Journal of Health Economics and Management 24(1): 33-56.
https://doi.org/10.1007/s10754-023-09362-z

Despite widespread public service provision, public funding, and private health insurance (PHI), 20% of all healthcare expenditure across the OECD is covered by out-of-pocket expenditure (OOPE). This creates an equity concern for the increasing number of individuals with chronic conditions and greater need, particularly if higher need coincides with lower income. Theoretically, individuals may mitigate OOPE risk by purchasing PHI, replacing variable OOPE with fixed expenditure on premiums. Furthermore, if PHI premiums are not risk-rated, PHI may redistribute some of the financial burden from less healthy PHI holders that have greater need to healthier PHI holders that have less need. We investigate if the burden of OOPE for individuals with greater need increases less strongly for individuals with PHI in the Australian healthcare system. The Australian healthcare system provides public health insurance with full, partial, or limited coverage, depending on the healthcare service used, and no risk rating of PHI premiums. Using data from the Household, Income and Labor Dynamics in Australia survey we find that individuals with PHI spend a greater share of their disposable income on OOPE and that the difference in OOPE share between PHI and non-PHI holders increases with greater need and utilization, contrary to the prediction that PHI may mitigate OOPE. We also show that OOPE is a greater concern for poorer individuals for whom the difference in OOPE by PHI is the greatest.

Correction: Universal Health Coverage in the Context of Population Ageing: Catastrophic Health Expenditure and Unmet Need For Healthcare

OKAMOTO S., SATA M., ROSENBERG M., *et al.*
2024
Health Economics Review 14(1): 20.
https://doi.org/10.1186/s13561-024-00495-6
Correction to: Health Econ Rev 14, 8 (2024)

E-santé

E-Health

Weaving EU Digital Health Policy into National Healthcare Practices. The Making of a Reimbursement Standard For Digital Health Technologies in Belgium

LIEV VROUW E., MARELLI L. ET VAN HYKEHAM I.
2024
Social Science & Medicine 346: 116620.
https://doi.org/10.1016/j.socscimed.2024.116620

Along the hopes and fears around the recent rise of Digital Health Technologies (DHT), EU and Member State (MS) policymakers have sought to find ways to translate these innovations into tangible trustworthy and reliable tools for health and care practices. While these translation-efforts have been developed across different healthcare contexts with their own histories, practices, and values, their increasing entanglement has over the years raised several implementation issues between EU and MS policy initiatives. While policymakers have struggled to understand the reasons behind this, this article proposes to 'move focus' towards a socio-technical understanding of DHT by investigating how these alignment attempts come about in practice. For this we focus on Belgium's front-running attempt to develop a reimbursement framework for DHT. Drawing on a document analysis of EU and Belgian policy, media, and industry publications (2016–2022), field observations, and interviews, we demonstrate how Belgian policymakers have tried to align their attempt to improve trust in DHT with existing EU efforts in this regard through the development of their 'mhealthBelgium validation pyramid'. With this, we show that rather than overcoming translation difficulties, the pyramid is in fact enacting frictions around 'trust', 'medical' devices, the 'empowered' patient, and 'valuable' data. Beyond mere technical accounts of the translation challenges at hand, this article therefore points to the way this pyramid is "locking-in" these frictions, and with this has hindered the implementation of DHT. Despite the Belgian government's announcement of a renewed reimbursement framework two years later, its emphasis on overcoming technical translation issues risks re-enacting these very same entrenched frictions.

Rapport 24-03. Systèmes d'IA générative en santé : enjeux et perspectives

NORDLINGER B., KIRCHNER C. ET DE FRESNOYE O.

2024

Bulletin de l'Académie Nationale de Médecine. (in Press)

https://doi.org/10.1016/j.banm.2024.03.005

La santé est un des domaines majeurs d'application des technologies dites d'intelligence artificielle. Tous les domaines de la santé et toutes les spécialités sont concernés. Les systèmes d'intelligence artificielle générative (SIAgen) impressionnent par leur capacité à produire en quelques secondes des textes souvent pertinents, mais aussi parfois erronés. Leurs champs d'applications dans le domaine de la santé sont vastes et peuvent aller de l'aide à la rédaction de notes d'information à la rédaction de thèses ou de projets de programme de recherche. Pour les utiliser à bon escient il est important d'en connaître les principes de fonctionnement. Les SIAgen fonctionnent à partir d'auto-apprentissage basé sur un nombre extrêmement élevé d'exemples, ce qui est très différent de l'approche humaine, qui s'appuie sur l'expérience, le contexte et un système de valeurs. Ils génèrent des textes avec une grande rapidité mais ne sont pas entraînés à rechercher ou à dire la vérité. Une validation humaine est donc toujours nécessaire. Par ce rapport, l'Académie nationale de médecine explicite plusieurs de ces avancées pour la santé, décrit les enjeux d'éthique associés et recommande des points d'actions à mettre en œuvre sans délai. Summary Healthcare is one of the major application fields of Artificial Intelligence technologies. All areas of healthcare and all specialties are concerned. Generative Artificial Intelligence systems are impressive in their ability to produce texts in a matter of seconds, often relevant, but sometimes erroneous. They can be used in a wide range of healthcare applications, from helping to write briefing notes to drafting theses and research programs. To use them properly, it is important to understand how they work. Large Language Models use neural networks trained on massive amounts of text data, which is very different from the human, experience-based approach. They generate language but are not trained to tell or search for the truth. Human validation is therefore always necessary. Through this report, the Académie nationale de médecine explains the resulting progress and discoveries for health, describes associated ethical issues and recommends action points to be implemented without delay.

Comment les usages des outils d'Intelligence Artificielle augmentent-ils la capacité d'agir des radiologues ?

PEREZ-TORRENTS J. ET MINVIELLE É.

2023

Journal de gestion et d'économie de la santé 3(3): 185-203.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2023-3-page-185.htm

Les usages croissants des outils d'Intelligence Artificielle (IA) dans le domaine médical, notamment en radiologie, soulèvent des questions cruciales sur l'augmentation des capacités des professionnels hautement qualifiés. Notre étude se concentre sur deux cadres théoriques : les « pratiques interrogatives » et le cadre conformation/exploration. À partir de 81 heures d'observations (par la méthode du shadowing) et de 9 entretiens menés dans deux établissements de santé faisant usage de l'outil d'IA pour le diagnostic des mammographies, nous découvrons que la collaboration entre les radiologues et l'outil d'IA renforce principalement leurs capacités existantes (conformation) plutôt qu'à en développer de nouvelles (exploration). Ces résultats suggèrent la nécessité d'un dialogue approfondi entre les concepteurs d'outils d'IA et les experts métier pour promouvoir des pratiques interrogatives orientées vers l'exploration, permettant ainsi d'accroître les capacités professionnelles.

The Association of Hospital Profitability and Digital Maturity – an Explorative Study Using Data From the German Digitalradar Project

VOGEL J., HOLLENBACH J., HAERING A., *et al.*

2024

Health Policy 142: 105012.

https://doi.org/10.1016/j.healthpol.2024.105012

German hospitals largely rely on public investments for digitization. As these have been insufficient, hospitals had to use own profits to foster digital transformation.

Thus, we assess if profitability affects digital maturity, and what other factors might be influential.

Improving Health and Reducing Health Inequality: An Innovation of Digitalization?

ZHONG M., QIANG D., WANG J., *et al.*

2024

Social Science & Medicine 348: 116847.

https://doi.org/10.1016/j.socscimed.2024.116847

Rationale The association between digitalization and individual health has attracted increasing attention from both scholars and policymakers. Existing research, however, has not agreed on whether digitization can improve health or reduce health inequality. Objective The purpose of this study is to clarify whether and how the development of digitalization may be related to health and health disparities. Methods We rely on China Family Panel Studies (CFPS) surveys from 2012 to 2018 to obtain a sample of 82,471 observations to explore the impact of digitalization on self-rated health and health inequality and its transmission mechanisms. The hypotheses are tested by Ordinary Least Squares Modeling. Results As expected, digitalization is significantly and positively correlated with self-rated health. Furthermore, the development of digitalization has led to a notable decrease in health inequality. The influencing mechanisms of digitalization include income, healthcare consumption and health behaviors. Both dimensions of digitalization—internet development and digital finance—generate significant effects and the effects of internet development are greater. Conclusions This study is the first to systematically investigate the impact of digitalization development on health and health inequality. Our findings provide evidence for the health promotion theory by clarifying the benefits of digitalization in improving residents' health and reducing health inequality. Therefore, utilizing the tools of digitalization efficiently could be a focus of policymakers aiming to accomplish the SDGs' health targets.

Économie de la santé

Health Economics

Physician Responses to Insurance Benefit Restrictions: The Case of Ophthalmology

ABIONA O., HAYWOOD P., YU S., *et al.*

2024

Health Economics 33(5): 911-928.

Abstract This study examines the impact of social insurance benefit restrictions on physician behaviour, using ophthalmologists as a case study. We examine whether ophthalmologists use their market power to alter their fees and rebates across services to compensate for potential policy-induced income losses. The results show that ophthalmologists substantially reduced their fees and rebates for services directly targeted by the benefit restriction compared to other medical specialists' fees and rebates. There is also some evidence that they increased their fees for services that were not targeted. High-fee charging ophthalmologists exhibited larger fee and rebate responses while the low-fee charging group raise their rebates to match the reference price provided by the policy environment.

Immigration, Policies of Integration and Healthcare Expenditure: A Longitudinal Analysis of the INHS (2002-2018)

D'ANDREAMATTEO A., NERI F., ANTONUCCI G., *et al.*

2024

Health Policy 142: 104960.

https://www.sciencedirect.com/science/article/pii/S0168851023002452

Immigration has become a structural phenomenon in Italy, a country reputed as being 'immigrant-friendly'. The increase in the proportion of immigrants has led to increasing efforts to design and implement health policies throughout the country while controlling public spending. Method Being interested in both the cross-sectional and time series dimensions of analysis, we used a PVAR (Panel Vector Autoregression) model, which combines the VAR technique with panel data models, to estimate the impact of regular immigration on health expenditure. Findings Our results confirm that an increase in the share of regular immigrants in the total population decreases the amount of aggregate public health expenditure. Conclusion Despite the intense activity by Italian governments on social and health integration policies for immigrants, policymakers may focus more on the implementation of national policies at regional and local levels, on their costs and with a specific focus on undocumented immigrants.

End-Of-Life Expenditure on Health Care For the Older Population: A Scoping Review

KOCOT E., FERRERO A., SHRESTHA S., *et al.*

2024

Health Economics Review 14(1): 17.

https://doi.org/10.1186/s13561-024-00493-8

The existing evidence shows that the pattern of health expenditure differs considerably between people at the end-of-life and people in other periods of their lives. The awareness of these differences, combined with a detailed analysis of future mortality rates is one of the key pieces of information needed for health spending prognoses. The general objective of this review was to identify and map the existing empirical evidence on end-of-life expenditure related to health care for the older population.

Child Health and Its Effect on Adult Social Capital Accumulation

LEBENBAUM M., DE OLIVEIRA C., GAGNON F., *et al.*

2024

Health Economics 33(5): 844-869.

https://doi.org/10.1002/hec.4792

Abstract Although studies have demonstrated important effects of poor health in childhood on stocks of human and health capital, little research has tested economic theories to investigate the effect of child health on social capital in adulthood. Studies on the influence of child health on adult social capital are mixed and have not used sibling fixed effects models to account for unmeasured family and genetic characteristics, that are likely to be important. Using the Add-Health sample, health in childhood was assessed as self-rated health, the occurrence of a physical health condition or mental health condition, while social capital in adulthood was measured as volunteering, religious service attendance, team sports participation, number of friends, social isolation, and social support. We used sibling fixed effects models, which attenuated several associations to non-significance. In sibling fixed effects models there was significant positive effects of greater self-rated health on participation in team sports and social support, and negative effect of mental health in childhood on social isolation in adulthood. These results suggest that children with poor health require additional supports to build and maintain their stock of social capital and highlight further potential benefits to efforts that address poor child health.

Profits over Care? An Analysis of the Relationship Between Corporate Capitalism in the Healthcare Industry and Cancer Mortality in the United States

PERRY T. ET BERNASEK A.

2024

Social Science & Medicine: 116851.

https://doi.org/10.1016/j.socscimed.2024.116851

The characteristic features of 21st-century corporate capitalism – monopoly and financialization – are increasingly being recognized by public health scholars as undermining the foundations of human health. While the “vectors” through which this is occurring are well known – poverty, inequality, climate change among others – locating the root cause of this process in the nature and institutions of contemporary capitalism is relatively new. Researchers have been somewhat slow to study the relationship between contemporary capitalism and human health. In this paper, we focus on one of the leading causes of death in the United States; cancer, and empirically estimate the relationship between various measures of financialization and monopoly in the US healthcare system and cancer mortality. The measures we focus on are for the hospital industry, the health insurance industry, and the pharmaceutical industry. Using a fixed effects model with different specifications and control variables, our analysis is at the state level for the years 2012–2019. These variables include data on population demographic controls, social and economic factors, and health behavior and clinical care. We compare Medicaid expansion states with non-Medicaid expansion states to investigate variations in state-level funded health insurance coverage. The results show a statistically significant positive correlation between the HHI index in the individual healthcare market and cancer mortality and the opioid dispensing rate and cancer mortality.

Marginal Cost Per QALY Estimates: What Are They Good For?

SAMPSON C. ET COOKSON G.

2024

Health Policy 142: 105036.

https://doi.org/10.1016/j.healthpol.2024.105036

Estimates of the marginal cost per quality-adjusted life year (MCPQ) are available for health care systems worldwide. Researchers routinely make claims about these estimates and how they should inform policy-making. This commentary considers these claims by taking a recent article from Health Policy as a case study. Claims are made about the past performance of the health service and about future decisions and relate to such considerations as productivity, the impact of technology approvals, cost-effectiveness thresholds, and budget allocation. We argue that the evidence does not justify these claims and MCPQ estimates should instead inform questions about the consequences of changes in expenditure.

Exploring Health Preference Heterogeneity in the UK: Using the Online Elicitation of Personal Utility Functions Approach to Construct EQ-5d-5l Value Functions on Societal, Group and Individual Level

SCHNEIDER P., DEVLIN N., VAN HOUT B., *et al.*

2024

Health Economics 33(5): 894-910.

https://doi.org/10.1002/hec.4805

Abstract A new method has recently been developed for valuing health states, called 'Online elicitation of Personal Utility Functions' (OPUF). In contrast to established methods, such as time trade-off or discrete choice experiments, OPUF does not require hundreds of respondents, but allows estimating utility functions for small groups and even at the individual level. In this study, we used OPUF to elicit EQ-5D-5L health state preferences from a (not representative) sample of the UK general population, and then compared utility functions on the societal-, group-, and individual level. A demo version of the survey is available at: https://eq5d5l.me. Data from 874 respondents were included in the analysis. For each respondent, we constructed a personal EQ-5D-5L value set. These personal value sets predicted respondents' choices in three hold-out discrete choice tasks with an accuracy of 78%. Overall, preferences varied greatly between individuals. However, PERMANOVA analysis showed that demographic characteristics explained only a small proportion of the variability between subgroups. While OPUF is still under development, it has important strengths: it can be used to construct value sets for patient reported outcome instruments such as EQ-5D-5L, while also allowing examination of underlying preferences in an unprecedented level of detail. In the future, OPUF could be used to complement existing methods, allowing valuation studies in smaller samples, and providing more detailed insights into the heterogeneity of preferences across subgroups.

The Cost of Illness and Burden of Suicide and Suicide Attempts in France

SEGAR L. B., LAIDI C., GODIN O., *et al.*

2024

BMC Psychiatry 24(1): 215.

https://doi.org/10.1186/s12888-024-05632-3

With 11,558 deaths and 200,000 suicide attempts in 2019, France is among the European countries most affected. The aim of this study was to determine the costs and burden of suicides and suicide attempts in France (population 67 million).

Compliance in the Public Versus the Private Realm: Economic Preferences, Institutional Trust and COVID-19 Health Behaviors

STERNBERG H., STEINERT J. I. ET BÜTHE T.

2024

Health Economics 33(5): 1055-1119.

https://doi.org/10.1002/hec.4807

Abstract To what extent do economic preferences and institutional trust predict compliance with physical distancing rules during the COVID-19 pandemic? We reexamine this question by introducing the theoretical and empirical distinction between individual health behaviors in the public and in the private domain (e.g., keeping a distance from strangers vs. abstaining from private gatherings with friends). Using structural equation modeling to analyze survey data from Germany's second wave of the pandemic (N = 3350), we reveal the following major differences between compliance in both domains: Social preferences, especially (positive) reciprocity, play an essential role in predicting compliance in the public domain but are barely relevant in the private domain. Conversely, individuals' degree of trust in the national government matters predominantly for increasing compliance in the private domain. The clearly strongest predictor in this domain is the perception pandemic-related threats. Our findings encourage tailoring communication strategies to either domain-specific circumstances or factors common across domains. Tailored communication may also help promote compliance with other health-related regulatory policies beyond COVID-19.

▶ Les règles de tarification des mutuelles : point d'appui à une représentation marchande de l'assurance santé ?

VASSEUR C.

2023

Journal de gestion et d'économie de la santé 4(4): 253-273.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2023-4-page-253.htm

L'article apporte des éléments explicatifs sur les règles de tarification des contrats individuels proposés par les mutuelles. Les mutuelles de santé sont des organismes particuliers dans le secteur de l'assurance maladie complémentaire ; ce sont des organismes non lucratifs qui revendiquent la présence de valeurs de solidarité dans leurs pratiques.La littérature existante en économie sur la tarification en assurance santé montre que les mutuelles ont tendance à proposer davantage de contrats ayant des mécanismes de redistribution. L'objectif de l'article est de comprendre pourquoi et comment les mutuelles peuvent faire vivre une politique de redistribution dans leur contrat via leur mode de tarification. Pour ce faire, l'article s'inscrit dans la lignée des travaux en économie des conventions et considère que les règles de tarification révèlent des tensions et des arbitrages internes dans les mutuelles de santé. Une méthode mixte est utilisée, associant démarche quantitative et qualitative. Mobilisant une enquête de la DREES sur les contrats les plus souscrits auprès des organismes complémentaires, le traitement statistique consiste à construire une classification des contrats individuels à partir de leurs modes de tarification. L'analyse qualitative prend la forme d'un traitement d'entretiens semi-directifs réalisés auprès d'acteurs mutualistes. L'article présente trois résultats principaux. D'abord, les règles de tarification les plus redistributives dans les contrats individuels sont introduites dans des segments particuliers (fonction publique et anciens salariés d'entreprises). Ensuite, dans un contexte de rapprochement des pratiques tarifaires des mutuelles avec celles des sociétés d'assurance, l'article montre une diversité des règles tarifaires dans ces organisations. Enfin, la solidarité est un principe constitutif des mutuelles avant d'être un mécanisme de redistribution. Il existe une pluralité de représentations associées à la solidarité : assistance, redistribution et participation à un collectif. L'argument de solidarité peut alors être mobilisé pour justifier à la fois des règles de tarification redistributive et une pratique d'assistance.

▶ Impact of Reimbursement Systems on Patient Care – a Systematic Review of Systematic Reviews

WAGENSCHIEBER E. ET BLUNCK D.

2024

Health Economics Review 14(1): 22.

https://doi.org/10.1186/s13561-024-00487-6

There is not yet sufficient scientific evidence to answer the question of the extent to which different reimbursement systems influence patient care and treatment quality. Due to the asymmetry of information between physicians, health insurers and patients, market-based mechanisms are necessary to ensure the best possible patient care. The aim of this study is to investigate how reimbursement systems influence multiple areas of patient care in form of structure, process and outcome indicators.

▶ Mitigating the Regressivity of Private Mechanisms of Financing Healthcare: An Assessment of 29 Countries

WAITZBERG R., ALLIN S., GRIGNON M., *et al.*

2024

Health Policy 143: 105058.

https://doi.org/10.1016/j.healthpol.2024.105058

Progressive financing of health care can help advance the equity and financial protection goals of health systems. All countries' health systems are financed in part through private mechanisms, including out-of-pocket payments and voluntary health insurance. Yet little is known about how these financing schemes are structured, and the extent to which policies in place mitigate regressivity. This study identifies the potential policies to mitigate regressivity in private financing, builds two qualitative tools to comparatively assess regressivity of these two sources of revenue, and applies this tool to a selection of 29 high-income countries. It provides new evidence on the variations in policy approaches taken, and resultant regressivity, of private mechanisms of financing health care. These results inform a comprehensive assessment of progressivity of health systems financing, considering all revenue streams, that appears in this special section of the journal.

Environnement et santé

Environnemental Health

Higher Air Pollution Exposure in Early Life Is Associated with Worse Health Among Older Adults: A 72-Year Follow-Up Study From Scotland

BARANYI G., WILLIAMSON L., FENG Z., *et al.*

2024

Health & Place 86: 103208.

https://doi.org/10.1016/j.healthplace.2024.103208

Air pollution increases the risk of mortality and morbidity. However, limited evidence exists on the very long-term associations between early life air pollution exposure and health, as well as on potential pathways. This study explored the relationship between fine particle (PM2.5) exposure at age 3 and limiting long-term illness (LLTI) at ages 55, 65 and 75 using data from the Scottish Longitudinal Study Birth Cohort 1936, a representative administrative cohort study. We found that early life PM2.5 exposure was associated with higher odds of LLTI in mid-to-late adulthood (OR = 1.10, 95% CI: 1.06, 1.14 per 10 μg m−3 increment) among the 2085 participants, with stronger associations among those growing up in disadvantaged families. Path analyses suggested that 15–21% of the association between early life PM2.5 concentrations and LLTI at age 65 (n = 1406) was mediated through childhood cognitive ability, educational qualifications, and adult social position. Future research should capitalise on linked administrative and health data, and explore causal mechanisms between environment and specific health conditions across the life course.

The Role of the Health Sector in Tackling Climate Change: A Narrative Review

OR Z. ET SEPPÄNEN A.-V.

2024

Health Policy 143: 105053.

https://doi.org/10.1016/j.healthpol.2024.105053

Climate change is one of the largest threats to population health and has already affected the ecosystem, food production, and health and wellbeing of populations all over the world. The healthcare sector is responsible for around 5% of greenhouse gas emissions worldwide and can play a key role in reducing global warming. This narrative review summarized the information on the role of healthcare systems in addressing climate change and strategies for reducing its negative impact to illustrate different types of actions that can support the ecological transformation of healthcare systems to help reaching sustainable development goals. A wide range of green interventions are shown to be effective to reduce the carbon footprint of healthcare and can have a meaningful impact if implemented systematically. However, these would not suffice unless accompanied by systemic mitigation strategies altering how healthcare is provided and consumed. Sustainable healthcare strategies such as reducing waste and low-value care will have direct benefits for the environment while improving economic and health outcomes. The healthcare sector has a unique opportunity to leverage its position and resources to provide a comprehensive strategy for fighting climate change and improving population health and the environment on which it depends.

État de santé

Health status

Quand le désordre sanitaire bouscule les relations sociales. Commentaire

ADJAMAGBO A.

2023

Sciences sociales et santé 41(4): 71-78.

https://www.cairn.info/revue-sciences-sociales-et-sante-2023-4-page-71.htm

The Health State of France Before COVID-19 Pandemic Between 1990 and 2019: An Analysis of the Global Burden of Disease Study 2019

FRANCIS-OLIVIERO F., CONSTANTINOU P., HANEEF R., *et al.*

2024

The Lancet Regional Health – Europe 39: 100848.

https://doi.org/10.1016/j.lanepe.2024.100848

Summary Background France faces nowadays some major challenges regarding its health care system including medically underserved areas, social health inequalities, and hospital pressures. Various indicators and sources of data allow us to describe the health status of a population and, consequently, to assess the impact of these challenges. We assessed the burden of diseases before COVID-19 in France in 2019 and its evolution from 1990 to 2019, and compared it with Western European countries. Methods We used specific Global Burden of Diseases (GBD) metrics: socio-demographic index (SDI), life expectancy (LE), healthy life expectancy (HALE), years of life lost (YLLs), years lived with disability (YLDs), and disability-adjusted life-years (DALYs) with their 95% uncertainty interval (95% UI). We compared French age-standardized metrics to those for other Western European Countries for both sexes and also between 1990 and 2019. We also described the specific causes of these different metrics. Findings We observed for life expectancy at birth in France a trend to an improvement over time from 77.2 (95% UI: 77.2–77.3) years in 1990 to 82.9 (82.7–83.1) in 2019, which represented the seventh highest life expectancy among 23 Western European countries. HALE at birth in France increased from 67.0 (64.0–69.7) to 71.5 (68.1–74.5), which represented the fourth highest HALE among 23 Western European countries. In France, the total number of DALY per 100.000 population tended to decrease from 25,192 (22,374–28,351) in 1990 to 18,782 (16,408–21,920) in 2019. As compared to other European countries, the burden due to cardiovascular diseases was lower. Neoplasms and cardio-vascular diseases were the two leading causes of YLLs. Mental and musculoskeletal disorders were the two leading causes of YLDs. Interpretation Overall, these results highlight a clear trend of improvement in the health status in France with certain differences between western European countries. The health policy makers need to devise interventional strategies to reduce the burden of diseases and injuries, with specific attention to causes such as cancers, cardiovascular diseases, mental health and musculoskeletal disorders. Funding Bill & Melinda Gates Foundation.

Impacts of Active Mobility on Individual Health Mediated By Physical Activities

KONG H., WU J. ET LI P.

2024

Social Science & Medicine 348: 116834.

https://doi.org/10.1016/j.socscimed.2024.116834

Active mobility, encompassing walking and cycling for transportation, is a potential solution to health issues arising from inadequate physical activity in modern society. However, the extent of active mobility's impact on individual physical activity levels, and its association with health as mediated by physical activities, is not fully quantified. This study aims to clarify the direct relationship between active mobility usage and individual health, as well as the indirect relationship mediated by physical activity, with a focus on varying levels of physical activity intensity. Utilizing data from the 2017 U.S. National Household Travel Survey (NHTS), we employed Poisson regression to predict active mobility usage based on socio-demographic and household socio-economic characteristics. A Structural Equation Model (SEM) was then used to investigate the direct and indirect effects of active mobility on individual health, mediated by physical activity. We further segmented individuals according to their intensity of physical activity to examine how such effect differs between different levels of physical activity. The study demonstrates that active mobility usage positively correlates with both the amount and intensity of physical activity. The effect of active mobility on individual health includes a direct positive effect (29%

for intensity, 67.7% for amount) and an indirect effect mediated by physical activity (71% for intensity, 32.3% for amount). Notably, the mediation effect of active mobility on health is more substantial in the context of vigorous physical activities compared to light or moderate activities. Our findings reveal a significant positive influence of active mobility on individual health, encompassing both direct and indirect effects mediated by physical activities. These results quantitatively underscore the health benefits of active mobility and suggest the importance of promoting active mobility as a strategy to improve public health.

Depression As a Mediator of the Association Between Vision And/Or Hearing Loss and Recent Substance Use: NHANES 2013–2018

MCCLINTOCK H. F., HINSON-ENSLIN A. M. ET NAHHAS R. W.

2024

Disability and Health Journal 17(2): 101575.

https://doi.org/10.1016/j.dhjo.2023.101575

Background Previous research has demonstrated a significant association between vision and/or hearing loss and lifetime substance use. Objective The objective of this analysis was to assess whether depression mediates the association between vision and/or hearing loss and recent substance use (RSU). Methods Data from 9408 NHANES 2013–2018 participants were used for a survey-weighted analysis to assess whether the indirect effect (IE) of disability status (neither, vision loss only, hearing loss only, both) on the outcome RSU (past 30-day use of marijuana, cocaine, methamphetamine, or heroin) was mediated by recent (past 2 weeks) depression (Patient Health Questionnaire- 9 items score; none = 0–4, mild or greater = 5+), adjusting for confounders. Results The estimated prevalence of vision and/or hearing loss, mild or greater depression, and RSU were 6.7 %, 24.1 %, and 16.8 %. RSU was significantly positively associated with disability status before (p = .018) but not after adjusting for depression (p = .160), and the indirect effects were statistically significant (p < .001). Conclusions The data are consistent with the hypothesis that recent depression mediates the association between vision and/or hearing loss and RSU. Initiatives may be needed that incorporate a focus on the prevention, management, or care for depression to intervene on the pathway between hearing and/or vision loss and RSU.

Global, Regional, and National Burden of Disorders Affecting the Nervous System, 1990-2021: A Systematic Analysis For the Global Burden of Disease Study 2021

STEINMETZ J. D., SEEHER K. M., SCHIESS N., *et al.*

2024

The Lancet Neurology.3(4) : 344 - 381

https://doi.org/10.1016/S1474-4422(24)00038-3

Background Disorders affecting the nervous system are diverse and include neurodevelopmental disorders, late-life neurodegeneration, and newly emergent conditions, such as cognitive impairment following COVID-19. Previous publications from the Global Burden of Disease, Injuries, and Risk Factor Study estimated the burden of 15 neurological conditions in 2015 and 2016, but these analyses did not include neurodevelopmental disorders, as defined by the International Classification of Diseases (ICD)-11, or a subset of cases of congenital, neonatal, and infectious conditions that cause neurological damage. Here, we estimate nervous system health loss caused by 37 unique conditions and their associated risk factors globally, regionally, and nationally from 1990 to 2021.

The Direct and Spillover Effects of Diabetes Diagnosis on Lifestyle Behaviours

THOMAS R. L. ET MENTZAKIS E.

2024

Health Economics 33(5): 952-970.

https://doi.org/10.1002/hec.4803

Abstract Using blood sample data we exploit an arbitrary cut-off of diabetes risk and through a fuzzy regression kink design we estimate the effect of a diabetes diagnosis on own and partner health-related behaviours. Diabetes diagnosis increases the probability of exercising, both for those diagnosed with diabetes and their partner. We also conduct mediation analysis which suggests that joint household participation is the channel behind this effect. Our results have significant implications for the understanding of the channels that induce behavioural change, and household decision making, as well as, for the evaluation of diabetes related policies.

Géographie de la santé

Geography of Health

Does the Neighborhood Built and Social Environment Reduce Long-Term Care Costs For Japanese Older People? The JAGES2010-2019 Cohort Study

CHEN Y.-R., HANAZATO M., SAITO M., *et al.*

2024

Health & Place 86: 103223.

https://doi.org/10.1016/j.healthplace.2024.103223

Japan's population has been aging steadily, evidenced by it spending JPY 11 trillion (USD 110 billion) on annual long-term care (LTC) costs in 2021. In this context, understanding the factors influencing LTC costs has become increasingly vital. Although studies have reported positive relationships between neighborhood environment and health outcomes, the connection between LTC costs and neighborhood environment remains unclear. To address this gap in the literature, this cohort study, conducted from 2010 to 2019 across seven Japanese municipalities and involving 34,982 older people, examined the relationship between eight neighborhood environment elements and the mean monthly cumulate costs (MMCC) of LTC. The results showed that older people who reported the presence of fresh food stores nearby and dangerous places for walking alone at night in the neighborhood had lower MMCC, by JPY 1,367.6 and 1,383.3 per month, respectively, than respondents who did not report the presence of these neighborhood elements. Meanwhile, older people whose neighborhoods had easily accessible facilities had higher MMCC of JPY 739.4. This study's key findings reveal significant relationships between neighborhood environment elements and LTC costs and can be used to support developments in urban design to support healthy aging and reduced LTC costs.

Neighbourhood Characteristics and Socioeconomic Inequalities in Child Mental Health: Cross-Sectional and Longitudinal Findings From the Growing up in Ireland Study

PUTRA I. G. N. E., MCINERNEY A. M., ROBINSON E., *et al.*

2024

Health & Place 86: 103180.

https://doi.org/10.1016/j.healthplace.2024.103180

This study examined the role of neighbourhood characteristics in explaining socioeconomic inequalities in child mental health (the total difficulties score from the Strengths and Difficulties Questionnaire) using data from Cohort '08 of Growing Up in Ireland Waves 3 (age 5; baseline) and 5 (age 9; follow-up). Twenty neighbourhood items were grouped into neighbourhood safety, built environments, cohesion, interaction, and disorder. Data were analysed using regression, single and multiple mediation, and network psychometric analyses. We found that neighbourhood safety, cohesion, interaction, and disorder were associated with child mental health. These four domains separately (by up to 18%) or in concert (by up to 23%) partially explained socioeconomic inequalities in child mental health. Built environments may explain socioeconomic inequalities in mental health in urban children only. Findings from network analysis indicated that specific concerns over "people being drunk or taking drugs in public" and "this is a safe neighbourhood" had the strongest connections with child mental health. Improving neighbourhood characteristics may be important to reduce socioeconomic inequalities in child mental health in Ireland.

Eviction From Rental Housing and Its Links to Health: A Scoping Review

SMITH P. D., KEENE D. E., DILDAY S., *et al.*

2024

Health & Place 86: 103182.

https://doi.org/10.1016/j.healthplace.2024.103182

Eviction from rental housing is common throughout the United States and globally. We synthesize the methods and key findings of recent research on eviction and health. Most studies found significant links between eviction exposures and poor health. Some studies found that eviction's impacts were most severe for marginalized groups. Growing evidence suggests that eviction prevention policies positively impact health.

Variations and Inequities in Access to Cardiac Diagnostic Services in Ontario Canada

WARDLE G., SANFILIPPO A. J., NARULA A., *et al.*

2024

Health Policy 143: 105033.

https://doi.org/10.1016/j.healthpol.2024.105033

Echocardiography is an essential diagnostic modality known to have wide regional utilization variations. This study's objectives were to quantify regional variations and to examine the extent to which they are explained by differences in population age, sex, cardiac disease prevalence (CDP), and social determinants of health (SDH) risk.

A Tale of Many Neighborhoods: Latent Profile Analysis to Derive a National Neighborhood Typology For the US

ZEWDIE H. Y., ROBINSON J. R., ADAMS M. A., *et al.*

2024

Health & Place 86: 103209.

https://doi.org/10.1016/j.healthplace.2024.103209

Neighborhoods are complex and multi-faceted. Analytic strategies used to model neighborhoods should reflect this complexity, with the potential to better understand how neighborhood characteristics together impact health. We used latent profile analysis (LPA) to derive a residential neighborhood typology applicable for census tracts across the US.

Handicap

Disability

Defining Pre-Existing Disability Among Adults Captured By the National Trauma Data Bank: A Descriptive Assessment of Patient Characteristics and Details of Injury

DRAPER K. D., ANGLES J. S., TURK M. A., *et al.*

2024

Disability and Health Journal 17(2): 101574.

https://doi.org/10.1016/j.dhjo.2023.101574

Background There is limited research on trauma in people with disability (PWD), despite potentially increased risk for trauma and negative outcomes following injury. Objective This study describes characteristics of trauma among both narrow and broad subsamples of PWD. Methods Data from the 2016 National Trauma Data Bank was used to identify two Disability Comparison Groups (DCGs). DCG-1 included adult patients with a functionally dependent health status, and DCG-2 included DCG-1 plus other adult patients with disability-associated diagnoses. Trauma characteristics (e.g., signs of life, intent of injury, mechanism of injury, and injury severity score [ISS]) were compared via logistic regression. Results Among the 782,241 reported trauma events, 39,011 belonged to DCG-1 and 193,513 to DCG-2. Falls caused most instances of trauma across both groups (DCG-1: 88.7 %; DCG-2: 67.3 %). Both DCGs were less likely than patients without disability to arrive at the facility without signs of life (DCG-1:aOR = 0.22, 95%CI 0.15–0.31; DCG-2:aOR = 0.40, 95%CI 0.36–0.45) or to have an ISS greater than 15 (DCG-1:aOR = 0.81, 95%CI 0.79–0.84; DCG-2:aOR = 0.92, 95%CI:0.91–0.94). They were, however, more likely to have an ISS greater than or equal to 8 (DCG-1:aOR = 1.14, 95%CI 1.11–1.16; DCG-2:aOR = 1.06, 95%CI 1.05–1.07). Conclusion PWD have greater odds for moderately scored injuries and presenting with signs of life at U.S. trauma centers compared to patients without disability. However, they can be more likely to have certain intents and mechanisms of trauma depending on their functional status and the nature of their impairment. Differences warrant further and continued assessment of trauma experiences among patients with pre-existing disability.

Prevalence of Meeting 24-Hour Movement Guidelines and Its Associations with Health Indicators in People with Disabilities: A Systematic Review and Meta-Analysis

HUANG J., LI X., LI G., *et al.*

2024

Disability and Health Journal: 101616. (in Press)

https://doi.org/10.1016/j.dhjo.2024.101616

Background Meeting the 24-h movement guidelines (i.e., physical activity, sedentary behavior, sleep) could generate health benefits to people with disabilities. However, no systematic reviews or meta-analyses have examined the prevalence of meeting these guidelines and associations with health indicators in this group. Objective This systematic review and meta-analysis aimed to examine the prevalence of meeting the 24-h movement guidelines and associations with health indicators among people with disabilities. Methods Six electronic databases were searched for studies published in English from inception to May 31, 2023. Meta-analyses with the random-effects model were used to determine the prevalence of meeting the 24-h movement guidelines. Qualitative syntheses were employed to describe the associations between meeting the guidelines and health indicators. Results Twenty-four studies comprising 77510 participants (41.6% females) with disabilities aged 6–65 years from eight countries were identified. Overall, 6.97% of the participants with disabilities met all 24-h movement guidelines, and 16.65% met none of the guidelines. Significant age ($P = 0.006$) and disability type ($P = 0.001$) differences were found in meeting all guidelines. Participants with disabilities who met all guidelines reported better psychosocial health indicators (9/9 studies) than those met none or only one of the guidelines. There was limited evidence or research for other health indicators. Conclusion There is some evidence showing that the prevalence of meeting all 24-h movement guidelines in people with disabilities is low. Meanwhile, there is preliminary evidence suggesting that meeting all guidelines is associated with better psychosocial health than meeting none of the guidelines.

▶ The Link Between Disability and Social Participation Revisited: Heterogeneity By Type of Social Participation and By Socioeconomic Status

KIM J., PARK G.-R. ET NAMKUNG E. H.

2024

Disability and Health Journal 17(2): 101543.

https://doi.org/10.1016/j.dhjo.2023.101543

Background While prior literature explores the impact of disability on social participation, the distinct characteristics of diverse social activities could further complicate this relationship. Furthermore, this relationship may exhibit heterogeneity when considering socioeconomic status (SES). Objective This study aims to investigate whether the relationship between disability and social participation differs depending on the type of social participation, and to what extent this relationship is moderated by SES. Methods Data from seven waves of the Korean Longitudinal Study of Ageing were analyzed. Various types of social participation, including socializing, leisure, volunteer, political, and religious activities, were considered. Individual fixed effects models were employed to account for unobserved individual-level heterogeneity. To investigate the potential moderating role of SES, an interaction term between disability and SES was included. Results Disability was associated with a decrease in social participation ($b = -0.088$). When differentiating types of social participation, the associations were negative for socializing and leisure activities ($b = -0.092$ and $b = -0.012$, respectively) and positive for volunteer activities ($b = 0.012$). The negative association between disability and social participation was generally stronger among higher-SES groups than lower-SES groups. Specifically, the negative association with leisure activities was more pronounced among the high-education groups. In contrast, the positive association with volunteer activities was more evident among the low-education group. Conclusions Disability has a negative association with engagement in socializing and leisure activities and a positive association with engagement in volunteer activities. Policymakers should consider the role of SES in complicating the relationship between disability and social participation.

▶ Unmet Need For Medical Care Among Medicare Beneficiaries By Health Insurance Literacy and Disability

PARK S. ET STIMPSON J. P.

2024

Disability and Health Journal 17(2): 101548.

https://doi.org/10.1016/j.dhjo.2023.101548

Background Navigating the US healthcare system requires considerable health insurance literacy, especially for adults with disabilities. Limited health insurance literacy may lead to suboptimal treatment, leading to unmet need for medical care. Objective We examined whether unmet need for medical care among Medicare beneficiaries differs by health insurance literacy and disability status. Methods Using data from the 2010–2019 Medicare Current Beneficiary Survey, we identified 48,989 Medicare beneficiaries, including those in traditional Medicare and Medicare Advantage. Our outcomes were three measures of unmet need for medical care. Our key independent variables were health insurance literacy and disability status. For each outcome, we estimated the adjusted rates of reporting unmet need for medical care by health insurance literacy and disability while controlling for individual-level characteristics. Results Unmet need for medical care was higher among Medicare beneficiaries with disabilities across all outcomes, but the highest rates were among those with disabilities and limited health insurance literacy (27.4% [95% CI: 24.9–29.9] for experiencing delayed care, 17.7% [95% CI: 15.6–19.9] for experiencing trouble in getting needed care, and 20.8% [95% CI: 18.5–23.1] for not seeing a doctor despite medical need). Notably, there was an increasing trend in experiencing delayed care and trouble getting needed care among Medicare beneficiaries with disabilities over time, especially for those with limited health insurance literacy. Conclusions Medicare beneficiaries with disabilities and limited health insurance literacy face disproportionate unmet need for medical care. Policies are needed to ensure that these beneficiaries have access to clear and accessible health insurance information.

▶ Polyhandicap, Profound Intellectual Multiple Disabilities : Concept and Definition of a Highly Specific Public Health Issue

ROUSSEAU M.-C., WINANCE M. ET BAUMSTARCK K.

2023

Revue d'Épidémiologie et de Santé Publique 71(6): 102184.

https://doi.org/10.1016/j.respe.2023.102184

Objectives The concept of polyhandicap first emerged in the late ‘60s in France, with actually a consensus on its definition. This consensus has yet to be reached internationally. The absence of an international consensus on a definition and name for persons with polyhandicap limits progress in research and health planning for these people. Methods This article describes the history of the emergence of the concept of polyhandicap in France and internationally. Results The emergence of the concept and definition of polyhandicap is part of the history of the development of special education and care for children with disabilities started at the end of the 19th century and during the first half of the 20th century. In France, between 1970 and 2002, working groups composed of professionals and family associations gradually developed and refined the definition of polyhandicap, differentiating it from other clinical entities such as cerebral palsy. Internationally, the term polyhandicap is used in 4 European countries : in France where it first appeared, in Italy, in French-speaking Belgium, and in French-speaking Switzerland but also outside the EU. Various terms may be used around the world to describe clinical entities similar to polyhandicap; the most frequently used in the literature is the term Profound Intellectual and Multiple Disabilities (PIMD) or PIMD Spectrum which does not systematically refer to an early brain injury. Discussion We are currently in the process of internationalizing the concept and definition of polyhandicap, and hopefully, as was the case for cerebral palsy in the 2000s, the various research teams working on this subject around the world will create collaborations and research networks targeting this specific population. Conclusion A consensus around a precise definition of polyhandicap is important to ensure that these people are recognized for their uniqueness and specific qualities and to provide them adapted care. Résumé Objectifs Le concept de polyhandicap est apparu fin des années 60 en France, sa définition est actuellement consensuelle. Ce consensus n'a pas encore été atteint au niveau international ce qui limite les progrès de la recherche et de la planification sanitaire pour ces personnes. Méthodes Cet article décrit l'histoire de l'émergence du concept de polyhandicap en France et au niveau international Résultats L'émergence du concept et de la définition du polyhandicap en France s'inscrit dans l'histoire du développement de l'éducation spécialisée et de la prise en charge des enfants handicapés amorcée à la fin du 19ème siècle et durant la première moitié du 20ème siècle. Entre 1970 et 2002, des groupes de travail composés de professionnels et d'associations de familles ont progressivement élaboré et affiné la définition du polyhandicap, en le différenciant d'autres entités cliniques proches comme la paralysie cérébrale. Au niveau international, le terme polyhandicap est utilisé dans 4 pays européens mais aussi en dehors de l'Union Européenne. Différents termes peuvent être utilisés dans le monde pour décrire des entités cliniques similaires au polyhandicap; le plus fréquemment utilisé dans la littérature est le terme Profound Intellectual and Multiple Disabilities (PIMD) ou PIMD spectrum qui désigne une entité clinique proche mais ne fait pas systématiquement référence à la précocité de l'atteinte cérébrale. Discussion Le concept et la définition du polyhandicap évoluent peu à peu vers un consensus à l'internationale et on peut espérer que, comme ce fut le cas pour la paralysie cérébrale dans les années 2000, les différentes équipes de recherche travaillant sur ce sujet à travers le monde créeront des collaborations et des réseaux de recherche ciblant cette population spécifique. Conclusions Un consensus autour d'une définition précise du polyhandicap est important pour que ces personnes soient reconnues dans leur singularité et leurs spécificités et qu'elles bénéficient d'une prise en charge adaptée.

▶ Variation in Identifying Children and Adolescents with Disability and Developmental Disability in Population-Based Public Health Surveys

RUSSELL L. A., TINKER S. C., RICE C. E., *et al.*

2024

Disability and Health Journal 17(2): 101556.

https://doi.org/10.1016/j.dhjo.2023.101556

Background The term "developmental disability" (DD) is inconsistently defined and applied depending on purpose and across sources, including in legislation. Objective This project aimed to identify existing definitions of disability and DD and to determine the extent to which each definition could be operationalized to produce prevalence estimates using data from U.S. national surveys. Methods Using data among children <18 years from the 2016–2018 National Health Interview Survey (NHIS) and National Survey of Children's Health (NSCH), we estimated the prevalence of two definitions of disability (Washington Group Short Set on Functioning, American Community Survey) and seven definitions of DD [Health and Human Services (ever/current), Developmental Disabilities Assistance and Bill of Rights Act of 2000 (1+, 2+, or 3+ components), and Diagnostic and Statistical Manual of Mental Disorders, 5th ed (ever/current)]. Complex sample design variables and weights were used to calculate nationally representative prevalence. Results Disability (NHIS: 5.2–6.3%; NSCH: 9.2–11.9%) and DD prevalence (NHIS: 0.6–18.0% and NSCH: 0.2–22.2%) varied depending on the definition and data source. For the same definition, NSCH prevalence estimates tended to be higher than NHIS estimates. Conclusions The substantial variability in estimated prevalence of disability and DD among children in the United States may be in part due to the surveys not representing all components of each definition. Different or additional questions in national surveys may better capture existing definitions of disability and DD. Considering the data collection goals may help determine the optimal definition to provide useful information for public health action.

Hôpital

Hospital

▶ Complément de rapport. Comment réformer les financements de la recherche hospitalière par les MERRI du ministère de la Santé et de la Prévention

BOITARD C., CLÉMENT B., FACON T., *et al.*

2024

Bulletin de l'Académie Nationale de Médecine 208(4): 414-417.

https://doi.org/10.1016/j.banm.2024.02.011

Résumé Nous présentons les principes et la méthodologie d'un projet de réforme du financement de la recherche par le ministère chargé de la Santé. L'objectif est d'aligner l'attribution de ces fonds, appelés MERRI, sur les pratiques internationales en la fondant sur des critères objectifs de qualité scientifique et de besoin médical. Une minorité de ces fonds serait attribuée aux hôpitaux sur une base concurrentielle et le reste sur une base contractuelle pluriannuelle, en utilisant des canaux de distribution sûrs et transparents. Un préciput substantiel serait alloué aux établissements. Cette réforme, qui vise à améliorer l'efficacité du financement de la recherche hospitalière en France, est très attendue par l'ensemble des chercheurs et des cliniciens. Summary We present the principles and methodology of a project to reform research funding by the French Ministry of Health. The aim is to bring the allocation of these funds, known as MERRI, into line with international practice by basing it on objective criteria of scientific quality and medical need. A minority of these funds would be allocated to hospitals on a competitive basis and the remainder on a multi-year contractual basis, using secure and transparent distribution channels. A substantial overhead would be allocated to the host hospitals. This reform, which aims to improve the efficiency of hospital research funding in France, is eagerly awaited by all researchers and clinicians.

Admission Avoidance Hospital At Home

EDGAR K., ILIFFE S., DOLL H. A., *et al.*

2024

Cochrane Database of Systematic Reviews(3).

https://doi.org//10.1002/14651858.CD007491.pub3

- Background Admission avoidance hospital at home provides active treatment by healthcare professionals in the patient's home for a condition that would otherwise require acute hospital inpatient care, and always for a limited time period. This is the fourth update of this review. Objectives To determine the effectiveness and cost of managing patients with admission avoidance hospital at home compared with inpatient hospital care.

Free-For-All: Does Crowding Impact Outcomes Because Hospital Emergency Departments Do Not Prioritise Effectively?

FRANCETIC I., MEACOCK R. ET SUTTON M.

2024

Journal of Health Economics 95: 102881.

https://doi.org/10.1016/j.jhealeco.2024.102881

Unexpected peaks in volumes of attendances at hospital emergency departments (EDs) have been found to affect waiting times, intensity of care and outcomes. We ask whether these effects of ED crowding on patients are caused by poor clinical prioritisation or a quality-quantity trade-off generated by a binding capacity constraint. We study the effects of crowding created by lower-severity patients on the outcomes of approximately 13 million higher-severity patients attending the 140 public EDs in England between April 2016 and March 2017. Our identification approach relies on high-dimensional fixed effects to account for planned capacity. Unexpected demand from low-severity patients has very limited effects on the care provided to higher-severity patients throughout their entire pathway in ED. Detrimental effects of crowding caused by low-severity patients materialise only at very high levels of unexpected demand, suggesting that binding resource constraints impact patient care only when demand greatly exceeds the ED's expectations. These effects are smaller than those caused by crowding induced by higher-severity patients, suggesting an efficient prioritisation of incoming patients in EDs.

Association Between Socioeconomic Status and Hospitalisation Requirement in Older Patients Attended at the Emergency Department: A Retrospective Cohort Study

GARCÍA-MARTÍNEZ A., ARTAJONA L., OSORIO G., *et al.*

2024

Journal of Healthcare Quality Research. (In press).

https://doi.org/10.1016/j.jhqr.2024.02.003

Introduction and objective : A low socioeconomic status (SES) has been associated with poor health results. The present study aimed to investigate if SES of older patients attending the emergency department is associated with the use of healthcare resources and outcomes. Patients and methods : Observational, retrospective study including consecutive patients 65 years or older admitted to the emergency department. Variables at baseline, index episode, and follow-up were recorded. SES was measured using an indirect theoretical index and patients were categorised into two groups according to whether they lived in a neighbourhood with a low or high SES. Primary outcomes included hospitalisation after the emergency department visit and prolonged hospitalisation (>7 days) at index episode. Secondary outcomes included emergency department re-consultant and hospital admission in the following 3 months after the index episode, and all-cause mortality after long-term follow-up. Logistic regression and cumulative hazards regression models were used to investigate associations between SES and outcomes. Results: The cohort included 553 patients (80 years [73–85], 50.5% female, 55.9% with low SES). After the emergency department visit, 234 patients (42.3%) required hospital admission. A low SES was inversely associated with hospitalisation with an adjusted odds ratio = 0.654 (95% CI 0.441–0.970). Among hospitalised patients, a low SES was associated with prolonged hospitalisation (adjusted odds ratio = 2.739; 95% CI 1.470–5.104). Follow-up outcomes, including all-cause mortality, were not associated with SES. Conclusions : Older patients living in more deprived urban areas were hospitalised less often after emergency department care, but hospital stays were longer. Understanding the effect of social determinants in healthcare use is mandatory to tailor resources to patient needs.

How Do Hospitals Respond to Payment Unbundling For Diagnostic Imaging of Suspected Cancer Patients?

HAYES H., STOKES J., SUTTON M., *et al.*

2024

Health Economics 33(5): 823-843.

https://doi.org/10.1002/hec.4804

Abstract Payments for some diagnostic scans undertaken in outpatient settings were unbundled from Diagnosis Related Group based payments in England in April 2013 to address under-provision. Unbundled scans attracted additional payments of between £45 and £748 directly following the reform. We examined the effect on utilization of these scans for patients with suspected cancer. We also explored whether any detected effects represented real increases in use of scans or better coding of activity. We applied difference-in-differences regression to patient-level data from Hospital Episodes Statistics for 180 NHS hospital Trusts in England, between April 2010 and March 2018. We also explored heterogeneity in recorded use of scans before and after the unbundling at hospital Trust-level. Use of scans increased by 0.137 scans per patient following unbundling, a 134% relative increase. This increased annual national provider payments by £79.2 million. Over 15% of scans recorded after the unbundling were at providers that previously recorded no scans, suggesting some of the observed increase in activity reflected previous under-coding. Hospitals recorded substantial increases in diagnostic imaging for suspected cancer in response to payment unbundling. Results suggest that the reform also encouraged improvements in recording, so the real increase in testing is likely lower than detected.

Association of Hospitals' Experience with Bundled Payment for Care Improvement Model with the Diffusion of Acute Hospital Care at Home

KANG S.-Y.

Health Services Research.

https://doi.org/10.1111/1475-6773.14302

Abstract Objective To examine whether hospitals' experience in a prior payment model incentivizing care coordination is associated with their decision to adopt a new payment program for a care delivery innovation. Data Sources Data were sourced from Medicare fee-for-service claims in 2017, the list of participants in Bundled Payment for Care Improvement initiatives (BPCI and BPCI-Advanced), the list of hospitals approved for Acute Hospital Care at Home (AHCaH) between November 2020 and August 2022, and the American Hospital Association Survey. Study Design Retrospective cohort study. Hospitals' adoption of AHCaH was measured as a function of hospitals' BPCI experiences. Hospitals' BPCI experiences were categorized into five mutually exclusive groups: (1) direct BPCI participation, (2) indirect participation through physician group practices (PGPs) after dropout, (3) indirect participation through PGPs only, (4) dropout only, and (5) no BPCI exposure. Data Collection/Extraction Methods All data are derived from pre-existing sources. General acute hospitals eligible for both BPCI initiatives and AHCaH are included. Principal Findings Of 3248 hospitals included in the sample, 7% adopted AHCaH as of August 2022. Hospitals with direct BPCI experience had the highest adoption rate (17.7%), followed by those with indirect participation through BPCI physicians after dropout (11.8%), while those with no exposure to BPCI were least likely to participate (3.2%). Hospitals that adopted AHCaH were more likely to be located in communities where more peer hospitals participated in the program (median 10.8% vs. 0%). After controlling for covariates, the association of the adoption of AHCaH with indirect participation through physicians after dropout was as strong as with early BPCI adopter hospitals (average marginal effect: 5.9 vs. 6.2 pp, $p < 0.05$), but the other categories were not. Conclusions Hospitals that participated in the bundled payment model either directly or indirectly PGPs were more likely to adopt a care delivery innovation requiring similar competence in the next period.

Pay-For-Performance and Patient Safety in Acute Care: A Systematic Review

SLAWOMIRSKI L., HENSHER M., CAMPBELL J., *et al.*

2024

Health Policy 143: 105051.

https://doi.org/10.1016/j.healthpol.2024.105051

Pay-for-performance (p4p) has been tried across all healthcare settings to address ongoing deficiencies in the quality and outcomes of care. The evidence for the effect of these policies has been inconclusive, especially in acute care. This systematic review focused on patient safety p4p in the hospital setting. Using the PRISMA guidelines, we searched five biomedical databases for studies using at least one outcome metric from database inception to March 2023, supplemented by reference tracking and internet searches. We identified 6122 potential titles of which 53 were included: 39 original investigations, eight literature reviews and six grey literature reports. Only five system-wide p4p policies have been implemented, and the quality of evidence was low overall. Just over half of the studies (52%) included failed to observe improvement in outcomes, with positive findings heavily skewed towards poor quality evaluations. The exception was the Fragility Hip Fracture Best Practice Tariff (BPT) in England, where sustained improvement was observed across various evaluations. All policies had a miniscule impact on total hospital revenue. Our findings suggest the importance of simplicity and transparency in policy design, involvement of the clinical community, explicit links to other quality improvement initiatives, and gradual implementation. We also propose a research agenda to lift the quality of evidence in this field.

Inégalités de santé

Health Inequalities

Gender Health Care Inequalities in Health Crisis: when Uncertainty Can Lead to Inequality

AGUILAR-PALACIO I., OBÓN-AZUARA B., CASTEL-FECED S., *et al.*

2024

Archives of Public Health 82(1): 46.

https://doi.org/10.1186/s13690-024-01276-7

In health crisis, inequalities in access to and use of health care services become more evident. The objective of this study is to analyse the existence and evolution of gender inequalities in access to and use of healthcare services in the context of the COVID-19 health crisis.

Immigrant-Blind Care: How Immigrants Experience the "Inclusive" Health System As They Access Care

AKALIN N.

2024

Social Science & Medicine 148 :116822.

https://doi.org/10.1016/j.socscimed.2024.116822

A growing body of scholarship examines the varying impact of legal status and race on accessing healthcare. However, a notable gap persists in comprehending the supplementary mechanisms that hinder immigrants' pathway to seek care. Drawing on ethnographic observations in various clinical settings and in-depth interviews with 28 healthcare professionals and 12 documented Haitian immigrants in a city in Upstate New York, between 2019 and 2021, I demonstrate the tension between the conceptualization and implementation of inclusive care practices by healthcare providers. I argue that the mere expansion and adoption of inclusive discourse among providers do not inherently ensure equity and the removal of barriers to healthcare access. This work contributes to the social study of medicine and race and ethnic studies by introducing the innovative concept of "immigrant-blind." Through this concept, the research sheds light on how providers' conceptualization of inclusivity proclaims medical encounters to be devoid of stratifications and rationalizes their practices which mask the profound impact of immigration status and immigration on immigrant health. Furthermore, these practices reinforce existing divisions within care settings and medical encounters, where immigration laws and enforcement practices operate and further exacerbate stratifications. By examining providers' uninformed implementation of culturally competent care practices, the findings reveal that providers stigmatize and essentialize immigrants during medical encounters. This highlights the imperative for a more nuanced and informed approach to healthcare provision, where genuine inclusivity is upheld, and barriers to access are dismantled to foster equitable and dignified healthcare experiences for all.

Health Shocks, Health and Labor Market Dynamics, and the Socioeconomic-Health Gradient in Older Singaporeans

CHENG T. C., KIM S. ET PETRIE D.

2024

Social Science & Medicine 348 : 116796.

https://doi.org/10.1016/j.socscimed.2024.116796

Health disparities by socioeconomic status (SES) are potentially shaped by how an individual's health status and work capacity are affected by the incidence of illness, and how these effects vary across SES groups. We examine the impact of illness on the dynamics of health status, work activity and income in older Singaporeans to gain new insights on how ill health shapes the socioeconomic health gradient. Our data comprise of 60 monthly waves (2015–2019) of panel survey data containing 445,464 person-observations from 11,827 unique respondents from Singapore. We apply a matched event-study difference-in-differences research design to track how older adults' health and work changes following the diagnosis of heart disease and cancer. Our focus is how the dynamics of health and work differ for different SES groups, which we measure by post-secondary education attainment. We find that the dynamics of how self-assessed health recovers following the diagnosis of a new heart disease or cancer do not vary significantly across SES groups. Work activity, however, varies significantly with less well-educated males and females being significantly less likely to be in active employment and have income from work, and are more likely to be in retirement following the onset of ill health. By contrast, more well-educated males work more, and earn more a year after the health shock than they did before they fell ill. Occupational differences likely played a role in how work activity of less well-educated men decline more after an acute health event compared with more well-educated men. Understanding the drivers of the socioeconomic health gradient necessitates a focus on individual-level factors, as well as system-level influences, that affect health and work.

The Health Disparities Research Industrial Complex

EZELL J. M.

2023

Social Science & Medicine: 116251.

https://doi.org/10.1016/j.socscimed.2023.116251

There is a need to better problematize the social processes involved in conducting, disseminating, and implementing findings from health disparities research. The Health Disparities Research Industrial Complex speaks to the exploitation and monetization of health disparities (research) by non-minoritized individuals. Actors and benefactors of the Health Disparities Research Industrial Complex includes non-minoritized researchers, students, funders, and scientific publishers. There is a need to co-develop health disparities research priorities with communities, curtail publishing, and better integrate underrepresented investigators.

The Privilege of Working From Home and Health Disparities During the Covid-19 Pandemic in Major American Cities

HUANG Y., LI Y., LI R., *et al.*

2024

Health & Place 86: 103183.

https://doi.org/10.1016/j.healthplace.2024.103183

Working from home (WFH) has been adopted as a key mitigation strategy in the COVID-19 pandemic; yet few research has studied its impact on pandemic outcomes. Using multiple sources of data including cellphone data and online survey during the pandemic, this study investigates the effect of WFH on intra-city health disparities during the COVID-19 pandemic in American cities. Pandemic data for zip code tabulation areas and cellphone mobility data for census block groups in New York City (NYC), Chicago, and Philadelphia are converted to census tract level, which are then merged with 2019 census data. WFH is measured with the proportion of workers who *potentially* can telework based on employment composition in census tracts and percentages of jobs in each industry that *actually* WFH during the pandemic. Results show that while infection and death rates are higher in NYC, intra-city disparities in pandemic outcomes are more pronounced in Philadelphia. Poisson regressions show a negative association between WFH and COVID-19 infection and death rates in NYC and Chicago, which is weakened by increased time spent at home during the pandemic and in minority neighborhoods (in NYC). In Philadelphia, WFH is barely relevant for infection rates but has a marginally positive association with death rates, which is also moderated by the time spent at home. This study demonstrates the relative effectiveness of WFH in mitigating pandemic outcomes and underscores the intersectionality between WFH and race/ethnicity and resident behaviors. It provides important policy implications for future pandemic mitigation.

Direct and Vicarious Exposure to Healthcare Discrimination and Erasure Among Transgender and Gender Independent Individuals: Testing the Indirect Effect of Mistrust in Healthcare on Utilization Behaviors

MASON K. L., HOOD K. B., PERRIN P. B., *et al.*

2024

Social Science & Medicine 348: 116806.

https://www.sciencedirect.com/science/article/pii/S0277953624002508

Rationale Direct exposure to gender identity-related discrimination and erasure among the transgender and gender independent (TGI) population are associated with healthcare underutilization, which may further exacerbate the health disparities that exist between this population and cisgender individuals in the United States (U.S.). Although the impacts of direct exposure to healthcare discrimination and erasure may have on TGI individuals are known, exposure to such harm vicariously (i.e., through observation or report) is underexplored. Objective The present study examined the relationships among direct and vicarious gender identity-related healthcare discrimination and erasure exposure and past-year healthcare utilization. Method Gender identity-based mistrust in healthcare was also assessed, as a mechanism through which direct and vicarious gender identity-related healthcare discrimination and erasure predict healthcare utilization behaviors among a sample (N = 385) of TGI adults in the U.S., aged 18 to 71 recruited online. Results indicated direct lifetime and vicarious healthcare discrimination and erasure exposure significantly predicted past-year healthcare underutilization when participants anticipated encountering gender identity-related healthcare discrimination. Mediational analyses indicated that higher levels of exposure to direct lifetime and vicarious healthcare discrimination and erasure were related to higher levels of mistrust in healthcare, through which past-year underutilization was significantly related. Conclusions These findings are vital to informing healthcare practice and policy initiatives aimed at ensuring the barriers that deleteriously influence the accessibility of healthcare among TGI individuals are ameliorated.

The Progressive Place Paradox: Status-Based Health Inequalities Are Magnified in More Economically Progressive Swiss Localities

MORRIS K. ET LAMPROPOULOS D.

2024

Health & Place 86: 103215.

https://doi.org/10.1016/j.healthplace.2024.103215

Low socioeconomic status (measured both objectively and subjectively) is systematically associated with worse health. Amid renewed interest in contextual influences on health inequalities, we ask whether variation in the prevailing ideological climate moderates the size of the health gap between low and high status individuals. Based on the minority stress hypothesis, we expect that living in an economically progressive place within Switzerland – places where more residents endorse the need for change to the economic status quo – will reduce the magnitude of the health gap. Multilevel modelling of MOSAiCH 2015–2020 data shows the opposite: low status individuals in progressive places report markedly lower subjective health and life satisfaction than similarly low status individuals in conservative places, such that status-based health inequalities are maximised in progressive places. We interpret this apparent progressive place paradox in terms of collective inefficacy and system frustration, which we argue is the corollary of system justification.

Une approche interdisciplinaire et territoriale pour réduire les vulnérabilités et les inégalités en santé

OUELLET N., ALBERIO M. ET TOUPIN I.

2023

Recherche en soins infirmiers 155(4): 30-36.

https://www.cairn.info/revue-recherche-en-soins-infirmiers-2023-4-page-30.htm

Les populations en situation de vulnérabilité sociale et économique présentent un risque important d’être fragilisées par rapport à leur santé et leur bien- être. La notion de vulnérabilité apparait pertinente pour mettre en lumière les défis à relever pour faire face aux inégalités ainsi que les circonstances fertiles pour développer des actions innovantes adaptées aux différents contextes. À partir d’une réflexion interdisciplinaire, nous explorons les conceptions de la vulnérabilité dans les publications scientifiques en santé et en sciences sociales, afin de faire ressortir les similarités et les divergences existantes. Les facteurs de vulnérabilité ressortent des écrits, tels l'âge, le sexe, les problèmes de santé, les facteurs socioéconomiques et l'environnement. Dans une perspective territoriale, nous présentons certains enjeux de vulnérabilité en tenant compte à la fois des éléments individuels et collectifs de ces expériences. Ces situations de vulnérabilité comportent des défis importants pour les professionnels et intervenants de différents secteurs de la santé, et des services sociaux, publics et communautaires. Agir en promotion de la santé requiert une bonne connaissance du territoire pour s'adapter aux dimensions liées aux déterminants de la santé, aux contextes communautaires et organisationnels, et utiliser des stratégies reconnues comme de bonnes pratiques adaptées aux véritables besoins des populations.

▶ Born on the Wrong Side of the Tracks: Exploring the Causal Effects of Segregation on Infant Health

VU H., GREEN T. L. ET SWAN L. E. T.

2024

Journal of Health Economics 95 : 102876.

https://doi.org/10.1016/j.jhealeco.2024.102876

Prior research has found that a high level of residential racial segregation, or the degree to which racial/ethnic groups are isolated from one another, is associated with worsened infant health outcomes, particularly among non-Hispanic (NH) Black infant populations. However, because exposure to segregation is non-random, it is unclear whether and to what extent segregation is causally linked to infant health. To overcome this empirical limitation, we leverage exogenous variation in the placement of railroad tracks in the 19th century to predict contemporary segregation, an approach first introduced by Ananat. (2011). In alignment with prior literature, we find that residential segregation has statistically significant associations with negative birth outcomes among Black infant populations in the area. Using OLS methods underestimates the negative impacts of segregation on infant health. We fail to detect comparable effects on health outcomes among NH White infant populations. Further, we identify several key mechanisms by which residential segregation could influence health outcomes among Black infant populations, including lower access to prenatal care during the first trimester higher levels of anti-Black prejudice, greater transportation barriers, and increased food insecurity. Given that poor birth outcomes have adverse effects on adults' health and well-being, the findings suggest that in-utero exposure to residential segregation could have important implications for Black-White inequality over the life course.

Médicaments

Pharmaceuticals

▶ The Impact of Reference Pricing on Prescribing Patterns, Costs, and Health Services Utilization of Proton Pump Inhibitors: A Quasi-Experimental Study in British Columbia, Canada

AU S. W. S., LAW M. R., CHENG L., *et al.*

2024

Health Policy: 105061.

https://doi.org/10.1016/j.healthpol.2024.105061

The Reference Drug Program (RDP) was established to steer patients toward equally safe and cost-effective medication under British Columbia's public drug coverage. Each RDP class covers at least one reference drug, and non-reference drugs are reimbursed up to the cost of the reference drug. In 2016, the RDP updated to include proton pump inhibitors (PPIs). This study evaluated the impact on drug expenditures, prescription patterns, and health services utilization. Methods We identified a cohort of individuals covered by Fair Pharmacare who used PPIs, and a control group of H2 Blockers users. We used interrupted time series analysis on administrative data from June 2014 to December 2019 on the following outcomes: new users, day supply, expenditures, drug costs, reference drug use, and physician visits and costs. Results : The RDP had little impact on overall PPI use patterns. We did not observe any changes in reference drug uptake, new users, physician visits, cost-savings, or significant changes to days supplied post-policy. Cost expenditure results were likely biased due to co-occurring changes to drug prices. Conclusion: Inclusion of PPIs to the RDP saw no cost-savings for the provincial drug program and had little impact on prescribing patterns. Overall, our findings are consistent with existing evidence that the RDP is safe for similar therapeutic alternatives, but the impact on PPI costs remains unclear.

Factors Influencing the Effects of Policies and Interventions to Promote the Appropriate Use of Medicines in High-Income Countries: A Rapid Realist Review

CHARBONNEAU M., MORGAN S. G., GAGNON C., *et al.*

2024

Health Policy 142: 105027.

https://doi.org/10.1016/j.healthpol.2024.105027

Background : The appropriate use of medicines has long been recognized as a fundamental component of medicine policies. We aimed to extract lessons from published research on how policy contexts and mechanisms can affect the outcomes of national- or health-system level interventions to promote appropriate medicine use (defined as an increase in underutilized medications or decrease in inappropriate medication use). Methods: We conducted a rapid realist review of published evidence concerning system-level policies to promote the appropriate use of medicines in high-income countries with universal prescription drug coverage. We searched MEDLINE and Embase to identify relevant publications. We used a realist evaluation framework to identify contexts, mechanisms, and outcomes for each intervention and to hypothesize which policy contexts and mechanisms supported successful outcomes in terms of relative changes in the prevalence of use of the specific medication classes targeted. Results From 1,318 identified studies, 18 met our inclusion criteria. 13 distinct policies were identified. Three main policy-related factors underpinned successful interventions: involving providers and patients through program interventions; central coordination through national agencies dedicated to medicine policies; and the establishment of an explicit and integrated national medicine policy strategy. Conclusion Policymakers can improve coordination of national pharmaceutical policies to reduce harms from inappropriate medicines use, thus improving health outcomes through cost-effective programs.

Insurance Barriers and Inequalities in Health Care Access: Evidence From Dual Practice

GOETJES E. ET BLANKART K. E.

2024

Health Economics Review 14(1): 23.

https://doi.org/10.1186/s13561-024-00500-y

We investigate access disparities in pharmaceutical care among German patients with type 2 diabetes, focusing on differences between public and private health insurance schemes. The primary objectives include investigating whether patients with private health insurance experience enhanced access to anti-diabetic care and analyzing whether the treatment received by public and private patients is influenced by the practice composition, particularly the proportion of private patients.

A Mixed Methods Analysis of the Medication Review Intervention Centered Around the Use of the 'Systematic Tool to Reduce Inappropriate Prescribing' Assistant (STRIPA) in Swiss Primary Care Practices

JUNGO K. T., DEML M. J., SCHALBETTER F., *et al.*

2024

BMC Health Services Research 24(1): 350.

https://doi.org/10.1186/s12913-024-10773-y

Electronic clinical decision support systems (eCDSS), such as the 'Systematic Tool to Reduce Inappropriate Prescribing' Assistant (STRIPA), have become promising tools for assisting general practitioners (GPs) with conducting medication reviews in older adults. Little is known about how GPs perceive eCDSS-assisted recommendations for pharmacotherapy optimization. The aim of this study was to explore the implementation of a medication review intervention centered around STRIPA in the 'Optimising PharmacoTherapy In the multimorbid elderly in primary CAre' (OPTICA) trial.

Has Pharmaceutical Innovation Reduced the Average Cost of U.S. Health Care Episodes?

LICHTENBERG F. R.

2024

International Journal of Health Economics and Management 24(1): 1-31.

https://doi.org/10.1007/s10754-023-09363-y

A number of authors have argued that technological innovation has increased U.S. health care spending. We investigate the impact that pharmaceutical innovation had on the average cost of U.S. health care episodes during the period 2000–2014, using data from the Bureau of Economic Analysis' Health Care Satellite Account and other sources. We analyze the relationship across approximately 200 diseases between the growth in the number of drugs that have been approved to treat the disease and the subsequent growth in the mean amount spent per episode of care, controlling for the growth in the number of episodes and other factors. Our estimates indicate that mean episode cost is not significantly related to the number of drugs ever approved 0–4 years before, but it is significantly inversely related to the number of drugs ever approved 5–20 years before. This delay is consistent with the fact (which we document) that utilization of a drug is relatively low during the first few years after it was approved, and that some drugs may have to be consumed for several years to have their maximum impact on treatment cost. Our estimates of the effect of pharmaceutical innovation on the average cost of health care episodes are quite insensitive to the weights used and to whether we control for 3 covariates. Our most conservative estimates imply that the drugs approved during 1986–1999 reduced mean episode cost by 4.7%, and that the drugs approved during 1996–2009 reduced mean episode cost by 2.1%. If drug approvals did not affect the number of episodes, the drugs approved during 1986–1999 would have reduced 2014 medical expenditure by about $93 billion. However, drug approvals may have affected the number, as well as the average cost, of episodes. We also estimate models of hospital utilization. The number of hospital days is significantly inversely related to the number of drugs ever approved 10–19 years before, controlling for the number of disease episodes. Our estimates imply that the drugs approved during 1984–1997 reduced the number of hospital days by 10.5%. The hospital cost reduction was larger than expenditure on the drugs.

Méthodologie – Statistique

Methodology-Statistics

"Cardinalizing" Self-Assessed Health in Studies of Health Inequalities: Risks and Challenges of Scaling on Health Utility Measures

GRIGNON M., ASADA Y., ASMA S., *et al.*

2023

Journal de gestion et d'économie de la santé 4(4): 274-300.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2023-4-page-274.htm

L'auto-évaluation de la santé (SAH) est une mesure de la santé largement utilisée. Elle est facile à administrer, permet d'obtenir une évaluation générale et subjective de la santé et présente une bonne corrélation avec les mesures objectives de la santé et de l'état de santé futur. Toutefois, sa nature ordinale a posé un défi analytique, en particulier pour la mesure des inégalités en matière de santé, et le débat se poursuit sur la meilleure façon de dériver une valeur cardinale sur la base des informations ordinales. La méthode la plus récente, proposée par Van Doorslaer et Jones, 2003, utilise la régression par intervalles avec les limites dérivées de la distribution empirique d'une mesure de l'utilité de la santé. Dans cet article, nous montrons que la méthode est sensible à de nombreux choix qui sont souvent négligés, notamment le choix de la variable d'échelle. Comme la variable d'échelle est souvent une mesure cardinale de l'utilité de la santé, nous mettons en doute l'hypothèse sous-jacente à la méthode selon laquelle l'HSA et toute mesure de l'utilité de la santé capturent le même concept de santé. À l'aide de l'Enquête nationale sur la santé de la population canadienne, de l'Enquête sur la santé dans les collectivités canadiennes et de l'Enquête nationale sur les mesures de la santé aux États-Unis, nous montrons empiriquement que la mesure des inégalités de santé est très sensible au choix de la population sur laquelle la variable d'échelle est mesurée et au choix de la mesure de l'utilité de la santé elle-même. Nous démontrons empiriquement le manque de concordance des classements de santé entre le SEP et quatre mesures de l'utilité de la santé couramment utilisées dans la littérature (EQ-5D, SF-6D, HUI3 et QWB). Cela suggère que la grande sensibilité de l'inégalité de santé aux choix d'échelles peut être due aux différents concepts capturés par le SEP et l'utilité de la santé.

Exploring the Measurement of Health Related Quality of Life and Broader Instruments: A Dimensionality Analysis

HEIJDRA SUASNABAR J. M., FINCH A. P., MULHERN B., *et al.*

2024

Social Science & Medicine 346: 116720.

https://doi.org/10.1016/j.socscimed.2024.116720

Background : Comprehensively measuring the outcomes of interventions and policy programmes impacting both health and broader areas of quality of life (QoL) is important for decision-making within and across sectors. Increasingly, broad QoL measures are being developed to capture outcomes beyond health-related quality of life (HRQoL). Jointly exploring the dimensionality of diverse instruments can improve our understanding about their evaluative space and how they conceptually build on each other. This study explored the measurement relationship between five broader QoL measures and the most widely used HRQoL measure, the EQ-5D. Methods Participants from the Dutch general population (n = 1002) completed six instruments (n = 126 items) in December of 2020. The measurement relationship was explored using qualitative and quantitative dimensionality assessment methods. This included a content analysis and exploratory factor analyses which were used to develop a confirmatory factor model of the broader QoL dimensions. Correlations between the identified dimensions and self-reported overall health and wellbeing were also explored. Results The final CFA model exhibited acceptable/good fit and described 12 QoL dimensions: 'psychological symptoms', 'social relations', 'physical functioning', 'emotional resilience', 'pain', 'cognition', 'financial needs', 'discrimination', 'outlook on life/growth', 'access to public services', 'living environment', and 'control over life'. All dimensions were positively correlated to self-reported health and wellbeing, but the magnitudes in associations varied considerably (e.g., 'pain' had the strongest correlation with overall health but a weak correlation with wellbeing). Conclusions This study contributes to a broader understanding of QoL by exploring the dimensionality and relationships among various QoL measures. A number of the dimensions identified are HRQoL-focused, with others covering broader constructs. Our findings offer insights for the development of comprehensive instruments, or use of instrument suites that capture multidimensional aspects of QoL. Further research should explore the relevance and feasibility/appropriateness of measuring the identified dimensions in different settings and populations.

Analyzing Health Outcomes Measured As Bounded Counts

MULLAHY J.

2024

Journal of Health Economics 95: 102875.

https://doi.org/10.1016/j.jhealeco.2024.102875

This paper assesses analytical strategies that respect the bounded-count nature of health outcomes encountered often in empirical applications. Absent in the literature is a comprehensive discussion and critique of strategies for analyzing and understanding such data. The paper's goal is to provide an in-depth consideration of prominent issues arising in and strategies for undertaking such analyses, emphasizing the merits and limitations of various analytical tools empirical researchers may contemplate. Three main topics are covered. First, bounded-count health outcomes' measurement properties are reviewed and their implications assessed. Second, issues arising when bounded-count outcomes are the objects of concern in evaluations are described. Third, the (conditional) probability and moment structures of bounded-count outcomes are derived and corresponding specification and estimation strategies presented with particular attention to partial effects. Many questions may be asked of such data in health research and a researcher's choice of analytical method is often consequential.

Politique de santé

Health Policy

Stakeholder Participation in the COVID-19 Pandemic Preparedness and Response Plans: A Synthesis of Findings From 70 Countries

AGUILERA B., DONYA R. S., VÉLEZ C.-M., *et al.*

2024

Health Policy 142: 105013.

https://doi.org/10.1016/j.healthpol.2024.105013

Stakeholder participation is a key component of a fair and equitable priority-setting in health. The COVID-19 pandemic highlighted the need for fair and equitable priority setting, and hence, stakeholder participation. To date, there is limited literature on stakeholder participation in the development of the pandemic plans (including the priority setting plans) that were rapidly developed during the pandemic. Drawing on a global study of national COVID-19 preparedness and response plans, we present a secondary analysis of COVID-19 national plans from 70 countries from the six WHO regions, focusing on stakeholder participation. We found that most plans were prepared by the Ministry of Health and acknowledged WHO guidance, however less than half mentioned that additional stakeholders were involved. Few plans described a strategy for stakeholder participation and/or accounted for public participation in the plan preparation. However, diverse stakeholders (including multiple governmental, non-governmental, and international organizations) were proposed to participate in the implementation of the plans. Overall, there was a lack of transparency about who participated in decision-making and limited evidence of meaningful participation of the community, including marginalized groups. The critical relevance of stakeholder participation in priority setting requires that governments develop strategies for meaningful participation of diverse stakeholders during pandemics such as COVID-19, and in routine healthcare priority setting.

A Model of How Health Literacy, Governance and Systems Leadership Contribute to the Implementation of the One Health Approach

BLANKART C. R., DE GANI S. M., CRIMLISK H., *et al.*

2024

Health Policy 143 : 105042.

https://doi.org/10.1016/j.healthpol.2024.105042

One Health is an important approach to addressing health threats and promoting health through interdisciplinary health, policy, legislation and leadership research to achieve better human and animal health and better outcomes for the planet. The Covid-19 pandemic has triggered an urgent awareness of the need to develop innovative integrative solutions to address root causes of such threats to health, which requires collaboration across disciplines and amongst different sectors and communities. We explore how achieving the Quadripartite Organizations' One Health Joint Plan of Action can be supported by the concepts of 'One Health literacy' and 'One Health governance' and promote both academic and policy dialogue. We show how One Health literacy and One Health governance influence and reinforce each other, while an interdisciplinary systems leadership approach acts as a catalyst and mechanism for understanding and enacting change. Based on our understanding of how these elements influence the implementation of the One Health approach, we describe a model for considering how external triggering events such as the Covid-19 pandemic may prompt a virtuous circle whereby exposure to and exploration of One Health issues may lead to improved One Health literacy and to better governance. We close with recommendations to international organisations, national governments and to leaders in policy, research and practice to enhance their influence on society, the planetary environment, health and well-being.

Priority Setting in Times of Crises: An Analysis of Priority Setting For the COVID-19 Response in the Western Pacific Region

ESSUE B. M., KAPIRIRI L., MOHAMUD H., *et al.*

2024

Health Policy 142: 105010.

https://doi.org/10.1016/j.healthpol.2024.105010

Background While priority setting is recognized as critical for promoting accountability and transparency in health system planning, its role in supporting rational, equitable and fair pandemic planning and responses is less well understood. This study aims to describe how priority setting was used to support planning in the initial stage of the pandemic response in a subset of countries in the Western Pacific Region (WPR). Methods We purposively sampled a subset of countries from WPR and undertook a critical document review of the initial national COVID-19 pandemic response plans. A pre-specified tool guided data extraction and the analysis examined the use of quality parameters of priority setting, and equity considerations. Results Nine plans were included in this analysis, from the following countries: Papua New Guinea, Tonga, The Philippines, Fiji, China, Australia, New Zealand, Japan, and Taiwan. Most commonly the plans described strong political will to respond swiftly, resource needs, stakeholder engagement, and defined the roles of institutions that guided COVID-19 response decision-making. The initial plans did not reflect strong evidence of public engagement or considerations of equity informing the early responses to the pandemic. Conclusion This study advances an understanding of how priority setting and equity considerations were integrated to support the development of the initial COVID-19 responses in nine countries in WPR and contributes to the literature on health system planning during emergencies. This baseline assessment reveals evidence of the common priority setting parameters that were deployed in the initial responses, the prioritized resources and equity considerations and reinforces the importance of strengthening health system capacity for priority setting to support future pandemic preparedness.

The Economic Effect of Financial Compensation in China's Healthcare System: Comprehensive Insights Regarding Supply and Demand Factors

GUO Y., HONG X., LI D., *et al.*

2024

Health Economics Review 14(1): 21.

https://doi.org/10.1186/s13561-024-00496-5

We aim to analyse the effects of government subsidies on residents' health and healthcare expenditure from the perspectives of supply and demand.

Prévention

Prevention

Co-Benefits From Health and Health Systems to Education

LEE I.

2024

Health Policy 142: 105016.

https://doi.org/10.1016/j.healthpol.2024.105016

This review draws on over 70 studies spanning 2000 to 2023 to analyze the causal effect of health on educational outcomes. Health and health system interventions during the prenatal, infant, and childhood period impact longer-run educational attainment and performance. The magnitude of these effects is both statistically and economically significant, comparable in size to impacts on educational outcomes of interventions found in the literature. These impacts of health and health system interventions differ across gender and socioeconomic status, illustrating how health and health systems can exacerbate or mitigate educational inequalities. By showing the intertwined nature of health and education, this review highlights the importance of a comprehensive approach in policy-making that aligns with the Sustainable Development Goals.

Economic Evaluation of a School-Based Strategy to Prevent Overweight and Obesity in French Adolescents: Insights From the PRALIMAP Randomised Trial

OMOROU A. Y., MANNEVILLE F., ACHIT H., *et al.*

2023

Public Health 215: 75-82.

https://doi.org/10.1016/j.puhe.2022.11.025

Objectives This study aimed to provide cost-effectiveness and budget impact analyses of a school-based overweight/obesity screening and care prevention strategy among adolescents. Study design Cost-effectiveness and budget impact analyses. Methods Data from 3538 adolescents who participated in a school-based randomised controlled trial in the Northeast of France were used. Costs (from a public payer's perspective) included screening for overweight and obesity and subsequent care. Effectiveness was measured as the change in body mass index (kilogram per square metre), prevalence of overweight/obesity, moderate physical activity energy expenditure, duration and frequency and total sitting time. The incremental cost-effectiveness ratio was calculated, and a budget impact analysis was conducted. Results The screening and care strategy resulted in an incremental cost-effectiveness ratio of €1634.48 per averted case of overweight/obesity and €255.43 per body mass index unit decrease. The costs for increasing moderate physical activity by 1000 metabolic equivalent of task-min/week, duration by 60 min/week and frequency 1 day/week were €165.28, €39.21 and €93.66 per adolescent, respectively. Decreasing total sitting time by 60 min/week had a cost of €8.49 per adolescent. The cost of implementing the strategy nationally was estimated to be €50.1 million with a payback period from 3.6 to 7.3 years. Conclusions The screening and care strategy could be an efficient way to prevent overweight and obesity among adolescents. Future studies should investigate how the current results could be achieved in schools with different settings and thus justify its relevance for overweight and obesity prevention to policy-makers.

Psychiatrie

Psychiatry

La grande précarité de la psychiatrie. Une tragédie

DAVID M.

2024

L'information psychiatrique 100(3): 151-155.

https://www.cairn.info/revue-l-information-psychiatrique-2024-3-page-151.htm

Factors Influencing the Length of Stay in Forensic Psychiatric Settings: A Systematic Review

DIMA A., WAZIR A., CLARK-CASTILLO R., *et al.*

2024

BMC Health Services Research 24(1): 400.

https://doi.org/10.1186/s12913-024-10863-x

Forensic psychiatry is often associated with long admissions and has a high cost of care. There is little known about factors influencing length of stay (LOS), and no previous systematic review has synthesised the available data. This paper aims to identify factors influencing the LOS in forensic psychiatry hospitals to inform care and interventions that may reduce the length of admissions.

Tabagisme et handicap psychique : étude observationnelle mixte dans un échantillon diversifié d'établissements et de services médico-sociaux

FERNANE A., SAETTA S., TRICHARD C., *et al.*

2024

Santé Publique 36(1): 33-44.

https://www.cairn.info/revue-sante-publique-2024-1-page-33.htm

Introduction : Une étude observationnelle multicentrique a été réalisée dans dix ESMS et mobilisait une méthodologie mixte (visite des structures, enquête par questionnaires, entretiens semi-directifs collectifs avec des professionnels et individuels avec des usagers). But de l'étude : Cet article vise à décrire la gestion et la prévention du tabagisme dans des établissements et services médico-sociaux (ESMS) accueillant des personnes avec un trouble psychique, et à caractériser et identifier les comportements tabagiques et les représentations de leurs usagers et professionnels. Résultats : L'étude a permis de distinguer les ESMS au regard de l'organisation des espaces du tabagisme et des actions de prévention du tabac. Elle a permis également de constater que 37 % des professionnels qui ont répondu déclaraient fumer du tabac, une partie d'entre eux expliquant fumer avec les usagers et leur donner parfois des cigarettes. Concernant la prévention, un consensus se dégageait chez les professionnels sur le fait d'aider les usagers qui souhaitaient arrêter. Les professionnels étaient cependant divisés à l'égard d'une prévention plus active, invoquant la liberté de l'usager et le fait que les ESMS sont des lieux de vie. 47 % des usagers se disaient fumeurs. 55 % des usagers fumeurs déclaraient vouloir arrêter. Les entretiens avec les usagers ont permis de constater que douze d'entre eux souhaitaient arrêter, une partie réclamant de l'aide et d'être davantage aidés par les professionnels. Conclusions : Cet état des lieux invite à développer des recherches interventionnelles dans les ESMS accueillant des personnes avec un trouble psychique qui pourraient tirer profit des actions de prévention du tabac repérées dans des structures enquêtées.

Santé mentale des médecins libéraux français pendant la deuxième vague de COVID 19

FRAJERMAN A., DEFLESSELLE E., COLLE R., *et al.*

2024

L'Encéphale 50(2): 192-199.

https://doi.org/10.1016/j.encep.2023.01.013

Résumé Introduction La pandémie de COVID-19 a créé une crise sanitaire mondiale ayant entraîné une souffrance psychologique du personnel soignant notamment les médecins hospitaliers. Nous avons montré que les niveaux de souffrance psychologiques étaient aussi élevés parmi les médecins libéraux. Aucune étude n'a à ce jour comparé les médecins généralistes avec les médecins de l'ensemble des autres spécialités libérales pendant la pandémie en France. Cette étude visait à comparer la souffrance psychologique en termes de burn-out, d'anxiété, de symptômes dépressifs et d'insomnie entre les médecins généralistes et les médecins libéraux de toutes les autres spécialités en France durant la deuxième vague épidémique. Méthodes Il s'agissait d'une étude transversale nationale en ligne adressée aux médecins libéraux utilisateurs de Doctolib. Nous avons utilisé le Copenhagen Burnout Inventory, l'Hospital and Anxiety Depression Scale, l'Insomnia Severity Index, afin d'évaluer burn-out, symptômes anxieux et dépressifs et insomnie. Nous avons évalué l'association entre la pandémie COVID-19, le travail et l'état psychologique.

COVID-19 Psychological Impact in General Practitioners: A Longitudinal Study

LANGE M., LICAJ I., STROIAZZO R., *et al.*

2024

L'Encéphale 50(2): 143-148.

https://doi.org/10.1016/j.encep.2023.03.001

Introduction COVID-19 may have negatively impacted the mental health of front-line healthcare workers, including general practitioners (GPs). This study sought to assess the psychological impact (stress, burnout and self-efficacy) of the COVID-19 outbreak in French GPs. Methods We carried out a postal-based survey of all GPs who worked in the French region of Normandy (departments of Calvados, Manche and Orne) from the exhaustive database of the Union Régionale des Médecins libéraux (URML Normandie) as of 15th April 2020 (one month after the first French COVID-19 sanitary lockdown). The second survey was conducted four months later. Four validated self-report questionnaires were used at both inclusion and follow-up : Perceived Stress scale (PSS), Impact of Event Scale-revised (IES-R), Maslach Burnout Inventory (MBI) and General Self-Efficacy scale (GSE). Demographic data were also collected. Results The sample consists of 351 GPs. At the follow-up, 182 answered the questionnaires (response rate : 51.8 %). The mean scores of MBI significantly increased during follow-up [Emotional exhaustion (EE) and Personal accomplishment, $P<0.01$]. Higher burnout symptoms were found at the 4-month follow-up in 64 (35.7 %) and 86 (48.0 %) participants (43 and 70 participant at baseline), according respectively to EE and depersonalisation scores ($P=0.01$ and 0.09, respectively). Conclusion This is the first longitudinal study that has shown the psychological impact of COVID-19 in French GPs. Based on validated a self-report questionnaire, burnout symptoms increased during follow-up. It is necessary to continue monitoring psychological difficulties of healthcare workers especially during consecutive waves of COVID-19 outbreak. Résumé Introduction La COVID-19 a eu une influence négative sur les professionnels de santé de soins premiers, dont les médecins généralistes (MGs). Cette étude visait à évaluer l'influence psychologique (stress, burn-out et efficacité) du confinement chez les MGs français. Méthode Nous avons réalisé une enquête postale auprès de tous les MGs exerçant en Normandie occidentale (départements du Calvados, de la Manche et de l'Orne) à partir de la base de données exhaustive de l'Union régionale des médecins libéraux (URML Normandie), le 15 avril 2020 (un mois après la premier confinement sanitaire). La deuxième enquête a été menée quatre mois après la première. Quatre questionnaires d'autoévaluation validés ont été utilisés à l'inclusion et durant le suivi : l'échelle de stress perçu (PSS), l'échelle d'impact des événements révisée (IES-R), l'inventaire de l'épuisement professionnel de Maslach (MBI) et l'échelle d'auto-efficacité générale (GSE). Des données démographiques ont également été collectées. Résultats L'échantillon était composé de 351 MGs. Durant le suivi, 182 ont répondu aux questionnaires (taux de réponse : 51,8 %). Les scores moyens de MBI ont significativement augmenté au cours du suivi [épuisement émotionnel (EE) et accomplissement personnel, P<0,01]. Des symptômes d'épuisement professionnel plus élevés ont été trouvés après quatre mois de suivi chez 64 (35,7 %) et 86 (48,0 %) participants (43 et 70 participants au départ), selon respectivement les scores EE et dépersonnalisation (P = 0,01 et 0,09, respectivement). Conclusion Il s'agit de la première étude longitudinale qui montre l'influence psychologique de la COVID-19 (et ses confinements) chez les MGs français. Sur la base d'un questionnaire d'autoévaluation validé, les symptômes d'épuisement professionnel ont augmenté au cours du suivi. Il est nécessaire de continuer à surveiller les difficultés psychologiques des professionnels de la santé, en particulier lors des futures vagues épidémiques de COVID-19.

▶ The Lancet Psychiatry Commission: Transforming Mental Health Implementation Research

MCGINTY E. E., ALEGRIA M., BEIDAS R. S., *et al.*

2024

The Lancet Psychiatry 11(1) 368-396

https://doi.org/10.1016/S2215-0366(24)00040-3

Effective mental health promotion, prevention, and treatment approaches exist but are not widely delivered at-scale to large groups or populations. Most people who could benefit from evidence-based mental health interventions—defined broadly to encompass policies, programmes, and individual-level practices or services—do not receive them. This implementation gap is sometimes termed a know–do gap—we know what mental health interventions can work, but we often do not know how to do those interventions in real-world settings. The growing field of implementation research, which seeks to understand what, why, and how interventions work (or do not work) in real-world settings, aims to identify approaches to overcome barriers to scaling. Although some progress has been made, implementation research can fall short of this goal. Often, research produces both interventions and implementation strategies (eg, financing, facilitation, training to improve mental health literacy or reduce stigma) that are difficult to deliver at scale owing to misalignment with the political, cultural, policy, system, community, provider, and individual realities of real-world settings. This Commission considers strategies for transforming how we conduct research to produce more actionable evidence to narrow the mental health implementation gap.

▶ Trauma and Mental Health in Young Adults Who Arrived in France As Unaccompanied and Separated Migrant Children

NORTON J., GANDUBERT C., PELLISSIER S., *et al.*

2024

L'Encéphale 50(2): 154-161.

https://doi.org/10.1016/j.encep.2023.04.003

Objectives The mental health of unaccompanied and separated minors (UASC) has been widely studied but not their first years of adulthood, often characterised by uncertainty after leaving child protection. The aim of this study was to estimate the prevalence of psychiatric disorders using standardised and validated research instruments and examine the effect of exposure to trauma. Methods One hundred and ten youth (92.7 % male, median age 19.7 [18.1–22.8]) from Chambery, Montpellier and La Rochelle were recruited to a cross-sectional exploratory study. During a face-to-face interview, somatoform disorder, anxiety, and depression were assessed using the Patient Health Questionnaire (score≥10) and post-traumatic stress disorder (PTSD) with the PTSD Checklist for DSM-5 (score≥33). Traumatic life events were assessed using the Life Events Checklist.

Stigmatization Towards Electro Convulsive Therapy: Impact of Practical Teaching on Medical and Nursing Students

QUILES C., SY H. ET VERDOUX H.

2024

L'Encéphale 50(2): 125-129.

https://doi.org/10.1016/j.encep.2023.01.009

Background This study explored the impact of theoretical and practical teaching on electro convulsive therapy (ECT) on medical and nursing students' stigmatizing attitudes towards ECT and representations of it. Method Fourth-year medical students and nursing students answered questions from the Questionnaire on Attitudes and Knowledge of ECT (QuAKE) and from the Mental Illness : Clinicians' Attitudes version 2 (MICA v2) scale. The questionnaires were completed before and after observing a 3-hour practical training session in the ECT unit. The endpoint was the impact of practical training as assessed by MICA and QuAKE scores. Multivariate analyses were used to explore the impact of practical training on MICA and QuAKE total scores. Results Stigmatizing attitudes and representations of both medical and nursing students towards ECT were reduced after practical training (β = –4.43 [95 % CI –6.15 ; –2.70] p = 0.0001). The impact was greater in medical students (β = –8.03 ; 95 % CI [–10.71 ; –5.43], P = 0.0001) than in nursing students (β = –2.77 ; 95 % CI [–4.98 ; to 0.44], P = 0.02). Gender, psychiatric history in close persons, and having already followed a psychiatric/ECT course had no independent impact on stigmatizing attitudes towards ECT and representations of it. Conclusion Practical training in ECT should be given to all health professionals to improve access to it. Résumé Contexte Cette étude explore l'impact de l'enseignement pratique de l'électroconvulsivothérapie (ECT) sur les attitudes stigmatisantes et les représentations négatives des étudiants en médecine et en soins infirmiers à l'égard des ECT. Méthode Des étudiants en médecine en quatrième année d'études et des étudiants en soins infirmiers ont complété le « Questionnaire on Attitudes and Knowledge of ECT » (QuAKE) et le questionnaire « Mental Illness : Clinicians' Attitudes version 2 » (MICA v2), avant et après l'observation d'une session de formation pratique de 3heures dans l'unité ECT. Des analyses multivariées ont été utilisées pour explorer l'impact de la formation pratique sur les scores totaux MICA et QuAKE. Résultats Les attitudes négatives et les représentations stigmatisantes des étudiants en médecine et en soins infirmiers à l'égard de l'ECT ont diminué après la formation pratique (β = –4,43 [IC 95 % –6,15 ; –2,70] p = 0,0001). L'impact était plus important chez les étudiants en médecine (β = – 8,03 ; IC 95 % [–10,71 ; –5,43], p = 0,0001) que chez les étudiants en soins infirmiers (β = –2,77 ; IC 95 % [–98 ; à 0,44], p = 0,02). Le sexe, les antécédents psychiatriques chez les personnes proches et le fait d'avoir déjà suivi un cours de psychiatrie/sur les ECT n'avaient pas d'impact sur les représentations et les attitudes stigmatisantes envers l'ECT. Conclusion Une formation pratique à l'ECT devrait être dispensée à tous les professionnels de santé afin d'améliorer l'accès à ce soin.

Pattern of Encounters to Emergency Departments For Suicidal Attempts in France: Identification of High-Risk Days, Months and Holiday Periods

ROCHOY M., PONTAIS I., CASERIO-SCHÖNEMANN C., *et al.*

2024

L'Encéphale. (In press)

https://doi.org/10.1016/j.encep.2023.11.018

Introduction Seasonal change in patterns of suicidal attempts is not well known in France and may differ from other western countries. We aimed to determine the peak times (days, months and holiday periods) of suicidal attempts in France. Methods We carried out a multicentre retrospective epidemiological study, using data from the Organization for Coordinated Monitoring of Emergencies (OSCOUR®) network. We aggregated daily data from January 1, 2010, to December 31, 2019. Variations in suicidal attempts on specific days were investigated by comparing their frequencies (ad hoc Z-scores). Results 114,805,488 ED encounters were recorded including 233,242 ED encounters regarding suicidal attempts. Men accounted for 45.7 %. A significantly higher frequency of ED encounters for suicidal acts were found on Sundays in the months of May-June for both sexes and on New Year's Day for all genders and age groups. An increased risk was also noted on July 14th (National Day) and June 22nd (Summer Solstice). A protective effect was noted on the day after Valentine's Day, on Christmas Day and Christmas time (in particular December 24 and 26). Conclusion Sundays, June, New Year's Day were at increased risk of suicidal attempts in France requiring a strengthening of prevention. Résumé Introduction Les variations saisonnières des tentatives de suicide sont mal connues en France et peuvent différer des autres pays occidentaux. Nous avons cherché à déterminer les périodes de pointe (jours, mois et périodes de vacances) des tentatives de suicide en France. Méthodes Nous avons réalisé une étude épidémiologique rétrospective multicentrique, en utilisant les données du réseau de l'Organisation de la surveillance coordonnée des urgences (OSCOUR®). Nous avons agrégé les données quotidiennes du 1er janvier 2010 au 31 décembre 2019. Les variations des tentatives de suicide sur des jours spécifiques ont été étudiées en comparant leurs fréquences (scores Z ad hoc). Résultats 114 805 488 consultations aux urgences ont été enregistrées dont 233 242 consultations aux urgences concernant des tentatives de suicide. Les hommes représentaient 45,7 % des consultations. Une fréquence significativement plus élevée de consultations aux urgences pour des actes suicidaires a été observée les dimanches des mois de mai et juin pour les deux sexes et le jour de l'an, pour tous les sexes et tous les groupes d'âge. Un risque accru a également été constaté le 14 juillet (fête nationale) et le 22 juin (solstice d'été). Un effet protecteur a été observé le lendemain de la Saint-Valentin, le jour de Noël et pendant la période de Noël (en particulier les 24 et 26 décembre). Conclusion Les dimanches, le mois de juin et le jour de l'an sont à risque accru de tentatives de suicide en France, ce qui nécessite un renforcement de la prévention.

▶ Social Ecological Determinants of the Mental Distress Among Syrian Refugees in Lebanon and Turkey: A Transnational Perspective

RUHNKE S. A., HERTNER L., KÖHLER J., *et al.*

2024

Social Science & Medicine 346: 116700.

https://doi.org/10.1016/j.socscimed.2024.116700

Syrian refugees in Lebanon report higher psychological burdening than those in Turkey. The two displacement contexts differ in the determination of mental health outcomes. Social exclusion and discrimination emerge as important predictors in both countries. Analysis calls for holistic action in both clinical practice and public policy.

Sociologie de la santé

Sociology of Health

▶ Les soins oncologiques de support : une ressource inégalement mobilisée face au cancer

KANE H., GOURRET BAUMGART J. ET DENIS F.

2023

Sciences sociales et santé 41(4): 5-31.

https://www.cairn.info/revue-sciences-sociales-et-sante-2023-4-page-5.htm

Alors que les inégalités de prévalence des cancers et de survie ont été bien documentées, moins de recherches ont été consacrées aux inégalités d'accès aux soins oncologiques de support. L'accès à ces soins qui contribuent à améliorer la qualité de vie constitue pourtant un enjeu d'équité en santé. Considérant comment les personnes souffrant d'un cancer mobilisent ces ressources, nous analysons les inégalités de recours à ces soins. La méthodologie associe des observations et des entretiens approfondis en région Centre-Val de Loire. Les résultats font ressortir d'importantes hétérogénéités dans l'accès aux soins oncologiques de support, qui sont proposés en fonction des besoins perçus par les professionnels, et selon les facultés des personnes à communiquer leurs besoins. Des disparités de recours s'ancrent dans des rapports différenciés à la maladie, aux médecines et au système de santé. Tandis que certains cumulent ces soins de support à diverses ressources hors de l'hôpital, d'autres se contentent d'un traitement curatif et spécifique de leur cancer. Positionnés de manière marginale et optionnelle, les soins oncologiques de support constituent une variable d'ajustement et un nœud de construction des inégalités sociales face au cancer.

Les soins de support, entre soins et soins de soi. Commentaire

MINO J.-C. ET LEFÈVE C.

2023

Sciences sociales et santé 41(4): 33-41.

https://www.cairn.info/revue-sciences-sociales-et-sante-2023-4-page-33.htm

Un·e pour tou·tes, tou·tes perdant·es ? La difficile prise en compte du corps dans les organisations. Commentaire

RÉMY E.

2023

Sciences sociales et santé 41(4): 107-113.

https://www.cairn.info/revue-sciences-sociales-et-sante-2023-4-page-107.htm

D'une « éthique d'exception » à une éthique de la santé publique. Patients et proches face à la COVID-19. Éthique et santé publique en temps de COVID-19

SPRANZI M., FOUREUR N. ET FAIDHERBE V.

2024

Santé Publique 36(1): 97-108.

https://www.cairn.info/revue-sante-publique-2024-1-page-97.htm

L'étude vise à analyser la perception que les patients et les proches de patients pris en charge pendant la crise de la COVID-19, ont pu avoir de leur prise en charge, et leurs réflexions éthiques sur la place et la définition de la santé publique. L'étude a utilisé une méthode qualitative et multicentrique. Les entretiens semi-directifs ont été conduits par une équipe pluridisciplinaire et analysés avec une approche thématique et une grille de lecture éthique à partir des principes de l'éthique biomédicale. Trois thèmes ont émergé : 1) Les patients ont exprimé peu de revendications de participer aux décisions médicales les concernant, contrairement aux proches qui se sont sentis exclus de leur rôle. Tous ont mis l'accent sur l'importance des soins de base par rapport aux soins techniques; 2) La gestion de la crise n'est pas jugée sévèrement, mais une crise de confiance importante a été mise en évidence, malgré la « transparence » affichée de l'information; 3) les contraintes collectives ont été largement acceptées au nom de la solidarité, mais on a jugé qu'elles doivent avoir des limites (temporelle et spatiales). Surtout, elles ne doivent pas empêcher des relations humaines simples et essentielles. L'étude met en évidence qu'il est nécessaire de développer une réflexion nouvelle autour de l'éthique de la santé publique : il convient de questionner les principes de « transparence » et de « proportionnalité » et d'adopter une définition de « santé publique » plus large que la minimisation du risque infectieux.

L'animation d'une communauté de pratique inter-organisationnelle : une condition d'amélioration des pratiques professionnelles dans les champs sanitaire et social

ZUCCHELLO A., DORSA M., LOMBRAIL P., *et al.*

2023

Journal de gestion et d'économie de la santé 3(3): 204-227.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2023-3-page-204.htm

Les communautés de pratiques regroupent des groupes de personnes concernées par une pratique commune dans l'objectif de l'améliorer par un partage de connaissance et d'expérience à son sujet. Elles sont identifiées comme des moyens privilégiés de gestion de la connaissance, pourtant leur animation reste peu décrite. La recherche visait à décrire la méthode d'animation d'une communauté de pratique intentionnelle inter-organisationnelle autour d'un projet dénommé ACESO pour ACcompagnement Evolutif et SOlidaire. La méthode d'animation s'apparentait à celle mise en œuvre par un tiers tercéisateur (Xhauflair et Pichault, 2012). Les tiers tercéisateurs s'appuient sur les expériences des acteurs pour développer leur pensée critique, les aider dans le passage à l'action et maintenir les changements dans la durée. Afin de caractériser le processus ayant abouti à une transformation des pratiques, l'analyse qualitative, mobilisant une triangulation des données (entretiens, focus groupe, analyses documentaires et observations participantes) s'est appuyée sur les cinq dimensions de la tercéisation. Les cinq dimensions de la tercéisation ont permis de rendre compte d'une partie du processus suivi. Deux autres dimensions ont été identifiées : le développement de valeurs communes comme socle d'une dynamique collaborative et la transformation du tercéisé en tercéisateur comme condition de la pérennité des changements. La tercéisation facilite la gestion des connaissances et l'auto-transformation des acteurs au sein d'une communauté de pratique. La transformation du tercéisé en tercéisateur facilite aussi la diffusion au sein de chacune des structures partenaires du projet. Ces résultats permettent de mieux comprendre l'intérêt d'un tiers tercéisateurs dans l'animation d'une communauté de pratique intentionnelle et dans la gestion de connaissance inter-organisationnelle.

Soins primaires

Primary Health Care

The Effects of the Veterans Health Administration's Referral Coordination Initiative on Referral Patterns and Waiting Times for Specialty Care

ASFAW D. A., PRICE M. E., CARVALHO K. M. *et al.*

Health Services Research. : 1-11

https://doi.org/10.1111/1475-6773.14303

Abstract Objective To investigate whether the Veterans Health Administration's (VA) 2019 Referral Coordination Initiative (RCI) was associated with changes in the proportion of VA specialty referrals completed by community-based care (CC) providers and mean appointment waiting times for VA and CC providers. Data Sources/Study Settings Monthly facility level VA data for 3,097,366 specialty care referrals for eight high-volume specialties (cardiology, dermatology, gastroenterology, neurology, ophthalmology, orthopedics, physical therapy, and podiatry) from October 1, 2019 to May 30, 2022. Study Design We employed a staggered difference-in-differences approach to evaluate RCI's effects on referral patterns and wait times. Our unit of analysis was facility-month. We dichotomized facilities into high and low RCI use based on the proportion of total referrals for a specialty. We stratified our analysis by specialty and the staffing model that high RCI users adopted: centralized, decentralized, and hybrid. Data Collection/Extraction Methods Administrative data on referrals and waiting times were extracted from the VA's corporate data warehouse. Data on staffing models were provided by the VA's Office of Integrated Veteran Care. Principal Findings We did not reject the null hypotheses that high RCI use do not change CC referral rates or waiting times in any of the care settings for most specialties. For example, high RCI use for physical therapy—the highest volume specialty studied—was associated with −0.054 (95% confidence interval [CI]: −0.114 to 0.006) and 2.0 days (95% CI: −4.8 to 8.8) change in CC referral rate and waiting time at CC providers, respectively, among centralized staffing model adopters. Conclusions In the initial years of the RCI program, RCI does not have a measurable effect on waiting times or CC referral rates. Our findings do not support concerns that RCI might be impeding Veterans' access to CC providers. Future evaluations should examine whether RCI facilitates Veterans' ability to receive care in their preferred setting.

Competition, Quality and Integrated Health Care

BREKKE K. R., SICILIANI L. ET STRAUME O. R.

2024

Journal of Health Economics 95: 102880.

https://doi.org/10.1016/j.jhealeco.2024.102880

Integration of health care services has been promoted in several countries to improve the quality and coordination of care. We investigate the effects of such integration in a model where providers compete on quality to attract patients under regulated prices. We identify countervailing effects of integration on quality of care. While integration makes coordination of care more profitable for providers due to bundled payments, it also softens competition as patient choice is restricted. We also identify circumstances due to asymmetries across providers and/or services under which integration either increases or reduces the quality of services provided. In the absence of synergies, integration generally leads to increases in quality for some services and reductions for others. The corresponding effect on health benefits depends largely on whether integration leads to quality dispersion or convergence across services. If the softening of competition effect is weak, integration is likely to improve quality and patient outcomes.

The Effects of Dental Hygienist Autonomy on Dental Care Utilization

CHEN J., MEYERHOEFER C. D. ET TIMMONS E. J.

Health Economics: 1-11.

https://doi.org/10.1002/hec.4832

Abstract We investigate the effects of regulations governing the practice autonomy of dental hygienists on dental care use with the 2001–2014 Medical Expenditure Panel Survey. We measure the strength of autonomy regulations by extending the Dental Hygiene Professional Practice Index to the years 2001–2014, allowing us to capture changes in regulations within states over time. Using a difference-in-differences framework applied to selected states, we find that relaxing supervision requirements to provide dental hygienists moderate autonomy results in an increase in total dental visits due to greater use of preventive dental care. However, the use of dental treatment decreases when states adopt the highest level of autonomy. Both sets of estimates increase in magnitude when we subset the sample to dental care provider shortage areas. In support of these findings, we show that dental visits shift to dental hygienists in shortage areas when states expand the scope of practice of hygienists, and that there is an increase in tasks performed by hygienists, such as cleanings and dental exams.

Access and Triage in Contemporary General Practice: A Novel Theory of Digital Candidacy

DAKIN F. H., RYBCZYNSKA-BUNT S., ROSEN R., *et al.*

2024

Social Science & Medicine: 116885.

https://doi.org/10.1016/j.socscimed.2024.116885

To access contemporary healthcare, patients must find and navigate a complex socio-technical network of human and digital actors linked in multi-modal pathways. Asynchronous, digitally-mediated triage decisions have largely replaced synchronous conversations between humans. In this paper, we draw on a large qualitative dataset from a multi-site study of remote and digital technologies in general practice to understand widening inequities of access. We theorise our data by bringing together traditional candidacy theory (in particular, concepts of self-assessment, help-seeking, adjudication and negotiation) and socio-technical and technology structuration theories (in particular, concepts of user configuration, articulation, distanciation, disembedding, and recursivity), thus producing a novel theory of digital candidacy. We propose that both human and technological actors (in different ways) embody social structures which affect how they 'act' in social situations. Digital technologies contain inbuilt assumptions about users' capabilities, needs, rights, and skills. Patients' ability to self-assess as sick, access digital platforms, self-advocate, and navigate multiple stages in the pathway, including adapting to and compensating for limitations in the technology, vary widely and are markedly patterned by disadvantage. Not every patient can craft an accurate digital facsimile on which the subsequent adjudication decision will be made; those who create incomplete, flawed or unpersuasive digital facsimiles may be deprioritised or misdirected. Staff who know about such patients may use articulation measures to ensure a personalised and appropriate access package, but they cannot identify or fully mitigate all such cases. The decisions and actions of human and technological agents at the time of an attempt to access care can significantly influence, disrupt, and reconstitute candidacy both immediately and recursively over time, and also recursively shape the system itself. These findings underscore the need for services to be (co-)designed with attention to the exclusionary tendencies of digital technologies and technology-supported processes and pathways.

Pratiques professionnelles et soins dentaires non programmés en Nouvelle-Aquitaine

FORTIN H., WEMAERE J., ROBIN S., *et al.*

2024

Santé Publique 36(1): 81-85.

https://www.cairn.info/revue-sante-publique-2024-1-page-81.htm

Dans un contexte de saturation des cabinets dentaires libéraux et de démographie médicale tendue, l'apport de réponses aux demandes de soins dentaires non programmés constitue une réelle problématique assez peu documentée. En partenariat avec l'Observatoire régional de la santé, l'URPS Chirurgiens-dentistes Nouvelle-Aquitaine a mené en mai-juin 2022 une enquête auprès de chirurgiens-dentistes libéraux. L'objectif était d'estimer le volume des demandes de soins non programmés en soins dentaires et de décrire les réponses apportées par les professionnels. Plus de huit professionnels sur dix ont déclaré être souvent sollicités pour des soins non programmés, et plus de quatre sur dix prévoyaient des créneaux spécifiques pour les assurer. Plus d'un quart d'entre eux ont déclaré répondre à 90 % des sollicitations pour ce type de soins et 40 % répondre à moins de la moitié des demandes. Les soins non programmés étaient pris en charge dans les 24 heures en moyenne pour la majorité des professionnels. L'éducation des patients a été citée comme une piste d'amélioration générale ou institutionnelle, devant la création d'une cotation spécifique pour les soins non programmés. Cette enquête permet de mieux connaître les difficultés des professionnels sur un sujet non encore investigué auprès de la profession dentaire. Elle documente l'acceptabilité de pistes de réponses pouvant être apportées pour améliorer les pratiques professionnelles et les organisations institutionnelles.

▶ Turnover Intention of Foreign Trained Physicians in German Rehabilitation Facilities—A Quantitative Study

JANSEN E., SCHMIDT J. ET MARQUARDT M.

2024

BMC Health Services Research 24(1): 402.

https://doi.org/10.1186/s12913-024-10902-7

Germany's medical specialist shortage is an acute challenge, especially in the rehabilitation segment. One countermeasure is to recruit foreign trained physicians (FTP), but the high turnover of FTP is a burden on the departments that train them and integrate them professionally. Preliminary research showed that currently one in three physician positions in German Pension Insurance (DRV) contract facilities is filled by FTP. This paper examines factors related to turnover intention of FTP in German rehabilitative departments.

▶ Health Care Utilization and Expenditures in Health Professional Shortage Areas

MCCLELLAN C. B.

2024

Medical Care Research and Review 0(0): 10775587241235705.

https://doi.org/10.1177/10775587241235705

Healthcare provider shortages are associated with adverse health outcomes, presumably stemming from the lack of access to primary care. This study examines the impact of Health Professional Shortage Areas (HPSAs) on healthcare utilization and spending across different types of care. Using the Medical Expenditure Panel Survey from 2002 to 2019, this study estimates the difference in healthcare utilization in HPSAs compared with non-HPSAs using a generalized random forest, which allows for more complex modeling of the outcome and a principled examination of heterogenous treatment effects. The results indicate HPSAs are associated with a 5% reduction in medical office visits, but no reduction in hospital-based care. These effects are concentrated in older persons living in urban areas, Black persons, and Medicaid beneficiaries. No statistically significant effects on annual spending were observed. These results offer insight into potential areas for further policy efforts aimed at reducing provider shortages.

▶ New Paramedic Scope of Practice in Poland Based on the 2022 Reform

NOWAK-ZAJĄC K., DOMAGAŁA A., BIELSKA I. A., *et al.*

2024

Health Policy 143: 105015.

https://doi.org/10.1016/j.healthpol.2024.105015

Emergency medical systems in the world are mainly based on two main models: the Franco-German System (FGS) and the Anglo-American System (AAS). The characteristic feature of the FGS is the "Stay and Play" principle, while the AAS system is based on the "Scoop and Run" principle. The Polish model is a mix of those two systems mainly based on the work of paramedics. Their scope of operations and powers have changed over time. As a result of the advocacy undertaken by paramedics in Poland, legislation was drafted and became law in June 2023. The central changes include: the introduction of a paramedic register, the establishment of a professional self-government of paramedics, the expansion of professional competencies such as the ability to declare death, and new opportunities for professional development including speciality training or paid training leave. This article discusses the new law in the context of previous legislative solutions in the field of emergency medicine in Poland and in other European countries.

A Comparison of Social Prescribing Approaches Across Twelve High-Income Countries

SCARPETTI G., SHADOWEN H., WILLIAMS G. A., *et al.*

2024

Health Policy 142: 104992.

https://doi.org/10.1016/j.healthpol.2024.104992

Social prescribing connects patients with community resources to improve their health and well-being. It is gaining momentum globally due to its potential for addressing non-medical causes of illness while building on existing resources and enhancing overall health at a relatively low cost. The COVID-19 pandemic further underscored the need for policy interventions to address health-related social issues such as loneliness and isolation.

Associations Between Corporate Ownership of Primary Care Providers and Doctor Wellbeing, Workload, Access, Organizational Efficiency, and Service Quality

SCOTT A., TAYLOR T., RUSSELL G., *et al.*

2024

Health Policy 142: 105028.

https://doi.org/10.1016/j.healthpol.2024.105028

Traditionally, in many countries general practices have been privately-owned independent small businesses. However, the last three decades has seen the rise of large corporate medical groups defined as private companies which are able to have non-GP shareholders and with branches across many locations. The greater prominence of profit motives may have implications for costs, access to care and quality of care. We estimate that 45% of GPs in Australia worked in a practice that was a private company, and within this group over one third (19.9% of total) worked in a corporate medical group (a private company with 10 or more practice locations). We examine the association between being in a corporate medical group and 19 outcomes classified into five groups: GP wellbeing, workload, patient access, organizational efficiency, and service quality. GPs who worked in such groups were more likely to be older, qualified overseas, and to have a conscientious personality. There was mixed evidence on GPs wellbeing, with GPs in corporate medical groups reporting a higher turnover of GPs but similar levels of job satisfaction. GP workload was similar in terms of hours worked and after hours work but they reported a lower work-life balance. Patient access was better in terms of lower fees charged to patients but there was weak evidence that patients waited longer. GPs in corporate medical groups reported higher organisational efficiency because GPs spent less time spent on administration and management, had more nurses per GP, but despite this GPs were more likely to undertake tasks someone less qualified could do suggesting that nurses were complements not substitutes. There were no differences in service quality (teaching, patient complaints, consultation length, patients seen per hour). Corporate medical groups have become a substantial part of primary care provision in Australia. There is evidence they are more efficient, patient access is better with lower out of pocket costs and there are no differences in our measures service quality, but concerns remain about GP's wellbeing and work-life balance. Further research is needed on continuity of care and patient reported experiences and health outcomes.

Change in Avoidable Hospitalizations For Low-Income Elders Following Quasi-Market Reform in Primary Care – Evidence From a Natural Experiment in Sweden

SVERÉUS S., PETZOLD M. ET REHNBERG C.

2024

Social Science & Medicine 346: 116711.

https://doi.org/10.1016/j.socscimed.2024.116711

Quasi-market reforms have been increasingly implemented in tax-funded health care, but their effects in terms of equity, quality and socioeconomic differentials in quality remain sparsely studied. We create a natural experiment setup exploiting the differential timing of a set of quasi-market reforms – including patient choice, free establishment of providers and changes in provider remuneration –, implemented in primary care in the two largest Swedish regions (Stockholm and Västra Götaland) in 2008–2009. Using a database with individual level data from 2005 to 2009, we construct a difference-in-difference-in-differences model that compares pre to post reform changes in avoidable hospitalizations (AHs) for low-income elders and a matched comparison group, in the region exposed to, versus unexposed to, reform (total N ≈ 200 000). The results show that for low-income elders – a group dominated by older women – reform led to higher AH rates, i.e., worse primary health care quality, than what would have been the case in absence of reform. Specifically, low-income elders exposed to reform missed out on improvements in AHs seen simultaneously in the unexposed region. At the same time, the reform had on average no effect for comparable, non-low-income, peers. The fact that this pattern was specific for avoidable hospitalizations – judged as amenable to interventions in primary care –, but not present for total hospitalizations, supports that it was driven by reform implementation rather than other factors.

▶ Exiting Primary Care Providers

ZOCHER K.

2024

Health Economics 33(5): 1033-1054.

https://doi.org/10.1002/hec.4800

This article studies the impact of primary care providers (PCPs) exit from the local health care system on patients' health care utilization. I compare patients with each other whose physicians have left the local health care system at different points in time due to retirement, relocation, or other reasons. Estimation results indicate that the imminent exit leads soon-leaving physicians to changing their treatment behavior, which has a significant impact on patients' health care spending. In addition, successors and new PCPs provide significantly more preventive services in the post-exit-period and refer patients more often to specialists for further examinations than the physicians who exit later. The increased inpatient expenditures in the post-exit period are caused by the new PCPs (through referrals). Self-initiated substitution behavior of patients (e.g., less PCP care, more specialist care) after the exit is observed but is low in magnitude. Although an overall increase in health service utilization is observed, mortality in the post-exit periods is significantly increased among affected patients. A possible explanation is the low frequency follow-up care of patients who were referred to hospitals by their former PCP in the notification-period.

Systèmes de santé

Health Systems

▶ The Dynamics of International Health System Reforms: Evidence of a New Wave in Response to the 2008 Economic Crisis and the COVID-19 Pandemic?

BERARDI C., SCHUT F. ET PAOLUCCI F.

2024

Health Policy 1463 : 105052.

https://doi.org/10.1016/j.healthpol.2024.105052

Global economic and health shocks, such as the 2008 global financial crisis and the COVID-19 pandemic typically impact healthcare financing and delivery. Cutler found that profound societal changes in the 20th century induced three waves of healthcare reform across seven major OECD countries. Our study investigates whether major crises in the 21st century induced similar reform waves. Through thematic analysis, we systematically compared health system changes in response to these shocks, using data from the Observatory on Health Systems and Policies and the OECD. Our analysis reveals similar overarching reform trends across countries in response to the 2008 economic crisis: a tendency toward re-centralization of health system governance to control and leverage the efficient rationalization of public health resources. This, to some extent, countered the effects of the market-based reforms of the previous wave. The reforms induced by the 2008 crisis were mediated by its repercussions on the countries' economies. In contrast, reforms in response to the pandemic aimed primarily to address the direct impact of the shock on the health system. Despite its negative economic impact, the pandemic resulted in a substantial but temporary increase in public health spending. A better understanding reform dynamics and their impact on overarching conflicting health system objectives may prevent unintended consequences and enhance health systems' resilience in response to future shocks.

The Impact of Devolution on Local Health Systems: Evidence From Greater Manchester, England

BRITTEON P., FATIMAH A., GILLIBRAND S., *et al.*

2024

Social Science & Medicine 348: 116801.

https://doi.org/10.1016/j.socscimed.2024.116801

Devolution and decentralisation policies involving health and other government sectors have been promoted with a view to improve efficiency and equity in local service provision. Evaluations of these reforms have focused on specific health or care measures, but little is known about their full impact on local health systems. We evaluated the impact of devolution in Greater Manchester (England) on multiple outcomes using a whole system approach. We estimated the impact of devolution until February 2020 on 98 measures of health system performance, using the generalised synthetic control method and adjusting for multiple hypothesis testing. We selected measures from existing monitoring frameworks to populate the WHO Health System Performance Assessment framework. The included measures captured information on health system functions, intermediatory objectives, final goals, and social determinants of health. We identified which indicators were targeted in response to devolution from an analysis of 170 health policy intervention documents. Life expectancy (0.233 years, S.E. 0.012) and healthy life expectancy (0.603 years, S.E. 0.391) increased more in GM than in the estimated synthetic control group following devolution. These increases were driven by improvements in public health, primary care, hospital, and adult social care services as well as factors associated with social determinants of health, including a reduction in alcohol-related admissions (−110.1 admission per 100,000, S.E. 9.07). In contrast, the impact on outpatient, mental health, maternity, and dental services was mixed. Devolution was associated with improved population health, driven by improvements in health services and wider social determinants of health. These changes occurred despite limited devolved powers over health service resources suggesting that other mechanisms played an important role, including the allocation of transformation funding and the alignment of decision-making across health, social care, and wider public services in the region.

Building the Infrastructure to Integrate Social Care in a Safety Net Health System

CALLAHAN C. M., CARTER A., CARTY H. S., *et al.*

American Journal of Public Health 0(0): e1-e7.

https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2024.307602

A recent National Academies report recommended that health systems invest in new infrastructure to integrate social and medical care. Although many health systems routinely screen patients for social concerns, few health systems achieve the recommended model of integration. In this critical case study in an urban safety net health system, we describe the human capital, operational redesign, and financial investment needed to implement the National Academy recommendations. Using data from this case study, we estimate that other health systems seeking to build and maintain this infrastructure would need to invest $1 million to $3 million per year. While health systems with robust existing resources may be able to bootstrap short-term funding to initiate this work, we conclude that long-term investments by insurers and other payers will be necessary for most health systems to achieve the recommended integration of medical and social care. Researchers seeking to test whether integrating social and medical care leads to better patient and population outcomes require access to health systems and communities who have already invested in this model infrastructure. (Am J Public Health. Published online ahead of print April 4, 2024:e1–e7. https://doi.org/10.2105/AJPH.2024.307602).

Travail et santé

Occupational Health

The Effects of Prostate and Testicular Cancers on Individual Labour Market Outcomes: An Evaluation From an Administrative Panel in France

BARNAY T., DUGUET E., LANFRANCHI J., *et al.*

2023

Journal de gestion et d'économie de la santé 4(4): 233-252.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2023-4-page-233.htm

Parmi les pays de l'OCDE, la France se situe au dix-huitième rang en termes de mortalité par cancer, avec un taux standardisé par âge pour 100 000 habitants de 210 en 2023. Nous estimons, pour la première fois en France, l'effet des cancers de la prostate et du testicule sur la participation au marché du travail (emploi, chômage et congés maladie) dans la population masculine jusqu'à cinq ans après l'apparition du cancer. À partir d'une base de données médicale administrative française, nous effectuons une analyse de différences en différences combinée à une méthode d'appariement exact pour contrôler l'effet de sélection (variables décalées) et l'hétérogénéité individuelle fixe non observable. Nous avons révélé des différences importantes dans l'effet négatif à long terme des deux cancers sur l'emploi : l'effet augmente significativement avec le temps pour atteindre 11 points de pourcentage pour les cancers de la prostate, mais seulement 3 points de pourcentage pour les cancers du testicule. L'année qui suit le diagnostic est caractérisée par une augmentation très importante des congés de maladie (de 22 à 28 pp) en raison de la nécessité de soins intensifs. Le cancer de la prostate entraîne une sortie permanente et croissante du marché du travail, atteignant un plafond quatre ans après le diagnostic (-11,5 points de pourcentage pour l'emploi) en faveur des situations de non-emploi. Ces résultats montrent qu'il est possible d'améliorer les politiques publiques françaises mises en place pour soutenir le retour au travail et le maintien dans l'emploi des survivants du cancer, en particulier au-delà d'un an, la période habituelle de traitement initial.

Évolution des inégalités de sinistralité au travail en France : les enseignements de l'enquête Sumer 2010-2017

HAVET N. ET PENOT A.

2023

Revue française d'économie XXXVIII(3): 61-105.

https://www.cairn.info/revue-francaise-d-economie-2023-3-page-61.htm

Cet article étudie l'évolution des inégalités de sinistralité en France afin de permettre le repérage des leviers d'action disponibles et l'amélioration de la prévention vers certains publics prioritaires. À partir de modélisations économétriques (logit, hurdle model) sur les éditions 2010 et 2017 de l'enquête Sumer, nous examinons notamment si les interdépendances entre expositions aux risques professionnels (contraintes physiques et psychosociales) et les accidents du travail se sont modifiées, tout en contrôlant les changements de structure des emplois. Nous trouvons qu'elles sont restées fortes et stables. La tendance à la hausse des expositions aux risques psychosociaux est donc inquiétante en soi et pour la lutte contre les accidents du travail.

Are Women Breaking the Glass Ceiling? A Gendered Analysis of the Duration of Sick Leave in Spain

MARTÍN-ROMÁN Á. L., MORAL A. ET PINILLOS-FRANCO S.

2024

International Journal of Health Economics and Management 24(1): 107-134.

https://doi.org/10.1007/s10754-023-09351-2

We study the gender gap in the duration of sick leave in Spain by splitting this duration into two types of days – those which are related to biological characteristics and those derived from behavioral reasons. Using the Statistics of Accidents at Work for 2011–2019, we found that women presented longer standard durations (i.e., purely attached to physiological reasons) compared to men. However, when estimating individuals' efficiency as the ratio between actual and standard durations, we found that women were more inefficient at lower levels of income, whereas in case of men, this occurred at higher levels of income. These results were reinforced when considering that men and women do not recover from the same injury at the same rate. Women were more efficient than men across all the compensation distribution, especially at higher income levels.

▶ The Impact of Health on Labour Market Outcomes: A Rapid Systematic Review

PINTOR M. P., FUMAGALLI E. ET SUHRCKE M.

2024

Health Policy 143: 105057.

https://doi.org/10.1016/j.healthpol.2024.105057

The relationship between an individual's health and their labour market outcomes has long been a subject of health economics research. This review aims to provide an up-to-date, global review of the substantive findings in the existing literature. We pay particular attention to causal effects, acknowledging the methodological complexities that have long challenged the research and emphasizing the importance of overcoming them to present robust, policy-relevant evidence. The recent literature shows a notable advancement in addressing these methodological issues compared to previous work.The evidence reviewed suggests that individuals with better health overwhelmingly exhibit higher earnings and often enhanced labour supply. These findings extend beyond geographical boundaries, as evidence from diverse regions underscores the global significance of this association. The review covers evidence from a wide range of health indicators and conditions – including e.g. self-reported health, chronic diseases, disability, nutritional health, infections, mental health, addictions and others. Within and across the different health domains, the health-related factors exert varying degrees of influence on labour market outcomes, highlighting the multifaceted nature of the health-labour relationship and its potentially profound implications for individuals, communities, and economies.

▶ Des « battantes » et des « faibles » ? Tenir au travail avec une endométriose

ROMERIO A.

2023

Sciences sociales et santé 41(4): 79-105.

https://www.cairn.info/revue-sciences-sociales-et-sante-2023-4-page-79.htm

L'article porte sur les conséquences de l'endométriose sur la vie professionnelle et s'appuie sur deux enquêtes, quantitative et qualitative. L'endométriose est une maladie chronique inflammatoire qui touche au minimum une femme sur dix en France. L'article montre qu'en rendant plus pénibles les activités de travail, l'endométriose constitue un enjeu de santé au travail. Loin de naturaliser une moindre capacité ou une vulnérabilité des femmes au travail, une approche attentive aux conditions d'emploi et de travail des femmes permet de rendre compte dans quelle mesure l'organisation du travail n'est pas favorable à la santé des femmes au travail, ce qui vient renforcer les inégalités de genre au travail. Le manque de reconnaissance de l'endométriose comme enjeu de santé au travail a des conséquences sur la manière dont cette maladie est appréhendée par les acteurs de la santé au travail et par l'entourage professionnel des femmes atteintes d'endométriose. Elles peinent à trouver des aménagements qui leur permettent de se maintenir en emploi et réalisent un important « travail en plus » pour tenir au travail et se maintenir en emploi.

▶ The Impact of Maternal Occupation on Children's Health: A Mediation Analysis Using the Parametric G-Formula

XU L. ET XU J.

2024

Social Science & Medicine 343: 116602.

https://doi.org/10.1016/j.socscimed.2024.116602

Background Previous studies have found that maternal occupational choice can directly impact fetal health and mothers' energy and time available for childcare. Moreover, reduced caregiving time is associated with poorer child health. However, how maternal occupational factors (work nature/income/stress) affect child health has not been fully explored. Methods Data were extracted from China Family Panel Studies (CFPS) from 2014 to 2020. A parametric G-formula Model was constructed to simulate the direct impact of maternal occupational factors (work nature, income, and stress) on child health. Furthermore, we explored their indirect effects mediated by maternal physical health, mental health, or occupational factors for the overall sample and by different age groups of the children. Results Maternal work nature and income had positive direct impacts on child health, especially for children whose mothers were employers of budgeted positions. Maternal work stress had a negative direct impact on children's health. Maternal work stress mediated the positive impact of maternal work income (9%). Maternal work stress affected children's health directly for children aged under 6, while for children aged 7–15, it had an indirect impact mediated by maternal physical health (43%), mental health (44%), and income (47%). Conclusion Attention should be paid to maternal occupational factors (especially to work stress) and to the varying care needs of children from their mothers at different ages to improve children's health and prevent the transmission of maternal occupation to children's health.

Vieillissement

Aging

Musculoskeletal Health and Life-Space Mobility in Older Adults: Findings From the Hertfordshire Cohort Study

BEVILACQUA G., D'ANGELO S., WESTBURY L. D., *et al.*

2024

Health & Place 86: 103184.

https://doi.org/10.1016/j.healthplace.2024.103184

This study explores the relationship between musculoskeletal conditions of ageing and life-space mobility (LSM) in 1110 community-dwelling older adults from the Hertfordshire Cohort Study. LSM is a novel measure which captures ability to mobilise within the home, locally and more widely. Among men, older age, care receipt, not driving a car, lower wellbeing, and reduced physical function were associated with lower LSM, while in women only driving status and physical function were associated with LSM. Osteoporosis, arthritis, and fractures had no significant associations with LSM in either gender. These findings provide support for sex-specificity in the determinants of LSM and inform novel approaches to improving mobility and health in older age.

Caring For Older Parents in Norway – How Does It Affect Labor Market Participation and Absence From Work?

GAUTUN H. ET BRATT C.

2024

Social Science & Medicine 346: 116722.

https://doi.org/10.1016/j.socscimed.2024.116722

As the population ages, younger generations will increasingly be called upon to provide informal care to their aging parents. To prepare for this development, it is essential to understand how employees combine the dual responsibilities of work and caring for aging parents. By analyzing data collected in Norway in 2022 from a nationally representative sample of 6049 respondents, aged 35 to 67, we investigated how caring for older parents affects labor market participation and work absence. We provide descriptive statistics and conduct analyses with structural equation modeling. These analyses indicated that caregiving had no substantial impact on overall participation in the workforce. However, employees did use work absences to assist their parents. We differentiate between using holidays, compensatory time, and three types of formal leave: paid, unpaid, and sick leave. More than a third of the formal leave was taken as sick leave. Women were moderately more likely to use work absence to care for their parents. We conclude that caregiving for older parents currently has little effect on work participation in Norway and attribute the favorable situation in Norway to its comprehensive public elderly care system. However, a contributing factor is Norway's generous sick leave policy. Although intended for use when employees are sick themselves, sick leave is used by employees to provide care to aging parents. Sick leave seems to act as a safety valve. To mitigate the effects of informal care on work participation, welfare states may create conditions that allow employees to combine work and informal care without resorting to unauthorized sick leave. A solution could be to extend the existing support scheme for employees with young children to those providing care for their aging parents.

Models For Delivery and Co-Ordination of Primary or Secondary Health Care (Or Both) to Older Adults Living in Aged Care Facilities

PUTRIK P., GROBLER L., LALOR A., *et al.*

2024

Cochrane Database of Systematic Reviews(3).

https://doi.org//10.1002/14651858.CD013880.pub2a

- Background The number of older people is increasing worldwide and public expenditure on residential aged care facilities (ACFs) is expected to at least double, and possibly triple, by 2050. Co-ordinated and timely care in residential ACFs that reduces unnecessary hospital transfers may improve residents' health outcomes and increase satisfaction with care among ACF residents, their families and staff. These benefits may outweigh the resources needed to sustain the changes in care delivery and potentially lead to cost savings. Our systematic review comprehensively and systematically presents the available evidence of the effectiveness, safety and cost-effectiveness of alternative models of providing health care to ACF residents. Objectives Main objective To assess the effectiveness and safety of alternative models of delivering primary or secondary health care (or both) to older adults living in ACFs. Secondary objective To assess the cost-effectiveness of the alternative models.

Index des auteurs
Author index