

Veille scientifique en économie de la santé

Watch on Health Economics Literature

Avril 2024 / April 2024

Assurance maladie	<i>Health Insurance</i>
Démographie	<i>Demography</i>
E-santé	<i>E-Health</i>
Économie de la santé	<i>Health Economics</i>
Environnement et santé	<i>Environmental Health</i>
État de santé	<i>Health Status</i>
Géographie de la santé	<i>Geography of Health</i>
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Hôpital	<i>Hospital</i>
Inégalités de santé	<i>Health inequalities</i>
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Travail et santé	<i>Occupational Health</i>
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Health Insurance**► Financial Incentives and Private Health Insurance Demand on the Extensive and Intensive Margins**KETTLEWELL N. ET ZHANG Y.
2024**Journal of Health Economics 94: 102863.**
<https://doi.org/10.1016/j.jhealeco.2024.102863>

In countries with dual public and private healthcare systems, individuals are often incentivized to purchase private health insurance through subsidies and penalty. We use administrative data from Australia to study how high-income earners respond on both the intensive and extensive margins to the simultaneous withdrawal of a premium subsidy, and the increase of a tax penalty. We estimate regression discontinuity models by exploiting discontinuous changes in the penalty and subsidy rates. Our setting is particularly interesting because means testing creates different incentives at the extensive and intensive margins. Specifically, we could expect to see higher take-up of insurance coupled with downgrading to less expensive plans. We find evidence that the penalty – despite being large in value – only has a modest effect on take-up. Our results show little evidence of downgrading, which is consistent with a low price elasticity for the high-income earners we study.

► The Value of Improving Insurance Quality: Evidence From Long-Run Medicaid AttritionLEE A. ET VABSON B.
2024**Journal of Health Economics 94: 102865.**
<https://doi.org/10.1016/j.jhealeco.2024.102865>

The US government increasingly provides public health insurance coverage through private firms. We examine associated welfare implications for beneficiaries, using a ‘revealed preference’ framework based on beneficiaries’ program attrition rates. Focusing on the Medicaid program in New York State, we exploit quasi-random variation in the initial assignment at birth to public versus private Medicaid based on birth weight. We find that infants assigned to private Medicaid at birth are less likely to subsequently leave Medicaid. We provide suggestive evidence that reduced attrition reflects ben-

eficiary responses to improved program quality, rather than alternative mechanisms such as private Medicaid plans reducing re-enrollment barriers.

► Bridging the Gap: Experimental Evidence on Information Provision and Health Insurance ChoicesQUIROGA GUTIERREZ A. C. ET BOES S.
2024**Health Economics n/a(n/a).**
<https://doi.org/10.1002/he.4820>

Abstract Previous research has shown that individuals do not always make rational decisions when selecting their health insurance, for example, due to the existence of information frictions or mental gaps. We study the effect of specific types of information provision for decision support on health plan choices and test their potential to improve decision quality by implementing a randomized laboratory experiment. We provide personalized and generic aids, differentiate between numerical and visual decision support, and provide one or two optional formats of personalized information. We find that generic aids have no effect on health plan choices while personalized information leads to better choices as measured by several indicators of decision quality. The largest effects were observed for those who “opted in” to visualize personalized information, with immediate and lasting improvements in health insurance decisions. By reducing information frictions, our results suggest that accessible and easy-to-use tools can positively impact health insurance navigation, improve decision-making, and reduce switching costs.

► Monitoring Progress Towards Universal Health Coverage in Europe: A Descriptive Analysis of Financial Protection in 40 CountriesTHOMSON S., CYLUS J., AL TAYARA L., *et al.*
2024**The Lancet Regional Health - Europe 37: 100826.**
<https://doi.org/10.1016/j.lanep.2023.100826>

Summary Background Ensuring that access to health

care is affordable for everyone—financial protection—is central to universal health coverage (UHC). Financial protection is commonly measured using indicators of financial barriers to access (unmet need for health care) and financial hardship caused by out-of-pocket payments for health care (impoverishing and catastrophic health spending). We aim to assess financial hardship and unmet need in Europe and identify the coverage policy choices that undermine financial protection. Methods We carry out a cross-sectional study of financial hardship in 40 countries in Europe in 2019 (the latest available year of data before COVID-19) using microdata from national household budget surveys. We define impoverishing health spending as out-of-pocket payments that push households below or further below a relative poverty line and catastrophic health spending as out-of-pocket payments that exceed 40% of a household's capacity to pay for health care. We link these results to survey data on unmet need for health care, dental care, and prescribed medicines and information on two aspects of coverage policy at country level: the main basis for entitlement to publicly financed health care and user charges for covered services. Findings Out-of-pocket payments for health care lead to financial hardship and unmet need in every country in the study, particularly for people with low incomes. Impoverishing health spending ranges from under 1% of households (in six countries) to 12%, with a median of 3%. Catastrophic health spending ranges from under 1% of households (in two countries) to 20%, with a median of 6%. Catastrophic health spending is consistently concentrated in the poorest fifth of the population and is largely driven by out-of-pocket payments for outpatient medicines, medical products, and dental care—all forms of treatment that should be an essential part of primary care. The median incidence of catastrophic health spending is three times lower in countries that cover over 99% of the population than in countries that cover less than 99%. In 16 out of the 17 countries that cover less than 99% of the population, the basis for entitlement is payment of contributions to a social health insurance (SHI) scheme. Countries that give greater protection from user charges to people with low incomes have lower levels of catastrophic health spending. Interpretation It is challenging to identify with certainty the coverage policy choices that undermine financial protection due to the complexity of the policies involved and the difficulty of disentangling the effects of different choices. The conclusions we draw are therefore tentative, though plausible. Countries are more likely to move towards UHC if they reduce out-of-pocket payments

in a progressive way, decreasing them for people with low incomes first. Coverage policy choices that seem likely to achieve this include de-linking entitlement from payment of SHI contributions; expanding the coverage of outpatient medicines, medical products, and dental care; limiting user charges; and strengthening protection against user charges, particularly for people with low incomes. Funding The European Union (DG SANTE and DG NEAR) and the Government of the Autonomous Community of Catalonia, Spain.

► Effects of Private Health Insurance on Waiting Time in Public Hospitals

YANG O., YONG J. ET ZHANG Y.

2024

[Health Economics n/a\(n/a\).](#)

<https://doi.org/10.1002/hec.4811>

Abstract The Australian government pays \$6.7 billion per year in rebates to encourage Australians to purchase private health insurance (PHI) and an additional \$6.1 billion to cover services provided in private hospitals. What is the justification for large government subsidies to a private industry when all Australians already have free coverage under Medicare? The government argues that more people buying PHI will relieve the burden on the public system and may reduce waiting times. However, the evidence supporting this is sparse. We use an instrumental variable approach to study the causal effects of higher PHI coverage in the area on waiting times in public hospitals in the same area. The instrument used is area-level average house prices, which correlate with average income and wealth, thus influencing the purchase of PHI due to tax incentives, but not directly affecting waiting times in public hospitals. We use 2014–2018 hospital admission and elective surgery waiting list data linked at the patient level from the Victorian Center for Data Linkage. These data cover all inpatient admissions in all hospitals in Victoria (both public and private hospitals) and those registered on the waiting list for elective surgeries in public hospitals in Victoria. We find that one percentage point increase in PHI coverage leads to about 0.34 days (or 0.5%) reduction in waiting times in public hospitals on average. The effects vary by surgical specialities and age groups. However, the practical significance of this effect is limited, if not negligible, despite its statistical significance. The small effect suggests that raising PHI coverage with the aim to taking the pressure off the public system is not an effective strategy in reducing waiting times in public

hospitals. Alternative policies aiming at improving the efficiency of public hospitals and advancing equitable

access to care should be a priority for policymakers.

Démographie

Demography

- **Global Age-Sex-Specific Mortality, Life Expectancy, and Population Estimates in 204 Countries and Territories and 811 Subnational Locations, 1950-2021, and the Impact of the COVID-19 Pandemic: A Comprehensive Demographic Analysis For the Global Burden of Disease Study 2021**

SCHUMACHER A. E., KYU H. H., AALI A., *et al.*
2024

The Lancet.

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Background : Estimates of demographic metrics are crucial to assess levels and trends of population health outcomes. The profound impact of the COVID-19 pandemic on populations worldwide has underscored the need for timely estimates to understand this unprecedented event within the context of long-term population health trends. The Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) 2021 provides new demographic estimates for 204 countries and territories and 811 additional subnational locations from 1950 to 2021, with a particular emphasis on changes in mortality and life expectancy that occurred during the 2020-2021 COVID-19 pandemic period.

E-santé

E-Health

- **Émergence du « e-patient » et du « e-soignant » autour d'un serious game en ETP**

AUBRY J.-D. ET RUSCH E.
2023

Santé Publique 35(6): 27-37.

<https://www.cairn.info/revue-sante-publique-2023-6-page-27.htm>

Introduction : L'avènement de la e-santé vient impacter de nombreux domaines dans la pratique soignante dont l'Éducation Thérapeutique du Patient (ETP). L'incidence de l'introduction de Technologies de l'Information et de la Communication (TIC) en santé de type serious game reste peu étudiée dans le domaine de l'e-ETP. But de l'étude : Questionner des patients ainsi que des professionnels de santé autour de l'usage d'un serious game afin de préciser l'incidence de ces technologies sur les pratiques soignantes, sur

la relation soignant-soigné ainsi que leurs intérêts et leurs limites. Méthode : Étude qualitative selon l'approche par théorisation ancrée au travers d'entretiens semi-directifs menés auprès de 6 professionnels de santé et 6 patients usagers du serious game DRAGO©, application sur smartphone visant à renforcer l'observance du traitement contre les allergies. Réalisation d'une analyse lexicométrique avec classement par thématiques et sous-thématiques puis répartition statistique des verbatims selon qu'ils portent une opinion favorable ou défavorable. Résultats : Les professionnels interrogés sont favorables à 64 % au sujet des innovations numériques en santé et les patients à 67 %. Les professionnels de santé émettent des réserves quant à l'éligibilité de leur patientèle à ces nouvelles technologies. Dans les deux catégories de populations, les questionnements éthiques autour de l'émergence de l'e-santé trouvent un écho positif à raison de 69 % d'avis favorables pour les professionnels de santé et

jusqu'à 83 % pour les patients. Les deux catégories sont plus réservées quant à l'incidence des TIC sur la relation de soin. Conclusion : Professionnels de santé comme patients estiment comme « acceptable » la présence de TIC en ETP, bien qu'ils restent vigilants sur l'incidence qu'ils peuvent avoir sur la relation de soin. Ces évolutions impliquent un nécessaire changement de pratiques des professionnels de santé amenant à penser et favoriser l'éclosion du profil du e-soignant de demain exerçant auprès de e-patient.

► **Jusqu'où la santé numérique va-t-elle transformer l'organisation des soins ?**

MINVIELLE E.

2024

Bulletin de l'Académie Nationale de Médecine
208(3): 312-316.

<https://doi.org/10.1016/j.banm.2023.10.004>

La santé numérique, comprise comme l'ensemble des nouvelles technologies de l'information (dont l'intelligence artificielle) appliquée à la santé, semble imposer

l'idée d'une révolution. Cette revue générale étudie leur valeur ajoutée en prenant le cas emblématique de l'apport de la télésurveillance dans l'organisation de la prise en charge des malades. En s'appuyant notamment sur une recherche menée en oncologie, le programme CAPRI, l'analyse montre que l'efficacité en matière de qualité des soins, d'expérience patient, et de contrôle des coûts dépend de l'usage qui est fait de la technologie. Les usages attendus, la meilleure coordination et la mise en œuvre d'un suivi efficace des patients, dépendent de trois facteurs : l'implantation de la technologie, mais aussi la manière d'organiser l'activité des infirmières de coordination pour traiter l'information, et l'adoption par les patients et les médecins. En particulier, l'adoption par les médecins est améliorée lorsque l'activité des infirmières permet de sélectionner les informations cliniques pertinentes, et d'assurer une délégation de tâches. C'est une évaluation de la transformation organisationnelle au prisme de ses usages que requiert l'innovation numérique. Des stratégies doivent être conçues à ce niveau des usages pour permettre de concrétiser les promesses de la santé numérique.

Économie de la santé

Health Economics

► **Do Expenditures on Public Health Reduce Preventable Mortality in the Long Run? Evidence From the Canadian Provinces**

AMMI M., ARPIN E., DEDEWANOU F. A., *et al.*

2024

Soc Sci Med 345: 116696.

<https://doi.org/10.1016/j.socscimed.2024.116696>

BACKGROUND: Investments in public health - prevention of illnesses, and promotion, surveillance, and protection of population health - may improve population health, however, effects may only be observed over a long period of time. **OBJECTIVE:** To investigate the potential long-run relationship between expenditures on public health and avoidable mortality from preventable causes. **METHODS:** We focused on the country spending the most on public health in the OECD, Canada. We constructed a longitudinal dataset on mortality, health care expenditures and socio-demographic information covering years 1979-2017 for

the ten Canadian provinces. We estimated error correction models for panel data to disentangle short-from long-run relationships between expenditures on public health and avoidable mortality from preventable causes. We further explored some specific causes of mortality to understand potential drivers. For comparison, we also estimated the short-run relationship between curative expenditures and avoidable mortality from treatable causes. **RESULTS:** We find evidence of a long-run relationship between expenditures on public health and preventable mortality, and no consistent short-run associations between these two variables. Findings suggest that a 1% increase in expenditures on public health could lead to 0.22% decrease in preventable mortality. Reductions in preventable mortality are greater for males (-0.29%) compared to females (-0.09%). These results are robust to different specifications. Reductions in some cancer and cardiovascular deaths are among the probable drivers of this overall decrease. By contrast, we do not find evidence

of a consistent short-run relationship between curative expenditures and treatable mortality, except for males. CONCLUSION: This study supports the argument that expenditures on public health reap health benefits primarily in the long run, which, in this case, represents a reduction in avoidable mortality from preventable causes. Reducing public health expenditures on the premise that they have no immediate measurable benefits might thus harm population health outcomes in the long run.

► **Financial Protection in Health Revisited: Is Catastrophic Health Spending Underestimated For Service- or Disease-Specific Analysis?**

ATAGUBA J. E., ICHOKU H. E., INGABIRE M.-G., *et al.*
2024

Health Economics n/a(n/a).

<https://doi.org/10.1016/j.socscimed.2024.116696>

Economists originally developed methods to assess financial catastrophe using total or aggregate out-of-pocket health spending. Aggregate out-of-pocket health spending is financially catastrophic when it exceeds a fixed proportion (i.e., threshold) of a household's total income or expenditure in a given period. However, these methods are now applied to assess financial catastrophe in disease- or service-specific rather than aggregate out-of-pocket health spending without using disease- or service-specific thresholds. This paper argues that not using disease- or service-specific thresholds for such assessments is misleading and underestimates the burden of financial catastrophe, especially among households from poorer backgrounds. It then proposed disease- or service-specific catastrophic payment thresholds, applied them to Nigeria and found that financial catastrophe was underestimated for the five service groups considered. The paper stresses the importance of using disease- or service-specific thresholds and avoiding unadjusted thresholds, which may leave poorer households behind as financially protected.

► **A New Look at Physicians' Responses to Financial Incentives: Quality of Care, Practice Characteristics, and Motivations**

BROSIG-KOCH J., HENNIG-SCHMIDT H., KAIRIES-SCHWARZ N., *et al.*

2024

Journal of Health Economics 94: 102862.

<https://doi.org/10.1016/j.jhealeco.2024.102862>

There is considerable controversy about what causes (in)effectiveness of physician performance pay in improving the quality of care. Using a behavioral experiment with German primary-care physicians, we study the incentive effect of performance pay on service provision and quality of care. To explore whether variations in quality are based on the incentive scheme and the interplay with physicians' real-world profit orientation and patient-regarding motivations, we link administrative data on practice characteristics and survey data on physicians' attitudes with experimental data. We find that, under performance pay, quality increases by about 7pp compared to baseline capitation. While the effect increases with the severity of illness, the bonus level does not significantly affect the quality of care. Data linkage indicates that primary-care physicians in high-profit practices provide a lower quality of care. Physicians' other-regarding motivations and attitudes are significant drivers of high treatment quality.

► **The Impact of Health on Economic Growth: A Narrative Literature Review**

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

2024

Health Policy 143: 105039.

<https://doi.org/10.1016/j.healthpol.2024.105039>

The nexus between health and economic growth is a dynamic and complex relationship. This article reviews the empirical evidence that has sought to assess the causal impact of health on growth, understood as growth in GDP per capita, and focusing on cross-country and selected single country studies. The review largely provides evidence in favour of a positive effect of population health on economic growth. However, the multitude of the factors at play and the possible bidirectional relationship between health and growth pose a challenge for the quantification of the effect and for the relative importance of the underlying mechanisms. There is notable heterogeneity between studies in the magnitude and, in some cases, even in

the sign of the effect. The evidence suggests that the health-growth relationship may depend on three main factors: the sample composition (i.e. a country's demographic stage or GDP per capita); the health dimension considered (e.g. health improvements at different life stages may affect productivity differently); and the model specification (e.g. whether or not initial life expectancy is controlled for in the analysis or the quality of the instrument). These findings advocate for a policy approach that integrates health considerations into economic strategies and emphasizes intersectoral collaboration to maximize the economic returns from improved health outcomes.

► **The Effect of Health-Care Privatisation on the Quality of Care**

GOODAIR B. ET REEVES A.
2024

The Lancet Public Health 9(3): e199-e206.
[https://doi.org/10.1016/S2468-2667\(24\)00003-3](https://doi.org/10.1016/S2468-2667(24)00003-3)

Over the past 40 years, many health-care systems that were once publicly owned or financed have moved towards privatising their services, primarily through outsourcing to the private sector. But what has the impact been of privatisation on the quality of care? A key aim of this transition is to improve quality of care through increased market competition along with the benefits of a more flexible and patient-centred private sector. However, concerns have been raised that these reforms could result in worse care, in part because it is easier to reduce costs than increase quality of health care. Many of these reforms took place decades ago and there have been numerous studies that have examined their effects on the quality of care received by patients. We reviewed this literature, focusing on the effects of outsourcing health-care services in high-income countries. We found that hospitals converting from public to private ownership status tended to make higher profits than public hospitals that do not convert, primarily through the selective intake of patients and reductions to staff numbers. We also found that aggregate increases in privatisation frequently corresponded with worse health outcomes for patients. Very few studies evaluated this important reform and there are many gaps in the literature. However, based on the evidence available, our Review provides evidence that challenges the justifications for health-care privatisation and concludes that the scientific support for further privatisation of health-care services is weak.

► **Effects of Nurse Visit Copayment on Primary Care Use: Do Low-Income Households Pay the Price?**

HAAGA T., BÖCKERMAN P., KORTELAINE M., *et al.*
2024

Journal of Health Economics 94: 102866.
<https://doi.org/10.1016/j.jhealeco.2024.102866>

Nurses are increasingly providing primary care, yet the literature on cost-sharing has paid little attention to nurse visits. We employ a staggered difference-in-differences design to examine the effects of adopting a 10-euro copayment for nurse visits on the use of public primary care among Finnish adults. We find that the copayment reduced nurse visits by 9%–10% during a one-year follow-up. There is heterogeneity by income in absolute terms, but not in relative terms. The spillover effects on general practitioner (GP) use are negative but small, with varying statistical significance. We also analyze the subsequent nationwide abolition of the copayment. However, we refrain from drawing causal conclusions from this due to the lack of credibility in the parallel trends assumption. Overall, our analysis suggests that moderate copayments can create a greater barrier to access for low-income individuals. We also provide an example of using a pre-analysis plan for retrospective observational data.

► **Administrator Perspectives on the Impact of COVID-19 on the Administration of the Patient Driven Payment Model in U.S. Skilled Nursing Facilities**

MEEHAN A., BRAZIER J. F., GRABOWSKI D. C., *et al.*
2024

Medical Care Research and Review 0(0): 10775587241233018.
<https://doi.org/10.1177/10775587241233018>

The Patient Driven Payment Model (PDPM) was implemented in U.S. skilled nursing facilities (SNFs) in October 2019, shortly before COVID-19. This new payment model aimed to reimburse SNFs for patients' nursing needs rather than the previous model which reimbursed based on the volume of therapy received. Through 156 semi-structured interviews with 40 SNF administrators from July 2020 to December 2021, this qualitative study clarifies the impact of COVID-19 on the administration of PDPM at SNFs. Interview data were analyzed using modified grounded theory and thematic analysis. Our findings show that SNF administrators shifted focus from management of the

PDPM to COVID-19-related delivery of care adaptations, staff shortfalls, and decreased admissions. As the pandemic abated, administrators re-focused their attention to PDPM. Policy makers should consider the continued impacts of the pandemic at SNFs, particularly on delivery of care, admissions, and staffing, on the ability of SNF administrators to administer a new payment model.

► **Risk Preferences over Health: Empirical Estimates and Implications For Medical Decision-Making**

MULLIGAN K., BAID D., DOCTOR J. N., *et al.*
2024

Journal of Health Economics 94: 102857.
<https://doi.org/10.1016/j.jhealeco.2024.102857>

Mainstream health economic theory implies that an expected gain in health-related quality of life (HRQoL) produces the same value for consumers, regardless of baseline health. Several strands of recent research call this implication into question. Generalized Risk-Adjusted Cost-Effectiveness (GRACE) demonstrates theoretically that baseline health status influences value, so long as consumers are not risk-neutral over health. Prior empirical literature casts doubt on risk-neutral expected utility-maximization in the health domain. We estimate utility over HRQoL in a nationally representative U.S. population and use our estimates to measure risk preferences over health. We find that individuals are risk-seeking at low levels of health, become risk-averse at health equal to 0.485 (measured on a 0–1 scale), and are most risk-averse at perfect health (coefficient of relative risk aversion=4.51). We develop the resulting implications for medical decision making, cost-effectiveness analyses, and the proper theory of health-related decision making under uncertainty.

► **Disentangling the Impact of Alternative Payment Models and Associated Service Delivery Models on Quality of Chronic Care: A Scoping Review**

SIMMONS C., POT M., LORENZ-DANT K., *et al.*
2024

Health Policy 143 : 105034
<https://doi.org/10.1016/j.healthpol.2024.105034>

Payment reforms are frequently implemented alongside service delivery reforms, thus rendering it difficult to disentangle their impact. This scoping review aims to link alternative payment arrangements within their context of service delivery, to assess their impact on quality of chronic care, and to disentangle, where possible, the impact of payment reforms from changes to service delivery. A search of literature published between 2013 and 2022 resulted in 34 relevant articles across five types of payment models: capitation/global budget (n=13), pay-for-coordination (n=10), shared savings/shared risk (n=6), blended capitation (n=3), and bundled payments (n=1). The certainty of evidence was generally low due to biases associated with voluntary participation in reforms. This scoping review finds that population-based payment reforms are better suited for collaborative, person-centred approaches of service delivery spanning settings and providers, but also highlights the need for a wider evidence base of studies disentangling the impact of financing from service delivery reforms. Limited evidence disentangling the two suggests that transforming service delivery to a team-based model of care alongside a purchasing reform shifting to blended capitation was more impactful in improving quality of chronic care, than the individual components of payment and service delivery. Further comparative studies employing causal inference methods, accounting for biases and quantifying aspects of service delivery, are needed to better disentangle the mechanisms impacting quality of care.

► **The Limitations and Potentials of Evaluating Economic Aspects of Community-Based Health Promotion: A Critical Review**

WEBER P., BIRKHOLZ L., STRAUB R., *et al.*

2024

Applied Health Economics and Health Policy 22(2): 165-179.

<https://doi.org/10.1007/s40258-023-00864-y>

Community-based health promotion (CBHP) interventions are promising approaches to address public health problems; however, their economic evaluation presents unique challenges. This review aims to explore the opportunities and limitations of evaluating economic aspects of CBHP, focusing on the assessment of intervention costs and outcomes, and the consideration of political-level changes and health equity. A systematic search of the PubMed, Web of Science and PsycInfo databases identified 24 CBHP interventions, the majority of which targeted disadvantaged communities. Only five interventions included a detailed cost/resource assessment. Outcomes at the operational level were mainly quantitative, related to sociodemographics and environment or health status, while outcomes at the political level were often qualitative, related to public policy, capacity building or networks/collaboration. The study highlights the limitations of traditional health economic evaluation methods in capturing the complexity of CBHP interventions. It proposes the use of cost-consequence analysis (CCA) as a more comprehensive approach, offering a flexible and multifaceted assessment of costs and outcomes. However, challenges remain in the measurement and valuation of outcomes, equity considerations, intersectoral costs and attribution of effects. While CCA is a promising starting point, further research and methodological advancements are needed to refine its application and improve decision making in CBHP.

► **Financial Incentives For Integrated Care: A Scoping Review and Lessons For Evidence-Based Design**

YORDANOV D., OXHOLM A. S., PRÆTORIUS T., *et al.*

2024

Health Policy 141: 104995.

<https://doi.org/10.1016/j.healthpol.2024.104995>

Background In response to the increasing prevalence of people with chronic conditions, healthcare systems restructure to integrate care across providers. However, many systems fail to achieve the desired outcomes. One likely explanation is lack of financial incentives for integrating care. **Objectives** We aim to identify financial incentives used to promote integrated care across different types of providers for patients with common chronic conditions and assess the evidence on (cost-)effectiveness and the facilitators/barriers to their implementation. **Methods** This scoping review identifies studies published before December 2021, and includes 33 studies from the United States and the Netherlands. **Results** We identify four types of financial incentives: shared savings, bundled payments, pay for performance, and pay for coordination. Substantial heterogeneity in the (cost-)effectiveness of these incentives exists. Key implementation barriers are a lack of infrastructure (e.g., electronic medical records, communication channels, and clinical guidelines). To facilitate integration, financial incentives should be easy to communicate and implement, and require additional financial support, IT support, training, and guidelines. **Conclusions** All four types of financial incentives may promote integrated care but not in all contexts. Shared savings appears to be the most promising incentive type for promoting (cost-)effective care integration with the largest number of favourable studies allowing causal interpretations. The limited evidence pool makes it hard to draw firm conclusions that are transferable across contexts.

Environmental Health

► **Environmental and Social Inequities in Continental France: An Analysis of Exposure to Heat, Air Pollution, and Lack of Vegetation**

ADELAIDE L., HOUGH I., SEYVE E., *et al.*
2024

J Expo Sci Environ Epidemiol.

<https://doi.org/10.1038/s41370-024-00641-6>

BACKGROUND: Cumulative environmental exposures and social deprivation increase health vulnerability and limit the capacity of populations to adapt to climate change. **OBJECTIVE:** Our study aimed at providing a fine-scale characterization of exposure to heat, air pollution, and lack of vegetation in continental France between 2000 and 2018, describing spatiotemporal trends and environmental hotspots (i.e., areas that cumulate the highest levels of overexposure), and exploring any associations with social deprivation. **METHODS:** The European (EDI) and French (FDep) social deprivation indices, the normalized difference vegetation index, daily ambient temperatures, particulate matter (PM(2.5) and PM(10)), nitrogen dioxide, and ozone (O(3)) concentrations were estimated for 48,185 French census districts. Reference values were chosen to characterize (over-)exposure. Hotspots were defined as the areas cumulating the highest overexposure to temperature, air pollution, and lack of vegetation. Associations between heat overexposure or hotspots and social deprivation were assessed using logistic regressions. **RESULTS:** Overexposure to heat was higher in 2015-2018 compared with 2000-2014. Exposure to all air pollutants except for O(3) decreased during the study period. In 2018, more than 79% of the urban census districts exceeded the 2021 WHO air quality guidelines. The evolution of vegetation density between 2000 and 2018 was heterogeneous across continental France. In urban areas, the most deprived census districts were at a higher risk of being hotspots (odds ratio (OR): 10.86, 95% CI: 9.87-11.98 using EDI and OR: 1.07, 95% CI: 1.04-1.11 using FDep). **IMPACT STATEMENT:** We studied cumulative environmental exposures and social deprivation in French census districts. The 2015-2018 period showed the highest overexposure to heat between 2000 and 2018. In 2018, the air quality did not meet the 2021 WHO guidelines in most census districts and 8.6 million people lived

in environmental hotspots. Highly socially deprived urban areas had a higher risk of being in a hotspot. This study proposes for the first time, a methodology to identify hotspots of exposure to heat, air pollution, and lack of vegetation and their associations with social deprivation at a national level.

► **Contribution of Cold Versus Climate Change to Mortality in London, UK, 1976–2019**

HAJAT S., GAMPE D. ET PETROU G.
2024

American Journal of Public Health 114 (4): 398-402

<https://doi.org/10.2105/AJPH.2023.307552>

Objectives. To quantify past reductions in cold-related mortality attributable to anthropogenic climate change. **Methods.** We performed a daily time-series regression analysis employing distributed lag nonlinear models of 1 203 981 deaths in Greater London, United Kingdom, in winter months (November–March) during 1976 to 2019. We made attribution assessment by comparing differential cold-related mortality impacts associated with observed temperatures to those using counterfactual temperatures representing no climate change. **Results.** Over the past decade, the average number of cold days (below 8 °C) per year was 120 in the observed series and 158 in the counterfactual series. Since 1976, we estimate 447 (95% confidence interval = 330, 559) annual cold-related all-cause deaths have been avoided because of milder temperatures associated with climate change. Annually, 241 cardiovascular and 73 respiratory disease deaths have been avoided. **Conclusions.** Anthropogenic climate change made some contribution to reducing previous cold-related deaths in London; however, cold remains an important public health risk factor. **Public Health Implications.** Better adaptation to both heat and cold should be promoted in public health measures to protect against climate change. In England, this has been addressed by the development of a new year-round Adverse Weather and Health Plan.

► **Analyse et évolution des dispositifs participatifs à Santé publique France autour des investigations locales en santé environnement**

PERREY C. ET EMPEREUR-BISSONNET P.

2023

Santé Publique 35(HS2): 67-71.

<https://www.cairn.info/revue-sante-publique-2023-HS2-page-67.htm>

Santé publique France développe des approches participatives, dans le champ des investigations locales en santé environnementale depuis une vingtaine d'années. Un premier bilan de cette activité a été réalisé en 2016. Il s'agissait de comparer quatre types de dispositif participatif mis en place sur différents sites pollués dans le but de réfléchir aux apports et limites de telles approches. L'implication des parties prenantes locales a permis l'expression de préoccupations de santé, d'attentes sur les études à mener, de points de désaccords ou d'incompréhension et de questionnements sur les résultats obtenus. Elles ont conduit dans certains cas à améliorer la qualité des résultats scientifiques produits, par l'intégration des savoirs locaux et la prise en compte des besoins exprimés, et parfois à accroître l'acceptabilité des options de gestion de la pollution de l'environnement. L'issue du processus relève d'une combinaison de multiples facteurs où la subjectivité des acteurs et le type de sollicitation jouent un rôle majeur. L'agence a depuis développé de nouveaux modes de participation axés sur des processus de co construction engagés en amont des investigations. Des

ateliers citoyens ont été installés pour concevoir et valoriser, avec des parties prenantes engagées et non engagées, l'étude de santé perçue qui va être réalisée autour du bassin industriel de Lacq. Santé publique France développe par ailleurs diverses méthodes visant notamment à évaluer les processus participatifs qu'elle met en œuvre.

► **Living with Particles: Disclosure of Pollution Information, Individual Responses, and Health Consequences**

SHI X., SHEN Y. ET SONG R.

2023

Journal of Health Economics 92: 102824.

<https://doi.org/10.1016/j.jhealeco.2023.102824>

Drawing on a panel dataset—the China Health and Retirement Longitudinal Survey (CHARLS)—and other city- and individual-level datasets, this study examines the causal impact of pollution information disclosure on individual outdoor activities and the health status of the middle-aged and elderly. Using city-level variations in disclosure timing, we found that the adoption of pollution information disclosure (PID) significantly reduces the probability of outdoor exercise, especially for those living in more polluted cities. This occurs mainly through enhanced awareness of environmental pollution, particularly for those who are more educated. However, the adoption of PID does not lead to an improvement in health status.

État de santé

Health Status

► **Estimating the Effects of Tobacco-21 on Youth Tobacco Use and Sales**

ABOUK R., DE P. K. ET PESKO M. F.

2024

Journal of Health Economics 94: 102860.

<https://doi.org/10.1016/j.jhealeco.2024.102860>

We examine the effect of raising the minimum legal sale age of tobacco to 21 (i.e., "T21"). We estimate difference-in-differences models using the Monitoring the Future (MTF) survey data and Nielsen Retail Scanner

data from 2012 to 2019. Outcomes include cigarette and e-cigarette use and sales. We find sizable reductions in e-cigarette and cigarette use for 12th graders. T21 also reduced cigarette sales by 12.4% and e-cigarette sales by 69.3% in counties with the highest percent quartile of individuals under 21 years of age. In terms of mechanisms, we find that T21 increases ID checking and perceived risks of using both products.

► **Why Do Drinkers Earn More? Job Characteristics As a Possible Link**

BAI Y. ET GRIGNON M.
2024

Health Econ [Ahead of print]
<https://doi.org/10.1002/hec.4808>

After some initial controversy, an inverted U-shape relationship between the consumption of alcohol and earnings seems to be an established result, at least in North America. It has been dubbed a “drinking premium”, at least in the lower portion of the consumption curve. It is still unclear, perhaps even counter-intuitive, why such a drinking premium exists and the literature suggests it is not causal but results rather from selection effects. We suggest here that part of the premium is linked to occupation: some occupations pay better, controlling for the usual human capital determinants, and also attract drinkers or induce workers to drink more. Using a sample of full-time employed or self-employed individuals aged 25-64 and not in poor health from the 2015-16 Canadian Community Health Survey (CCHS), we confirm the existence of a drinking premium and a positive return to the quantity or frequency of drinking up to high levels of consumption. Using information on jobs held by respondents, linked to a data set of job characteristics, we find that controlling for job characteristics reduces the premium or return to drinking by approximately 30% overall, and up to 50% for female workers.

► **Social Identity and Health-Related Behavior: A Systematic Review and Meta-Analysis**

DE HOOG N. ET PAT-EL R.
2024

Social Science & Medicine 344: 116629.
<https://doi.org/10.1016/j.socscimed.2024.116629>

This paper examined the relationship between social identity and health-related behavior, exploring whether social identities are associated with multiple health-related behaviors or only specific ones, and whether this association varies on the type of social identity, the type of social identity measures or the expected relationship between identity and behavior. In a systematic review and meta-analysis we assessed whether the pattern of findings can be explained by the social identity approach. An extensive literature search was conducted in several databases including EBSCO-host and PubMed, using elaborate search terms

related to social identity and health-related behavior. This resulted in 10728 potential articles, with 115 articles (with 248 effect sizes from 133 independent samples, N = 112.112) included in the meta-analysis. We found a small but positive overall association between social identification and health-related behavior, which was present for actual behavior, as well as for intention and attitudes. This association was stronger for health-related social identities, positive health-related behaviors, when the expected relationship was positive and when indirect social identity measures were used. However, not all findings could be explained by the social identity approach, indicating a need for further research to better understand the relationship between social identity and health-related behavior, in order to more effectively incorporate social identity into health interventions.

► **Do Informal Care Recipients Internalise Carer Burden? Examining the Impact of Informal Care Receipt on Health Behaviours**

ELLIOTT J., FRANCTIC I., MEACOCK R., *et al.*
2024

Applied Health Economics and Health Policy 22(2): 209-225.
<https://doi.org/10.1007/s40258-023-00843-3>

Providing informal care has a negative effect on the caregiver’s health and well-being, but little is known about how individuals respond to receiving informal care. Care recipients may improve their health behaviours to minimise the onerousness of caregiving and the stress faced by their carer from seeing a loved one in ill-health.

► **Co-construction d’une étude sur la santé des Gens du voyage : retours d’expériences**

MONDEILH A., SPANJERS L., BRABANT G., *et al.*
2023

Santé Publique 35(HS2): 61-66.
<https://www.cairn.info/revue-sante-publique-2023-HS2-page-61.htm>

Introduction : L’état de santé des Gens du voyage est moins favorable qu’en population générale du fait de conditions de vie plus précaires. Il n’existe pas en France d’études épidémiologiques les concernant, accentuant leur invisibilité dans les programmes de santé publique. La discrimination à leur égard,

leur méfiance envers l'État et les institutions et leur non-priorisation de la santé ont justifié la conduite d'une recherche participative sur leur santé, menée conjointement en Nouvelle-Aquitaine par des chercheurs, des décideurs, des acteurs associatifs et avec des Gens du voyage volontaires. But de l'étude : L'objectif de cet article est de partager les difficultés, les apports et les enjeux de la co-construction de cette recherche. Résultats : La démarche a permis l'expression et la prise en compte des attentes spécifiques et parfois divergentes des parties prenantes. Elle a nécessité un temps d'acculturation réciproque, ayant abouti à une participation élevée à l'étude (74 %), à l'acquisition de nouvelles connaissances et compétences et à l'identification de controverses. Cette approche participative a permis une meilleure appropriation de l'étude et une plus forte conscientisation des questions de santé par les personnes interrogées, notamment grâce à la co-construction du questionnaire et des outils de communication. Conclusion : Cette démarche souligne la nécessité d'intégrer pleinement et dès le départ les parties prenantes à la gouvernance du projet de recherche. Cette démarche était d'autant plus cruciale qu'elle a concerné des personnes socialement exclues, et vise à ne pas les exclure davantage dans la production de connaissances les concernant.

► **The Contributions of Avoidable Causes of Death to Gender Gap in Life Expectancy and Life Disparity in the US and Canada: 2001–2019**

PANDEY S., HAJIZADEH M. ET KIADALIRI A.
2024

Social Science & Medicine 345 : 116751.
<https://doi.org/10.1016/j.socscimed.2024.116751>

► **Housing Cost Burden and External Causes of Mortality: Variations Across Housing Regimes in High-Income Countries, 2010–2020**

PARK G.-R.
2024

Social Science & Medicine 345: 116672.
<https://doi.org/10.1016/j.socscimed.2024.116672>

Objectives While comparative studies reported that generous welfare state improves population health, they did not take into account the roles of housing as a cornerstone of welfare state. To reduce knowledge gaps, this study aims to estimate (a) the link between

housing affordability stress and mortality rate due to external causes and (b) the moderating effects of housing regime on such association. Methods Using country level panel data from the databases of the Organisation for Economic Co-operation and Development (OECD), fixed effects were performed to estimate the effects of housing costs to income ratio on mortality rates due to external causes (accidents, intentional self-harm, and assault). Also, we tested whether housing regimes moderate the association between housing cost burden and mortality rate. Results An increased level of housing cost burden predicted mortality rates due to accidents and intentional self-harm. Such association was pronounced for countries with higher rates of homeownership and limited access to market self-help. In addition, when homeownership rates and debt-to-income ratios are taken into account as time-varying variables, the elevated mortality risks associated with both increased housing cost burden and higher homeownership are mitigated in countries where debt relative to income increases. Conclusion Our findings suggest that different housing systems shape divergent patterns of mortality risks associated with housing affordability stress. Future studies may wish to incorporate housing in macro comparative studies on population health.

► **Worldwide Trends in Underweight and Obesity From 1990 to 2022: A Pooled Analysis of 3663 Population-Representative Studies with 222 Million Children, Adolescents, and Adults**

PHELPS N. H., SINGLETON R. K., ZHOU B., *et al.*
2024

The Lancet. 403 (10431): 1027-1050
[https://doi.org/10.1016/S0140-6736\(23\)02750-2](https://doi.org/10.1016/S0140-6736(23)02750-2)

Background Underweight and obesity are associated with adverse health outcomes throughout the life course. We estimated the individual and combined prevalence of underweight or thinness and obesity, and their changes, from 1990 to 2022 for adults and school-aged children and adolescents in 200 countries and territories.

► **La santé du sommeil : une approche multi-dimensionnelle au service de la prévention et de la santé globale des populations**

PHILIP P., MICOULAUD-FRANCHI J.-A., TAILLARD J.,
et al.

2024

Bulletin de l'Académie Nationale de Médecine.

<https://doi.org/10.1016/j.banm.2023.12.013>

Résumé Le sommeil est une fonction essentielle à la santé physique et mentale. Il n'est pas seulement un processus physiologique puisqu'il implique une interaction dynamique entre l'homéostasie de l'organisme, horloges circadiennes et les comportements de l'individu. Ainsi, il peut être perturbé par l'altération de ces processus physiologiques (troubles du sommeil) mais également par des comportements inadéquats (mauvaise hygiène de sommeil). Ces comportements sont soumis à des facteurs individuels (psychologie), sociaux (parentalité), sociétaux (profession), et environnementaux (lumière), et se manifestent principalement par une durée trop longue ou trop courte, une irrégularité, ou une temporalité inappropriée. Cette mauvaise hygiène a des conséquences non seulement sur la qualité du sommeil (insomnie) et de l'éveil (sommolence) mais également sur le fonctionnement (conduite automobile, performance au travail) et la santé physique (cardiovasculaire, métabolique) et mentale (anxiété, dépression). Ceci est d'autant plus alarmant compte tenu de la croissance épidémique de ces mauvais comportements dans nos sociétés : la durée de sommeil semble se raccourcir sur les 30 dernières années, surtout la semaine, tandis que l'inadéquation entre les rythmes circadiens endogènes et le rythme de travail des individus (jetlag social) est de plus en plus fréquente. Il s'agit désormais de répondre à cet enjeu de santé publique en proposant des stratégies pour favoriser la bonne hygiène de sommeil en population générale. Cette situation soulève de nombreux défis. L'hygiène de sommeil est en compétition avec de nombreux comportements modernes (écran, travail, vie nocturne) et les interventions de prévention individuelle visant à la modifier montrent des résultats parfois hétérogènes. La part importante de facteurs sociaux, sociétaux, et environnementaux impliquent d'y associer des mesures de prévention collective comme le recul de l'heure de début des cours en milieu scolaire et universitaire ou la suppression du changement d'heure. L'implémentation de stratégies de prévention accessible, personnalisée, et intégrée, autour de la quantité, la régularité, et la temporalité du sommeil constitue un enjeu majeur dans les années

à venir pour améliorer la santé du sommeil et la santé globale en population générale.

► **Le point de vue des enfants en foyer et famille d'accueil sur leur santé : étude comparative**

TOUSSAINT E., FLORIN A. ET GALHARRET J.-M.

2023

Santé Publique 35(6): 17-25.

<https://www.cairn.info/revue-sante-publique-2023-6-page-17.htm>

Bien qu'elle constitue un enjeu majeur, la santé des enfants et adolescents pris en charge au titre de la protection de l'enfance reste majoritairement explorée à partir d'éléments renseignés par les adultes dans le cadre des études françaises. Cette étude vise ainsi à pallier le manque d'études intégrant le propre point de vue des jeunes et à explorer certains aspects liés à la santé, tels que les enfants et adolescents peuvent eux-mêmes en rendre compte, en comparant la santé d'enfants accueillis en foyer ou famille d'accueil à celle d'enfants de la population générale. L'échantillon est constitué de 477 enfants placés (versus 23 672 qui ne le sont pas). Les données ont été recueillies dans le cadre d'une enquête transversale réalisée par l'UNICEF France entre octobre 2020 et mars 2022 auprès de 25 300 enfants et adolescents de 6 à 18 ans ayant répondu à un questionnaire papier ou en ligne auto-administré. Les principaux résultats de cette étude confirment les constats existants concernant les besoins de soins de santé beaucoup plus importants des enfants et des adolescents placés hors de leur domicile (famille d'accueil, foyer) comparativement à leurs pairs. Ils soulignent notamment une plus grande souffrance psychologique liée à leurs histoires de vie, les pratiques constituant un risque pour la santé, les violences sexuelles et le risque suicidaire. La discussion aborde la complexité des enjeux associés à leur santé et souligne l'intérêt de prendre en compte le point de vue de l'enfant lui-même.

Geography of Health

► **A French Classification to Describe Medical Deserts: A Multi-Professional Approach Based on the First Contact with the Healthcare System**

BONAL M., PADILLA C., CHEVILLARD G., *et al.*
2024

International Journal of Health Geographics 23(1): 5.
<https://doi.org/10.1186/s12942-024-00366-7>

Increasing inequalities in accessibility to primary care has generated medical deserts. Identifying them is key to target the geographic areas where action is needed. An extensive definition of primary care has been promoted by the World Health Organization: a first level of contact with the health system, which involves the co-presence of different categories of health professionals alongside the general practitioner for the diagnosis and treatment of patients. Previous analyses have focused mainly on a single type of provider while this study proposes an integrated approach including various ones to define medical deserts in primary care.

► **Exploring Recent Trends (2014–21) in Preferencing and Accepting Queensland Medical Internships in Rural Hospitals**

MCGRAIL M., WOOLLEY T., PINIDIYAPATHIRAGE J.,
et al.
2024

BMC Health Services Research 24(1): 236.
<https://doi.org/10.1186/s12913-024-10683-z>

Medical internship is a key transition point in medical training from student to independent (junior) doctor. The national Regional Training Hubs (RTH) policy began across Australia in late 2017, which aims to build medical training pathways for junior doctors within a rural region and guide students, interns and trainees towards these. This study aims to explore preferencing and acceptance trends for rural medical internship positions in Queensland. Moreover, it focuses on internship preference and acceptance outcomes prior to and following the establishment of RTHs, and their association with key covariates such as rural training immersions offered by medical schools.

Handicap

Disability

► **Medical Care Use and Mortality Rate After the Onset of Disability: A 6-Year Follow-Up Study Based on National Data in Taiwan**

CHEN S.-H. ET PU C.
2024

Disability and Health Journal: 101596.
<https://doi.org/10.1016/j.dhjo.2024.101596>

Background The onset of disability is a major health challenge, and people with disability can be particularly underserved in the years immediately after the disability onset. **Objective** To analyze the excess mortality rate of people with recent-onset disability and their health-care utilization during the period after disability onset (1–6 years after onset). **Methods** We used

whole-population claims data from 2015 to 2020 (for approximately 23 million individuals) from Taiwan's National Health Insurance (NHI) system. These NHI claims data were linked to the National Death Records and National Disability Registry. Each individual with a disability was followed until their death or December 31, 2020. The age-standardized mortality rate and outpatient and inpatient utilization were compared between individuals with and without disability. Finally, Cox regressions were estimated to determine excess mortality for the individuals with disability. **Results** The age-standardized mortality rates for the people with disability and those without disability were 1020.35/10,000 and 463.83/10,000, respectively. The people with disability utilized significantly more medical care under the NHI system. Mortality rates differed

substantially among disability types. The Cox regression revealed a hazard ratio of 1.47 (95% CI = 1.46, 1.48) for all-cause mortality for people with disability, and significant sex differences in mortality risk were observed for some causes of death. Conclusion According to the excess mortality rates within 6 years

of disability onset observed in this study, the NHI may not be sufficient to reduce health disparity between people with and without disabilities. In addition, specific characteristics of each type of disability should be considered.

Hospital

► Do Responses to News Matter? Evidence From Interventional Cardiology

AVDIC D., VON HINKE S., LAGERQVIST B., *et al.*
2024

Journal of Health Economics 94: 102846.
<https://doi.org/10.1016/j.jhealeco.2023.102846>

We examine physician responses to a global information shock and how these impact their patients. We exploit international news over the safety of an innovation in healthcare, the drug-eluting stent. We use data on interventional cardiologists' use of stents to define and measure cardiologists' responsiveness to the initial positive news and link this to their patients' outcomes. We find substantial heterogeneity in responsiveness to news. Patients treated by cardiologists who respond slowly to the initial positive news have fewer adverse outcomes. This is not due to patient-physician sorting. Instead, our results suggest that the differences are partially driven by slow responders being better at deciding when (not) to use the new technology, which in turn affects their patient outcomes.

► Nurses' Intention to Leave, Nurse Workload and In-Hospital Patient Mortality in Italy: A Descriptive and Regression Study

CATANIA G., ZANINI M., CREMONA M. A., *et al.*
2024

Health Policy 143: 105032.
<https://doi.org/10.1016/j.healthpol.2024.105032>

Higher nurse-to-patient ratios are associated with poor patient care and adverse nurse outcomes, including emotional exhaustion and intention to leave. We examined the effect of nurses' intention to leave and

nurse-patient workload on in-hospital patient mortality in Italy. A multicentered descriptive and regression study using clinical data of patients aged 50 years or older with a hospital stay of at least two days admitted to surgical wards linked with nurse variables including workload and education levels, work environment, job satisfaction, intention to leave, nurses' perception of quality and safety of care, and emotional exhaustion. The final dataset included 15 hospitals, 1046 nurses, and 37494 patients. A 10% increase in intention to leave and an increase of one unit in nurse-patient workload increased likelihood of inpatient hospital mortality by 14% (odds ratio 1.14; 1.02-1.27 95% CI) and 3.4% (odds ratio 1.03; 1.00-1.06 95% CI), respectively. No other studies have reported a significant association between intention to leave and patient mortality. To improve patient outcomes, the healthcare system in Italy needs to implement policies on safe human resources policy stewardship, leadership, and governance to ensure nurse wellbeing, higher levels of safety, and quality nursing care.

► The End of an Era? Activity-Based Funding Based on Diagnosis-Related Groups: A Review of Payment Reforms in the Inpatient Sector in 10 High-Income Countries

MILSTEIN R. ET SCHREYÖGG J.
2024

Health Policy 141: 104990.
<https://doi.org/10.1016/j.healthpol.2023.104990>

Context Across the member countries of the Organisation for Economic Co-Operation and Development, policy makers are searching for new ways to pay hospitals for inpatient care to move from

volume to value. This paper offers an overview of the latest reforms and their evidence to date. Methods We reviewed reforms to DRG payment systems in 10 high-income countries: Australia, Austria, Canada (Ontario), Denmark, France, Germany, Norway, Poland, the United Kingdom (England), and the United States. Findings We identified four reform trends among the observed countries, them being (1) reductions in the overall share of inpatient payments based on DRGs, (2) add-on payments for rural hospitals or their exclusion from the DRG system, (3) episode-based payments, which use one joint price to pay providers for all services delivered along a patient pathway, and (4) financial incentives to shift the delivery of care to less costly settings. Some countries have combined some or all of these measures with financial adjustments for quality of care. These reforms demonstrate a shift away from activity and efficiency towards a diversified set of targets, and mirror efforts to slow the rise in health expenditures while improving quality of care. Where evaluations are available, the evidence indicates mixed success in improving quality of care and reducing costs and expenditures.

► **Introducing a Measure of Hospital Community Orientation**

STABLER H. S., BEEBE T. ET WHITE K.

2024

Medical Care Research and Review 81(2): 96-106.

<https://doi.org/10.1177/10775587231225795>

Policymakers have long sought to encourage hospitals to assume a more collaborative role in improving community health. By urging hospitals to interact with community stakeholders, more integrative relationships may result that can better address local health issues. This study establishes a composite measure of hospital community orientation, defined as the extent to which a hospital uses community resources and knowledge in its community benefit (CB) work, based on an expansion of CB regulations that require non-profit hospitals (NPHs) to develop strategies to address prioritized health issues. We collected data on each proposed intervention from 125 randomly selected NPHs over three reporting periods. Confirmatory factor analysis was used to assess how well a single-factor model approximated community orientation. We conclude that using hospital community orientation measurement is a useful metric to assess the effects of expanded CB regulations, as well as to determine how NPHs have interacted with communities over time.

► **Exploring the Influence of a Financial Incentive Scheme on Early Mobilization and Rehabilitation in ICU Patients: An Interrupted Time-Series Analysis**

UNOKI Y., ONO S., SASABUCHI Y., *et al.*

2024

BMC Health Services Research 24(1): 242.

<https://doi.org/10.1186/s12913-024-10763-0>

Clinical guidelines recommend early mobilization and rehabilitation (EMR) for patients who are critically ill. However, various barriers impede its implementation in real-world clinical settings. In 2018, the Japanese universal healthcare coverage system announced a unique financial incentive scheme to facilitate EMR for patients in intensive care units (ICU). This study evaluated whether such an incentive improved patients' activities of daily living (ADL) and reduced their hospital length of stay (LOS).

Health inequalities

► **Using Data on Biomarkers and Siblings to Study Early-Life Economic Determinants of Type-2 Diabetes**

ALESSIE R. J. M., ANGELINI V., VAN DEN BERG G. J., *et al.*

2024

Health Economics [Ahead of Print].

<https://doi.org/10.1002/hec.4815>

We study the effect of economic conditions early in life on the occurrence of type-2 diabetes in adulthood using contextual economic indicators and within-sibling pair variation. We use data from Lifelines: a longitudinal cohort study and biobank including 51,270 siblings born in the Netherlands from 1950 onward. Sibling fixed-effects account for selective fertility. To identify type-2 diabetes we use biomarkers on the hemoglobin A1c concentration and fasting glucose in the blood. We find that adverse economic conditions around birth increase the probability of type-2 diabetes later in life both in males and in females. Inference based on self-reported diabetes leads to biased results, incorrectly suggesting the absence of an effect. The same applies to inference that does not account for selective fertility.

► **Mothers' School Starting Age and Infant Health**

BORRA C., GONZÁLEZ L. ET PATIÑO D.

2024

Health Economics [Ahead of Print].

<https://doi.org/10.1002/hec.4809>

Abstract We study the effects of women's school starting age on the infant health of their offspring. In Spain, children born in December start school a year earlier than those born the following January, despite being essentially the same age. We follow a regression discontinuity design to compare the health at birth of the children of women born in January versus the previous December, using administrative, population-level data. We find small and insignificant effects on average weight at birth, but, compared to the children of December-born mothers, the children of January-born mothers are more likely to have very low birthweight. We then show that January-born women have the

same educational attainment and the same partnership dynamics as December-born women. However, they finish school later and are (several months) older when they have their first child. Our results suggest that maternal age is a plausible mechanism behind our estimated impacts of school starting age on infant health.

► **The Socioeconomic Consequences of Loneliness: Evidence From a Nationally Representative Longitudinal Study of Young Adults**

BRYAN B. T., THOMPSON K. N., GOLDMAN-MELLOR S., *et al.*

2024

Social Science & Medicine 345: 116697.

<https://doi.org/10.1016/j.socscimed.2024.116697>

The negative health consequences of loneliness have led to increasing concern about the economic cost of loneliness in recent years. Loneliness may also incur an economic burden more directly, by impacting socioeconomic position. Much of the research to date has focused on employment status which may not fully capture socioeconomic position and has relied on cross-sectional data, leaving questions around the robustness of the association and reverse causation. The present study used longitudinal data to test prospective associations between loneliness and multiple indicators of social position in young adulthood, specifically, whether participants who were lonelier at age 12 were more likely to be out of employment, education and training (NEET) and lower on employability and subjective social status as young adults. The data were drawn from the Environmental Risk (E-Risk) Longitudinal Twin Study, a birth cohort of 2,232 individuals born in England and Wales during 1994–1995. Loneliness and subjective social status were measured at ages 12, 18 and 26. Employability and NEET status were assessed at age 18. Findings indicate that greater loneliness at age 12 was prospectively associated with reduced employability and lower social status in young adulthood. The association between loneliness and lower social status in young adulthood was robust when controlling for a range of confounders using a sibling-control design. Results also indicate that loneliness is unidirectionally associated with reduced sub-

jective social status across adolescence and young adulthood. Overall, our findings suggest that loneliness may have direct costs to the economy resulting from reduced employability and social position, underlining the importance of addressing loneliness early in life.

► **Keeping It Political and Powerful:
Defining the Structural Determinants
of Health**

HELLER J. C., GIVENS M. L., JOHNSON S. P., *et al.*
2024

The Milbank Quarterly [Ahead of Print]
<https://doi.org/10.1111/1468-0009.12695>

Policy Points The structural determinants of health are 1) the written and unwritten rules that create, maintain, or eliminate durable and hierarchical patterns of advantage among socially constructed groups in the conditions that affect health, and 2) the manifestation of power relations in that people and groups with more power based on current social structures work—implicitly and explicitly—to maintain their advantage by reinforcing or modifying these rules. This theoretically grounded definition of structural determinants can support a shared analysis of the root causes of health inequities and an embrace of public health’s role in shifting power relations and engaging politically, especially in its policy work. Shifting the balance of power relations between socially constructed groups differentiates interventions in the structural determinants of health from those in the social determinants of health.

► **Co-Benefits From Health and Health
Systems to Education**

LEE I.
2024

Health Policy 142 : 105016.
<https://doi.org/10.1016/j.healthpol.2024.10501600265>

This review draws on over 70 studies spanning 2000 to 2023 to analyze the causal effect of health on educational outcomes. Health and health system interventions during the prenatal, infant, and childhood period impact longer-run educational attainment and performance. The magnitude of these effects is both statistically and economically significant, comparable in size to impacts on educational outcomes of interventions found in the literature. These impacts of health and health system interventions differ across gender

and socioeconomic status, illustrating how health and health systems can exacerbate or mitigate educational inequalities. By showing the intertwined nature of health and education, this review highlights the importance of a comprehensive approach in policy-making that aligns with the Sustainable Development Goals.

► **Hope in Adolescence and Subsequent
Health and Well-Being in Adulthood:
An Outcome-Wide Longitudinal Study**

LONG K. N. G., WILKINSON R., COWDEN R. G., *et al.*
2024

Social Science & Medicine: 116704.
<https://doi.org/10.1016/j.socscimed.2024.116704>

Background A sense of hopelessness is rising at alarming levels among adolescents in the United States. There is urgent need to understand the potential implications of being hopeful on adolescents’ future health and wellbeing. **Methods** This study utilized data from the National Longitudinal Study of Adolescent to Adult Health (N = 11,038, mean age at baseline = 15 years) to prospectively examine the relationship between baseline hope and a wide range of outcomes 12 years later. Thirty-eight outcomes were examined in the domains of physical health, health behavior, mental health, psychological well-being, social factors, and civic and prosocial behavior. Regression models were used to regress each outcome on baseline hope separately. Models controlled for a wide range of factors as well as prior values of the exposure (hope) and each outcome. **Results** Having hope for the future in adolescence was associated with improvements in 11 subsequent outcomes after Bonferonni correction, including higher cognition and self-rated health, less physical inactivity, fewer depressive symptoms, lower perceived stress, and improvement on a number of psychological and social factors including greater happiness, more satisfaction with parenting, and increased voting and volunteering in adulthood. There were also a number of associations that were close to the null, which are equally important to explore and understand. **Implications** The results of the study may have important implications for hope-based efforts and programs aimed at improving the lives of young people and promoting their current and future well-being.

► **Income Inequality and Deaths of Despair Risk in Canada, Identifying Possible Mechanisms**

LOVEROCK A., BENNY C., SMITH B. T., *et al.*
2024

Social Science & Medicine 344: 116623.
<https://doi.org/10.1016/j.socscimed.2024.116623>

Background Declines in life expectancy in developed countries have been attributed to increases in drug-related overdose, suicide, and liver cirrhosis, collectively referred to as deaths of despair. Income inequality is proposed to be partly responsible for increases in deaths of despair rates. This study investigated the associations between income inequality, deaths of despair risk in Canada, and potential mechanisms (stress, social cohesion, and access to health services). Methods We obtained data from the Canadian Community Health Survey and the Canadian Vital Statistics Database from 2007 to 2017. A total of 504,825 Canadians were included in the analyses. We used multilevel survival analyses, as measured by the Gini coefficient, to examine the relationships between income inequality and mortality attributed to drug overdose, suicide, death of despair, and all-cause. We then used multilevel path analyses to investigate whether each mediator (stress, social cohesion, and access to mental health professionals), which were investigated using separate mediation models, influenced the relationship between income inequality and drug overdose, suicide, deaths of despair, and all-cause death. Results Adjusted multilevel survival analyses demonstrated significant relationships between a one-SD increase in Gini coefficient was associated with an increased hazard for drug overdose (HR_{adj.} = 1.28; 95 CI = 1.05, 1.55), suicide (HR_{adj.} = 1.24; 95 CI = 1.06, 1.46), deaths of despair (HR_{adj.} = 1.26; 95 CI = 1.12, 1.40), and all-cause death (HR_{adj.} = 1.04; 95 CI = 1.02, 1.07). Adjusted path analyses indicated that stress, social cohesion, and access to mental health professionals significantly mediated the association between income inequality and mortality outcomes. Conclusion Income inequality is associated with deaths of despair and this relationship is mediated by stress, social cohesion, and access to mental health professionals. Findings should be applied to develop programs to address income inequality in Canada.

► **The Impact of Socioeconomic Status on Health Practices Via Health Lifestyles: Results of Qualitative Interviews with Americans From Diverse Socioeconomic Backgrounds**

MCCOY C. A., JOHNSTON E. ET HOGAN C.
2024

Social Science & Medicine 344: 116618.
<https://doi.org/10.1016/j.socscimed.2024.116618>

We performed 55 qualitative interviews with Americans from diverse socioeconomic backgrounds from a small city in the Northeast to better understand the complex process through which socioeconomic status (SES) influences the health practices persons carry out. We argue that SES not only influences health practices directly, but also via shaping interviewees' health lifestyles. We describe four connected ways that SES shapes interviewees' health lifestyles: (a) the impact of physical and mental illness on how much time, energy, and resources can be devoted to health; (b) the impact of social connections on opportunities to engage in healthy practices; (c) variation in interviewees' sense of control over health and health practices; and (d) how intentional and planned out interviewees' health lifestyles are. Although explored previously, the aim of this study is to examine how these elements come together to form into distinct styles of health shaped by the socioeconomic background of our respondents.

► **Aversion to Health Inequality — Pure, Income-Related and Income-Caused**

ROBSON M., O'DONNELL O. ET VAN OURTI T.
2024

Journal of Health Economics 94: 102856.
<https://doi.org/10.1016/j.jhealeco.2024.102856>

We design a novel experiment to identify aversion to pure (univariate) health inequality separately from aversion to income-related and income-caused health inequality. Participants allocate resources to determine health of individuals. Identification comes from random variation in resource productivity and information on income and its causal effect. We gather data (26,286 observations) from a sample of UK adults (n = 337) and estimate pooled and participant-specific social preferences while accounting for noise. The median person has strong aversion to pure health inequality, challenging the health maximisation objective of economic evaluation. Aversion to health inequality is even stronger when it is related to income. However,

the median person prioritises health of poorer individuals less than is assumed in the standard measure of income-related health inequality. On average, aversion to that inequality does not become stronger

when low income is known to cause ill-health. There is substantial heterogeneity in all three types of inequality aversion.

Médicaments

Pharmaceuticals

► **Why Prescribe Antibiotics? A Systematic Review of Knowledge, Tension, and Motivation Among Clinicians in Low-, Middle- and High-Income Countries**

CHAN O. S. K., LAM W., ZHAO S., *et al.*
2024

Social Science & Medicine 345: 116600.

<https://doi.org/10.1016/j.socscimed.2024.116600>

Medical professionals such as physicians and veterinarians are responsible for appropriate antimicrobial prescription (AMP) and use. Although seemingly straightforward, the factors influencing antibiotic prescription, a category of antimicrobials, are complex. Many studies have been conducted in the past two decades on this subject. As a result, there is a plethora of empirical evidence regarding the factors influencing clinicians' AMP practices. Aim: A systematic review of AMR studies on AMP was conducted, condensing findings according to a combination of the Knowledge, Attitude, and Practice (KAP) and Capacity, Opportunity, Motivation—Behavior (COM-B) models. Review findings were then synthesized and analyzed for policy implementation according to the Consolidated Framework for Implementation Research (CFIR). Design and methodology: A systematic literature review was conducted according to PRISMA guidelines to identify peer-reviewed papers indexed in pre-determined medical science, social sciences, and humanities databases that apply the KAP model in their investigations. Antimicrobial prescription factors were compared and contrasted among low- and middle-income countries (LMICs) and high-income countries (HICs). Findings: The KAP model is a heuristic and structured framework for identifying and classifying respondents' knowledge. However, other than medical knowledge, factors that influence prescription decision-making can be expanded to include attitudes, perception, personal affinities, professional circumstances, relational pressure, and social norms.

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

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

2024

Health Policy 142: 105027.

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

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

► **The Impact of Prescription Drug Coverage on Disparities in Adherence and Medication Use: A Systematic Review**

KAPLAN C. M., WATERS T. M., CLEAR E. R., *et al.*
2024

[Medical Care Research and Review 81\(2\): 87-95.](#)
<https://doi.org/10.1177/10775587231218050>

Prescription drug cost-sharing is a barrier to medication adherence, particularly for low-income and minority populations. In this systematic review, we examined the impact of prescription drug cost-sharing and policies to reduce cost-sharing on racial/ethnic and income disparities in medication utilization. We screened 2,145 titles and abstracts and identified 19 peer-reviewed papers that examined the interaction between cost-sharing and racial/ethnic and income disparities in medication adherence or utilization. We found weak but inconsistent evidence that lower cost-sharing is associated with reduced disparities in adherence and utilization, but studies consistently found that significant disparities remained even after adjusting for differences in cost-sharing across individuals. Study designs varied in their ability to measure the causal effect of policy or cost-sharing changes on disparities, and a wide range of policies were examined across studies. Further research is needed to identify the types of policies that are best suited to reduce disparities in medication adherence.

► **Évaluation de la pratique pharmaceutique en établissement de santé : une étude exploratoire comparant les processus en France et au Québec**

MARC M., RAMBOURG P. ET BUSSIÈRES J.-F.
2024

[Annales Pharmaceutiques Françaises.](#)
<https://doi.org/10.1016/j.pharma.2024.02.010>

Contexte : Afin d'assurer le respect du cadre juridique et normatif, les ordres professionnels qui encadrent l'exercice de la pharmacie ont mis en place un processus d'inspection professionnelle. En sus de ce processus, d'autres organismes externes exigent également un processus d'agrément, d'autorisation, de certification ou de validation des pratiques professionnelles. Objectifs : L'objectif principal est d'identifier et de comparer les modalités d'évaluation de la pratique pharmaceutique en établissement de santé (ES) en France et au Québec. Méthodes : Il s'agit d'une étude descriptive. L'étude porte sur les activités applicables

à la pharmacie à usage intérieur (PUI) en France et au département de pharmacie au Québec et à ses membres. Nous avons recensé les activités d'évaluation de la pratique pharmaceutique en consultant quelques pairs en France et au Québec, puis identifié et cartographié les organismes responsables de ces activités d'évaluation, consulté le cadre juridique applicable, mené des rencontres semi-structurées avec des représentants d'autorités et rédigé des tableaux comparatifs par types d'activités d'évaluation. Résultats : Afin d'identifier et de comparer les modalités d'évaluation de la pratique pharmaceutique en ES en France et au Québec, notre démarche nous a permis d'identifier davantage d'organismes en France (i.e. Haute Autorité de santé, les agences régionales de santé, l'Ordre national des pharmaciens, l'Agence de sûreté nucléaire, l'Agence de la biomédecine et l'Agence nationale de sécurité du médicament et des produits de santé) qu'au Québec (i.e. Agrément Canada, l'Ordre des Pharmaciens du Québec et Santé Canada). L'étude met en évidence le cadre juridique et les référentiels applicables, les experts-visiteurs, les modalités d'évaluation et les particularités pour l'évaluation de l'établissement de santé, de la PUI et des membres de la PUI. Conclusions : Cette étude met en évidence les processus d'évaluation de la pratique pharmaceutique en établissement de santé. En France comme au Québec, on reconnaît l'importance du circuit du médicament dans l'ES, de l'aménagement et de l'opération d'une PUI et de l'exercice de la pharmacie. S'il existe davantage de similitudes pour l'évaluation du circuit du médicament dans l'ES et la PUI, des différences importantes sont observées pour l'évaluation des individus. Nous pensons que la publication d'une analyse comparée peut contribuer aux discussions et échanges afin de profiter des meilleures pratiques de chaque pays.

► **Tackling Medicine Shortages During and After the COVID-19 Pandemic: Compilation of Governmental Policy Measures and Developments in 38 Countries**

VOGLER S.
2024

[Health Policy 143: 105030.](#)
<https://doi.org/10.1016/j.healthpol.2024.105030>

In response to increasing shortages of medicines, governments have implemented legislative and non-legislative policy measures. This study aimed to map these

policies across high-income countries in Europe and beyond as of 2023 and to analyse developments in governmental approaches since the beginning of the pandemic. Information was collated from 38 countries (33 European countries, Australia, Brazil, Canada, Israel and Saudi Arabia) based on a survey conducted with public authorities involved in the Pharmaceutical Pricing and Reimbursement Information (PPRI) network in 2023. 34 countries requested pharmaceutical companies to notify national registers of upcoming shortages and 20 countries obliged manufacturers and/or wholesalers to stock supply reserves of critically needed medicines. Further common measures included export bans for defined medicines (18 coun-

tries), regulatory measures to facilitate import and use of alternative medicines (35 countries) and multi-stakeholder coordination (28 countries). While the legislation of 26 countries allows imposing sanctions, particularly for non-compliance to reporting requirements, fines were rather rarely imposed. Since 2022, at least 18 countries provided financial incentives, usually in the form of price increases of some off-patent medicines. Overall, several policies to address medicine shortages were taken in recent years, in some countries as part of a comprehensive package (e.g., Australia, Germany). Further initiatives to secure medicine supply in a sustainable manner were being prepared or discussed.

Méthodologie- Statistiques

Methodology-Statistics

► **Les défis de la recherche participative : au-delà des bonnes intentions**

BERTRAND K. ET PETIAU A.

2023

Santé Publique 35(HS2): 7-11.

<https://www.cairn.info/revue-sante-publique-2023-HS2-page-7.htm>

► **Participatory Value Evaluation (PVE): A New Preference-Elicitation Method For Decision Making in Healthcare**

BOXEBELD S., MOUTER N. ET VAN EXEL J.

2024

Applied Health Economics and Health Policy 22(2): 145-154.

<https://doi.org/10.1007/s40258-023-00859-9>

Participatory value evaluation (PVE) has recently been introduced in the field of health as a new method to elicit stated preferences for public policies. PVE is a method in which respondents in a choice experiment are presented with various policy options and their attributes, and are asked to compose their portfolio of preference given a public-resource constraint. This paper aims to illustrate PVE's potential for informing healthcare decision making and to position it relative to established preference-elicitation methods. We first describe PVE and its theoretical background. Next, by

means of a narrative review of the eight existing PVE applications within and outside the health domain, we illustrate the different implementations of the main features of the method. We then compare PVE to several established preference-elicitation methods in terms of the structure and nature of the choice tasks presented to respondents. The portfolio-based choice task in a PVE requires respondents to consider a set of policy alternatives in relation to each other and to make trade-offs subject to one or more constraints, which more closely resembles decision making by policymakers. When using a flexible budget constraint, respondents can trade-off their private income with public expenditures. Relative to other methods, a PVE may be cognitively more demanding and is less efficient; however, it seems a promising complementary method for the preference-based assessment of health policies. Further research into the feasibility and validity of the method is required before researchers and policymakers can fully appreciate the advantages and disadvantages of the PVE as a preference-elicitation method.

► **Vers de bonnes pratiques en recherche participative**

DOCAGNE F., BARTHÉLÉMY C. ET SPIRE B.
2023

Santé Publique 35(HS2): 107-109.

<https://www.cairn.info/revue-sante-publique-2023-HS2-page-107.htm>

Le Groupe de réflexion avec les associations de malades (Gram) de l'Inserm a réfléchi, en consultant des associations et des chercheurs de l'Inserm et en puisant dans l'expérience de ses membres, à des points d'attention en matière de bonnes pratiques pouvant guider les partenaires impliqués dans des projets de recherche participative. Dans cet article, nous présentons ces points d'attention en rappelant la nécessité de laisser toute sa place à la concertation entre les partenaires pour que les projets de recherche participative s'effectuent dans les meilleures conditions possibles, aussi bien pour les associations que pour les chercheurs.

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

HEIJDRASUASNABAR J. M., FINCH A. P., MULHERN B., *et al.*
2024

Social Science & Medicine 346: 116720.

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

Background Comprehensively measuring the outcomes of interventions and policy programmes impacting both health and broader areas of quality of life (QoL) is important for decision-making within and across sectors. Increasingly, broad QoL measures are being developed to capture outcomes beyond health-related quality of life (HRQoL). Jointly exploring the dimensionality of diverse instruments can improve our understanding about their evaluative space and how they conceptually build on each other. This study explored the measurement relationship between five broader QoL measures and the most widely used HRQoL measure, the EQ-5D. Methods Participants from the Dutch general population (n = 1002) completed six instruments (n = 126 items) in December of 2020. The measurement relationship was explored using qualitative and quantitative dimensionality assessment methods. This included a content analysis and exploratory factor analyses which were used to develop a confirmatory factor model of the broader QoL dimen-

sions. Correlations between the identified dimensions and self-reported overall health and wellbeing were also explored. Results The final CFA model exhibited acceptable/good fit and described 12 QoL dimensions: 'psychological symptoms', 'social relations', 'physical functioning', 'emotional resilience', 'pain', 'cognition', 'financial needs', 'discrimination', 'outlook on life/growth', 'access to public services', 'living environment', and 'control over life'. All dimensions were positively correlated to self-reported health and wellbeing, but the magnitudes in associations varied considerably (e.g., 'pain' had the strongest correlation with overall health but a weak correlation with wellbeing). Conclusions This study contributes to a broader understanding of QoL by exploring the dimensionality and relationships among various QoL measures. A number of the dimensions identified are HRQoL-focused, with others covering broader constructs. Our findings offer insights for the development of comprehensive instruments, or use of instrument suites that capture multi-dimensional aspects of QoL. Further research should explore the relevance and feasibility/appropriateness of measuring the identified dimensions in different settings and populations.

► **Prédire le passage en invalidité : les méthodes d'apprentissage automatique appliquées aux données de santé françaises**

METTE C., VERBOUX D., RACHAS A., *et al.*
2023

Santé Publique 35(6): 65-85.

<https://www.cairn.info/revue-sante-publique-2023-6-page-65.htm>

Introduction : Le recours à la pension d'invalidité a des implications morbides (physiques ou psychiques) et sociales (baisse du revenu). Il a aussi des conséquences économiques pour la société, avec des dépenses croissantes depuis 2011 (+4,9 % en moyenne par année). Prévenir la perte de la capacité à travailler devrait permettre de limiter ces conséquences, mais nécessite de cibler les personnes à risque. Le développement des méthodes d'intelligence artificielle ouvre des perspectives en ce sens. But de l'étude : Cibler les personnes ayant une « forte » probabilité de devenir bénéficiaires d'une pension d'invalidité dans l'année au regard de leurs caractéristiques sociodémographiques et médicales (pathologies, arrêts de travail, médicaments et actes médicaux) à partir de méthodes d'apprentissage automatique supervisé. Méthodes : Parmi les bénéfici-

ciaires du régime général âgés de 21 à 64 ans en 2017, comparaison des caractéristiques de 2014 à 2016 entre les nouveaux bénéficiaires d'une pension d'invalidité en 2017 et ceux n'en bénéficiant pas. La détermination de la frontière entre ces deux groupes a été testée à l'aide de la régression logistique, des arbres de décision, des forêts aléatoires, de la classification naïve bayésienne et des séparateurs à vaste marge. Les performances des modèles ont été comparées au regard de la justesse, la précision, la sensibilité, la spécificité et l'AUC (Area Under the Curve). Le pouvoir prédictif de chaque facteur est estimé à partir de l'AUC. Résultats : La régression logistique boostée avait les meilleures performances sur trois des cinq critères retenus, mais une faible sensibilité. La meilleure sensibilité était obtenue avec les séparateurs à vaste marge, avec une justesse proche de la régression logistique boostée mais une précision et une spécificité inférieures. Les forêts aléatoires offraient la meilleure capacité discriminatoire. Les facteurs les plus prédictifs du risque de passer en invalidité étaient le bénéfice d'au moins 30 jours d'indemnités journalières pour maladie en 2014, 2015 et 2016 et le fait d'être âgé de 55 à 64 ans. Conclusion : Les méthodes d'apprentissage supervisé sont apparues pertinentes pour le ciblage des personnes les plus à risque de recourir à la pension d'invalidité et, plus largement, pour le pilotage d'autres prestations sociales.

► Participation des acteurs, pratiques de chercheurs

MORGNY C., SCHEPENS F. ET SPOSITO-TOURIER M.
2023

Santé Publique 35(HS2): 49-53.

<https://www.cairn.info/revue-sante-publique-2023-HS2-page-49.htm>

Introduction : L'activité professionnelle représente une injonction à participer au collectif et alimente notre identité. En être privé peut engendrer une exclusion sociale. En parallèle, l'injonction à l'autonomie est prégnante dans notre société. La personne en situation de handicap peut souffrir d'une stigmatisation sociale et se trouver en tension entre handicap/autonomie/travail. Le travail est alors essentiel pour s'identifier comme un travailleur et non comme une personne dépendante. But de l'étude : La recherche participative présentée poursuit un double objectif : donner la parole à une population stigmatisée – les travailleurs handicapés – et à leurs proches ; comprendre et analyser avec eux les stratégies utilisées pour pouvoir travailler ou se maintenir en emploi et les répercussions de celles-ci sur la santé au travail et le rapport aux risques. Résultats : Les échanges entre le groupe de pairs et l'équipe scientifique ont permis d'affiner les questionnements initiaux, de reformuler des analyses, de modifier des supports de communication, pour les rendre plus acceptables et accessibles. Cette démarche participative a modifié nos pratiques de chercheurs en permettant aux personnes concernées par la recherche d'en devenir des acteurs. Conclusion : Pour des populations subissant une domination symbolique, la recherche participative permet de redonner confiance aux personnes et légitimité aux savoirs expérientiels.

Politique de santé

Health Policy

- **Les droits sociaux au prisme des étrangers. L'accès aux prestations non contributives et à l'aide sociale en France (1949-1958)**

CANEPA G.
2023

Revue d'histoire de la protection sociale 16(1): 50-75.

<https://www.cairn.info/revue-d-histoire-de-la-protection-sociale-2023-1-page-50.htm>

Cet article analyse le problème de la territorialité des droits sociaux à travers les mécanismes d'inclusion et d'exclusion des différents groupes d'étrangers dans les accords internationaux signés par la France entre la fin de la Seconde Guerre mondiale et l'établissement du marché unique européen (1949-1958). Il analyse en particulier les différences de traitement entre droits assurantiels et prestations non contributives et d'aide sociale. Malgré les extensions consenties, ces dernières ont continué à différencier les étrangers entre eux et à exclure certains groupes, posant ainsi la question des modes de légitimation de l'accès aux différents droits sociaux par les États nationaux.

- **Policy Interventions to Enhance Medical Care For People with Obesity in the United States—Challenges, Opportunities, and Future Directions**

JOLIN J. R., KWON M., BROCK E., *et al.*
2024

The Milbank Quarterly n/a(n/a).

<https://doi.org/10.1111/1468-0009.12693>

Policy Points Health policymakers have insufficiently addressed care for people with obesity (body mass index ≥ 30 kg/m²) in the United States. Current federal policies targeting obesity medications reflect this unfortunate reality. We argue for a novel policy framework to increase access to effective obesity therapeutics and care, recognizing that, though prevention is critical, the epidemic proportions of obesity in the United States warrant immediate interventions to augment care. Reducing barriers to and improving the quality of existing anti-obesity medications, intensive behavioral therapy, weight management nutrition and dietary counseling, and bariatric surgery are critical. Moreover, to ensure continuity of care and patient' clinician trust, combating physician and broader weight stigma must represent a central component of any viable obesity care agenda.

Prévention

Prevention

- **Sibling Spillovers and the Choice to Get Vaccinated: Evidence From a Regression Discontinuity Design**

HUMLUM M. K., MORTHORST M. O. ET THINGHOLM P. R.
2024

Journal of Health Economics 94: 102843.

<https://doi.org/10.1016/j.jhealeco.2023.102843>

We investigate the effects of introducing population-wide free-of-charge Human Papillomavirus (HPV) vaccination programs on the targeted adolescent cohorts and their siblings. For identification, we rely on regression discontinuity designs and high-quality

Danish administrative data to exploit that date of birth determines program eligibility. We find that the programs increased the HPV vaccine take-up of both the targeted children (53.2 percentage points for girls and 36.0 percentage points for boys) and their older same-sex siblings (4.5 percentage points for sisters and 3.5 percentage points for brothers). We show that while the direct effects of the programs reduced HPV vaccine take-up inequality, the spillover effects, in contrast, contributed to an increase in vaccine take-up inequality highlighting the potential importance of spillover effects in the determination of distributional consequences of public health programs. Finally, we find some evidence of cross-vaccine spillovers.

Psychiatry

► **Reducing Wait Times and Avoiding Unnecessary Use of High-Cost Mental Health Services Through a Rapid Access and Stabilization Program: Protocol For a Program Evaluation Study**

ADU M. K., DA LUZ DIAS R., OBUOBI-DONKOR G., *et al.*

2024

BMC Health Serv Res 24(1): 247.

<https://doi.org/10.1186/s12913-024-10697-7>

BACKGROUND: Emergency psychiatric care, unplanned hospital admissions, and inpatient health care are the costliest forms of mental health care. According to Statistics Canada (2018), almost 18% (5.3 million) of Canadians reported needing mental health support. However, just above half of this figure (56.2%) have reported their needs were fully met. In light of this evidence there is a pressing need to provide accessible mental health services in flexible yet cost-effective ways. To further expand capacity and access to mental health care in the province, Nova Scotia Health has launched a novel mental health initiative for people in need of mental health care without requiring emergency department visits or hospitalization. This new service is referred to as the Rapid Access and Stabilization Program (RASP). This study evaluates the effectiveness and impact of the RASP on high-cost health services utilization (e.g. ED visits, mobile crisis visits, and inpatient treatments) and related costs. It also assesses healthcare partners' (e.g. healthcare providers, policymakers, community leaders) perceptions and patient experiences and satisfaction with the program and identifies sociodemographic characteristics, psychological conditions, recovery, well-being, and risk measures in the assisted population. **METHOD:** This is a hypothesis-driven program evaluation study that employs a mixed methods approach. A within-subject comparison (pre- and post-evaluation study) will examine health services utilization data from patients attending RASP, one year before and one year after their psychiatry assessment at the program. A controlled between-subject comparison (cohort study) will use historical data from a control population will examine whether possible changes in high-cost health services utilization are associated with the intervention (RASP). The primary analysis involves extracting

secondary data from provincial information systems, electronic medical records, and regular self-reported clinical assessments. Additionally, a qualitative sub-study will examine patient experience and satisfaction, and health care partners' impressions. **DISCUSSION:** We expect that RASP evaluation findings will demonstrate a minimum 10% reduction in high-cost health services utilization and corresponding 10% cost savings, and also a reduction in the wait times for patient consultations with psychiatrists to less than 30 calendar days, in both within-subject and between-subject comparisons. In addition, we anticipate that patients, healthcare providers and healthcare partners would express high levels of satisfaction with the new service. **CONCLUSION:** This study will demonstrate the results of the Mental Health and Addictions Program (MHAP) efforts to provide stepped-care, particularly community-based support, to individuals with mental illnesses. Results will provide new insights into a novel community-based approach to mental health service delivery and contribute to knowledge on how to implement mental health programs across varying contexts.

► **Causal Beliefs About Mental Illness: A Scoping Review**

AHUVIA I. L., SOTOMAYOR I., KWONG K., *et al.*

2024

Soc Sci Med 345: 116670.

<https://doi.org/10.1016/j.socscimed.2024.116670>

Research on causal beliefs about mental illness—the beliefs people hold about what causes a particular mental illness, or mental illnesses in general—is split across a number of theories and disciplines. Although research on this subject has provided a number of insights and practical applications, the diversity of theories, terminology, and keywords makes it challenging for a new reader to gain a comprehensive understanding. We sought to address this by conducting a systematic scoping review of research on causal beliefs. This review included English-language articles from any year that mentioned causal beliefs for mental illness in their title or abstract. We identified articles in two stages. In the first stage, we used a narrow set of search terms referring specifically to causal beliefs (1227 records identified, 417 included). In the second

stage, we used a comprehensive set of terms relevant to research on causal beliefs (10,418 records identified, 3838 included). We analyzed articles qualitatively, organizing them into one of five theories or categories: the common-sense model of self-regulation, explanatory models, mental health literacy, biogenetic causal beliefs, and other research on causal beliefs. We provide a comprehensive summary of these literatures in terms of their history, typical research questions and study design, findings, and practical applications. These theories differ in their theoretical orientation towards causal beliefs, research methods, findings, and applications. However, they broadly share a view of causal beliefs as multifaceted, culturally determined, and relevant for additional psychosocial variables such as mental illness stigma and help-seeking. We conclude by making recommendations for researchers, clinicians, public health messaging, and for individuals with mental illness.

► **Measuring the Overall Performance of Mental Healthcare Providers**

ARAGON M. J., GRAVELLE H., CASTELLI A., *et al.*

2024

Soc Sci Med 344: 116582.

<https://doi.org/10.1016/j.socscimed.2024.116582>

To date there have been no attempts to construct composite measures of healthcare provider performance which reflect preferences for health and non-health benefits, as well as costs. Health and non-health benefits matter to patients, healthcare providers and the general public. We develop a novel provider performance measurement framework that combines health gain, non-health benefit, and cost and illustrate it with an application to 54 English mental health providers. We apply estimates from a discrete choice experiment eliciting the UK general population's valuation of non-health benefits relative to health gains, to administrative and patient survey data for years 2013-2015 to calculate equivalent health benefit (eHB) for providers. We measure costs as forgone health and quantify the relative performance of providers in terms of equivalent net health benefit (eNHB): the value of the health and non-health benefits minus the forgone benefit equivalent of cost. We compare rankings of providers by eHB, eNHB, and by the rankings produced by the hospital sector regulator. We find that taking account of the non-health benefits in the eNHB measure makes a substantial difference to the evaluation of provider performance. Our study demonstrates that the pro-

vider performance evaluation space can be extended beyond measures of health gain and cost, and that this matters for comparison of providers.

► **Health Service Utilisation of People Living with Psychosis: Validity of Self-Report Compared with Administrative Data in a Randomised Controlled Trial**

DOLAR V., CHATTERTON M. L., LE L. K.-D., *et al.*

2024

Applied Health Economics and Health Policy 22(2): 255-264.

<https://doi.org/10.1007/s40258-023-00849-x>

Self-reported service use informs resource utilisation and cost estimates, though its validity for use within economic evaluations is uncertain.

► **Temporal Trends in Mental Health in the United States By Gender Identity, 2014–2021**

FEIR D. ET MANN S.

2024

American Journal of Public Health 0(0): e1-e4.

<https://doi.org/10.2105/AJPH.2024.307603>

Objectives. To examine the temporal trends in the transgender–cisgender mental health disparity in the United States. Methods. We used 2014–2021 US Behavioral Risk Factor Surveillance System Survey data with logistic and ordinary least squares regression to document temporal trends in the transgender–cisgender disparity in self-reports of the number of poor mental health days in the past month and frequent mental distress. Results. In 2014, cisgender individuals reported a mean average of 3.68 (95% confidence interval [CI] = 3.65, 3.70) poor mental health days compared with a mean average of 5.42 (95% CI = 4.68, 6.16) poor mental health days among transgender respondents. The size of this disparity adjusted by differences in observable characteristics increased by 2.75 days (95% CI = 0.58, 4.91) over the sample period. In 2014, 11.4% (95% CI = 11.3%, 11.5%) of cisgender adults reported frequent mental distress compared with 18.9% (95% CI = 15.9%, 22%) of transgender adults. By 2021, 14.6% (95% CI = 15.9%, 22%) of cisgender adults and 32.9% (95% CI = 30.7%, 35.1%) of transgender adults reported frequent mental distress. Conclusions. Policies are needed to address the worsening mental health of transgender and gender-nonconforming people in the

United States.

► **Mental Health Integrated Care Models in Primary Care and Factors that Contribute to Their Effective Implementation: A Scoping Review**

ISAACS A. N. ET MITCHELL E. K. L.

2024

International Journal of Mental Health Systems
18(1): 5.

<https://doi.org/10.1186/s13033-024-00625-x>

In the state of Victoria, Australia, the 111-day lockdown due to the COVID-19 pandemic exacerbated the population's prevailing state of poor mental health. Of the 87% of Australians who visit their GP annually, 71% of health problems they discussed related to psychological issues. This review had two objectives: (1) To describe models of mental health integrated care within primary care settings that demonstrated improved mental health outcomes that were transferable to Australian settings, and (2) To outline the factors that contributed to the effective implementation of these models into routine practice.

► **Adolescent Mental Health and Well-Being: A Public Health of Consequence, February 2024**

KAPADIA F.

2024

American Journal of Public Health 114(2): 158-160.

<https://doi.org/10.2105/AJPH.2023.307543>

► **Police-Mental Health Co-Response Versus Police-As-Usual Response to Behavioral Health Emergencies: A Pragmatic Randomized Effectiveness Trial**

LOWDER E. M., GROMMON E., BAILEY K., *et al.*

2024

Social Science & Medicine 345 : 116723.

<https://doi.org/10.1016/j.socscimed.2024.116723>

Background People with mental illness are overrepresented in United States (US) criminal legal systems. In response, alternatives to traditional police response to behavioral health emergencies have become more common, despite limited evidence for their effectiveness. We conducted the first randomized controlled trial of a police-mental health co-response team to

determine program effectiveness relative to a police-as-usual response on key outcomes identified by community stakeholders. Methods Between January 2020 and March 2021, we randomized behavioral health emergency calls for service in one of six police districts in Indianapolis, Indiana to receive a co-response or police-as-usual response during operational hours between 10 a.m. and 5 p.m. Mondays – Fridays. Eligible calls for service were determined via pre-specified phrases indicating a behavioral health incident over the police dispatch radio. Researchers then communicated random assignment with the co-response team to indicate whether they should respond or withhold. Logistic and negative binomial regression were used to assess group differences in emergency medical services (EMS) events within 12 months of the randomized incident along with jail booking, outpatient encounters, and emergency department visits. Findings We randomized 686 calls for service with co-response completed in 264 cases and police-as-usual response in 267 cases. The overall rate of attrition was similar across conditions and the final sample included 211 co-responses and 224 police-as-usual responses. We found no significant differences in any EMS event (odds ratio [OR]: 1.26; 95% confidence interval [CI]: 0.85–1.88, $p = .246$) or event counts (incidence rate ratio [IRR]: 0.85; 95% CI: 0.52–1.37, $p = .504$). We also found no differences in secondary outcomes (jail booking, outpatient encounters, and emergency department visits). Discussion A police-mental health co-response team model was not more effective than traditional police response on key outcomes. Co-response team models, such as the one reported here, may unintentionally foster emergency services utilization among persons with behavioral health needs. Without a functioning national mental health system, communities in the US will continue to struggle to identify solutions to meet the needs of community members with complex behavioral health issues.

► **A Bridge Too Far? Social Network Structure As a Determinant of Depression in Later Life**

QU T.

2024

Social Science & Medicine 345: 116684.

<https://doi.org/10.1016/j.socscimed.2024.116684>

Existing research has documented various determinants of mental health related to individuals' social connections, but less is known about the role of the structural features of interpersonal networks. This is especially true in the case of bridging, which refers to ties to people who are otherwise disconnected from each other. By intersecting theories of social networks and gerontology, this study employs within- and between-person analysis with data from the National Social Life, Health, and Aging Project (NSHAP) to examine the association between social network bridging and depression in later life. The study finds that bridging, particularly between kin and non-kin members in the network, is associated with increased depressive symptoms in later life. This association is contingent on social support and strain respondents experienced, and it exhibits variations within individuals over time, especially among older adults in the youngest age cohort (57–64 years old included in NSHAP in 2005). In closing, the paper discusses the extent to which heterogeneous network structures may be one mechanism that shapes mental health trajectories in the context of later life-course experiences.

► **The 'Diagnostic Gap' and 'Economic Burden' of Depression: Global Mental Health in Neoliberal Poland (2010s–2020s)**

SZULEŃKA B.

2024

Social Science & Medicine 344: 116649.

<https://doi.org/10.1016/j.socscimed.2024.116649>

While critical sociologists and anthropologists of health have questioned Global Mental Health policies as postcolonial, developmental agendas, little is known on how this critique applies within the central and eastern European countries. As this article shows with the case of Poland, since the advent of capitalism and liberal democracy, the psychiatric conceptualization of depression has steadily aligned with global mental health (GMH) frameworks, amplifying pre-existing trends towards biomedical dominance in Polish psy-

chiatry and the economic framing of mental health in policy-making. These trends are evidenced by the study of Polish Psychiatry, an official journal issued by Polish Psychiatric Association and health policy documents published since the 2010s, including statements by the Ministry of Health. Two findings are presented: first, the logic of 'closing the gap' between Poland and the West has shaped how depression prevalence data is produced and interpreted by state medical institutions and in expert psychiatric discourse; second, the reconceptualization of mental illness through its supposed economic cost has become a dominant approach to depression in Polish psychiatry and public health. Thus, in showing how the Global Mental Health agenda has permeated the specific context of Poland, promoting more individual and biomedical conceptions of mental illness, this case study enables advancing the postcolonial critique of mental health.

Sociology of Health

► **Co-construire un projet de recherche en oncologie avec les personnes concernées : retour d'expérience et leçons apprises**

BAILLAT L., BAUQUIER C., PANNARD M., *et al.*
2023

Santé Publique 35(HS2): 15-19.

<https://www.cairn.info/revue-sante-publique-2023-HS2-page-15.htm>

La participation des citoyen·nes aux recherches dans le champ du cancer se développe intensivement. Dans ce contexte, le projet de recherche IMPAQT visait à promouvoir la participation des patient·es (ayant été atteint·es de cancer à toutes les étapes de la recherche. C'est guidé par les besoins des patientes-chercheuses du groupe de recherche IMPAQT que s'est construit le projet Perce-Neige. Fondé sur les principes de démarche communautaire, ce projet comporte un double objectif : méthodologique, afin d'appréhender la collaboration et caractériser la démarche communautaire, et empirique, concernant les troubles cognitifs liés aux traitements anticancéreux auprès des soignant·es. L'ensemble des outils méthodologiques visant à répondre à ces objectifs ont été co-construits par l'ensemble du groupe IMPAQT. La participation à la recherche des personnes concernées propose une nouvelle forme d'articulation entre savoirs experts et expérientiels et impose des modes d'organisation spécifiques. La co-construction de la recherche et des outils méthodologiques nécessite également une actualisation régulière des connaissances, des modes d'organisation spécifiques, ainsi qu'une capacité réflexive permettant de réajuster et d'accompagner constamment la démarche. Il apparaît aussi que la mobilisation des personnes concernées, possédant des savoirs d'expérience, soulève des enjeux émotionnels. En conclusion, la participation des personnes concernées à la recherche constitue un levier essentiel dans l'identification, l'élaboration et l'ancrage social et psychosocial des problématiques de santé en cancérologie.

► **Accessibiliser les pratiques de recherche sur le handicap : une approche par les droits humains**

BÉAL A., BRUNO C., DELANAUD É., *et al.*
2023

Santé Publique 35(HS2): 73-78.

<https://www.cairn.info/revue-sante-publique-2023-HS2-page-73.htm>

Nous présentons la démarche de recherche participative Capdroits portant initialement sur la polémique autour de l'article 12 de la convention internationale des personnes handicapées, « Reconnaissance de la personnalité juridique dans des conditions d'égalité ». Elle a pour objectif de favoriser la participation des personnes concernées par cet article 12. Elle regroupe des chercheurs académiques, des personnes expertes de la relation d'aide et d'accompagnement et des personnes directement concernées par les situations d'empêchements. But de l'étude : Nous présentons dans cette contribution notre démarche de recherche participative, la méthodologie de « mise en problème public de l'expérience », et les manières dont elle s'est déployée. Nous montrerons comment les productions et les valorisations ont été rendus accessibles, tout en identifiant des tensions à l'œuvre. Résultats : Deux phases de recherche ont été construites et déployées depuis 2015 construites à travers une méthodologie expérimentale de « mise en problème public de l'expérience ». Plusieurs productions collaboratives ont été développées, destinées à divers types de réceptions, rendues possibles grâce aux pratiques d'accessibilisation ; mais mettant néanmoins en évidence des tensions produites dans les processus participatifs. Conclusions : L'épistémologie que nous construisons collectivement depuis 2015, a un horizon radical dans son ambition de réduire les inégalités sociales et cognitives en promouvant les savoirs expérientiels tout en perpétuant des inégalités. Notre capacité à dialoguer apparaît comme notre manière de co-construire une épistémologie radicale, imparfaite mais volontaire.

► **La recherche-action participative menée au « Lieu de répit » Marseille, un catalyseur de transformation sociale**

BECHLA I., MOHAND A. ET ROBERT J.

2023

Santé Publique 35(HS2): 31-35.

<https://www.cairn.info/revue-sante-publique-2023-HS2-page-31.htm>

Introduction : La recherche-action participative (RAP) menée au « Lieu de répit » (LDR) a accompagné l'émergence du modèle interventionnel innovant, tout en faisant une large place à la participation des personnes souffrant de troubles psychiques. Celle-ci a également produit des résultats scientifiques pertinents et favorisé l'empowerment collectif. But de l'étude : L'article rend compte d'une intervention au colloque « Recherches participatives en santé et bien-être des populations : défis et pratiques », organisé par l'Institut pour la recherche en santé publique (IReSP) les 9 et 10 mars 2022. Résultats : Trois acteurs de la RAP présentent des points de vue situés sur les relations interpersonnelles, l'organisation de la RAP et les effets de la participation. Celle-ci est favorisée par un ensemble de facteurs contextuels, humains et organisationnels. Conclusions : Bien que complexes à mettre en œuvre, les recherches participatives en santé sont nécessaires à la production de nouvelles connaissances, tout en répondant à de nouvelles exigences épistémiques.

► **Recherche participative : perspectives croisées autour des savoirs académiques et expérientiels dans le domaine des addictions**

BERTRAND K., KNIGHT S. ET JAUFFRET-ROUSTIDE M.

2023

Santé Publique 35(HS2): 85-90.

<https://www.cairn.info/revue-sante-publique-2023-HS2-page-85.htm>

Les recherches participatives peuvent contribuer à améliorer les services dans le domaine des addictions. Toutefois, une implication superficielle des personnes détenant un savoir expérientiel comporte le risque de reproduire des situations d'iniquités sociales plutôt que de renforcer leur pouvoir d'agir. Cet article a pour objectif d'exposer un bilan critique, co-construit par le dialogue entre personnes détenant des savoirs académiques et expérientiels, au regard des différents types de participation et de collaboration ayant été réalisées au fil des ans, tout en posant un regard sur les enjeux de la professionnalisation ou de la formalisation du rôle de personnes détenant une expertise de vécu dans le cadre de recherches participatives en addictions. Les résultats de l'analyse critique réalisée permettent de dresser un bilan critique co-construit qui comprend les thèmes suivants : 1) la description du parcours de collaboration et de la diversité des implications en recherche de la personne détenant un savoir expérientiel; 2) les réflexions conceptuelles autour des termes utilisés et des identités qui y sont liées; 3) les facilitateurs de la collaboration; 4) les obstacles et défis rencontrés. Ce dialogue entre savoirs académiques et expérientiels permet de souligner la nécessité de revoir les règles institutionnelles pour mieux reconnaître le statut des personnes détenant un savoir expérientiel en recherche. La reconnaissance des compétences en lien avec l'admissibilité à des postes de recherche ne devrait pas se limiter à l'obtention de diplômes. Le savoir expérientiel devrait être intégré comme un type d'expertise reconnu dans le cadre des embauches.

Primary health care

► **Avis de l'Académie nationale de médecine concernant les praticiens à diplômes hors Union européenne (Padhue)**

ACADÉMIE NATIONALE DE MÉDECINE
2024

Bulletin de l'Académie Nationale de Médecine.
<https://doi.org/10.1016/j.banm.2024.02.004>

► **“We Have Knowledge that Is Unique”:
Patient Activism and the Promotion
of Trans-Inclusive Primary Care**

BLUS-KADOSH I. ET HARTAL G.
2024

Social Science & Medicine 344: 116654.
<https://doi.org/10.1016/j.socscimed.2024.116654>

Despite growing visibility of the trans population in Israel, there has been limited research on trans healthcare in a local context, particularly in the field of primary care medicine. Primary care encompasses services provided in locally distributed clinics and has a crucial role in providing both preventive and specialized healthcare. The aim of this study is to outline barriers to trans-inclusive primary care and measures employed by the trans community to overcome them. Biopower and counter-conduct are used as analytical frameworks to examine the trans-exclusionary features of the Israeli healthcare system and steps taken to resist it. To examine these issues, 19 medical care professionals and 20 trans people and activists were interviewed, and a variety of relevant texts were analyzed. Our results indicate trans-exclusionary features in primary healthcare, such as ambiguity regarding trans-inclusive services offered, sex-specific treatments, and lack of medical training programs dedicated to the trans population. To overcome these difficulties, the Israeli trans community has accumulated communal experiential knowledge and transferred it to physicians and policymakers in a localized and informal manner. We argue that by using informal practices, the trans community can provide support and information to its own members as well as operate alongside power systems, albeit in a slow and lengthy manner. More generally, the findings of this study highlight how patient activism is employed by marginalized populations, who face not only health disparities, but institutional

discrimination as well.

► **An International Comparative Policy
Analysis of Opioid Use Disorder
Treatment in Primary Care Across Nine
High-Income Jurisdictions**

CHIU K., PANDYA S., SHARMA M., *et al.*
2024

Health Policy 141: 104993.
<https://doi.org/10.1016/j.healthpol.2024.104993>

Background Opioid use disorder (OUD) and opioid-related harms are current health priorities in many high-income countries such as Canada. Opioid agonist therapy (OAT) is an effective evidence-based treatment for OUD, but access is often limited. Aims To describe and compare OUD treatment policies across nine international jurisdictions, and to understand how they are situated within their primary care and health systems. Methods Using policy documents, we collected data on health systems, drug use epidemiology, drug policies, and OUD treatment from Australia, Canada, France, Germany, Ireland, Portugal, Sweden, Switzerland, and Taiwan. We used the health system dynamics framework and adapted definitions of low- and high-threshold treatment to describe and compare OUD treatment policies, and to understand how they may be shaped by their health systems context. Results Broad similarities across jurisdictions included the OAT pharmacological agents used and the need for supervised dosing; however, preferred OAT, treatment settings, primary care and specialist physicians' roles, and funding varied. Most jurisdictions had elements of lower-threshold treatment access, such as the availability of treatment through primary care and multiple OAT options, but the higher-threshold criteria of supervised dosing. Conclusions From the Canadian perspective, there are opportunities to improve accessibility of OUD care by drawing on how different jurisdictions incorporate multidisciplinary care, regulate OAT medications, remunerate healthcare professionals, and provide funding for services.

► **The FlaQuM-Quickscan: A Starting Point to Include Primary Care Professionals' Perspectives in the Evaluation of Hospital Quality Priorities**

CLAESSENS F., SEYS D., VAN DER AUWERA C., *et al.*
2024

Journal of Healthcare Quality Research 39(2): 89-99.
<https://doi.org/10.1016/j.jhqr.2023.12.002>

Introduction Today, primary care professionals' (PCPs) perspectives on hospital quality are unknown when evaluating hospital quality priorities. The aims of the present study were to identify key healthcare quality attributes from PCPs' perspective, to validate an instrument that measures PCPs' experiences of healthcare quality multidimensionally and to define hospital quality priorities based on PCPs' experiences. **Material and methods** Focus groups with PCPs were conducted to identify quality attributes through a qualitative in-depth analysis. A multicentre study of 18 hospitals was used to quantitatively assess construct, discriminant and criterion validity of the FlaQuM-Quickscan, an instrument that measures 'Healthcare quality for patients and kin' (part 1) and 'Healthcare quality for professionals' (part 2). To set quality priorities, scores on quality domains were analyzed descriptively and between-hospital variation was examined by evaluating differences in hospitals' mean scores on the quality domains using one-way Analysis of Variance (ANOVA). **Results** Identified key attributes largely corresponded with Lachman's multidimensional quality model. Including 'Communication' as a new quality domain was recommended. The FlaQuM-Quickscan was completed by 550 PCPs. Confirmatory factor analyses showed reasonable to good fit, except for the Root Mean Square Error of Approximation (RMSEA) in part 2. The 'Equity' domain scored the highest in parts 1 and 2. Domains 'Kin-centred care' and 'Accessibility and timeliness' scored the lowest in part 1 and 'Resilience' and 'Partnership and co-production' in part 2. Significant variation in hospitals' mean scores was observed for eleven domains in part 1 and sixteen domains in part 2. **Conclusions** The results gained a better understanding of PCPs' perspective on quality. The FlaQuM-Quickscan is a valid instrument to measure PCPs' experiences of hospital quality. Identified priorities indicate that hospital management should focus on multifaceted quality strategies, including technical domains, person-and kin-centredness, core values and catalysts.

► **The Impact of Scope-Of-Practice Restrictions on Access to Medical Care**

GUO J., KILBY A. E. ET MARKS M. S.
2024

Journal of Health Economics 94: 102844.
<https://www.sciencedirect.com/science/article/pii/S0167629623001212>

We study the impact of scope-of-practice laws in a highly regulated and important policy setting, the provision of medication-assisted treatment for opioid use disorder. We consider two natural experiments generated by policy changes at the state and federal level that allow nurse practitioners more practice autonomy. Both experiments show that liberalizations of prescribing authority lead to large improvements in access to care. Further, we use rich address-level data to answer key policy questions. Expanding nurse practitioner prescribing authority reduces urban-rural disparities in health care access. Additionally, expanded autonomy increases access to care provided by physicians, driven by complementarities between providers.

► **Engaging Interdisciplinary Innovation Teams in Federally Qualified Health Centers**

JUNG O. S., SATTERSTROM P. ET SINGER S. J.
2024

Medical Care Research and Review 0(0): 10775587241235244.
<https://doi.org/10.1177/10775587241235244>

To foster bottom-up innovations, health care organizations are leveraging interdisciplinary frontline innovation teams. These teams include workers across hierarchical levels and professional backgrounds, pooling diverse knowledge sources to develop innovations that improve patient and worker experiences and care quality, equity, and costs. Yet, these frontline innovation teams experience barriers, such as time constraints, being new to innovation, and team-based role hierarchies. We investigated the practices that such teams in federally qualified health centers (FQHCs) used to overcome these barriers. Our 20-month study of two FQHC innovation teams provides one of the first accounts of how practices that sustained worker engagement in innovation and supported their ideas to implementation evolve over time. We also show the varied quantity of engagement practices used at different stages of the innovation process. At a time when FQHCs face pressure to innovate amid staff

shortages, our study provides recommendations to support their work.

► **Une maison de santé pluriprofessionnelle coordonne un plan de prévention sexuelle pluridisciplinaire en milieu scolaire**

LETESSIER M., MIGNOT D., MEJRI I., *et al.*

2023

Santé Publique 35(6): 87-127.

<https://www.cairn.info/revue-sante-publique-2023-6-page-87.htm>

Introduction : En milieu rural français, s'informer sur la santé sexuelle et identifier des acteurs de santé dans ce domaine s'avère difficile pour les adolescents. Malgré les recommandations nationales et internationales, les programmes de prévention en milieu scolaire restent insuffisants en France. L'objectif du projet mené par la maison de santé pluriprofessionnelle (MSP) de Montval-sur-Loir (Sarthe) était de proposer un plan de prévention psychoaffective et sexuelle (PPAS) en milieu scolaire en coordonnant des acteurs locaux. Méthode : La MSP a élaboré le PPAS par une méthode de recherche-intervention. La première étape évaluait les besoins en santé sexuelle du territoire et identifiait la population cible. La deuxième étape était la création d'un comité de pilotage pour l'élaboration participative du PPAS et la définition du cadre conceptuel et des modalités d'intervention. La troisième étape correspondait au déroulement du PPAS et au retour d'expérience des intervenants et des participants. Résultats : Le PPAS s'adressait aux élèves de quatrième des deux collèges de Montval-sur-Loir durant les années scolaires 2020-2021 et 2021-2022. La co-construction du PPAS a abouti à une intervention sur la contraception et les infections sexuellement transmissibles, des ateliers artistiques à propos du consentement et des stéréotypes de genre, des groupes de parole, une intervention sur la pornographie visant les parents d'élèves. Conclusion : Le PPAS créé par la MSP de Montval-sur-Loir est novateur car il coordonne les acteurs de santé locaux autour des adolescents et de leurs parents, dans un milieu rural défavorisé, en respectant les recommandations nationales sur l'éducation à la santé sexuelle.

► **Public Reporting and Consumer Demand in the Home Health Sector**

LI J.

2024

Medical Care Research and Review 81(2): 122-132.

<https://doi.org/10.1177/10775587231221852>

Health care report cards improve information and are a crucial part of health care reform of the federal government of the United States. I exploit a natural experiment in the home health sector to assess whether a higher rating under the star ratings program affects patient choice. Higher rated agencies increased their market share by 1.4% or 0.25 (95% confidence interval: [-0.63, 1.12]) percentage points, a practically and statistically insignificant amount. I find no evidence of heterogeneous effects across the rating distribution or over time. I also find precise null effects among consumers expected to be more responsive, including community-entry patients and patients in competitive markets with more options and star types. Agencies may have modestly impeded consumer choice by engaging in some patient selection behaviors, although the evidence is only weakly suggestive. The star ratings are unlikely to improve home health quality despite continued policymaker interest.

► **When Patients Demur: Resisting Diagnostic Closure in US Primary Care**

MCARTHUR A.

2024

Social Science & Medicine 344: 116619.

<https://doi.org/10.1016/j.socscimed.2024.116619>

Patients are more engaged in their healthcare than ever before, including in the process of diagnostic sensemaking. But in acute primary care encounters, the interactional flow of the visit is shaped by an orientation toward the physician as the authority over diagnostic reasoning. Once physicians close diagnostic inquiry and transition into counseling, their assessment – and the extent to which it converges with the patient's perspective – comes into full view. Yet this is precisely when patients have reduced occasions to speak up if they do have concerns, as the "train has left the station" both diagnostically and interactionally. Using conversation analysis and a dataset of 75 video recordings of acute primary care encounters in the US, this article examines how patients speak up in this constrained environment. The concept of diagnosis demurrals is proposed to describe how patients

resist diagnostic closure by renewing the relevance of diagnostic inquiry, either in response to a diagnosis or at any point following the transition into counseling. Findings suggest that patients demur more frequently than prior studies on diagnosis resistance may have predicted, but they do so in ways that maintain deference to the physician's authority over matters of diagnosis: speaking up primarily outside the diagnostic moment, relying on actions in their own domain of expertise (e.g., their illness experience), and working to additionally soften the epistemic and interactional inappropriateness of their demurral. This behavior sits at the nexus of two opposing forces: patients may be more engaged, but their participation is constrained by a continued legacy of medical authority over diagnosis, to which patients themselves continue to respond and reproduce.

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

SCOTT A., TAYLOR T., RUSSELL G., *et al.*
2024

Health Policy 142: 105028.

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

Traditionally, in many countries general practices have been privately-owned independent small businesses. However, the last three decades has seen the rise of large corporate medical groups defined as private companies which are able to have non-GP shareholders and with branches across many locations. The greater prominence of profit motives may have implications for costs, access to care and quality of care. We estimate that 45% of GPs in Australia worked in a practice that was a private company, and within this group over one third (19.9% of total) worked in a corporate medical group (a private company with 10 or more practice locations). We examine the association between being in a corporate medical group and 19 outcomes classified into five groups: GP wellbeing, workload, patient access, organizational efficiency, and service quality. GPs who worked in such groups were more likely to be older, qualified overseas, and to have a conscientious personality. There was mixed evidence on GPs wellbeing, with GPs in corporate medical groups reporting a higher turnover of GPs but similar levels of job satisfaction. GP workload was similar in terms of hours worked and after hours work but they

reported a lower work-life balance. Patient access was better in terms of lower fees charged to patients but there was weak evidence that patients waited longer. GPs in corporate medical groups reported higher organizational efficiency because GPs spent less time spent on administration and management, had more nurses per GP, but despite this GPs were more likely to undertake tasks someone less qualified could do suggesting that nurses were complements not substitutes. There were no differences in service quality (teaching, patient complaints, consultation length, patients seen per hour). Corporate medical groups have become a substantial part of primary care provision in Australia. There is evidence they are more efficient, patient access is better with lower out of pocket costs and there are no differences in our measures service quality, but concerns remain about GP's wellbeing and work-life balance. Further research is needed on continuity of care and patient reported experiences and health outcomes.

► **An Integrated Primary Care Service to Reduce Cardiovascular Disease Risk in People with Severe Mental Illness: Primrose-A - Thematic Analysis of Its Acceptability, Feasibility, and Implementation**

SHAW P., MIFSUD A., OSBORN D., *et al.*
2024

BMC Health Services Research 24(1): 255.

<https://doi.org/10.1186/s12913-024-10628-6>

Cardiovascular disease among patients with severe mental illness in England is a major preventable contributor to premature mortality. To address this, a nurse and peer-coach delivered service (Primrose-A) was implemented in three London general practices from 2019 (implementation continued during COVID-19). This study aimed to conduct interviews with patient and staff to determine the acceptability of, and experiences with, Primrose-A.

► **Exiting Primary Care Providers**

ZOCHER K.

2024

Health Economics n/a(n/a).

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

Abstract This article studies the impact of primary care providers (PCPs) exit from the local health care system on patients' health care utilization. I compare patients with each other whose physicians have left the local health care system at different points in time due to retirement, relocation, or other reasons. Estimation results indicate that the imminent exit leads soon-leaving physicians to changing their treatment behavior, which has a significant impact on patients'

health care spending. In addition, successors and new PCPs provide significantly more preventive services in the post-exit-period and refer patients more often to specialists for further examinations than the physicians who exit later. The increased inpatient expenditures in the post-exit period are caused by the new PCPs (through referrals). Self-initiated substitution behavior of patients (e.g., less PCP care, more specialist care) after the exit is observed but is low in magnitude. Although an overall increase in health service utilization is observed, mortality in the post-exit periods is significantly increased among affected patients. A possible explanation is the low frequency follow-up care of patients who were referred to hospitals by their former PCP in the notification-period.

Systèmes de santé

Health systems

► **Administrative Burden For Patients in U.S. Health Care Settings Post-Affordable Care Act: A Scoping Review**

ILEA P. ET ILEA I.

2024

Social Science & Medicine 345: 116686.

<https://doi.org/10.1016/j.socscimed.2024.116686>

Administrative burdens are the costs associated with receiving a service or accessing a program. Based on the Herd & Moynihan framework, they occur in three subcategories: learning costs, compliance costs, and psychological costs. Administrative burdens manifest inequitably, more significantly impacting vulnerable populations. Administrative burdens may impact the health of those trying to access services, and in some cases block access to health-promoting services entirely. This scoping review examined studies focused on the impact on patients of administrative burden administrative burden in health care settings in the U.S. following the passage of the Affordable Care Act. We queried databases for empirical literature capturing patient administrative burden, retrieving 1578 records, with 31 articles ultimately eligible for inclusion. Of the 31 included studies, 18 used quantitative methods, nine used qualitative methods, three used mixed methods, and one was a case study. In terms of administrative burden subcategories, most patient outcomes reported

were learning (22 studies) and compliance costs (26 studies). Psychological costs were the most rarely reported; all four studies describing psychological costs were qualitative in nature. Only twelve studies connected patient demographic data with administrative burden data, despite previous research suggesting an inequitable burden impact. Additionally, twenty-eight studies assessed administrative burden and only three attempted to reduce it via an intervention, resulting in a lack of data on intervention design and efficacy.

► **The Distribution Structure of Medical and Care Resources Based on Regional Characteristics Throughout Japan in 2020**

KUSUNOKI T. ET YOSHIKAWA T.

2024

BMC Health Services Research 24(1): 222.

<https://doi.org/10.1186/s12913-024-10699-5>

Given Japan's rapidly aging population, the Ministry of Health, Labour and Welfare's policy of reducing hospital beds and replacing medical care with nursing care requires the establishment of a coordinated system of medical and care services tailored to regional characteristics. To gain useful knowledge for the development of such a system, this study aimed to identify

differences in the structure of the relationship between medical and care resources due to differences in regional characteristics.

► **Health and Health System Effects on Poverty: A Narrative Review of Global Evidence**

O'DONNELL O.
2024

Health Policy 142: 105018.

<https://doi.org/10.1016/j.healthpol.2024.105018>

Ill-health causes poverty. The effect runs through multiple mechanisms that span lifetimes and cross generations. Health systems can reduce poverty by improving health and weakening links from ill-health to poverty. This paper maps routes through which ill-health can cause poverty and identifies those that are potentially amenable to health policy. The review confirms that ill-health is an important contributor to poverty and it finds that the effect through health-related loss of earnings is often larger than that through medical expenses. Both effects are smaller in countries that are closer to universal health coverage and have higher social safety nets. The paper also reviews evidence from low- and middle-income countries (LMICs) and the United States (US) on the poverty-reduction effectiveness of public health insurance (PubHI) for low-income households. This reveals that PubHI does not always deliver financial protection to its targeted population in LMICs. Countries that have succeeded in achieving this goal often combine extension of coverage with supply-side interventions to build capacity

and avoid perverse provider incentives in response to insurance. In the US, PubHI is effective in reducing poverty by shielding low-income households with children from healthcare costs and, consequently, generating long-run improvements in health that increase lifetime earnings. Poverty reduction is a potentially important co-benefit of health systems.

► **De la démocratie en santé à l'innovation sociale. Les apports potentiels du codesign pour une coproduction des services publics de santé**

YATIM F. ET SEBAI J.
2023

Politiques & management public 40(4): 445-469.

<https://www.cairn.info/revue-politiques-et-management-public-2023-4-page-445.htm>

La recherche présentée dans cet article traite de la participation des usagers au sein du système de santé, en mobilisant les résultats d'une enquête qualitative menée dans les hôpitaux. Les analyses menées mettent en évidence une variété de formes de participation et des démarches de coproduction menées dans les établissements en collaboration avec les usagers, dépassant parfois les obligations réglementaires en matière de respect des droits individuels et collectifs. Toutefois, ces analyses montrent également que ces démarches restent fortement localisées selon des contextes propres aux établissements. Aussi il existe un enjeu pour dépasser les contextes locaux et aboutir au développement de démarches d'innovation sociale notamment en mobilisant le codesign.

Travail et santé

Occupational Health

► **Expérience et intensité du télétravail : quels liens avec le bien-être après une année de crise sanitaire en France ?**

REBOUL E., PAILHÉ A. ET COUNIL É.
2024

Population Prépublication(0): 523-556.

<https://www.cairn.info/revue-population-2024-0-page-523.htm>

Mobilisé massivement pendant la pandémie de Covid-19, le télétravail est désormais une forme installée d'organisation du travail; or ses effets sur le bien-être des travailleurs et travailleuses restent ambivalents et débattus. S'appuyant sur une enquête longitudinale représentative de la population française (EpiCov), cet article retrace, au moyen d'une analyse de séquences, les trajectoires d'activité de près de 40 000 actifs occupés et, en particulier, l'usage du télétra-

vail pendant la première année de crise sanitaire en France. Il examine ensuite, au moyen de régressions, ses répercussions sur l'articulation vie personnelle/vie professionnelle et la santé mentale dans une période d'accalmie (été 2021) permettant de se rapprocher des conditions de travail habituelles. Dans ce contexte, le télétravail apparaît comme un vecteur fort d'amélioration de l'articulation entre vie personnelle et vie professionnelle, et ce d'autant plus que le nombre de jours télétravaillés est élevé. Ce bénéfice est plus marqué pour les femmes et les parents, et indépendant de l'expérience du télétravail pré-pandémie. Le télétravail ne semble pas, en moyenne, affecter la dépression et les troubles anxieux.

► **Why Do Physicians Go to Work when They Are Sick? Presenteeism at Different Career Stages**

URBANO GONZALO O., MARCO GÓMEZ B., PÉREZ ÁLVAREZ C., *et al.*

2024

Journal of Healthcare Quality Research 39(2): 100-108.

<https://doi.org/10.1016/j.jhqr.2024.01.004>

Introduction and Objective Physicians find it difficult to take on the role of the patient and they show unusual behaviors when ill. One of these behaviors is presenteeism, which is working while sick. The objective of

this research is to analyze the factors that contribute to the phenomenon of presenteeism in Spanish physicians. Material and methods Mixed methodology study: one national survey through the General Council of Medical Associations website (quantitative part), 22 semistructured interviews with sick residents and practicing physicians, and three focus groups involving professionals from the occupational health services (qualitative). A bivariate analysis using parametric and non-parametric tests. The significance level was $p < 0.05$ (95% confidence interval). Qualitative analysis using the comparative-constant method until saturation of information. Results Presenteeism is reported by 89.4% of doctors who responded to the survey, and it is more common among women. Contributing factors include fear of overburdening colleagues (the main reason and more common among women 58.14% vs 48.35%), self-perception of doing one's duty (the second reason and more common among men, 44.63% vs 33.14%) and economic impact and difficulty in accepting the role of a sick person. This behavior has an impact on patient safety, and is part of the hidden curriculum that also affects the training of medical professionals. Conclusions Presenteeism is a widespread and accepted practice among medical professionals. Although normalized, and even appreciated as a way to avoid overburdening colleagues, presenteeism has important implications for clinical ethics and patient safety.

Vieillessement

Aging

► **La vulnérabilité, limite à l'autonomie juridique du patient ?**

BIOY X.

2023

Droit, Santé et Société 2(2): 9-18.

<https://www.cairn.info/revue-droit-sante-et-societe-2023-2-page-9.htm>

Les liens entre autonomie et vulnérabilité, dans le contexte de la santé et du droit, sont complexes car la protection des patients peut être temporaire ou institutionnalisée pour une longue période, mais aussi parfois les deux. D'une part, la notion de vulnérabilité prévient

la perte d'autonomie (en marge de la protection civile), non pour établir le manque d'autonomie mais pour l'éviter; d'autre part, la notion de vulnérabilité corrige les effets excessifs des régimes de protection en les affinant et en affirmant leur subsidiarité.

► **30 ans d'inégalités de retraite entre les femmes et les hommes en France**

BONNET C. ET TRÉGUIER J.

2023

Retraite et société 91(2): 153-168.

<https://www.cairn.info/revue-retraite-et-societe-2023-2-page-153.htm>

Ces varia de Retraite et société réunissent comme à l'accoutumé des articles venus d'horizons différents : France, Québec, Portugal, étude comparative entre pays européens, et même Japon. L'ouvrage offre un focus, à travers une revue de littérature francophone, sur la notion d'empowerment afin de mieux saisir la diversité de ses usages et emprunts dans le champ de la vieillesse. Il questionne également les liens entre différentes morphologies spatiales de familles montréalaises et les proximités relationnelles et affectives. En s'appuyant sur les données de l'enquête Share (Survey on Health, Ageing and Retirement in Europe), réalisée de 2004 à 2017, il propose ensuite une analyse comparative entre les configurations familiales des natifs et des non-natifs âgés de plus de 50 ans résidant dans certains pays européens. Ce numéro évoque aussi l'organisation sociale du care au Portugal, notamment en partant de sa forte présence dans le débat public et de son rapport avec le vieillissement. La rubrique informative traite de trois sujets majeurs : le premier a trait au phénomène de Kodokushi (la mort en solitude), assez méconnu en Europe et véritable préoccupation au Japon où la mort (comme la vie) de certains individus, souvent âgés, semble devenue invisible; les deux autres portent sur la retraite : bilan des débats des décennies précédentes, notamment autour des réformes successives, et inégalités de retraite de ces 30 dernières années (toujours persistantes) entre les femmes et les hommes.

► **Nursing Homes Increasingly Rely on Staffing Agencies For Direct Care Nursing**

BOWBLIS J. R., BRUNT C. S., XU H., *et al.*

2024

Health Affairs 43 (3): 327-335

<https://doi.org/10.1377/hlthaff.2023.01101>

When nursing homes experience a shortage in directly employed nursing staff, they may rely on temporary workers from staffing agencies to fill this gap. This article examines trends in the use of staffing agencies among nursing homes during the prepandemic

and COVID-19 pandemic era (2018-2022). In 2018, 23 percent of nursing homes used agency nursing staff, accounting for about 3 percent of all direct care nursing hours worked. When used, agency staff were commonly present for ninety or fewer days in a year. By 2022, almost half of all nursing homes used agency staff, accounting for 11 percent of all direct care nursing staff hours. Agency staff were increasingly used to address chronic staffing shortages, with 13.8 percent of nursing homes having agency staff present every day. Agency staff were 50?60 percent more expensive per hour than directly employed nursing staff, and nursing homes that used agency staff often had lower five-star ratings. Policy makers need to consider post-pandemic changes to the nursing home workforce as part of nursing home reform, as increased reliance on agency staff may reduce the financial resources available to increase nursing staff levels and improve the quality of care.

► **Comment et avec qui vivent les migrants âgés en Europe ?**

CARELLA M. ET ZANASI F.

2023

Retraite et société 91(2): 65-96.

<https://www.cairn.info/revue-retraite-et-societe-2023-2-page-65.htm>

Dans les sociétés occidentales, la part de la population âgée née à l'étranger connaît une augmentation. Malgré cette tendance, les conditions de vie des migrants âgés restent un sujet de recherche rarement abordé. En se fondant sur les données de l'enquête sur la santé, le vieillissement et la retraite en Europe (SHARE) de 2004 à 2017, notre étude propose une analyse comparative entre les configurations familiales des natifs et des non-natifs âgés de 50 ans et plus (personnes vivant seules, avec un conjoint, au sein d'une famille avec enfants ou d'un ménage complexe) résidant dans certains pays européens sélectionnés (Allemagne, Autriche, Danemark, Italie, Espagne, Grèce, Suède). L'importance de notre analyse réside dans la tentative d'explorer dans quelle mesure les migrants âgés peuvent compter sur un réseau familial capable de leur apporter un soutien dans un moment de vie potentiellement fragile. Les résultats montrent que les pays de destination autant que les pays d'origine des migrants peuvent exercer une influence sur les configurations familiales. De manière générale, les personnes âgées nées à l'étranger ont tendance à adopter les formes familiales typiques du pays d'ac-

cueil. La cohabitation avec des enfants est plus répandue en Europe du Sud, tandis que le fait de vivre seul ou uniquement avec un partenaire est plus fréquent en Europe du Nord. Néanmoins, on constate des différences lorsqu'on observe les ménages composés de trois générations. Les familles multigénérationnelles sont plus fréquentes en Europe du Sud parmi les personnes nées à l'étranger et, en particulier, parmi celles qui ont émigré après l'âge de 40 ans. Lorsqu'on observe cette structure à travers le prisme du pays d'origine, les migrants intra-européens sont plus susceptibles de vivre uniquement avec un partenaire, tandis que ceux issus d'autres continents (par exemple, l'Afrique et l'Asie) résident plus souvent avec des enfants ou au sein de ménages composés de trois générations.

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

GAUTUN H. ET BRATT C.

2024

Social Science & Medicine 346: 116722.

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

As the population ages, younger generations will increasingly be called upon to provide informal care to their aging parents. To prepare for this development, it is essential to understand how employees combine the dual responsibilities of work and caring for aging parents. By analyzing data collected in Norway in 2022 from a nationally representative sample of 6049 respondents, aged 35 to 67, we investigated how caring for older parents affects labor market participation and work absence. We provide descriptive statistics and conduct analyses with structural equation modeling. These analyses indicated that caregiving had no substantial impact on overall participation in the workforce. However, employees did use work absences to assist their parents. We differentiate between using holidays, compensatory time, and three types of formal leave: paid, unpaid, and sick leave. More than a third of the formal leave was taken as sick leave. Women were moderately more likely to use work absence to care for their parents. We conclude that caregiving for older parents currently has little effect on work participation in Norway and attribute the favorable situation in Norway to its comprehensive public elderly care system. However, a contributing factor is Norway's generous sick leave policy. Although intended for use when employees are sick themselves, sick leave is used by employees to provide care to aging parents. Sick

leave seems to act as a safety valve. To mitigate the effects of informal care on work participation, welfare states may create conditions that allow employees to combine work and informal care without resorting to unauthorized sick leave. A solution could be to extend the existing support scheme for employees with young children to those providing care for their aging parents.

► **The Consequences of Unmet Needs For Assistance with Daily Life Activities Among Older Adults: A Systematic Review**

HUANG J., QIAN X., CHOI E. P. H., *et al.*

2024

Medical Care Research and Review 0(0): 10775587241233798.

<https://doi.org/10.1177/10775587241233798>

Many older adults are experiencing unmet needs for assistance with the activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Such unmet needs might threaten their physical and psychosocial well-being. We conducted a systematic review to provide a comprehensive picture of the health consequences of unmet ADL/IADL needs among older adults. Twenty-eight published articles were included for qualitative synthesis. We found that unmet ADL/IADL needs were consistently associated with higher health care utilization (e.g., hospitalization, medical spending) and adverse psychosocial consequences (e.g., anxiety, depression), while the findings of falls and mortality remain inconsistent. More studies are needed to draw firm conclusions and to allow for quantitative synthesis. This review advocates for more coordinated and comprehensive long-term care services for older adults. Future studies should explore how the adverse health outcomes identified in this review can be prevented or improved by adequately meeting older adults' needs for assistance.

► **Understanding Policy Amenable Risk Factors: Alcohol Consumption and Long-Term Care Use Among People over 65 Years Old**

MALISAUSKAITE G., NIZALOVA O., GOUSIA K., *et al.*

2024

Social Science & Medicine 347 : 116746.

<https://doi.org/10.1016/j.socscimed.2024.116746>

Objectives This study aims to explore the effect of past alcohol consumption frequency on formal and infor-

mal long-term care (LTC) use in old age and explore the different channels through which it may affect LTC use. Motivation The existing literature has mainly focused on risk factors associated with a nursing home entry, but this evidence is outdated, not UK-focused, and does not look into other types of care, such as informal care. The results of this study will help in modelling the future demand for various types of care and the corresponding public spending. Methods We use the English Longitudinal Study of Ageing (ELSA) (2002–2017) dataset to conduct longitudinal, individual-level analysis. We explore how the previous frequency of alcohol consumption affects formal and informal care use. We focus on people aged 65 and over with no previous LTC use and run regressions with and without instrumental variables (IV) to estimate how alcohol consumption patterns in the previous wave (2 years before) affect formal and informal care use. For IV regressions, we use the polygenic score for alcohol use, available for a subsample of ELSA respondents, as an instrument while also accounting for sociodemographic characteristics, lifestyle choices, and health conditions. Results The main IV estimates suggest that frequent alcohol consumption has a weakly significant positive effect on the onset of formal LTC care use compared to none/rare drinking. This relationship diminishes and is not statistically significant when we directly control for health status. We find no statistically significant effect towards informal LTC use. These results contrast with the estimates without IV, which suggest that frequent alcohol consumption is negatively associated with informal care use and no or weakly negative association with formal care use. Discussion Our findings suggest that unobserved confounding is important when studying the relationship between alcohol consumption and LTC. We hypothesise that primarily alcohol effects LTC through its adverse effect on health. In addition, unobserved factors like preferences towards seeking care, social behaviour may be related to alcohol consumption and affect access to care. We speculate alcohol may have a damaging effect on personal relationships and could indicate the burden eventually falling on formal care. In as far as the polygenic score IV can account for unobserved preference-behaviour differences, the results (weakly) support the hypothesis that these latter processes are relevant, especially for informal care use.

► Tracking Long-Term Services and Supports Rebalancing Through Workforce Data

NE'EMAN A.

2024

[Health Services Research n/a\(n/a\).](#)

<https://doi.org/10.1111/1475-6773.14293>

Abstract Objective To understand trends in the long-term services and supports (LTSS) workforce and assess workforce data as a measure of progress in shifting LTSS resources from institutional to community-based settings. **Data Sources/Study Setting** Workforce data from the American Community Survey from 2008 to 2022. **Study Design** Measures of LTSS rebalancing and institutional and community workforce supply per 1000 persons with LTSS needs were constructed. After showing national trends over the study period, state fixed effects regressions were used to evaluate the within-state relationship of these measures with existing measures of LTSS utilization. Workforce supply measures were compared to the percentage of state Medicaid LTSS spending spent in the community to assess their utility for across state comparisons. Each state's progress in LTSS rebalancing over the study period was then shown using workforce data. **Data Collection/Extraction Methods** A sample of 336,316 LTSS workers and 3,015,284 people with LTSS needs over the study period was derived from American Community Survey data. **Principal Findings** From 2008 to 2022, the percentage of the LTSS workforce employed in the community rose from 44% to 58%. Thirty states saw more than a 10 percentage point increase. From 2008 to 2013, the size of the community workforce expanded dramatically but has since stagnated. In contrast, the institutional workforce entered a long-term decline beginning in 2015 that accelerated during the COVID-19 pandemic. State fixed effects regressions showed that measures of workforce supply have a strong relationship with LTSS utilization measures for older adults, but not for younger people with disabilities. **Conclusions** Workforce data can serve as an effective measure of changes in LTSS utilization for older adults. This offers researchers and policymakers a useful alternative to administrative claims, bypassing threats to comparability from coding changes and the shift to managed care. Additional data is needed on workforce trends in services for younger LTSS consumers.

► **Self-Identified Barriers to Health Services Among Migrants 50 Years of Age or Older: Population-Based Survey Study of Russian Speakers in Finland**

SAFAROV N., KEMPPAINEN L., WREDE S., *et al.*

2024

BMC Health Services Research 24(1): 252.

<https://doi.org/10.1186/s12913-024-10728-3>

The compounded effect of a migratory background and ageing increases the risk of unequal medical treatment opportunities. The aim of this article is to investigate the social determinants of barriers to health services.

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