

Veille scientifique en économie de la santé

Watch on Health Economics Literature

Novembre 2024 / November 2024

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Démographie	<i>Demography</i>
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Assurance maladie

Health Insurance

► **Does Health Aid Matter to Financial Risk Protection? A Regression Analysis Across 159 Household Surveys, 2000–2016**

GABANI J., SUHRCKE M., NEELSEN S., *et al.*
2024

Social Science & Medicine 356: 117148.

<https://doi.org/10.1016/j.socscimed.2024.117148>

Introduction Universal Health Coverage (UHC) is a widely accepted objective among entities providing development assistance for health (DAH) and DAH recipient governments. One key metric to assess progress with UHC is financial risk protection, but empirical evidence on the extent to which DAH is associated to financial risk protection (and hence UHC) is scarce. Methods Our sample is comprised of 65 countries whose DAH per capita is above the population-weighted average DAH per capita across all countries. The sample comprises of 1.7 million household observations, for the period 2000–2016. We run country and year fixed effects regressions, and pseudo-panel models, to assess the association between DAH and three measures of financial risk protection: catastrophic health expenditure (i.e., out-of-pocket health expenditures larger than 10% of total household expenditures [‘CHE10%’]), out-of-pocket health expenditure as a share of total expenditure (‘OOP%’), and impoverishment due to health expenditures, at the 1.90US\$ per day poverty line (‘IMP190’). Results on average, DAH investment does not appear to be significantly associated with financial risk protection outcomes. However, we find suggestive evidence that a 1 US\$ increase in DAH per capita is negatively associated (i.e., an improvement) with at least one financial risk protection outcome for the poorest household quintile within countries (in fixed effects models, IMP190: 0.05 percentage points, $p < 0.1$; in pseudo-panel models, CHE10%: 0.12 percentage points, $p < 0.01$). DAH is also negatively associated (i.e., an improvement) with most financial risk protection outcomes when it is largely channelled via government systems (i.e., when it is “on-budget”) (CHE10%: 0.68 percentage points, $p < 0.05$). Several robustness checks confirm these results. Discussion DAH investments require careful planning to improve financial risk protection. For example, positive DAH effects for the poorest quintiles of the population might be driven by DAH targeting poorer populations

and doing so effectively. Our results also suggest that channelling more resources via governments might be a promising avenue to enhance the impact of DAH on financial risk protection.

► **Health Insurance Coverage Projections For the US Population and Sources of Coverage, By Age, 2024–34**

HALE J., HONG N., HOPKINS B., *et al.*
2024

Health Affairs 43(7): 922-932.

<https://doi.org/10.1377/hlthaff.2024.00460>

In the Congressional Budget Office’s projections of health insurance coverage, 92.3 percent of the US population, or 316 million people, have coverage in 2024, and 7.7 percent, or 26 million, are uninsured. The uninsured share of the population will rise over the course of the next decade, before settling at 8.9 percent in 2034, largely as a result of the end of COVID-19 pandemic-related Medicaid policies, the expiration of enhanced subsidies available through the Affordable Care Act health insurance Marketplaces, and a surge in immigration that began in 2022. The largest increase in the uninsured population will be among adults ages 19–44. Employment-based coverage will be the predominant source of health insurance, and as the population ages, Medicare enrollment will grow significantly. After greater-than-expected enrollment in 2023, Marketplace enrollment is projected to reach an all-time high of twenty-three million people in 2025.

► **Expanding Medicare Coverage of Anti-Obesity Medicines Could Increase Annual Spending By \$3.1 Billion to \$6.1 Billion**

IPPOLITO B. ET LEVY J. F.
2024

Health Aff (Millwood) 43(9): 1254-1262.

<https://doi.org/10.1377/hlthaff.2024.00356>

The introduction of highly effective anti-obesity drugs, such as Wegovy, has prompted debate over Medicare’s prohibition on coverage of such products. In this study, we estimated the costs of allowing Medicare coverage of anti-obesity medications. Our analysis incorporated

data on drug costs, real-world adherence rates, and potential changes to other health care spending. Using Medicare claims, we also documented beneficiaries' eligibility for nearly identical products approved for different indications. Assuming that anti-obesity drugs were covered in 2025 and that 5 percent or 10 percent of newly eligible patients were prescribed one, annual Part D costs were estimated to increase by \$3.1 billion or \$6.1 billion, respectively. The marginal costs of this policy could fall by as much as 62.5 percent from baseline estimates if products were approved for additional indications in coming years because these additional conditions are common among people with obesity. This would increase Medicare spending but would occur regardless of a policy change. Longer-term estimates come with significant uncertainty about utilization and price changes, but these results are consistent with this policy change likely increasing Medicare costs by the low to middle tens of billions of dollars over ten years.

► **Effects of Medicaid Managed Care on Early Detection of Cancer: Evidence From Mandatory Medicaid Managed Care Program in Pennsylvania**

KWON Y., ROBERTS E. T., COLE E. S., *et al.*

2024

Health Serv Res 59(5): e14348.

<https://doi.org/10.1111/1475-6773.14348>

OBJECTIVE: To examine changes in late- versus early-stage diagnosis of cancer associated with the introduction of mandatory Medicaid managed care (MMC) in Pennsylvania. **DATA SOURCES AND STUDY SETTING:** We analyzed data from the Pennsylvania cancer registry (2010-2018) for adult Medicaid beneficiaries aged 21-64 newly diagnosed with a solid tumor. To ascertain Medicaid and managed care status around diagnosis, we linked the cancer registry to statewide hospital-based facility records collected by an independent state agency (Pennsylvania Health Care Cost Containment Council). **STUDY DESIGN:** We leveraged a natural experiment arising from county-level variation in mandatory MMC in Pennsylvania. Using a stacked difference-in-differences design, we compared changes in the probability of late-stage cancer diagnosis among those residing in counties that newly transitioned to mandatory managed care to contemporaneous changes among those in counties with mature MMC programs. **DATA COLLECTION/EXTRACTION METHODS:** N/A. **PRINCIPAL FINDINGS:** Mandatory MMC

was associated with a reduced probability of late-stage cancer diagnosis (-3.9 percentage points; 95% CI: -7.2, -0.5; $p = 0.02$), particularly for screening-amenable cancers (-5.5 percentage points; 95% CI: -10.4, -0.6; $p = 0.03$). We found no significant changes in late-stage diagnosis among non-screening amenable cancers. **CONCLUSIONS:** In Pennsylvania, the implementation of mandatory MMC for adult Medicaid beneficiaries was associated with earlier stage of diagnosis among newly diagnosed cancer patients with Medicaid, especially those diagnosed with screening-amenable cancers. Considering that over half of the sample was diagnosed with late-stage cancer even after the transition to mandatory MMC, Medicaid programs and managed care organizations should continue to carefully monitor receipt of cancer screening and design strategies to reduce barriers to guideline-concordant screening or diagnostic procedures.

► **Que pensent les Français des dynamiques démographiques en France et dans le monde ? Les enseignements d'une enquête d'opinion dans la lignée des enquêtes de conjoncture de l'Ined**

DE LUCA BARRUSSE V., LEFÈVRE C. ET VÉRON J.
2024

Population 79(1): 13-40.

<https://doi.org/10.3917/popu.2401.0013>

En 2018 a été menée l'enquête Pop Aware, dans le cadre du panel Elipss, représentatif de la population française. En étudiant tout autant les connaissances que les opinions relatives aux dynamiques démographiques, en France et dans le monde, cette enquête poursuit un double objectif : d'une part, elle reprend des questions posées des décennies plus tôt sur la situation française, permettant ainsi des comparaisons dans le temps; d'autre part, elle introduit de nouvelles réflexions, en étendant notamment le champ de son questionnement aux enjeux mondiaux. Les enquêtés considèrent les questions démographiques comme importantes, et ce, de façon relativement indépendante des caractéristiques sociodémographiques et des opinions politiques. Ils expriment aussi une préférence pour la stabilité de la population plutôt que pour sa décroissance, malgré une augmentation des opinions liant dynamique démographique et problèmes environnementaux, notamment chez les jeunes. Ce degré élevé de sensibilité aux phénomènes démographiques est entretenu à la fois par les médias et par l'école. Il n'est pas récent. Des enquêtes de conjoncture et d'opinion publique réalisées sur une période de 60 ans le mettaient déjà en évidence. La conduite d'enquêtes similaires, dans d'autres pays comme en France, serait pertinente pour saisir d'éventuelles variations, dans l'espace et dans la durée, des manifestations de cet intérêt pour la démographie.

► **Évolutions régionales des naissances pendant l'épidémie de Covid-19 en Allemagne, en Espagne, en France et en Italie. Le rôle des facteurs économiques et de la surmortalité**

LUPPI F., ARPINO B., ROSINA A., *et al.*
2024

Population 79(1): 143-159.

<https://doi.org/10.3917/popu.2401.0143>

Les données recueillies au début de la pandémie de Covid-19 révèlent des effets contrastés sur le nombre de naissances en Europe. Cette note de recherche compare les tendances régionales du taux global de fécondité (TGF) avant et après le début de la pandémie dans les quatre pays européens les plus peuplés : l'Allemagne, l'Espagne, la France et l'Italie. Elle examine la relation entre l'évolution du TGF pendant la pandémie et différents facteurs : les décès liés au Covid-19, les changements sur le marché du travail, et la population exposée au risque de pauvreté. Les données régionales sur les naissances mensuelles entre janvier 2018 et décembre 2021 proviennent des instituts nationaux de statistiques, tandis que les données supplémentaires sont fournies par Eurostat. Notre analyse comporte deux ensembles de régressions. Premièrement, des modèles de régression linéaire à effets fixes sont mis en œuvre au niveau régional pour chaque pays, afin d'estimer les effets de trois périodes pandémiques sur le TGF mensuel. Deuxièmement, les coefficients de régression obtenus sont intégrés, en tant que variables dépendantes, dans des régressions linéaires pondérées qui incluent des variables régionales relatives aux évolutions du marché du travail, au risque de pauvreté, et à la surmortalité. Nos résultats révèlent des disparités régionales (au sein des pays) quant à l'évolution des naissances pendant la pandémie. Ils mettent en évidence une relation significative entre la baisse de la natalité et la hausse du chômage des jeunes.

► **Changement climatique : la « faute » à la surpopulation ?**

PISON G.

2024

Informations sociales 211(3): 33-44.

<https://doi.org/10.3917/inso.211.0033>

Une idée répandue est que nous serions trop nombreux sur Terre et que la « surpopulation » serait l'une des principales causes, sinon la première, de la dégradation de l'environnement et de l'érosion de la biodiversité. L'une des mesures prioritaires serait d'arrêter la croissance démographique. En réalité, il est très probable que l'humanité n'échappera pas à un surcroît de

près de 2 milliards d'habitants d'ici 2050 en raison de l'inertie démographique que nul ne peut empêcher. Les politiques de population des États n'ont cependant en général que des effets modestes sur l'évolution de la fécondité, et leurs objectifs ne sont pas écologiques. Du côté des individus, l'« éco-anxiété » et l'idée d'avoir moins d'enfants pour « sauver la planète » ne semblent pas expliquer les niveaux de fécondité relativement bas observés aujourd'hui dans beaucoup de pays développés. Les intentions de fécondité sont moindres chez les personnes particulièrement inquiètes des défis globaux, mais leur crainte est plus souvent associée à la « surpopulation » ou à l'inflation qu'à celle du changement climatique.

E-santé

E-Health

► **Digital Health Technologies and Inequalities: A Scoping Review of Potential Impacts and Policy Recommendations**

BADR J., MOTULSKY A. ET DENIS J. L.

2024

Health Policy 146: 105122.

<https://doi.org/10.1016/j.healthpol.2024.105122>

Digital health technologies hold promises for reducing health care costs, enhancing access to care, and addressing labor shortages. However, they risk exacerbating inequalities by disproportionately benefitting a subset of the population. Use of digital technologies accelerated during the Covid-19 pandemic. Our scoping review aimed to describe how inequalities related to their use were conceptually assessed during and after the pandemic and understand how digital strategies and policies might support digital equity. We used the PRISMA Extension for scoping reviews, identifying 2055 papers through an initial search of 3 databases in 2021 and complementary search in 2022, of which 41 were retained. Analysis was guided by the eHealth equity framework. Results showed that digital inequalities were reported in the U.S. and other high-income countries and were mainly assessed through differences in access and use according to individual sociodemographic characteristics. Health disparities related to technology use and the interaction between

context and technology implementation were more rarely documented. Policy recommendations stressed the adoption of an equity lens in strategy development and multilayered and intersectoral collaboration to align interventions with the needs of specific subgroups. Finally, findings suggested that evaluations of health and wellbeing distribution related to the use of digital technologies should inform digital strategies and health policies.

► **The Role of Contact-Tracing Mobile Apps in Pandemic Prevention: A Multidisciplinary Perspective on Health Beliefs, Social, and Technological Factors**

BEN NASR I., KONDRATEVA G., KHVATOVA T., *et al.*

2024

Soc Sci Med 358: 117204.

<https://doi.org/10.1016/j.socscimed.2024.117204>

During the recent COVID-19 pandemic, governments implemented mobile applications for contact tracing as a rapid and effective solution to mitigate the spread of the virus. However, these seemingly straightforward solutions did not achieve their intended objectives. In line with previous research, this paper aims to investigate the factors that influence the acceptance and usage of contact-tracing mobile apps (CTMAs) in the context of disease control. The research model in this

paper integrates the Unified Theory of Acceptance and Use of Technology and the Health Belief Model (HBM). The present study involved a diverse sample of 770 French participants of all genders, ages, occupations, and regions. Critical elements from the Health Belief Model, technological factors related to the app, and social factors, including the centrality of religiosity, were assessed using well-established measurement scales. The research's findings demonstrate that several factors, such as perceived benefits and perceived severity, social influence, health motivation, and centrality of religiosity, significantly impact the intention to use a CTMA. These findings suggest that CTMAs hold promise as valuable tools for managing future epidemics. However, addressing challenges, revising implementation strategies, and potentially collaborating with specialized industry partners under regulatory frameworks are crucial. This practical insight can guide policymakers and public health officials in their decision-making.

► **La cybersécurité en santé**

BÉVIÈRE-BOYER B., LAUDIE A. ET KARATHANASIS T.
2024

Droit, Santé et Société 6(2).

<https://doi.org/10.3917/dsso.112.0003>

► **An Evaluation of the COVID-19 Self-Service Digital Contact Tracing System in New Zealand**

CHAMBERS T., ANGLEMYER A., CHEN A. T., *et al.*
2024

Health Policy 144: 105073.

<https://doi.org/10.1016/j.healthpol.2024.105073>

Background Digital contact tracing (DCT) aims to improve time-to-isolation (timeliness) and find more potentially exposed individuals (sensitivity) to enhance the utility of contact tracing. The aim of this study was to evaluate the public uptake of a DCT self-service survey and its integration with the Bluetooth exposure notification system within the New Zealand Covid Tracer App (NZCTA). **Methods** We adopted a retrospective cohort study design using community COVID-19 cases from February 2022 to August 2022 in New Zealand (1.2 million cases). We examined the proportion of cases completing a self-service survey and the time to complete the survey by age, sex and ethnicity. **Results** Overall, 66% of cases completed

their self-service survey. Completion was influenced by age, sex and ethnicity. The median completion time was 1.8 h (IQR 0.2, 17.2), with 95% of those completing this survey doing so within 48 h of case identification. Around 13% of all survey completers also uploaded their Bluetooth data, which resulted in an average of 663 cases per day notifying 4.5 contacts per case. **Conclusion** The combination of high public uptake and rapid response times suggest self-service DCT could be a useful tool for future outbreaks, particularly if implemented in conjunction with manual processes and other DCT tools (e.g. Bluetooth) to address issues related to performance (sensitivity, timeliness), effectiveness, and health equity.

► **La diffusion des outils et services e-santé auprès de leurs utilisateurs : l'exemple de « Mon espace santé » en France**

HAYAR S. ET MÉRIADE L.

2024

Gestion et management public (5): 9-29

<https://shs.cairn.info/revue-gestion-et-management-public-2024-3-page-9>

Les pouvoirs publics souhaitent tirer parti des perspectives offertes par le numérique en santé pour améliorer l'information et la prise en charge des patients tout en luttant contre les inégalités de santé dans les territoires. Cependant, en France, si au cours des quinze dernières années, cette transformation digitale du secteur de la santé s'est particulièrement développée, elle a aussi connu des résultats très variables et parfois encore assez décevants. Pour notamment renforcer et accélérer cette transformation digitale, de nombreux travaux ont décrit en détail les modalités et facteurs favorisant l'adoption et l'appropriation des outils et services numériques en santé. En revanche, beaucoup moins de travaux ont porté leur attention sur la phase de diffusion aux utilisateurs de ces outils et services alors qu'elle détermine significativement leur adoption et appropriation. Pour combler ce manque, à partir de la théorie de la diffusion des innovations, nous proposons d'analyser les modalités de diffusion à ses utilisateurs de l'outil « Mon espace santé » proposé et mis en œuvre par la Caisse nationale d'assurance maladie en France. À partir d'une participation observante au sein des équipes chargées de la diffusion de cet outil, nous décrivons les éléments de diffusion de cette innovation digitale (système social, innovation, canaux de communication, temps). Les résultats de cette analyse nous permettent, dans un premier temps,

sur le plan théorique, de proposer un premier cadre d'analyse de la diffusion des innovations digitales en santé. L'application de ce cadre d'analyse nous autorise ensuite une caractérisation des modalités de diffusion de l'innovation digitale en santé « centrée sur l'utilisateur » aux côtés de celles relatives à sa conception déjà très illustrées dans la littérature. Ces modalités sont décrites à travers les principales composantes de la diffusion de « Mon espace santé » (différents rôles de l'utilisateur, canaux de communication utilisés et étapes de diffusion) et trois de ses principes directeurs (utilisateur-acteur, État-plateforme, déploiement incitatif centré sur l'utilisateur). Sur le plan pratique, ces composantes et principes de diffusion représentent autant de pistes d'amélioration de la diffusion des innovations digitales en santé dans le secteur public.

► **Targeting Machine Learning and Artificial Intelligence Algorithms in Health Care to Reduce Bias and Improve Population Health**

HURD T. C., COBB PAYTON F. ET HOOD D. B.

2024

The Milbank Quarterly 102(3): 577-604.

<https://doi.org/10.1111/1468-0009.12712>

Policy Points Artificial intelligence (AI) is disruptively innovating health care and surpassing our ability to define its boundaries and roles in health care and regulate its application in legal and ethical ways. Significant progress has been made in governance in the United States and the European Union. It is incumbent on developers, end users, the public, providers, health care systems, and policymakers to collaboratively ensure that we adopt a national AI health strategy that realizes the Quintuple Aim; minimizes race-based medicine; prioritizes transparency, equity, and algorithmic vigilance; and integrates the patient and community voices throughout all aspects of AI development and deployment.

► **Transformation digitale des services publics locaux et valeur publique : une étude de cas sur la santé et la formation professionnelle en France**

PORCHER S., CRISTOFINI O., GIMENEZ J., *et al.*

2024

Gestion et management public (5): 31-47.

<https://shs.cairn.info/revue-gestion-et-management-public-2024-3-page-31>

Le lien entre digitalisation et création de valeur publique reste à explorer. Dans cette optique, cette recherche présente une analyse qualitative de 42 entretiens semi-directifs menés avec des acteurs publics et privés de la santé et de la formation professionnelle opérant dans 10 régions de France. Les résultats montrent que la digitalisation peut créer de la valeur publique lorsqu'elle donne lieu à (i) une reconfiguration des organisations publiques visant la prise en compte des besoins exprimés par les acteurs de terrain; (ii) un mode de coordination favorisant l'apport des citoyens-usagers dans la création de nouveaux services; et (iii) l'alignement des valeurs des parties prenantes impliquées dans la création de valeur découlant de ces services. Partant de ces résultats, trois leviers de création de valeur publique induite par la digitalisation sont proposés pour contribuer à la littérature et aider les acteurs publics locaux à s'engager avec plus de possibilités de succès dans les projets de transformation digitale.

► **Telehealth Delivery Differs Significantly By Physician and Practice Characteristics**

YU J., CIVELEK Y., CASALINO L. P., *et al.*

2024

Health Affairs 43(9): 1311-1318.

<https://doi.org/10.1377/hlthaff.2024.00052>

In this study of 2022 Medicare fee-for-service claims, we found that female physicians, primary care physicians, psychiatrists, and physicians in nonrural practices delivered relatively higher proportions of visits via telehealth.

► **State Out-Of-Pocket Caps on Insulin Costs: No Significant Increase in Claims or Utilization**

ANDERSON K. E., CHAIYAKUNAPRUK N., GUTIERREZ E. J., *et al.*

2024

Health Affairs 43(8): 1137-1146.

<https://doi.org/10.1377/hlthaff.2024.00118>

Nearly all patients with type 1 diabetes and 20–30 percent of patients with type 2 diabetes use insulin to manage glycemic control. Approximately one-quarter of patients who use insulin report underuse because of cost. In response, more than twenty states have implemented monthly caps on insulin out-of-pocket spending, ranging from \$25 to \$100. Using a difference-in-differences approach, this study evaluated whether state-level caps on insulin out-of-pocket spending change insulin usage among commercially insured enrollees. The study included 33,134 people ages 18–64 who had type 1 diabetes or who used insulin to manage type 2 diabetes with commercial insurance coverage that was subject to state-level oversight and was included in the 25 percent sample of the IQVIA PharMetrics database during 2018–21. Insulin out-of-pocket caps did not significantly increase quarterly insulin claims for enrollees who had type 1 diabetes or who used insulin to manage type 2 diabetes. State-level caps on insulin out-of-pocket spending for commercial enrollees did not significantly increase insulin use; that may be in part because of out-of-pocket expenses being lower than cap amounts.

► **The Road to Value Can't Be Paved with a Broken Medicare Physician Fee Schedule**

BERENSON R. A. ET HAYES K. J.

2024

Health Affairs 43(7): 950-958.

<https://doi.org/10.1377/hlthaff.2024.00299>

Value-based payment has been promoted for increasing quality, controlling spending, and improving patient and practitioner experience. Meanwhile, needed reforms to fee-for-service payment (the Medicare Physician Fee Schedule) have been ignored as policy makers seek to move payment toward alternatives,

even though the fee schedule is an intrinsic part of Alternative Payment Models. In this article, we show how value-based payment and the fee schedule should be viewed as complementary, rather than as separate silos. We trace the origins of embedded flaws in the fee schedule that must be fixed if value-based payment is to succeed. These include payment distortions that directly compromise value by overpaying for certain procedures and imaging services while underpaying for services that add value for beneficiaries. We also show how the fee schedule can accommodate bundled payments and population-based payments that are central to Alternative Payment Models. We draw two conclusions. First, the Centers for Medicare and Medicaid Services should correct misvalued services and establish a hybrid payment for primary care that blends fee-for-service and population-based payment. Second, Congress should alter the thirty-five-year-old statutory basis for setting Medicare fees to allow CMS to explicitly consider policy priorities such as workforce shortages in refining fee levels.

► **A Structural Microsimulation Model For Demand-Side Cost-Sharing in Healthcare**

BOONE J. ET REMMERSWAAL M.

2024

Journal of Health Economics 97: 102900.

<https://doi.org/10.1016/j.jhealeco.2024.102900>

Demand-side cost-sharing reduces moral hazard in healthcare but increases exposure to out-of-pocket expenditure. We introduce a structural microsimulation model to evaluate both total and out-of-pocket expenditure for different cost-sharing schemes. We use a Bayesian mixture model to capture the healthcare expenditure distributions across different age-gender categories. We estimate the model using Dutch data and simulate outcomes for a number of policies. The model suggests that for a deductible of 300 euros shifting the starting point of the deductible away from zero to 400 euros leads to an average 4% reduction in healthcare expenditure and 47% lower out-of-pocket payments.

► **What Is the Relationship Between Changes in the Size of Economies and Mortality Derived Population Health Measures in High Income Countries: A Causal Systematic Review**

BROOK A., RENDALL G., HEARTY W., *et al.*
2024

Social Science & Medicine: 117190.

<https://doi.org/10.1016/j.socscimed.2024.117190>

Context : The economy has been long recognised as an important determinant of population health and a healthy population is considered important for economic prosperity. **Aim** To systematically review the evidence for a causal bidirectional relationship between aggregate economic activity (AEA) at national level for High Income Countries, and 1) population health (using mortality and life expectancy rates as indicators) and 2) inequalities in population health. **Methods** We undertook a systematic review of quantitative studies considering the relationship between AEA (GDP, GNI, GNP or recession) and population health (mortality or life expectancy) and inequalities for High Income Countries. We searched eight databases and grey literature. Study quality was assessed using an adapted version of the Effective Public Health Practice Project's Quality Assessment tool. We used Gordis' adaptation of the Bradford-Hill framework to assess causality. The studies were synthesised using Cochrane recommended alternative methods to meta-analysis and reported following the Synthesis without Meta-analysis (SWiM) guidelines. We assessed the certainty of the evidence base in line with GRADE principles. **Findings** Of 21,099 records screened, 51 articles were included in our analysis. There was no evidence for a consistent causal relationship (either beneficial or harmful) of changes in AEA leading to changes in population health (as indicated by mortality or life expectancy). There was evidence suggesting that better population health is causally related to greater AEA, but with low certainty. There was insufficient evidence to consider the causal impact of AEA on health inequalities or vice versa. **Conclusions** Changes in AEA in High Income Countries did not have a consistently beneficial or harmful causal relationship with health, suggesting that impacts observed may be contextually contingent. We tentatively suggest that improving population health might be important for economic prosperity. Whether or not AEA and health inequalities are causally linked is yet to be established.

► **Assessing the Equity and Coverage Policy Sensitivity of Financial Protection Indicators in Europe**

CYLUS J., THOMSON S., TAYARA L. A., *et al.*
2024

Health Policy 147: 105136.

<https://doi.org/10.1016/j.healthpol.2024.105136>

Progress towards universal health coverage is monitored by the incidence of catastrophic spending. Two catastrophic spending indicators are commonly used in Europe: Sustainable Development Goal (SDG) indicator 3.8.2 and the WHO Regional Office for Europe (WHO/Europe) indicator. The use of different indicators can cause confusion, especially if they produce contradictory results and policy implications. We use harmonised household budget survey data from 27 European Union countries covering 505,217 households and estimate the risk of catastrophic spending, conditional on household characteristics and the design of medicines co-payments. We calculate the predicted probability of catastrophic spending for particular households, which we call LISAs, under combinations of medicines co-payment policies and compare predictions across the two indicators. Using the WHO/Europe indicator, any combination of two or more protective policies (i.e. low fixed co-payments instead of percentage co-payments, exemptions for low-income households and income-related caps on co-payments) is associated with a statistically significant lower risk of catastrophic spending. Using the SDG indicator, confidence intervals for every combination of protective policies overlap with those for no protective policies. Although out-of-pocket medicines spending is a strong predictor of catastrophic spending using both indicators, the WHO/Europe indicator is more sensitive to medicines co-payment policies than the SDG indicator, making it a better indicator to monitor health system equity and progress towards UHC in Europe.

► **State Mandates to Cap Out-Of-Pocket Insulin Costs Are No Longer Necessary**

GOLDMAN D. P.
2024

Health Affairs 43(8): 1156-1158.

<https://doi.org/10.1377/hlthaff.2024.00751>

During the past five years, many states have imposed out-of-pocket spending caps on insulin. In most cases, these reforms have had limited impact, in part because of the limits of state authority. Meanwhile, changes at

the federal level and actions by manufacturers and commercial plans have made some of the caps non-binding. It is not surprising that efforts to measure the impact of these caps yield conflicting results.

► **‘Managing Values’ in Health Economics Modelling: Philosophical and Practical Considerations**

HARVARD S. ET WINSBERG E. B.
2024

Social Science & Medicine 358: 117256.
<https://doi.org/10.1016/j.socscimed.2024.117256>

Stakeholder involvement has been proposed as a key strategy for appropriately managing value-laden decisions or ‘value judgments’ in health economics modelling. Philosophers of science, however, conceive of stakeholder involvement in research in conflicting ways, and also propose alternative strategies for ‘managing values’ in science. Furthermore, all proposed strategies for managing values in science raise philosophical questions and practical challenges that are difficult to resolve. As a result, health economists who seek to appropriately inform value judgments in modelling must currently go without straightforward guidance. There is a need to further explore how health economists should manage value judgments in modelling, taking into account philosophical debates and contextual constraints. This paper discusses core proposals for managing values in science and identifies philosophical questions and practical challenges these proposals leave unresolved. It further considers how this could potentially inform processes to manage value judgments in health economics modelling, using examples from an ongoing modelling project called LEAP (Lifetime Exposures and Asthma Outcomes Projection). We conclude that all strategies to ‘manage values’ in health economics modelling have strengths and weaknesses, but are generally compatible with one another, suggesting that health economists may use a combination of strategies. Further research is needed to explore the effects of strategies to ‘manage values’ in health economics modelling.

► **Association Between Mandatory Bundled Payments and Changes in Socioeconomic Disparities For Joint Replacement Outcomes**

KILARU A. S., LIAO J. M., WANG E., *et al.*
2024

Health Serv Res 59(5): e14369.
<https://doi.org/10.1111/1475-6773.14369>

OBJECTIVE: To determine whether mandatory participation by hospitals in bundled payments for lower extremity joint replacement (LEJR) was associated with changes in outcome disparities for patients dually eligible for Medicare and Medicaid. **DATA SOURCES AND STUDY SETTING:** We used Medicare claims data for beneficiaries undergoing LEJR in the United States between 2011 and 2017. **STUDY DESIGN:** We conducted a retrospective observational study using a differences-in-differences method to compare changes in outcome disparities between dual-eligible and non-dual eligible beneficiaries after hospital participation in the Comprehensive Care for Joint Replacement (CJR) program. The primary outcome was LEJR complications. Secondary outcomes included 90-day readmissions and mortality. **DATA EXTRACTION METHODS:** We identified hospitals in the US market areas eligible for CJR. We included beneficiaries in the intervention group who received joint replacement at hospitals in markets randomized to participate in CJR. The comparison group included patients who received joint replacement at hospitals in markets who were eligible for CJR but randomized to control. **PRINCIPAL FINDINGS:** The study included 1,603,555 Medicare beneficiaries (mean age, 74.6 years, 64.3% women, 11.0% dual-eligible). Among participant hospitals, complications decreased between baseline and intervention periods from 11.0% to 10.1% for dual-eligible and 7.0% to 6.4% for non-dual-eligible beneficiaries. Among nonparticipant hospitals, complications decreased from 10.3% to 9.8% for dual-eligible and 6.7% to 6.0% for non-dual-eligible beneficiaries. In adjusted analysis, CJR participation was associated with a reduced difference in complications between dual-eligible and non-dual-eligible beneficiaries (-0.9 percentage points, 95% CI -1.6 to -0.1). The reduction in disparities was observed among hospitals without prior experience in a voluntary LEJR bundled payment model. There were no differential changes in 90-day readmissions or mortality. **CONCLUSIONS:** Mandatory participation in a bundled payment program was associated with reduced disparities in joint replacement complications for Medicare beneficiaries with low income. To our knowledge, this

is the first evidence of reduced socioeconomic disparities in outcomes under value-based payments.

► **Adverse Selection and Network Design Under Regulated Plan Prices: Evidence From Medicaid**

KREIDER A. R., LAYTON T. J., SHEPARD M., *et al.*

2024

Journal of Health Economics 97: 102901.

<https://doi.org/10.1016/j.jhealeco.2024.102901>

► **Modes de financement et principes d'attribution des droits sociaux : origine, polysémie et usages de la notion de contributivité**

MATH A.

2024

La Revue de l'Ires 110-111(2): 5-17.

<https://doi.org/10.3917/rdli.110.0005>

La notion de « contributivité » s'étant surtout développée depuis une quarantaine d'années dans le cadre français, ce numéro de La Revue de l'IRES offre peu de perspectives internationales, mis à part des incursions de Pierre Concialdi sur la mise en place de l'assurance sociale en matière de retraite dans les années 1930 aux États-Unis (la Social Security) et les analyses de Lola Isidro sur les textes de droit européen et international. Les contributions de ce numéro recourent à des approches théoriques et empiriques en s'appuyant sur l'histoire longue de la construction des différentes prises en charge des risques sociaux. Ils portent sur différents champs ou risques sociaux : les retraites, l'indemnisation du chômage et les prestations familiales. Nous proposons ci-après une brève présentation des contributions de ce numéro.

► **Adaptation of the Foster-Greer-Thorbecke Poverty Measures For the Measurement of Catastrophic Health Expenditures**

OGWANG T. ET MWABU G.

2024

Health Econ 33(10): 2419-2436.

<https://doi.org/10.1002/hec.4880>

In this paper we provide an adaptation of the Foster-Greer-Thorbecke (FGT) family of poverty measures for the measurement and analysis of catastrophic health expenditure (CHE). The adaptation entails introduc-

ing the FGT-type family of CHE measures with a single CHE aversion parameter whose value can be increased to put greater emphasis on the health expenditure proportions that overshoot the prescribed threshold proportions for CHE characterization by the greatest margins. The subgroup decomposition property of the FGT-type family of CHE measures (i.e., the ability to isolate the contributions of the various mutually exclusive population subgroups to the overall FGT-type CHE measure) is discussed along with other normative properties. We also show how the estimation and subgroup decomposition of the FGT-type family of CHE measures can be conveniently accomplished using ordinary least squares regression. An illustrative example is also provided to show how the FGT approach can provide valuable insights into the distribution of CHE among the healthcare spending units that incur CHE.

► **The Effect of Next Generation Accountable Care Organizations on Medicare Expenditures**

PARASHURAM S., LEE W., ROWAN K., *et al.*

2024

Health Affairs 43(7): 933-941.

<https://doi.org/10.1377/hlthaff.2022.01648>

The Next Generation Accountable Care Organization (NGACO) model (active during 2016–21) tested the effects of high financial risk, payment mechanisms, and flexible care delivery on health care spending and value for fee-for-service Medicare beneficiaries. We used quasi-experimental methods to examine the model's effects on Medicare Parts A and B spending. Sixty-two ACOs with more than 4.2 million beneficiaries and more than 91,000 practitioners participated in the model. The model was associated with a \$270 per beneficiary per year, or approximately \$1.7 billion, decline in Medicare spending. After shared savings payments to ACOs were included, the model increased net Medicare spending by \$56 per beneficiary per year, or \$96.7 million. Annual declines in spending for the model grew over time, reflecting exit by poorer-performing NGACO, improvement among the remaining NGACO, and the COVID-19 pandemic. Larger declines in spending occurred among physician practice ACOs and ACOs that elected population-based payments and risk caps greater than 5 percent.

► **Use of High- and Low-Value Health Care Among US Adults, By Income, 2010–19**

PARK S. ET WADHERA R. K.
2024

Health Affairs 43(7): 1021-1031.
<https://doi.org/10.1377/hlthaff.2023.00661>

Health care payment reforms in the US have aimed to encourage the use of high-value care while discouraging the use of low-value care. However, little is known about whether the use of high- and low-value care differs by income level. Using data from the 2010?19 Medical Expenditure Panel Survey, we examined the use of specified types of high- and low-value care by income level. We found that high-income adults were significantly more likely than low-income adults to use nearly all types of high-value care. Findings were consistent across age categories, although differences by income level in the use of high-value care were smaller among the elderly. Our analysis of differences in the use of low-value care had mixed results. Among nonelderly adults, significant differences between those with high and low incomes were found for five of nine low-value services, and among elderly adults, significant differences by income level were found for three of twelve low-value services. Understanding the mechanisms underlying these disparities is crucial to developing effective policies and interventions to ensure equitable access to high-value care and discourage low-value services for all patients, regardless of income.

► **Les droits des patients remis en question**

RAYMOND G., VERVIALLE A. ET BOUVET E.
2024

Les Tribunes de la santé 80(2): 27-34.
<https://doi.org/10.1684/seve1.2024.23>

Hausse des franchises, transports sanitaires tendance « taxis-brousse », « Taxe lapin » en embuscade : mieux vaut être en forme quand l'État décide de colmater ses mauvais comptes, profitant de l'urgence à faire des économies pour dénoncer la prétendue irresponsabilité de l'utilisateur du système de santé. Le refrain n'est pas nouveau, mais tend à s'amplifier depuis une vingtaine d'années, aux dépens des valeurs de solidarité de notre système de protection sociale, des droits des patients et, au final, de la démocratie en santé.

► **Can Revenue Collection For Public Funding in Health Care Be Progressive? An Assessment of 29 Countries**

RICE T., VRANGBÆK K., SAUNES I. S., *et al.*
2024

Health Policy 148: 105147.
<https://doi.org/10.1016/j.healthpol.2024.105147>

Most research on health care equity focuses on accessing services, with less attention given to how revenue is collected to pay for a country's health care bill. This article examines the progressivity of revenue collection among publicly funded sources: income taxes, social insurance (often in the form of payroll) taxes, and consumption taxes (e.g., value-added taxes). We develop methodology to derive a qualitative index that rates each of 29 high-income countries as to its progressivity or regressivity for each of the three sources of revenue. A variety of data sources are employed, some from secondary data sources and other from country representatives of the Health Systems and Policy Monitor of the European Observatory on Health Systems and Policies. We found that countries with more progressive income tax systems used more income-based tax brackets and had larger differences in marginal tax rates between the brackets. The more progressive social insurance revenue collection systems did not have an upper income cap and exempted poorer persons or reduced their contributions. The only pattern regarding consumption taxes was that countries that exhibited the fewest overall income inequalities tended to have least regressive consumption tax policies. The article also provides several examples from the sample of countries on ways to make public revenue financing of health care more progressive.

► **Equity in National Healthcare Economic Evaluation Guidelines: Essential or Extraneous?**

SAYGIN AVSAR T., YANG X. ET LORGELLY P.
2024

Social Science & Medicine 357: 117220.
<https://doi.org/10.1016/j.socscimed.2024.117220>

Background The focus on health maximisation in a healthcare economic evaluation (HEE) – that is health gains are of equal value regardless of the recipient – has significant implications as health systems attempt to address persistent and growing health inequities. This study aimed to systematically compare and contrast the equity principles of different health tech-

nology assessment (HTA) agencies and how equity is addressed in HEE guidelines. Methods HTA agencies were identified through the ISPOR, GEAR, iDSI, HTAi, INAHTA, HTAsiaLink, and RedETSA websites in June 2021 and updated in August 2023. Agencies websites were then searched to retrieve HEE guidelines. The guidelines were grouped into two categories: well-established and newly-developed agency guidelines, based on whether or not they published their first guidelines before 2009. Data extracted summarised the methodological details in the reference cases, including specifics on how equity featured and in what role. In those agencies where equity did not feature explicitly in the HEE guidelines, an additional search of the agency website was undertaken to understand if equity featured in those agencies' decision-making frameworks. Results The study included 46 guidelines from 51 countries. Only 30% of the guidelines were explicit about the equity assumptions. Health equity (using a broad definition) was mentioned in 29 guidelines and 14 included a specific definition while only seven recommended specific methods to incorporate inequalities. Addressing equity concerns was usually suggested as an additional analyses rather than a key part of the assessment. It was unclear how equity was incorporated into decision-making processes. In addition, equity was mentioned in other guidance – such as decision-making frameworks - provided by five agencies that did not mention it in the HEE guidelines, and 7 of 14 topic selection criteria that were identified. Conclusion Equity is given less attention than efficiency in HEE guidelines. This indicates that HTA agencies while subscribing to an extra-welfarist approach have a narrow evaluative space – focusing on maximising health and not considering the opportunity cost of the equity constraint. The omission of equity and the lack of systematic approaches in guidelines poses a threat to the international endeavours to reduce inequities. It is timely for HTA agencies to reconsider their positions on equity explicitly.

► **Integrating Maternity Care Through Bundled Payments in the Netherlands: Early Results and Policy Lessons**

SCHEEFHALS Z. T. M., STRUIJS J. N., WONG A., *et al.*
2024

Health Affairs 43(9): 1263-1273.

<https://doi.org/10.1377/hlthaff.2023.01637>

Bundled payments are increasingly used globally to move health care delivery in a value-based direction.

However, evidence remains scant in key clinical areas. We evaluated bundled payments for maternity care in the Netherlands during the period 2016–18. We used a quasi-experimental difference-in-differences design to measure the association between the bundled payment model and changes in key clinical and economic outcomes. Bundled payments were associated with an increase in outpatient, midwife-led births and a reduction in in-hospital, obstetrician-led births, along with changes in the use of labor inductions and planned versus emergency cesarean deliveries. Total spending on maternity care decreased by US\$328 (5 percent) per pregnancy. No changes in maternal or neonatal health outcomes were observed. Several policy lessons emerged. First, bundled payments appeared to help affect providers' behavior in the maternity care setting. Second, bundled payments seemed to exert heterogeneous effects across participating maternity care networks, as the same financial incentive translated into different changes in clinical practices and outcomes. Third, alternative payment models should be designed with clear goals and definitions of success to guide evaluation and implementation.

► **Is Redistribution Good For Our Health? Examining the Macroc correlation Between Welfare Generosity and Health Across EU Nations over the Last 40 Years**

SCRUGGS L., FOX A. ET REYNOLDS M. M.

2024

Journal of Health Politics, Policy and Law 49(5): 855-884.

<https://doi.org/10.1215/03616878-11257040>

Context: Social determinants of health are finally getting much-needed policy attention, but their political origins remain underexplored. In this article, the authors advance a theory of political determinants as accruing along three pathways of welfare state effects (redistribution, poverty reduction, and status preservation), and they test these assumptions by examining impacts of policy generosity on life expectancy (LE) over the last 40 years. Methods: The authors merge new and existing welfare policy generosity data from the Comparative Welfare Entitlement Project with data on LE spanning 1980–2018 across 21 countries in the Organization for Economic Cooperation and Development. They then examine relationships between five welfare policy generosity measures and LE using cross-sectional differencing and autoregressive lag models. Findings: The authors find consistent

and positive effects for total generosity (an existing measure of social insurance generosity) on LE at birth across different model specifications in the magnitude of an increase in LE at birth of 0.10–0.15 years ($p < 0.05$) as well as for a measure of status preservation (0.11, $p < 0.05$). They find less consistent support for redistribution and poverty reduction measures. Conclusions: The authors conclude that in addition to generalized effects of policy generosity on health, status-preserving social insurance may be an important, and relatively overlooked, mechanism in increasing LE over time in advanced democracies.

► **Adverse Childhood Experiences: Health Care Utilization and Expenditures in Adulthood**

SELDEN T. M., BERNARD D. M., DECKER S. L., *et al.*
2024

Health Affairs 43(8): 1117-1127.
<https://doi.org/10.1377/hlthaff.2023.01271>

Adverse childhood experiences (ACEs) have been shown to be strong predictors of socioeconomic status, risky health behaviors, chronic health conditions, and adverse outcomes. However, less is known about their association with adult health care utilization and expenditures. We used new data from the 2021 Medical Expenditure Panel Survey–Household Component (MEPS-HC) to provide the first nationally representative estimates of ACEs-related health care utilization and expenditure differences based on direct observation, rather than model-based extrapolation. Compared to demographically similar adults without ACEs, those with ACEs had substantially higher utilization and 26.3 percent higher expenditures. The aggregate spending difference across the 157.6 million US adults with ACEs was \$292 billion in 2021. Moreover, we observed large, graded relationships between ACEs and health status, health behaviors, and some dimensions of socioeconomic status. We also found associations between ACEs and a range of adverse adult circumstances, also newly measured in the 2021 MEPS, including financial and housing problems, social network problems, little or no life satisfaction, stress, food insecurity, verbal abuse, physical harm, and discrimination.

► **L'évolution des instruments de régulation des dépenses de santé résultant des prescriptions médicales**

TANO M. ET DEGRASSAT-THEAS A.
2024

Revue de droit sanitaire et social 2024(3): 484-497.

La maîtrise médicalisée des dépenses de santé s'est imposée aux prescripteurs, comme tous les acteurs du système de santé, à travers différents instruments qui ciblent notamment la demande de soins et donc les prescriptions médicales. Encadrée par des actes de force normative variée, la contractualisation entre prescripteurs libéraux ou salariés des hôpitaux, l'assurance maladie et l'Etat se développe, intégrant initialement des systèmes de sanction puis des incitations financières. Des références médicales opposables (RMO) au contrat d'amélioration de la qualité et de l'efficacité des soins (CAQES), ces instruments interrogent sur ce qui reste de la liberté de prescription, et nécessitent d'être évalués afin d'en vérifier les bénéfices pour l'assurance maladie et les patients.

► **Colorado Insulin Copay Cap: Lower Out-Of-Pocket Payments, Increased Prescription Volume and Days' Supply**

UKERT B. D., GIANNOUCHOS T. V. ET BUCHMUELLER T. C.
2024

Health Affairs 43(8): 1147-1155.
<https://doi.org/10.1377/hlthaff.2023.01592>

In 2020, Colorado became the first state to cap out-of-pocket spending for insulin prescriptions, requiring fully insured health plans to cap out-of-pocket spending at \$100 for a thirty-day supply. We provide the first evidence on the association of Colorado's Insulin Affordability Program with patient out-of-pocket spending, the amounts paid by plans per insulin prescription, and prescription filling. Using statewide claims data from the period 2018–21, we focused on the first two years that the copay cap law was in effect. We found that Colorado's Insulin Affordability Program was associated with significant reductions in out-of-pocket spending for insulin prescriptions, with the mean out-of-pocket payment per thirty-day supply falling nearly in half (from \$62.59 to \$35.64). Average plan payments increased slightly more (\$31.39) than the decrease in out-of-pocket spending, as the total amount paid per prescription increased by about 1 percent. The average insulin user realized annual savings

of \$184, while the mean number of fills and the mean days' supply per year increased by 4.2 percent and 11.4 percent, respectively.

► **Sources of Specialist Physician Fee Variation: Evidence From Australian Health Insurance Claims Data**

YONG J., ELSHAUG A. G., MENDEZ S. J., *et al.*
2024

Health Policy 147: 105119.

<https://doi.org/10.1016/j.healthpol.2024.105119>

This study explores the variation in specialist physician fees and examines whether the variation can be attributed to patient risk factors, variation between physicians, medical specialties, or other factors. We use health insurance claims data from a large private health insurer in Australia. Although Australia has a publicly funded health system that provides universal

health coverage, about 44% of the population holds private health insurance. Specialist physician fees in the private sector are unregulated; physicians can charge any price they want, subject to market forces. We examine the variation in fees using two price measures: total fees charged and out-of-pocket payments. We follow a two-stage method of removing the influence of patient risk factors by computing risk-adjusted prices at patient-level, and aggregating the adjusted prices over all claims made by each physician to arrive at physician-level average prices. In the second stage, we use variance-component models to analyse the variation in the physician-level average prices. We find that patient risk factors account for a small portion of the variance in fees and out-of-pocket payments. Physician-specific variation accounts for the bulk of the variance. The results underscore the importance of understanding physician characteristics in formulating policy efforts to reduce fee variation.

Environnement et santé

Environmental Health

► **Multi-Criteria Model to Characterise and Reduce Municipal Vulnerability to the Potential Health Impacts of Climate Change on Population Health**

BARBOSA H. P., GALL A. R.-L. ET THOMAS M.-F.
2024

Environnement, Risques & Santé 23(4): 199-206.

<https://doi.org/10.1684/ers.2024.1813>

Le changement climatique constitue une menace pour la santé publique de plus en plus reconnue par la communauté scientifique. Il impacte de façon directe et indirecte la santé et le bien-être des populations selon différentes voies d'exposition et peut exacerber les inégalités territoriales de santé. Cet article présente un modèle d'aide multicritère à la décision pour estimer la vulnérabilité de 59 territoires de la région Bretagne aux impacts potentiels du changement climatique sur la santé. Le modèle est composé de 24 critères qui caractérisent l'exposition climatique, la sensibilité environnementale et socio-économique des territoires. Ces critères sont des facteurs de risque ou de protection pour la santé, et constituent des leviers

d'action sur lesquels les territoires peuvent agir pour réduire leur vulnérabilité. Les résultats de la modélisation permettent d'établir un classement relatif des 59 territoires en fonction de leur exposition et de leur sensibilité, du plus au moins vulnérable. Ce diagnostic de vulnérabilité est une première étape dans l'élaboration d'un plan local d'adaptation au changement climatique.

► **Le groupe Santé Environnement (GSE), un objet juridique non identifié**

BRIMO S.
2024

Revue de droit sanitaire et social 2024(4): 658-667.

Instance informelle, dont l'existence n'est prévue par aucune norme législative ou réglementaire, le Groupe Santé Environnement est chargé d'orienter les politiques nationales en matière de santé environnementale et d'expertiser les plans nationaux qui s'y rapportent. Toutefois, l'exercice de cette mission interroge tant en raison des règles de fonctionnement

de l'institution, qui compte plus d'une centaine de membres, qu'en raison de modalités de leur choix et des obligations qui leur incombent.

► **Can Environmental Impact Be Considered As a Dimension of the Proper Use of Medicines? From the 5th Forum of the Association For the Proper Use of Medicines**

HAMON P. A., BIENVENU A. L., GIMENES N., *et al.*
2024

Ann Pharm Fr.

[10.1016/j.pharma.2024.07.001](https://doi.org/10.1016/j.pharma.2024.07.001)

Through their footprint throughout their life cycle, from production to use, medicines have a significant impact on the environment. Reducing this impact is rarely considered from the perspective of the choices that healthcare professionals might have to make when prescribing or dispensing medicines. Should we consider environmental impact, alongside effectiveness and tolerance, one of the dimensions of the proper use of medicines? To address this question, the 5th Forum of the Association for the Proper Use of Medicines highlighted the main sources of pharmaceutical pollution: the carbon footprint linked to production, greenhouse gas emissions, the impact of residues on water and waste from packaging. While the eco-design of medicines should make it possible to limit their environmental impact upstream, there are still few initiatives aimed at their use. The Swedish "Hazard Score" assessment tool, which classifies compounds according to their potential to pollute the aquatic environment, was presented as a tool for guiding prescription choices. Through the exchanges between the various stakeholders (public authorities, doctors, pharmacists, manufacturers, patients) during this forum, recommendations were drawn up both on scientific and ethical grounds.

► **Prenatal Exposure to Particulate Matter and Infant Birth Outcomes: Evidence From a Population-Wide Database**

JAHANSHAHI B., JOHNSTON B., MCGOVERN M. E., *et al.*

2024

Health Econ 33(9): 2182-2200.

<https://doi.org/10.1002/hec.4862>

There are growing concerns about the impact of pollution on maternal and infant health. Despite an extensive correlational literature, observational studies which adopt methods that seek to address potential biases due to unmeasured confounders draw mixed conclusions. Using a population database of births in Northern Ireland (NI) linked to localized geographic information on pollution in mothers' postcodes (zip-codes) of residence during pregnancy, we examine whether prenatal exposure to PM(2.5) is associated with a comprehensive range of birth outcomes, including placental health. Overall, we find little evidence that particulate matter is related to infant outcomes at the pollution levels experienced in NI, once we implement a mother fixed effects approach that accounts for time-invariant factors. This contrasts with strong associations in models that adjust for observed confounders but without fixed effects. While reducing ambient air pollution remains an urgent public health priority globally, our results imply that further improvements in short-run levels of prenatal PM(2.5) exposure in a relatively low-pollution, higher-income country context, are unlikely to impact birth outcomes at the population level.

► **Cost of Carbon in the Total Cost of Healthcare Procedures: A Methodological Challenge**

PUGLIESI P. S., MARRAUD L. ET LEJEUNE C.

2024

Applied Health Economics and Health Policy 22(5): 599-607.

<https://doi.org/10.1007/s40258-024-00890-4>

Economic evaluations aim to compare the costs and the results of health strategies to guide the public decision-making process. Cost estimation is, thus, a cornerstone of this approach. At present, a few national evaluation agencies recommend incorporating the cost of greenhouse gas (GHG) emissions from healthcare actions into the calculation of healthcare costs. Our main goal is to describe and discuss the methodology

for integrating the cost of GHG emissions into the field of applied economic evaluations. To estimate this cost, three steps are required: (1) identifying and quantifying the physical flows linked to the production and management of the outputs of healthcare interventions, (2) estimating the quantity of GHG that can be attributed to each physical flow, and (3) valuing these GHG emissions in monetary terms. Integrating the cost of GHG emissions into the calculation of the costs of health-

care interventions is both useful and relevant from a perspective of collective intergenerational well-being. This approach has been made possible thanks to the existence of accounting and monetary valuation methods for emissions. Agencies specialized in health economic evaluations could take up this issue to resolve ongoing questions, thus providing researchers with a methodological framework and public decision-makers with some key insights.

État de santé

Health Status

► Reducing Health-Related Stigma in Adults Living with Chronic Non-Communicable Diseases: A Systematic Review and Meta-Analysis

AKYIREM S., EKPOR E., BATTEN J., *et al.*

2024

Social Science & Medicine 356: 117153.

<https://doi.org/10.1016/j.socscimed.2024.117153>

Purpose The purpose of this systematic review was to synthesize the components of interventions that are aimed at reducing stigma among adults living with chronic non-communicable diseases (NCDs). A secondary objective was to assess the effectiveness of interventions in reducing health-related stigma. **Methods** A search was conducted on OVID MEDLINE, OVID APA PsycINFO, EBSCO CINAHL Complete, Web of Science, and Cochrane Central in July 2023 for articles that report the development and/or testing of health-related stigma-reduction interventions among adults with NCDs. The quality of included studies was assessed using the Joanna Briggs Institute critical appraisal checklists. Intervention components were narratively synthesized. The DerSimonian-Laird random effect model was used to pool standardized mean differences across studies. **Results** Nineteen articles were included in the review. Interventions addressed individual level (intrapersonal and interpersonal) and structural level stigmas. Components of intrapersonal interventions included cognitive exercises, stress reduction, promoting self-efficacy, developing communication skills, and listening to other patients' stories. Contact-based interventions were used in many interpersonal interventions. Structural interventions

included mass media campaigns and training for healthcare professionals. Pooled intervention effects indicated a significant reduction in stigma levels post-intervention for both persons with NCD (Hedge's $g = -1.13$; 95% CI: -1.66, -0.60, $I^2 = 85\%$, $N = 6$ studies) and those without (Hedge's $g = -2.45$, 95% -4.84, -0.06; $I^2 = 97\%$, $N = 2$ studies). **Conclusion** Interventions to address NCD stigma, although multifaceted, are often not multilevel. Future studies are needed to design and test multilevel NCD stigma-reduction interventions.

► Does the Time Spent in Retirement Improve Health? An IV-Poisson Assessment on the Incidence of Cardiovascular Diseases

FONTANA D., ARDITO C., LEOMBRUNI R., *et al.*

2024

Social Science & Medicine 354: 117084.

<https://doi.org/10.1016/j.socscimed.2024.117084>

In recent decades, pension reforms have been implemented to address the financial sustainability of social security systems, resulting in an increase in the retirement age. This adjustment has led to ongoing debates about the relationship between retirement and health. This study investigates the impact of time spent in retirement on the risk of cardiovascular disease (CVD) in Italy. It uses a comprehensive dataset that includes socio-economic, health, and behavioural risk factors, which is linked to administrative hospitalisation and mortality registers. To address the potential endogeneity of retirement, we employ an instrumental variables approach embedded in a Poisson rate model. The

results show that, on average, years spent in retirement have a beneficial effect on the risk of CVD for both men and women. Each additional year spent in retirement reduces the incidence of such diseases by about 17% for men and 29% for women. Stratified analyses and robustness tests show that the benefits of retirement appear to be more robust and pronounced in men and in certain groups, particularly men in manual occupations or with poor ergonomic conditions at work. These results highlight that delaying access to retirement may lead to an increased burden of CVD in the older population. In addition, the protective effect of retirement on the development of CVD among workers with poorer ergonomic conditions underlines the different impact of increasing the retirement age on different categories of workers and the need for targeted and differentiated policies to avoid hitting the more vulnerable.

► **Are Employment and Social Integration More Strongly Associated with Deaths of Despair than Psychological or Economic Distress?**

GLEI D. A., LEE C., BROWN C. L., *et al.*
2024

Social Science & Medicine 357: 117197.

<https://doi.org/10.1016/j.socscimed.2024.117197>

The label “deaths of despair” for rising US mortality related to drugs/alcohol/suicide seems to implicate emotional distress as the cause. However, a Durkheimian approach would argue that underlying structural factors shape individuals’ behavior and emotions. Despite a growing literature on deaths of despair, no study has directly compared the effects of distress and structural factors on deaths of despair versus other causes of mortality. Using data from the Midlife in the United States study with approximately 26 years of mortality follow-up, we evaluated whether psychological or economic distress, employment status, and social integration were more strongly associated with drug/alcohol/suicide mortality than with other causes. Cox hazard models, adjusted for potential confounders, showed little evidence that psychological or economic distress were more strongly associated with mortality related to drugs/alcohol/suicide than mortality from other causes. While distress measures were modest, but significantly associated with these deaths, the associations were similar in magnitude for many other types of mortality. In contrast, detachment from the labor force and lower social integra-

tion were both strongly associated with drug/alcohol/suicide mortality, more than for many other types of mortality. Differences in the estimated percentage dying of despair between age 25 and 65 were larger for employment status (2.0% for individuals who were neither employed nor retired versus only 0.6% for currently employed) and for social integration (1.9% for low versus 0.7% for high integration) than for negative affect (1.2% for high versus 0.8% for no negative affect). Most of the association between distress and drug/alcohol/suicide mortality appeared to result from confounding with structural factors and with pre-existing health conditions that may influence both the perception of distress and mortality risk. While deaths of despair result from self-destructive behavior, our results suggest that structural factors may be more important determinants than subjective distress.

► **Who Should Value Children’s Health and How? An International Delphi Study**

POWELL P. A., ROWEN D., KEETHARUTH A., *et al.*
2024

Social Science & Medicine 355: 117127.

<https://doi.org/10.1016/j.socscimed.2024.117127>

Valuing child health necessitates normative methodological decisions on whose preferences should be elicited and who should be imagined as experiencing impaired health. Formal guidance is limited and expert consensus unclear. This study sought to establish the degree of consensus among expert stakeholders on normative issues of who to ask and who should be imagined when valuing child health (7-17 years) to inform UK health technology assessment. Sixty-two experts (n=47 in Round 2) from 18 countries participated in a modified, two-round online Delphi survey. Participants were expert stakeholders in child health valuation, including academics (n=38); industry/consultancy representatives (including the charity/not-for-profit sector; n=13); and UK policy/government representatives (n=11). The Delphi survey was modified between rounds and consisted of 9-point Likert, categorical, multiple-choice, and free-text questions on normative issues in valuing child health. Responses were analysed descriptively and thematically. A priori criterion of ≥ 75% agreement was established for formal consensus, while areas approaching consensus (≥ 70% agreement) and without consensus were identified as a future research primer. Consensus was observed that older adolescents (aged 16-17 years) and adults (18+ years) should be asked to value child

health states. There was consensus that the former should think about themselves when valuing the health states and the latter should imagine a child of some form (e.g., imagining themselves as a child or another hypothetical child). However, no consensus was evident on what form this should take. Several other methodological issues also reached consensus. These findings are largely consistent with recent views elicited qualitatively from members of the public and other stakeholders on normative issues in valuing child health. The results mean that, contrary to what has been done in previous child health valuation studies, efforts should be made to involve both older adolescents (16+ years) and adults in child health valuation.

► Cancer Incidence Trends in Successive Social Generations in the US

ROSENBERG P. S. ET MIRANDA-FILHO A.

2024

JAMA Network Open 7(6): e2415731-e2415731.

<https://doi.org/10.1001/jamanetworkopen.2024.15731>

The incidence of some cancers in the US is increasing in younger age groups, but underlying trends in cancer patterns by birth year remain unclear. To estimate cancer incidence trends in successive social generations. In this cohort study, incident invasive cancers were ascertained from the Surveillance, Epidemiology, and End Results (SEER) program's 13-registry database (November 2020 submission, accessed August 14, 2023). Invasive cancers diagnosed at ages 35 to 84 years during 1992 to 2018 within 152 strata were defined by cancer site, sex, and race and ethnicity. Invasive cancer. Stratum-specific semiparametric age-period-cohort (SAGE) models were fitted and incidence per 100 000 person-years at the reference age of 60 years was calculated for single-year birth cohorts from 1908 through 1983 (fitted cohort patterns [FCPs]). The FCPs and FCP incidence rate ratios (IRRs) were compared by site for Generation X (born between 1965 and 1980) and Baby Boomers (born between 1946 and 1964). A total of 3.8 million individuals with invasive cancer (51.0% male; 8.6% Asian or Pacific Islander, 9.5% Hispanic, 10.4% non-Hispanic Black, and 71.5% non-Hispanic White) were included in the analysis. In Generation X vs Baby Boomers, FCP IRRs among women increased significantly for thyroid (2.76; 95% CI, 2.41-3.15), kidney (1.99; 95% CI, 1.70-2.32), rectal (1.84; 95% CI, 1.52-2.22), corpus uterine (1.75; 95% CI, 1.40-2.18), colon (1.56; 95% CI, 1.27-1.92), and pancreatic (1.39; 95% CI, 1.07-1.80) cancers; non-Hodgkins lymphoma (1.40; 95% CI, 1.08-

1.82); and leukemia (1.27; 95% CI, 1.03-1.58). Among men, IRRs increased for thyroid (2.16; 95% CI, 1.87-2.50), kidney (2.14; 95% CI, 1.86-2.46), rectal (1.80; 95% CI, 1.52-2.12), colon (1.60; 95% CI, 1.32-1.94), and prostate (1.25; 95% CI, 1.03-1.52) cancers and leukemia (1.34; 95% CI, 1.08-1.66). Lung (IRR, 0.60; 95% CI, 0.50-0.72) and cervical (IRR, 0.71; 95% CI, 0.57-0.89) cancer incidence decreased among women, and lung (IRR, 0.51; 95% CI, 0.43-0.60), liver (IRR, 0.76; 95% CI, 0.63-0.91), and gallbladder (IRR, 0.85; 95% CI, 0.72-1.00) cancer and non-Hodgkins lymphoma (IRR, 0.75; 95% CI, 0.61-0.93) incidence decreased among men. For all cancers combined, FCPs were higher in Generation X than for Baby Boomers because gaining cancers numerically overtook falling cancers in all groups except Asian or Pacific Islander men. In this model-based cohort analysis of incident invasive cancer in the general population, decreases in lung and cervical cancers in Generation X may be offset by gains at other sites. Generation X may be experiencing larger per-capita increases in the incidence of leading cancers than any prior generation born in 1908 through 1964. On current trajectories, cancer incidence could remain high for decades.

► Chronic Disease Onset and Wellbeing Development: Longitudinal Analysis and the Role of Healthcare Access

STACHERL B. ET SAUZET O.

2023

European Journal of Public Health 34(1): 29-34.

<https://doi.org/10.1093/eurpub/ckad167>

Experiencing the onset of a chronic disease is a serious health event impacting living conditions and wellbeing. Investigating wellbeing development and its predictors is crucial to understand how individuals adapt to chronic illnesses. This study (i) analyzed the impact of a chronic disease on wellbeing development, and (ii) explored spatial healthcare access as potential moderating factor. Data were obtained from the German Socio-economic Panel, a nationally representative household survey. A prospective sample of 3847 individuals was identified for whom the onset of cancer, cardiopathy, diabetes or stroke was observed between 2008 and 2020. Mixed models using an interrupted time series approach were performed to identify immediate level changes and longitudinal trend changes in wellbeing (operationalized with health and life satisfaction) after disease onset. Further, spatial access to healthcare (operationalized by two-stage floating

catchment area measures) as potential moderating factor was examined using interaction effects. Chronic disease onset had an immediate negative level impact on health and life satisfaction. For health satisfaction, a negative pre-onset wellbeing trend was offset (but not reversed). A small positive trend was observed for life satisfaction after disease onset. Spatial access to healthcare was not associated with the magnitude of wellbeing reduction at onset. Health and life satisfaction levels drop with the onset of a chronic disease with no recovery trend for health and little recovery for life satisfaction, implying persistently lower wellbeing levels after a chronic illness onset. Spatial access to healthcare does not affect the wellbeing change after disease onset.

► **Differences in Cancer Rates Among Adults Born Between 1920 and 1990 in the USA: An Analysis of Population-Based Cancer Registry Data**

SUNG H., JIANG C., BANDI P., *et al.*

2024

The Lancet Public Health 9(8): e583-e593.

[https://doi.org/10.1016/S2468-2667\(24\)00156-7](https://doi.org/10.1016/S2468-2667(24)00156-7)

Background Trends in cancer incidence in recent birth cohorts largely reflect changes in exposures during early life and foreshadow the future disease burden. Herein, we examined cancer incidence and mortality trends, by birth cohort, for 34 types of cancer in the USA.

► **Le muscle dans tous ses états : un enjeu de santé publique majeur**

TIENNOT-HERMENT L.

2024

Les Tribunes de la santé 80(2): 87-95.

<https://www.jle.com/10.1684/tsa.2024.21>

Le muscle est capital dans toutes nos fonctions motrices, respiratoires et cardiaques. Sans muscle, les gestes de notre quotidien sont impossibles. L'Association française contre les myopathies (AFM) a été créée pour comprendre et trouver des thérapies lorsque ce muscle est dysfonctionnel. Pour disposer des moyens financiers d'une recherche innovante, l'AFM crée en France, en 1987, le premier Téléthon, qui rencontre un succès immédiat. La création de l'Institut de Myologie, un pôle d'excellence dédié au muscle, à l'initiative de l'AFM-Téléthon, a permis, avec les moyens du Téléthon, d'avancer sur les connaissances relatives aux pathologies neuromusculaires, épine dorsale de la myologie. Et de mieux comprendre le muscle, organe méconnu mais majeur, et dont l'interaction des protéines qu'il sécrète (myokines) a des propriétés bénéfiques. Le muscle, enjeu majeur de santé publique, doit donc faire l'objet d'une politique de santé publique spécifique. Nous avons donc imaginé un Plan Muscle transversal et national qui permettrait de placer le muscle au cœur des stratégies de prévention, en lui accordant une véritable place dans les parcours de santé, de faire reconnaître la myologie comme discipline médicale et scientifique transversale, et d'intensifier et financer la recherche sur le muscle.

Geography of Health

► The Health Implications of Neighborhood Networks Based on Daily Mobility in US Cities

BRAZIL N., CHAKALOV B. T. ET KO M.
2024

Social Science & Medicine 354: 117058.

<https://doi.org/10.1016/j.socscimed.2024.117058>

A large body of research has been dedicated to understanding the neighborhood conditions that impact health, which outcomes are affected, and how these associations vary by demographic and socioeconomic neighborhood and individual characteristics. This literature has focused mostly on the neighborhoods in which individuals reside, thus failing to recognize that residents across race/ethnicity and class spend a non-trivial amount of their time in neighborhoods far from their residential settings. To address this gap, we use mobile phone data from the company SafeGraph to compare racial inequality in neighborhood socioeconomic advantage exposure across three scales: the neighborhoods that residents live in, their adjacent neighborhoods, and the neighborhoods that they regularly visit. We found that the socioeconomic advantage levels in neighborhood networks differ from the levels at the residential and adjacent scales across all ethnoracial neighborhoods. Furthermore, socioeconomic advantage at the network level is associated with diabetes and hypertension prevalence above and beyond its impact at the residential and adjacent levels. We also find ethnoracial differences in these associations, with greater beneficial consequences of network socioeconomic advantage exposure to hypertension and diabetes for white neighborhoods. Future social determinants of health research needs to reconceptualize exposure to include the larger neighborhood network that a community is embedded in based on where their residents travel to and from.

► Unequal Geographies of Gender-Affirming Care: A Comparative Typology of Trans-Specific Healthcare Systems Across Europe

KIELY E., MILLET N., BARON A., *et al.*
2024

Social Science & Medicine 356: 117145.

<https://doi.org/10.1016/j.socscimed.2024.117145>

Rationale Gender-affirming healthcare can carry significant benefits for trans people. However, there are substantial geographical inequalities in the provision of and access to trans-specific healthcare across Europe. Comparative healthcare systems research has typically focused on universal services, neglecting provision which serves specific groups within populations (e.g., trans people). Objective This study aimed to develop a comparative typology of trans-specific healthcare systems across 28 European countries (the EU 27 plus the UK), and to examine country-level correlates which may influence or be influenced by these systems. Methods Using hierarchical and k-means cluster analysis, countries were classified into four types based on measures of trans-specific healthcare provision, regulation and access. Possible country-level correlates (including socio-political climate, medical outcomes and the general healthcare system) were investigated. Results and discussion The cluster analysis identified four clusters of trans-specific healthcare systems in Europe, characterized as: 1) Centralized conservative (highly centralized, extensive range of treatments, few trans-specific government policies); 2) Centralized reformist (highly centralized, extensive range of treatments, multiple trans-specific government policies); 3) Decentralized marketized (highly decentralized, moderate range of treatments, few trans-specific government policies); 4) Underdeveloped (highly decentralized, limited range of treatments, few or no trans-specific government policies). We found statistically significant differences between the clusters in rates of: public support for trans people; gender identity concealment; treatment access; overall health expenditure; gender inequality. Conclusions The study develops a novel typology of trans-specific healthcare systems in Europe. It also identifies a range of potential drivers and outcomes of geographical divergences and inequalities in trans-specific healthcare provision. Building on this typology, future comparative research should aim to link the structure of healthcare systems to outcomes for trans people. Comparative healthcare systems research must account for the distinctive forms taken by services and systems that provide healthcare to specific groups within populations.

Handicap

Disability

► **Disability Mortality Disparity: Risk of Mortality For Disabled Adults Nearly Twice that For Nondisabled Adults, 2008–19**

LANDES S. D.
2024

Health Affairs 43(8): 1128-1136.

<https://doi.org/10.1377/hlthaff.2023.01197>

After years of advocacy by the disability community and allied organizations, on September 26, 2023, the National Institute on Minority Health and Health Disparities (NIMHD) designated disabled people as a health disparities population in the US. During its deliberations, the NIMHD emphasized that there was not sufficient empirical evidence on health disparities between disabled and nondisabled adults. My study

addressed this gap by examining 2008–19 data from the National Health Interview Survey Linked Mortality Files on people ages eighteen and older to identify, categorize, and quantify disparities in mortality risk among disabled and nondisabled adults. The risk of mortality during the study period was 1.9 times higher overall for disabled compared with nondisabled adults. The risk increased with the number of reported disabilities and varied by disability category. These findings underscore the need to improve access to high-quality, evidence-based health care among disabled people. To gain a full understanding of the scope of disparity and the interventions needed to mitigate it, it is critical to develop more equitable and inclusive measures of disability and ableism for use in population health surveys.

Hôpital

Hospital

► **Fitting In? Physician Practice Style After Forced Relocation**

CHEN A. J., RICHARDS M. R. ET SHRIVER R.
2024

Health Serv Res 59(4): e14340.

<https://doi.org/10.1111/1475-6773.14340>

OBJECTIVE: This study aims to examine how variation in physicians' treatment decisions for newborn deliveries responds to changes in the hospital-level norms for obstetric clinical decision-making. **DATA SOURCES:** All hospital-based births in Florida from 2003 through 2017. **STUDY DESIGN:** Difference-in-differences approach is adopted that leverages obstetric unit closures as the source of identifying variation to exogenously shift obstetricians to a new, nearby hospital with different propensities to approach newborn deliveries less intensively. **DATA EXTRACTION:** Births attributed to physicians continuously observed 2 years before the closure event and 2 years after the closure event (treatment group physicians) or for identical time periods around a randomly assigned placebo closure date

(control group physicians). **PRINCIPAL FINDINGS:** All of the physicians meeting our inclusion criteria shifted their births to a new hospital less than 20 miles from the hospital shuttering its obstetric unit. The new hospitals approached newborn births more conservatively, and treatment group physicians sharply became less aggressive in their newborn birth clinical management (e.g., use of C-section). The immediate 11-percentage point (33%) increase in delivering newborns without any procedure behavior change is statistically significant (p value <0.01) and persistent after the closure event; however, the physicians' payer and patient mix are unchanged. **CONCLUSIONS:** Obstetric physician behavior change appears highly malleable and sensitive to the practice patterns of other physicians delivering newborns at the same hospital. Incentives and policies that encourage more appropriate clinical care norms hospital-wide could sharply improve physician treatment decisions, with benefits for maternal and infant outcomes.

► **Retrospective Analysis of Hospitalization Costs Using Two Payment Systems: The Diagnosis Related Groups (DRG) and the Queralt System, a Newly Developed Case-Mix Tool For Hospitalized Patients**

FOLGUERA J., BUJ E., MONTERDE D., *et al.*

2024

Health Economics Review 14(1): 45.

<https://doi.org/10.1186/s13561-024-00522-6>

Hospital services are typically reimbursed using case-mix tools that group patients according to diagnoses and procedures. We recently developed a case-mix tool (i.e., the Queralt system) aimed at supporting patient management. In this study, we compared the performance of a broadly used tool (i.e., the APR-DRG) with the Queralt system.

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

KANG S. Y.

2024

Health Services Research 59(4): e14302.

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

Abstract Objective To examine whether hospitals' experience in a prior payment model incentivizing care coordination is associated with their decision to adopt a new payment program for a care delivery innovation. **Data Sources** Data were sourced from Medicare fee-for-service claims in 2017, the list of participants in Bundled Payment for Care Improvement initiatives (BPCI and BPCI-Advanced), the list of hospitals approved for Acute Hospital Care at Home (AHCaH) between November 2020 and August 2022, and the American Hospital Association Survey. **Study Design** Retrospective cohort study. **Hospitals' adoption of AHCaH** was measured as a function of hospitals' BPCI experiences. Hospitals' BPCI experiences were categorized into five mutually exclusive groups: (1) direct BPCI participation, (2) indirect participation through physician group practices (PGPs) after dropout, (3) indirect participation through PGPs only, (4) dropout only, and (5) no BPCI exposure. **Data Collection/Extraction Methods** All data are derived from pre-existing sources. **General acute hospitals eligible for both BPCI initiatives and AHCaH** are included. **Principal Findings** Of 3248 hospitals included in the sample, 7% adopted

AHCaH as of August 2022. Hospitals with direct BPCI experience had the highest adoption rate (17.7%), followed by those with indirect participation through BPCI physicians after dropout (11.8%), while those with no exposure to BPCI were least likely to participate (3.2%). Hospitals that adopted AHCaH were more likely to be located in communities where more peer hospitals participated in the program (median 10.8% vs. 0%). After controlling for covariates, the association of the adoption of AHCaH with indirect participation through physicians after dropout was as strong as with early BPCI adopter hospitals (average marginal effect: 5.9 vs. 6.2 pp, $p < 0.05$), but the other categories were not. **Conclusions** Hospitals that participated in the bundled payment model either directly or indirectly PGPs were more likely to adopt a care delivery innovation requiring similar competence in the next period.

► **Hospital Nurse Staffing Legislation: Mixed Approaches in Some States, While Others Have No Requirements**

KRISHNAMURTHY N., MUKHERJEE N., COHEN B., *et al.*

2024

Health Affairs 43(8): 1172-1179.

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Legislative agendas aimed at regulating nurse staffing in US hospitals have intensified after acute workforce disruptions triggered by COVID-19. Emerging evidence consistently demonstrates the benefits of higher nurse staffing levels, although uncertainty remains regarding whether and which legislative approaches can achieve this outcome. The purpose of this study was to provide a comprehensive updated review of hospital nurse staffing requirements across all fifty states. As of January 2024, seven states had laws pertaining to staffing ratios for at least one hospital unit, including California and Oregon, which had ratios pertaining to multiple units. Eight states required nurse staffing committees, of which six specified a percentage of committee members who must be registered nurses. Eleven states required nurse staffing plans. Five states had pending legislation, and one state, Idaho, had passed legislation banning minimum nurse staffing requirements. The variety of state regulations provides an opportunity for comparative evaluations of efficacy and feasibility to inform new legislation on the horizon.

► **Gouvernance publique hospitalière : entre paradoxes et tensions. Le point de vue des cadres de santé**

MAQUART A. ET LETHIELLEUX L.

2024

Gestion et management public (5): 49-70

<https://shs.cairn.info/revue-gestion-et-management-public-2024-3-page-49>

L'hôpital a connu des réformes au fil du temps (Debrosse, 2010; Dent, 2005) se manifestant par la mise en œuvre d'une nouvelle gouvernance hospitalière (Fray, 2009). L'hôpital est devenu une entreprise (Vallancien, 2008) où se confrontent une logique managériale inspirée des politiques libérales et la culture historique du soin. On peut alors s'interroger sur la possibilité d'intégrer ces nouveaux modes de gestion au sein de l'hôpital public et les inévitables paradoxes qui peuvent en découler. L'objectif de cet article est de confronter le point de vue des cadres de santé avec cette logique managériale, d'identifier leur perception de la gouvernance publique hospitalière et d'en identifier les tensions. À partir des travaux de l'école de proximité (Boschma, 2005), il s'agit également de mieux comprendre les paradoxes et les tensions institutionnelles, et d'identifier le rôle managérial des cadres de santé. La solution réside-t-elle dans le modèle de gouvernance ou bien dans le management lui-même ? Les entretiens semi-directifs, réalisés en 2020, auprès de 40 cadres de santé ont été analysés à l'aide du logiciel Alceste. Il en ressort deux principaux résultats : une meilleure compréhension de la nature de la gouvernance publique hospitalière dans la survenance des tensions observées et le rôle du management dans la gestion des tensions et paradoxes de l'hôpital public.

► **Hospital Competition when Patients Learn Through Experience**

SÁ L. ET STRAUME O. R.

2024

Journal of Health Economics 97: 102920.

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We study competing hospitals' incentives for quality provision in a dynamic setting where healthcare is an experience good. In our model, the utility a patient derives from choosing a particular provider depends on a subjective component specific to the match between the patient and the provider, which can only be learned through experience. We find that the experience-good

nature of healthcare can either reinforce or dampen the demand responsiveness to quality and the hospitals' incentives for quality provision, depending on two key factors: the shape of the distribution of match-specific utilities and the cost relationship between quality provision and treatment volume. We establish conditions under which ignoring the experience dimension of healthcare leads to inaccurate assessments of the competitiveness of hospital markets.

► **Emergency Department Visits and Hospital Capacity in the US: Trends in the Medicare Population During the COVID-19 Pandemic**

SMULOWITZ P. B., O'MALLEY A. J., MCWILLIAMS J. M., *et al.*

2024

Health Affairs 43(7): 970-978.

<https://doi.org/10.1377/hlthaff.2023.01153>

Although emergency department (ED) and hospital overcrowding were reported during the later parts of the COVID-19 pandemic, the true extent and potential causes of this overcrowding remain unclear. Using data on the traditional fee-for-service Medicare population, we examined patterns in ED and hospital use during the period 2019-2022. We evaluated trends in ED visits, rates of admission from the ED, and thirty-day mortality, as well as measures suggestive of hospital capacity, including hospital Medicare census, length-of-stay, and discharge destination. We found that ED visits remained below baseline throughout the study period, with the standardized number of visits at the end of the study period being approximately 25 percent lower than baseline. Longer length-of-stay persisted through 2022, whereas hospital census was considerably above baseline until stabilizing just above baseline in 2022. Rates of discharge to postacute facilities initially declined and then leveled off at 2 percent below baseline in 2022. These results suggest that widespread reports of overcrowding were not driven by a resurgence in ED visits. Nonetheless, length-of-stay remains higher, presumably related to increased acuity and reduced available bed capacity in the postacute care system.

► **Rates of Patient Safety Indicators in Belgian Hospitals Were Low but Generally Higher than in US Hospitals, 2016–18**

VAN WILDER A., BRUYNEEL L., COX B., *et al.*

2024

Health Affairs 43(9): 1274-1283.

<https://doi.org/10.1377/hlthaff.2023.01120>

More than two decades ago, the Agency for Healthcare Research and Quality developed its Patient Safety Indicators (PSIs) to monitor potentially preventable and severe adverse events within hospitals. Application of PSIs outside the US was explored more than a decade ago, but it is uncertain whether they remain relevant within Europe, as no up-to-date assessments of overall PSI-associated adverse event rates or interhospital variability can be found in the literature. This article assesses the nationwide occurrence and variability of thirteen adverse events for a case study of Belgium. We studied 4,765,850 patient stays across all 101 hospitals for 2016–18. We established that although adverse event rates were generally low, with an adverse event observed in 0.1 percent of medical hospital stays and in 1.2 percent of surgical hospital stays, they were higher than equivalent US rates and were prone to considerable between-hospital variability. Failure-to-rescue rates, for example, equaled 23 percent, whereas some hospitals exceeded nationwide central line–associated bloodstream infection rates by a factor of 8. Policy makers and hospital managers can prioritize PSIs that have high adverse event rates or large variability, such as failure to rescue or central line–associated bloodstream infections, to improve the quality of care in Belgian hospitals.

► **Specialty Economies of Scope in English Hospitals: Cost Arguments For Colocation**

WILLANS R. ET HOLLINGSWORTH B.

2024

Social Science & Medicine 357: 117174.

<https://doi.org/10.1016/j.socscimed.2024.117174>

Objective Current policy responses to COVID-19 disruption and care backlogs suggest potential changes to the location and structure of hospital healthcare supply. However, few studies investigating the cost effects of hospital reorganisation consider changes in the mix of outputs or test for the existence of economies of scope in hospital healthcare. Attempts to create dedicated hubs to address healthcare demand backlogs could have unintended adverse cost effects where these are provided outside existing hospital arrangements. To evaluate this, we investigate the existence and size of economies of scope in English hospital healthcare. Data We use cost and activity data from the English NHS, linked to aggregated staff wage information and information taken from hospital financial statements. Cost and activity data was obtained from NHS England's Costing Publications. Wage data was extracted from the NHS's Electronic Staff Record via the NHS England Workforce Statistics Team, and published hospital financial accounts were aggregated and linked together at the organisation level. Results General Surgery exhibited positive economies of scope when provided alongside other healthcare, as to a lesser extent did General Medicine and Obstetric/Gynaecology healthcare. There was little evidence for economies of scope in Diagnostic and Pathology services, Orthopaedics, or Emergency Care. Few (2/28) output cross-products (cost complementarities) were statistically significant, but Baumol's wider definition of scope economies demonstrates that scope economies are present in some specialties. Conclusion Policymakers seeking to maximise the amount of healthcare provided and minimise the costs of doing so may wish to consider retaining General Surgery, General Medicine and Obstetric/Gynaecology healthcare supply alongside the provision of other clinical specialties. There is limited evidence that reconfiguring supply by centralizing other specialty groups into fewer providers would increase costs.

Inégalités de santé

Health inequalities

► Did the COVID-19 Pandemic Reshape Equity in Healthcare Use in Europe?

ARNAULT L., JUSOT F. ET RENAUD T.

2024

Social Science & Medicine 358: 117194.

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Promoting equity in healthcare use requires to respect both principles of horizontal equity, that guarantees everyone the same use of healthcare for a given level of need, and vertical equity, that requires the sick-est to receive more care than others, in a proportion deemed appropriate. This study explores the extent to which horizontal and vertical equity in healthcare use among individuals aged 50+ in Europe has been restructured during the COVID-19 pandemic. Using the variance as an inequality measure, we assess horizontal equity in healthcare use based on the fairness gap approach and propose two new measures of vertical equity. The sample includes 24,965 respondents of the SHARE survey from 18 European countries, who participated in wave 8 just before the pandemic and the second SHARE Corona survey in 2021. These data provide information on use of physician and hospital care over the year for each period, as well as on a wide range of health and socio-economic variables. Although pro-rich inequities in healthcare use were observed in some countries before the outbreak, our results do not reveal any significant evolution in horizontal equity during the pandemic. Conversely, vertical equity in healthcare use would have significantly declined in most countries, especially in Central or Eastern Europe. Telemedicine appears to have played a protective role against this decline in vertical equity in countries where it was heavily used during the pandemic. Our results support the case for public policies aimed at restoring access to care for individuals with the highest needs.

► The Risk of Perpetuating Health Disparities Through Cost-Effectiveness Analyses

BASU S., VENKATARAMANI A. S. ET SCHILLINGER D.

2024

Health Affairs 43(8): 1165-1171.

<https://doi.org/10.1377/hlthaff.2023.01583>

Cost-effectiveness analyses are commonly used to inform health care and public health policy decisions. However, standard approaches may systematically disadvantage marginalized groups by incorporating assumptions of persisting health inequities. We examined how competing risks, baseline health care costs, and indirect costs can differentially affect cost-effectiveness analyses for racial and ethnic minority populations. We illustrate that these structural factors can reduce estimated quality-adjusted life-years and cost savings for disadvantaged groups, making interventions focused on disadvantaged populations appear less cost-effective. For example, analyses of a sugar-sweetened beverage tax may estimate higher costs per quality-adjusted life-year gained for Black versus White populations because of differences in competing risks and insurance status that manifest in higher health care cost savings from averted disease among White people. To ensure that cost-effectiveness assessments do not perpetuate inequities, alternative approaches are needed that account for the impact of structural factors on different groups and that consider scenarios in which health inequities are reduced. Sensitivity analyses focusing on health equity could help advance interventions that disproportionately benefit disadvantaged communities.

► The Political Determinants of Health and the European Union

BROOKS E., GODZIEWSKI C. ET DERUELLE T.

2024

Journal of Health Politics, Policy and Law 49(5): 673-689.

<https://doi.org/10.1215/03616878-11257064>

Models of the determinants of health have gained significant traction since the publication of the “rainbow model” of health inequalities (Dahlgren and Whitehead

1991). Researchers have developed conceptions of the social, economic, political, commercial, environmental, and behavioral determinants of health, and policy makers have enshrined elements of these in the strategies and agendas that guide health policy and wider policy activity. Some of the resulting approaches have become mainstream pillars of public health and health policy. Following a 2008 World Health Organization (WHO) commission and a wealth of research activity, the social determinants of health (SDoH) model, which encompasses economic, political, and environmental factors, is now well established (Marmot and Wilkinson 2006; Navarro 2009; WHO 2008). More recently, attention to the commercial determinants of health (CDoH) has increased markedly, and this field has become a frontier in global health research and practice (De Lacy-Vawdon and Livingstone 2020; Freudenberg et al. 2021; Gilmore et al. 2023; Maani, Petticrew, and Galea 2022; Mialon 2020). Although these models conform to a biomedical paradigm of “health determination,” which presents its own set of concerns when applied to social processes and phenomena, they have also contributed to a more holistic understanding of health in academic and policy circles.

► **Does College Selectivity Reduce Obesity? A Partial Identification Approach**

BRUNELLO G., CHRISTELIS D., SANZ-DE-GALDEANO A., *et al.*

2024

Health Economics 33(10): 2306-2320.

<https://doi.org/10.1002/hec.4869>

Abstract We use data from the National Longitudinal Study of Adolescent to Adult Health to investigate whether the quality of tertiary education -measured by college selectivity-causally affects obesity prevalence in the medium run (by age 24–34) and in the longer run (about 10 years later). We use partial identification methods, which allow us, while relying on weak assumptions, to overcome the potential endogeneity of college selectivity as well as the potential violation of the stable unit treatment value assumption due to students interacting with each other, and to obtain informative identification regions for the average treatment effect of college selectivity on obesity. We find that attending a more selective college causally reduces obesity, both in the medium and in the longer run. We provide evidence that the mechanisms through which the impact of college selectivity on obesity operates include an increase in income, a reduction in phys-

ical inactivity and in the consumption of fast food and sweetened drinks.

► **Taking a Health Economic Perspective in Monitoring Health Inequalities: A Focus on Excess Weight**

MUJICA F. P. ET CANDIO P.

2024

Health Policy 148: 105144.

<https://doi.org/10.1016/j.healthpol.2024.105144>

Background Traditional approaches to monitoring health inequalities predominantly rely on headcount methods. However, these methods fail to reflect the non-linear health economic implications of changes in disease severity. Alternative, distribution-sensitive metrics are available which could more adequately inform financial planning and policy decision making. **Methods** We describe the design of the Foster-Greer-Thorbecke (FGT) index, and discuss its relative merits as a summary monitoring metric of health inequalities in the population, compared to the Erreygers concentration index. We illustrate the FGT index by conducting a comparative longitudinal analysis of adult excess inequalities in England using Health Survey for England data from 2009 to 2019. **Findings** Excess weight inequalities have steadily increased in the English adult population, especially over the last five years. Going beyond headcount, the FGT index analyses revealed that, unlike the rest of the population, the average overweight adult from the most socio-economically deprived group is either obese (30.3 BMI for females) or at the brink of obesity (29.1 BMI for males). These results underscore a deepening divide in obesity severity between communities, with the most socioeconomically deprived groups being increasingly and disproportionately affected. **Conclusions:** The FGT index can address some shortcomings of traditional approaches to inequality measurement and local governments should consider adopting it as an alternative population health metric. Future research should apply and develop more refined distribution-sensitive measures of health inequality.

► **Corrigendum to “Impacts of an Interpretation Fee on Immigrants’ Access to Healthcare: Evidence From a Danish Survey Study Among Newly Arrived Immigrants” Health Policy 136c (2023) 104893**

NIELSEN M. R. ET JERVELUND S. S.

2024

Health Policy 148: 105151.

<https://doi.org/10.1016/j.healthpol.2024.105151>

► **Educational Outcomes Are an Underused Metric For Child and Life Course Health**

SPRAGUE N. L., BRANAS C. C., RUNDLE A. G., *et al.*

2024

American Journal of Public Health 114(9): 864-869.

<https://doi.org/10.2105/ajph.2024.307761>

► **Impact of Medical Insurance Integration on Reducing Urban-Rural Health Disparity: Evidence From China**

TANG Y., FU R. ET NOGUCHI H.

2024

Social Science & Medicine 357: 117163.

<https://doi.org/10.1016/j.socscimed.2024.117163>

The urban-rural health disparity poses a significant challenge for countries worldwide. China encounters substantial disparities in healthcare services and health outcomes between urban and rural regions. In 2015, the Chinese government integrated the medical insurance schemes for urban and rural residents into a unified program, with the goal of mitigating the disparities and enhancing the sustainability and efficiency of the medical insurance system. Using data from the China Health and Retirement Longitudinal Study (CHARLS), we explored the impact of this integration on health outcomes and the health disparity between urban and rural residents, employing a triple difference approach with propensity score matching. We found that both urban and rural residents benefited from the medical insurance reform, experiencing improvements in their health outcomes to some extent. Urban residents reported better self-reported health, while rural residents exhibited improved health in terms of both self-reported health and number of diagnosed diseases. Notably, the disparity in activities of daily living (ADL) difficulties decreased. However, we also observed a worsening trend in ADL difficulties, espe-

cially among the elderly and the working population. This underscores the urgent need for further attention to health behaviors and healthcare resource allocation to these socio-demographic groups.

► **Educational Mismatch and Mental Health: Evidence From China**

XU Q. ET CHEN Y.

2024

Social Science & Medicine 356: 117140.

<https://doi.org/10.1016/j.socscimed.2024.117140>

Education is one of the most important social determinants of mental health. Many studies have shown that overeducation has different and complex correlations with mental health status under different circumstances. However, few studies have compared overeducation and undereducation in the Chinese context to illustrate their different associations with mental health. Our study attempts to evaluate the potential association between educational mismatch and workers’ mental health in China by subdividing educational mismatch into overeducation and undereducation. By using the 2020 Chinese Family Panel Survey (CFPS) data, we screened out 7225 valid cross-sectional samples and used an ordered logit model to identify the association between educational mismatch and mental health. The findings show that overeducation is strongly associated with better psychological status, while undereducation is significantly associated with worsening psychological status. The mediating effect test shows that income satisfaction has penalty and premium effects respectively in different contexts. In addition, we found that undereducation was not significantly associated with worse psychological status in the lower job satisfaction and stable employment groups, whereas overeducation was not significantly associated with better psychological status only in precarious employment. Our research provides evidence that developing policies and interventions to improve national education can help improve national health.

Pharmaceuticals

► Experiences and Interest in Value-Based Payment Arrangements For Medical Products Among Medicaid Agencies: An Exploratory Analysis

BHUIYAN KHAN B., GEMME V., CHUPP E., *et al.*
2024

The Milbank Quarterly 102(3): 713-731.

<https://doi.org/10.1111/1468-0009.12703>

Policy Points State Medicaid experience with value-based payment (VBP) arrangements for medical products is still relatively limited, and states face a number of challenges in designing and implementing such arrangements, particularly because of the resource-intensive nature of arrangements and data needed to support measurement of desired outcomes. A number of success factors and opportunities to support VBP arrangement efforts were identified through this study, including leveraging established venues or processes for collaboration with manufacturers, engaging external and internal partners in VBP efforts to bolster capabilities, acquiring access to new data sources, and utilizing annual renegotiation of contracts to allow for adjustments. Context To date, uptake of value-based payment (VBP) arrangements for medical products and knowledge of their design and impact have been mainly concentrated among private payers. Interest and activity are expanding to Medicaid; however, their experiences and approaches to VBP arrangements for medical products are not well characterized. Methods This study sought to characterize the use of VBP arrangements for medical products among state Medicaid agencies through the use of a two-staged, mixed-methods approach. A survey and semistructured interviews were conducted to gain an understanding of state experiences with VBP arrangements for medical products. The survey and interviews were directed at senior leaders from nine states through the survey, with respondents from seven of these states additionally participating in the semistructured interviews. Findings Although experience with VBP arrangements for medical products among states varied, there were similarities across their motivations and general processes or phases employed in their design and implementation. States collectively identified a number of significant challenges to VBP arrangements, such as manufacturer engagement,

outcomes measurement, and the time, expertise, and resources required to design and implement them. We outline a range of strategies to help address these gaps and make it easier for states to pursue VBP arrangements, including more direct engagement from the Center for Medicare and Medicaid Services, state-to-state peer learning and collaboration, data infrastructure and sharing, and additional research to inform fit-for-purpose VBP arrangement approaches. Conclusions Findings from this study suggest that it may be easier for states to pursue VBP arrangements for medical products if there is greater clarity on processes employed that support design and implementation as well as effective strategies to address common challenges associated with contract negotiations. As states gain more experience, it will be important to monitor the design and implementation of common VBP arrangements to assess impact on the Medicaid program and the populations it serves.

► Impact environnemental des médicaments : tenir compte des données de consommation

REVUE PRESCRIRE

2024

Prescrire : la revue 2024(490): 618-623.

► Biosimilar Uptake in the US: Patient and Prescriber Factors

HONG D., KESSELHEIM A. S., SARPATWARI A., *et al.*
2024

Health Affairs 43(8): 1159-1164.

<https://doi.org/10.1377/hlthaff.2023.01215>

Among 196,766 commercially insured and Medicare Advantage patients who newly initiated biologic drugs with available biosimilar versions, biosimilar initiation increased from 1 percent in 2013 to 34 percent in 2022. Patients were less likely to initiate biosimilars if they were younger than age eighteen or the drug was prescribed by a specialist or administered in a hospital outpatient facility.

► **Consumer Out-Of-Pocket Drug Prices Grew Faster than Prices Faced By Insurers After Accounting For Rebates, 2007–20**

MALLATT J., DUNN A. ET FERNANDO L.
2024

Health Affairs 43(9): 1284-1289.
<https://doi.org/10.1377/hlthaff.2023.01344>

The rising price of branded drugs has garnered considerable attention from the public and policy makers. This article investigates the complexities of pharmaceutical pricing, with an emphasis on the overlooked aspects of manufacturer rebates and out-of-pocket prices. Rebates granted by pharmaceutical manufacturers to insurers reduce the actual prices paid by insurers, causing the true prices of prescriptions to diverge from official statistics. We combined claims data on branded retail prescription drugs with estimates on rebates to provide new price index measures based on pharmacy prices, negotiated prices (after rebates), and out-of-pocket prices for the commercially insured population during the period 2007–20. We found that although retail pharmacy prices increased 9.1 percent annually, negotiated prices grew by a mere 4.3 percent, highlighting the importance of rebates in price measurement. Surprisingly, consumer out-of-pocket prices diverged from negotiated prices after 2016, growing 5.8 percent annually while negotiated prices remained flat. The concern over drug price inflation is more reflective of the rapid increase in consumer out-of-pocket expenses than the stagnated inflation of negotiated prices paid by insurers after 2016.

► **Early Access Programs For Medical Devices in France: Overview of Recent Reforms and Outcomes (2015-2022)**

MARTIN T., HERVIAS A., ARMOIRY X., *et al.*
2024

Health Policy 148: 105146.
<https://doi.org/10.1016/j.healthpol.2024.105146>

The medical technology sector is characterised by a constant influx of innovations with the potential to revolutionize patient care. In France, there are several pathways for medical devices to enter the market, from diagnosis-related group tariffs to reimbursement lists. However, traditional regulatory pathways can delay market access for innovative technologies. In response, France has established Early Access Programs to expedite patient access to medical devices. This paper looks at three of these Early Access Programs for medical

devices. Innovation Funding, introduced in its final version in 2015, provides temporary coverage for innovative devices and facilitates data collection for informed funding decisions. Transitional Coverage (PECT), established in 2021, targets CE-marked devices for rare or serious conditions. Transitional coverage for digital health applications (PECAN), introduced in 2022, covers digital medical devices, either therapeutic or for patient monitoring. Innovation funding has been granted to 16 technologies out of 35 applications (46%) since 2015. 6 technologies out of 11 (64%) applications benefit from PECT. PECAN, in its first year, has granted a telemonitoring solution with a favourable opinion. The French experience could provide valuable lessons for the development of a harmonised European framework to ensure that innovative medical technologies benefit those who need them, while maintaining high safety standards.

► **Modeling of Drinking and Driving Behaviors Among Adolescents and Young Adults in the United States: Complexities and Intervention Outcomes**

HOSSEINICHIMEH N., MACDONALD R., LI K., *et al.*
2024

Social Science & Medicine 354: 117087.

<https://doi.org/10.1016/j.socscimed.2024.117087>

Alcohol-impaired driving is a formidable public health problem in the United States, claiming the lives of 37 individuals daily in alcohol-related crashes. Alcohol-impaired driving is affected by a multitude of interconnected factors, coupled with long delays between stakeholders' actions and their impacts, which not only complicate policy-making but also increase the likelihood of unintended consequences. We developed a system dynamics simulation model of drinking and driving behaviors among adolescents and young adults. This was achieved through group model building sessions with a team of multidisciplinary subject matter experts, and a focused literature review. The model was calibrated with data series from multiple sources and replicated the historical trends for male and female individuals aged 15 to 24 from 1982 to 2020. We simulated the model under different scenarios to examine the impact of a wide range of interventions on alcohol-related crash fatalities. We found that interventions vary in terms of their effectiveness in reducing alcohol-related crash fatalities. In addition, although some interventions reduce alcohol-related crash fatalities, some may increase the number of drinkers who drive after drinking. Based on insights from simulation experiments, we combined three interventions and found that the combined strategy may reduce alcohol-related crash fatalities significantly without increasing the number of alcohol-impaired drivers on US roads. Nevertheless, related fatalities plateau over time despite the combined interventions, underscoring the need for new interventions for a sustained decline in alcohol-related crash deaths beyond a few decades. Finally, through model calibration we estimated time delays between actions and their consequences in the system which provide insights for policymakers and activists when designing strategies to reduce alcohol-related crash fatalities.

► **Les appariements : finalités, pratiques et enjeux de qualité**

KOUMARIANOS H., LEFEBVRE O. ET MALHERBE L.
2024

Courrier des statistiques(11): 117-140.

Les appariements rapprochent les données individuelles issues de fichiers différents. Dans un contexte de disponibilité croissante de sources, notamment administratives, ils sont de plus en plus fréquemment utilisés dans la statistique publique, à des fins d'analyse, pour éclairer des questions nouvelles, ou pour améliorer des processus de production. Ces traitements statistiques posent souvent des difficultés, liées aux imperfections des données utilisées et à leur volume. Un cadre juridique approprié est nécessaire pour les mettre en œuvre, compte tenu des enjeux de respect des secrets, en particulier la protection des données à caractère personnel. Une bonne connaissance des données utilisées et une attention particulière pour déterminer le paramétrage sont également indispensables pour assurer la meilleure qualité possible du résultat au regard de l'usage attendu, un appariement n'étant jamais fiable à 100 %. La qualité de ces appariements est donc un enjeu majeur pour la statistique publique et passe par des évaluations directes du processus, nécessairement complétées par l'étude des impacts statistiques des appariements sur les données produites.

► **Validated Administrative Data Based ICD-10 Algorithms For Chronic Conditions: A Systematic Review**

KUANG A., XU C., SOUTHERN D. A., *et al.*
2024

Journal of Epidemiology and Population Health 72(4): 202744.

<https://doi.org/10.1016/j.jep.2024.202744>

Objective This systematic review aimed to identify ICD-10 based validated algorithms for chronic conditions using health administrative data. **Methods** A comprehensive systematic literature search using Ovid MEDLINE, Embase, PsycINFO, Web of Science and CINAHL was performed to identify studies, published between 1983 and May 2023, on validated algorithms

for chronic conditions using administrative health data. Two reviewers independently screened titles and abstracts and reviewed full text of selected studies to complete data extraction. A third reviewer resolved conflicts arising at the screening or study selection stages. The primary outcome was validated studies of ICD-10 based algorithms with both sensitivity and PPV of $\geq 70\%$. Studies with either sensitivity or PPV $< 70\%$ were included as secondary outcomes. Results Overall, the search identified 1686 studies of which 54 met the inclusion criteria. Combining a previously published literature search, a total of 61 studies were included for data extraction. The study identified 40 chronic conditions with high validity and 22 conditions with moderate validity. The validated algorithms were based on administrative data from different countries including Canada, USA, Australia, Japan, France, South Korea, and Taiwan. The algorithms identified included several types of cancers, cardiovascular conditions, kidney diseases, gastrointestinal disorders, and peripheral vascular diseases, amongst others. Conclusion With ICD-10 prominently used across the world, this up-to-date systematic review can prove to be a helpful resource for research and surveillance initiatives using administrative health data for identifying chronic conditions.

► **Population Stratification Based on Healthcare Trajectories: A Method For Encouraging Adaptive Learning at Meso Level**

LAMBERT A. S., LEGRAND C., SCHOLTES B., *et al.*
2024

Health Policy 148: 105137.

<https://doi.org/10.1016/j.healthpol.2024.105137>

This paper proposes a method to support population management by evaluating population needs using population stratification based on healthcare trajectories. Reimbursed healthcare consumption data for the first semester of 2017 contained within the inter-mutualist database were analysed to create healthcare trajectories for a subset of the population aged between 60 and 79 ($N = 22,832$) to identify (1) the nature of health events, (2) key transitions between lines of care, (3) the relative duration of different events, and (4) the hierarchy of events. These factors were classified using a K-mers approach followed by multinomial mixture modelling. Five population groups were identified using this healthcare trajectory approach: “low users”, “high intensity of nursing care”, “transitional care & nursing care”, “transitional care”, and “long time in

hospital”. This method could be used by loco-regional governing bodies to learn reflectively from the place where care is provided, taking a systems perspective rather than a disease perspective, and avoiding the one-size-fits-all definition. It invites decision makers to make better use of routinely collected data to guide continuous learning and adaptive management of population health needs.

► **Stimulating Implementation of Clinical Practice Guidelines in Hospital Care From a Central Guideline Organization Perspective: A Systematic Review**

THOONSEN A. C., VAN SCHOTEN S. M., MERTEN H., *et al.*

2024

Health Policy 148: 105135.

<https://doi.org/10.1016/j.healthpol.2024.105135>

Background The uptake of guidelines in care is inconsistent. This review focuses on guideline implementation strategies used by guideline organizations (governmental agencies, scientific/professional societies and other umbrella organizations), experienced implementation barriers and facilitators and impact of their implementation efforts. Methods We searched PUBMED, EMBASE and CINAHL and conducted snowballing. Eligibility criteria included guidelines focused on hospital care and OECD countries. Study quality was assessed using the Mixed Methods Appraisal Tool. We used framework analysis, narrative synthesis and summary statistics. Results Twenty-six articles were included. Sixty-two implementation strategies were reported, used in different combinations and ranged between 1 and 16 strategies per initiative. Most frequently reported strategies were educational session(s) and implementation supporting materials. The most commonly reported barrier and facilitator were respectively insufficient healthcare professionals’ time and resources; and guideline’s credibility, evidence base and relevance. Eighty-five percent of initiatives that measured impact achieved improvements in adoption, knowledge, behavior and/or clinical outcomes. No clear optimal approach for improving guideline uptake and impact was found. However, we found indications that employing multiple active implementation strategies and involving external organizations and hospital staff were associated with improvements. Conclusion Guideline organizations employ diverse implementation strategies and encounter multiple barriers and facilitators. Our study

uncovered potential effective implementation practices. However, further research is needed on effective tailoring of implementation approaches to increase uptake and impact of guidelines.

► **The Integration of Geographic Methods and Ecological Momentary Assessment in Public Health Research: A Systematic Review of Methods and Applications**

ZHANG Y., LI D., LI X., *et al.*

2024

Social Science & Medicine 354: 117075.

<https://doi.org/10.1016/j.socscimed.2024.117075>

With the widespread prevalence of mobile devices, ecological momentary assessment (EMA) can be combined with geospatial data acquired through geographic techniques like global positioning system (GPS) and geographic information system. This technique enables the consideration of individuals' health and behavior outcomes of momentary exposures in spatial contexts, mostly referred to as "geographic ecological momentary assessment" or "geographically explicit EMA" (GEMA). However, the definition, scope, methods, and applications of GEMA remain unclear and unconsolidated. To fill this research gap, we conducted a systematic review to synthesize methodological insights, identify common research interests and applications, and furnish recommendations for future

GEMA studies. We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analysis guidelines to systematically search peer-reviewed studies from six electronic databases in 2022. Screening and eligibility were conducted following inclusion criteria. The risk of bias assessment was performed, and narrative synthesis was presented for all studies. From the initial search of 957 publications, we identified 47 articles included in the review. In public health, GEMA was utilized to measure various outcomes, such as psychological health, physical and physiological health, substance use, social behavior, and physical activity. GEMA serves multiple research purposes: 1) enabling location-based EMA sampling, 2) quantifying participants' mobility patterns, 3) deriving exposure variables, 4) describing spatial patterns of outcome variables, and 5) performing data linkage or triangulation. GEMA has advanced traditional EMA sampling strategies and enabled location-based sampling by detecting location changes and specified geofences. Furthermore, advances in mobile technology have prompted considerations of additional sensor-based data in GEMA. Our results highlight the efficacy and feasibility of GEMA in public health research. Finally, we discuss sampling strategy, data privacy and confidentiality, measurement validity, mobile applications and technologies, and GPS accuracy and missing data in the context of current and future public health research that uses GEMA.

Politique de santé

Health Policy

► **A Hexagonal Aim As a Driver of Change For Health Care and Health Insurance Systems**

BRECHAT P. H., FAGERLIN A., ARIOTTI A., *et al.*

2024

The Milbank Quarterly 102(3): 544-557.

<https://doi.org/10.1111/1468-0009.12702>

Policy Points Improving health systems requires the pursuit of both patient-centered care and a supportive environment for health professionals. This Quadruple Aim includes improving the experience of care, improving the health of populations, reducing per capita costs

of care, and improving the work life of the care providers. We propose expanding a recently defined Fifth Aim of health equity to include health democracy, ensuring that the health and health care wants, needs, and responsibilities of populations are being met, and also propose adding a Sixth Aim of preserving and improving the health of the environment to create the best health possible. As social tension and environmental changes continue to impact the structure of our society, this "Hexagonal Aim" might provide additional ethical guiderails as we set our health care goals to foster sustainable and improved population health.

► **Les malades des reins et la démocratie en santé : une histoire semée d'embûches**

CAILLÉ Y.

2024

Les Tribunes de la santé 80(2): 77-86.

<https://10.1684/tsa.2024.16>

Mal connue, peu médiatisée, longtemps silencieuse, la maladie rénale chronique dégrade fortement la vie de celles et ceux qu'elle frappe. Elle provoque une mortalité prématurée importante, entraîne souffrances, handicap et invalidité, altère profondément la qualité de vie, empêche de travailler, appauvrit des personnes touchées. Encore conscients et peut-être encore coupables d'être les survivants d'une maladie récemment mortelle, souvent âgés, affaiblis, dépendants d'une machine ou d'une équipe médicale, les malades du rein ne disposent pas de tous les atouts pour acquérir la capacité de mobilisation que l'on retrouve dans d'autres pathologies. L'épopée de l'émergence des traitements par dialyse et greffe a laissé des traces. La survie étant assurée, bien-être et qualité de vie sont souvent considérés comme secondaires. Leurs droits sont peu connus et peu promus, leur parole est peu recherchée, et lorsqu'elle s'exprime elle est souvent contestée. Les intérêts financiers et les rentes de situation de la dialyse, toujours en contradiction avec les intérêts des patients et de la santé publique, sont autant d'embûches sur le chemin de la démocratie en santé en néphrologie.

► **Ce que l'art et la culture font aux organisations de santé : dialogue fertile et expériences troublantes**

DELANOË-VIEUX C., HAN S. ET LIOT F.

2024

Revue française des affaires sociales 242(2).

<https://doi.org/10.3917/rfas.242.0007>

Partie 1 - Culture et Santé : politique intersectorielle et territoire; Partie 2 - Espaces, institutions et enjeux éthiques; Partie 3 - Art et design comme ressources thérapeutiques

► **Un effet secondaire méconnu de la crise du Covid : la place des patients dans la gouvernance hospitalière**

HIRSCH M.

2024

Les Tribunes de la santé 80(2): 45-52.

<https://shs.cairn.info/revue-les-tribunes-de-la-sante-2024-2-page-45>

La loi du 4 mars 2002 relative aux droits des malades a reconnu la participation des usagers et de leurs associations au fonctionnement du système de santé. La loi du 21 juillet 2009, dite « Hôpital, patients, santé, territoires » a consacré l'existence de commission des usagers au sein des hôpitaux. Mais la présence des patients dans les instances de décision a été plus tardive. Les patients n'ont pas été considérés comme une « partie prenante » au même titre que les différents acteurs de la communauté hospitalière. Leur participation a longtemps été écartée, au motif qu'elle « dénaturerait » les discussions et que tout ne pouvait être dit en leur présence. À l'AP-HP, où ces réticences avaient fait renoncer à leur entrée au directoire, l'esprit très collectif dans lequel a été géré la crise a conduit, naturellement, à les intégrer dans les cellules de crise où ils ont joué un rôle actif, au moment où se prenaient les décisions les plus délicates. Ceci a permis de les intégrer parmi les membres du directoire à l'AP-HP, avant que cette possibilité soit officiellement ouverte par la loi du 26 avril 2021.

► **Policy Recommendations For Coordinated and Sustainable Growth of the Behavioral Health Workforce**

LAST B. S. ET CRABLE E. L.

2024

The Milbank Quarterly 102(3): 526-543.

<https://doi.org/10.1111/1468-0009.12711>

Policy Points Demand for behavioral health services outpaces the capacity of the existing workforce, and the unmet need for behavioral health services is expected to grow. This paper summarizes research and policy evidence demonstrating that the long-standing challenges that impede behavioral health workforce development and retention (i.e., low wages, high workloads, training gaps) are being replicated by growing efforts to expand the workforce through task-sharing delivery to nonspecialist behavioral health providers (e.g., peer specialists, promotores de salud). In this paper, we describe policy opportunities to sustain behavioral health workforce growth to meet demand while supporting fair wages, labor protections, and rigorous training.

► **L'action de groupe en santé**

LEQUILLER C.

2024

Les Tribunes de la santé 80(2): 63-75.

<https://shs.cairn.info/revue-les-tribunes-de-la-sante-2024-2-page-63>

Outil au service de la démocratie sanitaire, l'action de groupe en santé a été introduite par la loi de modernisation de notre système de santé du 26 janvier 2016. Elle offre aux associations d'usagers du système de santé agréées un nouveau droit d'ester en justice, dont, dans les faits, elles se saisissent peu. Comment dès lors expliquer ce bilan mitigé et renforcer l'efficacité de ce dispositif afin d'assurer la pleine effectivité du droit à indemnisation des victimes d'accidents sériels liés à des produits de santé ?

► **Démocratie sanitaire : surgissement, permanence, nouveaux enjeux**

SAOUT C.

2024

Les Tribunes de la santé 80(2): 15-26.

<https://shs.cairn.info/revue-les-tribunes-de-la-sante-2024-2-page-15>

La démocratie sanitaire, telle qu'elle est formulée dans la loi du 4 mars 2002, résulte d'un processus participatif mis en place par les pouvoirs publics pour répondre à la montée des inquiétudes dans de nombreux domaines de la santé : la sécurité des soins bien sûr, mais tout autant les aspirations individuelles et collectives de la personne en tant qu'acteur de ses soins et dans le système de santé. Les contours adoptés par la loi fondatrice, comme celles qui l'ont suivie, les processus d'émergence des évolutions légales initiales et postérieures ainsi que les pratiques aujourd'hui sédimentées dans l'ensemble du système de santé offrent un paysage puissant de ce qu'une Nation peut construire pour augmenter le pouvoir d'agir de ses citoyens dans le domaine de la santé. C'est un patrimoine précieux face aux nouveaux enjeux du système de santé.

► **Bilan du fonctionnement de l'Office national d'indemnisation des accidents médicaux. Avancées et difficultés 22 ans après sa création**

TOUJAS F. ET LELOUP S.

2024

Les Tribunes de la santé 80(2): 53-62.

<https://shs.cairn.info/revue-les-tribunes-de-la-sante-2024-2-page-53>

Vingt-deux ans après sa création par la loi du 4 mars 2002, l'Office national d'indemnisation des accidents médicaux (Oniam) est un établissement public unique au monde qui exerce plusieurs missions d'indemnisation au service des victimes du fonctionnement du système de santé français. Suite au rapport de la Cour des comptes de 2017, un plan de redressement a été mis en œuvre. Le renouvellement de la présidence du conseil d'administration courant 2023 a donné lieu à la présentation de plusieurs pistes d'améliorations visant à poursuivre la modernisation de l'établissement et à mieux prendre en compte les attentes des victimes.

► **An Elephant in the Room? Explaining Agenda-Setting in Antimicrobial Resistance Policies in 30 European Countries**

VOGELER C. S. ET PARTH A.-M.

2024

Social Science & Medicine 356: 117164.

<https://doi.org/10.1016/j.socscimed.2024.117164>

Antimicrobial resistances (AMR) present a particularly challenging cross-sectoral policy problem, affecting human and animal health as well as the environment. Compared to the actual problem pressure, the public awareness for AMR is comparatively low and the issue has not been high on the political agenda in most. Given the rising problem pressure, we aim to find out as to what degree and under which conditions political parties bring AMR on the political agenda. By means of multilevel logit regressions based on 173 electoral manifestos in 30 European countries from 2015 to 2020, we explore the conditions that explain whether AMR are taken up in manifestos. The empirical findings indicate firstly that AMR are only addressed by political parties in Northern and Western Europe, in no case in Eastern, and only in one case in Southern Europe, though resistant bacteria are more widely spread in the latter. Secondly, Green parties are those who are most likely to address the AMR challenge. Thirdly, vote share is positively associated with AMR agenda-setting, while EU membership is insignificant and the national average on antibiotics consumption is negatively related to AMR agenda-setting. Finally, AMR are surprisingly mainly perceived as a problem of the agricultural policy subsystem despite its

cross-sectoral policy character. The study makes theoretical and empirical contributions: regarding theory, the article shows that typical variables that are used for agenda-setting are less explanatory for complex intersectoral policies. This is also accompanied by the empirical contribution: since problem awareness and complexity of policy problems are correlated, AMR are reduced to an agricultural issue and as such, it is taken over by political parties that have expertise on agricultural-environmental topics.

► **La place des usagers dans le système de santé : nouveaux enjeux, nouvelle étape ?**

VOITURIER J.

2024

Les Tribunes de la santé 80(2): 35-44.

<https://shs.cairn.info/revue-les-tribunes-de-la-sante-2024-2-page-35>

Le rôle des associations d'usagers a connu une évolution, légitimée par la loi du 4 mars 2002 vers une reconnaissance de leur participation dans les instances de décision des politiques de santé et plus largement dans les politiques sociales. La crise du Covid-19 a néanmoins mis en lumière les limites et les freins à cette participation. Fort de ces constats et au regard de l'évolution des politiques sanitaires et sociales, il est temps d'envisager une nouvelle étape.

► **Impact of the Targeted Poverty Alleviation Policy on Older Adults' Healthcare Utilization: A Quasi-Experimental Analysis From China**

WANG X. ET YE X.

2024

Social Science & Medicine 356: 117146.

<https://doi.org/10.1016/j.socscimed.2024.117146>

China implemented the Targeted Poverty Alleviation (TPA) policy in 2015 to fight against poverty. In order to assess the health performance of the TPA policy, this study aims to evaluate the impact of the TPA policy on healthcare utilization among older adults who normally have higher vulnerability to poverty and diseases. Drawing on data from four waves of the China Health and Retirement Longitudinal Study (CHARLS), we investigated the impact of the TPA policy on older individuals' outpatient and inpatient utilization using the difference-in-differences (DID) approach. In total, 5285 older respondents were incorporated into a final sample. The results indicated that the implementation of the TPA policy had a significantly positive impact on increasing inpatient care utilization for poor older adults. However, its impact on outpatient service utilization was not significant. To ensure that the increased level of inpatient care utilization was not caused by deteriorating health status, we further analyzed the impact of the TPA policy on poor older adults' health outcomes. Results indicated that the TPA policy improved self-rated health and reduced the number of ADL limitations among older adults in registered poor households. The positive impact of the TPA policy on inpatient care utilization was found to be most beneficial for older adults in poor households who were female, coupled, and aged 70 years and above. The TPA policy in China improved healthcare access for economically disadvantaged older adults and contributed to the enhancement of their health outcomes. This evidence may have broad implications for other low- and middle-income countries aiming to reduce poverty and achieve health equity.

Prevention

► **Social Stigma and COVID-19 Vaccine Refusal in France**

PERETTI-WATEL P., FRESSARD L., GIRY B., *et al.*
2024

Journal of Health Politics, Policy and Law 49(4): 567-598.

<https://doi.org/10.1215/03616878-11186095>

Context: In 2021, French health authorities strongly promoted vaccination against COVID-19. The authors assumed that refusing this vaccine became a stigma, and they investigated potential public stigma toward unvaccinated people among the French population. **Methods:** A representative sample of the French adult population (N = 2,015) completed an online questionnaire in September 2021. The authors focused on participants who were already vaccinated against COVID-19 or intended to get vaccinated (N = 1,742). A cluster analysis was used to obtain contrasted attitudinal pro-

files, and the authors investigated associated factors with logistic regressions. **Findings:** Regarding attitudes toward unvaccinated people, a majority of respondents supported several pejorative statements, and a significant minority also endorsed social rejection attitudes. The authors found four contrasting attitudinal profiles: moral condemnation only (32% of respondents), full stigma (26%), no stigma (26%), and stigma rejection (16%). Early vaccination, civic motives for it, faith in science, rejection of political extremes, and being aged 65 or older were the main factors associated with stigmatizing attitudes toward unvaccinated people. **Conclusions:** The authors found some evidence of stigmatization toward unvaccinated people, but further research is needed, especially to investigate perceived stigmatization among them. The authors discuss their results with reference to the concept of “folk devils” and from a public health perspective.

Prévision-Evaluation

Prevision-Evaluation

► **Évaluation des politiques publiques : vers une pratique intégrée au pilotage de l'action publique**

GOTER F. ET KHENNICHE S.
2024

Action publique. Recherche et pratiques 21(2): 56-56.

► **Sorties de prison : intérêt de l'intervention psychiatrique dans les structures d'accompagnement vers la sortie**

CANO J.-P., PONZIO R. ET GUIRESSE G.
2024

L'information psychiatrique 100(6): 391-398.

<https://shs.cairn.info/revue-l-information-psychiatrique-2024-6-page-391>

Les sorties de prison demeurent un axe de préoccupations pour diverses raisons, allant de l'inquiétude du grand public et des professionnels du milieu judiciaire et pénitentiaire sur la question du risque de récidive en milieu ouvert ou de la réinsertion sociale, à l'insatisfaction des professionnels de santé accompagnant les détenus en raison des ruptures de prises en charge, aux difficultés fréquentes à organiser les relais de soins et à la prévalence problématique des troubles psychiatriques en détention. En 2018, l'administration pénitentiaire a décidé de focaliser une attention particulière sur le public des détenus sortants de prison, en initiant le développement de parc immobilier de nouvelles structures pénitentiaires dénommées « structures d'accompagnement vers la sortie » (SAS). Ces SAS n'ont vocation à accueillir qu'une faible partie des détenus sortants, sélectionnés sur différents critères par l'administration pénitentiaire. Les unités sanitaires exerçant en prison ont été sollicitées afin de proposer des projets de dispositifs de soins sur ces structures en milieu pénitentiaire à part. Cet article propose d'expliquer le contexte et les enjeux sanitaires des sorties de détention, de présenter les SAS, et enfin de présenter plus spécifiquement l'activité de l'unité sanitaire de la SAS Bordeaux-Gradignan.

► **COVID-19 Crisis and the Incidence of Hospital Admissions For Psychosis in France**

DANAN L. N., POULLÉ J., BANNAY A., *et al.*
2024

Encephale 50(4): 386-390.

<https://doi.org/10.1016/j.encep.2023.08.003>

OBJECTIVES: We aimed to assess the impact of the COVID-19 crisis on the occurrence of new hospital admissions for cases of psychosis in France. **METHOD:**

We conducted a retrospective observational study from the French national PMSI database. We included patients hospitalized between 2018 and 2020 with a principal diagnosis of schizophrenia or delusional disorder with no history of psychosis in the previous 10 years. In total, we included 77,172 inpatients at crisis centers and/or in full-time hospitalization at 465 French hospitals. We assessed the number of inpatients during the year of the Covid crisis (2020) and the two years prior (2018, 2019). **RESULTS:** The number of inpatients in full-time hospitalization decreased gradually from 2018 to 2020 by 10.6%. This downward trend was observed in all age groups. In contrast, in crisis centers the number of inpatients increased by 13.4% between 2019 and 2020, while a 7.6% decrease was seen between 2018 and 2019. The greatest increase was observed in the 31-60-year age category, and particularly amongst 46-60-year-olds, i.e. 38.0%. **CONCLUSION:** The COVID-19 crisis was associated with an increase in the number of inpatients with a new episode of psychosis in crisis centers but not in full-time hospitalization. The profile of patients in crisis centers was different from that seen in preceding years and included more middle-to-late age adults. Particular attention should be given to this category of patients in the crisis environment to prevent the occurrence of new cases of psychosis in France.

► **Le parcours de soins en prison du point de vue des patients-détenus. Quelles représentations, quelles expériences, quels vécus ?**

DENIS A. ET BERGADE P.
2024

L'information psychiatrique 100(6): 385-390.

<https://shs.cairn.info/revue-l-information-psychiatrique-2024-6-page-385>

À l'épreuve de l'évolution des réponses pénales dans la société française depuis les lois respectives de 1994 et 1998 pour les auteurs de violences, le traitement social et sanitaire en a éprouvé des effets, notamment dans ses points d'appuis dans la construction d'espaces de soins. De l'incitation au soin en milieu carcéral aux soins pénalement ordonnés, les soins psychiques aux auteurs de violences évoluent. Comment les détenus

se représentent-ils le soin somatique et psychique ? Comment rencontrent-ils les soins et les soignants en prison, comment les supportent-ils, les investissent-ils, et les poursuivent-ils en milieu ouvert ? À partir des propos des détenus-patients, patients-détenus, nous tenterons d'être le plus proche de leurs confidences, leurs efforts à se livrer sur la détention avec ses espaces de souffrance et de soin.

► Prevalence of Mental Disorders in French Prisons: A Systematic Review

ECK M., DA COSTA J., WATHELET M., *et al.*

2024

Encephale 50(4): 446-464.

<https://doi.org/10.1016/j.encep.2023.11.028>

INTRODUCTION : The prevalence of psychiatric disorders among prisoners remains a major public health issue worldwide. In France, despite the increasing number of persons who are incarcerated (+ 30 % between 1992 and 2002 with a 120 % prison overcrowding), and a historical concern about the mental health of persons in detention and its management, no systematic review has been published on this subject. The aim of this article is to present the results of a systematic review of the literature on the prevalence of psychiatric disorders in French prisons. **METHOD :** The reporting of this systematic review conforms to the PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) checklist. We searched the PubMed and Web of Science databases. We used combinations of keywords relating to prison (prison*, jail*, inmate*), to psychiatry ("mental health", psychiatr*), and to France (France, French). This work was completed with a search through the digital libraries of the École des Hautes Études en Santé Publique (EHESP) and of the Système Universitaire de Documentation (Sudoc) to obtain data from academic works and the gray literature. References cited in studies included in this review were also examined. All references published up to September 2022, written in English or French, presenting the results of original quantitative studies on the prevalence of psychiatric disorders in correctional settings were included. Two researchers independently extracted data from included references according to a pre-established protocol. **RESULTS :** Among 501 records identified, a total of 35 papers based on 24 epidemiological studies met the eligibility criteria for inclusion in this review : 16 were cross-sectional, 7 retrospective and 1 both cross-sectional and retrospective. All papers were published between 1999 and

2022. We found one European study, 5 international studies, 18 regional or local studies. Of these, 21 studies had all-male or mixed gender samples (but when the sample was mixed gender, it was always at least 92 % male). Almost half of the studies (n=11) involved a small sample of fewer than 500 persons. Half of the studies involved a sample of recently incarcerated persons : 6 involved a random sample of persons in detention, and 1 involved a sample of people incarcerated for more than 5 years. The last 5 studies focused on persons aged over 50 years and incarcerated for more than one year (n=1), incarcerated for sexual offences (n=2), placed in disciplinary cells (n=1) or in a special wing for radicalized or suspected radicalized individuals (n=1). Nine studies used standardized and validated diagnostic tools. According to the 4 studies involving representative samples and using standardized and validated diagnostic tools, the prevalence of the following psychiatric disorders was : 29.4-44.4 % for anxiety disorders, 5-14.2 % for PTSD, 28-31.2 % for mood disorders, 6.9-17 % for psychotic disorders, 32 % for personality disorders and 11 % for ADHD. **CONCLUSION :** This systematic review of the literature highlights the high prevalence of psychiatric disorders in French prisons. The data collected are in line with international studies. The great methodological heterogeneity of the papers included in this review calls for further rigorous research to better understand the rates of mental disorders in French prisons and to explore their determinants.

► L'éthique des soins en milieu pénitentiaire à l'épreuve... des soins

FÉDÈLE M.

2024

L'information psychiatrique 100(6): 409-414.

<https://doi.org/10.1684/ipe.2024.2741>

Parmi les phrases qui reviennent souvent lorsqu'on nous interroge sur l'exercice de la psychiatrie en milieu pénitentiaire, se trouve en bonne place : « Quand on travaille en prison la spécificité de notre exercice est liée au lieu, pas à nos pratiques de soin qui sont les mêmes qu'en milieu libre ». Pourtant, la question qui s'impose dans nos pratiques cliniques, et quel que soit le lieu d'exercice aujourd'hui n'est-elle pas : « Peut-on encore soigner ? » Nous vivons dans un monde de servitude à des logiques radicales de norme, de compétitivité qui génère de la violence entre les hommes. La relation de soin n'est pas protégée de cela de fait. La première étape du souci éthique implique de

savoir prendre le temps de réfléchir collectivement à comment ne pas être aveugle des « forces » qui nous entourent, en prison comme ailleurs, pas pour sombrer dans un pessimisme morbide, ni au contraire dans un optimisme culturaliste, mais pour gagner en discernement et nous recentrer, en tant que professionnels de la relation de soin, autour de notre responsabilité politique : traiter de la question des singularités dans la rencontre, du registre de l'accueil, trouver des perspectives. Ou comme le rapportait du philosophe Clément Rosset, Philippe Gouet, philosophe au sein du groupe de réflexion éthique du CHGR de Rennes, de considérer une « fierté éthique » à créer et à recréer, incessamment et dans chaque situation singulière, la valeur de l'humanité que le monde et la vie qui ne cessent de démentir et de prononcer la ruine.

► Mourir sans entraves

JOVELET G.

2024

L'information psychiatrique 100(6): 421-427.

<https://shs.cairn.info/revue-l-information-psychiatrique-2024-6-page-421>

L'article apporte une réflexion sur la fin de vie et sur l'aide active à mourir qui font débat de société. En quoi les psychiatres, les soignants, sont-ils concernés par cette problématique particulièrement complexe ? Après avoir analysé le contexte et ses enjeux, fait un rappel historique notionnel, l'auteur commente les différents points de vue et arguments, ce qui le conduit au concept de fait polémique. Une judiciarisation de l'aide active à mourir peu évoquée dans les débats est-elle envisageable, souhaitable ?

► Organization of French Outpatient Psychiatric Clinics and Delay to Appointment

LAMER A., CARETTE F., MOBI H., *et al.*

2024

Encephale 50(4): 465-468.

<https://doi.org/10.1016/j.encep.2023.09.005>

OBJECTIVES: The goals of the study were to obtain a glimpse of the several types of organization of outpatient psychiatric clinics, as well as an overview of delays between a request for and the first appointment. We also look at geographical variability of appointment scheduling delays and assess the impact of the number of new applications on delays. **METHODS:** We analyzed

information collected from a phone survey conducted with the 103 adult outpatient psychiatric clinics of the French region Hauts-de-France. This survey had a one-week inclusion period in November 2022 and focused on the organization and delays before obtaining an appointment. **RESULTS:** This study indicates that organizations seem to be homogeneous. Eighty-one outpatient psychiatric clinics (96.4%) receive with scheduled appointments. The initial evaluation by a nurse followed with a proposal for the organization of care seems to be the common practice. It also appears that primary psychiatric structures were capable of providing a response within a reasonable time frame in making a first appointment with a mental health professional. On the other hand, delays were much longer and heterogeneous for first appointments with psychiatrists and psychologists. **CONCLUSIONS:** The organizations of the outpatient psychiatric clinics of the French region Hauts-de-France seem homogeneous. The evaluation by a nurse followed with a care proposal is the common practice. Primary psychiatric structures are able to provide a response within a reasonable time, with half the centers proposing an appointment with a nurse within 10.0 days.

► Le consentement en prison : réalité ou illusion ?

LÉCU A.

2024

L'information psychiatrique 100(6): 399-402.

<https://shs.cairn.info/revue-l-information-psychiatrique-2024-6-page-399>

Comment s'assurer du consentement aux soins lorsqu'une personne est détenue ? S'agit-il d'un véritable consentement libre et éclairé ? Ne nous payons-nous pas de mots en faisant signer des formulaires de consentement à des personnes qui ne sont pas libres de leurs mouvements ? Comment le Code de la santé publique est-il un soutien pour respecter le consentement de nos patients, ou son absence ? Ne faut-il pas aller jusqu'à retourner la question aux praticiens eux-mêmes : qu'est-ce consentir à travailler en prison ? À quelles conditions cela est-il encore possible ?

► **The Lancet Psychiatry Commission on Youth Mental Health**

MCGORRY P. D., MEI C. ET DALAL N.
2024

The Lancet Psychiatry 11(9): 731-774.

[https://doi.org/10.1016/S2215-0366\(24\)00163-9](https://doi.org/10.1016/S2215-0366(24)00163-9)

Mental ill health, which has been the leading health and social issue impacting the lives and futures of young people for decades, has entered a dangerous phase. Accumulating research evidence indicates that in many countries, the mental health of emerging adults has been declining steadily over the past two decades, with a major surge of mental ill health driven by the COVID-19 pandemic, the measures taken to contain it, and its aftermath. This alarming trend signals a warning that global megatrends (major, long-lasting societal changes such as environmental, social, economic, political, or technological changes) and changes in many societies around the world in the past two decades have harmed the mental health of young people and increased mental ill health among them.

► **The Longitudinal Dispositions of People Diagnosed with Adjustment or Severe Stress Disorders**

POREMSKI D., HARIRAM J., WONG W. K., *et al.*
2024

BMC Psychiatry 24(1): 457.

<https://doi.org/10.1186/s12888-024-05904-y>

Adjustment and stress-related disorders are prevalent among psychiatric service users. Despite their prevalence, little is known about their prognosis. To reduce that gap, the present article documents the service use and diagnostic outcomes of people with adjustment or stress-related disorders presenting at Singapore's largest psychiatric emergency department.

► **Strategies, Processes, Outcomes, and Costs of Implementing Experience Sampling-Based Monitoring in Routine Mental Health Care in Four European Countries: Study Protocol For the IMMERSE Effectiveness-Implementation Study**

REININGHAUS U., SCHWANNAUER M., BARNE I., *et al.*

2024

BMC Psychiatry 24(1): 465.

<https://doi.org/10.1186/s12888-024-05839-4>

Recent years have seen a growing interest in the use of digital tools for delivering person-centred mental health care. Experience Sampling Methodology (ESM), a structured diary technique for capturing moment-to-moment variation in experience and behaviour in service users' daily life, reflects a particularly promising avenue for implementing a person-centred approach. While there is evidence on the effectiveness of ESM-based monitoring, uptake in routine mental health care remains limited. The overarching aim of this hybrid effectiveness-implementation study is to investigate, in detail, reach, effectiveness, adoption, implementation, and maintenance as well as contextual factors, processes, and costs of implementing ESM-based monitoring, reporting, and feedback into routine mental health care in four European countries (i.e., Belgium, Germany, Scotland, Slovakia).

► **Sommeil et santé mentale chez l'enfant et l'adolescent**

SCHRODER C. M., ZANFONATO T., ROYANT-PAROLA S., *et al.*

2024

Bulletin de l'Académie Nationale de Médecine 208(7): 928-934.

<https://doi.org/10.1016/j.banm.2024.05.003>

Résumé : Le sommeil et la santé mentale de l'enfant et de l'adolescent sont fortement intriqués, et leurs liens sont complexes et multimodaux. La mise en place du sommeil est un processus évolutif tout au long du neurodéveloppement : il suit et optimise la maturation cérébrale de l'enfant. La survenue de troubles du sommeil ou des rythmes veille-sommeil durant cette période ne doit pas être négligée en raison de leur impact sur le bien-être physique et mental des plus jeunes. De manière transdiagnostique, le sommeil peut constituer un biomarqueur du risque de conversion

d'un trouble psychiatrique, et la prise en charge efficace des troubles du sommeil de l'enfant et de l'adolescent apporte un bénéfice clinique dans l'expression des troubles pédopsychiatriques. Notamment dans les troubles du neurodéveloppement, les altérations du sommeil sont fréquentes et mènent à une aggravation des symptômes diurnes, alors que leur prise en charge les atténue. Chez l'adolescent, particulièrement à risque de développer un syndrome de retard de phase avec privation de sommeil, les répercussions de la dette de sommeil sur la santé mentale est significativement élevée, et il semble qu'une relation existe entre l'apparition de troubles du sommeil et le risque de passage à l'acte suicidaire. Toutes ces considérations amènent les pouvoirs publics à mener des politiques de santé ambitieuses pour la promotion du sommeil dans ses meilleures conditions, dès la petite enfance.

► **La loi 94-43 du 18 janvier 1994 : repères historiques et choix institutionnels**

SENON J.-L.
2024

L'information psychiatrique 100(6): 415-419.

<https://shs.cairn.info/revue-l-information-psychiatrique-2024-6-page-415>

Nous fêtons récemment le 30^e anniversaire de la loi du 18 janvier 1994 qui a confié à l'hôpital la santé en milieu pénitentiaire dans un colloque réunissant nombre de professionnels de la santé mais aussi pénitentiaires pour échanger sur l'évolution des pratiques sur ces trois dernières décennies entre hôpital et prison. Il s'agit là d'un témoignage d'un membre de la commission du Haut Conseil de la santé publique qui a été à l'origine de la loi, témoignage qui apporte quelques éléments sur les « piliers » sanitaires et psychiatriques mais aussi pénitentiaires de celle-ci marqués par l'humanisme de l'après-guerre 1939-1945. Ces piliers, ancrés dans l'histoire de l'hôpital comme de la prison, sont aussi une façon de rendre hommage à ceux qui ont inspiré une approche d'humanité tant en psychiatrie où Marie-Rose Mamelet a conçu la circulaire de 1960 sur le secteur et incité au développement des CMPR, qu'au niveau de la prison avec la réforme de Paul Amor et plus tard l'apport novateur de Robert Badinter. Les valeurs, moyens et limites de l'intervention sanitaire en milieu pénitentiaire sont esquissées.

► **Association Between COVID-19 and Subsequent Depression Diagnoses—A Retrospective Cohort Study**

SMITH L., SÁNCHEZ G. F. L., KONRAD M., *et al.*
2024

Journal of Epidemiology and Population Health 72(4): 202532.

<https://doi.org/10.1016/j.jep.2024.202532>

Background The present study aimed to investigate the association between COVID-19 and the cumulative incidence of depression and the potential role of sick leave in a large representative sample of German adults. **Methods** This retrospective cohort study was based on the Disease Analyzer database (IQVIA) data. This study included individuals aged ≥ 16 years with a COVID-19 diagnosis in 1284 general practices in Germany between March 2020 and December 2021, and the propensity score matched cohort without COVID-19. Univariable Cox regression analysis assessed the association between COVID-19 and depression. **Results** The present study included 61,736 individuals with and 61,736 without COVID-19 (mean age 46.1 years; 49% women). Patients visited their physicians about 4.3 times per year during the follow-up period. About 25.5% of patients were diagnosed with COVID-19 in 2020 and 74.5% in 2021. In this representative sample of German adults, COVID-19 infection was associated with a higher cumulative incidence of depression, and this cumulative incidence was greater in women than men. As compared with non-COVID-19, COVID-19 with ≤ 2 weeks sick leave duration was associated with 17% higher depression risk (HR: 1.17; 95% CI: 1.09–2.16), COVID-19 with >2 –4 weeks sick leave duration with 37% higher depression risk (HR: 1.37; 95% CI: 1.11–1.69), and COVID-19 with >4 weeks sick leave duration with 2 times higher depression risk (HR: 2.00; 95% CI: 1.45–2.76). **Conclusion** COVID-19 sick leave was positively associated with a risk for depression, and the longer the duration of sick leave, the higher the cumulative incidence of depression.

► **Funding of Psychiatry in France, the Problem of Expensive Drugs. Example of Esketamine in the Case of Resistant Depressive Episodes**

TAILLEFER DE LAPORTALIÈRE T., JULLIEN A., EYVRARD F., *et al.*

2024

Encephale 50(4): 469-472.

<https://doi.org/10.1016/j.encep.2023.09.007>

In France, the funding of mental health institutions relies on an annual budget allocation. Esketamine, a non-competitive NMDA glutamate receptor antagonist, has been approved for adults with treatment-resistant major depressive disorder since 2019. However, due to its high cost (€200 per 28 mg device, excluding tax), the

aim of this work was to evaluate whether the income received by an institution for the management of a patient treated with Esketamine could cover the purchase of devices, based on real clinical data. Within our institution, seven patients underwent treatment with Esketamine during the study period resulting in a total usage of 714 devices, amounting to a purchase cost of €142,800. Over the course of the follow-up period, the institution received €149,054 in revenue for the treatment of these patients. Our analysis reveals that the expense associated with Esketamine constitutes 95.8 % of the income generated from caring for these patients. This not only raises questions about the pricing of this drug but also highlights the lack of a funding system for costly psychiatric drugs. This concern extends to somatic treatments associated with psychiatric care.

Sociologie de la santé

Sociology of Health

► **Navigating Artificial Intelligence in Care Homes: Competing Stakeholder Views of Trust and Logics of Care**

NEVES B. B., OMORI M., PETERSEN A., *et al.*

2024

Social Science & Medicine 358: 117187.

<https://doi.org/10.1016/j.socscimed.2024.117187>

The COVID-19 pandemic shed light on systemic issues plaguing care (nursing) homes, from staff shortages to substandard healthcare. Artificial Intelligence (AI) technologies, including robots and chatbots, have been proposed as solutions to such issues. Yet, socio-ethical concerns about the implications of AI for health and care practices have also been growing among researchers and practitioners. At a time of AI promise and concern, it is critical to understand how those who develop and implement these technologies perceive their use and impact in care homes. Combining a sociological approach to trust with Annemarie Mol's logic of care and Jeanette Pol's concept of fitting, we draw on 18 semi-structured interviews with care staff, advocates, and AI developers to explore notions of human-AI care. Our findings show positive perceptions and experiences of AI in care homes, but also ambivalence. While integrative care incorporating humans and technology was salient across interviewees, we

also identified experiential, contextual, and knowledge divides between AI developers and care staff. For example, developers lacked experiential knowledge of care homes' daily functioning and constraints, influencing how they designed AI. Care staff demonstrated limited experiential knowledge of AI or more critical views about contexts of use, affecting their trust in these technologies. Different understandings of 'good care' were evident, too: 'warm' care was sometimes linked to human care and 'cold' care to technology. In conclusion, understandings and experiences of AI are marked by different logics of sociotechnical care and related levels of trust in these sensitive settings.

Soins de santé primaire

Primary Healthcare

► **Exploring the Accessibility of Primary Health Care Data in Europe's COVID-19 Response: Developing Key Indicators For Managing Future Pandemics (Eurodata Study)**

ARES-BLANCO S., GUIADO-CLAVERO M., LYGIDAKIS C., *et al.*

2024

BMC Primary Care 25(1): 221.

<https://doi.org/10.1186/s12875-024-02413-5>

Primary Health Care (PHC) plays a crucial role in managing the COVID-19 pandemic, with only 8% of cases requiring hospitalization. However, PHC COVID-19 data often goes unnoticed on European government dashboards and in media discussions. This project aims to examine official information on PHC patient care during the COVID-19 pandemic in Europe, with specific objectives: (1) Describe PHC's clinical pathways for acute COVID-19 cases, including long-term care facilities, (2) Describe PHC COVID-19 pandemic indicators, (3) Develop COVID-19 PHC activity indicators, (4) Explain PHC's role in vaccination strategies, and (5) Create a PHC contingency plan for future pandemics.

► **Formulating Cancer Worries: How Doctors Establish Medical Expertise and Authority to Facilitate Patients' Care Choices**

BEACH W. A.

2024

Social Science & Medicine 354: 117071.

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Video recordings of oncology interviews reveal how doctors rely on worry to establish medical expertise, facilitate treatment decision-making, and construct worry parameters to help patients understand whether there is a reasonable need for worry or not. Doctors express worry as frequently as cancer patients during oncology interviews, but they face a dilemma: how to provide care for cancer patients without directly stating they are worried about them? Plausible explanations are offered for why doctors do not state personal worries. Conversation analytic methods were employed to identify how doctors rely on worry to achieve distinct

social actions. Four worry formulations are examined: (1) variations of "we worry" (and at times, non-specific and second person "you"), (2) hypothetical worry scenarios, (3) dismissing worry and offering assurance, and (4) doctors claiming they are not worried, bothered, or alarmed. Doctors align with and speak for the professionals and institutions they represent, expressing collective worries and claiming the legitimate right to worry (or not). Doctors also avoid abandoning patients to their own decision-making, yet do not formulate worry to coerce deference or dictate patients' choices. In all cases patients agreed and displayed minimal resistance to doctors' worry formulations. These findings contribute to ongoing work across institutional settings where participants have been shown to construct objective, legitimate claims meriting worries about diverse problems. Work is underway to examine when and how patients explicitly raise and doctors respond to cancer worries. Clinical implications are raised for how doctors can use worry to legitimize best treatment options, help patients minimize their worries, rely on hypothetical scenarios allowing patients to compare how other patients managed their cancer, and not dismiss the importance of minimizing the need to worry as a resource for offering reassurance.

► **Structural Changes in a Danish Social Housing Area: The Impact of Forced Permanent Rehousing on Contact Frequency with General Practitioner and Use of Antidepressants**

BLOHM F. S., NYGAARD S. S., JØRGENSEN T. S. H., *et al.*

2024

Social Science & Medicine 355: 117088.

<https://doi.org/10.1016/j.socscimed.2024.117088>

There is a lack of knowledge about the health consequences of politically initiated forced permanent rehousing (FPR) of residents in social housing areas. This study investigates if FPR is associated with the contact frequency with general practitioner (GP) and the proportion of residents who use antidepressants. The study included 432 rehoused residents matched 1:2 with remaining residents and residents from a comparable neighbouring area without exposure to

rehousing. For GP contact frequency, we conducted a difference-in-difference analysis while the proportion of residents who used antidepressants was investigated through descriptive statistics. We found high GP contact frequency in the three groups, but no significant differences. Further, we found a low proportion of residents who used antidepressants in all groups, but a small increase from baseline to follow-up. Our results thus suggest that FPR neither affected the rehoused residents' GP contact frequency nor the proportion who used antidepressants.

► Specialist Use Among Privately Insured Children with Disabilities

CHIEN A. T., WISK L. E., BEAULIEU N., *et al.*
2024

Health Services Research 59(4): e14199.

<https://doi.org/10.1111/1475-6773.14199>

Abstract Objective To investigate primary care practice ownership and specialist-use patterns for commercially insured children with disabilities. **Data Sources and Study Setting** A national commercial claims database and the Health Systems and Provider Database from 2012 to 2016 are the data sources for this study. **Study Design** This cross-sectional, descriptive study examines: (1) the most visited type of pediatric primary care physician and practice (independent or system-owned); (2) pediatric and non-pediatric specialist-use patterns; and (3) how practice ownership relates to specialist-use patterns. **Data Collection/Extraction Methods** This study identifies 133,749 person-years of commercially insured children with disabilities aged 0–18 years with at least 24 months of continuous insurance coverage by linking a national commercial claims data set with the Health Systems and Provider Database and applying the validated Children with Disabilities Algorithm. **Principal Findings** Three-quarters (75.9%) of children with disabilities received their pediatric primary care in independent practices. Nearly two thirds (59.6%) used at least one specialist with 45.1% using nonpediatric specialists, 28.8% using pediatric ones, and 17.0% using both. Specialist-use patterns varied by both child age and specialist type. Children with disabilities in independent practices were as likely to see a specialist as those in system-owned ones: 57.1% (95% confidence interval [95% CI] 56.7%–57.4%) versus 57.3% (95% CI 56.6%–58.0%), respectively ($p = 0.635$). The percent using two or more types of specialists was 46.1% (95% CI 45.4%–46.7%) in independent practices, comparable to that in systems 47.1% (95% CI 46.2%–48.0%)

($p = 0.054$). However, the mean number of specialist visits was significantly lower in independent practices than in systems—4.0 (95% CI 3.9%–4.0%) versus 4.4 (95% CI 4.3%–4.6%) respectively—reaching statistical significance with $p < 0.0001$. **Conclusions** Recognizing how privately insured children with disabilities use pediatric primary care from pediatric and nonpediatric primary care specialists through both independent and system-owned practices is important for improving care quality and value.

► COVID-19 Federal Funding to Health Centers: Tracking Distribution, Locations, and Patient Characteristics

COLE M. B., WRIGHT B., KETT P. M., *et al.*
2024

Health Affairs 43(8): 1190-1197.

<https://doi.org/10.1377/hlthaff.2024.00018>

In 2020 and 2021, health centers received federal funding to support their COVID-19 pandemic response, yet little is known about how the funds were distributed. This study identified ten sources of funding distributed to 1,352 centers, ranging from \$19 to \$1.22 billion per center. When we examined patient and organizational characteristics by quartiles of funding per patient, health centers in the highest-funded quartile (quartile 4) were more likely rural and in the South; employed lower percentages of physicians; and had the highest percentages of sicker, uninsured, and unhoused patients. Centers in the lowest-funded quartile (quartile 1) were more likely urban, employed lower percentages of nurse practitioners, and had the highest percentages of Medicaid enrollees. With the end of pandemic-related funding in 2023, combined with Medicaid unwinding concerns, targeted investment is needed to mitigate a financial cliff and help maintain health centers' capacity to provide high-quality services to those most in need.

► Attractiveness Crisis: Caring For Those Who Care

FRANÇOIS P.
2024

Journal of Epidemiology and Population Health 72(2): 202382.

<https://doi.org/10.1016/j.jep.2024.202382>

► **Quand les localités créent des centres de santé. Ajustements locaux d'une politique étatique de répartition médicale**

JOUBERT L.

2024

Sociologies pratiques 48(1): 9-22.

<https://shs.cairn.info/revue-sociologies-pratiques-2024-1-page-9>

À l'heure où les inégalités sociales et territoriales de santé sont reconnues comme un problème majeur de santé publique, des formes d'action et de solidarités par le bas viennent ajuster des politiques publiques centralisées et orientées vers la médecine libérale. Ces « localités », collectivités territoriales et associations, participent à l'attractivité de la médecine sur le territoire en créant des centres de santé, structures salariales sans profit pratiquant le tiers payant. Le développement de cette offre de soins médicaux contribue à recomposer la structure du système de santé : au niveau politique, le local rééquilibrant le national, et au niveau professionnel, le recours au salariat se substituant à l'exercice libéral. Il s'inscrit dans un processus d'hybridation des réponses à un problème public : du libéral et du salariat, du central et du local, du public et du privé, associatif ou non, du professionnel de santé et du profane, ainsi que du politique et de l'administré.

► **How Do Patients Perceive the Retirement of Their General Practitioner? A Qualitative Interview Study in France**

KEREBEL Y., DUGUET T., KAPASSI A., *et al.*

2024

BMJ Open 14(6): e078166.

<https://doi.org/10.1136/bmjopen-2023-078166>

Objectives The perspective of general practitioners' (GPs) on retirement and the factors influencing their attitude towards retirement have been previously investigated. However, while the number of GPs has been declining for many years in France, leading to the emergence of medical deserts, the impact on their patients remains to be explored. The aim of this study was to understand patients' perceptions of their GP's retirement. **Design** A semistructured interview-based qualitative study was conducted, using Interpretative Phenomenological Analysis. **Setting** Interviews were conducted in two general practices located in Essonne, Ile-de-France, France, between January and April 2014. **Participants** Thirteen women and five men, aged 21–94 years, were included in this study. **Exclusion**

criteria were the non-declaration of the physician as the declared doctor and being under 18 years of age. **Results** The GP–patient relationship is a link that is built up over time, over the course of several consultations. Patients choose their GP based on qualities or skills they value. In this way, the physician chosen is unique for their patients; this choice reflects a certain loyalty to their physician. The interaction with the family sphere reinforces this relationship through the multiple links created during care. When a GP retires, this link is broken. Patients' reactions can range from indifference to real grief. **Conclusion** This study confirms the importance of the link between the GPs and their patients and highlights the need to prepare patients for their GP's retirement. No data are available. No additional data available.

► **Healthcare Professionals As Change Agents: Factors Influencing Bottom-Up, Personal Initiatives on Appropriate Care a Qualitative Study in the Netherlands**

KRIJGSHELD M., SCHMIDT E., LEVELS E., *et al.*

2024

Health Policy 147: 105120.

<https://doi.org/10.1016/j.healthpol.2024.105120>

INTRODUCTION: Healthcare organisations face multiple challenges, often conceptualised as appropriate care. It requires change on different levels: healthcare systems (macro), healthcare organisations (meso), and healthcare professionals (micro). This study focuses on bottom-up changes initiated by healthcare professionals. The aim is to investigate hindering and stimulating factors healthcare professionals experience. **MATERIALS AND METHODS:** The study used a qualitative design with purposive sampling of eight Dutch healthcare professionals who initiated changes. We conducted online interviews and used Atlas TI with a combination of open, axial, and selective coding for data analysis. **RESULTS:** The results indicate that professionals are often mission-driven when they initiate change, support from clients and peers may help them overcome barriers. Conversely, peers who feel threatened in their autonomy hinder initiatives of professionals, especially when their changes have financial consequences for their organization. **CONCLUSION:** Aligning and integrating macro- and micro-level initiatives is crucial to advancing the movement towards appropriate care and stimulating bottom-up initiatives of healthcare professionals. More research remained needed, in particular studies on the hindering or stimu-

lating role of employers and healthcare professionals' representatives, and the adoption of the concept of appropriate care by patients.

► **Percentage of Dentists and Dental Practices Affiliated with Private Equity Nearly Doubled, 2015–21**

NASSEH K., LOSASSO A. T. ET VUJICIC M.
2024

Health Affairs 43(8): 1082-1089.

<https://doi.org/10.1377/hlthaff.2023.00574>

Over the course of the past twenty years, private equity (PE) has played a role in acquiring medical practices, hospitals, and nursing homes. More recently, PE has taken a greater interest in acquiring dental practices, but few data exist about the scope of PE activity within dentistry. We analyzed dentist provider data for the period 2015–21 to examine trends in PE acquisition of dental practices. The percentage of dentists affiliated with PE increased from 6.6 percent in 2015 to 12.8 percent in 2021. During this period, PE affiliation increased particularly among larger dental practices and among dental specialists such as endodontists, oral surgeons, and pediatric dentists. PE-affiliated dental practices were more likely to participate in Medicaid than practices not affiliated with PE. Future research should investigate whether PE's role in dentistry affects the affordability and quality of dental services.

► **A Multi-Dimensional Framework of Valued Output For Primary Care in England**

NERI M., CUBI-MOLLA P. ET COOKSON G.
2024

Applied Health Economics and Health Policy 22(5): 609-617.

<https://doi.org/10.1007/s40258-024-00895-z>

Improving efficiency and productivity are key aspects to ensure that general practices in England can meet the needs of a growing population with increasingly demanding and costly healthcare needs. However, current evidence on the efficiency and productivity of general practices is weak, partly due to suboptimal approaches to measure their 'valued' output. To overcome this limitation, this paper presents a multi-dimensional framework and indicators of valued output from the healthcare decision-maker's perspective. We identified existing primary care performance

frameworks through a targeted literature review. We reviewed the frameworks and selected the dimensions relating to the impact on patients' health outcomes, corresponding with the definition of 'valued' output from the healthcare decision-maker perspective. For each dimension, we reviewed the National Institute for Health and Care Excellence (NICE) evidence base and guidance on best practice to develop indicators of valued output. Clinical experts and representatives of the main primary care stakeholders reviewed and validated the framework's comprehensiveness and development process. Based on a review of three existing frameworks, we synthesised a multi-dimensional output framework comprising 13 dimensions for significant primary care-related conditions and services and 51 indicators of valued output. Each indicator of valued output measures a healthcare episode and the resulting impact on patient's health. The multi-dimensional framework and indicators provide a theoretical tool to improve the measurement of primary care output in economic efficiency and productivity studies. Future research should explore the measurability of the indicators through available datasets and the implementation of the framework through analytical approaches for efficiency measurement.

► **Precision Medicine in Primary Care: How GPs Envision "Old" and "New" Forms of Personalization**

POT M., SPALLETTA O. ET GREEN S.
2024

Social Science & Medicine 358: 117259.

<https://doi.org/10.1016/j.socscimed.2024.117259>

Visions of precision or personalized medicine (PM) are gaining currency around the globe. While the potential of PM in specialist medicine has been in focus, primary care is also considered to be a fruitful area for the application of PM. "Low-tech" forms of personalization and attention to individual patients are already central features of primary care practice, and primary care thus constitutes an area in which "old" and "new" forms of personalization (may) come together. Against this backdrop, we explore general practitioners' (GPs) views on PM and how they envision the future of personalization in primary care. We draw on 45 qualitative interviews with GPs from Austria, Denmark, and the United States. Along the lines of major "promises" of PM—tailoring treatment decisions, improving disease prevention, empowering patients—we show that in some areas GPs consider PM to be a continuation

or extension of existing practices of personalization, while in other cases, GPs envision that PM may negatively disrupt current forms of personalization in primary care. We suggest that this ambivalent stance towards PM can be understood through the lens of GPs' views on core values and practices of primary care.

► **Un centre de santé porté par un centre hospitalier universitaire ? L'expérience des hôpitaux universitaires de Marseille**

ROTILY M. ET CREMIEUX F.

2024

Regards(63): 365-380.

Les centres hospitaliers ont aujourd'hui des liens ténus avec les acteurs et organisations des soins primaires. La transition épidémiologique vers les maladies chroniques et le vieillissement de la population, ainsi que les nouveaux modes de prise en charge (examens à visée diagnostique nécessitant un appareillage lourd, thérapies complexes mises en œuvre par des équipes multidisciplinaires, changement des modes d'organisation, en particulier le raccourcissement des durées de séjour) bouleversent la donne. Une question majeure qui se pose alors est celle de l'articulation entre les soins primaires et les soins hospitaliers, à ce moment pivot dans la prévention et la prise en charge des maladies chroniques, de la montée des inégalités sociales et territoriales, et en prévision des futures pandémies et catastrophes environnementales. Les établissements de soins ont-ils un rôle à jouer, une place à occuper dans l'organisation des soins primaires ? Pour aborder cette question, nous voudrions ici rapporter l'histoire originale de la création du premier centre de santé français porté par un CHU, l'Assistance Publique- Hôpitaux de Marseille (AP- HM) dans les quartiers Nord de la ville. Nous décrirons, à deux voix, celles de soignants et de directeurs d'établissement, l'historique de ce projet, les raisons qui ont conduit à sa création et ses suites, nous analyserons les freins et les facilitateurs de cette expérience et tenterons d'en dégager des perspectives.

► **Senior-Focused Primary Care Organizations Increase Access For Medicare Advantage Members, Especially Underserved Groups**

SWANKOSKI K. E., SUTHERLAND A., BOUDREAU E., *et al.*

2024

Health Affairs 43(9): 1225-1234.

<https://doi.org/10.1377/hlthaff.2023.01357>

Population-based payment in Medicare Advantage (MA) can foster innovation in care delivery by giving risk-bearing providers flexibility and strong incentives to enhance care and engage patients. This may particularly benefit historically underserved groups for whom payments often exceed costs. In this study, using data from Humana MA plans, we examined "senior-focused" primary care organizations that are supported predominantly by population-based payments in contracts with MA plans. We explored whether such organizations supported by such payment are associated with better care and improved equity compared with other primary care organizations receiving other forms of payment in MA. Analyses of data from 462,872 MA beneficiaries in 2021 showed that senior-focused primary care organizations served more Black and dually eligible beneficiaries than other primary care organizations serving MA beneficiaries, and regression-adjusted analysis showed that senior-focused primary care patients received 17 percent more primary care visits. Differences were largest among Black and dual-eligible beneficiaries. These findings suggest that risk-bearing organizations in MA are responding to current payment dynamics and providing enhanced care and access to patients, particularly historically underserved populations.

► **More Doctors, Better Health? a Generalised Synthetic Control Approach to Estimating Impacts of Increasing Doctors Under Brazil's Mais Medicos Programme**

THOMAS R. L., MILLETT C., SOUSA SOARES R. D., *et al.*

2024

Social Science & Medicine 358: 117222.

<https://doi.org/10.1016/j.socscimed.2024.117222>

ABSTRACT Worldwide, there are an insufficient number of primary care physicians to provide accessible, high-quality primary care services. Better knowledge

on the health impacts of policies aimed at improving access to primary care physicians is important for informing future policies. Using a generalised synthetic control estimator (GSC), we estimate the effect of the increase in primary care physicians from the Programa Mais Médicos in Brazil. The GSC allows us to estimate a continuous treatment effects which are heterogeneous by region. We exploit the variation in physicians allocated to each Brazilian microregion to identify the impact of an increasing Mais Médicos primary care physicians. We explore hospitalisations and mortality rates (both total and from ambulatory care sensitive conditions) as outcomes. Our analysis differs from previous work by estimating the impact of the increase in physician numbers, as opposed to the overall impact of programme participation. We examine the impact on hospitalisations and mortality rates and employ a panel dataset with monthly observations of all Brazilian microregion over the period 2008-2017. We find limited effects of an increase in primary care physicians impacting health outcomes - with no significant impact of the Programa Mais Médicos on hospitalisations or mortality rates. Potential explanations include substitution of other health professionals, impacts materialising over the longer-term, and poor within-region allocation of Mais Médicos physicians.

► Approaches For Delivery of Refractive and Optical Care Services in Community and Primary Care Settings

UMAEFULAM V., SAFI S., LINGHAM G., *et al.*

2024

Cochrane Database of Systematic Reviews 5(5): CD016043.

<https://doi.org/10.1002/14651858.CD016043>

Background Uncorrected refractive error is a leading cause of vision impairment which, in most cases, can be managed with the appropriate spectacle correction. In 2021, the World Health Assembly endorsed a global target of a 40 percentage point increase in effective coverage of refractive error by 2030. To achieve this global target, equitable access to refractive and optical services within community and primary care settings needs to be strengthened. This review will inform the development of technical guidance to support improvements in the testing and correction of refractive error among World Health Organization (WHO) member states. **Objectives** To determine the range of approaches for delivery of refractive and optical care services in community and primary care settings, and

the methods employed for their evaluation. **Search methods** We searched CENTRAL, MEDLINE, Embase and Global Health databases, grey literature, and annual reports and websites of relevant organizations involved in eye care delivery from January 2002 to November 2022 to identify approaches for refractive and optical service delivery. **Selection criteria** We included observational and interventional studies, reviews, and reports from relevant organizations related to delivering refractive services and optical services for preschool and school aged children and adults in community and primary care settings published between January 2002 and November 2022. We searched for studies and reports published within the last 20 years because vision impairment due to uncorrected refractive error has only recently become a public health and eye health priority, therefore we did not expect to find much relevant literature until after 2002. **Data collection and analysis** Two review authors screened titles, abstracts and full texts, and extracted data. We resolved any discrepancies through discussion. We synthesized data, and presented results as tables, figures, and case studies. This project was led by the World Health Organization (WHO) Vision and Eye Care Programme. **Main results** We identified 175 studies from searches of databases and grey literature, 146 records from company reports, and 81 records from website searches of relevant organizations that matched our inclusion criteria. Delivery approaches for refractive and optical services in community care included school based, pharmacy, and outreach models, whereas primary care approaches comprised vision centre, health centre, and a combination of vision or health centre and door to door delivery. In community care, school based and outreach approaches were predominant, while in primary care, a vision centre approach was mainly used. In the WHO African region, the school based and outreach approaches were mainly reported while, in the Americas, the outreach approach was mostly used. Very few approaches for service delivery were reported in the WHO Eastern Mediterranean region. Prominent gaps exist in the evaluation of the approaches, and few studies attempted to evaluate the approaches for delivery of refractive and optical care services. **Authors' conclusions** We comprehensively describe a range of approaches for delivery of refractive and optical services in community and primary care. Further evaluation of their effectiveness will better inform the application of these service delivery approaches. The study outcomes will help guide WHO member states in strengthening refractive and optical services at com-

munity and primary care levels. Funding This scoping review was supported by the Vision and Eye care Programme, World Health Organization and ATScale Global Partnership. Registration The protocol of this scoping review was published in the Open Source Framework. Plain language summary What are the different ways eye tests are carried out and spectacles provided in the community and in health clinics worldwide? Key messages 1. Outreach (a community based approach to provide eye care in various settings, which are often not permanent locations), and school based service delivery approaches were mainly used to provide eye care in the community, while vision centres were mainly used in primary care (first line health care). 2. In the World Health Organization (WHO) South East Asia region, eye care was most often delivered using outreach and vision centres, whereas in the African region, school based delivery and outreach were mainly reported. In the Americas, outreach was mostly used. 3. We need more information from the WHO Eastern Mediterranean region, and we need research to evaluate which approaches are most effective. Why is it important to provide eye tests and spectacles? Many sight problems are easily solved by wearing spectacles (eye glasses). However, millions of people around the world don't have access to the tests and facilities they need to get the correct spectacles. This is a problem for many people because eye care services may be expensive, or located far away. Poor vision can affect children's ability to learn at school, and lead to people being unable to work. Governments, health services, eye care organizations, and charities use different approaches to provide eye care services to a wide variety of people. This might be by bringing services to people in the community or by providing accessible primary eye care services locally. What did we want to find out? The World Health Organization (WHO) is working on advice to countries to help them improve their eye care services. The first step is to understand what eye care services are currently available worldwide, where they are based, and how they work. This information allows us to find the gaps in the evidence, to see where future research should be focused, and will help with the WHO guidance. What did we do? We searched for evidence about the different ways people can access eye tests and get spectacles in the community and at local health centres or doctors' clinics (primary care) anywhere in the world. We needed as much information as possible, so we gathered evidence from medical studies, and also from annual reports and websites of eye care organizations. We grouped the evidence according to the different

ways eye tests and spectacles were provided, and we described how and where the services were delivered. What did we find? We found 175 studies, 146 records from eye care organizations and 81 records from websites (402 resources in total), which reported the ways eye care services were delivered in the community or in primary care. Most eye care services included eye tests, assessing the need for spectacles, and providing spectacles. The services were mainly carried out by eye care providers and sometimes with other people, like nurses, doctors and teachers. Community eye care services are provided where people live or work. Schools (154 resources): teachers are trained to give vision tests in school, or eye care workers visit the school to conduct tests. Sometimes a van or bus, equipped as an eye test centre, visits the school. Spectacles are usually prescribed if needed, and follow ups or referrals for further eye care can be arranged. Schools sometimes partner with community or primary healthcare centres to provide eye care services. Pharmacies (3 resources): community pharmacies provide vision tests and spectacles. Outreach (157 resources): eye care providers go out into the community to provide care, for example in workplaces or homes. Outreach services are not in a permanent place but may be somewhere for a short period. They often visit very remote areas. They may offer free eye tests and spectacles. In primary care, patients visit a permanent location to receive eye care services. Vision centres (53 resources) are eye care clinics staffed by trained eye care workers. They carry out tests and provide spectacles. Patients usually pay for spectacles, but they may get a voucher to help with the cost. Health centres (16 resources) are healthcare facilities but not eye care clinics. They usually provide eye tests and spectacles. Vision and health centres plus door to door delivery (11 resources): a combination of services provided by vision and health centres and home visits. In the WHO South East Asia region, the outreach and vision centre approaches were most common. In the WHO African region, the school based and outreach approaches were mainly reported. In the WHO Americas region, the outreach approach was mostly used. What are the limitations of the evidence? We found very few reports of how eye care services are delivered in the WHO Eastern Mediterranean region, so our picture of services there is limited. There was limited information about how well the delivery methods worked, so more research is needed about this. How up to date is this evidence? The evidence is up to date to November 2022.

► **Identifying Innovations Produced By Primary Health Care Centers and Evaluating Their Scalability: The SPRINT Occitanie Cross-Sectional Study in France**

VANDEVENTER A., MERCIER G., BONNEL C., *et al.*
2024

BMC Health Serv Res 24(1): 824.

<https://doi.org/10.1186/s12913-024-11237-z>

BACKGROUND: Practice-based research is one of the levers identified by the World Health Organization (WHO) to strengthen primary health care. The scaling of health and social care innovations has the potential to reduce inequities in health and to expand the benefits of effective innovations. It is now rapidly gaining the attention of decision-makers in health and social care, particularly in high-income countries. To meet the challenge of declining numbers of primary care physicians in France, Multi-professional Healthcare Centers (MHC) were created to bring together medical and paramedical professionals. They are a source of innovation in meeting the health challenges facing our populations. Specific methodology exists to identify health innovations and assess their scalability. A working group, including end-users and specialists, has adapted this methodology to the French context and the University department of general practice of Montpellier-Nîmes (France) launched a pilot study in Occitanie, a French region. **OBJECTIVE:** To identify and evaluate the scalability of innovations produced in pluri-professional healthcare centers in the Occitanie region. **METHODS:** A pilot, observational, cross-sectional study was carried out. The SPRINT Occitanie study was based on a questionnaire with two sections: MHC information and the modified Innovation Scalability Self-Administered Questionnaire (ISSaQ), version 2020. The study population was all 279 MHC in the Occitanie region. **RESULTS:** 19.3% (54) of MHC in the Occitanie region, responded fully or incompletely to the questionnaire. Four out of 5 U-MHCs were represented. Five MHC presented multiple innovations. The average per MHC was 1.94 (+/- 2.4) innovations. 26% of them (n=9) had high scalability, 34% (n=12) medium scalability and 40% (n=14) low scalability. The main innovation represented (86%) were healthcare program, service, and tool. **CONCLUSIONS:** In our cross-sectional study, a quarter of the innovations were highly scalable. We were able to demonstrate the importance of MHC teams in working on primary care research through the prism of innovations. Primary-care innovations must be detected, evaluated, and

extracted to improve their impact on their healthcare system.

► **The Economic Impact of Community Paramedics Within Emergency Medical Services: A Systematic Review**

WILKINSON-STOKES M., TEW M., YAP C. Y. L., *et al.*
2024

Applied Health Economics and Health Policy 22(5): 665-684.

<https://doi.org/10.1007/s40258-024-00902-3>

Globally, emergency medical services (EMSs) report that their demand is dominated by non-emergency (such as urgent and primary care) requests. Appropriately managing these is a major challenge for EMSs, with one mechanism employed being specialist community paramedics. This review guides policy by evaluating the economic impact of specialist community paramedic models from a healthcare system perspective.

Systèmes de santé

Healthcare systems

► Penser le futur de notre système de santé

CONSEIL DE L'ORDRE NATIONAL DES MÉDECINS
2024

Médecins : Bulletin de l'Ordre national des médecins(91): 18-26.

À bout de souffle, sinistré, épuisé... Autant de qualificatifs utilisés pour décrire notre système de santé, écartelé entre des besoins toujours plus importants, des impératifs de solvabilité incontournables, une financiarisation galopante et une centralisation que beaucoup jugent sclérosante. Alors comment sortir de l'impasse ?

► Administering a Chill Pill? Better Regulation and the Potential For Regulatory Chill in European Union Health Policy

BROOKS E. ET LAUBER K.
2024

Journal of Health Politics, Policy and Law 49(5): 743-768.

<https://doi.org/10.1215/03616878-11257072>

The European Union's "good governance" program, known as Better Regulation, seeks to improve the quality of EU legislation by controlling the policy-making process. Despite its importance, it is rarely accounted for in the EU health policy literature. Seeking to address this gap, this article introduces Better Regulation in the context of health policy making. It conceptualizes a model of regulatory chill, drawn from the literature on international trade, to interrogate the impact of Better Regulation on EU policy-making processes. Using examples from the literature and data from a series of interviews with EU officials, it explores potential pathways of response and anticipatory chill, identifying direct enforcement of Better Regulation, its utilization by corporate actors, interpretation of its provision by officials, and feedback loops as possible routes of influence. The article argues that such an approach not only presents methodological challenges but also offers a valuable way of conceptualizing the relevance of political institutions in general, and Better Regulation specifically, for health. As part of broader calls for attention to the political determinants of health, the article's

findings highlight the particular, and often overlooked, importance of metaregulatory policy frameworks.

► Les systèmes de santé français et écossais. : Se comparer pour relever des défis communs

BUBIEN Y., REILHAC A. ET RENAUD M.
2024

Gestions hospitalières 2024(636): 277-282.

Pour sa septième édition européenne, le think tank Graph s'est réuni à Édimbourg, en Écosse, du 28 juin au 1^{er} juillet 2023, afin d'explorer le paysage du système de santé écossais. Ce fut l'occasion, par le biais de conférences présentées par les acteurs du NHS Scotland et de visites des principaux hôpitaux du pays, de saisir les perspectives concrètes sur les enjeux jalonnant le système de santé écossais. À travers une approche comparative avec le système de santé français, ce séminaire a permis d'appréhender les différences et les similitudes des problématiques auxquelles les deux nations font face, tant dans leurs origines que dans les solutions envisagées. Il a également permis de découvrir le fonctionnement et la structuration du NHS Scotland, l'une des quatre entités du National Health Service (NHS) britannique qui fête ses 75 ans cette année.

► EU Economic Governance As a Supranational Determinant of Health Inequalities in the Eurozone

CERON M.
2024

Journal of Health Politics, Policy and Law 49(5): 805-830.

<https://doi.org/10.1215/03616878-11257048>

The COVID-19 pandemic raises the question of austerity's problematic social toll for health in the south of Europe. Has EU economic governance constrained health spending? If so, have these spending levels led to inequalities, which in turn shaped responses to the pandemic? EU economic governance is often dismissed as ineffective because of its poor track record of compliance. Yet austerity is blamed for negative

health outcomes. This article shows that the EU fiscal rule is a determinant of health because it affects fiscal policies of European countries. First, the analysis of EU member states during 1995–2018 shows that austerity policies affect health spending and health inequalities. Euro-area countries under the EU Excessive Deficit Procedure significantly consolidated their health spending. The contractionary effect was concentrated in southern countries, contributing to rising health inequalities across the core and periphery. Finally, the analysis shows the pandemic implications of health inequalities, as periphery countries with a track record of high consolidation display more stringent (and costly) COVID-19 response models. This analysis contributes to understanding the supranational determinants of health in the EU, showing the pervasive spillover effects of the fiscal framework on national health policies.

► **A Framework For Studying EU Health Policy Through a Political Determinants of Health Lens: The Case of the European Health Union**

FISCHER T., MAUER N. ET TILLE F.

2024

Journal of Health Politics, Policy and Law 49(5): 691-720.

<https://doi.org/10.1215/03616878-11257056>

Context: The COVID-19 pandemic has highlighted how the European Union (EU) impacts national health systems and people's health. In November 2020, the European Commission launched the European Health Union (EHU) to better coordinate and maximize EU member states' abilities to deal with cross-border health threats. This article scrutinizes the early institutionalization of the EHU and its implications for EU health policy as a political determinant of health (PDoH). Methods: The article explores how EU health policy may be appreciated from a PDoH perspective. It draws from EU documents and existing research to analyze the early-stage institutionalization of the EHU. The study complements this policy output-focused perspective with an outcome-based exploratory assessment of EU health policy as a PDoH focusing on three examples: joint vaccine procurement, health reforms and investments under the Recovery and Resilience Facility, and the development of a European Health Data Space. Findings: The article shows that the policy change triggered by the EHU and the potential impact on citizens' health are not necessarily congruent.

Modest change can have a potentially strong impact on health outcomes and vice versa. Conclusions: The article argues that the PDoH perspective provides a useful approach that is complementary to policy output-based perspectives, allowing for a more comprehensive assessment of the EU's role in health.

► **HERA-Lding More Integration in Health? Examining the Discursive Legitimation of the European Commission's New Health Emergency Preparedness and Response Authority**

GODZIEWSKI C. ET RUSHTON S.

2024

Journal of Health Politics, Policy and Law 49(5): 831-854.

<https://doi.org/10.1215/03616878-11257008>

Context: Since COVID-19, the European Commission (EC) has sought to expand its activities in health through the development of a European Health Union and within it the Health Emergencies Preparedness and Response Authority (HERA). Methods: The authors applied a discourse analysis to documents establishing HERA to investigate how the EC legitimated the creation of this institution. They focused on how it framed health emergencies, how it framed the added value of HERA, and how it linked HERA to existing EU activities and priorities. Findings: Their analysis demonstrates that security-based logics have been central to the EC's legitimation of HERA in alignment with a "securitization of health" occurring worldwide in recent decades. This legitimation can be understood as part of the EC's effort to promote future integration in health in the absence of new competences. Conclusions: Securitization has helped the EC raise its profile in health politically without additional competences, thereby laying the groundwork for potential future integration. Looking at the discursive legitimation of HERA sheds light not only on whether the EC is expanding its health powers but also how it strategizes to do so. HERA, while constrained, allows the EC to further deepen security-driven integration in health.

► **Solidarity As a Political Determinant of Health: Insights From EU Competition Policy**

GUY M.

2024

Journal of Health Politics, Policy and Law 49(5): 783-803.

<https://doi.org/10.1215/03616878-11257016>

Context: The connection between law and political determinants of health is not well understood, but nevertheless it is suggested that the two are inseparable, and this represents an upstream level with scope for influencing other determinants of health (particularly social determinants). Solidarity underpins European health care systems, and given its clear link with redistribution, it can be seen as a means for addressing health inequities. As such, solidarity may be seen as a political determinant of health in the specific context of European Union (EU) competition policy. Methods: A range of EU case law, treaty provisions, and European Commission publications relating to EU competition policy are analyzed. Findings: Solidarity is typically juxtaposed as antithetical to competition and thus as underpinning exceptions to the applicability of prohibitions on anticompetitive agreements, abuse of dominance, and state aid. Case law indicates an additional dynamic between definitions of solidarity at the EU and national levels. Conclusions: This analysis leads to two groups of considerations when framing solidarity as a political determinant of health in the EU competition policy context: first, the predominance of solidarity suggests it may shape competition reforms; second, the EU–member state dynamic indicates less EU-level reach into national competition reforms in health care than may be expected.

► **Political Determinants of Health: Health Care Privatization and Population Health in Europe**

MOISE A. D. ET POPIC T.

2024

Journal of Health Politics, Policy and Law 49(5): 769-782.

<https://doi.org/10.1215/03616878-11257024>

Context: The extent to which health care reforms affect health remains understudied. Health care reforms result in policy outputs that determine provision of medical services, which have consequences for the health of the population. The authors scrutinize this

relationship between health policy outputs and population health by focusing on legislative changes implying privatization of health care delivery and finance. They ask the following question: What is the relationship between reforms that privatize health care provision and population health in terms of health outcomes and inequalities. Methods: They answer this question by relying on fixed-effects time-series cross-section models. The authors use an original dataset of health care reforms passed in 36 European countries from 1989 to 2019. Health outcomes are operationalized with measures of subjective health status, unmet health needs, and resulting health inequalities. Findings: Their results show that privatization of health care is associated with higher rates of bad subjective health and unmet health needs several years after the passing of reforms. These effects are stronger for individuals in the lower tiers of income and education, resulting in greater socioeconomic inequalities. Conclusions: The article contributes to conceptualization of the political determinants of health as health policy outputs and a better understanding of the relationship between policy outputs and population health outcomes.

► **The EU As a Political Determinant of Global Health: The Case of Research and Development Incentives For Orphan Medicines and Biotechnology**

PEREHUDOFF K. ET IPPEL K. A.

2024

Journal of Health Politics, Policy and Law 49(5): 911-938.

<https://doi.org/10.1215/03616878-11257032>

Context: The European Union (EU) governs global health through its constituent laws, institutions, actors, and policies. However, it is unclear whether or how these political factors interact to position the EU as a political determinant of global health. Methods: The authors conduct a case study of the political factors influencing the adoption of the EU's Biotechnology Directive 98/44/EC and Orphan Medicines Regulation 141/2000. Findings: The European Commission (EC) generally framed both of its proposals around economical and biomedical paradigms aligned with the needs of the EU's industry and patients, whereas the European Parliament (EP) contested some of these frames and proposed amendments supporting global access to medical products. The political factors influencing the adoption (in the Biotechnology Directive) or rejection (in the Orphan Regulation) of the EP's amendments

include the complementarity between the EP and EC proposals, the EP's power in the intra- and interinstitutional negotiating process, the existence and support of civil society, and the alignment with member state priorities in the Council. Conclusions: In the late 1990s, the EU was an internally fragmented and politicized player concerning global health matters. These political factors should be considered for a coherent post-2022 EU strategy on global health.

► **No Country For Sick Men: The Political Determinants of Health Policy in Poland**

RIEDEL R. ET SZYSZKOWSKA E.

2024

Journal of Health Politics, Policy and Law 49(5): 893-909.

<https://doi.org/10.1215/03616878-11257000>

Context: The objective of this article is to explain the political factors determining the relatively weak performance of the Polish health care (HC) sector. This can be treated as a critical case for several reasons. First, the Poles are among the most unsatisfied patients in the European Union, with one of the lowest life expectancy levels. Second, Poland spends one of the lowest shares of gross domestic product on HC-related expenditures among OECD countries. Third, the country is facing medical personnel shortages. Methods: The analysis is based on the mixed-methods approach. The authors rely on quantitative data outsourced from a survey, which is supplemented by the semistructured, in-depth interviews with selected key HC stakeholders representing patients' advocacy groups, medical personnel organizations, and high-level decision-makers. Findings: The Polish HC system remains weak due to the postcommunist legacy in terms of organization, a short-term approach by politicians, and weak decision-making processes. Conclusions: The HC policy inertia in Poland is determined by a group of interrelated political factors that effectively block the development of any positive reform.

► **The EU As Active and Passive Political Determinant of Forced Migrants' Health: Insights From the Case of Germany**

ROOS M.

2024

Journal of Health Politics, Policy and Law 49(5): 721-741.

<https://doi.org/10.1215/03616878-11256992>

Context: This article examines the EU's function as a political determinant of health (PDoH) in national-level regulation of forced migrants' access to health(care), with a focus on Germany. It sheds light on the role the EU has come to play—and has been assigned—in national policy making under the impact of different crises. Methods: By applying the concepts of claims and frames/framing, the article examines in a document analysis how and to what end(s) the EU as a polity and specific EU legislation were invoked in German draft legislation. Findings: Increasing Europeanization in the areas of health and migration has not only forced national legislators to adapt legislation to abide by EU rules and standards, it has also prompted governmental actors to shift responsibility for policy reforms to the EU—even in cases where not all of these reforms were legally required. Conclusions: The EU's role as a PDoH must be considered from two angles: the EU's active potential to determine public health through its policies and laws, and its passive—to some extent involuntary—potential to do so through the strategic invoking of EU norms, rules, and (in)competences by actors across the EU multilevel governance system.

Travail et santé

Occupational Health

► Intérim : troubles dans la prévention

BARLET B., BARNIER L.-M. ET MASCOVA E.
2024

Travail et emploi(169-170-171): 147-173.

La santé au travail des salariés intérimaires fait l'objet d'un suivi particulier, le problème de leur sur-accidentalité étant régulièrement mis à l'agenda. Pourtant, ce constat dissimule les lacunes dans l'objectivation et la prise en charge des expositions professionnelles des intérimaires. Il s'agit moins d'une ignorance que de dispositifs de suivi qui peinent à déclencher et à équiper l'action de prévention. L'analyse porte sur trois dispositifs institués de suivi des risques professionnels : l'enregistrement administratif des accidents du travail et des maladies professionnelles par la Caisse nationale de l'assurance maladie des travailleurs salariés (Cnam- TS), le suivi de l'état de santé des intérimaires par les services de santé au travail et l'évaluation et la prévention des risques organisées par les entreprises de travail temporaire. Pour chacun de ces dispositifs, sont analysés les initiatives, les efforts et les arguments déployés par celles et ceux qui sont chargés de ces questions et qui se trouvent ainsi placés en difficulté pour agir

► Diversity of Flexible Working Time Arrangements and Workers' Health: An Analysis of a Workers' Panel and Linked Employer-Employee Data For France

ERHEL C., GUERGOAT-LARIVIÈRE M. ET MOFAKHAMI M.
2024

Social Science & Medicine 356: 117129.

<https://doi.org/10.1016/j.socscimed.2024.117129>

Flexible working time arrangements (FWTA) have increased over the last decades, favored by labor market deregulation, the decentralization of collective bargaining and the development of new technologies. The negative impact of some non-standard working hours on health (like night work, shift work) is quite well-known but other forms of FWTA have been studied less so far. This article aims to investigate the relationship between FWTA and workers' health. It

focuses on employer-oriented FWTA and uses a job demands-control framework to identify different types of working time demands and control. The study uses individual data from the French working conditions survey, including panel data from 2013-2019 (64,981 employees) and cross-sectional employer-employee linked data from 2019 (5,687 employees from 4,672 workplaces). We identify empirically two main dimensions of employer-oriented FWTA, based on 14 working time variables. The first type involves "atypical working hours", such as working weekends, nights, early mornings, evenings, or doing shift work. The second type – "work overflow" – is characterized by long working hours, overtime, taking work home, and having variable working hours. Using a fixed-effects model based on panel data, we show that both types of FWTA have a negative impact on workers' self-rated general health and mental health, as measured by the WHO-5 index. The study also finds that workers who have more control – both individual and collective – to face these demands demonstrate better health. Workers with control over their working hours report better health and are less negatively affected by FWTA. Moreover, workplace-level practices have ambiguous relationships with workers' health. However, those involving social dialogue and workers' participation have more favorable effects: the positive effect of health and safety committees is especially clear. To improve workers' health in the context of increased flexible working time arrangements, public policies should promote the development of control over working time and participation of workers to social dialogue on working time related issues.

► Job Burnout and Anxiety Among Medical Staff: A Latent Profile and Moderated Mediation Analysis

HAO S. ET ZHANG X.
2024

Social Science & Medicine 356: 117141.

<https://doi.org/10.1016/j.socscimed.2024.117141>

Background Due to work pressure, work intensity, and the impact of emergencies such as the epidemic, job burnout and mental health problems among medical staff have become increasingly prominent. Objectives

Our study aims to characterize the patterns of burnout in Chinese medical staff, explore the profile differences on anxiety and self-esteem, examine whether the differences in these profiles on anxiety were mediated by self-esteem, and investigate whether this mediating process was moderated by positive coping styles among medical staff. Methods Data were collected from 602 medical staff in China by a convenient sampling method. A latent profile and moderated mediation analysis were performed. Results Latent profile analysis on three burnout dimensions [emotional exhaustion, cynicism, and professional efficacy] indicated two burnout profiles: low burnout (82.47% of the sample) and high burnout (17.53%). Medical staff with a low burnout profile had lower levels of emotional exhaustion and cynicism than those with a high burnout profile. It was also determined that self-esteem mediates burnout and anxiety in both high- and low-burnout medical staff. The moderating role of positive coping styles was also identified ($\beta = 0.30$, 95%CI: 0.058–0.550). Conclusions The identification of two distinct burnout patterns (low burnout and high burnout) provides clinical administrators with clear goals for individualizing support and interventions for medical

staff with different levels of burnout. Furthermore, attention should be given to self-esteem and positive coping styles, as they act as potential mediators and moderators of medical staff's mental health problems.

► **La tarification AT- MP : sur quelques éclairages jurisprudentiels récents**

TAURAN T.
2024

Revue de droit sanitaire et social 2024(3): 524-535.

La mise en œuvre de la tarification AT- MP soulève d'innombrables problèmes juridiques pour les entreprises et les organismes sociaux. La présente étude met en exergue certains d'entre eux, en soulignant les éclairages jurisprudentiels apportés par la Cour de cassation. Tel est le cas notamment en matière de classification des établissements de l'entreprise selon un « code risque », du compte spécial réservé à certaines maladies professionnelles, de l'application de ristournes (ou de cotisations supplémentaires) aux employeurs ou encore de l'impact de la responsabilité d'un tiers dans la fixation des cotisations.

Vieillessement

Aging

► **Travailler en Ehpad pendant le premier confinement. Tenir malgré des conditions de travail dégradées**

CARADEC V., BONNEL G. ET CASTRA M.
2024

Vie sociale 45(1): 69-82.

<https://doi.org/10.3917/vsoc.229.0069>

Cet article étudie comment les conditions de travail en Ehpad (établissements d'hébergement pour personnes âgées dépendantes) ont été impactées par le premier confinement lié à l'épidémie de Covid-19 (mars-juin 2020) en se montrant attentif à la fois aux transformations objectives du travail et aux expériences subjectives des professionnel·les. S'appuyant sur les témoignages de professionnel·les recueillis dans le cadre de l'enquête CovidEhpad et travaillant dans une cinquantaine d'ehpad, il décrit comment la période de confinement s'est caractérisée

à la fois par une intensification du travail, un accroissement de sa pénibilité et une augmentation de la charge mentale. Les relations sociales au travail ont, quant à elles, été marquées à la fois par des solidarités et des tensions. En conclusion, l'article s'interroge sur ce qui a permis à la plupart des professionnel·les de tenir au travail malgré ces conditions dégradées.

► **Conditions de travail et conditions pour faire du « bon travail » dans le secteur social et médico-social**

DEVETTER F.-X., DUSSUET A. ET PUISSANT E.
2024

Vie sociale 45(1): 117-131.

<https://doi.org/10.3917/vsoc.229.0117>

Les métiers du vieillissement, en établissements ou dans l'aide à domicile, cumulent un ensemble de

contraintes physiques, temporelles et psychosociales aujourd'hui assez bien identifiées tant par des travaux quantitatifs que qualitatifs. L'invisibilité de la pénibilité est désormais largement dénoncée. Pour autant, les pistes d'amélioration demeurent peu avancées. Après avoir brièvement rappelé les différentes contraintes auxquelles sont exposées les salariées (essentiellement les agentes de service hospitalier, aides médico – psychologiques et aides – soignantes en établissements et les auxiliaires de vie sociale et aides à domicile dans les services d'aide et d'accompagnement à domicile), cet article identifie les principales raisons qui compliquent l'amélioration des conditions d'emploi de ces métiers. En conclusion, les auteurs tentent d'esquisser des pistes de transformations qui permettraient de dépasser au moins partiellement ces blocages.

► **“Successful” Ageing in Later Older Age: A Sociology of Class and Ageing in Place**

GIBSON K., KINGSTON A., MCLELLAN E., *et al.*

2024

Social Science & Medicine 358: 117258.

<https://doi.org/10.1016/j.socscimed.2024.117258>

Supporting people to ‘age in place’ – to live independently at home and remain connected to the community – is an international policy priority. But the process of ageing in place is mediated in a socio-cultural context where neoliberal tropes of successful ageing reproduce a pervasive model about ‘ageing well’ by elevating ideals of individualised choice and self-governance. Based on two waves of qualitative interviews and interim observations, we employ a Bourdieusian logic to explore the ramifications of this context on the experiences of 46 people in later older age (80+) ageing in place in North East England. All participants enacted everyday improvisatory practices to render their homes habitable. But our participants – most of whom were located in middle-class social positions – supplemented such improvisations with a strategic disposition to plan for and actively shape their ageing-in-place futures. Our participants conveyed a distinct sense of agency over their ageing futures. Underpinning their orientations to practice was an awareness of the value attached to individually ‘ageing well’ and a distancing from the agedness associated with the fourth age. Our analysis demonstrates the role of capital, accrued throughout the life course, in bringing such future trajectories into effect. The central argument of this paper therefore is that the embodiment of (neoliberal) ideals of successful

ageing in place requires the deployment of classed capital. In sum, contrary to the individualising narratives ubiquitous in policy pertaining to ageing well, we show the importance of classed structural moorings in this process.

► **Four Years and More than 200,000 Deaths Later: Lessons Learned From the COVID-19 Pandemic in US Nursing Homes**

KONETZKA R. T., GRABOWSKI D. C. ET MOR V.

2024

Health Affairs 43(7): 985-993.

<https://doi.org/10.1377/hlthaff.2023.01460>

Nursing home residents and staff were disproportionately affected by the COVID-19 pandemic, drawing attention to long-standing challenges of poor infection control, understaffing, and substandard quality of care in many facilities. Evolving practices and policies during the pandemic often focused on these challenges, with little effect. Despite the emergence of best practices to mitigate transmission of the virus, even the highest-quality facilities experienced outbreaks, indicating a larger systemic problem, rather than a quality problem at the facility level. Here we present a narrative review and discussion of the evolution of policies and practices and their effectiveness, drawing on evidence from the United States that was published during 2020-23. The lessons learned from this experience point to the need for more fundamental and nuanced changes to avoid similar outcomes from a future pandemic: greater integration of long-term care into public health planning, and ultimately a shift in the physical structure of nursing homes. More incremental measures such as vaccination mandates, higher staffing, and balancing infection control with resident quality of life will avoid some adverse outcomes, but without more systemic change, nursing home residents and staff will remain at substantial risk for repetition of the poor outcomes from the COVID-19 pandemic.

► **Inégalités dans l'accès aux soins de longue durée, en comparaison internationale**

MARX P.

2024

Regards(63): 345-355.

L'accélération du vieillissement démographique et l'émergence croissante des pathologies chroniques constituent une tendance mondiale majeure qui nécessite une prise de conscience et des réformes substantielles. De nombreux pays sont confrontés à une augmentation significative de la demande de soins de longue durée (SLD) en raison des évolutions démographiques et épidémiologiques rapides, ainsi que d'une transformation des structures traditionnelles de prise en charge des individus. Ces évolutions provoquent de nombreuses inégalités d'accès aux soins que les modèles traditionnels de prise en charge peinent à gommer. Les soins de longue durée englobent une gamme de soins et d'assistances techniques et humaines très variés. Cette spécificité doit être envisagée dans le cadre d'un parcours coordonné tout en valorisant les expériences de terrain qui, plus encore que les dispositifs législatifs, permettront à nos sociétés d'accompagner les plus fragiles tout en rapprochant les générations.

► **Dementia, Nurse Staffing, and Health Outcomes in Nursing Homes**

MUKAMEL D. B., LADD H., SALIBA D., *et al.*

2024

Health Services Research 59(4): e14270.

<https://doi.org/10.1111/1475-6773.14270>

Abstract Objective To estimate and contrast the relationships between nurse staffing and health outcomes in nursing homes with low and high dementia census, to understand the association of staffing hours with dementia care quality. **Data Sources and Study Setting** A national sample of nursing homes during 2017–2019 (pre-COVID). Data included the Payroll-Based Journal, Medicare Claims, Nursing Home Care Compare, and Long-Term Care Focus. **Study Design** Retrospective, regression analyses. We estimated separate linear models predicting six long-term facility-level outcomes. Independent variables included staffing hours per resident-day (HPRD) interacted with the facility percentage of dementia residents, controlling for other resident and facility characteristics. **Data Collection/Extraction Methods** Hospital-based nursing homes, those with fewer than 30% dementia residents, and

missing data were excluded. **Principal Findings** We found that registered nurses and certified nurse assistants HPRDs were likely to exhibit positive returns in terms of outcomes throughout most of the range of HPRD for both high and low-census dementia facilities, although, high- and low-dementia facilities differed in most outcome rates at all staffing levels. Average predicted antipsychotics and activities of daily living as functions of HPRD were worse in higher dementia facilities, independent movement, and hospitalizations did not differ significantly, and Emergency Rooms and pressure sores were worse in lower dementia facilities. Average marginal effects were not statistically different [CI included zero] between the high and low dementia facilities for any outcome. **Conclusions** These findings suggest that increasing staffing will improve outcomes by similar increments in both low- and high-dementia facilities for all outcomes. However, at any given level of staffing, absolute differences in outcomes between low- and high-dementia facilities remain, suggesting that additional staffing alone will not suffice to close these gaps. Further studies are required to identify opportunities for improvement in performance for both low- and high-dementia census facilities.

► **« Affronter ensemble la crise sanitaire » : les effets de l'épidémie de Covid-19 sur les relations de travail en Ehpad**

PLAULT M., TRIPLET L. ET XING-BONGIOANNI J.

2024

Vie sociale 45(1): 83-97.

<https://doi.org/10.3917/vsoc.229.0083>

Comment les professionnelles des établissements d'hébergement pour personnes âgées dépendantes (ehpad) ont-elles fait face à l'épidémie de Covid-19 ? À partir d'une enquête menée entre 2021 et 2022 qui articule méthodes qualitatives et quantitatives, cet article vise à étudier la dimension relationnelle des conditions de travail dans les ehpad pendant la première année de la crise sanitaire. Il montre que les travailleuses de première ligne du secteur (aides-soignantes, infirmières, agentes de service) ont surmonté l'aggravation de leurs conditions de travail et l'incertitude liée à l'épidémie grâce à la solidarité qui s'est exprimée sous la forme d'un soutien moral mais aussi d'une forte entraide concrète au travail. L'épidémie a par ailleurs bouleversé l'organisation du travail en ehpad en amenant certains cadres à « remettre la blouse ». Si ces pratiques n'ont pas perduré sur le long terme faute d'une

institutionnalisation de la part des établissements, les sentiments d'injustice et de manque de reconnaissance partagés par de nombreuses soignantes et agentes de service depuis la sortie de la crise risquent d'affaiblir leur engagement et la force des collectifs de travail à moyen et long terme.

► **Réforme des retraites et emploi des seniors**

RAGOT X. ET TOUZÉ V.

2024

Revue de l'OFCE 184(1): 5-13.

<https://doi.org/10.3917/reof.184.0005>

Ce numéro s'organise en trois parties et rassemble sept contributions. La première partie revient sur les caractéristiques de la « réforme Borne 2023 » et réunit 2 articles intitulés « Vers un nouveau recul de l'âge de la retraite : la réforme Borne 2023 » et « Apories d'une réforme de la retraite reposant sur l'unique paramètre de l'âge pour prolonger la vie active ». La seconde partie est dédiée à la « modélisation macroéconomique » appliquée pour traiter des réformes et de l'âge de la retraite. Cette partie réunit trois articles. Enfin, la dernière partie offre une mise en perspective de l'appréciation du sujet des retraites et de l'emploi des seniors à un niveau européen. Le numéro se termine par une contribution intitulée « Maintien des seniors dans l'emploi en Europe : quel bilan face au défi posé par le recul de l'âge de la retraite ? ».

► **Dual-Eligible Nursing Home Residents: Enrollment Growth in Managed Care Plans that Coordinate Care, 2013–20**

ROBERTS E. T., CHEN X., MACNEAL E., *et al.*

2024

Health Affairs 43(9): 1296-1305.

<https://doi.org/10.1377/hlthaff.2023.01579>

Dual-eligible beneficiaries have insurance through two distinct and uncoordinated programs: Medicaid, which pays for long-term care; and Medicare, which pays for medical care, including hospital stays. Concern that this system leads to poor quality and inefficient care, particularly for dual-eligible nursing home residents, has led policy makers to test managed care plans that provide incentives for coordinating care across Medicare and Medicaid. We examined enrollment in three such plans among dual-eligible beneficiaries receiving long-term nursing home care. Two of those

plans, Medicare-Medicaid plans and Fully Integrated Dual Eligible Special Needs Plans, are integrated care plans that establish a global budget including Medicare and Medicaid spending. The third, Institutional Special Needs Plans, puts insurers and nursing homes at risk for Medicare spending but not Medicaid spending. Among dual-eligible nursing home residents, enrollment in these plans increased from 6.5 percent of residents per month in 2013 to 16.9 percent in 2020. Enrollment varied across counties but did not vary appreciably with respect to nursing home characteristics, including the share of residents with Medicaid. As policy makers pursue strategies to coordinate medical and long-term care for dual-eligible beneficiaries, it remains critical to evaluate how these plans influence the care of dual-eligible nursing home residents.

► **The Effect of Retirement Eligibility on Mental Health in the United Kingdom: Heterogeneous Effects By Occupation**

SPEARING J.

2024

Health Economics 33(8): 1621-1648.

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Abstract I investigate heterogeneity across occupational characteristics in the effect of retirement eligibility on mental health in the United Kingdom. I use K-means clustering to define three occupational clusters, differing across multiple dimensions. I estimate the effect of retirement eligibility using a Regression Discontinuity Design, allowing the effect to differ by cluster. The effects of retirement eligibility are beneficial, and greater in two clusters: one comprised of white-collar jobs in an office setting and another of blue-collar jobs with high physical demands and hazards. The cluster with smaller benefits mixes blue- and white-collar uncompetitive jobs with high levels of customer interaction. The results have implications for the distributional effect of raising the retirement age.

► **La réforme des services à caractère social et médico-social à domicile : entre restructuration ambitieuse des prestations et délicate recomposition territoriale**

VITOUR A.

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La réforme des services à domicile implique une redéfinition des catégories de services à caractère social et médico-social : les SSIAD, SAAD et SPASAD disparaissent au profit d'une nouvelle catégorie, le SAD, service autonomie à domicile. Les conditions d'organisation et de fonctionnement de ces futurs SAD sont fixés dans un cahier des charges national et leurs modalités de financement sont également redéfinies. La mise en œuvre concrète des SAD implique une importante recomposition de l'offre sur le territoire, laquelle se heurte à de nombreuses difficultés pratiques.

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