

Veille scientifique en économie de la santé

Watch on Health Economics Literature

Février 2021 / February 2021

Assurance maladie	<i>Health Insurance</i>
E-santé – Technologies médicales	<i>E-health – Medical technologies</i>
Économie de la santé	<i>Health Economics</i>
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Health Insurance**► Health Insurance As A State Institution:
The Effect Of Single-Payer Insurance
On Expenditures In OECD Countries**BICHAY N.
2020**Social Science & Medicine 265: 113454.**
<https://doi.org/10.1016/j.socscimed.2020.113454>

A growing literature in comparative political economy and health economics has argued several cost-saving effects of a single-payer healthcare system. Despite this growing evidence, there has been no large-scale empirical examination of whether such an effect exists cross-nationally over time. This paper serves as the first attempt to find and calculate the extent to which healthcare spending is affected by the utilization of a single-payer scheme. I introduce an original dataset for OECD countries that measures when and where systems that qualify as single-payer exist, and employ it to test whether significant differences exist in health expenditures. Results demonstrate a significant difference between single- and multi-payer system expenditures. I estimate the utilization of a single-payer system is associated with decreased expenditure equal to 0.750 percentage-points of a nation's GDP. This would equate to the United States saving well over \$1.5 trillion over ten years.

**► The Social, Political, And Economic Effects
Of The Affordable Care Act: Introduction
To The Issue**CAMPBELL A. L. ET SHORE-SHEPPARD L.
2020**RSF: The Russell Sage Foundation Journal of the
Social Sciences 6(2): 1-40.**
<https://www.jstor.org/stable/10.7758/rsf.2020.6.2.01>

The Patient Protection and Affordable Care Act, commonly referred to as the ACA and signed into law on March 23, 2010, was the most significant reform of the American health-care system since the passage of Medicare and Medicaid a half century earlier. As former President Barack Obama noted in his personal assessment, the law was intended to “improve the accessibility, affordability, and quality of health care” (Obama 2016). In service of these goals, the “afford-

able care” portion of the measure sought to expand coverage to the uninsured through Medicaid expansion and the creation of insurance marketplaces with sliding-scale premium subsidies, cost-sharing subsidies, and rate restrictions, as well as the requirement that dependents be permitted to remain on parental insurance plans up to age twenty-six. The “patient protection” portion included new regulations aimed at increasing access and improving insurance coverage, such as guaranteed issue, a prohibition on pre-existing condition exclusions, no annual or lifetime caps on expenditures for covered services, coverage of essential health benefits, and free preventive care, among others. This portion also included provisions implementing pilot and demonstration projects aimed at exploring new payment and care models such as accountable care organizations or bundled payments, and new care coordination models for dual Medicare-Medicaid eligibles and other populations. Last were a number of additional provisions—such as increased funding for community health centers and incentives for states to continue rebalancing their Medicaid long-term care spending toward home- and community-based services—also intended to improve the availability of health care and its alignment with need.

**► The Impact Of Insurance Expansions
On The Already Insured: The Affordable
Care Act And Medicare**CAREY C. M., MILLER S. ET WHERRY L. R.
2020**American Economic Journal: Applied Economics
12(4): 288-318.**
<https://doi.org/10.1257/app.20190176>

Some states have not adopted the Affordable Care Act (ACA) Medicaid expansions due to concerns that the expansions may impair access to care and utilization for those who are already insured. We investigate such negative spillovers using a large panel of Medicare beneficiaries. Across many subgroups and outcomes, we find no evidence that the expansions reduced utilization among Medicare beneficiaries and can rule out all but very small changes in utilization or spending. These results indicate that the expansions in Medicaid did not impair access to care or utilization for the

Medicare population.

► **The Impact Of The Affordable Care Act On Health Care Access And Self-Assessed Health In The Trump Era (2017-2018)**

COURTEMANCHE C., MARTON J., UKERT B., *et al.*

2020

Health Services Research 55(S2): 841-850.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13549>

This aim of this study is to estimate the impact of the major components of the ACA (Medicaid expansion, subsidized Marketplace plans, and insurance market reforms) on health care access and self-assessed health during the first 2 years of the Trump administration (2017 and 2018). Data Source The 2011-2018 waves of the Behavioral Risk Factor Surveillance System (BRFSS), with the sample restricted to nonelderly adults. The BRFSS is a commonly used data source in the ACA literature due to its large number of questions related to access and self-assessed health. In addition, it is large enough to precisely estimate the effects of state policy interventions, with over 300 000 observations per year. Design We estimate difference-in-difference-in-differences (DDD) models to separately identify the effects of the private and Medicaid expansion portions of the ACA using an identification strategy initially developed in Courtemanche *et al.* (2017). The differences come from: (a) time, (b) state Medicaid expansion status, and (c) local area pre-2014 uninsured rates. We examine ten outcome variables, including four measures of access and six measures of self-assessed health. We also examine differences by income and race/ethnicity. Principal Findings Despite changes in ACA administration and the political debate surrounding the ACA during 2017 and 2018, including these fourth and fifth years of postreform data suggests continued gains in coverage. In addition, the improvements in reported excellent health that emerged with a lag after ACA implementation continued during 2017 and 2018. Conclusions While gains in access and self-assessed health continued in the first 2 years of the Trump administration, the ongoing debate at both the federal and state level surrounding the future of the ACA suggests the need to continue monitoring how the law impacts these and many other important outcomes over time.

► **Measuring Universal Health Coverage Based On An Index Of Effective Coverage Of Health Services In 204 Countries And Territories, 1990-2019: A Systematic Analysis For The Global Burden Of Disease Study 2019**

LOZANO R., FULLMAN N., MUMFORD J. E., *et al.*

2020

The Lancet 396(10258): 1250-1284.

[https://doi.org/10.1016/S0140-6736\(20\)30750-9](https://doi.org/10.1016/S0140-6736(20)30750-9)

Achieving universal health coverage (UHC) involves all people receiving the health services they need, of high quality, without experiencing financial hardship. Making progress towards UHC is a policy priority for both countries and global institutions, as highlighted by the agenda of the UN Sustainable Development Goals (SDGs) and WHO's Thirteenth General Programme of Work (GPW13). Measuring effective coverage at the health-system level is important for understanding whether health services are aligned with countries' health profiles and are of sufficient quality to produce health gains for populations of all ages.

► **Universal Health Coverage: Are Older Adults Being Left Behind? Evidence From Aging Cohorts In Twenty-Three Countries**

MACINKO J., CRISTINA DRUMOND ANDRADE F., BOF DE ANDRADE F., *et al.*

2020

Health Affairs 39(11): 1951-1960.

<https://doi.org/10.1377/hlthaff.2019.01570>

Countries around the world have committed to achieving universal health coverage as part of the Sustainable Development Goals agreed upon by all United Nations members, intended to be achieved by 2030. But important population groups such as older adults are rarely examined as part of Sustainable Development Goals monitoring and evaluation efforts. This study uses recent (2014-16) high-quality, individual-level data from several aging cohorts representing more than 100,000 adults ages fifty and older in twenty-three high- and middle-income countries. After individual characteristics and health needs were controlled for, national rates varied up to tenfold for poor access (no doctor visit) and threefold for potential overutilization (fifteen or more doctor visits and multiple hospitalizations) in the past year. Catastrophic expenditures (25 percent or more of household income spent out of pocket on health care) averaged 9 percent, with

the highest rates observed in middle-income countries and among sicker populations in some high-income countries. Strengthening universal health coverage for older adults will require greater tailoring and targeting of benefits to meet this population's health needs while protecting them from catastrophic health expenditures.

► **Le programme de retour à domicile (Prado) de l'Assurance maladie : faciliter les parcours de soins**

MINONZIO J.

2020

Informations sociales 201(1): 66

<https://www.cairn.info/revue-informations-sociales-2020-1-page-66.htm>

Le système de protection sociale français est composé de différents dispositifs qui, dans leur diversité, poursuivent un objectif commun : protéger les individus face aux aléas qui peuvent réduire leur autonomie (handicap, vieillissement...), leurs ressources financières (chômage, séparation d'un conjoint...) ou générer des dépenses supplémentaires (maladie, naissance d'un enfant...). La protection sociale des Trente Glorieuses a privilégié une prise en charge collective des risques sociaux dans un contexte de stabilité relative des carrières et des familles. Mais depuis trois décennies, les discontinuités et ruptures professionnelles ou conjugales interrogent la pertinence et l'efficacité du droit social. Et pour faire face à la complexité croissante des trajectoires individuelles, la notion de parcours de vie a irrigué progressivement les sciences sociales (récits de vie, enquêtes sur longues périodes, panels...) et les politiques publiques (portabilité des droits sociaux, compte pénibilité...). Reflétant l'intérêt croissant pour la perspective longitudinale, ce numéro d'Informations sociales en présente les principaux débats et enjeux selon trois dimensions. Les outils théoriques et méthodologiques développés depuis deux décennies permettent d'analyser la dynamique des trajectoires et des inégalités sur le long terme (première partie). Des réformes récentes ont visé une meilleure prise en compte de la complexité des parcours individuels et la mise en place d'une nouvelle génération de droits sociaux (deuxième partie). Au total, il est recherché une meilleure prise en compte des itinéraires individuels par les politiques d'accompagnement social et les organisations qui les mettent en œuvre (troisième partie).

► **The Effects Of Public Health Insurance On Health Behaviors: Evidence From The Fifth Year Of Medicaid Expansion**

SONI A.

2020

Health Economics 29(12): 1586-1605.

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4155>

This study examines the longer term relationship between public health insurance expansions and health behaviors. I leverage geographic and temporal variation in the implementation of the Affordable Care Act-facilitated Medicaid expansions and provide the first estimates of the expansions' behavioral impacts during their first 5 years. Using national survey data from the 2010 to 2018 Behavioral Risk Factors Surveillance System and a difference-in-differences regression design, I show that the Medicaid expansions increase utilization of certain forms of preventive care, while reducing heavy drinking. I also find suggestive evidence that the expansions reduce smoking and increase the probability of exercise. These results stand in contrast with earlier studies that used only 2 or 3 years of postexpansion data and found no detectable effect of the Medicaid expansions on health behaviors in the short run. My results, combined with evidence from previous studies, suggest that public insurance expansions may not prompt an immediate change in health behaviors, but newly eligible populations do increase investments in healthy behaviors over time. In the long run, Medicaid expansions may help reduce engagement in risky behaviors like drinking and smoking among low-income people.

E-santé – Technologies médicales

E-health – Medical technologies

► Télémédecine : des limites persistantes

DELMAS V.

2020

Gestions Hospitalières(598): 458-460.

La télémédecine est passée de technique future à pratique actuelle; pourtant l'essentiel reste en devenir. En libérant - temporairement - le cadre réglementaire et les possibilités de financement pour éviter les consultations physiques dans la lutte contre la covid-19, le volume de recours à la télémédecine a explosé mais la plupart des dispositifs s'inscrivent encore dans une phase expérimentale.

► L'IA en santé : des mythes aux réalités

LUCAS J., PARMENTIER F., JAAFAR D., *et al.*

2020

Gestions Hospitalières(598): 400-445.

Ce dossier sur l'intelligence artificielle aborde ses différentes applications dans le domaine de la santé ainsi que les aspects éthiques et réglementaires.

Économie de la santé

Health Economics

► High Rates Of Partial Participation In The First Year Of The Merit-Based Incentive Payment System

APATHY N. C. ET EVERSON J.

2020

Health Affairs 39(9): 1513-1521.

<https://doi.org/10.1377/hlthaff.2019.01648>

There has been widespread concern over the design of the Merit-based Incentive Payment System (MIPS) since its authorization with the Medicare Access and CHIP Reauthorization Act of 2015. Using detailed performance data from 2017, the first implementation year of MIPS, we found that although 90 percent of participating clinicians reported performance equal to or better than the low performance threshold of 3 out of 100 (a calculated composite score), almost half of clinicians did not participate in at least one of the three program categories (quality, advancing care information, and improvement activities). The decision to participate in each category explained 86 percent of the total variance in clinicians' overall score, whereas actual performance explained just 14 percent, as a result of the ease of achieving high scores within each category. Still, 74 percent of clinicians who only

partially participated in the program received positive payment adjustments. These findings underline concerns that MIPS's design may have been too flexible to effectively incentivize clinicians to make incremental progress across all targeted aspects of the program. In turn, this is likely to lead to resistance when payment penalties become more severe in 2022, as required by the MIPS authorizing legislation.

► Are Changes In Medical Group Practice Characteristics Over Time Associated With Medicare Spending And Quality Of Care?

BAKER L. C., PESKO M., RAMSAY P., *et al.*

2020

Medical Care Research and Review 77(5): 402-415.

<https://www.doi.org/10.1177/1077558718812939>

Physician practices have been growing in size, and becoming more commonly owned by hospitals, over time. We use survey data on physician practices surveyed at two points in time, linked to Medicare claims data, to investigate whether changes in practice size or ownership are associated with changes in the use of care management, health information technology

(HIT), or quality improvement processes. We find that practice growth and becoming hospital-owned are associated with adoption of more quality improvement processes, but not with care management or HIT. We then investigate whether growth or becoming hospital-owned are associated with changes in Medicare spending, 30-day readmission rates, or ambulatory care sensitive admission rates. We find little evidence for associations with practice size and ownership, but the use of care management practices is associated with lower rates of ambulatory care sensitive admissions.

► **Does Independent Needs Assessment Limit Use Of Publicly Financed Long-Term Care?**

BAKX P., DOUVEN R. ET SCHUT F. T.

2021

Health Policy 125(1) :41-46

<https://doi.org/10.1016/j.healthpol.2020.09.003>

In health care the assessment of patients' needs is typically entrusted to health care providers. By contrast, in publicly financed long-term care (LTC) needs assessment is often delegated to an independent assessor. One rationale offered for independent needs assessment in LTC is to limit the scope for moral hazard and supplier-induced demand, which may be particularly strong in case of public LTC insurance. We study whether independent needs assessment restricts use of publicly financed LTC at the intensive margin (i.e. after people are being assessed to be eligible for receiving care). Therefore, we link nationwide Dutch administrative datasets about individual LTC use and eligibility decisions by the independent assessment agency in 2012. We find for virtually all types of care, all population subgroups, and all regions that LTC use by patients was substantially less than the maximum amount of care allowed by the independent assessor. This suggests that in the Netherlands independent needs assessment in LTC does not impose a binding constraint on use once a person is considered eligible for care. Still, independent needs assessment may have reduced LTC use at the extensive margin. A significant proportion of the applications for care (16%) was rejected. In addition, the independent assessment may deter some people from applying.

► **La recherche d'un mode de financement unique des établissements de soins : le mythe de la convergence tarifaire**

DOMIN J.-P.

2020

Revue française d'administration publique 174(2): 475-486.

<https://www.cairn.info/revue-francaise-d-administration-publique-2020-2-page-475.htm>

Ce travail s'intéresse à la mise en œuvre, depuis le début des années 2000, d'un nouveau mode de financement dans les établissements hospitaliers : la tarification à l'activité. Si la convergence tarifaire entre les secteurs publics et privés constitue le mot d'ordre et la cible prioritaire des politiques depuis 2004, il n'en reste pas moins que sa mise en œuvre, d'une part, est assez complexe et, d'autre part, ne tient pas compte des spécificités de chacun des deux secteurs. La mise en œuvre de la convergence tarifaire est d'autant plus délicate que la différence de coûts entre les deux secteurs est aujourd'hui assez bien documentée (effets de taille et de gamme d'activités, caractéristiques des patients, prise en charge des pathologies lourdes...).

► **On Measuring The Inequity Of Financing Health Care In The United States And The Redistribution Of Income Through Health Care Financing In Canada**

GRIGNON M. L., ALLIN S., CORSCADDEN L., *et al.*

2020

American Journal of Public Health 110(11): 1603-1604.

<https://doi.org/10.2105/AJPH.2020.305891>

As a society, we must care about not only how efficiently health care services are provided but also how equitably they are distributed. First, we want to know if health care services are consumed according to need or ability to pay. Different measures of equity in health care utilization exist depending on whether one considers specific services to be needs or wants. If the former, we want to see utilization independent of income; if the latter, we accept that high-income individuals utilize more than low-income individuals for the same level of need. However, even with that definition, we do not want utilization of the lowest-income individuals to fall below a certain threshold. Second, we want to know if the burden of paying for these health care services is equitably distributed. A system in which low-income individuals use as much

health care as those with high incomes but must sacrifice a larger fraction of their budget to do so could be considered inequitable.

► **Getting The Price Right: How Some Countries Control Spending In A Fee-For-Service System**

GUSMANO M. K., LAUGESSEN M., RODWIN V. G., *et al.*
2020

Health Affairs 39(11): 1867-1874.

<https://doi.org/10.1377/hlthaff.2019.01804>

Although the US has the highest health care prices in the world, the specific mechanisms commonly used by other countries to set and update prices are often overlooked, with a tendency to favor strategies such as reducing the use of fee-for-service reimbursement. Comparing policies in three high-income countries (France, Germany, and Japan), we describe how payers and physicians engage in structured fee negotiations and standardize prices in systems where fee-for-service is the main model of outpatient physician reimbursement. The parties involved, the frequency of fee schedule updates, and the scope of the negotiations vary, but all three countries attempt to balance the interests of payers with those of physician associations. Instead of looking for policy importation, this analysis demonstrates the benefits of structuring negotiations and standardizing fee-for-service payments independent of any specific reform proposal, such as single-payer reform and public insurance buy-ins.

► **Health Care, Overconsumption And Uneconomic Growth: A Conceptual Framework**

HENSHER M., CANNY B., ZIMITAT C., *et al.*
2020

Social Science & Medicine 266: 113420.

<https://doi.org/10.1016/j.socscimed.2020.113420>

Concerns have grown in recent decades that economic growth in many rich countries may, in fact, be uneconomic. Uneconomic growth occurs when expansion in economic activity causes environmental and social costs that are greater than the benefits of that additional activity. Health care has enjoyed a close historical relationship with economic growth, with health care spending consistently growing faster than GDP over the long term. This paper explores the possible relationship between health care and uneconomic

growth. It summarises the rapidly growing evidence on the harms caused by poor quality health care and by the overuse of health care, and on the environmental harms caused by health care systems. Further, it develops a conceptual framework for considering the overconsumption of health care and the joint harms to human health and the natural environment that ensue. This framework illustrates how health-damaging overconsumption in the wider economy combines with unnecessary or low-quality health care to create a cycle of “failure demand” and defensive expenditure on health care services. Health care therefore provides important sectoral insights on the phenomenon of uneconomic growth. There are rich opportunities for interdisciplinary research to quantify the joint harms of overconsumption in health and health care, and to estimate the optimal scale of the health sector from novel perspectives that prioritise human and planetary health and well-being over GDP and profit.

► **Reducing Medical Waste To Improve Equity In Care**

HUGHES D. L. ET MEADOWS P. D.

2020

American Journal of Public Health 110(12): 1749-1750.

<https://doi.org/10.2105/AJPH.2020.305962>

The longstanding problem of medical waste continues to bedevil our nation’s health care system. Although defined narrowly as “inefficient and wasteful spending,” medical waste encompasses a wide range of complex and interrelated issues: clinical inefficiencies, missed prevention opportunities, overuse, administrative waste, excessive prices, and fraud and abuse. The economic costs associated with medical waste are staggering, ranging from \$760 billion to \$935 billion, which accounts for approximately 25% of total US health care spending.¹ Yet, the United States continues to rank last in life expectancy among high-income countries. Medical waste affects every American. It is a major driver of rising health care costs, which, at an individual level, translates to increased premium contributions and out-of-pocket medical expenses. At a population level, medical waste crowds out resources that could be repurposed to support other high-value priorities. One obvious example is public health, which continues to be grossly underfunded; public health expenditures are projected to fall from 3.0% of total health expenditures to 2.4% by 2023.

► **Is It Unfair For The Affluent To Be Able To Purchase “Better” Healthcare? Existential Standards And Institutional Norms In Healthcare Attitudes Across 28 Countries**

IMMERGUT E. M. ET SCHNEIDER S. M.
2020

Social Science & Medicine 267: 113146.
<https://doi.org/10.1016/j.socscimed.2020.113146>

Existing research has found that individuals often perceive healthcare inequalities as unfair; yet, there is high variation in unfairness perceptions between countries. This raises the question of whether the institutional context of the healthcare system is associated with what people perceive as unfair. Using data from the ISSP study and OECD health expenditure data from 2011/13, we explore whether individual attitudes about the unfairness of healthcare inequality – the ability to purchase “better” healthcare for the affluent – vary systematically with a country’s institutional environment: namely, with the prevalence of cost barriers to healthcare access, and with the degree and type of public healthcare financing. Three general findings emerge from the analysis: (1) Higher cost barriers correlate with lower levels of perceived unfairness in healthcare inequality, suggesting those exposed to greater levels of inequality tend to be more accepting of inequality. This finding is consistent with empirical justice theory and the expected relevance of an ‘existential’ standard of justice, stemming from individuals’ proclivities to accept the status quo as just. (2) Further, greater public financing of healthcare correlates with higher perceived unfairness. Drawing on neo-institutionalist theory, this may suggest that greater public financing enshrines access to healthcare as a universal right, and hence provides an ideational framing that delegitimizes unequal opportunities for purchasing better healthcare. (3) Further, higher unfairness perceptions of lower income and educational groups are more strongly associated with greater public financing than those of their respective comparison groups. This may indicate that the normative right to healthcare is of particular importance to the disadvantaged, which could potentially explain the political quiescence on healthcare of lower income and educated persons in societies that lack universal health systems. In sum, this study contributes to the larger debate on the interrelatedness of healthcare institutions and public opinion, and specifically on perceptions of unfairness.

► **The Impact Of The Health-Care Sector On National Economies In Selected European Countries**

JAGRIČ T., BROWN C., BOYCE T., *et al.*
2021

Health Policy 125(1) : 90-97
<https://doi.org/10.1016/j.healthpol.2020.10.009>

Policy-makers face pressures to improve lives and safeguard public finances sustainably. In this analysis, we estimate the economic importance of the health-care sector in 19 European national economies. We use input–output tables for the year 2010 and sectoral data to estimate a set of multipliers: simple, total, truncated, type I and type II multipliers for output, income, value-added, employment and import multiplier. The analysis reveals similarities in the economic importance of the health-care sector for the national economies of the observed countries. Results suggest prevailing positive effects on national economies (value-added, employment and household income) when spending on health-care sector products and services increases, especially in comparison to the effects of increases in spending in other sectors. The importance of the health-care sector is connected to countries’ levels of development; the benefits are especially promising in countries with lower levels of gross domestic product (GDP) per capita, where changes in the health-care sector have a larger impact on employment in the national economy than similar changes in more developed countries. The health-care sector therefore can play an important role as an instrument of economic policy.

► **Parental Beliefs And Willingness To Pay For Reduction In Their Child’s Asthma Symptoms: A Joint Estimation Approach**

MUSSIO I., BRANDT S. ET HANEMANN M.
2021

Health Economics 30(1): 129-143.
<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4181>

Many aspects of asthma—in particular the relationship between beliefs, averting behaviors, and symptoms—are not directly observable from market data. An approach that combines observable market data with nonmarket valuation to gather data on unobservable aspects of the illness can improve efforts to quantify the burden of asthma if it accounts for the endogeneity in the system. Such approaches are used

in the valuation of recreation but have not been widely used to value the burden of a chronic illness. We estimate parents' willingness to pay (WTP) to reduce their child's asthma symptoms using a three-equation model that combines revealed preference, contingent valuation, and burden of asthma, increasing the efficiency of estimation and correcting for endogeneity. WTP for a device that reduces a child's asthma symptoms by 50% is \$125/month (s.d. \$20). Parents' valuations are driven by beliefs about asthma and by their degree of worry about asthma between episodes. There is a non-linear relationship between the number of days with symptoms and WTP per symptom day. The experience of living with asthma affects families' responses to a contingent valuation scenario, because it influences willingness to spend money to manage the illness and their subjective perceptions and beliefs about the illness itself.

► **Biens méritoires et nudges dans le domaine de la santé publique**

OGUER F.
2020

Revue d'économie politique 130(5): 799-821.
<https://www.cairn.info/revue-d-economie-politique-2020-5-page-799.htm>

Cet article envisage les biens (dé)méritoires dans le domaine de la santé publique (vaccination, dépistage du cancer ou du cholestérol, tabac). Il adopte une approche de théorie des jeux et de design d'information fondée sur des nudges modélisés comme un degré d'interventionnisme intermédiaire entre un paternalisme faible et un paternalisme fort. Le jeu en information complète et le jeu de signal indiquent qu'un État suffisamment paternaliste a intérêt à avoir recours aux nudges pour déclencher un comportement vertueux chez l'individu, et à faire preuve d'autoritarisme dans le cas d'addiction ou d'externalités. Le niveau optimal de nudges à mettre en œuvre étant une information privée, l'État peut demander à un régulateur de le conseiller sur le degré d'interventionnisme qu'il doit mettre en place. Le jeu en termes de design d'information vérifie que l'influence du régulateur se réduit avec l'information supplémentaire que l'État peut acquérir sur le type de l'individu sélectionné.

► **Cost And Effects Of Integrated Care: A Systematic Literature Review And Meta-Analysis**

ROCK S., BERNTSON D., GIL-SALMERÓN A., *et al.*
2020

The European Journal of Health Economics 21(8): 1211-1221.

<https://doi.org/10.1007/s10198-020-01217-5>

Health and care services are becoming increasingly strained and healthcare authorities worldwide are investing in integrated care in the hope of delivering higher-quality services while containing costs. The cost-effectiveness of integrated care, however, remains unclear. This systematic review and meta-analysis aims to appraise current economic evaluations of integrated care and assesses the impact on outcomes and costs.

► **Excess Medical Care Spending: The Categories, Magnitude, And Opportunity Costs Of Wasteful Spending In The United States**

SPEER M., MCCULLOUGH J. M., FIELDING J. E., *et al.*
2020

American Journal of Public Health 110(12): 1743-1748.

<https://doi.org/10.2105/AJPH.2020.305865>

Landmark reports from reputable sources have concluded that the United States wastes hundreds of billions of dollars every year on medical care that does not improve health outcomes. While there is widespread agreement over how wasteful medical care spending is defined, there is no consensus on its magnitude or categories. A shared understanding of the magnitude and components of the issue may aid in systematically reducing wasteful spending and creating opportunities for these funds to improve public health. To this end, we performed a review and crosswalk analysis of the literature to retrieve comprehensive estimates of wasteful medical care spending. We abstracted each source's definitions, categories of waste, and associated dollar amounts. We synthesized and reclassified waste into 6 categories: clinical inefficiencies, missed prevention opportunities, overuse, administrative waste, excessive prices, and fraud and abuse. Aggregate estimates of waste varied from \$600 billion to more than \$1.9 trillion per year, or roughly \$1800 to \$5700 per person per year. Wider recognition by public health stakeholders of the human and economic costs of medical waste has the potential to catalyze health system transformation.

Health Status

► **Suicide des médecins et des professionnels de santé : Revue systématisée de la littérature et méta-analyse**

DUTHEIL F., AUBERT C., PEREIRA B., *et al.*
2020

Archives des Maladies Professionnelles et de l'Environnement 81(5): 478.

<https://doi.org/10.1016/j.admp.2020.03.157>

Nous avons cherché à réaliser une revue systématique de la littérature et une méta-analyse sur le risque de suicide chez les professionnels de santé. Méthode Les recherches ont été effectuées dans les bases de données PubMed, Cochrane Library, Science Direct et Embase jusqu'en avril 2019 avec les mots-clés suivants : suicide* AND (« health-care worker* » OR physician* OR nurse*). Quand il était possible, nous avons stratifié les résultats par sexe, zones géographiques, périodes et spécialités. Résultats Un total de 61 articles ont été inclus. Le SMR global des suicides était 1,44 (95CI 1,16, 1,72) avec une hétérogénéité importante ($I^2 = 94\%$, $p < 0,001$). Les femmes étaient à risque plus élevé (SMR = 1,90; 95CI 1,49, 2,58; ES = 0,67; 95CI 0,19, 1,14; $p < 0,001$ comparé aux hommes). Les médecins des USA étaient à plus haut risque (ES = 1,34; 95CI 1,28, 1,55; $p < 0,001$ vs reste du monde). Le taux de suicide a diminué avec le temps, spécifiquement en Europe (ES = 0,18; 95CI 0,00, 0,37; $p = 0,044$). Certaines spécialités sembleraient plus à risque telles que les anesthésistes, les psychiatres et les médecins généralistes. Il y a 1 % (95CI 1,0, 2,0; $p < 0,001$) de tentatives de suicide et 17 % (95CI 12, 21; $p < 0,001$) d'idées suicidaires chez les médecins. Il n'y a pas assez de données sur les autres professionnels pour réaliser des méta-analyses. Conclusion Les médecins sont à risque de suicide, spécialement les femmes. Le taux de suicide diminue avec le temps, spécifiquement en Europe. La prévalence élevée des médecins ayant fait une tentative de suicide ou de ceux ayant eu des idées suicidaires devraient servir à mettre en place des stratégies préventives. Enfin l'absence de donnée sur les autres professionnels de santé, suggère un besoin d'investigations.

► **Mortality Convergence In The Enlarged European Union: A Systematic Literature Review**

HRZIC R., VOGT T., JANSSEN F., *et al.*
2020

European Journal of Public Health 30(6): 1108-1115.

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

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

► **Global Burden Of 87 Risk Factors In 204 Countries And Territories, 1990-2019: A Systematic Analysis For The Global Burden Of Disease Study 2019**

MURRAY C. J. L., ARAVKIN A. Y., ZHENG P., *et al.*
2020

The Lancet 396(10258): 1223-1249.

[https://doi.org/10.1016/S0140-6736\(20\)30752-2](https://doi.org/10.1016/S0140-6736(20)30752-2)

Rigorous analysis of levels and trends in exposure to leading risk factors and quantification of their effect on human health are important to identify where public health is making progress and in which cases current efforts are inadequate. The Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) 2019 provides a standardised and comprehensive assessment of the magnitude of risk factor exposure, relative risk, and attributable burden of disease.

► **Trends In Adolescent Drinking Across 39 High-Income Countries: Exploring The Timing And Magnitude Of Decline**

VASHISHTHA R., PENNAY A., DIETZE P., *et al.*
2020

European Journal of Public Health(Ahead of pub).

<https://doi.org/10.1093/eurpub/ckaa193>

Evidence suggests adolescent alcohol consumption has declined since the turn of the millennium in almost all high-income countries. However, differences in the timing and magnitude of the decline have not been explored across countries. We examined trends in adolescent past month or monthly alcohol consumption prevalence from cross-national or national survey reports for 39 countries and four US territories. For each country, we calculated the magnitude of the decline in youth drinking as the relative change in prevalence from the peak year to the most recent year available. Heat maps were utilized to present the timing and magnitudes of these declines. The timing and extent of youth drinking declines have varied markedly across countries. The decline began in the USA before 1999, followed by Northern European countries in the early 2000s; Western Europe and Australasia in the mid-2000s. The steepest declines were found for Northern Europe and the UK, and the shallowest declines were observed in Eastern and Southern European countries. Previous analyses of the decline in adolescent drinking have emphasized the wide reach of the changes and their near-coincidence in time. Our analysis points to the other side of the picture that there were limits to

the wide reach, and that there was considerable variation in timing. These findings suggest that as well as broader explanations that stretch across countries, efforts to explain recent trends in adolescent drinking should also consider factors specific to countries and regions.

► **Global Burden Of 369 Diseases And Injuries In 204 Countries And Territories, 1990-2019: A Systematic Analysis For The Global Burden Of Disease Study 2019**

VOS T., LIM S. S., ABBAFATI C., *et al.*

2020

The Lancet 396(10258): 1204-1222.

[https://doi.org/10.1016/S0140-6736\(20\)30925-9](https://doi.org/10.1016/S0140-6736(20)30925-9)

In an era of shifting global agendas and expanded emphasis on non-communicable diseases and injuries along with communicable diseases, sound evidence on trends by cause at the national level is essential. The Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) provides a systematic scientific assessment of published, publicly available, and contributed data on incidence, prevalence, and mortality for a mutually exclusive and collectively exhaustive list of diseases and injuries.

Geography of Health

► **Training, Migration and Retention of Doctors : Is Ireland a Danaides' Jar? Comment on «Doctor Retention : A Cross-sectional Study of How Ireland Has Been Losing the Battle »**

CHEVILLARD G.
2020

Int J Health Policy Manag(Ahead of pub).
<https://www.doi.org/10.34172/ijhpm.2020.217>

In a context of global shortage of doctors, Ireland is in a paradoxical situation: the country trained a lot of medical students, native or foreign, but has difficulties to retain them. The paper of Brugha and his colleagues analyzes junior doctors' migration intentions, the reasons they leave, the likelihood of them returning and the characteristics of those who plan to emigrate. Results show determinants of junior doctor's emigration and may be useful to better calibrate the doctors' retention strategy of Ireland.

► **De la territorialisation des pratiques de santé aux communautés professionnelles territoriales de santé**

DE FONTGALLAND C. ET ROUZAUD-CORNABAS M.
2020

Santé Publique 32(2): 239-246.
<https://www.cairn.info/revue-sante-publique-2020-2-page-239.htm>

Les communautés professionnelles territoriales de santé ont notamment vocation à organiser la coordination des professionnels de santé du 1^{er} et 2^e recours pour mieux structurer les parcours de soins et améliorer le recours aux soins. Les flux de patients de 2nd recours libéral dessinent des territoires dont l'échelle et l'organisation peuvent servir de base au maillage de ces communautés. Méthode : L'analyse des flux de patientèle des médecins spécialistes libéraux en région Centre- Val de Loire, en 2015 (données du SNIIRAM), a permis de classer les spécialités médicales selon leur échelle d'attractivité (régionale, départementale, infra-départementale), puis de les fusionner pour identifier des pôles d'attraction communs. Ces pôles empiriques ont été soumis à l'appréciation des professionnels de santé du terrain pour affiner

le découpage du territoire. Les bassins de patientèle des Centres Hospitaliers (données du PMSI) ont également été comparés aux bassins de patientèle libéraux. Résultats : Une vingtaine de pôles d'attraction se distinguent sur six départements. Les communes ont été réparties en cinq classes, selon leur degré d'attraction à un pôle. L'ensemble du territoire a été intégré à un maillage en bassins de santé autour de pôles d'attractions, cohérents avec les habitudes de travail des professionnels de santé. La concordance avec les bassins de patientèle hospitaliers a renforcé la pertinence de ce découpage. Conclusion : Les flux de patients répondent à une réelle logique territoriale qui, confrontée aux pratiques des professionnels de santé, dessine des territoires pertinents pour une première approche des CPTS.

► **La grande mobilité géographique domicile-travail : l'inscription spatiale des inégalités entre travailleurs**

SIGAUD T.
2019

Travail et emploi 160(4): 75-102.
<https://www.cairn.info/revue-travail-et-emploi-2019-4-page-75.htm>

Alors que se multiplient les injonctions à la mobilité géographique des travailleurs, les grandes mobilités domicile-travail sont encore mal connues et souvent ramenées à un simple arbitrage professionnel. En exploitant le Recensement de la population 2015, l'article propose une définition de la grande mobilité domicile-travail qui permet d'identifier, décrire et localiser près de 500 000 grands mobiles en France métropolitaine. Loin d'être une ressource univoque qui serait au service des travailleurs, la grande mobilité reproduit les segmentations socioprofessionnelles et spatiales qui structurent les inégalités entre travailleurs et révèle le jeu notamment des inégalités de genre.

► **How To Address Medicines Shortages: Findings From A Cross-Sectional Study Of 24 Countries**

VOGLER S. ET FISCHER S.

2020

Health Policy 124 (12) : 1287-1292.

<https://doi.org/10.1016/j.healthpol.2020.09.001>

Shortages of medicines have become a major public health challenge. The aim of this study was to survey national measures to manage and combat these shortages. A questionnaire survey was conducted with public authorities involved in the Pharmaceutical Pricing and Reimbursement Information (PPRI) network. Responses relating to measures as of March / April 2020 were received from 24 countries (22 European countries, Canada and Israel). In 20 countries, manufacturers are requested to notify – usually on an oblig-

atory basis – upcoming and existing shortages, which are recorded in a register. Further measures include a regular dialogue with relevant stakeholders (18 countries), financial sanctions for manufacturers in cases of non-supply and/or non-compliance with reporting or stocking requirements (15 countries) and simplified regulatory procedures (20 countries). For defined medicines, supply reserves have been established (14 countries), and legal provisions allow the issuing of export bans (10 countries). Some measures have been introduced since the end of 2019 and countries are planning and discussing further action. While governments reacted by taking national measures, the COVID-19 crisis might serve as an opportunity to join forces in cross-country collaboration and develop joint (e.g. European) solutions to address the shortage issue in a sustainable manner. A practical first step could be to work on a harmonisation of the national registers.

Handicap

Disability

► **L'accueil en consultation de gynécologie des personnes en situation de handicap mental**

FREYENS A., DUPONT E., BOUTAULT-CARADEC D.,
et al.

2020

Médecine : De La Médecine Factuelle a Nos Pratiques 16(7): 301-304.

Les consultations gynécologiques des femmes en situation de handicap mental concernent plusieurs acteurs : le praticien, la patiente, et parfois la personne qui l'accompagne. Elles mettent en jeu le rapport au corps, au handicap, à l'intimité, parfois à la maternité ou à la maladie. Côté soignants, les jeunes médecins généralistes s'estiment insuffisamment formés aux questions du handicap tandis que, côté soignées, les femmes vivant avec un handicap mental se retrouvent souvent démunies lors de ces consultations. Cet article met en lumière les obstacles (pratiques, relationnels, communicationnels) au bon déroulement d'une consultation et propose des pistes d'amélioration.

► **Rapport Piveteau : des solutions contre les ruptures dans l'accompagnement du handicap**

GRELLEY P.

2020

Informations sociales 201(1): 103-103.

<https://www.cairn.info/revue-informations-sociales-2020-1-page-103.htm>

Le système de protection sociale français est composé de différents dispositifs qui, dans leur diversité, poursuivent un objectif commun : protéger les individus face aux aléas qui peuvent réduire leur autonomie (handicap, vieillissement...), leurs ressources financières (chômage, séparation d'un conjoint...) ou générer des dépenses supplémentaires (maladie, naissance d'un enfant...). La protection sociale des Trente Glorieuses a privilégié une prise en charge collective des risques sociaux dans un contexte de stabilité relative des carrières et des familles. Mais depuis trois décennies, les discontinuités et ruptures professionnelles ou conjugales interrogent la pertinence et l'efficacité du droit social. Et pour faire face à la complexité croissante des trajectoires individuelles, la notion de parcours de vie a irrigué progressivement les sciences sociales (récits

de vie, enquêtes sur longues périodes, panels...) et les politiques publiques (portabilité des droits sociaux, compte pénibilité...). Reflétant l'intérêt croissant pour la perspective longitudinale, ce numéro d'Informations sociales en présente les principaux débats et enjeux selon trois dimensions. Les outils théoriques et méthodologiques développés depuis deux décennies permettent d'analyser la dynamique des trajectoires et des inégalités sur le long terme (première partie). Des réformes récentes ont visé une meilleure prise en compte de la complexité des parcours individuels et la mise en place d'une nouvelle génération de droits sociaux (deuxième partie). Au total, il est recherché une meilleure prise en compte des itinéraires individuels par les politiques d'accompagnement social et les organisations qui les mettent en œuvre (troisième partie).

► **Socioeconomic Factors In Disability Retirement Due To Mental Disorders In Finland**

KAROLAAKSO T., AUTIO R., NÄPPILÄ T., *et al.*
2020

European Journal of Public Health 30(6) : 1218-1224
<https://doi.org/10.1093/eurpub/ckaa132>

Previous research has identified low socioeconomic status (SES) as an epidemiological risk factor for early retirement and disability pension (DP) due to mental disorders. This study aims to examine these associations in greater detail, with separate consideration of the risk factors for mood disorders (F30–39) and non-affective psychotic disorder (F20–29) DP. In this case-control setting the subjects (N = 36 879) were all those granted DP due to a mental disorder for the first time between 2010 and 2015 in Finland. All the subjects were matched with three controls for their gender, age and hospital district (N = 94 388). Three measures of dimensions of SES were used: education, income and occupational status, as well as family type as a control factor. Differences between DP recipients and controls, and between diagnostic groups, were studied using calculated characteristics and conditional logistic regression models. DP recipients often lived alone and had low educational and income levels. These characteristics were more prominent in non-affective psychotic disorder than in mood disorder DP. In white-collar occupational groups, the risk of DP was greater compared with blue-collar workers. Students were associated with the highest level of risk for all mental and mood disorder DPs. We found evidence of SES factors

associating with mental disorder-related severe loss of working and studying ability in a disorder-specific way. Notably, white-collar workers had an increased risk of mental disorder DP. This could be related to the psychosocially demanding contemporary working life in non-manual work.

► **Determinants Of Inequalities In Years With Disability: An International-Comparative Study**

NUSSELDER W. J., RUBIO VALVERDE J., BOPP M., *et al.*

2020

European Journal of Public Health (Ahead of pub).
<https://doi.org/10.1093/eurpub/ckaa194>

Persons with a lower socioeconomic position spend more years with disability, despite their shorter life expectancy, but it is unknown what the important determinants are. This study aimed to quantify the contribution to educational inequalities in years with disability of eight risk factors: father's manual occupation, low income, few social contacts, smoking, high alcohol consumption, high body-weight, low physical exercise and low fruit and vegetable consumption. We collected register-based mortality and survey-based disability and risk factor data from 15 European countries covering the period 2010–14 for most countries. We calculated years with disability between the ages of 35 and 80 by education and gender using the Sullivan method, and determined the hypothetical effect of changing the prevalence of each risk factor to the prevalence observed among high educated ('upward levelling scenario'), using Population Attributable Fractions. Years with disability among low educated were higher than among high educated, with a difference of 4.9 years among men and 5.5 years among women for all countries combined. Most risk factors were more prevalent among low educated. We found the largest contributions to inequalities in years with disability for low income (men: 1.0 year; women: 1.4 year), high body-weight (men: 0.6 year; women: 1.2 year) and father's manual occupation (men: 0.7 year; women: 0.9 year), but contributions differed by country. The contribution of smoking was relatively small. Disadvantages in material circumstances (low income), circumstances during childhood (father's manual occupation) and high body-weight contribute to inequalities in years with disability.

Hospitals

Dormont, F., Pierru, F. La tarification à l'activité (T2A) à la française. » *Revue française d'administration publique* 174(2) : 487-497

<https://www.cairn.info/revue-francaise-d-administration-publique-2020-2-page-487.htm>

L'administration hospitalière est, paradoxalement, à la fois méconnue et trop connue. Elle forme un paysage institutionnel aussi mouvant que complexe, qui demeure le pré carré de professionnels et d'experts. Depuis la fin des années 1980, les impératifs de maîtrise des dépenses de santé et de sécurité sanitaire ont entraîné une succession de réformes qui l'ont certes renforcée en termes de compétences et de moyens, mais qui ont également eu pour effet de la rendre chroniquement instable. Dans le même temps, les récents mouvements sociaux et la crise sanitaire rappellent – s'il le fallait – à quel point l'administration des hôpitaux est cruciale. Avec la crise du Covid-19, les difficultés qu'elle rencontre se sont brutalement inscrites dans l'horizon quotidien des Français. Ses organisations, ses circuits de décision, ses pratiques managériales se sont ainsi retrouvées sous les feux de l'actualité. Ce dossier de la *Revue française d'administration publique*, auquel ont participé des praticiens et des chercheurs issus de plusieurs disciplines, livre un état des lieux de l'administration hospitalière à la veille de la grande pandémie de 2020. Trois entrées ont été privilégiées : la morphologie administrative et les interconnexions entre acteurs du système de santé publique; les dynamiques professionnelles qui sous-tendent le fonctionnement des hôpitaux; les instruments d'action publique permettant le pilotage de l'institution sanitaire en France. Ces différentes contributions donnent des clés de lecture utiles pour comprendre les enjeux et les évolutions récentes de l'administration des hôpitaux.

► **Les transformations de l'administration hospitalière**

COUTY E. ET PIERRU F.
2020

Revue française d'administration publique 174(2): 351-362. <https://www.cairn.info/revue-francaise-d-administration-publique-2020-2-page-351.htm>

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la fois méconnue et trop connue. Elle forme un paysage institutionnel aussi mouvant que complexe, qui demeure le pré carré de professionnels et d'experts. Depuis la fin des années 1980, les impératifs de maîtrise des dépenses de santé et de sécurité sanitaire ont entraîné une succession de réformes qui l'ont certes renforcée en termes de compétences et de moyens, mais qui ont également eu pour effet de la rendre chroniquement instable. Dans le même temps, les récents mouvements sociaux et la crise sanitaire rappellent – s'il le fallait – à quel point l'administration des hôpitaux est cruciale. Avec la crise du Covid-19, les difficultés qu'elle rencontre se sont brutalement inscrites dans l'horizon quotidien des Français. Ses organisations, ses circuits de décision, ses pratiques managériales se sont ainsi retrouvées sous les feux de l'actualité. Ce dossier de la *Revue française d'administration publique*, auquel ont participé des praticiens et des chercheurs issus de plusieurs disciplines, livre un état des lieux de l'administration hospitalière à la veille de la grande pandémie de 2020. Trois entrées ont été privilégiées : la morphologie administrative et les interconnexions entre acteurs du système de santé publique; les dynamiques professionnelles qui sous-tendent le fonctionnement des hôpitaux; les instruments d'action publique permettant le pilotage de l'institution sanitaire en France. Ces différentes contributions donnent des clés de lecture utiles pour comprendre les enjeux et les évolutions récentes de l'administration des hôpitaux.

► **L'éducation précédant la sortie de l'hôpital : nouvelle forme d'éducation thérapeutique. Critères de qualité et perspectives d'application à notre contexte**

ALBANO M. G., GAGNAYRE R., DE ANDRADE V., *et al.*
2020

Recherche en soins infirmiers 141(2): 70-77.

<https://www.cairn.info/revue-recherche-en-soins-infirmiers-2020-2-page-70.htm>

L'ETP sh (Éducation thérapeutique précédant la sortie de l'hôpital) est une pratique développée sous le nom de « discharge education » dans les pays anglo-saxons. Cette nouvelle forme d'éducation thérapeutique s'adresse à des patients aigus ou chroniques et intéresse

toutes les spécialités hospitalières ; elle vise à faciliter la transition hôpital-domicile et éviter les réadmissions précoces. Cet examen de 43 études scientifiques porte spécifiquement sur la description, l'analyse et l'évaluation de l'ETP sh, ainsi que sur des recommandations. Près de la moitié des études sont publiées dans des revues de sciences infirmières. L'ETP sh est une intervention éducative intense et brève (de 30 minutes à une heure) délivrée majoritairement dans des situations aiguës. La pédiatrie représente, avec les soins postopératoires, le plus grand nombre de publications. Dans la plupart des études, l'ETP sh se révèle efficace pour améliorer des paramètres cliniques et psychosociaux, réduire les réadmissions précoces, augmenter les compétences et l'observance des patients. Pour atteindre ses buts, l'ETP sh doit être structurée et comporter un suivi systématique. Centrée sur les besoins, les capacités d'apprentissage du patient, elle fait appel à une pédagogie spécifique, interactive, à laquelle les soignants doivent être formés. L'analyse de la recherche internationale ne laisse aucun doute sur les apports positifs de l'ETP sh. Il serait important que soignants et décideurs s'en saisissent comme une opportunité d'améliorer la qualité des soins et de les humaniser.

► **Trajectoires professionnelles et influence des intermédiaires en milieu hospitalier**

BELORGEY N.
2020

Revue française d'administration publique 174(2): 405-423.

<https://www.cairn.info/revue-francaise-d-administration-publique-2020-2-page-405.htm>

La plupart des positions de pouvoir ou d'influence à l'hôpital sont occupées par des personnes relevant de quatre types de trajectoires professionnelles : médecins, directeurs d'hôpitaux, ingénieurs, cadres de santé. S'y ajoutent, pour dessiner la galaxie des intermédiaires du pouvoir hospitalier, les grandes administrations, les syndicats et les cabinets de conseil. Ces dernières décennies ont été marquées par une capacité croissante d'influence des cabinets de conseil, mais uniquement car ceux-ci sont parvenus à recruter des personnes issues des quatre filières traditionnelles. Cet article retrace la provenance en termes de recrutement de cette catégorie d'acteurs particuliers que sont les intermédiaires hospitaliers, et analyse leur positionnement en s'appuyant sur des données portant sur la période 2003-2008, qui correspond à un moment important de la réforme du système de santé.

► **Expertise, indicateurs de qualité et rationalisation de l'hôpital : le pouvoir discret de la « nébuleuse intégratrice »**

BERTILLOT H.
2020

Revue française d'administration publique 174(2): 425-441.

<https://www.cairn.info/revue-francaise-d-administration-publique-2020-2-page-425.htm>

Dans l'ombre du déploiement d'instruments inspirés des logiques du New Public Management, des indicateurs conçus pour évaluer la qualité hospitalière se sont généralisés depuis une quinzaine d'années. Cet article est centré sur le travail de légitimation de ces indicateurs par divers experts : chercheurs en gestion, experts au sein des fédérations hospitalières, de sociétés savantes médicales ou d'organismes régionaux d'évaluation. Situés à l'interface de l'administration hospitalière et des mondes hospitaliers locaux, ces experts constituent une nébuleuse interconnectée d'acteurs multi-positionnés, qui a contribué activement à l'intégration institutionnelle du secteur.

► **Travailler à l'hôpital : un siècle et demi de reconfigurations des métiers**

CHEVANDIER C.
2020

Revue française d'administration publique 174(2): 317-328.

<https://www.cairn.info/revue-francaise-d-administration-publique-2020-2-page-317.htm>

Depuis le milieu du XIXe siècle, l'activité des hôpitaux n'a cessé de se modifier, nécessitant la mise en place de nouveaux métiers, dont le principal est celui d'infirmière. Mais les métiers en eux-mêmes, les qualifications comme les pratiques, ont singulièrement évolué tandis que les effectifs n'ont cessé de croître. Après la Libération, la mise en place de l'État social s'est accompagnée de la promotion d'un nouveau métier, celui de directeur, qui s'est peu à peu imposé face au corps médical.

► **In-Hospital Interventions For Reducing Readmissions To Acute Care For Adults Aged 65 And Over: An Umbrella Review**

CONROY T., HEUZENROEDER L. ET FEO R.

2020

International Journal for Quality in Health Care
32(7): 414-430.

<https://doi.org/10.1093/intqhc/mzaa064>

The aim of this umbrella review was to synthesize existing systematic review evidence on the effectiveness of in-hospital interventions to prevent or reduce avoidable hospital readmissions in older people (≥ 65 years old). A comprehensive database search was conducted in May 2019 through MEDLINE, EMBASE, CINAHL, the JBI Database of Systematic Reviews, DARE and Epistemonikos. Systematic reviews and other research syntheses, including meta-analyses, exploring the effectiveness of hospital-based interventions to reduce readmissions for people aged 65 and older, irrespective of gender or clinical condition, were included for review. If a review did not exclusively focus on this age group, but data for this group could be extracted, then it was considered for inclusion. Only reviews in English were included. Data extracted for each review included the review objective, participant details, setting and context, type of studies, intervention type, comparator and findings. Twenty-nine reviews were included for analysis. Within these reviews, 11 intervention types were examined: in-hospital medication review, discharge planning, comprehensive geriatric assessment, early recovery after surgery, transitional care, interdisciplinary team care, in-hospital nutrition therapy, acute care geriatric units, in-hospital exercise, postfall interventions for people with dementia and emergency department-based palliative care. Except for discharge planning and transitional care, none of the interventions significantly reduced readmissions among older adults. There is limited evidence to support the effectiveness of existing hospital-based interventions to reduce readmissions for people aged 65 and older.

► **La réforme hospitalière, creuset d'une administration spécialisée. Analyse de la formation et des transformations de la direction des hôpitaux (1970-2010)**

GAY R.

2020

Revue française d'administration publique **174(2):**
329-349.

<https://www.cairn.info/revue-francaise-d-administration-publique-2020-2-page-329.htm>

Depuis qu'elles se succèdent pour maîtriser la dépense publique à partir des années 1970, les réformes hospitalières affectent la division du travail administratif et la distribution de capacités d'action entre organisations publiques. C'est ainsi que, au fil des réformes, se constitue une direction des hôpitaux au ministère de la santé, puis se définit son domaine d'intervention et s'éprouve son autonomie d'action. Il se dégage de l'analyse trois séquences historiques décrivant un processus discontinu de concentration organisationnelle des tâches administratives auquel peuvent concourir d'autres processus politiques déconnectés des réformes et qui interroge l'homogénéité culturelle de la direction.

► **La sécurité liée aux soins : écarts entre l'expérience et la satisfaction de patients hospitalisés à partir d'entretiens menés par des représentants d'utilisateurs**

GROSS O., AGOSTINI B., BELLEVAL P., *et al.*

2020

Revue d'Épidémiologie et de Santé Publique **68(6):**
337-346.

<https://doi.org/10.1016/j.respe.2020.10.004>

Cet article vise à rendre compte des résultats d'une enquête qualitative menée par des représentants d'utilisateurs (RUs) dans le but de connaître l'expérience de la sécurité des soins des patients hospitalisés. Il s'agissait de repérer les facteurs associés à la sécurité des soins et en particulier les événements porteurs de risques, dont les patients peuvent rendre compte. Méthodes Après avoir été formés à cet effet, huit RUs de l'AP-HP ont mené des entretiens semi-directifs auprès de quatorze patients hospitalisés dans onze services hospitaliers distincts répartis sur neuf hôpitaux. Résultats Huit types de facteurs composés de 30 facteurs contributifs pouvant être repérés par des patients ont été identifiés : 1) des facteurs liés aux besoins élémentaires des patients; 2) à la personnalisation des soins; 3) des facteurs professionnels; 4) organisationnels; 5) liés à la communication; 6) à la réactivité des soignants; 7) aux risques infectieux; 8) à la continuité des soins. Le sentiment général des patients sur leur hospitalisation reste excellent malgré des expériences plus nuancées, voire parfois négatives. Conclusion Ce résultat paradoxal montre que l'expérience des patients est bien plus riche d'enseignements que leur satisfaction. Enfin, au vu de cette étude, l'acceptabilité

de ce type de recherche, à savoir une recherche menée par des RUs, est excellente et nous concluons sur sa faisabilité, en dépit de quelques limites principalement d'ordre organisationnel.

► **A Systematic Review Of The Association Between Hospital Cost/Price And The Quality Of Care**

JAMALABADI S., WINTER V. ET SCHREYÖGG J.
2020

Applied Health Economics and Health Policy 18(5): 625-639.

<https://doi.org/10.1007/s40258-020-00577-6>

Limited empirical evidence exists regarding the effect of price changes on hospital behavior and, ultimately, the quality of care. Additionally, an overview of the results of prior literature is lacking.

► **Cancer Care At Home Or In Local Health Centres Versus In Hospital: Public Policy Goals And Patients' Preferences In The Rhône-Alps Region In France**

MARGIER J., GAFNI A. ET MOUMJID N.
2020

Health Policy(Ahead of pub).

<https://doi.org/10.1016/j.healthpol.2020.11.011>

In France, cancer treatments are mainly provided in hospitals, which are expensive and crowded. Health decision-makers therefore want to develop alternative structures such as home care and local health centres. The aims of this paper are to elicit cancer patients' preferences for home, local health centre, or hospital, and analyze factors affecting these choices: patients' characteristics, experiences of care, expectations and perceptions of cancer management. Methods We developed a decision aid composed of 1) information on the 3 options 2) a questionnaire to measure preferences; 3) a questionnaire on sociodemographics and experiences of care, 386 patients participated in the survey. Results hospital was the preferred option for 71% of the participants, especially for complicated care, followed by home care (24%) and local health centres (5%). Main reasons for preferring hospital were the wish to separate home life and place of care, wanting to avoid being a burden on their relatives. Reasons influencing a preference for home care were wanting to avoid trips, maintain their lifestyle, and finding hospitals frightening. Neither socio-demographics nor

even experience of care seemed to explain preferences. Conclusion A quarter of patients preferred home care, which is highly disproportionate to the home care currently available. This suggests that hindrances to developing alternatives to hospital do not come from patients' reluctance to make use of them, but rather from healthcare providers' objections.

► **Administrer le système hospitalier ou administrer le système de santé ?**

MARROT B.

2020

Revue française d'administration publique 174(2): 443-458.

<https://www.cairn.info/revue-francaise-d-administration-publique-2020-2-page-443.htm>

L'administration hospitalière est, paradoxalement, à la fois méconnue et trop connue. Elle forme un paysage institutionnel aussi mouvant que complexe, qui demeure le pré carré de professionnels et d'experts. Depuis la fin des années 1980, les impératifs de maîtrise des dépenses de santé et de sécurité sanitaire ont entraîné une succession de réformes qui l'ont certes renforcée en termes de compétences et de moyens, mais qui ont également eu pour effet de la rendre chroniquement instable. Dans le même temps, les récents mouvements sociaux et la crise sanitaire rappellent – s'il le fallait – à quel point l'administration des hôpitaux est cruciale. Avec la crise du Covid-19, les difficultés qu'elle rencontre se sont brutalement inscrites dans l'horizon quotidien des Français. Ses organisations, ses circuits de décision, ses pratiques managériales se sont ainsi retrouvées sous les feux de l'actualité. Ce dossier de la Revue française d'administration publique, auquel ont participé des praticiens et des chercheurs issus de plusieurs disciplines, livre un état des lieux de l'administration hospitalière à la veille de la grande pandémie de 2020. Trois entrées ont été privilégiées : la morphologie administrative et les interconnexions entre acteurs du système de santé publique; les dynamiques professionnelles qui sous-tendent le fonctionnement des hôpitaux; les instruments d'action publique permettant le pilotage de l'institution sanitaire en France. Ces différentes contributions donnent des clés de lecture utiles pour comprendre les enjeux et les évolutions récentes de l'administration des hôpitaux.

► **Evaluating Hospital Readmissions For Persons With Serious And Complex Illness: A Competing Risks Approach**

MAY P., GARRIDO M. M., DEL FABBRO E., *et al.*

2020

Medical Care Research and Review 77(6): 574-583.

<https://journals.sagepub.com/doi/abs/10.1177/1077558718823919>

Hospital readmission rate is a ubiquitous measure of efficiency and quality. Individuals with life-limiting illnesses account heavily for admissions but evaluation is complicated by high-mortality rates. We report a retrospective cohort study examining the association between palliative care (PC) and readmissions while controlling for postdischarge mortality with a competing risks approach. Eligible participants were adult inpatients admitted to an academic, safety-net medical center (2009-2015) with at least one diagnosis of cancer, heart failure, chronic obstructive pulmonary disease, liver failure, kidney failure, AIDS/HIV, and selected neurodegenerative conditions. PC was associated with reduced 30-, 60-, and 90-day readmissions (subhazard ratios = 0.57, 0.53, and 0.52, respectively [all $p < .001$]). Hospital PC is associated with a reduction in readmissions, and this is not explained by higher mortality among PC patients. Performance measures only counting those alive at a given end point may underestimate systematically the effects of treatments with a high-mortality rate.

► **Worth The Wait: The Impact Of Government Funding On Hospital Emergency Waiting Times**

MCQUESTIN D. ET NOGUCHI M.

2020

Health Policy 124(12) :1340-1344

<https://doi.org/10.1016/j.healthpol.2020.09.008>

In the absence of a price mechanism, emergency department waiting times act as a rationing device to equate demand for treatment with available supply. Sustained increases to demand stemming from population growth, aging populations, and rising comorbidities has caused waiting times internationally to rise. This has resulted in increased calls for higher funding from governments and commitments from both state and national governments to address excessive waiting times. This paper aims to determine the effectiveness of government funding for improving the median waiting times for treatment and the proportion of patients

seen within clinically recommended waiting times. For this purpose, an econometric analysis was conducted on a panel of data on Victorian local health networks over the period 2015–2018. This is supplemented with a discussion of the alternative measures which governments might take to both address demand for emergency treatment, and also ensure that waiting time reductions can be maintained over the long-term.

► **Les comparaisons internationales des hôpitaux : apports et limites des statistiques disponibles**

PARIS V.

2020

Revue française d'administration publique 174(2): 363-384.

<https://www.cairn.info/revue-francaise-d-administration-publique-2020-2-page-363.htm>

Cet article présente une revue critique des données disponibles pour les comparaisons internationales de l'offre et de l'activité hospitalières et des dépenses associées. Il montre que les différences entre pays résultent à la fois du rôle joué par les hôpitaux dans les systèmes de santé, de différences dans le champ couvert par les statistiques nationales et de variations géographiques dans le recours aux soins. Les comparaisons portant sur l'ensemble des établissements et des séjours ne permettent pas de porter un jugement éclairé sur l'adéquation de l'offre ou sur l'efficacité des hôpitaux, qui nécessitent des analyses plus fines au niveau d'un diagnostic ou d'une intervention.

► **Introduction. L'administration hospitalière, entre pandémie virale et épidémie de réformes**

PIERRU F.

2020

Revue française d'administration publique 174(2): 301-315.

<https://www.cairn.info/revue-francaise-d-administration-publique-2020-2-page-301.htm>

L'administration hospitalière est, paradoxalement, à la fois méconnue et trop connue. Elle forme un paysage institutionnel aussi mouvant que complexe, qui demeure le pré carré de professionnels et d'experts. Depuis la fin des années 1980, les impératifs de maîtrise des dépenses de santé et de sécurité sanitaire ont entraîné une succession de réformes qui l'ont certes

renforcée en termes de compétences et de moyens, mais qui ont également eu pour effet de la rendre chroniquement instable. Dans le même temps, les récents mouvements sociaux et la crise sanitaire rappellent – s’il le fallait – à quel point l’administration des hôpitaux est cruciale. Avec la crise du Covid-19, les difficultés qu’elle rencontre se sont brutalement inscrites dans l’horizon quotidien des Français. Ses organisations, ses circuits de décision, ses pratiques managériales se sont ainsi retrouvées sous les feux de l’actualité. Ce dossier de la Revue française d’administration publique, auquel ont participé des praticiens et des chercheurs issus de plusieurs disciplines, livre un état des lieux de l’administration hospitalière à la veille de la grande pandémie de 2020. Trois entrées ont été privilégiées : la morphologie administrative et les interconnexions entre acteurs du système de santé publique; les dynamiques professionnelles qui sous-tendent le fonctionnement des hôpitaux; les instruments d’action publique permettant le pilotage de l’institution sanitaire en France. Ces différentes contributions donnent des clés de lecture utiles pour comprendre les enjeux et les évolutions récentes de l’administration des hôpitaux.

► **Development Of The General Surgery Prioritisation Tool Implemented In New Zealand In 2018**

SRIKUMAR G., EGLINTON T. ET MACCORMICK A. D.

2020

[Health Policy 124\(10\): 1043-1049.](#)

<https://doi.org/10.1016/j.healthpol.2020.07.018>

Patients waitlisted for elective general surgery in New Zealand used to be prioritised by multiple tools that were inconsistent, did not reflect clinical judgement and were not validated. We describe the development and implementation of a national prioritisation tool for elective general surgery in New Zealand, which could be applicable to other OECD countries. The tool aims to achieve equity of access, transparency, reliability and should be aligned with clinical judgement. The General Surgery Prioritisation Tool Working Group commenced development of a prioritisation tool in 2014 which showed strong correlation with clinical judgement ($r=0.89$), excellent test-retest reliability ($r=0.98$) and significantly lower variability ($p < 0.001$). Preliminary findings showed no significant difference in scores attributable to age, gender or ethnicity. General Surgeons were in favour of the tool criteria and agreed on the importance of prioritisation; however a minor-

ity opposed its introduction. Health organisations and general practitioner groups were in favour, however, along with many surgeons, expressed apprehensions regarding subjectivity, manipulation, equity of access and degree of benefit. Despite reservations, the majority of stakeholders were supportive and through collaboration between clinicians and the government, the tool was implemented in 2018 in New Zealand. Overall, the prioritisation tool is a reliable method of assessing priority, demonstrating transparency and reflecting clinical judgement, with equity of access to be further assessed by evaluation in clinical practice.

► **Pathways To Reduced Emergency Department And Urgent Care Center Use: Lessons From The Comprehensive Primary Care Initiative**

TIMMINS L., PEIKES D. ET MCCALL N.

2020

[Health Services Research 55\(6\): 1003-1012.](#)

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13579>

The aim of this study is to determine the association between a large-scale, multi-payer primary care redesign—the Comprehensive Primary Care (CPC) Initiative—on outpatient emergency department (ED) and urgent care center (UCC) use and to identify the types of visits that drive the overall trends observed. Data Sources Medicare claims data capturing characteristics and outcomes of 565 674 Medicare fee-for-service (FFS) beneficiaries attributed to 497 CPC practices and 1 165 284 beneficiaries attributed to 908 comparison practices. Study Design We used an adjusted difference-in-differences framework to test the association between CPC and beneficiaries’ ED and UCC use from October 2012 through December 2016. Regression models controlled for baseline practice and patient characteristics and practice-level clustering of standard errors. Our key outcomes were all-cause and primary care substitutable (PC substitutable) outpatient ED and UCC visits, and potentially primary care preventable (PPC preventable) ED visits, categorized by the New York University Emergency Department Algorithm. We used a propensity score-matched comparison group of practices that were similar to CPC practices before CPC on multiple dimensions. Both groups of practices had similar growth in ED and UCC visits in the two-year period before CPC. Principal Findings Comprehensive Primary Care practices had 2% ($P = .06$) lower growth in all-cause ED

visits than comparison practices. They had 3% ($P = .02$) lower growth in PC substitutable ED visits, driven by lower growth in weekday PC substitutable visits (4%, $P = .002$). There was 3% ($P = .04$) lower growth in PPC preventable ED visits with no weekday/nonweekday differential. As expected, our falsification test showed no difference in ED visits for injuries. UCC visits had 9% lower growth for both all-cause ($P = .08$) and PC substitutable visits ($P = .07$). Conclusions Our results suggest that greater access to the practice and more effective primary care both contributed to the lower growth in ED and UCC visits during the initiative.

► **Does Formal Home Care Reduce Inpatient Length Of Stay?**

WALSH B., LYONS S., SMITH S., *et al.*

2020

Health Economics 29(12) : 1620-1636

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4158>

Formal home care is an appropriate substitute for

acute hospital care for many older people. However, limited empirical evidence exists on the extent of substitution between the supply of home care and hospital use. This study examines whether patients from areas with a better supply of home care have lower inpatient length of stay (LOS). We link administrative data on over 300,000 public hospital inpatient admissions in Ireland between 2012 and 2015 to region-year panel data on public home care supply. In addition to modeling average LOS, we estimate unconditional quantile regressions to examine whether home care supply has a disproportionately strong impact on long LOS. We find that inpatients from areas with higher per capita home care supply have lower average LOS; a 10% increase in home care is associated with a 1.2%–2.1% reduction in LOS. This result is driven by the subset of patients with the longest LOS, likely delayed discharges. Stronger results were found for stroke and hip fracture patients, who might be expected to have higher than average propensity to use home care services, and for patients from a region that experienced an unusually large increase in home care supply.

Inégalités de santé

Health Inequalities

► **Cautionary Tails Of Grip Strength In Health Inequality Studies: An Analysis From The Canadian Longitudinal Study On Aging**

ASADA Y., GRIGNON M., HURLEY J., *et al.*

2020

Social Science & Medicine 265: 113382.

<https://doi.org/10.1016/j.socscimed.2020.113382>

Self-rated health is widely used in studies of the socioeconomic gradient of health in community-based populations. Its subjectivity may lead to under- or over-estimation of a true underlying socioeconomic gradient and has increased interest in searching for alternative, objective measures of health. Grip strength has emerged as one such alternative for community-based older populations, yet no study has directly assessed the relationship between these two measures and compared their associations with socioeconomic status and health behaviours. Using 26,754 participants aged 45–85 years in the baseline data of the Canadian

Longitudinal Study on Aging Comprehensive Cohort, we estimated adjusted-grip strength through indirect standardization using age, sex, height, weight, and their square terms and used ANOVA to assess the variance of adjusted-grip strength within and between each self-rated health category. We ran four separate logistic regression models, examining unhealthy tails (those reporting poor health vs. not and those at the bottom 8th percentile of adjusted-grip strength vs. above) and healthy tails (those reporting excellent health vs. not and those at the top 20th percentile of adjusted-grip strength vs. below). Stronger adjusted-grip strength correlated with better self-rated health, but only 2% of the total variance of adjusted-grip strength was explained by variance between the self-rated health categories. While self-rated health largely showed the expected socioeconomic gradients and positive relationships with health enhancing behaviours, adjusted-grip strength showed no clear, consistent associations with either socioeconomic or health behaviour variables. The results give caution about using grip

strength as an objective alternative to self-rated health in studies of social inequalities in health. Empirical approaches demand careful considerations as to which dimensions of health and corresponding measures of health are most relevant to the context being studied.

► **Impact Of Fees On Access To Dental Care: Evidence From France**

BAS A.-C., DOURGNON P., AZOGUI-LEVY S., *et al.*
2020

European Journal of Public Health 30(6): 1066-1071.
<https://doi.org/10.1093/eurpub/ckaa143>

For financial reasons, dental prosthetics is one of the major unmet dental healthcare needs [Financial-SUN (F-SUN)]. Private fees for dental prosthetics result in significant out-of-pocket payments for users. This study analyzes the impact of geo-variations in protheses fees on dental F-SUN. Using a nationwide French declarative survey and French National Health Insurance administrative data, we empirically tested the impact of prosthetic fees on dental F-SUN, taking into account several other enabling factors. Our empirical strategy was built on the homogeneous quality of the dental prosthesis selected and used to compute our price index. Unmet dental care needs due to financial issues concern not only the poorest but also people with middle incomes. The major finding is the positive association between dental fees and difficulty in gaining access to dental care when other enabling factors are taken into account (median fee in the highest quintile: OR=1.35; P value = 0.024; 95% CI 1.04–1.76). People with dental F-SUN are those who have to make a greater financial effort due to a low/middle income or a lack of complementary health insurance. For identical financial reasons, the tendency to give up on healthcare increases as health deteriorates. The results underscore the need for fee regulation regarding dental prosthetics. This is in line with the current French government dental care reform.

► **Unmet Social Needs Among Low-Income Adults In The United States: Associations With Health Care Access And Quality**

COLE M. B. ET NGUYEN K. H.
2020

Health Services Research 55(S2): 873-882.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13555>

The aim of this study is to describe social needs among low-income adults and estimate the relationship between level of unmet social needs and key indicators of health care access and quality. Data Source National survey data from 12 states from the 2017 Behavioral Risk Factor Surveillance System, which added a “Social Determinants of Health” Module in 2017. Study Design We examined differences in eight measures of health care access and quality (eg, check-up in last 12 months, inability to see doctor due to cost, receipt of eye examination for diabetics) for low-income adults with 0, 1, 2-3, and 4+ unmet social needs based on 7 social needs measures. We used adjusted logistic regression models to estimate the association between level of unmet need and each outcome. Principal Findings Most common unmet social needs included not having enough money for balanced meals (33 percent) or food (32 percent). After adjusting for observable characteristics, higher levels of unmet social need were associated with poorer access and quality. Compared to those with no reported unmet needs, having 4+ unmet needs was significantly associated with reduced probability of having a yearly check-up (65 percent vs 78 percent, adjusted difference = -7.1 percentage points (PP)), receiving a flu vaccine (33 percent vs 42 percent, adjusted difference = -5.4 PP), having a personal doctor (74 percent vs 80 percent, adjusted difference = -3.1 PP), and having a foot (63 percent vs 80 percent, adjusted difference = -12.8 PP) or eye examination (61 percent vs 73 percent, adjusted difference = -12.6 PP) for diabetic patients, and increased probability of being unable to see a doctor due to cost (44 percent vs 9 percent, adjusted difference = 27.9 PP) and having diabetes affect the eyes (22 percent vs 19 percent, adjusted difference = 8.0 PP) at $p = 0.05$. Conclusions Higher levels of unmet social needs were associated with poorer access to and quality of care among low-income adults. Addressing social needs both inside and outside of health care settings may help mitigate these negative effects. Additional research on if and how to effectively do so is critical.

► **Changes In Coverage And Access To Dental Care Five Years After ACA Medicaid Expansion**

ELANI H. W., SOMMERS B. D. ET KAWACHI I.
2020

Health Affairs 39(11): 1900-1908.
<https://doi.org/10.1377/hlthaff.2020.00386>

With the implementation of the Affordable Care Act (ACA), millions of low-income adults gained health coverage. We examined how the ACA's expansion of Medicaid eligibility affected dental coverage and the use of oral health services among low-income adults, using data from the National Health Interview Survey from the period 2010-2018. We found that the ACA increased rates of dental coverage by 18.9 percentage points in states that provide dental benefits through Medicaid. In terms of utilization, expansion states that provide dental benefits saw the greatest increase in people having a dental visit in the past year (7.2 percentage points). However, there was no significant change in the overall share of people who had a dental visit in the past year, although the expansion was associated with a significant increase in this metric among White adults. The expansion was also associated with a 1.4-percentage-point increase in complete teeth loss, which may be a marker of both poor oral health and the potential gaining of access to dental services (with subsequent tooth extractions). Our findings suggest that in addition to expanded coverage, policies need to tackle other barriers to accessing dental care to improve population oral health.

► **An Overview Of Reviews On Strategies To Reduce Health Inequalities**

GARZÓN-ORJUELA N., SAMACÁ-SAMACÁ D. F.,
LUQUE ANGULO S. C., *et al.*
2020

International Journal for Equity in Health 19(1): 192.
<https://doi.org/10.1186/s12939-020-01299-w>

Governments are incentivized to develop and implement health action programs focused on equity to ensure progress with effective strategies or interventions.

► **Intersectional Migration-Related Health Inequalities In Europe: Exploring The Role Of Migrant Generation, Occupational Status & Gender**

GKIOULEKA A. ET HUIJTS T.
2020

Social Science & Medicine 267: 113218.
<https://doi.org/10.1016/j.socscimed.2020.113218>

Integrating intersectionality theory and employing a quantitative design, the current study explores how migration-related health inequalities in Europe interact with migrant generation, occupational status and gender. Multilevel logistic regression analyses are conducted using pooled data from six waves of the European Social Survey (2004–2014), from 27 countries for two subjective health measures (general self-reported health and hampering conditions). The results reveal multiple relationships of health inequality that operate simultaneously and the complexity through which the combination of social privilege and disadvantage can have a particularly negative impact on individual health. The 'healthy migrant effect' seems to apply particularly for first-generation immigrants working as manual employees, and within occupational categories, in certain cases non-migrant women are more susceptible to poor health than migrant men. This evidence highlights how the health impact of migration is subject to additional dimensions of social positioning as well as the importance of an intersectional perspective for the monitoring of health inequalities in Europe.

► **An Overview Of Health Policies For Asylum-Seekers In Germany**

GOTTLIEB N. ET SCHÜLLE M.
2021

Health Policy 125(1) :115-121
<https://doi.org/10.1016/j.healthpol.2020.09.009>

Health policies for asylum-seekers are a subject of debate across European countries. However, information on current strategies to respond to these populations' health needs is scarce. To facilitate comparative research, this paper renders a detailed overview of Germany's asylum-seeker health policies. Following a description of the historic development and administrative structure of asylum-seeker health care in Germany, we provide a detailed account of asylum-seekers' scope of health entitlements, as it is defined by federal law. We explain the main mech-

anisms that are used to implement the law on local levels and regulate health care access; namely, the electronic health insurance card and the health care voucher. Financing and billing structures are described, and main points of critique of Germany's asylum-seeker health policies are summarized. Our description highlights fragmentation and internal variations as central features of Germany's asylum-seeker health policies. It explicates how these features are rooted in decentralization, and in the regulation of restricted health benefits through a parallel system, separate from statutory health insurance. As a case-study, Germany's asylum-seeker health policies illustrate the administrative, economic and ethical burdens implied in granting health benefits through a parallel system, and in absence of central health governance. The (re)integration of asylum-seeker health care in statutory health insurance could reduce these burdens and contribute to equitable health care access.

► **Mortality Due To Cancer Treatment Delay: Systematic Review And Meta-Analysis**

HANNA T. P., KING W. D., THIBODEAU S., *et al.*

2020

BMJ 371: m4087.

The objective of this paper is to quantify the association of cancer treatment delay and mortality for each four week increase in delay to inform cancer treatment pathways. Design Systematic review and meta-analysis. Data sources Published studies in Medline from 1 January 2000 to 10 April 2020. Eligibility criteria for selecting studies Curative, neoadjuvant, and adjuvant indications for surgery, systemic treatment, or radiotherapy for cancers of the bladder, breast, colon, rectum, lung, cervix, and head and neck were included. The main outcome measure was the hazard ratio for overall survival for each four week delay for each indication. Delay was measured from diagnosis to first treatment, or from the completion of one treatment to the start of the next. The primary analysis only included high validity studies controlling for major prognostic factors. Hazard ratios were assumed to be log linear in relation to overall survival and were converted to an effect for each four week delay. Pooled effects were estimated using DerSimonian and Laird random effect models. Results The review included 34 studies for 17 indications (n = 1 272 681 patients). No high validity data were found for five of the radiotherapy indications or for cervical cancer surgery. The association between delay and increased mortality was significant

($P < 0.05$) for 13 of 17 indications. Surgery findings were consistent, with a mortality risk for each four week delay of 1.06-1.08 (eg. colectomy 1.06, 95% confidence interval 1.01 to 1.12; breast surgery 1.08, 1.03 to 1.13). Estimates for systemic treatment varied (hazard ratio range 1.01-1.28). Radiotherapy estimates were for radical radiotherapy for head and neck cancer (hazard ratio 1.09, 95% confidence interval 1.05 to 1.14), adjuvant radiotherapy after breast conserving surgery (0.98, 0.88 to 1.09), and cervix cancer adjuvant radiotherapy (1.23, 1.00 to 1.50). A sensitivity analysis of studies that had been excluded because of lack of information on comorbidities or functional status did not change the findings. Conclusions Cancer treatment delay is a problem in health systems worldwide. The impact of delay on mortality can now be quantified for prioritisation and modelling. Even a four week delay of cancer treatment is associated with increased mortality across surgical, systemic treatment, and radiotherapy indications for seven cancers. Policies focused on minimising system level delays to cancer treatment initiation could improve population level survival outcomes.

► **Health Inequalities In Eastern Europe. Does The Role Of The Welfare Regime Differ From Western Europe?**

JUTZ R.

2020

Social Science & Medicine 267: 113357.

<https://doi.org/10.1016/j.socscimed.2020.113357>

When we study the impact of social policy on health inequalities, we find that most research is based on Western European countries. This study expands the geographical focus by including post-communist countries from Eastern Europe, Russia, and the Caucasus. The 2008/2009 round of the European Values Study (EVS) provides a unique opportunity for this analysis since it covers 23 post-communist countries and 20 Western European countries. The study uses multilevel cross-sectional analyses to examine the moderating role of welfare regimes on socioeconomic health inequalities. Many reviews claim that the results for welfare systems and health inequalities are inconsistent. However, since the studies selected for the reviews are mainly focused on Western Europe—only a few include Central Eastern European countries—we still need to find out how welfare regimes in post-communist countries moderate the link between socioeconomic status and health. A cluster analysis based on 13 social and economic indicators generates 4 welfare

clusters within the post-communist countries which are used for further analyses. Regarding the achievements of the communist countries in compulsory secondary education, the expectation is that the educational health inequalities differ between Eastern and Western Europe. The multilevel analyses confirm that social gradients in health related to education and income exist in both Western and Eastern Europe. However, while income-related health inequalities are similar, educational health inequalities are most pronounced in the welfare cluster of the EU Member States of Central and Eastern Europe.

► **Gender Patterns In Immigrants' Health Profiles In France: Tobacco, Alcohol, Obesity And Self-Reported Health**

KHLAT M., LEGLEYE S. ET BRICARD D.

2020

International Journal of Environmental Research and Public Health 17(23): 8759.

<https://doi.org/doi:10.3390/ijerph17238759>

To date, little attention has been given to gender differences in the health of migrants relative to native-born. In this study, we examine the health profile of the largest immigrant groups in metropolitan France, considering several health indicators and with a special interest in the gendered patterns. Methods: The data originate from the 2017 Health Barometer survey representative of metropolitan France. A subsample of 19,857 individuals aged 18–70 years was analysed using modified Poisson regression, and risk ratio estimates (RR) were provided for the different migrant groups regarding alcohol use, current smoking, obesity and less-than-good self-reported health, adjusting for age and educational level. Results: None of the groups of male migrants differs from the native-born in terms of self-reported health, and they have healthier behaviours for alcohol (men from sub-Saharan Africa: 0.42 (0.29–0.61)) and from the Maghreb: 0.30 (0.1–0.54)) and smoking (men from sub-Saharan Africa: 0.64 (0.4–0.84)), with less frequent obesity (men from the Maghreb: 0.61 (0.3–0.95)). The latter, however, more frequently report current smoking (1.21 (1.0–1.46)). For women, less-than-good health is more frequently reported by the groups from sub-Saharan Africa (1.42 (1.1–1.75)) and from the Maghreb (1.55 (1.3–1.84)). Healthier behaviours were found for alcohol (women from overseas départements: 0.38 (0.1–0.85)) and from the Maghreb: (0.18 (0.0–0.57)) and current smoking (women from southern Europe: 0.68 (0.4–0.97), from sub-Saharan Africa:

0.23 (0.1–0.38) and from the Maghreb: 0.42 (0.2–0.61)). Conversely, some were more frequently obese (women from overseas départements: 1.79 (1.2–2.56) and from sub-Saharan Africa: 1.67 (1.2–2.23)). In the latter two groups from Africa, there is a larger relative male excess for tobacco than in the native-born (male-to-female ratios of respectively 2.87 (1.6–5.09) and 3.1 (2.0–4.65) vs 1.13 (1.0–1.20)) and there is a female excess for obesity (0.51 (0.2–0.89) and 0.41 (0.2–0.67)) in contrast with the native-born (1.07 (0.9–1.16)). The female disadvantage in terms of less-than-good self-reported health is more pronounced among migrants from the Maghreb than among the natives (0.56(0.4–0.46) vs. 0.86 (0.8–0.91)). Conclusion: Considering a set of four health indicators, we provide evidence for distinctive gender patterns among immigrants in France. Male immigrants have a healthy behavioural profile in comparison with the natives and no health disadvantage. Female immigrants have a more mixed profile, with a health disadvantage for the non-Western groups from Africa. The contribution to this discordance of socioeconomic factors and gender relations needs to be investigated.

► **Se sentir pauvre. Un indicateur spécifique de l'insécurité sociale ?**

PAUGAM S.

2020

Revue française de sociologie 61(2): 281-292.

<https://www.cairn.info/revue-francaise-de-sociologie-2020-2-page-281.htm>

Dans cet article, l'auteur revient sur l'approche relationnelle de la pauvreté pour interroger les effets des normes institutionnelles de définition de la pauvreté sur le sentiment d'infériorité de la population concernée.

► **Non-recours au soin des populations précaires**

PELLET R., RODOLPHE C. ET DERGHAM M.

2020

Médecine : De La Médecine Factuelle à Nos Pratiques 16(8): 354-359.

Cet article traite du non-recours au soin de populations précaires, déjà sujettes à différents phénomènes de discrimination directe. Il cherche à définir l'expression polymorphe du non-recours et à en expliquer l'origine et sa pérennisation au sein du système de santé.

► **Accès aux soins des personnes sans-abri : des inégalités aux discriminations ?**

PICHON P.
2020

Médecine : De La Médecine Factuelle à Nos Pratiques 16(7): 313-316.

Cet article dresse un bref panorama de la prise en charge contemporaine socio-sanitaire des personnes sans-abri. Il montre les conséquences de la spécificité de ces prises en charge et interroge la notion de « discrimination indirecte » complémentirement à celle d'inégalité.

► **Épidémie de Covid-19 : des vulnérables et des invincibles**

SEHILI D. ET DUFOURNET T.
2020

Médecine : De La Médecine Factuelle à Nos Pratiques 16(7): 296-300.

La démonstration générale soutenue dans cet article vise à comprendre les comportements transgressifs, voire « déviants » en lien avec la non-observance des consignes pour faire face à la crise sanitaire. Cette première partie d'article propose de faire une analyse comparative entre l'épidémie de COVID-19 et celle du VIH/SIDA afin de montrer la prégnance de rhétoriques similaires, reposant sur le ciblage stigmatisant de certaines populations, au sein des discours politiques, médicaux et médiatiques. Cette focalisation sur des pratiques individuelles, plutôt que sur la prise en compte de conditions de prévention socialement inégalitaires, induit une reconnaissance in fine différentielle du risque et de la transgression. Pour le dire autrement, le ciblage de populations pensées comme « vulnérables » ou « invincibles » doit se lire comme des discriminations, négatives ou positives, en termes de génération et de genre (ce qui est développé plus particulièrement ici) et de classe et de race (ce qui sera présenté dans une seconde partie d'article).

► **Le rôle du capital humain prémigratoire dans l'intégration économique des immigrants en France : compétences métier vs compétences transversales**

UKRAYINCHUK N. ET CHOJNICKI X.
2020

Population 75(2): 325-357.
<https://www.cairn.info/revue-population-2020-2-page-325.htm>

L'objectif de cet article est de différencier le rôle joué par les compétences transversales et les compétences métier accumulées à l'étranger, sur les chances d'accéder à un emploi en France, ainsi que sur l'adéquation de cet emploi et du niveau de salaire avec les compétences prémigratoires. Pour quantifier l'impact de la transférabilité du capital humain, les données de l'enquête Trajectoires et Origines (2008) sont utilisées. Le capital humain prémigratoire joue un rôle important aussi bien sur les chances d'accès à un emploi, que pour le maintien ou la progression de la position socioprofessionnelle, ainsi que pour la rémunération des immigrants. En utilisant plusieurs indicateurs d'intégration des immigrants, quantitatifs et qualitatifs, on s'aperçoit qu'à l'exception des compétences linguistiques, les autres compétences transversales ne jouent pas le rôle attendu en tant que vecteur d'intégration. À l'inverse, les compétences métier permettent une meilleure intégration économique. Par ailleurs, les effets négatifs d'un faible niveau de transférabilité des compétences métier sur l'intégration économique se maintiennent.

► **Educational Inequalities In Self-Rated Health And Social Relationships – Analyses Based On The European Social Survey 2002-2016**

VONNEILICH N., LÜDECKE D. ET VON DEM KNESEBECK O.
2020

Social Science & Medicine 267: 112379.
<https://doi.org/10.1016/j.socscimed.2019.112379>

While there is evidence for educational health inequalities in Europe, studies on time trends and on the explanatory contribution of social relations are less consistent. It has been shown that the use of welfare state typologies can be helpful to examine health inequalities in a comparative perspective. Against this background, analyses are focused on three research questions: (1) How did educational inequalities in self-rated health (SRH) develop between 2002 and 2016 in different European countries? (2) In how far can structural and functional aspects of social relations help to explain these inequalities? (3) Do these explanatory contributions vary between different types of welfare states? Methods Data stem from the European Social Survey. Data from 20 countries across 8 waves (2002–2016) was included in the sample (allocated to 5 types of welfare states). Structural aspects of social relations were measured by living with a partner, frequency of

social contacts and social participation. Availability of emotional support was used as functional dimension. Educational level was assessed based on the International Standard Classification of Education. SRH was measured in all waves on a five-point scale by one question: "How is your health in general? Would you say it is very good, good, fair, bad or very bad?" Results Across all countries, educational inequalities were increasing between 2002 and 2016. Explanatory

contribution of emotional support, living with a partner, and social contacts was small (5% or less across the eight waves). Social participation explained 11% of the educational inequalities in SRH in the European countries. There were small variations in the explanatory contribution of social participation between welfare states. Conclusions Promoting social participation, especially of people with low education is a possible intervention to reduce inequalities in SRH in Europe.

Médicaments

Pharmaceuticals

► **Conflit d'intérêts et traitements anti-Alzheimer : de la construction à la contestation d'une promesse médicale**

DALGALARRONDO S. ET HAURAY B.
2020

Sciences sociales et santé 38(3): 77-104.

<https://www.cairn.info/revue-sciences-sociales-et-sante-2020-3-page-77.htm>

Cet article a pour ambition d'analyser la trajectoire des médicaments anti- Alzheimer (AA) à l'aune de la question des conflits d'intérêts. Il met d'abord en lumière la

constitution d'une économie politique de la promesse des médicaments AA, au sein de laquelle les stratégies des laboratoires ont eu un rôle structurant. Il montre surtout comment l'affirmation de la problématique du conflit d'intérêts au cours des années 2000 a pu remettre en cause cette promesse, ses effets sur la crédibilité des savoirs, sur les hiérarchies médicales, et finalement sa capacité à être mobilisée comme un répertoire efficace d'action. Cette recherche s'appuie sur un travail documentaire et des entretiens avec des acteurs français clés de cette histoire.

Méthodologie – Statistique

Methodology - Statistics

► **Improving The Quality Of Systematic Reviews In Public Health: Introduction To The Series**

BERO L. A.
2020

American Journal of Public Health 110(11): 1601-1602.

<https://doi.org/10.2105/AJPH.2020.305914>

► **Intelligence artificielle et travail des données**

GUEYDIER P.
2020

Revue d'éthique et de théologie morale 307(3): 29-41.

<https://www.cairn.info/revue-d-ethique-et-de-theologie-morale-2020-3-page-29.htm>

Le terme de « donnée », omniprésent dans les débats sur l'intelligence artificielle, induit une sorte de dimension naturelle au détriment des processus et des acteurs qui lui ont donné naissance et la gouvernent. Les big data et l'intelligence artificielle recherchent

une modélisation des comportements sociaux qui se concrétisera, au cours des années 2010, par la théorie du nudge comme convergence entre données, algorithmes apprenants et objectifs politico-sociaux. Le réductionnisme de cette ingénierie sociale croit possible et souhaitable la réification des relations

humaines. Ainsi, seule une action externe permettrait de « changer la société » ; la créativité et le pluralisme des acteurs impliqués n'étant pas suffisants. Conception que l'on peut qualifier de dépolitisée voire déshumanisée des rapports sociaux.

Politique de santé

Health Policy

► Personalised Medicine And The State: A Political Discourse Analysis

BURAU V., NISSEN N., TERKILDSEN M. D., *et al.*
2021

Health Policy 125(1) :122-125

<https://doi.org/10.1016/j.healthpol.2020.10.005>

The last decade has seen a range of health policy initiatives relating to personalised medicine. There is an emerging body of studies that demonstrates the continued importance of states in the development of personalised medicine. This paper contributes to this literature by focusing on how political discourses construct the role of states in personalised medicine. Based on a case study of the introduction of a national programme in Denmark, the analysis identifies specific discursive mechanisms in this construction. The material consists of documents from key national stakeholders, media coverage and interviews with experts at the national level. The analysis found three types of discursive mechanisms. Firstly, mechanisms can relate to problem definitions, and these were concerned with a number of salient problems of health services. Secondly, mechanisms can relate to underlying assumptions, and these were about the possibility of engineering healthcare improvement through data and by extension personalised medicine. Thirdly, mechanisms can relate to discursive effects, and here the state emerged as a highly influential governor. These mechanisms are likely to be highly relevant for other countries, but future research needs to test this. Health policy practitioners and health administrators thus need to invest effort into influencing political discourses around personalised medicines, in addition to the formulation of policies itself.

► La loi Evin de régulation du marketing de l'alcool. Quelle efficacité dans le cas de publicités/packagings orientés luxe vs. produit ?

DIOUF J. F. ET GALLOPEL-MORVAN K.
2020

Journal de gestion et d'économie de la santé 3(3): 123-153.

<https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2020-3-page-123.htm>

En France, la loi Evin (1991) impose que les publicités pour des marques d'alcool présentent ces produits de manière objective et informative. En termes de santé publique et de marketing social, cette recherche questionne l'intérêt d'une telle régulation pour protéger les jeunes de l'attractivité et de l'envie de consommer de l'alcool. Sur le plan théorique, elle teste son effet sur les différentes variables de la persuasion publicitaire (croyances, intentions, etc.). Méthode : 26 entretiens individuels semi-directifs ont été menés sur des jeunes (15-29 ans) exposés à des packagings et publicités pour marques d'alcool dont le contenu était objectif (conformément à la loi Evin : stimuli « produit ») ou connoté luxe (stimuli « luxe »). Les questions posées aux répondants étaient relatives à l'attractivité de ces stimuli, à l'envie d'acheter, etc. Les données ont été traitées via une analyse de contenu thématique manuelle et le logiciel NVIVO. Résultats : Les différentes variables de la persuasion publicitaire sont stimulées dans un sens défavorable à la santé publique dès lors que les stimuli sont « luxe » : attention, évocations, qualité perçue, attractivité, image perçue du consommateur, envie d'acheter le produit présenté. Conclusion : Ces résultats montrent que le contenu publicitaire influence la motivation à traiter le message via les routes cognitive et affective de la persua-

sion. La régulation des messages commerciaux pour les marques d'alcool (Loi Evin) apparaît alors pertinente pour limiter l'influence, sur les jeunes, des publicités diffusées par les industriels de l'alcool.

► **Réforme des études de santé : quel système de formation pour les futurs médecins ?**

FIDEL D.
2020

Médecins : Bulletin De L'ordre National Des Médecins (Le) (69): 18-24.

En septembre 2020, la Paces disparaît au profit de deux nouvelles voies d'accès aux études médicales : le PASS et la LAS. Cela signe également la fin du numerus clausus, remplacé par un numerus apertus, plus souple et territorial. La réforme du deuxième cycle - qui sera mise en place à la rentrée 2022 - vise essentiellement à garantir un meilleur équilibre entre enseignement des connaissances et développement des connaissances. Le troisième cycle des études de santé sera désormais rythmé en trois phases, pour une autonomisation et une responsabilité progressive des futurs médecins. La troisième phase s'accompagne désormais d'un nouveau statut de docteur junior.

► **Agences régionales de santé : mission impossible**

PIERRU F.
2020

Revue française d'administration publique 174(2): 385-403.

<https://www.cairn.info/revue-francaise-d-administration-publique-2020-2-page-385.htm>

Créées en 2010, issues d'une fusion des services déconcentrés de l'État et des services régionaux de l'assurance maladie, les agences régionales de santé (ARS) sont, depuis la crise dite des « gilets jaunes » et, surtout, la pandémie de Covid-19, sur la sellette. À rebours des analyses de type ingénierie administrative, cet article cherche à comprendre la fragilité de ces fausses agences en les ré-encadrant dans leur environnement économique, social et politique. Il souligne en particulier que les ARS sont dans une position structurellement intenable entre l'État central, entré en mode de consolidation budgétaire depuis 2010, et des acteurs « territoriaux » qu'elles ont pour charge de tenir et de piloter à distance. De plus, déjà mal dotées en moyens humains et matériels, elles ont subi le rabot budgétaire alors que leurs missions sont des plus larges. Cet article est donc la chronique de l'échec programmé d'agences n'ayant pas les moyens de répondre aux attentes d'une société sécularisée et politiquement désenchantée pour qui la protection de la vie est devenue une sorte d'idéologie de remplacement.

Politique publique

Public Policy

► **Stratégies numériques de diffusion auprès des décideurs, des résultats des chercheurs en santé publique**

MONTAGNI I., STAHL-TIMMINS W., MONNERAUD L.,
et al.
2019

Les Enjeux de l'information et de la communication 20/2(2): 27-42.

<https://www.cairn.info/revue-les-enjeux-de-l-information-et-de-la-communication-2019-2-page-27.htm>

L'élaboration de politiques fondées sur des données probantes est un phénomène de plus en plus répandu

qui encourage les chercheurs et les décideurs à communiquer efficacement entre eux. Les médias digitaux sont censés faciliter les échanges entre les deux acteurs, mais leur disponibilité et leur utilisation n'ont pas encore été examinées en détail. Avec une approche interdisciplinaire, cet article vise à fournir une taxonomie des médias digitaux utilisés par les chercheurs et les décideurs pour partager leurs connaissances dans le domaine spécifique de la santé publique. Dans le cadre de la digital health communication, nous décrivons le web classique, le web 2.0 ainsi que six autres médias digitaux (hypertexte, images, vidéos, audio, infographie et jeux) à disposition des chercheurs et des

décideurs en santé. Ensuite, nous discutons des risques et des possibilités liés à la vulgarisation scientifique en ligne pour l'élaboration des politiques de santé. Enfin, nous formulons des recommandations fondées sur la

théorie et sur la pratique destinées aux chercheurs afin qu'ils diffusent au mieux les résultats de leurs recherches sur la santé aux décideurs via Internet.

Politique sociale

Social Policy

► **Quelques remarques sur les mesures d'adaptation de la protection sociale liées à la crise de la Covid-19**

ELBAUM M.
2020

Regards 57(1): 37-44.

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

Particulièrement mises en lumière à l'occasion de la crise sanitaire du coronavirus, les réalités et les difficultés du secteur du grand âge appellent des révisions conséquentes. Ce dossier de Regards présente ce que développe la protection sociale, ce qu'observent et proposent des gériatres et des gérontologues, mais aussi ce qui s'innove à travers le monde. Les réflexions portent sur l'assurabilité de la dépendance, sur l'organisation des parcours selon les attentes, les besoins, les configurations territoriales. Une clé d'entrée consiste à envisager les vulnérabilités des personnes âgées également comme gisement pour de nouvelles idées et activités. L'ambition générale vise la prévention de la perte d'autonomie, en agissant notamment au moment du passage à la retraite, en luttant contre l'isolement, en aidant à adapter les pratiques alimentaires. Tout ceci au service d'un bien-vieillir. Les chocs de l'épidémie de Covid-19 et du confinement commandent des observations sur les impacts pour la protection sociale. L'ensemble de l'édifice a été bousculé, financièrement et matériellement. S'occupant des premiers concernés, amortissant les secousses économiques et soutenant l'activité, le système – dont les soignants ont été applaudis – a su réagir. Les questions d'avenir sont cependant lourdes. Le thème mérite bien un second dossier dans cette livraison de la revue.

► **Réforme de la protection sociale et prise en compte de la diversité des trajectoires individuelles**

GAZIER B.
2020

Informations sociales 201(1): 46-56.

<https://www.cairn.info/revue-informations-sociales-2020-1-page-46.htm>

Les tendances à la fragmentation de l'emploi mettent au défi notre système de protection sociale largement fondé sur l'accès à l'emploi stable. Cet article résume les apports et limites du système existant, puis évoque les grandes options de réforme actuellement discutées et, enfin, propose quelques principes autour desquels pourrait s'organiser un nouveau système cohérent et solidaire.

► **Le revenu de base dans un monde fini**

GIRAUD G.
2020

Études (12): 53-66.

<https://www.cairn.info/revue-etudes-2020-12-page-53.htm>

Dans un contexte de crise sociale croissante et face à la nécessaire transformation écologique de nos sociétés, la question du revenu universel doit être examinée à frais nouveaux, indépendamment du mythe de la robotisation du monde. C'est, en bien des cas, un moyen d'assurer un travail digne pour le plus grand nombre, qui permet aux plus défavorisés d'échapper à l'ubérisation du marché de l'emploi. Des expérimentations montrent que sa mise en œuvre peut être profitable à la société.

Prevention

► **Des formes différenciées de réception d'actions de prévention de l'obésité. L'exemple d'un programme de sport-santé à destination d'étudiants obèses**

KNOBÉ S.

2020

Revue française des affaires sociales(3): 51-67.

<https://www.cairn.info/revue-francaise-des-affaires-sociales-2020-3-page-51.htm>

Depuis les années 2000 en France, de nombreuses actions de prévention de l'obésité ont été développées et mises en œuvre à différentes échelles territoriales. Elles encouragent la modification des pratiques sur les plans alimentaire et physique, et s'adressent à différents publics, adultes ou enfants, par la diffusion de normes corporelles légitimes. En matière d'activité physique, des seuils de durée et d'intensité de pratique hebdomadaire sont recommandés. Mais comment la participation à de telles actions préventives est-elle vécue par les bénéficiaires ? Grâce à une enquête qualitative auprès d'une dizaine d'étudiants, cet article interroge la réception sociale des pratiques physiques proposées dans le cadre d'un programme de sport-santé. Les résultats mettent en évidence différentes formes de réception, illustrées par les portraits de quatre étudiantes, tenant compte des socialisations sportives antérieures, des pratiques effectives, de leur évolution et du sens que les étudiantes leur attribuent. La participation apparaît comme une ressource variable – physique, subjective, transitionnelle ou de consolidation – selon les formes de réception observées.

► **Categories Of Systematic Influences Applied To Increase Cancer Screening Participation: A Literature Review And Analysis**

RAHBK O. J., JAUERNIK C. P., PLOUG T., *et al.*

2020

European Journal of Public Health(Ahead of pub).

<https://doi.org/10.1093/eurpub/ckaa158>

Health authorities can influence citizens in subtle ways that render them more likely to participate in cancer screening programmes, and thereby possibly increase

the beneficial effects. If the influences become too severe, the citizens' ability to make a personal choice may be lost on the way. The purpose of this analysis was to identify and categorize the influences while questioning whether they still permit the citizens to make their own choices regarding participation. A two-stringed approach was used to obtain empirical examples of systematic influences that aim to raise participation rates in cancer screening programmes: First, a systematic literature search was conducted on three databases. Second, relevant experts were contacted via internationally based e-mail lists and asked for examples of systematic influences in cancer screening. The present analysis was based on direct, conventional content analysis to address different categories of systematic influences. The literature search yielded 19 included articles and the expert inquiry yielded 11 empirical examples of which content analysis of the empirical examples generated six major categories of systematic influence: (i) misleading presentation of statistics, (ii) misrepresentation of harms vs. benefits, (iii) opt-out systems, (iv) recommendation of participation, (v) fear appeals and (vi) influencing the general practitioners and other healthcare professionals. The six categories of identified influences work through psychological biases and personal costs and are still in widely use. The use of these types of influence remains ethically questionable in cancer screening programmes since they might compromise informed decision making.

► **L'accompagnement du patient dans la pratique pharmaceutique : point sur les dispositifs formalisés**

RENET S., CORNILLET N., HUON J. F., *et al.*

2020

Annales Pharmaceutiques Françaises 78(6): 525-533.

<https://doi.org/10.1016/j.pharma.2020.06.004>

L'évolution de la prise en charge des patients a conduit le pharmacien à changer de posture et se rendre au plus près du patient. Afin d'assurer au mieux cette prise en charge, plusieurs dispositifs éducatifs et d'accompagnement sont apparus : « conseils », « consultations » et « entretiens pharmaceutiques », « bilan de médication partagé » ou encore « éducation thérapeutique

du patient ». Tous ces dispositifs ont pour objectif « de garantir les meilleures conditions d'initiation, de suivi et d'observance et d'évaluation du traitement », en prenant en compte les désirs et besoins des patients. Bien qu'ils comportent des similitudes, des différences significatives existent (c'est-à-dire, réglementaires, fonctionnelles, organisationnelles, éducationnelles). L'objectif est ici de clarifier les différents dispositifs d'accompagnement afin de mieux connaître leurs champs d'application et les mettre en pratique.

► **Optimisation des entretiens pharmaceutiques à l'officine – Bilan et retour de cette mission mise en place en 2013 et perspectives de développement dans le département du Calvados**

ROUX C., FAGUAI E., EMO P., *et al.*

2020

Annales Pharmaceutiques Françaises 78(6): 487-496.

<https://doi.org/10.1016/j.pharma.2020.06.006>

Les entretiens pharmaceutiques ont été mis en place en France en 2013 suite à la signature de l'avenant no 1 de la convention nationale des pharmaciens signée en 2012. Ces entretiens doivent être menés dans un espace de confidentialité en pharmacie ou au domicile du patient. Cette démarche a pour objectif de diminuer la fréquence des effets indésirables des traitements médicaux (anti-vitamines K, anticoagulants oraux directs et corticoïdes inhalés) et d'améliorer l'utilisation pour garantir la sécurité du patient. Cette mission valorise également l'expertise du pharmacien qui est rémunérée par les caisses primaires d'assurance maladie à hauteur de 50 euros par an et par patient. L'étude effectuée, sur la base d'un sondage et d'entretiens individuels, a permis dans un premier temps de faire un état des lieux de la mission sur la totalité du calvados. Cette étape a permis de relever que les entretiens pharmaceutiques étaient proposés par 40 % des pharmacies seulement; une forte tendance à la baisse a aussi été observée dans 85 % de ces officines depuis 2013. Cependant, 8 pharmaciens sur 10 ont reconnu un réel bénéfice des entretiens pharmaceutiques pour leurs patients. De nouvelles initiatives sont prises et des entretiens non conventionnés sont également de plus en plus effectués (tabac, suivi de grossesse, diabète...). Ces constats nous ont encouragés à rechercher les causes de la non-pratique des entretiens pharmaceutiques. Elles ont été identifiées, quantifiées, analysées et classées pour permettre de proposer des axes d'optimisation à la fois adaptés et

réalisables financièrement à court, moyen et long terme. Neuf propositions concrètes ont été exposées selon trois axes principaux d'amélioration : la communication, la rémunération et l'organisation.

► **Rapport 19-07. Rapport sur l'évolution des programmes de dépistage « organisé » des cancers du sein, du côlon et du rectum, et du col utérin, en France**

SANCHO-GARNIER H., TRIBOULET J. P., VILLET R., *et al.*

2019

Bulletin de l'Académie Nationale de Médecine 203(8): 641-652.

<https://doi.org/10.1016/j.banm.2019.10.005>

Le dépistage des cancers est une démarche de santé publique pour réduire la mortalité d'un cancer donné. L'intervention identifie les porteurs probables de ce cancer par un « test » proposé à une population asymptomatique dont la majorité des individus ne sont pas porteurs de ce cancer. Le bénéfice du dépistage s'objective par la baisse de la mortalité due au cancer ciblé dans la population testée. Les effets indésirables (faux positifs, examens et traitements inutiles, faux négatifs...) doivent aussi être mesurés afin de s'assurer que les bénéfices sont supérieurs aux effets négatifs. Ces données ne sont connues et gérables que dans le cadre d'un programme organisé. À l'heure actuelle, seuls les cancers du sein, du colon-rectum et du col de l'utérus satisfont à ces principes et font l'objet d'un dépistage organisé en France. Cette balance bénéfice/risque doit être estimée régulièrement, car elle se modifie avec le temps en raison des acquis médicaux (nouveaux tests...) ou de modifications épidémiologiques (nouvelles populations atteintes...). En conséquence, cette évaluation doit entraîner une interrogation régulière sur les programmes en cours et une mise en place rapide des ajustements nécessaires. Dans l'état actuel des évaluations, en ce qui concerne les cancers du sein, seul le dépistage organisé (DO) est préconisé en France de 50 à 74 ans; le taux actuel de participation (50 %) devrait être stimulé pour atteindre 70 %. La détection individuelle (hors DO), avant ou après 50 ans, non justifiée par un risque familial ou un symptôme doit être clairement déconseillée. Les travaux de recherche pour un meilleur ciblage de la population soumise au dépistage doivent être soutenus. En ce qui concerne les cancers colorectaux, le dépistage doit avant tout être mieux ciblé sur une tranche d'âge plus efficiente soit : 55-75 chez les hommes et 60-80 chez les femmes.

Sous peine de rester inefficace, le taux de participation doit être au moins doublé par diverses mesures d'organisation dont la prise en charge totale du reste à payer. La possibilité d'utiliser d'autres tests doit être également évaluée. Enfin pour les cancers du col de l'utérus où le dépistage par frottis cervical a largement démontré son efficacité, il reste à convaincre les 40 % de femmes non participantes. Dans ce but il faut mettre en place des mesures adaptées : élargissement des habilitations à prélever (infirmières...), utilisation

des tests HPV, remboursement du reste à charge... Par ailleurs grâce à l'existence d'un vaccin efficace ce cancer pourrait être éradiqué. Malheureusement actuellement plus de 70 % des jeunes filles françaises ne sont pas vaccinées; il est capital d'augmenter la couverture vaccinale en luttant contre les lobbies anti-vaccin, en vaccinant les garçons (évacuation de porteurs de virus et prévention des cancers buccaux et oropharyngés), et en intégrant l'information sur les virus HPV dans le programme d'éducation sanitaire à l'école.

Prévision – Evaluation

Prevision - Evaluation

► **Death By Austerity? The Impact Of Cost Containment On Avoidable Mortality In Italy**

ARCÀ E., PRINCIPE F. ET VAN DOORSLAER E.
2020

Health Economics 29(12): 1500-1516.

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4147>

Does austerity in health care affect health and health-care outcomes? We examine the intended and unintended effects of the Italian austerity policy Piano di Rientro aimed at containing the cost of the health-care sector. Using an instrumental variable strategy that exploits the temporal and geographical variation induced by the policy rollout, we find that the policy was successful in alleviating deficits by reducing expenditure, mainly in the southern regions, but also resulted in a 3% rise in avoidable deaths among both men and women, a reduction in hospital capacity and a rise in south-to-north patient migration. These findings suggest that—even in a high-income country with relatively low avoidable mortality like Italy—spending cuts can hurt survival.

► **Perception du malade chronique chez les professionnels de santé : une évolution marquée par les indicateurs d'évaluation de programmes d'éducation thérapeutique du patient entre 2011 et 2017 au CHU de Clermont-Ferrand, France**

CHERILLAT M. S., BERLAND P., ODOUL J., *et al.*
2020

Revue d'Épidémiologie et de Santé Publique(Ahead of pub).

<https://doi.org/10.1016/j.respe.2020.10.007>

Depuis 2010, en France, les programmes d'éducation thérapeutique du patient (ETP) sont soumis à autorisation par l'Agence régionale de santé (ARS). Tous les quatre ans, les programmes sont obligatoirement réévalués, ce qui implique la possibilité de changer les critères utilisés pour gérer chaque programme. Dans notre hôpital, nous étudions l'évolution des indicateurs d'évaluation d'ETP dans 17 programmes qui ont été autorisés et renouvelés au moins une fois par l'ARS. Méthode L'ensemble des indicateurs d'évaluation de programmes d'ETP est classé en structure, processus, résultats et sont aussi considérés l'activité du programme, les indicateurs pédagogiques et psychosociaux, ainsi que les indicateurs biocliniques. Nous avons étudié si les indicateurs étaient complétés, utilisés et à la fin, reconduits ou créés pour le renouvellement des programmes. Les tests statistiques ont été utilisés afin de comparer les changements du nombre d'indicateurs dans chaque catégorie avant et après le processus de renouvellement. Résultats À la première autorisation, il y a eu 533 indicateurs, et 550 à la deuxième. Les changements concernent la réduction du nombre d'indicateurs de résultats (43,7 % à 35,1 %), alors que les indicateurs de processus augmentent (36,8 % à 43,1 %) ($p=0,0141$). La catégorie d'indicateurs la plus collectée (55,5 %) est la catégorie activité du programme (54,7 %) en comparaison à la catégorie des indicateurs pédagogiques et psychosociaux et des indicateurs biocliniques ($p<0,0001$). La catégorie activité du programme augmente au cours des renou-

vementements (67,6 %) ($p=0,0002$). Les indicateurs pédagogiques et psychosociaux ne sont pas collectés, ou très peu. Parmi les indicateurs pédagogiques et psychosociaux, il existe une importante augmentation des indicateurs relatifs aux compétences et changements en faveur de comportements favorables à la santé. Les indicateurs strictement biocliniques sont abandonnés au profit d'indicateurs en lien avec l'évolution de la maladie, son impact et la gestion des risques. Conclusion L'importance donnée aux indicateurs de processus et de structure traduit le fait que les indicateurs sont structurés en grande partie par les demandes de l'ARS. Même si cette première étude est à approfondir, elle montre une évolution dans la conception des évaluations pédagogiques et psychosociales chez les professionnels de santé, susceptible de traduire un intérêt de ces professionnels de santé pour la manière dont les patients gèrent leur maladie, leur mode de vie et leur quotidien

► **A Scoping Review Of Qualitative Research On Perceptions Of One's Own Alcohol Use**

MORRIS S., STEWART D., MADDEN M., *et al.*

2020

European Journal of Public Health(Ahead of pub).

<https://doi.org/10.1093/eurpub/ckaa211>

This scoping review aims to map the extent, range and nature of qualitative research on people's 'perceptions' of their own alcohol consumption. A systematic search of five electronic databases was conducted. A total of 915 abstracts were screened and 452 full texts examined, of which 313 papers met the inclusion criteria (including a report of qualitative data on perceptions, experiences or views of people's own drinking in peer-reviewed journals published in English). This study maps the available literature assembled over approximately 30 years, which was found to be extensive and diverse. Many existing studies are focused largely on people's 'experiences' of their own drinking behaviours, particularly when they were drinking in ways commonly understood as heavy, risky or problematic. Fewer studies focused on populations whose drinking was not heavy or was risky in less obvious ways, such as older adults prescribed medications for chronic health conditions. Most studies were conducted since 2010, with the rate of publications increasing since 2014. This review identifies gaps in the evidence regarding people's perceptions of their own drinking and opportunities for qualitative studies to make valuable contributions to alcohol research. Gaps discussed

include patterns of drinking that are less obviously problematic, and in relation to consumption of alcohol in those parts of the world where overall consumption and harms from alcohol are high. Such studies could usefully be informed by existing studies in the evidence mapping.

► **A Systematic Review Of Economic Evaluations Of Public Health Interventions Targeting Alcohol, Tobacco, Illicit Drug Use And Problematic Gambling: Using A Case Study To Assess Transferability**

NYSTRAND C., GEBRESLASSIE M., SSEGONJA R., *et al.*
2020

Health Policy 125(1) :54-74

<https://doi.org/10.1016/j.healthpol.2020.09.002>

The aim of this study is to and assess the cost-effectiveness of public health interventions targeting the use of alcohol, illicit drugs and tobacco, as well as problematic gambling behavior (ANDTS), and consider whether the results from these evaluations are transferable to the Swedish setting. Methods A systematic review of economic evaluations within the area of ANDTS was conducted including studies published between January 2000 and November 2018, identified through Medline, PsychINFO, Web of Science, the National Health Service Economic Evaluation Database and Health Technology Assessment. The quality of relevant studies and the possibilities of transferring results were assessed using criteria set out by the Swedish Agency for Health Technology Assessment. Results Out of 54 relevant studies, 39 were of moderate to high quality and included in the review, however none for problematic gambling. Eighty-one out of a total of 91 interventions were cost-effective. The interventions largely focusing on taxed-based policies or screening and brief interventions. Thirteen of these studies were deemed to have high potential for transferability, with effect estimates considered relevant, and with good feasibility for implementation in Sweden. Conclusions Interventions targeting alcohol- and illicit-drug use and tobacco use are cost-effective approaches, and results may be transferred to the Swedish setting. Caution must be taken regarding cost estimates and the quality of the evidence which the studies are based upon.

Psychiatry

► **Évolution et enjeux à venir de la pair-aidance dans le champ de la psychiatrie en France**

BERTAUD E.
2020

L'Évolution Psychiatrique(Ahead of pub).
<https://doi.org/10.1016/j.evopsy.2020.10.006>

À un moment charnière de son évolution en France dans le champ de la psychiatrie - entre premières expérimentations et recherche d'une officialisation de sa professionnalisation - il s'agira d'interroger la pair-aidance dans ses enjeux à venir. Méthode La synthèse des écrits concernant le mouvement d'intégration de la pair-aidance en psychiatrie laisse apparaître une place toujours plus grande accordée à cette pratique dans les textes officiels et recommandations de santé mentale, mais également des questionnements liés principalement au positionnement de ces nouveaux professionnels au sein des équipes. L'étude de l'évolution des concepts sur lesquels se fonde la pair-aidance peut également donner une idée de son avenir possible au sein du champ de la psychiatrie. Résultats Si des mouvements militants se soutenant de l'empowerment ont connu au cours de leur histoire un mouvement de disempowerment, il est à penser que la pair-aidance en psychiatrie devra également faire face à cette évolution. Discussion L'enjeu est de permettre que survive, à la formalisation des interventions des pair-aidants et à leur professionnalisation, la vivacité d'un discours initial. Conclusions Une réflexion actuelle sur la pair-aidance permet d'interroger la façon dont se conçoit actuellement le rapport à l'autre en psychiatrie.

► **Discrimination et stigmatisation des patients psychotiques dans les soins somatiques**

BOUGEROL C., CHARLES R., BALLY J. N., *et al.*
2020

Médecine : De La Médecine Factuelle a Nos Pratiques 16(7): 305-308.

Les patients psychotiques souffrent de discrimination dans la société, mais également auprès des professionnels de santé. Cette stigmatisation peut conduire

à un biais de raisonnement diagnostique et à des soins sub-optimaux. Pour lutter contre cette discrimination, certains centres mettent en place des adaptations du système de soins, notamment ambulatoires

► **Depression In Women And Men, Cumulative Disadvantage And Gender Inequality In 29 European Countries**

BRACKE P., DELARUELLE K., DEREUDDRE R., *et al.*
2020

Social Science & Medicine 267: 113354.
<https://doi.org/10.1016/j.socscimed.2020.113354>

Macro-sociological theories stress the contribution of gender inequality to this gender gap in depression, while cumulative advantage/disadvantage theory (CAD) reminds us that mental health inequalities accumulate over the life course. We explore the complementarity of both perspectives in a variety of European countries using data of the European Social Survey (2006 2012, 2014, N of countries = 29; N of men = 53,680 and N of women = 63,103) and using an 8-item version of the CES-D. Results confirm that the relevance of gender stratification for the mental health of women and men in Europe depends on age. The gender gap is nearly absent amongst adults in their twenties in the most gender equal countries, while an impressive gender gap is present amongst older adults in gender unequal countries, in accordance with CAD theory. These effects occur on top of the mental health consequences of taking up work and family roles at various life stages. The convergence of the results predicted by gender stratification and cumulative disadvantage theories strengthen the case for the link between gender, disadvantage and depression.

► **Association Of Continuity Of Care With Readmission, Mortality And Suicide After Hospital Discharge Among Psychiatric Patients**

CHOI Y., NAM C. M., LEE S. G., *et al.*
2020

International Journal for Quality in Health Care 32(9): 569-576.
<https://doi.org/10.1093/intqhc/mzaa093>

The objective of this study was to identify the association between continuity of ambulatory psychiatric care after hospital discharge among psychiatric patients and readmission, mortality and suicide. Nationwide nested case-control study. South Korea. Psychiatric inpatients. Continuity of psychiatric outpatient care was measured from the time of hospital discharge until readmission or death occurred, using the continuity of care index. Readmission, all-cause mortality and suicides within 1-year post-discharge. Of 18 702 psychiatric inpatients in the study, 8022 (42.9%) were readmitted, 355 (1.9%) died, and 108 (0.6%) died by suicide within 1 year after discharge. Compared with the psychiatric inpatients with a high continuity-of-care score, a significant increase in the readmission risk within 1 year after discharge was found in those with medium and low continuity of care scores. An increased risk of all-cause mortality within 1 year after hospital discharge was shown in the patients in the low continuity group, relative to those in the high-continuity group. The risk of suicide within 1 year after hospital discharge was higher in those with medium and low continuity of care than those with high continuity of care. The results of this study provide empirical evidence of the importance of continuity of care when designing policies to improve the quality of mental health care, such as increasing patient awareness of the importance of continuity and implementation of policies to promote continuity.

► **Offre de soins et recours aux hospitalisations psychiatriques en milieu pénitentiaire : une étude observationnelle dans le Nord de la France**

ECK M., PLANCKE L., HORN M., *et al.*

2020

Revue d'Épidémiologie et de Santé Publique 68(5): 273-281.

<https://doi.org/10.1016/j.respe.2020.06.005>

La prévalence des troubles psychiatriques est élevée dans les prisons françaises. Pourtant, l'efficacité des dispositifs de soins en place (unités sanitaires en milieu pénitentiaire [USMP], services médico-psychologiques régionaux [SMRP] et unités d'hospitalisation spécialement aménagées [UHSA]) est peu étudiée. L'objectif principal de cette étude est de décrire, dans les vingt prisons du Nord de la France (Hauts-de-France, Eure, Seine-Maritime), le recours aux hospitalisations psychiatriques à temps complet ainsi que l'offre de soins psychiatriques dans les unités sanitaires de ces éta-

blissements. Méthodes Nous avons réalisé une étude descriptive à partir de bases médico-administratives et de résultats d'enquête. Pour chaque établissement pénitentiaire, pour l'année 2016, les données suivantes ont été collectées : 1) effectifs et taux d'occupation des postes pour les professionnels de la santé mentale et 2) taux d'hospitalisation en psychiatrie (à l'UHSA de Lille-Seclin ou dans les hôpitaux de secteur psychiatrique). Résultats L'offre de soins est incomplète et inégale selon les prisons : 40 % des postes de psychiatres ne sont pas pourvus dans les unités sanitaires étudiées. L'accès à l'UHSA varie considérablement selon l'établissement d'origine : plus celui-ci est éloigné de l'UHSA, moins les personnes incarcérées y sont hospitalisées. Aucune corrélation n'a été retrouvée entre la distance prison-UHSA et le taux d'hospitalisation toute orientation confondue (UHSA et hôpitaux de secteur psychiatrique). Conclusion Malgré les avancées permises par la création des UHSA, l'accès aux soins psychiatriques reste problématique depuis la prison ; ceci s'explique par l'éloignement géographique de certains établissements, le nombre de places limité en UHSA et les effectifs médicaux insuffisants dans les USMP.

► **Measuring The Patient Experience Of Mental Health Care: A Systematic And Critical Review Of Patient-Reported Experience Measures**

FERNANDES S. ET FOND G.

2020

DovePress 14: 2147-2161.

<https://doi.org/10.2147/ppa.s255264>

There is growing concern about measuring patient experience with mental health care. There are currently numerous patient-reported experience measures (PREMs) available for mental health care, but there is little guidance for selecting the most suitable instruments. The objective of this systematic review was to provide an overview of the psychometric properties and the content of available PREMs. METHODS: A comprehensive review following the preferred reporting items for systematic reviews and meta-analysis (PRISMA) guidelines was conducted using the MEDLINE database with no date restrictions. The content of PREMs was analyzed using an inductive qualitative approach, and the methodological quality was assessed according to Pesudovs quality criteria. RESULTS: A total of 86 articles examining 75 PREMs and totaling 1932 items were included. Only four PREMs used statistical methods from item response

theory (IRT). The 1932 items covered seven key mental health care domains: interpersonal relationships (22.6%), followed by respect and dignity (19.3%), access and care coordination (14.9%), drug therapy (14.1%), information (9.6%), psychological care (6.8%) and care environment (6.1%). Additionally, a few items focused on patient satisfaction (6.7%) rather than patient experience. No instrument covered the latent trait continuum of patient experience, as defined by the inductive qualitative approach, and the psychometric properties of the instruments were heterogeneous. **CONCLUSION:** This work is a critical step in the creation of an item library to measure mental health care patient-reported experience that will be used in France to develop, validate, and standardize item banks and computerized adaptive testing (CAT) based on IRT. It will also provide internationally replicable measures that will allow direct comparisons of mental health care systems. **TRIAL REGISTRATION:** NCT02491866.

► **Infirmière en pratique avancée dans le domaine de la psychiatrie. Retour d'expérience d'une faisant fonction IPA en équipe mobile de psychiatrie du sujet âgé : entretien**

GAKOU S.

2020

L'information psychiatrique 96(7): 533-537.

<https://www.cairn.info/revue-l-information-psychiatrique-2020-7-page-533.htm>

Cet article rend compte de l'expérience d'une infirmière qui a débuté en 2002 son exercice en tant qu'infirmière au sein de l'établissement public de santé (EPS) Maison Blanche. Son choix s'est porté sur le domaine de la psychiatrie, discipline qui nécessite une véritable expertise clinique et organisationnelle ainsi que des qualités humaines telles que l'empathie, l'écoute, la bienveillance. Le métier d'infirmier en psychiatrie nécessite de prendre le temps individuellement avec chaque patient. Ce soignant aide l'individu présentant un trouble psychique à découvrir et cerner ses difficultés tout en lui proposant les moyens de les résoudre. La relation de soin créée prend en compte la personne dans sa globalité permettant ainsi de rétablir l'intégrité physique et psychique du patient. Cette pratique correspondait à ses attentes.

► **Soins sans consentement et mesures d'isolement en psychiatrie adulte : où en est-on ? L'exemple de la région Centre-Val de Loire via le Programme de médicalisation des systèmes d'information 2012–2017**

LAURENT O., GODILLON L., BIOTTEAU M., *et al.*

2020

Revue d'Épidémiologie et de Santé Publique 68(3): 155-161.

<https://doi.org/10.1016/j.respe.2020.02.001>

En France, le cadre légal des soins sans consentement a été modifié par les lois de 2011 et 2013 et celui des pratiques d'isolement par la loi de 2016. L'objectif était de décrire l'évolution des modes légaux de soins et des pratiques d'isolement en région Centre-Val de Loire entre 2012 et 2017, à partir des données du RIM-P. Méthodes Ont été sélectionnés les adultes (≥ 18 ans) domiciliés en Centre-Val de Loire et hospitalisés en psychiatrie ou suivis en programme de soins (hospitalisations temps partiel ou consultations) de 2012 à 2017. Le numéro anonyme et l'identifiant permanent du patient ont été utilisés pour le chaînage. Résultats En 2017, 13 942 patients de la région ont été hospitalisés en psychiatrie, dont 2378 en soins sans consentement (17 %), stable depuis 2012. Parmi eux, 3 % avaient des soins en cas de péril imminent (+54 % depuis 2013, stabilisation depuis 2016), et 11 % des soins à la demande d'un tiers (-13 %). Des disparités interdépartementales persistaient. Les mesures d'isolement concernaient 10 % des patients hospitalisés à temps plein (stable), 27 % des patients en soins sans consentement et 3 % des patients en soins libres exclusifs (stable). À noter que 25 % des patients isolés étaient en soins libres exclusifs. Les patients étaient isolés 12 jours en moyenne, consécutifs ou non, un peu moins pour les patients en soins libres exclusifs (10 jours). Conclusion Le taux régional de soins sans consentement et la durée moyenne des isolements étaient inférieurs aux données nationales (24 % SSC en temps plein en 2015; 15 jours d'isolement/patient), alors qu'une augmentation du recours aux soins en péril imminent et la persistance de mesures d'isolement en soins libres (recommandées seulement en dernier recours) étaient retrouvées, devant amener à une analyse des pratiques par les établissements. Les limites du RIM-P sont multiples : absence d'incitation tarifaire, structuration complexe. Les données du registre des pratiques d'isolement et de contention interne aux établissements, complémentaires au PMSI depuis 2018, pourraient permettre une analyse plus fine, notamment pour la contention.

► **Availability And Accessibility Of Primary Mental Health Services For Adolescents: An Overview Of National Recommendations And Services In EU**

MICHAUD P.-A., VISSER A., VERVOORT J. P. M., *et al.*
2020

European Journal of Public Health 30(6): 1127-1133.
<https://doi.org/10.1093/eurpub/ckaa102>

Mental health problems in adolescence can profoundly jeopardize adolescent current and future health and functioning. We aimed to describe existing recommendations and services regarding the delivery of primary mental health care for adolescents in 31 European countries. Data on the availability and accessibility of primary mental health services were collected, as part of the Horizon 2020-funded project Models of Child Health Appraised. One expert from each country answered a closed items questionnaire during years 2017–18. All 31 participating countries had some policy or recommendations regarding the availability and accessibility of primary mental health services for adolescents, but their focus and implementation varied largely between and within countries. Only half of the participating countries had recommendations on screening adolescents for mental health issues and burdens. Merely a quarter of the countries had ambulatory facilities targeting specifically adolescents throughout the whole country. Just over half had some kind of suicide prevention programs. Same-day access to primary care in case of -health emergencies was possible in 21 countries, but often not throughout the whole country. Nineteen countries had strategies securing accessible mental health care for vulnerable adolescents. Overall, around half of European countries had strategies securing access to various primary mental health care for adolescents. They frequently did not guarantee care over the whole country and often tackled a limited number of situations. EU countries should widen the range of policies and recommendations governing the delivery of mental health care to adolescents and monitor their implementation.

► **De l'infirmier de secteur psychiatrique à l'infirmier de pratique avancée en santé mentale et psychiatrie**

PERRIN-NIQUET A.
2020

L'information psychiatrique 96(7): 511-517.
<https://www.cairn.info/revue-l-information-psychiatrique-2020-7-page-511.htm>

La formation d'infirmier de secteur psychiatrique était adaptée à une politique de soin en santé mentale et psychiatrie. La réforme des études infirmières de 1992 a donné un coup d'arrêt à cette formation de spécialité clinique. Les deux réformes d'études, 1992 et 2009, ont diminué très fortement les temps d'enseignements théorique et clinique. Les infirmiers arrivant dans cette discipline manquent de connaissance. Simultanément, de nombreux changements dans les domaines thérapeutique et institutionnel, s'ils sont intéressants par certains aspects, entraînent des difficultés dans le cadre de l'organisation des soins et la réalisation du travail clinique. Dans ce contexte, un nouveau métier apparaît : infirmier de pratique avancée.

► **Le risque d'incarcération des personnes suivies en psychiatrie. Une étude longitudinale rétrospective dans le département français de l'Oise à partir du Recueil d'informations médicalisé en psychiatrie**

PLANCKE L., GONFROY J., LANCELEVÉE C., *et al.*
2020

Revue d'Épidémiologie et de Santé Publique (Ahead of pub).
<https://doi.org/10.1016/j.respe.2020.10.001>

Les personnes présentant des troubles mentaux sont surreprésentées en prison par rapport à la population générale. Dans une étude réalisée en Picardie en 2017, un quart des entrants avaient eu un contact avec un service de psychiatrie avant leur incarcération. En l'absence d'étude de ce type en France, nous avons mené une étude rétrospective dont l'objectif principal était d'estimer la probabilité d'incarcération de personnes souffrant de troubles mentaux. Méthodes En utilisant les bases du Recueil d'informations médicalisé en psychiatrie (RimP), nous avons recherché, parmi les patients majeurs suivis en psychiatrie en milieu libre par l'Établissement public de santé mentale (EPSM) de l'Oise en 2015–2016, ceux qui avaient fait l'objet d'un enregistrement par le Dispositif de soins psychiatriques (DSP) en milieu carcéral, rattaché au même EPSM; cet enregistrement, marqueur d'une incarcération, constituait l'événement étudié. Des analyses de survie (Kaplan-Meier), simples, puis stratifiées, par âge, sexe, antécédents, diagnostic principal et intensité de la prise en charge en milieu libre, ont été menées pour calculer les probabilités d'incarcération. Un modèle de Cox multivarié a été employé en vue d'identifier les facteurs associés à leur incarcération. Résultats

Parmi les 25 029 personnes suivies en psychiatrie par l'EPSM de l'Oise en 2015-2016, 126 avaient connu une incarcération dans l'année suivant leur inclusion dans l'étude, soit une probabilité de 0,45 % (Intervalle de confiance à 95 % : 0,37–0,55 %). Les patients incarcérés étaient plus jeunes (36,6 ans en moyenne versus 44,7 – p t-test < 0,0001), des hommes (96,8 % versus 43,7 % – p < 0,0001), avaient plus d'antécédents de détention (11,1 % versus 0,6 % – p < 0,0001) et d'hospitalisation en psychiatrie (20,6 % versus 10,1 % – p < 0,0001). La probabilité d'incarcération à 12 mois pour la population suivie en psychiatrie était 3,2 fois supérieure au taux de détention de la population majeure de l'Oise, sur la même période. Conclusion Notre étude confirme la surincarcération des personnes présentant des troubles mentaux. Prévu à partir de 2020, le codage de l'identifiant-patient national unique dans tous les actes et séjours décrits dans le RimP, permettra la généralisation de la mesure de l'indicateur proposé à l'ensemble du territoire français.

► **Physician Remuneration Schemes, Psychiatric Hospitalizations And Follow-Up Care: Evidence From Blended Fee-For-Service And Capitation Models**

VU T., ANDERSON K. K., DEVLIN R. A., *et al.*

2021

Social Science & Medicine 268: 113465.

<https://doi.org/10.1016/j.socscimed.2020.113465>

Psychiatric hospitalizations could be reduced if mental illnesses were detected and treated earlier in the primary care setting, leading to the World Health

Organization recommendation that mental health services be integrated into primary care. The mental health services provided in primary care settings may vary based on how physicians are incentivized. Little is known about the link between physician remuneration and psychiatric hospitalizations. We contribute to this literature by studying the relationship between physician remuneration and psychiatric hospitalizations in Canada's most populous province, Ontario. Specifically, we study family physicians (FPs) who switched from blended fee-for-service (FFS) to blended capitation remuneration model, relative to those who remained in the blended FFS model, on psychiatric hospitalizations. Outcomes included psychiatric hospitalizations by enrolled patients and the proportion of hospitalized patients who had a follow-up visit with the FP within 14 days of discharge. We used longitudinal health administrative data from a cohort of practicing physicians from 2006 through 2016. Because physicians practicing in these two models are likely to be different, we employed inverse probability weighting based on estimated propensity scores to ensure that switchers and non-switchers were comparable at the baseline. Using inverse probability weighted fixed-effects regressions controlling for relevant confounders, we found that switching from blended FFS to blended capitation was associated with a 6.2% decrease in the number of psychiatric hospitalizations and a 4.7% decrease in the number of patients with a psychiatric hospitalization. No significant effect of remuneration on follow-up visits within 14 days of discharge was observed. Our results suggest that the blended capitation model is associated with fewer psychiatric hospitalizations relative to blended FFS.

Sociologie de la santé

Sociology of Health

► **Les pratiques de repérage de la situation sociale des patients. Analyse anthropologique de discours de praticiens libéraux**

DESPRÈS C.

2020

Revue d'Épidémiologie et de Santé Publique 68(4): 235-242.

<https://doi.org/10.1016/j.respe.2020.06.001>

Des études montrent une différenciation des soins, parfois une discrimination en fonction des catégories sociales qui contribuent à la production d'inégalités. En miroir, quand le système de santé traite également tous les patients, qu'il n'intègre pas leurs difficultés, on parle d'inégalités par omission, ce qui a amené des acteurs de santé publique à préconiser de recueillir systématiquement la situation sociale des patients. L'objectif de l'article est d'analyser les pratiques de

recueil de la situation socioéconomique des patients et leurs conséquences. Méthodes Elles reposent sur plus de 50 entretiens semi-directifs auprès de médecins et dentistes libéraux. Ils ont fait l'objet d'une analyse socio-anthropologique des discours. Résultats La situation sociale est évaluée de manière proactive chez quelques-uns par le biais de questions systématiques, chez d'autres, selon des critères subjectifs et indirects. Elle est très souvent ignorée, par désintérêt, et plus rarement par choix pour se protéger de risques de stigmatisation des patients les plus démunis. Différentes logiques président à ces attitudes : sélectives, d'égalité, d'équité, relationnelles, de protection identitaire. Lorsqu'il y a repérage, la justification essentielle est d'ajuster le parcours de soins à d'éventuels obstacles économiques. Conclusion Pour les praticiens qui cherchent à connaître la situation sociale des patients, la justification principale est d'adapter le parcours de soins aux obstacles financiers. Dans la majorité des cas, les critères sont subjectifs et indirects. Ces pratiques introduisent de l'arbitraire là où l'Etat avait cherché à produire de la justice sociale. Les questionnements systématiques peuvent constituer une violence symbolique supplémentaire pour des personnes fréquemment disqualifiées et portent le risque de l'assignation de stéréotypes, voire de préjugés mais ils peuvent survenir en l'absence de questionnements et de manière inconsciente. De plus, si le médecin passe à côté de problématiques sociales qui peuvent générer des obstacles à se soigner, il ne pourra pas ajuster ses soins. Certains praticiens ont insisté sur la temporalité du questionnement, sa contextualisation, dans un cadre relationnel de confiance.

► **Introduction - Conflits d'intérêts et santé publique : l'apport des sciences sociales**

HAURAY B.
2020

Sciences sociales et santé 38(3): 5-19.

<https://www.cairn.info/revue-sciences-sociales-et-sante-2020-3-page-5.htm>

Au cours des dernières décennies, la catégorie de « conflit d'intérêts » s'est imposée comme la modalité essentielle de problématisation de l'influence des intérêts particuliers, tout particulièrement économiques, sur les savoirs, pratiques et politiques sanitaires et de mise en cause des dangers qu'elle peut représenter pour la santé publique (Hauray, Henry et Dalgalarrondo, 2015). De la gestion de la pandémie de grippe H1N1 (et plus récemment de Covid-19) au maintien sur le

marché du Mediator, de l'évaluation des risques du glyphosate à la question de l'étiquetage des informations nutritionnelles des produits alimentaires, elle s'est largement imposée auprès de lanceurs d'alerte, de collectifs engagés dans la dénonciation de l'usage de certains produits, de scientifiques récusant les conclusions d'articles scientifiques ou d'expertises, ou auprès de journalistes enquêtant sur des décisions publiques. Ce phénomène n'est pas spécifique à la France. Dès 2009, un influent rapport de l'Institute of Medicine américain affirmait dans sa préface : « Il est rare qu'il ne se passe une semaine sans une histoire dans les médias sur les conflits d'intérêts » (Lo et Field, 2009 : xi). Cette catégorie vise, dans sa définition dominante, des situations dans lesquelles les jugements ou les actions d'un professionnel concernant son intérêt premier (notamment soigner son patient, produire des savoirs ou des expertises valides, prendre des décisions de santé publique) risquent d'être induit ment influencés par un intérêt qualifié de second.

► **« Ces patients qui ne font pas ce qu'il faut ». Étude des impacts de la moralité sanitaire dans la prise en charge des corps malades en oncologie**

LORETTI A.
2020

Revue française des affaires sociales(3): 33-49.

<https://www.cairn.info/revue-francaise-des-affaires-sociales-2020-3-page-33.htm>

La santé publique s'intéresse de manière croissante aux comportements individuels. De plus en plus d'interventions visent à favoriser des « conduites vertueuses » et à transformer les comportements. Si ces politiques sont considérées comme éthiquement justifiées parce qu'elles agissent pour le « mieux-être » de la population, elles font aussi l'objet de critiques liées à leur normativité et certains chercheurs ont pu décrire la santé publique comme une entreprise de moralisation des comportements de santé. À partir d'une enquête par observations et entretiens portant sur la prise en charge de patients atteints de cancers, cet article propose de traiter des conséquences pratiques de la moralité sanitaire en oncologie. Plus précisément, nous nous intéresserons à la réception des normes de « bonne gestion » de son corps par les patients et les soignants, puis nous nous pencherons sur leur traduction dans la prise en charge des corps malades.

► **Fondamentaux des soins : un cadre et un processus pratique pour répondre aux besoins physiques, psychosociaux et relationnels des personnes soignées**

REY S., SAVOIE C., VOYER P., *et al.*

2020

Recherche en soins infirmiers 142(3): 7-30.

<https://www.cairn.info/revue-recherche-en-soins-infirmiers-2020-3-page-7.htm>

Depuis 2008, un regroupement international soutient la promotion d'une meilleure réponse aux besoins fondamentaux des personnes soignées. Ce regroupement propose un cadre sur les fondamentaux des soins. Ce cadre est centré sur la relation entre l'infirmier, la personne soignée et ses proches ainsi que sur la réponse aux besoins physiques, psychosociaux et relationnels. Un processus pratique soutient l'application concrète de ce cadre. Le but de cet article discursif est de présenter la traduction française du cadre des fondamentaux des soins et de son processus pratique. Pour commencer, le processus de traduction sera brièvement expliqué. Ensuite, le cadre sur les fondamentaux des soins et les étapes de son processus pratique seront présentés. Afin de permettre une meilleure appropriation du contenu par le lecteur, une illustration clinique présente la situation de M. Perron, atteint d'une maladie d'Alzheimer, et de sa conjointe, qui est sa proche aidante. Enfin, la discussion aborde l'utilité du cadre des fondamentaux des soins et de son processus pratique au niveau des quatre grands axes de la discipline infirmière, soit la pratique, la gestion, la formation et la recherche. Cet article ouvre la voie au développement de connaissances sur les fondamentaux des soins au niveau de la francophonie.

► **L'intelligence artificielle peut être utile pour l'exercice de la médecine. Pourrait-elle améliorer la relation malade-médecin ?**

ROUY J. L. ET ABRAMOVICI F.

2020

Médecine : De La Médecine Factuelle a Nos Pratiques 16(8): 340-342.

Cette possibilité de remplacer le médecin par une machine n'est pas née par hasard : dans des domaines, encore limités aujourd'hui, la question se pose déjà. Des résultats, par exemple, de dépistage de certains cancers, d'examen en dermatologie, en échographie, en ophtalmologie etc. commencent à être comparés

entre médecin et ordinateur. Les conclusions laissent parfois penser que la machine pourrait faire aussi bien, sinon mieux que le médecin. Il ne s'agit probablement là que d'un début. Pourquoi des patients accepteraient-ils des résultats d'un médecin s'ils savent qu'une machine est plus fiable ? Pourquoi, dans ces conditions, ces mêmes patients ne pourraient-ils pas exiger d'avoir l'avis de la machine plutôt que celui du médecin ? Quelques aménagements déontologiques sont à prévoir.

► **Comprendre la méfiance vis-à-vis des vaccins : des biais de perception aux controverses**

WARD J. K. ET PERETTI-WATEL P.

2020

Revue française de sociologie 61(2): 243-273.

<https://www.cairn.info/revue-francaise-de-sociologie-2020-2-page-243.htm>

En France comme ailleurs, les autorités de santé sont aujourd'hui confrontées à une défiance inédite des populations à l'égard de la vaccination. Pour appréhender ce phénomène, les chercheurs et les experts de santé publique ont encore largement recours à l'approche traditionnelle du Public Understanding of Science (PUS). Cette approche défend un modèle déficitaire qui souligne les lacunes des profanes, qui seraient insuffisamment éduqués ; elle souligne aussi les multiples biais cognitifs qui affecteraient leurs perceptions ; enfin, elle diagnostique la montée d'un mouvement antiscience. Cet article dresse un état des lieux des connaissances relatives aux attitudes vis-à-vis des vaccins disponibles en France, en saisissant ce cas pour mettre la PUS à l'épreuve. Il montre que la limite principale de cette approche réside dans son incapacité à intégrer la dimension sociale et culturelle de la cognition. Il esquisse, enfin, un modèle alternatif au PUS qui place en son cœur la dimension culturelle de toute cognition et permet d'articuler les attitudes des individus avec l'émergence des controverses et les structures sociales.

Primary Health Care

► **Adaptation Of Independent Midwives To The COVID-19 Pandemic: A National Descriptive Survey**

BAUMANN S., GAUCHER L., BOURGUEIL Y., *et al.*
2020

Midwifery: 102918.

<https://doi.org/10.1016/j.midw.2020.102918>

The main objective of this survey was to identify how independent midwives, mainly working in primary care, adapted their practices at the beginning of the COVID-19 pandemic in France. Our assumption was that this practice adaptation would vary according to both geographical area (timing of pandemic effect) and whether they practiced alone or in a group. Design We conducted an online national survey of independent midwives in France from March 16–23, 2020. Setting All districts in mainland France and the overseas territories. Participants Respondents from the population of all independent midwives working in France. Measurements and findings The primary outcome measure was the proportion of midwives reporting that they had adapted their practices to the context of the COVID-19 pandemic, and the rank, in order of frequency, of the postponed or cancelled activities. Results : Of the 1517 midwives who responded, i.e., 20.3% of the independent midwives in France, 90.6% reported adapting one or more of their practices . The main adjustment was the postponement or cancellation of consultations deemed non-essential, listed in descending order: postpartum pelvic floor rehabilitation (n = 1270, 83.7%), birth preparation (n = 1188, 78.3%), non-emergency preventive gynaecology consultation (n = 976, 64.3%), early prenatal interview (n = 170, 11.2%), and postnatal follow-up (n = 158, 10.4%). Key conclusions Without guidelines, each midwife had to decide individually if and how to adapt her practice. Postpartum pelvic floor rehabilitation and birth preparation have been strongly affected. The results of this national survey indicate that a large majority of midwives have adapted their practices, independently of the local course of the pandemic, and that this reduction of contacts with women raises questions in this period of anxiety about intermediate-term adaptations to guarantee the continuity and safety of care. Implications for practice This study's results can be used to develop tools to handle cancelled consulta-

tions. Video, also called virtual, visits and coordination between independent practitioners and hospitals are probably the major challenges in the current context.

► **General Practitioners' Income And Activity: The Impact Of Multi-Professional Group Practice In France**

CASSOU M., MOUSQUÈS J. ET FRANC C.
2020

The European Journal of Health Economics 21(9): 1295-1315.

<https://doi.org/10.1007/s10198-020-01226-4>

France has first experimented, in 2009, and then generalized a practice level add-on payment to promote Multi-Professional Primary Care Groups (MPCGs). Team-based practices are intended to improve both the efficiency of outpatient care supply and the attractiveness of medically underserved areas for healthcare professionals. To evaluate its financial attractiveness and thus the sustainability of MPCGs, we analyzed the evolution of incomes (self-employed income and wages) of General Practitioners (GPs) enrolled in a MPCG, compared with other GPs. We also studied the impacts of working in a MPCG on GPs' activity through both the quantity of medical services provided and the number of patients encountered. Our analyses were based on a quasi-experimental design, with a panel dataset over the period 2008–2014. We accounted for the selection into MPCG by using together coarsened exact matching and difference-in-differences (DID) design with panel-data regression models to account for unobserved heterogeneity. We show that GPs enrolled in MPCGs during the period exhibited an increase in income 2.5% higher than that of other GPs; there was a greater increase in the number of patients seen by the GPs' (88 more) without involving a greater increase in the quantity of medical services provided. A complementary cross-sectional analysis for 2014 showed that these changes were not detrimental to quality in terms of bonuses related to the French pay-for-performance program for the year 2014. Hence, our results suggest that labor and income concerns should not be a barrier to the development of MPCGs, and that MPCGs may improve patient access to primary care services.

► **A Controlled Trial Of Dissemination And Implementation Of A Cardiovascular Risk Reduction Strategy In Small Primary Care Practices**

CYKERT S., KEYSERLING T. C., PIGNONE M., *et al.*

2020

Health Services Research 55(6): 944-953.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13571>

The objective of this study is to assess the effect of dissemination and implementation of an intervention consisting of practice facilitation and a risk-stratified, population management dashboard on cardiovascular risk reduction for patients at high risk in small, primary care practices. Study Setting A total of 219 small primary care practices (≤ 10 clinicians per site) across North Carolina with primary data collection from electronic health records (EHRs) from the fourth quarter of 2015 through the second quarter of 2018. Study Design We performed a stepped-wedge, stratified, cluster randomized trial of a one-year intervention consisting of practice facilitation utilizing quality improvement techniques coupled with a cardiovascular dashboard that included lists of risk-stratified adults, aged 40-79 years and their unmet treatment opportunities. The primary outcome was change in 10-Year ASCVD Risk score among all patients with a baseline score ≥ 10 percent from baseline to 3 months postintervention. Data Collection/ Extraction Methods Data extracts were securely transferred from practices on a nightly basis from their EHR to the research team registry. Principle Findings ASCVD risk scores were assessed on 437 556 patients and 146 826 had a calculated 10-year risk ≥ 10 percent. The mean baseline risk was 23.4 percent (SD \pm 12.6 percent). Postintervention, the absolute risk reduction was 6.3 percent (95% CI 6.3, 6.4). Models considering calendar time and stepped-wedge controls revealed most of the improvement (4.0 of 6.3 percent) was attributable to the intervention and not secular trends. In multivariate analysis, male gender, age > 65 years, low-income ($< \$40\ 000$), and Black race ($P < .001$ for all variables) were each associated with greater risk reductions. Conclusion A risk-stratified, population management dashboard combined with practice facilitation led to substantial reductions of 10-year ASCVD risk for patients at high risk. Similar approaches could lead to effective dissemination and implementation of other new evidence, especially in rural and other under-resourced practices. Registration: ClinicalTrials.Gov 15-0479.

► **Impact des modèles de soins intégrant l'accès direct à la kinésithérapie dans un contexte de soins primaires ou d'urgence pour les patients présentant une affection musculosquelettique : revue de la littérature**

DEMONT A., QUENTIN J. ET BOURMAUD A.

2020

Revue d'Épidémiologie et de Santé Publique 68(5): 306-313.

<https://doi.org/10.1016/j.respe.2020.08.001>

Les affections musculosquelettiques sont confrontées à une augmentation de leur prévalence, principalement en raison de la sédentarité. Des données probantes fortes soutiennent le recours précoce à un traitement de première ligne incluant la kinésithérapie. De nouveaux modèles innovants en soins primaires et aux urgences ont été développés et utilisent les compétences du masseur-kinésithérapeute pour la prise en charge précoce et de première ligne des patients souffrant d'affections musculosquelettiques. L'objectif de cette revue était d'identifier et de décrire les études évaluant les modèles de soins intégrant l'accès direct à la kinésithérapie en soins primaires et aux urgences pour les patients présentant une affection musculosquelettique et proposer des perspectives sur l'application de ces deux modèles en France. Méthodes Une revue de la littérature a été réalisée à partir de l'inclusion d'études provenant de quatre bases de données scientifiques, PubMed, CINAHL, Embase et PEDro. Les articles recherchés devaient traiter de l'efficacité clinique ou de l'efficacité de ces modèles de soins dans un contexte de soins primaires ou d'urgence. Une méthode narrative de revue de la littérature a été utilisée. La synthèse porte sur l'analyse qualitative des études incluses. Résultats Au total, 39 études ont été incluses dans cette revue : 19 sur l'évaluation de l'accès direct à la kinésithérapie en soins primaires et 20 sur l'évaluation de l'accès direct aux urgences. Celles-ci rapportaient que les différents modèles de soins intégrant l'accès direct en soins primaires ou aux urgences fournissaient de meilleurs résultats en termes de qualité et d'accès aux soins tout en maintenant une sécurité similaire. La méthodologie des études incluses a cependant été estimée comme de qualité hétérogène. Conclusion Les études portant sur ces nouveaux modèles de soins intégrant l'accès direct à la kinésithérapie en soins primaires et aux urgences permettent de retenir deux enseignements : ils n'ont pas vocation à remplacer le médecin et encouragent la collaboration entre professionnels de la santé afin d'améliorer l'ac-

cès pour les patients à des soins efficaces. Il convient de s'intéresser désormais aux facteurs de dissémination permettant d'assurer l'efficacité de ces modèles innovants dans d'autres pays, comme la France.

► **Income-Related Inequality In Affordability And Access To Primary Care In Eleven High-Income Countries**

DOTY M. M., TIKKANEN R. S., FITZGERALD M., *et al.*
2020

Health Affairs: 10.1377/hlthaff.2020.01566.

<https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.01566>

A high-performing health care system strives to achieve universal access, affordability, high-quality care, and equity, aiming to reduce inequality in outcomes and access. Using data from the 2020 Commonwealth Fund International Health Policy Survey, we report on health status, socioeconomic risk factors, affordability, and access to primary care among US adults compared with ten other high-income countries. We highlight health experiences among lower-income adults and compare income-related disparities between lower- and higher-income adults across countries. Results indicate that among adults with lower incomes, those in the US fare relatively worse on affordability and access to primary care than those in other countries, and income-related disparities across domains are relatively greater throughout. The presence of these disparities should strengthen the resolve to find solutions to eliminate income-related inequality in affordability and primary care access.

► **The Impact Of Nurse Delegation Regulations On The Provision Of Home Care Services: A Four-State Case Study**

DUDLEY N., MILLER J., BRESLIN M. L., *et al.*
2020

Medical Care Research and Review 0(0): 1077558720960902.

<https://journals.sagepub.com/doi/abs/10.1177/1077558720960902>

The objective of this study was to explore how home care workers and the agencies that employ them interact with their state's nurse practice act in the provision of care. Using a qualitative case study approach, we selected four states with varying levels of restrictiveness in their nurse delegation regulations. We con-

ducted interviews (N = 45) with state leaders, agency leaders, and home care workers to learn how these policies affect the home care workforce's ability to perform care tasks for their clients in order to allow clients to remain in their own homes. We found that increased training and input from registered nurses is needed to identify appropriate health maintenance tasks to delegate to home care workers and support development of training strategies. The federal government could support the development of evidence-based guidelines for training and competency testing as well as for appropriate delegation of health maintenance tasks.

► **The Role Of The State In Financing And Regulating Primary Care In Europe: A Taxonomy**

ESPINOSA-GONZÁLEZ A. B., DELANEY B. C., MARTI J., *et al.*

2020

Health Policy(Ahead of pub).

<https://doi.org/10.1016/j.healthpol.2020.11.008>

Traditional health systems typologies were based on health system financing type, such as the well-known OECD typology. However, the number of dimensions captured in classifications increased to reflect health systems complexity. The study aims to develop a taxonomy of primary care (PC) systems based on the actors involved (state, societal and private) and mechanisms used in governance, financing and regulation, which conceptually represents the degree of decentralisation of functions. We use nonlinear canonical correlations analysis and agglomerative hierarchical clustering on data obtained from the European Observatory on Health Systems and Policy and informants from 24 WHO European Region countries. We obtain four clusters: 1) Bosnia Herzegovina, Czech Republic, Germany, Slovakia and Switzerland: corporatist and/or fragmented, with state involvement in regulation of supply, without gatekeeping; 2) Greece, Ireland, Israel, Malta, Sweden, and Ukraine: public and (re)centralised financing and regulation with private involvement, without gatekeeping; 3) Finland, Norway, Spain and United Kingdom: public financing and devolved regulation and organisation, with gatekeeping; and 4) Bulgaria, Croatia, France, North Macedonia, Poland, Romania, Serbia, Slovenia and Turkey: public and deconcentrated with professional involvement in regulation, and gatekeeping. This taxonomy can serve as a framework for performance comparisons and a means to analyse the effect that different actors and levels of

devolution or fragmentation of PC delivery may have in health outcomes.

► **The Evolving Role Of Medical Assistants In Primary Care Practice: Divergent And Concordant Perspectives From MAs And Family Physicians**

FRAHER E. P., CUMMINGS A. ET NEUTZE D.
2020

Medical Care Research and Review 0(0): 1077558720966148.

<https://journals.sagepub.com/doi/abs/10.1177/1077558720966148>

Medical assistants (MAs) are a flexible and low-cost resource for primary care practices and their roles are swiftly transforming. We surveyed MAs and family physicians in primary care practices in North Carolina to assess concordance in their perspectives about MA roles, training, and confidence in performing activities related to visit planning; direct patient care; documentation; patient education, coaching or counseling; quality improvement; population health and communication. For most activities, we did not find evidence of role confusion between MAs and physicians, physician resistance to delegate tasks to properly trained MAs, or MA reluctance to pursue training to take on new roles. Three areas emerged where the gap between the potential and actual implementation of MA role transformation could be narrowed—population health and panel management; patient education, coaching, and counseling; and scribing. Closing these gaps will become increasingly important as our health care system moves toward value-based models of care.

► **Primary Care Visits Can Reduce The Risk Of Potentially Avoidable Hospitalizations Among Persons With Diabetes In France**

GEORGESCU V., GREEN A., JENSEN P. B., *et al.*
2020

European Journal of Public Health 30(6): 1056-1061.

<https://doi.org/10.1093/eurpub/ckaa137>

Diabetes is a frequent chronic condition, which can lead to costly complications if not managed well in the primary care setting. Potentially avoidable hospitalizations (PAH) are considered as an indirect measure of primary care. However, the association between primary care use and PAH in diabetic patients has not been investigated in France. We investigate the asso-

ciation between primary care indicators and PAH at an individual level among persons with diabetes in a population-based cohort study on the French national health insurance database (EGB sample). PAH occurrence in 2013 was modeled as a function of primary care use and access, health status and socio-economic indicators over the exposure period 2011–12 using a cause-specific hazards model with death as a competing event. We included 25 293 diabetics in our cohort, among which 385 (1.5%) experienced at least 1 PAH in 2013. After adjustment on health status indicators, primary care use had a protective effect against PAH. Diabetic patients who had seen a general practitioner (GP) 10–14 times had a reduced hazard of PAH compared to less frequent encounters (HR=0.49, P<0.001). The effect size decreased when the number of encounters increased, suggesting a remaining confounding effect of health status. For the first time in France, this study shows a protective effect of the number of GP encounters against PAH at an individual level and highlights the importance of a frequent monitoring of diabetic patients in the primary care setting to prevent PAH occurrence.

► **Understanding How Health Systems Facilitate Primary Care Redesign**

HARVEY J. B., VANDERBRINK J., MAHMUD Y., *et al.*
2020

Health Services Research 55(S3): 1144-1154.

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The objective of this paper is to understand how health systems are facilitating primary care redesign (PCR), examine the PCR initiatives taking place within systems, and identify barriers to this work. Study Setting A purposive sample of 24 health systems in 4 states. Study Design Data were systematically reviewed to identify how system leaders define and implement initiatives to redesign primary care delivery and identify challenges. Researchers applied codes which were based on the theoretical PCR literature and created new codes to capture emerging themes. Investigators analyzed coded data then produced and applied a thematic analysis to examine how health systems facilitate PCR. Data Collection Semi-structured telephone interviews with 162 system executives and physician organization leaders from 24 systems. Principal Findings Leaders at all 24 health systems described initiatives to redesign the delivery of primary care, but many were in the early stages. Respondents described the use of

centralized health system resources to facilitate PCR initiatives, such as regionalized care coordinators, and integrated electronic health records. Team-based care, population management, and care coordination were the most commonly described initiatives to transform primary care delivery. Respondents most often cited improving efficiency and enhancing clinician job satisfaction, as motivating factors for team-based care. Changes in payment and risk assumption as well as community needs were commonly cited motivators for population health management and care coordination. Return on investment and the slower than anticipated rate in moving from fee-for-service to value-based payment were noted by multiple respondents as challenges health systems face in redesigning primary care. Conclusions Given their expanding role in health care and the potential to leverage resources, health systems are promising entities to promote the advancement of PCR. Systems demonstrate interest and engagement in this work but face significant challenges in getting to scale until payment models are in alignment with these efforts.

► **Socioeconomic Inequalities In Out-Of-Hours Primary Care Use: An Electronic Health Records Linkage Study**

JANSEN T., HEK K., SCHELLEVIS F. G., *et al.*
2020

European Journal of Public Health 30(6): 1049-1055.
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Low socioeconomic position (SEP) is related to higher healthcare use in out-of-hours primary care services (OPCSs). We aimed to determine whether inequalities persist when taking the generally poorer health status of socioeconomically vulnerable individuals into account. To put OPCS use in perspective, this was compared with healthcare use in daytime general practice (DGP). Electronic health record (EHR) data of 988 040 patients in 2017 (251 DGPs, 27 OPCSs) from Nivel Primary Care Database were linked to socio-demographic data (Statistics, The Netherlands). We analyzed associations of OPCS and DGP use with SEP (operationalized as patient household income) using multilevel logistic regression. We controlled for demographic characteristics and the presence of chronic diseases. We additionally stratified for chronic disease groups. An income gradient was observed for OPCS use, with higher probabilities within each lower income group [lowest income, reference highest income group: odds ratio (OR) = 1.48, 95% confidence interval (CI):

1.45–1.51]. Income inequalities in DGP use were considerably smaller (lowest income: OR = 1.17, 95% CI: 1.15–1.19). Inequalities in OPCS were more substantial among patients with chronic diseases (e.g. cardiovascular disease lowest income: OR = 1.60, 95% CI: 1.53–1.67). The inequalities in DGP use among patients with chronic diseases were similar to the inequalities in the total population. Higher OPCS use suggests that chronically ill patients with lower income had additional healthcare needs that have not been met elsewhere. Our findings fuel the debate how to facilitate adequate primary healthcare in DGP and prevent vulnerable patients from OPCS use.

► **Equity In Access To Zero-Fees And Low-Cost Primary Health Care In Aotearoa New Zealand: Results From Repeated Waves Of The New Zealand Health Survey, 1996-2016**

JEFFREYS M., IRURZUN LOPEZ M., RUSSELL L., *et al.*
2020

Health Policy 124(11): 1272-1279.

<https://doi.org/10.1016/j.healthpol.2020.08.009>

Primary Health Care in Aotearoa New Zealand is mainly funded through capitation-based funding to general practices, supplemented by a user co-payment. Funding is designed in part to keep the costs of care low for key groups in the population who have higher health needs. We investigated changes in the socio-demographic determinants of no-cost and low-cost access to Primary Health Care using data from sequential waves of the New Zealand Health Survey (1996/97–2016/17). Fees paid were self-reported and inflated using CPI-adjustment to the value of the 2018NZD. Over the 20-year study period, there was an increase in the population accessing low-cost care. Access to low-cost care was particularly high for Pacific people, but also higher for Māori and Asian people compared to Other/New Zealand European ethnicities. Area-level deprivation was a stronger predictor of access to low-cost care for non-Māori than for Māori. Although Māori were more likely than non-Māori to access low-cost care at all levels of deprivation, this was less evident in more deprived compared to more affluent areas. Given ongoing reported inequity for Māori being less able to afford primary health care, we suggest that future policies to improve access should be fully aligned with the articles of Te Tiriti o Waitangi and should focus on equity.

► **Effect Of Access To After-Hours Primary Care On The Association Between Home Nursing Visits And Same-Day Emergency Department Use**

JONES A., BRONSKILL S. E., SCHUMACHER C., *et al.*
2020

The Annals of Family Medicine 18(5): 406-412.

<https://www.annfammed.org/content/annalsfm/18/5/406.full.pdf>

Previous work has demonstrated that home care patients have an increased risk of visiting the emergency department after a home nursing visit on the same day. We investigated whether this association is modified by greater access to after-hours primary care. **Methods** We conducted a population-based case-cross-over study of home care patients in Ontario, Canada in 2014-2016. Emergency department visits after 5:00 pm were selected as case periods and matched, within the same patient, to control periods within the previous week. The association between home nursing visits and same-day emergency department visits was estimated with conditional logistic regression. Access to after-hours primary care, measured on the patient and practice level, was tested for effect modification using an interaction term approach. Analysis was performed separately for all emergency department visits and a less urgent subset not admitted to hospital. **RESULTS** A total of 11,840 patients contributed cases to the analysis. Patients with a history of after-hours primary care use had a smaller increased risk of a same-day after-hours emergency department visit (OR=1.18; 95% CI, 1.06-1.30) compared with patients with no after-hours care (OR=1.31; 95% CI, 1.25-1.39). The modifying effect was stronger among emergency department visits not admitted to hospital (OR=1.11; 95% CI, 0.97-1.28 vs OR=1.41; 95% CI, 1.31-1.51). **Conclusion** Greater access to after-hours primary care reduced the risk of less-urgent emergency department use associated with home nursing visits. These findings suggest increasing access to after-hours primary care could prevent some less-urgent emergency department visits.

► **Associations Between Continuity Of Primary And Specialty Physician Care And Use Of Hospital-Based Care Among Community-Dwelling Older Adults With Complex Care Needs**

JONES A., BRONSKILL S. E., SEOW H., *et al.*
2020

PloS one 15(6): e0234205-e0234205.

<https://pubmed.ncbi.nlm.nih.gov/32559214>

While research suggests that higher continuity of primary and specialty physician care can improve patient outcomes, their effects have rarely been examined and compared concurrently. We investigated associations between continuity of primary and specialty physician care and emergency department visits and hospital admissions among community-dwelling older adults with complex care needs. **Methods:** We conducted a retrospective cohort study of home care patients in Ontario, Canada, from October 2014 to September 2016. We measured continuity of primary and specialty physician care over the two years prior to a home care assessment and categorized them into low, medium, and high groups using terciles of the distribution. We used Cox regression models to concurrently test the associations between continuity of primary and specialty care and risk of an emergency department visit and hospital admission within six months of assessment, controlling for potential confounders. We examined interactions between continuity of care and count of chronic conditions, count of physician specialties seen, functional impairment, and cognitive impairment. **RESULTS:** Of 178,686 participants, 49% had an emergency department visit during follow-up and 27% had a hospital admission. High vs. low continuity of primary care was associated with a reduced risk of an emergency department visit (HR=0.90 (0.89-0.92)) as was continuity of specialty care (HR=0.93 (0.91-0.95)). High vs. low continuity of primary care was associated also with a reduced risk of a hospital admission (HR=0.94 (0.92-0.96)) as was continuity of specialty care (HR=0.92 (0.90-0.94)). The effect of continuity of specialty care was moderately stronger among patients who saw four or more physician specialties. **Conclusion:** Higher continuity of primary physician and specialty physician care had independent, protective effects of similar magnitude against emergency department use and hospital admissions. Improving continuity of specialty care should be a priority alongside improving continuity of primary care in complex, older adult populations with significant specialist use.

► **Collaboration Of Primary Care And Public Health At The Local Level: Observational Descriptive Study Of French Local Health Contracts**

KENDIR C., BRETON E., LE BODO Y., *et al.*

2020

[Prim Health Care Res Dev 21: e61.](#)

<https://doi.org/10.1017/s1463423620000559>

In this paper, we report on a study investigating the involvement of primary care providers in French local health contracts. **BACKGROUND:** Worldwide actions are carried out to improve collaboration between primary care and public health to strengthen primary health-care and consequently community health. In France, the local health contract is an instrument mobilising local stakeholders from different sectors to join in their actions to improve the health of the population. **Methods:** We developed an instrument to analyse the frequency and nature of involvement of primary care providers in 428 action plans extracted from a sample of 17 contracts (one per French region). The number of primary care actions were counted, and thematic analyses were conducted to identify the nature and level of involvement of the professionals. **Findings:** Primary care providers were involved in 20.1% (n=86) of the action plans and were mostly described as a target of the action rather than leaders or partners. Within those action plans, 76.7% (n=66) of these action plans aimed to improve access to care for local communities; an issue that appears as the main driver of collaboration between public health and primary care actors.

► **Can General Practitioners Be More Productive? The Impact Of Teamwork And Cooperation With Nurses On GP Activities**

LOUSSOUARN C., FRANC C., VIDEAU Y., *et al.*

2020

[Health Econ\(Ahead of pub\).](#)

<https://doi.org/10.1002/hec.4214>

The integration of primary care organizations and interprofessional cooperation is encouraged in many countries to both improve the productive and allocative efficiency of care provision and address the unequal geographical distribution of general practitioners (GPs). In France, a pilot experiment promoted the vertical integration of and teamwork between GPs and nurses. This pilot experiment relied on the staffing and training of nurses; skill mixing, including the authoriza-

tion to shift tasks from GPs to nurses; and new remuneration schemes. This article evaluates the overall impact of this pilot experiment over the period 2010-2017 on GP activities based on the following indicators: number of working days, patients seen at least once, patients registered, and visits delivered. We control for endogeneity and reduce selection bias by using a case-control design combining coarsened exact matching and difference-in-differences estimates on panel data. We find a small positive impact on the number of GP working days (+1.2%) following enrollment and a more pronounced effect on the number of patients seen (+7.55%) or registered (+6.87%). However, we find no effect on the number of office and home visits. In this context, cooperation and teamwork between GPs and nurses seem to improve access to care for patients.

► **Community Participation And Empowerment In Primary Health Care In Emilia-Romagna: A Document Analysis Study**

LUISI D. ET HÄMEL K.

2020

[Health Policy\(Ahead of pub\).](#)

<https://doi.org/10.1016/j.healthpol.2020.11.007>

Community participation and empowerment are seen as fundamental for achieving equitable, people-centred primary health care. Emilia-Romagna region introduced the Casa della Salute aiming to foster comprehensive primary health care and support community participation. Since the 1990s, community involvement has been promoted to improve the regional health system. The pivotal role of third sector organisations as service providers and advocates for users' rights has been underlined. This contribution explores the evolution of the meaning and conceptualisation of community participation and empowerment in policies addressing the Casa della Salute. A qualitative document analysis study was undertaken. Three national and twelve regional documents dated between 2006 and 2019 were evaluated. The policies continuously address community participation. The Casa della Salute is seen as a designated place to promote participation and empowerment. The documents point to the need for democratic practice and shared decision-making power; third sector organisations are seen as salient community representatives and mediators. However, the policies show only a vague conceptualisation of how to empower communities; moreover, strategies to promote participation of vulnerable groups are lack-

ing. Policies that consider the ambiguous role of the third sector, specify community empowerment, identify strategies to facilitate it and collaborate with vulnerable groups could be beneficial for further progress.

► **Socioeconomic Inequalities In Waiting Times For Primary Care Across Ten OECD Countries**

MARTIN S., SICILIANI L. ET SMITH P.
2020

Social Science & Medicine 263: 113230.
<https://doi.org/10.1016/j.socscimed.2020.113230>

Waiting times for health care are a major policy concern across OECD countries. Waiting times are generally tolerated in publicly-funded health systems and perceived as equitable if access to care is not based on socioeconomic status. Although a growing literature has documented that socioeconomic status is negatively associated with waiting times for secondary care in several countries, less is known about waiting time inequalities in primary care, which is the focus of this study. We exploit the Commonwealth Fund's International Health Policy Survey of Adults in 2010, 2013 and 2016 and include ten OECD countries (Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom). Waiting time for primary care is measured by the time reported to get an appointment to see a doctor or a nurse. We employ interval regression models to investigate for each country whether socioeconomic status (household income and education) are associated with the waiting time for a primary care appointment. We control for age, gender, chronic conditions, and whether the individual holds private health insurance. We find a negative association between household income and waiting times in Canada, Germany, Norway and Sweden.

► **Impact Of Interprofessional Collaboration On Chronic Disease Management: Findings From A Systematic Review Of Clinical Trial And Meta-Analysis**

PASCUCCI D., SASSANO M., NURCHIS M. C., *et al.*
2020

Health Policy(Ahead of pub).
<https://doi.org/10.1016/j.healthpol.2020.12.006>

Improvement of chronic disease management demands effective collaborative relationships between

health and social-care which is achieved through teamwork. Interprofessional Education (IPE) and Interprofessional Collaboration (IPC) are recognized as essential for the delivery of effective and efficient healthcare. Although IPC and IPE are key components of primary care, evidence of studies evaluating how an IPE intervention prior to IPC improved chronic patient outcomes remains scarce. The aim of this study was to assess the impact of IPC interventions on the management of chronic patients compared to usual care. A systematic review and meta-analysis of Randomized Controlled Trials (RCTs) on IPC interventions on chronicity management and their impact on clinical and process outcomes was conducted. Of the 11,128 papers initially retrieved, 23 met the inclusion criteria. Meta-analyses results showed the reduction of systolic blood pressure (Mean Difference (MD) -3.70; 95% CI -7.39, -0.01), glycosylated hemoglobin (MD -0.20; 95% CI -0.47, -0.07), LDL cholesterol (MD -5.74; 95% CI -9.34, -2.14), diastolic blood pressure (MD -1.95; 95% CI -3.18, -0.72), days of hospitalization (MD -2.22; 95% CI -4.30, -0.140). A number of positive findings for outcomes related to IPC were found reflecting an improvement of quality of care and an enhancement in the delivery of patient-centered and coordinated care. Moreover, the need for a purposeful systemic approach linking interprofessional education with interprofessional collaboration and patient health and wellbeing is necessary.

► **Maison de santé Decazeville-Aubin : une dynamique de prévention et de promotion de la santé**

REVUE PRESCRIRE
2020

Revue Prescrire 40(444): 779-782.

Cet article fait un retour d'expérience de la maison de santé Decazeville-Aubin implantée dans deux communes aveyronnaises proches. L'équipe de la maison de santé a développé des coopérations avec les professionnels voisins et du secteur médico-social, organisé des délégations de tâches et favorisé l'accueil de jeunes collègues. Elle a aussi engagé de nombreuses actions de prévention et de promotion de la santé.

► **How GPs Adapted Their Practices And Organisations At The Beginning Of COVID-19 Outbreak: A French National Observational Survey**

SAINT-LARY O., GAUTIER S., LE BRETON J., *et al.*
 2020

BMJ Open 10(12): e042119.

<https://doi.org/10.1136/bmjopen-2020-042119>

The aim of this study is to describe how general practitioners (GPs) adapted their practices to secure and maintain access to care in the epidemic phase. A secondary objective was to explore if GPs' individual characteristics and type of practice determined their adaptation. Design: Observational study using an online questionnaire. Organisational changes were measured by a main question and detailed in two specific outcomes. To identify which GPs' characteristics impacted organisational changes, successive multivariate logistic modelling was performed. First, we identified the GPs' characteristics related to organisational changes with a univariate analysis. Then, we tested the adjusted associations between this variable and the following GPs' characteristics: age, gender and type of practice. Setting: The questionnaire was administered online between 14 March and 21 March 2020. Practitioners were recruited by email using the contact lists of different French scientific GP societies. Participants: The target population was GPs currently practising in France (n = 46 056). We obtained a total of 7481 responses. Primary outcome: Proportion of GPs who adapted their practice. Secondary outcome: GPs' characteristics related to organisational changes. Results: Among the 7481 responses, 5425 were complete and were analysed. 3849 GPs (70.9%) changed their activity, 3605 GPs (66.5%) increased remote consultations and 2315 GPs (42.7%) created a specific pathway for probable patients with COVID-19. Among the 3849 GPs (70.9%) who changed their practice, 3306 (91.7%) gave more answers by phone, 996 (27.6%) by email and 1105 (30.7%) increased the use of video consultations. GPs working in multi-professional group practices were more likely to have changed their activity since the beginning of the epidemic wave than GPs working in mono-professional group or single medical practices (adjusted OR: 1.32, 95% CI 1.12 to 1.56, p = 0.001). Conclusions: French GPs adapted their practices regarding access to care for patients in the context of the Covid-19 epidemic. This adaptation was higher in multi-professional group practices.

► **Assessing Primary Care Organization And Performance: Literature Synthesis And Proposition Of A Consolidated Framework**

SENN N., BRETON M., EBERT S. T., *et al.*
 2020

Health Policy(Ahead of pub).

<https://doi.org/10.1016/j.healthpol.2020.10.004>

Many frameworks describing primary care (PC) organization exist. This study proposes a consolidated framework based on the synthesis of published frameworks for the assessment of primary care organization and performance. Approach We conducted a review of the literature to identify relevant existing frameworks that aimed to describe PC organization or/and monitor its activities. First, we extracted all domains from the frameworks and then hierarchically organized them into domains, dimensions and elements. Second, we mapped key domains. Third, we grouped together domains covering the same field to build a consolidated framework. Finally, the consolidated framework was assessed by 10 international experts in PC evaluation using a survey. Results We retained seven frameworks. The consolidated framework comprises four domains: 1) population needs; 2) organization and structure of PC practices; 3) delivery of PC services and 4) patient and population health outcomes. We added five connecting constructs to the framework in order to link the domains: accessibility, appropriateness, productivity, efficiency, effectiveness, equity and integration. None of the previously published frameworks encompassed all domains, dimensions and elements of the new consolidated framework. Conclusion We propose a consolidated framework of PC organization based on the synthesis of seven published frameworks. This unitary framework may provide a foundation for comparative assessment across various contexts to support researchers and policy makers.

► **How French General Practitioners Respond To Declining Medical Density: A Study On Prescription Practices, With An Insight Into Opioids Use**

SILHOL J., VENTELLOU B. ET ZAYTSEVA A.
 2020

The European Journal of Health Economics 21(9): 1391-1398.

<https://doi.org/10.1007/s10198-020-01222-8>

Disparities in physicians' geographical distribution

lead to highly unequal access to healthcare, which may impact quality of care in both high and low-income countries. This paper uses a 2013–2014 nationally representative survey of French general practitioners (GPs) matched with corresponding administrative data to analyze the effects of practicing in an area with weaker medical density. To avoid the endogeneity issue on physicians' choice of the location, we enriched our variable of interest, practicing in a relatively underserved area, with considering changes in medical density between 2007 and 2013, thus isolating GPs who only recently experienced a density decline (identifying assumption). We find that GPs practicing in underserved areas do shorter consultations and tend to substitute time-consuming procedures with alternatives requiring fewer human resources, especially for pain management. Results are robust to considering only GPs newly exposed to low medical density. Findings suggest a significant impact of supply-side shortages on the mix of healthcare services used to treat patients, and point to a plausible increased use of painkillers, opioids in particular.

► **Team-Based Primary Care Practice And Physician's Services: Evidence From Family Health Teams In Ontario, Canada**

SOMÉ N. H., DEVLIN R. A., MEHTA N., *et al.*
2020

Social Science & Medicine 264: 113310.
<https://doi.org/10.1016/j.socscimed.2020.113310>

Team-based primary care offers a wide range of health services to patients by using interdisciplinary health care providers committed to delivering comprehensive, coordinated and high-quality care through team collaboration. Ontario's Family Health Team (FHT), the largest team-based practice model in Canada, was introduced to improve access to and effectiveness of primary health care services, and was available primarily for physicians paid under blended capitation models (Family Health Organizations and Family Health Networks). Using health administrative data on physicians practicing under blended capitation models in Ontario between 2006 and 2015, we study the impact of switching from non-FHT to FHTs on the production of capitated comprehensive care services, after-hours services, non-incentivized services, and services provided to non-enrolled patients by family physicians. We find that when in FHTs, physicians increase the production of total services and non-incentivized services by 26% and 5% per annum and reduce capitated

comprehensive care services by 3.2% per annum. When in FHTs, physicians also see and enroll more patients relative to those practicing in non-FHTs. We find evidence of improved access to physician's services under team-based primary care, but switching to FHTs has no effect on the production of after-hours services and services provided to non-enrolled patients.

► **Le rôle du médecin généraliste dans la prise en charge des pathologies psychiatriques**

TABRIL T., CHEKIRA A., HOUSNI TOUHAMI Y. O., *et al.*
2020

Revue d'Épidémiologie et de Santé Publique 68(3): 185-192.
<https://doi.org/10.1016/j.respe.2020.05.002>

Les pathologies psychiatriques sont responsables d'une part majeure de la morbidité dans le monde. Il existe d'importantes lacunes de diagnostic et de traitement pour les troubles psychiatriques. Au Maroc, la constatation d'une pénurie de psychiatres devrait amener logiquement à une collaboration avec les médecins généralistes. Notre objectif est d'analyser la perception de la capacité des médecins généralistes à prendre en charge les troubles psychiatriques, étudier les difficultés rencontrées dans la prise en charge de ces pathologies, et évaluer leur degré de collaboration avec les structures de prise en charge en santé mentale. Méthodes Il s'agit d'une enquête transversale auprès des médecins généralistes exerçant en milieu urbain et rural, dans les secteurs libéral et public, et ce, à l'échelle nationale du royaume du Maroc.

Health Systems**► Association Between Specialist Compensation And Accountable Care Organization Performance**

GANGULI I., LUPO C., MAINOR A. J., *et al.*
2020

Health Services Research 55(5): 722-728.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13323>

The objective of this study is to determine if Medicare Shared Savings Program Accountable Care Organizations (ACOs) using cost reduction measures in specialist compensation demonstrated better performance. Data Sources National, cross-sectional survey data on ACOs (2013-2015) linked to public-use data on ACO performance (2014-2016). Study Design We compared characteristics of ACOs that did and did not report use of cost reduction measures in specialist compensation and determined the association between using this approach and ACO savings, outpatient spending, and specialist visit rates. Principal Findings Of 160 ACOs surveyed, 26 percent reported using cost reduction measures to help determine specialist compensation. ACOs using cost reduction in specialist compensation were more often physician-led (68.3 vs 49.6 percent) and served higher-risk patients (mean Hierarchical Condition Category score 1.09 vs 1.05). These ACOs had similar savings per beneficiary year (adjusted difference \$82.6 [95% CI -77.9, 243.1]), outpatient spending per beneficiary year (-24.0 [95% CI -248.9, 200.8]), and specialist visits per 1000 beneficiary years (369.7 [95% CI -9.3, 748.7]). Conclusion Incentivizing specialists on cost reduction was not associated with ACO savings in the short term. Further work is needed to determine the most effective approach to engage specialists in ACO efforts.

► Assessing Health Systems' Preparedness For Providing Care For Refugees, Asylum Seekers And Migrants: A Scoping Review

KOCOT E. ET SZETELA A.
2020

European Journal of Public Health 30(6): 1157-1163.

<https://doi.org/10.1093/eurpub/ckaa135>

Health care systems and care professionals often

face the challenge of providing adequate health care for migrant groups. The objective of this study is to answer the question of whether and how meeting the special health system requirements regarding refugees (R), asylum seekers (AS) and migrants (M) (RASM) is checked and evaluated. A scoping review was used as a methodology of the research, with four electronic databases, websites of relevant organizations and European projects searched, using a strictly defined search strategy. Finally, 66 studies were included in the analysis. The included studies presented assessment of different types, aspects and facilities of health care, as well as various methods of analysis. In the vast majority of the studies (n = 52, 78%) interviews or questionnaires were used to collect data. The studies were mostly declared to be qualitative. The main issues assessed in the studies can be categorized into three groups: (i) legal aspects, (ii) before receiving health care and (iii) during health care usage. RASM inflow is a big challenge for health care system in many countries. The first step to guarantee adequate health care for RASM is assessing how the system is functioning. This makes it possible to find gaps, indicate the directions of activities needed and monitor progress. Further work on the development of a comprehensive tool, checked in terms of validity and reliability assessment, and enabling examination of many aspects of health care for RASM should be carried out.

► Health System Affiliation Of Physician Organizations And Quality Of Care For Medicare Beneficiaries Who Have High Needs

KRANZ A. M., DEYOREO M., ESHETE-ROESLER B., *et al.*

2020

Health Services Research 55(S3): 1118-1128.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13570>

The aim of this paper is to test the hypothesis that health systems provide better care to patients with high needs by comparing differences in quality between system-affiliated and nonaffiliated physician organizations (POs) and to examine variability in quality across health systems. Data Sources 2015 Medicare

Data on Provider Practice and Specialty linked physicians to POs. Medicare Provider Enrollment, Chain, and Ownership System (PECOS) and IRS Form 990 data identified health system affiliations. Fee-for-service Medicare enrollment and claims data were used to examine quality. Study Design This cross-sectional analysis of beneficiaries with high needs, defined as having more than twice the expected spending of an average beneficiary, examined six quality measures: continuity of care, follow-up visits after hospitalizations and emergency department (ED) visits, ED visits, all-cause readmissions, and ambulatory care-sensitive hospitalizations. Using a matched-pair design, we estimated beneficiary-level regression models with PO random effects to compare quality of care in system-affiliated and nonaffiliated POs. We then limited the sample to system-affiliated POs and estimated models with system random effects to examine variability in quality across systems. Principal Findings Among 2 323 301 beneficiaries with high needs, 52.3% received care from system-affiliated POs. Rates of ED visits were statistically significantly different in system-affiliated POs (117.5 per 100) and nonaffiliated POs (106.8 per 100, $P < .0001$). Small differences in the other five quality measures were observed across a range of sensitivity analyses. Among systems, substantial variation was observed for rates of continuity of care (90% of systems had rates between 70.8% and 89.4%) and follow-up after ED visits (90% of systems had rates between 56.9% and 73.5%). Conclusions Small differences in quality of care were observed among beneficiaries with high needs receiving care from system POs and nonsystem POs. Health systems may not confer hypothesized quality advantages to patients with high needs.

► **Health System Integration With Physician Specialties Varies Across Markets And System Types**

MACHTA R. M., D. RESCHOVSKY J., JONES D. J., *et al.*
2020

Health Services Research 55(S3): 1062-1072.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13584>

The objective of this study is to examine system integration with physician specialties across markets and the association between local system characteristics and their patterns of physician integration. Data Sources Data come from the AHRQ Compendium of US Health Systems and IQVIA OneKey database. Study

Design We examined the change from 2016 to 2018 in the percentage of physicians in systems, focusing on primary care and the 10 most numerous nonhospital-based specialties across the 382 metropolitan statistical areas (MSAs) in the US. We also categorized systems by ownership, mission, and payment program participation and examined how those characteristics were related to their patterns of physician integration in 2018. Data Collection/Extraction Methods We examined local healthcare markets (MSAs) and the hospitals and physicians that are part of integrated systems that operate in these markets. We characterized markets by hospital and insurer concentration and systems by type of ownership and by whether they have an academic medical center (AMC), a 340B hospital, or accountable care organization. Principal Findings Between 2016 and 2018, system participation increased for primary care and the 10 other physician specialties we examined. In 2018, physicians in specialties associated with lucrative hospital services were the most commonly integrated with systems including hematology-oncology (57%), cardiology (55%), and general surgery (44%); however, rates varied substantially across markets. For most specialties, high market concentration by insurers and hospital-systems was associated with lower rates of physician integration. In addition, systems with AMCs and publicly owned systems more commonly affiliated with specialties unrelated to the physicians' potential contribution to hospital revenue, and investor-owned systems demonstrated more limited physician integration. Conclusions Variation in physician integration across markets and system characteristics reflects physician and systems' motivations. These integration strategies are associated with the financial interests of systems and other strategic goals (eg, medical education, and serving low-income populations).

► **Mortality And Healthcare Resource Utilization Following Acute Myocardial Infarction According To Adherence To Recommended Medical Therapy Guidelines**

PLAKHT Y., GREENBERG D., GILUTZ H., *et al.*
2020

Health Policy 124(11): 1200-1208.

<https://doi.org/10.1016/j.healthpol.2020.07.004>

Guideline recommended medical therapy (GRMT) plays a pivotal role in improving long-term outcomes and healthcare burden of acute myocardial infarction (AMI) patients. We evaluated patients' adherence to

GRMT following AMI and the association with long-term (up-to 10 years) mortality, healthcare resource utilization and costs. Methods AMI patients hospitalized in a tertiary medical center in Israel that survived at least a year following post-discharge and enrolled in the two largest health plans were analyzed. Data were obtained from computerized medical records. Patients were defined as adherent when $\geq 80\%$ of the GRMT prescriptions were issued during the first post-discharge year. Hospitalizations, emergency department (ED) visits, primary care utilization and outpatient consulting clinic and other ambulatory services expenditure were calculated annually. Results Overall 8287 patients qualified for the study (mean age 65.0 ± 13.6 years, 69.7% males). Adherent patients ($n=1767$, 21.3%) were more likely to be younger, women and increased prevalence of most traditional cardiovascular risk factors. Throughout the follow-up, 2620 patients (31.6%) died, 22.0% versus 34.2%, in the adherent vs. the non-adherent group (adjHR = 0.816, 95% CI: 0.730–0.913, $p < 0.001$). Reduced hospitalizations (adjOR = 0.783, $p < 0.001$), ED visits (adjOR = 0.895, $p = 0.033$), and costs (adjOR = 0.744, $p < 0.001$), yet increased primary clinics (adjOR = 2.173, $p < 0.001$) ambulatory (adjOR = 1.072, $p = 0.018$) and consultant (adjOR = 1.162, $p < 0.001$) visits, were observed. Conclusions Adherence to GRMT following AMI is associated with decreased mortality, hospitalizations and costs.

► Care Integration Within And Outside Health System Boundaries

SINGER S. J., SINAIKO A. D., TIETSCHERT M. V., *et al.*
2020

Health Services Research 55(53): 1033-1048.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13578>

The aim of this paper is to examine care integration—efforts to unify disparate parts of health care organizations to generate synergy across activities occurring within and between them—to understand whether and at which organizational level health systems impact care quality and staff experience. Data Sources Surveys administered to one practice manager (56/59) and up to 26 staff (828/1360) in 59 practice sites within 24 physician organizations within 17 health systems in four states (2017-2019). Study Design We developed manager and staff surveys to collect data on organizational, social, and clinical process integration, at four organizational levels: practice site, physician organization, health system, and outside health systems. We

analyzed data using descriptive statistics and regression. Principal Findings Managers and staff perceived opportunity for improvement across most types of care integration and organizational levels. Managers/staff perceived little variation in care integration across health systems. They perceived better care integration within practice sites than within physician organizations, health systems, and outside health systems—up to 38 percentage points (pp) lower ($P < .001$) outside health systems compared to within practice sites. Of nine clinical process integration measures, one standard deviation (SD) (7.2-pp) increase in use of evidence-based care related to 6.4-pp and 8.9-pp increases in perceived quality of care by practice sites and health systems, respectively, and a 4.5-pp increase in staff job satisfaction; one SD (9.7-pp) increase in integration of social services and community resources related to a 7.0-pp increase in perceived quality of care by health systems; one SD (6.9-pp) increase in patient engagement related to a 6.4-pp increase in job satisfaction and a 4.6-pp decrease in burnout; and one SD (10.6-pp) increase in integration of diabetic eye examinations related to a 5.5-pp increase in job satisfaction (all $P < .05$). Conclusions Measures of clinical process integration related to higher staff ratings of quality and experience. Action is needed to improve care integration within and outside health systems.

► The Best Person (Or Machine) For The Job: Rethinking Task Shifting In Healthcare

VAN SCHALKWYK M. C. I., BOUREK A., KRINGOS D. S., *et al.*

2020

Health Policy 124(12) : 1379-1386

<https://doi.org/10.1016/j.healthpol.2020.08.008>

Globally, health systems are faced with the difficult challenge of how to get the best results with the often limited number of health workers available to them. Exacerbating this challenge is the task of meeting ever-changing needs of service users and managing unprecedented technological advances. The process of matching skills to changing needs and opportunities is termed task shifting. It involves questioning health service goals, what health workers do, asking if it can be done in a better way, and implementing change. Task shifting in healthcare is often conceptualised as a process of transferring responsibility for 'simple' tasks from high-skilled but scarce health workers to those with less expertise and lower pay, and predominantly

viewed as a means to reduce costs and promote efficiency. Here we present a position paper based on the work and expertise of the European Commission Expert Panel on Effective ways of Investing in Health. It contends that this is over simplistic, and aims to provide a new task shifting framework, informed by relevant evidence, and a series of recommendations. While far from comprehensive, there is a growing body of evidence that certain tasks traditionally undertaken by one type of health worker can be undertaken by others (or machines), in some cases to a higher standard, thus challenging the persistence of rigid professional boundaries. Task shifting has the potential to contribute to health systems strengthening when accompanied by adequate planning, resources, education, training and transparency.

► **The Impacts Of Accountable Care Organizations On Patient Experience, Health Outcomes And Costs: A Rapid Review**

WILSON M., GUTA A., WADDELL K., *et al.*

2020

Journal of Health Services Research & Policy 25(2): 130-138.

<https://journals.sagepub.com/doi/abs/10.1177/1355819620913141>

Accountable care organizations were implemented as a system-level approach to address quality differences and curb increasing healthcare costs in the United States of America, and have garnered the interest of policy makers in other countries to support better management of patients. The objectives of this paper are to: (1) identify the impacts of accountable care organizations on improving the quadruple aim goals of improving patient experience of care, enhancing population health outcomes, reducing the per capita cost of health care and ensuring positive provider experiences and (2) determine how and why such impacts have been achieved through accountable care organizations. **Methods**We used a rapid review approach, searching Health Systems Evidence (for systematic reviews) and PubMed (for reviews and studies). Results were reviewed for inclusion independently by two researchers. Data were extracted by one reviewer and checked for consistency by another. **Results**We identified one recent systematic review and 59 primary studies that addressed the first objective (n = 54), the second objective (n = 4) or both objectives (n = 1). The reviewed studies suggest that accounta-

ble care organizations reduce costs without reducing quality. Key findings related to objective 1 include: (1) there are positive trends across the quadruple-aim outcomes for accountable care organizations as compared to Medicare fee-for-service or group physician fee-for-service models; (2) accountable care organizations produced modest cost savings, which are largely attributable to savings in outpatient expenses among the most medically complex patients and reductions in the delivery of low-value services; (3) accountable care organization models met the majority of quality measures and perform better than their fee-for-service counterparts and (4) there is relatively little evidence about the impact of accountable care organizations on provider experience. Qualitative studies related to objective 2 highlighted mechanisms that were important for enabling accountable care organizations, including supplemental staff to enhance coordination and accountable care organization-wide electronic health records. **Conclusions**General trends and increased adoption of models similar to accountable care organizations outside of the USA suggest that these models outperform traditional fee-for-service models across the quadruple aim goals, although with mixed evidence about health outcomes.

Occupational Health**► How Does Cognition Relate To Employment In Multiple Sclerosis? A Systematic Review**

CLEMENS L. ET LANGDON D.

2018

Multiple Sclerosis and Related Disorders 26: 183-191.<https://doi.org/10.1016/j.msard.2018.09.018>

Almost half of people with multiple sclerosis (MS), with low levels of physical disability, are unemployed. It is likely that the impact of “invisible” symptoms of MS, such as cognition, are involved. Evidence also suggests that cognition is a mediating factor between physical disabilities and unemployment. Methods A systematic review was conducted to investigate the link between objective cognitive performance and unemployment in MS. The search was carried out in September 2017 using identical search terms across three search engines: PubMed, PSYCH Info and Web of Science. Inclusion criteria included peer review, participant age range of 18 to 65, objective neuropsychological testing and self-reported employment information. Results The search returned a total of 910 articles of which 13 were considered eligible for inclusion. The eligible studies consistently found that people with MS who were unemployed, or who had more negative work-related events, performed less well on neuropsychological tests than both employed people with MS and healthy control groups. People with MS who were employed or had no changes in their work situation also performed less well than healthy controls on neuropsychological tests. Significant between group differences were seen in the following cognitive domains: information processing speed, immediate recall, delayed recall and executive function. Conclusion Difficulties with employment and/or reduced work hours were associated with cognitive impairment in MS.

► Is It Time To Rethink The Way We Assess The Burden Of Work-Related Cancer?

COUNIL E. ET HENRY E.

2019

Current Epidemiology Reports 6(2): 138-147.<https://doi.org/10.1007/s40471-019-00190-9>

Population attributable fractions (PAFs) are increasingly used for setting cancer prevention priorities. Our review aims, first, to gather published estimates of the percentage of cancer attributed to causal agents in the workplace and, second, to analyze them from the perspective of their potential effects on population health inequities.

► Employment Vulnerability Of People With Severe Mental Illness

DIBY A. S., LENGAGNE P. ET REGAERT C.

2020

Health Policy(Ahead of pub).<https://doi.org/10.1016/j.healthpol.2020.10.008>

Using French longitudinal register insurance data, we compare the employment status of persons with severe chronic mental illness, before and after the first medico-administrative recognition of the illness by the Statutory Health Insurance, with that of people without recognised mental illness. The study focuses on persons of working age with a work history before this recognition. Our empirical approach relies on a double difference method with coarsened exact matching. Before recognition, subjects had lower employment rates than those without mental illness but relatively high, reflecting their initial employment attachment; employment rates decrease sharply after the recognition period. A large employment rate gap between persons with and without severe mental illness develops during the four years after recognition. We examine whether the magnitude of the decrease is sensitive to the macro-economic context. Findings show that the decline in employment rates was significantly more pronounced during the Great Recession compared with the pre-crisis period, amongst women. Coordinated early health and labour policies, implemented in the phase of the entry into the public chronic illness insurance scheme, have the potential to play a key role in preventing the deterioration of the economic and social well-being of persons with severe mental illnesses.

► **Employment And Earnings Trajectories Before And After Sickness Absence Due To Major Depressive Disorder: A Nationwide Case–Control Study**

HAKULINEN C., BÖCKERMAN P., PULKKI-RÅBACK L.,
et al.

2020

Occupational and Environmental Medicine:
oemed-2020-106660.

<https://doi.org/10.1136/oemed-2020-106660>

The aim of this study is to examine employment and earnings trajectories before and after the first sickness absence period due to major depressive disorder (MDD). Methods All individuals (n = 158 813) in Finland who had a first sickness absence period (lasting longer than 9 days) due to MDD between 2005 and 2015 were matched with one randomly selected individual of the same age and gender with no history of MDD. Employment status and earnings were measured using register-based data annually from 2005 to 2015. Generalised estimating equations were used to examine the trajectories of employment and earnings before and after MDD diagnosis in men and women separately. Results Sickness absence due to MDD was associated with increased probability of non-employment during and after the year of the first sickness absence period. In men, but not in women, the probability of being employed was lower 5 years before the sickness absence period due to MDD. When compared with the individuals in the control group, men had around 34% and women 15% lower earnings 1 year, and 40% and 23%, respectively, 5 years, after the first sickness absence period due to MDD. More severe MDD and longer duration of sickness absence period were associated with lower probability of being employed. Conclusions Sickness absence due to MDD was associated with considerable reduction in employment and earnings losses. For men and individuals with more severe MDD, this reduction was before the first sickness period. This supports a reciprocal association between employment and earnings with MDD.

► **Télétravail : un travail à distance du monde**

LEDERLIN F.

2020

Études (11): 35-45.

<https://www.cairn.info/revue-etudes-2020-11-page-35.htm>

Subitement mis en lumière par la pandémie de Covid-19, le télétravail s'est imposé en quelques mois comme le moyen efficace de maintenir une partie de l'activité économique durant la crise, et comme une pratique viable, durable et même confortable pour des millions de travailleurs dans le monde. Mais, au-delà de ces bénéfices immédiats, quel rapport aux autres, à nous-mêmes et, en définitive, au monde, cette modalité de travail instaure-t-elle ? Cette réflexion critique vise à ouvrir le débat.

► **Arrêts maladie chez les hospitaliers : impact fort des conditions de travail**

REVUE PRESCRIRE

2020

Revue Prescrire 40(444): 786-787.

Selon des enquêtes menées en France au cours des années 2010, le nombre de jours d'arrêt maladie observé chez les professionnels hospitaliers varie peu entre le secteur public et le secteur privé. Les raisons de ces arrêts maladie sont surtout liées aux conditions de travail, ainsi qu'à l'âge des salariés. Pénibilité des tâches et mécontentement par rapport à l'évolution de leur métier semblent être les principaux déterminants de l'état de santé des personnels hospitaliers, surtout infirmiers et aides-soignants.

Ageing**► Does Ageing Alter The Contribution Of Health To Subjective Well-Being?**

BUSSIÈRE C., SIRVEN N. ET TESSIER P.

2020

Soc Sci Med 268: 113456.<https://doi.org/10.1016/j.socscimed.2020.113456>

Older adults regularly report rising levels of Subjective Well-Being (SWB) over time, despite a concomitant decline in their health. One possible explanation is that individuals develop psychological mechanisms to diminish the contribution of health to their well-being as they get older. This research examines whether observational data are consistent with this hypothesis of hedonic adaptation to health decline with ageing, in all aspects of SWB, and for different birth cohorts over time. Using longitudinal data from the Survey of Health, Ageing and Retirement in Europe (SHARE) between 2007 and 2015 in 10 European countries for respondents aged 50 onwards (4 waves, 41,258 individuals), we estimated panel fixed-effects models for outcomes measuring the three aspects of SWB: evaluative (life satisfaction), experienced (positive and negative affectivity) and eudemonic well-being (sense of purpose and meaning in life). We decomposed age in birth cohort and time fixed effects. Changes over time in the contribution of health to SWB were estimated by interaction terms between health and time fixed effects. Results showed that the value of health changes over time and for different birth cohorts in ways that depend on the measure of SWB. Ageing increases the importance of health for both eudemonic and experienced well-being. By contrast, the association between health and life satisfaction weakens with age, except for individuals aged 80 and above for which it strengthens. Our results thus offer only little support for hedonic adaptation to health decline with age, restricted to life satisfaction and individuals under 80 years of age. These findings caution against the use of mean estimations over the lifespan to determine the value of health as well as against the use of the various forms of SWB interchangeably in public policy analysis and economic evaluations of healthcare.

► Vivre à domicile ou en institution : quels sont les déterminants de la prise en charge de la perte d'autonomie des personnes âgées ?

CARRÈRE A.

2020

Regards 57(1): 127-139.<https://www.cairn.info/revue-regards-2020-1-page-127.htm>

Particulièrement mises en lumière à l'occasion de la crise sanitaire du coronavirus, les réalités et les difficultés du secteur du grand âge appellent des révisions conséquentes. Ce dossier de Regards présente ce que développe la protection sociale, ce qu'observent et proposent des gériatres et des gérontologues, mais aussi ce qui s'innove à travers le monde. Les réflexions portent sur l'assurabilité de la dépendance, sur l'organisation des parcours selon les attentes, les besoins, les configurations territoriales. Une clé d'entrée consiste à envisager les vulnérabilités des personnes âgées également comme gisement pour de nouvelles idées et activités. L'ambition générale vise la prévention de la perte d'autonomie, en agissant notamment au moment du passage à la retraite, en luttant contre l'isolement, en aidant à adapter les pratiques alimentaires. Tout ceci au service d'un bien-vieillir. Les chocs de l'épidémie de Covid-19 et du confinement commandent des observations sur les impacts pour la protection sociale. L'ensemble de l'édifice a été bousculé, financièrement et matériellement. S'occupant des premiers concernés, amortissant les secousses économiques et soutenant l'activité, le système – dont les soignants ont été applaudis – a su réagir. Les questions d'avenir sont cependant lourdes. Le thème mérite bien un second dossier dans cette livraison de la revue.

► Modes de prise en charge de la perte d'autonomie : l'offre contraint-elle les choix des personnes âgées ?

CARRÈRE A. ET JUSOT F.

2020

Revue économique 71(6): 1069-1099.<https://www.cairn.info/revue-economique-2020-6-page-1069.htm>

Cet article s'intéresse à la sensibilité de la demande

de prise en charge de la perte d'autonomie vis-à-vis de l'offre. En nous appuyant sur un modèle théorique, nous estimons la probabilité de choisir un mode de prise en charge grâce à une modélisation multinomiale utilisant les données des enquêtes CARE (Capacités, aides et ressources des seniors). Des restes à charge et densités théoriques sont estimés pour chaque alternative et individu afin d'évaluer l'effet de ces deux déterminants sur la décision de recourir à un mode de prise en charge spécifique. Cet article révèle que les choix sont contraints à la fois par le reste à charge de la prise en charge, sa variété et sa quantité mais que leur effet est limité.

► **Les évolutions de la pension de réversion en France**

CHARTIER F. ET COLLIN C.

2020

Retraite et société 83(1): 171-188.

<https://www.cairn.info/revue-retraite-et-societe-2020-1-page-171.htm>

La pension de réversion n'est pas qu'une pension accordée en grande majorité à des veuves âgées ayant peu de ressources; la réversion, c'est aussi le résultat de parcours professionnels, conjugaux, patrimoniaux et c'est, par-dessus tout, le reflet d'une certaine représentation de la société. Ce nouveau numéro de *Retraite et société* nous rappelle l'importance de ce dispositif dans la France d'aujourd'hui mais aussi les ambiguïtés qu'il produit avec une juxtaposition de logiques disparates selon les différents régimes, parfois difficiles à justifier. En outre, les transformations structurelles et démographiques qui ont lieu depuis quelques années bousculent nos systèmes tels qu'ils avaient été pensés et conçus en d'autres temps. Les auteurs de ce dossier, à travers leurs contributions, nous proposent de simuler le prolongement de ces transformations et d'observer les incidences possibles sur la pension de réversion. Ils s'interrogent également sur les évolutions possibles de cette pension dans un contexte de discussions autour d'un régime de retraite universel en points. Et dans une perspective plus européenne, ils nous offrent une lecture approfondie des expériences grecque et finlandaise.

► **Common Cause And Mechanism For All Pathologies Of Aging?**

COMBES G. F., PELLAY F. X. ET RADMAN M.

2020

Med Sci (Paris) 36(12): 1129-1134.

Health is harmony, aging and its diseases (are) functional disharmony at the molecular, cellular and tissue levels. Our observations lead us to think that there seems to be a common cause and a common mechanism for aging and its many and diverse diseases. This common cause is the oxidative damage to particular proteins emerging from a combination of imperfect folding and oxidative stress. This common cause jointly goes with the biological clock common to various age-related diseases, whose the incidence increases exponentially over time and causes 90% of human mortality. Pharmacological interventions on the common cause could avoid and simultaneously attenuate all degenerative and malignant diseases, as it is the natural case of super-centenarians.

► **'More Than One Red Herring'? Heterogeneous Effects Of Ageing On Health Care Utilisation**

COSTA-FONT J. ET VILAPLANA-PRieto C.

2020

Health Economics 29(S1): 8-29.

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4035>

We study the effect of ageing, defined as an extra year of life, on health care utilisation. We disentangle the direct effect of ageing, from other alternative explanations such as the presence of comorbidities and endogenous time to death (TTD) that are argued to absorb the effect of ageing (so-called 'red herring' hypothesis). We exploit individual level end of life data from several European countries that record the use of medicine, outpatient and inpatient care and long-term care. Consistently with the 'red herring hypothesis', we find that corrected TTD estimates are significantly different from uncorrected ones, and their effect size exceeds that of an extra year of life, which in turn is moderated by individual comorbidities. Corrected estimates suggest an overall attenuated effect of ageing, which does not influence outpatient care utilisation. These results suggest the presence of 'more than one red herring' depending on the type of health care examined.

► **Building ‘Implicit Partnerships’? Financial Long-Term Care Entitlements In Europe**

COSTA-FONT J. ET ZIGANTE V.
 2020

Policy Sciences 53(4): 697-712.
<https://doi.org/10.1007/s11077-020-09403-1>

The design of public subsidies for long-term care (LTC) programmes to support frail, elderly individuals in Europe is subject to both tight budget constraints and increasing demand pressures for care. However, what helps overcoming the constraints that modify LTC entitlements? We provide a unifying explanation of the conditions that facilitate the modification of public financial entitlements to LTC. We build on the concept of ‘implicit partnerships’, an implicit (or ‘silent’) agreement, encompassing the financial co-participation of both public funders, and families either by both allocating time and/or financial resources to caregiving. Next, we provide suggestive evidence of policy reforms modifying public entitlements in seven European countries which can be classified as either ‘implicit user partnerships’ or ‘implicit caregiver partnerships’. Finally, we show that taxpayers attitudes mirror the specific type of implicit partnership each country has adopted. Hence, we conclude that the modification of long-term care entitlements require the formation of some type of ‘implicit partnership’.

► **Cinquième « risque », cinquième « branche » ? Vers une politique rénovée de prise en charge de la perte d'autonomie des personnes âgées ?**

FERRAS B.
 2020

Regards 57(1): 195-211.
<https://www.cairn.info/revue-regards-2020-1-page-195.htm>

Particulièrement mises en lumière à l’occasion de la crise sanitaire du coronavirus, les réalités et les difficultés du secteur du grand âge appellent des révisions conséquentes. Ce dossier de Regards présente ce que développe la protection sociale, ce qu’observent et proposent des gériatres et des gérontologues, mais aussi ce qui s’innove à travers le monde. Les réflexions portent sur l’assurabilité de la dépendance, sur l’organisation des parcours selon les attentes, les besoins, les configurations territoriales. Une clé d’entrée consiste à envisager les vulnérabilités des personnes âgées également comme gisement pour de nouvelles idées et activités. L’ambition générale vise la prévention de la

perte d’autonomie, en agissant notamment au moment du passage à la retraite, en luttant contre l’isolement, en aidant à adapter les pratiques alimentaires. Tout ceci au service d’un bien-vieillir. Les chocs de l’épidémie de Covid-19 et du confinement commandent des observations sur les impacts pour la protection sociale. L’ensemble de l’édifice a été bousculé, financièrement et matériellement. S’occupant des premiers concernés, amortissant les secousses économiques et soutenant l’activité, le système – dont les soignants ont été applaudis – a su réagir. Les questions d’avenir sont cependant lourdes. Le thème mérite bien un second dossier dans cette livraison de la revue.

► **The Involvement Of Informal Caregivers In Self-Help Of The Elderly: How Far?**

FONTAINE R. ET JUIN S.
 2020

Med Sci (Paris) 36(12): 1188-1195.

► **Parcours professionnels, facteurs démographiques et financiers : quels effets sur la réversion ?**

GODET F., LIN V. ET WILNER L.
 2020

Retraite et société 83(1): 51-74.
<https://www.cairn.info/revue-retraite-et-societe-2020-1-page-51.htm>

Certains facteurs démographiques, économiques et financiers sont susceptibles d’avoir de fortes répercussions sur les futures pensions de réversion. Cet article propose d’évaluer, à l’aide du modèle de micro-simulation Destinie, développé à l’Insee, la sensibilité de la réversion à la réduction des écarts générés d’espérance de vie, à la convergence des trajectoires professionnelles féminines et masculines, ou encore à des variantes (paramétriques ou systémiques) du dispositif actuel. Ainsi, la généralisation de la condition de ressources qui prévaut actuellement pour le régime général créerait des économies pour les caisses de retraite tout en étant redistributive. Une logique d’« assurance veuvage », qui viserait à maintenir le niveau de vie au moment du décès du conjoint, générerait des « gagnants » et des « perdants », avec un effet redistributif globalement neutre.

► **L’avenir de l’Ehpad est au domicile : expérimentation d’un dispositif d’accompagnement renforcé au domicile dans le cadre de l’article 51**

LAUTMAN A.

2020

Regards 57(1): 187-194.

<https://www.cairn.info/revue-regards-2020-1-page-187.htm>

Particulièrement mises en lumière à l’occasion de la crise sanitaire du coronavirus, les réalités et les difficultés du secteur du grand âge appellent des révisions conséquentes. Ce dossier de Regards présente ce que développe la protection sociale, ce qu’observent et proposent des gériatres et des gérontologues, mais aussi ce qui s’innove à travers le monde. Les réflexions portent sur l’assurabilité de la dépendance, sur l’organisation des parcours selon les attentes, les besoins, les configurations territoriales. Une clé d’entrée consiste à envisager les vulnérabilités des personnes âgées également comme gisement pour de nouvelles idées et activités. L’ambition générale vise la prévention de la perte d’autonomie, en agissant notamment au moment du passage à la retraite, en luttant contre l’isolement, en aidant à adapter les pratiques alimentaires. Tout ceci au service d’un bien-vieillir. Les chocs de l’épidémie de Covid-19 et du confinement commandent des observations sur les impacts pour la protection sociale. L’ensemble de l’édifice a été bousculé, financièrement et matériellement. S’occupant des premiers concernés, amortissant les secousses économiques et soutenant l’activité, le système – dont les soignants ont été applaudis – a su réagir. Les questions d’avenir sont cependant lourdes. Le thème mérite bien un second dossier dans cette livraison de la revue.

► **Investigating The Relationship Between Social Care Supply And Healthcare Utilization By Older People In England**

LIU D., PACE M. L., GODDARD M., *et al.*

2021

Health Economics 30(1): 36-54.

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4175>

Abstract Since 2010, adult social care spending in England has fallen significantly in real terms whilst demand has risen. Reductions in social care supply may also have impacted demand for NHS services, particularly for those whose care is provided at the interface of the health and care systems. We analyzed a panel dataset of 150 local authorities (councils) to test poten-

tial impacts on hospital utilization by people aged 65 and over: emergency admission rates for falls and hip fractures (“front-door” measures); and extended stays of 7 days or longer; and 21 days or longer (“back-door” measures). Changes in social care supply were assessed in two ways: gross current expenditure (per capita 65 and over) adjusted by local labor costs and social care workforce (per capita 18 and over). We ran negative binomial models, controlling for deprivation, ethnicity, age, unpaid care, council class, and year effects. To account for potential endogeneity, we ran instrumental variable regressions and dynamic panel models. Sensitivity analysis explored potential effects of funding for integrated care (the Better Care Fund). There was no consistent evidence that councils with higher per capita spend or higher social care staffing rates had lower hospital admission rates or shorter hospital stays.

► **Parcours des personnes âgées dans le système de santé**

LUSSIER M.-D.

2020

Regards 57(1): 115-126.

<https://www.cairn.info/revue-regards-2020-1-page-115.htm>

La population âgée et très âgée qui bénéficie de l’amélioration de son espérance de vie en bonne santé a la particularité de cumuler la polypathologie et la chronicité. La réflexion sur la prise en charge et l’accompagnement de cette population concentre ainsi les efforts par les enjeux qu’elle cristallise. Les premiers travaux sur les parcours de cette population au sein du système de santé ont permis de mieux s’approprier ce concept et de modéliser des actions à mener. Nous nous attacherons ici à préciser comment surgit la notion de parcours, comment améliorer la gestion des maladies chroniques, leur prise en charge et l’accompagnement des personnes. Nous nous appuyerons sur les expériences étrangères, les enseignements de l’expérimentation nationale Personnes Âgées En Risque de Perte d’Autonomie (Paerpa) pour identifier les pratiques probantes et invariantes dans la mise en œuvre des parcours de santé..

► **Quel avenir pour l'assurance dépendance ?**

MAYEUR P.

2020

Regards 57(1): 213-224.

<https://www.cairn.info/revue-regards-2020-1-page-213.htm>

La question du caractère assurable de la dépendance totale est fréquemment posée et reposée. L'expérience pousse à répondre positivement à cette question. Principalement en raison de l'attentisme des différents acteurs lié à l'annonce à chaque fois repoussée de la mise en place d'un cinquième risque, le marché, malgré de multiples produits, ne s'est pas développé à la hauteur des attentes. Le rapport Libault de 2019 a pu considérer que l'offre n'était pas suffisamment « mûre ». Pourtant, au regard des restes à charge liés principalement aux dépenses d'hébergement, l'assurance dépendance constitue un complément utile et nécessaire pour garantir le patrimoine des classes moyennes. Elle apporte également des solutions appréciables en matière d'aide aux aidants et d'accompagnement des personnes aidées. Elle mérite ainsi d'être favorisée. Plutôt que d'imaginer un produit unique, il apparaît souhaitable d'articuler de manière harmonieuse le recours à l'assurance privée par rapport aux dispositifs publics mis en place, ce qui passe par la définition d'une charte.

► **Are Frail Elderly People In Europe High-Need Subjects? First Evidence From The SPRINTT Data**

SICSIC J., RAVESTEIJN B. ET RAPP T.

2020

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Physical frailty and sarcopenia (PF&S) has received growing attention in empirical models of health care use. However, few articles focused on objective measures of PF&S to assess the extent of care consumption among the frail population at risk of dependency. Using baseline data from the SPRINTT study, a sample of 1518 elderly people aged 70+ recruited in eleven European countries, we analyse the association between various PF&S measures and health care / long term care (LTC) use. Multiple health care and LTC outcomes are modelled using linear probability models adjusted for a range of individual characteristics and country fixed effects. We find that PF&S is associated with a significant increase in emergency admissions and hospitalizations, especially among low-income

elders. All PF&S measures are significantly associated with increased use of formal and informal LTC. There is a moderating effect of income on LTC use: poor frail elders are more likely to use any of the formal LTC services than rich frail elders. Our results are robust to various statistical specifications. They suggest that the inclusion of PF&S in the eligibility criteria of public LTC allowances could contribute to decrease the economic gradient in care use among the elderly community-dwelling European population.

► **Politique de prévention de la perte de l'autonomie. Stratégie ICOPE de l'OMS, mise en œuvre opérationnelle en Occitanie**

TAKEDA C., GUYONNET S. ET VELLAS B.

2020

Regards 57(1): 87-94.

<https://www.cairn.info/revue-regards-2020-1-page-87.htm>

Le Gérontopôle du CHU de Toulouse, en lien avec l'OMS a développé une application appelée « ICOPE MONITOR » qui correspond à l'étape 1 de ICOPE (figure 2). À travers l'étude INSPIRE, l'un des objectifs est d'implémenter à large échelle le programme ICOPE de l'OMS pour un vieillissement en santé et la prévention de la perte d'autonomie, afin de suivre plus de 200 000 seniors en Occitanie d'ici 3 à 5 ans, puis de l'étendre rapidement au niveau national.

► **Étude de la fragilité de la personne âgée et de l'activité physique en médecine générale : à propos d'une étude prospective**

ZULFIQAR A. A., LORENZO-VILLALBA N., PEIXOTO A., *et al.*

2020

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La fragilité est un état transitoire et réversible pouvant entraîner une morbi-mortalité importante et une perte d'autonomie. Elle est au cœur des enjeux de santé publique et de la prévention de la dépendance. L'activité physique est souvent décrite comme un facteur protecteur de la dépendance et comme un facteur limitant la fragilité. Notre objectif est d'analyser la relation entre activité physique et fragilité chez la personne âgée. Méthodes Une étude observationnelle transversale a été réalisée dans trois cabinets

de médecine générale situés dans le département de l'Eure. Les patients âgés de 65 ans et plus ont été inclus au décours d'une consultation avec leur médecin généraliste. Les patients dépendants aux termes de l'échelle ADL ont été exclus. Le niveau d'activité physique a été apprécié par le questionnaire de Ricci et Gagnon, qui définit un profil actif pour un score ≥ 18 points. La fragilité a été recherchée par l'échelle de Fried et la grille modifiée SEGA volet A. Une analyse multivariée a été réalisée pour ajuster les scores de fragilité à l'âge, au sexe et au niveau d'activité physique. Résultats Parmi les 70 patients inclus, 36 étaient actifs (51 %) et 34 inactifs (49 %). La prédominance était féminine avec 47 femmes (67 %). L'âge moyen était de 75,3 ans. Douze patients avaient été diagnostiqués comme fragiles (17 %) avec l'échelle de Fried et 24 (34 %) avec la grille SEGA A. L'analyse bivariée mettait en évidence une fragilité plus importante selon les critères de Fried chez les patients inactifs que chez les patients actifs (Fried moyen des patients actifs 0,56 IC95 [0,31; 0,80], contre 1,76 [1,21; 2,32] chez les inactifs, $p < 0,0001$). La différence de moyenne était aussi significative avec le score de SEGA volet A (6,42 IC95 [5,34; 7,49] chez les actifs, contre 8,65 IC95 [7,15; 10,15] chez les inactifs, $p = 0,017$). En analyse multivariée, l'échelle de Fried était essentiellement influencée par l'âge et l'ADL, tandis que le score de SEGA était impacté par le sexe féminin et le niveau d'activité physique. Conclusion L'activité physique semble avoir une action positive sur la fragilité. Il serait intéressant de proposer un dépistage systématique de la fragilité en médecine générale, pour mettre en place des mesures préventives, dont l'activité physique. Les initiatives encourageant et favorisant l'activité physique des seniors sont à renforcer.

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