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

Veille scientifique
en économie de la santé

Watch on Health Economics Literature

Juin 2024 / June 2024

Assurance maladie	*Health Insurance*
E-santé – Technologies médicales	*E-Health – Medical Technologies*
Économie de la santé	*Health Economics*
Environnement et santé	*Environnemental Health*
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Handicap	*Disability*
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Travail et santé	*Occupational Health*
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Veille scientifique en économie de la santé / **Watch on Health Economics Literature**

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Health Insurance

Impact of the Affordable Care Act on Access to Accredited Facilities for Cancer Treatment

SABIK L. M., KWON Y., DRAKE C., *et al.*

2024

Health Services Research.

https://doi.org/10.1111/1475-6773.14315

Abstract Objective To examine differential changes in receipt of surgery at National Cancer Institute (NCI)-designated comprehensive cancer centers (NCI-CCC) and Commission on Cancer (CoC) accredited hospitals for patients with cancer more likely to be newly eligible for coverage under Affordable Care Act (ACA) insurance expansions, relative to those less likely to have been impacted by the ACA. Data Sources and Study Setting Pennsylvania Cancer Registry (PCR) for 2010–2019 linked with discharge records from the Pennsylvania Health Care Cost Containment Council (PHC4). Study Design Outcomes include whether cancer surgery was performed at an NCI-CCC or a CoC-accredited hospital. We conducted a difference-in-differences analysis, estimating linear probability models for each outcome that control for residence in a county with above median county-level pre-ACA uninsurance and the interaction between county-level baseline uninsurance and cancer treatment post-ACA to capture differential changes in access between those more and less likely to become newly eligible for insurance coverage (based on area-level proxy). All models control for age, sex, race and ethnicity, cancer site and stage, census-tract level urban/rural residence, Area Deprivation Index, and year- and county-fixed effects. Data Collection/Extraction Methods We identified adults aged 26–64 in PCR with prostate, lung, or colorectal cancer who received cancer-directed surgery and had a corresponding surgery discharge record in PHC4. Principal Findings We observe a differential increase in receiving care at an NCI-CCC of 6.2 percentage points (95% CI: 2.6–9.8; baseline mean = 9.8%) among patients in high baseline uninsurance areas (p = 0.001). Our estimate of the differential change in care at the larger set of CoC hospitals is positive (3.9 percentage points [95% CI: –0.5-8.2; baseline mean = 73.7%]) but not statistically significant (p = 0.079). Conclusions Our findings suggest that insurance expansions under the ACA were associated with increased access to NCI-CCCs.

Scope and Incentives for Risk Selection in Health Insurance Markets with Regulated Competition: A Conceptual Framework and International Comparison

VAN KLEEF R. C., REUSER M., MCGUIRE T. G., *et al.*

2024

Medical Care Research and Review 81(3): 175–194.

https://doi.org/10.1177/10775587231222584

In health insurance markets with regulated competition, regulators face the challenge of preventing risk selection. This paper provides a framework for analyzing the scope (i.e., potential actions by insurers and consumers) and incentives for risk selection in such markets. Our approach consists of three steps. First, we describe four types of risk selection: (a) selection by consumers in and out of the market, (b) selection by consumers between high- and low-value plans, (c) selection by insurers via plan design, and (d) selection by insurers via other channels such as marketing, customer service, and supplementary insurance. In a second step, we develop a conceptual framework of how regulation and features of health insurance markets affect the scope and incentives for risk selection along these four dimensions. In a third step, we use this framework to compare nine health insurance markets with regulated competition in Australia, Europe, Israel, and the United States.

E-santé – Technologies médicales

E-Health – Medical Technologies

Efficiency and Productivity Gains of Robotic Surgery: The Case of the English National Health Service

MAYNOU L., MCGUIRE A. ET SERRA-SASTRE V.

2024

Health Economics 1-26

https://doi.org/10.1002/hec.4838

Abstract This paper examines the effect of new medical technology (robotic surgery) on efficiency gains and productivity changes for surgical treatment in patients with prostate cancer from the perspective of a public health sector organization. In particular, we consider three interrelated surgical technologies within the English National Health System: robotic, laparoscopic and open radical prostatectomy. Robotic and laparoscopic techniques are minimally invasive procedures with similar clinical benefits. While the clinical benefits in adopting robotic surgery over laparoscopic intervention are unproven, it requires a high initial investment cost and carries high on-going maintenance costs. Using data from Hospital Episode Statistics for the period 2000–2018, we observe growing volumes of prostatectomies over time, mostly driven by an increase in robotic-assisted surgeries, and further analyze whether hospital providers that adopted a robot see improved measures of throughput. We then quantify changes in total factor and labor productivity arising from the use of this technology. We examine the impact of robotic adoption on efficiency gains employing a staggered difference-in-difference estimator and find evidence of a 50% reduction in length of stay (LoS), 49% decrease in post-LoS and 44% and 46% decrease in postoperative visits after 1 year and 2 years, respectively. Productivity analysis shows the growth in radical prostatectomy volume is sustained with a relatively stable number of urology surgeons. The robotic technique increases total production at the hospital level between 21% and 26%, coupled with a 29% improvement in labor productivity. These benefits lend some, but not overwhelming support for the large-scale hospital investments in such costly technology.

The Impact of Telemedicine on Medicare Utilization, Spending, and Quality, 2019–22

NAKAMOTO C. H., CUTLER D. M., BEAULIEU N. D., *et al.*

2024

Health Affairs 43(5): 691-700.

https://doi.org/10.1377/hlthaff.2023.01142

Telemedicine use remains substantially higher than it was before the COVID-19 pandemic, although it has fallen from pandemic highs. To inform the ongoing debate about whether to continue payment for telemedicine visits, we estimated the association of greater telemedicine use across health systems with utilization, spending, and quality. In 2020, Medicare patients receiving care at health systems in the highest quartile of telemedicine use had 2.5 telemedicine visits per person (26.8 percent of visits) compared with 0.7 telemedicine visits per person (9.5 percent of visits) in the lowest quartile of telemedicine use. In 2021–22, relative to those in the lowest quartile, Medicare patients of health systems in the highest quartile had an increase of 0.21 total outpatient visits (telemedicine and in-person) per patient per year (2.2 percent relative increase), a decrease of 14.4 annual non-COVID-19 emergency department visits per 1,000 patients per year (2.7 percent relative decrease), a $248 increase in per patient per year spending (1.6 percent relative increase), and increased adherence for metformin and statins. There were no clear differential changes in hospitalizations or receipt of preventive care.

Digitally Mediated Relationships: How Social Representation in Technology Influences the Therapeutic Relationship in Primary Care

STEELE GRAY C., RAMACHANDRAN M., BRINTON C., *et al.*

2024

Social Science & Medicine: 116962.

https://doi.org/10.1016/j.socscimed.2024.116962

Relationships, built on trust, knowledge, regard, and loyalty, have been demonstrated to be fundamental to health care delivery. Strong relationships

between patients and providers have been linked to more compassionate care delivery, and better patient experience and outcomes, and may be particularly important in primary care models. The rapid adoption of digital technologies since the onset of COVID-19 has led health care systems to seriously consider a "digital-first" primary care delivery model. Questions remain regarding what impact this transformation will have on the therapeutic relationship. Using a rapid ethnographic approach this study explores how patient and provider understandings of therapeutic relationships and digital health technologies may influence relationship-building or maintenance between patients with complex care needs and their care providers. Three team-based primary care sites in Toronto, Ontario, Canada were included in the study. Across the three sites 9 patients with chronic health conditions, 1 caregiver, and 10 healthcare providers (including family physicians, family medicine residents, social workers, and nurse practitioners) participated. Interviews were conducted with all participants and 8 observations of virtual clinical encounters (phone and video visits) were conducted. Using social representation theory as a lens, analysis revealed that participants' constructions of therapeutic relationships and digital technologies were informed by their identities, experiences, and expectations. For participants to see technologies as enabling to the therapeutic relationship, there needed to be alignment between how participants viewed the role of technology in care and in their lives, and how they recognized (or constructed) a good therapeutic relationship. This exploratory work suggests the need to think about how both patients' and providers' views of technology may determine whether digital technologies can be leveraged to meet patient needs while maintaining, or building, strong therapeutic relationships.

Économie de la santé

Health Economics

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

FUMAGALLI E., PINNA PINTOR M. 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.

▶ Medicare Advantage Health Risk Assessments Contribute up to $12 Billion Per Year to Risk-Adjusted Payments

JAMES H.O., DANA B.H., *et al.*
2024
Health Affairs 43(5): 614-622.
https://doi.org/10.1377/hlthaff.2023.00787

With Medicare Advantage (MA) enrollment surpassing 50 percent of Medicare beneficiaries, accurate risk-adjusted plan payment rates are essential. However, artificially exaggerated coding intensity, where plans seek

to enhance measured health risk through the addition or inflation of diagnoses, may threaten payment rate integrity. One factor that may play a role in escalating coding intensity is health risk assessments (HRAs)—typically in-home reviews of enrollees' health status—that enable plans to capture information about their enrollees. In this study, we evaluated the impact of HRAs on Hierarchical Condition Categories (HCC) risk scores, variation in this impact across contracts, and the aggregate payment impact of HRAs, using 2019 MA encounter data. We found that 44.4 percent of MA beneficiaries had at least one HRA. Among those with at least one HRA, HCC scores increased by 12.8 percent, on average, as a result of HRAs. More than one in five enrollees had at least one additional HRA-captured diagnosis, which raised their HCC score. Potential scenarios restricting the risk-score impact of HRAs correspond with $4.5–$12.3 billion in reduced Medicare spending in 2020. Addressing increased coding intensity due to HRAs will improve the value of Medicare spending and ensure appropriate payment in the MA program.

▶ Evaluating the Influence of Taxation and Social Security Policies on Psychological Distress: A Microsimulation Study of the UK During the COVID-19 Economic Crisis

KOPASKER D., BRONKA P., THOMSON R. M., *et al.*

2024

Social Science & Medicine: 351 :116953.

https://doi.org/10.1016/j.socscimed.2024.116953

Economic determinants are important for population health, but actionable evidence of how policies can utilise these pathways remains scarce. This study employs a microsimulation framework to evaluate the effects of taxation and social security policies on population mental health. The UK economic crisis caused by the COVID-19 pandemic provides an informative context involving an economic shock accompanied by one of the strongest discretionary fiscal responses amongst OECD countries. The analytical setup involves a dynamic, stochastic, discrete-time microsimulation model (SimPaths) projecting changes in psychological distress given predicted economic outcomes from a static tax-benefit microsimulation model (UKMOD) based on different policy scenarios. We contrast projections of psychological distress for the working-age population from 2017 to 2025 given the observed policy environment against a counterfactual scenario where pre-crisis policies remained in place. Levels of psychological distress and potential cases of common mental disorders (CMDs) were assessed with the 12-item General Health Questionnaire (GHQ-12). The UK policy response to the economic crisis is estimated to have prevented a substantial fall (over 12 percentage points,%pt) in the employment rate in 2020 and 2021. In 2020, projected psychological distress increased substantially (CMD prevalence increase >10%pt) under both the observed and the counterfactual policy scenarios. Through economic pathways, the policy response is estimated to have prevented a further 3.4%pt [95%UI 2.8%pt, 4.0%pt] increase in the prevalence of CMDs, approximately 1.2 million cases. Beyond 2021, as employment levels rapidly recovered, psychological distress returned to the pre-pandemic trend. Sustained preventative effects on poverty are estimated, with projected levels 2.1%pt [95%UI 1.8%pt, 2.5%pt] lower in 2025 than in the absence of the observed policy response. The study shows that policies protecting employment during an economic crisis are effective in preventing short-term mental health losses and have lasting effects on poverty levels. This preventative effect has substantial public health benefits.

▶ La régulation des dépassements d'honoraires : un exercice impossible ?

MARIE R.

2024

Revue de droit sanitaire et social 2024(2): 193-201.

Cet article s'intéresse à la régulation des dépassements d'honoraire et à ses évolutions. La désaffection croissante pour le secteur 1 des nouveaux entrants dans certaines spécialités médicales invite aujourd'hui de faire un état des lieux de la situation afin d'envisager quelles pourraient être les pistes d'évolutions (remise à niveau de la CCAM et modifications des conditions d'accès au secteur 2).

▶ 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 81(3): 223–232.

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.

Local Government Spending and Mental Health: Untangling the Impacts Using a Dynamic Modelling Approach

MELIANOVA E., MORRIS T. T., LECKIE G., *et al.*

2024

Social Science & Medicine 348: 116844.

https://doi.org/10.1016/j.socscimed.2024.116844

This study investigated the impact of local government spending on mental health in England between 2013 and 2019. Guided by the "Health in All Policies" vision, which encourages the integration of health in all decision-making areas, we explored how healthcare and multiple nonmedical budgeting decisions related to population mental health. We used random curve general cross-lagged modelling to dynamically partition effects into the short-run (from t to t + 1) and long-run (from t to t + 2) impacts, account for unobserved area-level heterogeneity and reverse causality from health outcomes to financial investments, and comprehensive modelling of budget items as an interconnected system. Our findings revealed that spending in adult social care, healthcare, and law & order predicted long-term mental health gains (0.004–0.081 SDs increase for each additional 10% in expenditure). However, these sectors exhibited negative short-term impulses (0.012–0.077 SDs decrease for each additional 10% in expenditure), markedly offsetting the long-term gains. In turn, infrastructural and environmental spending related to short-run mental health gains (0.005–0.031 SDs increase for each additional 10% in expenditure), while the long-run effects were predominantly negative (0.005–0.028 SDs decrease for each additional 10% in expenditure). The frequent occurrence of short-run and long-run negative links suggested that government resources may not be effectively reaching the areas that are most in need. In the short-term, negative effects could also imply temporary disruptions to service delivery largely uncompensated by later mental health improvements. Nonetheless, some non-health spending policies, such as law & order and infrastructure, can be related to long-lasting positive mental health impacts.

Analysing Changes to the Flow of Public Funding Within Local Health and Care Systems: An Adaptation of the System of Health Accounts Framework to a Local Health System in England

MOSS C., ANSELMI L., MORCIANO M., *et al.*

2023

Health Policy 137: 104904.

https://doi.org/10.1016/j.healthpol.2023.104904

Financial flows relating to health care are routinely analysed at national and international level. They have rarely been systematically analysed at local level, despite sub-national variation due to population needs and decisions enacted by local organisations. We illustrate an adaptation of the System of Health Accounts framework to map the flow of public health and care funding within local systems, with an application for Greater Manchester (GM), an area in England which agreed a health and social care devolution deal with the central government in 2016. We analyse how financial flows changed in GM during the four years post-devolution, and whether spending was aligned with local ambitions to move towards prevention of ill-health and integration of health and social care. We find that GM decreased spending on public health by 15%, and increased spending on general practice by 0.1% in real terms. The share of total local expenditure paid to NHS Trusts for general and acute services increased from 70.3% to 71.6%, while that for community services decreased from 11.7% to 10.3%. Results suggest that GM may have experienced challenges in redirecting resources towards their goals. Mapping financial flows at a local level is a useful exercise to examine whether spending is aligned with system goals and highlight areas for further investigation.

Economic Evaluations of Obesity-Targeted Sugar-Sweetened Beverage (SSB) Taxes – A Review to Identify Methodological Issues

THIBOONBOON K., LOURENCO R. D. A., CRONIN P., *et al.*

2024

Health Policy: 144 :105076.
https://doi.org/10.1016/j.healthpol.2024.105076

Introduction Economic evaluations of public health interventions like sugar-sweetened beverage (SSB) taxes face difficulties similar to those previously identified in other public health areas. This stems from challenges in accurately attributing effects, capturing outcomes and costs beyond health, and integrating equity effects. This review examines how these challenges were addressed in economic evaluations of SSB taxes. Methods A systematic review was conducted to identify economic evaluations of SSB taxes focused on addressing obesity in adults, published up to February 2021. The methodological challenges examined include measuring effects, valuing outcomes, assessing costs, and incorporating equity. Results Fourteen economic evaluations of SSB taxes were identified. Across these evaluations, estimating SSB tax effects was uncertain due to a reliance on indirect evidence that was less robust than evidence from randomised controlled trials. Health outcomes, like quality-adjusted life years, along with a healthcare system perspective for costs, dominated the evaluations of SSB taxes, with a limited focus on broader non-health consequences. Equity analyses were common but employed significantly different approaches and exhibited varying degrees of quality. Conclusion Addressing the methodological challenges remains an issue for economic evaluations of public health interventions like SSB taxes, suggesting the need for increased attention on those issues in future studies. Dedicated methodological guidelines, in particular addressing the measurement of effect and incorporation of equity impacts, are warranted.

Environnement et santé
Environnemental Health

Quelles priorités en santé-environnement ? Classement par coûts socio-économiques des déterminants de santé-environnement comme outil d'aide à la décision

RAPHAËL K., CYRILLE H. ET LAURIE M.

2024

Environnement, Risques & Santé 23(2): 99-108.
https://10.1684/ers.2024.1793

Contexte :Le système de santé a engagé sa transition écologique suivant un impératif de réduction des émissions de gaz à effet de serre et d'efficience face aux défis du changement climatique. Par ailleurs, on estime que plus de 70 % des pathologies non transmissibles seraient dues à des déterminants environnementaux de la santé. L'hypothèse est posée qu'en agissant de façon préventive et promotrice en santé sur ces déterminants, il est possible de réduire le poids des pathologies liées à l'environnement sur le système de santé, et donc d'appuyer sa résilience. Objectifs : La présente recherche a pour objectif de classer les risques sanitaires liés à l'environnement sous le prisme de déterminants de santé-environnement et de les hiérarchiser en fonction de leurs coûts socio-économiques, dans un but d'appui à la transition et d'aide à la décision. Méthodes : La méthode de l'étude de portée (scoping review) a été utilisée pour définir le périmètre de la santé-environnement et les déterminants que recoupe ce champ. Une fois les bases de données pertinentes sélectionnées, les données relatives aux impacts sanitaires et environnementaux de ces déterminants ont été réunies dans un tableau de synthèse. La traduction socio-économique uniformisée de ces impacts a permis de hiérarchiser ces déterminants. Résultats Les déterminants de santé-environnement pesant le plus sur la société sont le bruit (147 Md€/an), la qualité de l'air extérieur (130 Md€/an) et la nutrition et l'activité physique (surpoids/obésité : 20,4 Md€/an ; inactivité physique/ sédentarité : 140 Md€/an). De surcroît, d'autres enjeux environnementaux, qui seront ici moins détaillés et utilisant d'autres indicateurs d'expositions et de mortalités, sont à considérer : les inondations continentales comme premier risque naturel en termes d'exposition et de dommages matériels ; les épisodes de grand froid et les vagues de chaleur / canicules comme les événements climatiques extrêmes les plus meurtriers.

État de santé

Health Status

Santé des soignants : État des lieux et leviers d'actions

CORNIBERT C., DENORMANDIE P. ET GUIDET B.

2024

Revue hospitalière de France: (617) : 26-29.

Plusieurs enquêtes récentes de grande envergure dressent un bilan inquiétant de la santé des professionnels de santé dans un contexte de post- crise sanitaire. Trois experts partagent leurs constats et recommandations, en insistant sur l'urgence d'agir ensemble, à la fois de façon systémique, politique et sociale.

The Hidden Toll of the Pandemic: Excess Mortality in Non-COVID-19 Hospital Patients

FETZER T., RAUH C. ET SCHREINER C.

2024

Journal of Health Economics: 95 :102882.

https://doi.org/10.1016/j.jhealeco.2024.102882

Seasonal infectious diseases can cause demand and supply pressures that reduce the ability of healthcare systems to provide high-quality care. This may generate negative spillover effects on the health outcomes of patients seeking medical help for unrelated reasons. Separating these indirect burdens from the direct consequences for infected patients is usually impossible because of a lack of suitable data and an absence of population testing. However, this paper finds robust empirical evidence of excess mortality among non-COVID-19 patients in an integrated public healthcare system: the English NHS. Analysing the forecast error in the NHS' model for predicted mortality, we find at least one additional excess death among patients who sought medical help for reasons unrelated to COVID-19 for every 42 COVID-19-related deaths in the population. We identify COVID-19 pressures as a key driver of non-COVID-19 excess mortality in NHS hospitals during the pandemic, and characterise the hospital populations and medical conditions that are disproportionately affected. Our findings have substantive relevance in shaping our understanding of the wider burden of COVID-19, and other seasonal diseases more generally, and can contribute to debates on optimal public health policy.

A Happiness Approach to Valuing Health States for Children

HUANG L., DEVLIN N., CHEN G., *et al.*

2024

Social Science & Medicine 348: 116802.

https://doi.org/10.1016/j.socscimed.2024.116802

Preference weights are widely used to score generic health states into utility indexes for estimation of quality adjusted life years (QALYs) and to aid health care funding decisions. To date, health state utilities are predominantly derived using stated preference methods based on decision utility. This paper tests an alternative and generates preference weights using experienced utility for children based on the Child Health Utility 9D (CHU9D) descriptive system. We estimate the relative values of the CHU9D health states with regard to experienced utility, where experienced utility is approximated by self-reported happiness. A nationally-representative longitudinal survey was used including 6090 Australian children aged 12–17 years surveyed over 2014–2018. The derived weights were then applied to calculate the utility decrements for a few common child health conditions. We found that the estimated utility decrements are largely similar to those estimated using the published CHU9D Australian adolescent weights based on decision utility, except for pain and depression. A smaller utility decrement for pain and a larger utility decrement for depression were indicated by experienced utility. We contribute to the literature by showing that using experienced utility methods to generate preference weights for health states is possible, and we discuss some important methodological challenges for future studies such as the impracticability of anchoring to 'dead' when utilizing experienced utility.

Childhood Migration Experience and Adult Health: Evidence from China's Rural Migrants

LI X., QIAO S. ET ZHANG D.

2024

Archives of Public Health 82(1): 53.

https://doi.org/10.1186/s13690-024-01280-x

Place of residence plays an influential role in shaping

individual development, and studies have established links between Childhood migration experience (CME) and health outcomes through maturity. Over the past three decades, China has undergone one of the largest rural-to-urban migrations, however, little is known about the effect of CME on rural migrants' adult health in China.

The Impact of Housing Insecurity on Mental Health, Sleep and Hypertension: Analysis of the UK Household Longitudinal Study and Linked Data, 2009-2019

MASON K. E., ALEXIOU A., LI A., *et al.*

2024

Social Science & Medicine: 351 :116939.

https://doi.org/10.1016/j.socscimed.2024.116939

ABSTRACT Background Housing insecurity is an escalating problem in the UK but there is limited evidence about its health impacts. Using nationally representative panel data and causally focussed methods, we examined the effect of insecure housing on mental health, sleep and blood pressure, during a period of government austerity. Methods We used longitudinal survey data (2009-2019, n = 11,164 individuals with annual data) from the UK Household Longitudinal Study. Outcomes were probable common mental disorder (GHQ-12), sleep disturbance due to worry, and new diagnoses of hypertension. The primary exposure was housing payment problems in the past year. Using doubly robust marginal structural models with inverse probability of treatment weights, we estimated absolute and relative health effects of housing payment problems, and population attributable fractions. In stratified analyses we assessed potentially heterogeneous impacts across the population, and potential modifying effects of government austerity measures. A negative control analysis was conducted to detect bias due to unmeasured confounding. Results Housing payment problems were associated with a 2.5 percentage point increased risk of experiencing a common mental disorder (95% CI 1.1%, 3.8%) and 2.0% increased risk of sleep disturbance (95% CI 0.7%, 3.3%). Estimates were larger for renters, younger people, less educated, households with children, and people living in areas most affected by austerity-related cuts to housing support services. We did not find consistent evidence for an association with hypertension (risk difference = 0.4%; 95% CI -0.1%, 0.9%). The negative control analysis was not indicative of unmeasured confounding. Conclusions Housing payment problems were associated with worse mental health and sleep disturbance in a large UK sample. Households at risk of falling into rent or mortgage arrears need more support, especially in areas where housing support services have been diminished. Substantial investment is urgently needed to improve supply of social and affordable housing.

Breast Cancer Incidence, Stage Distribution, and Treatment Shifts During the 2020 COVID-19 Pandemic: A Nationwide Population-Level Study

PEACOCK H. M., VAN WALLE L., SILVERSMIT G., *et al.*

2024

Archives of Public Health 82(1): 66.

https://doi.org/10.1186/s13690-024-01296-3

The first COVID-19 wave in 2020 necessitated temporary suspension of non-essential medical services including organized cancer screening programs in Belgium. This study assessed the impact of the pandemic on breast cancer (BC) incidence, stage at diagnosis, and management in Belgium in 2020.

Géographie de la santé

Geography of Health

Effects of Residential Socioeconomic Polarization on High Blood Pressure Among Nursing Home Residents

ABDEL MAGID H. S., JAROS S., LI Y., *et al.*

2024

Health & Place 87: 103243.

https://doi.org/10.1016/j.healthplace.2024.103243

Objective Neighborhood concentration of racial, income, education, and housing deprivation is known to be associated with higher rates of hypertension. The objective of this study is to examine the association between tract-level spatial social polarization and hypertension in a cohort with relatively equal access to health care, a Veterans Affairs nursing home. Methods 41,973 long-term care residents aged ≥65 years were matched with tract-level Indices of Concentration at the Extremes across four socioeconomic domains. We modeled high blood pressure against these indices controlling for individual-level cardiovascular confounders. Results We found participants who had resided in the most disadvantaged quintile had a 1.10 (95% 1.01, 1.19) relative risk of high blood pressure compared to those in the other quintiles for the joint measuring race/ethnicity and income domain. Conclusions We achieved our objective by demonstrating that concentrated deprivation is associated with worse cardiovascular outcomes even in a population with equal access to care. Measures that jointly consider economic and racial/ethnic polarization elucidate larger disparities than single domain measures.

Neighborhood Physical Environments and Change in Cardiometabolic Risk Factors over 14 Years in the Study of Women's Health Across the Nation

APPELHANS B. M., LANGE-MAIA B. S., YEH C., *et al.*

2024

Health & Place 87: 103257.

https://doi.org/10.1016/j.healthplace.2024.103257

Background Neighborhood physical environments may influence cardiometabolic health, but prior studies have been inconsistent, and few included long follow-up periods. Methods Changes in cardiometabolic risk factors were measured for up to 14 years in 2830 midlife women in the Study of Women's Health Across the Nation, a multi-ethnic/racial cohort of women from seven U.S. sites. Data on neighborhood food retail environments (modified Retail Food Environment Index) and walkability (National Walkability Index) were obtained for each woman's residence at each follow-up. Data on neighborhood access to green space, parks, and supermarkets were available for subsets (32–42%) of women. Models tested whether rates of change in cardiometabolic outcomes differed based on neighborhood characteristics, independent of sociodemographic and health-related covariates. Results Living in more (vs. less) walkable neighborhoods was associated with favorable changes in blood pressure outcomes (SBP: –0.27 mmHg/year, $p = 0.002$; DBP: –0.22 mmHg/year, $p < 0.0001$; hypertension status: ratio of ORs = 0.79, $p < 0.0001$), and small declines in waist circumference (–0.09 cm/year, $p = 0.03$). Small-magnitude associations were also observed between low park access and greater increases in blood pressure outcomes (SBP: 0.37 mmHg/year, $p = 0.003$; DBP: 0.15 mmHg/year, $p = 0.04$; hypertension status: ratio of ORs = 1.16, $p = .04$), though associations involving DBP and hypertension were only present after adjustment for sociodemographic variables. Other associations were statistically unreliable or contrary to hypotheses. Conclusion Neighborhood walkability may have a meaningful influence on trajectories of blood pressure outcomes in women from midlife to early older adulthood, suggesting the need to better understand how individuals interact with their neighborhood environments in pursuit of cardiometabolic health.

When Everyone's Doing It: The Relative Effects of Geographical Context and Social Determinants of Health on Teen Birth Rates

BARDIN S. ET FOTHERINGHAM A. S.

2024

Health & Place 87: 103249.

https://doi.org/10.1016/j.healthplace.2024.103249

Geographic disparities in teen birth rates in the U.S. persist, despite overall reductions over the last two decades. Research suggests these disparities might be driven by spatial variations in social determinants of

health (SDOH). An alternative view is that "place" or "geographical context" affects teen birth rates so that they would remain uneven across the U.S. even if all SDOH were constant. We use multiscale geographically weighted regression (MGWR) to quantify the relative effects of geographical context, independent of SDOH, on county-level teen birth rates across the U.S. Findings indicate that even if all counties had identical compositions with respect to SDOH, strong geographic disparities in teen birth rates would still persist. Additionally, local parameter estimates show the relationships between several components of SDOH and teen birth rates vary over space in both direction and magnitude, confirming that global regression techniques commonly employed to examine these relationships likely obscure meaningful contextual differences in these relationships. Findings from this analysis suggest that reducing geographic disparities in teen birth rates will require not only ameliorating differences in SDOH across counties but also combating community norms that contribute to high rates of teen birth, particularly in the southern U.S. Further, the results suggest that if geographical context is not incorporated into models of SDOH, the effects of such determinants may be interpreted incorrectly.

▶ Urban Densification in the Netherlands and Its Impact on Mental Health: An Expert-Based Causal Loop Diagram

BEENACKERS M. A., KRUIZE H., BARSTIES L., *et al.*

2024

Health & Place 87: 103218.

https://doi.org/10.1016/j.healthplace.2024.103218

Urban densification is a key strategy to accommodate rapid urban population growth, but emerging evidence suggests serious risks of urban densification for individuals' mental health. To better understand the complex pathways from urban densification to mental health, we integrated interdisciplinary expert knowledge in a causal loop diagram via group model building techniques. Six subsystems were identified: five subsystems describing mechanisms on how changes in the urban system caused by urban densification may impact mental health, and one showing how changes in mental health may alter urban densification. The new insights can help to develop resilient, healthier cities for all.

▶ Transport Accessibility and Hospital Attributes: A Nonlinear Analysis of Their Impact on Women's Prenatal Care Seeking Behavior

JIANG H., WANG Y., CHENG Y., *et al.*

2024

Health & Place 87: 103250.

https://doi.org/10.1016/j.healthplace.2024.103250

Ensuring women receive vital prenatal care is crucial for maternal and newborn health. Limited research explores factors influencing prenatal care-seeking from a geospatial perspective. This study, based on a substantial Wuhan dataset (23,947 samples), investigates factors influencing prenatal care-seeking, focusing on transport accessibility and hospital attributes. Findings indicate a nuanced relationship: (1) A non-linear trend, resembling an inverted "U," reveals the complex interplay between transport accessibility, hospital attributes, and prenatal care visits. Hospital attributes have a more pronounced impact than transport accessibility. (2) Interaction analysis underscores that lower prenatal care visits relate to low-income and education levels, despite reasonable public transport accessibility. (3) Spatial disparities are significant, with suburban areas facing increased obstacles compared to urban areas, particularly for those in suburban rural areas. This study enhances understanding by emphasizing threshold effects and spatial heterogeneity, offering valuable perspectives for refining prenatal care policies and practices.

▶ Exploring Residential Relocation–Differences Between Newcomers and Settled Residents in Health, Travel Behaviour and Neighbourhood Perceptions

KIENAST-VON EINEM C., PANTER J., OGILVIE D., *et al.*

2024

Health & Place 87: 103254.

https://doi.org/10.1016/j.healthplace.2024.103254

This study explores whether people who have recently moved to an area differ from longer-term residents in their health, travel behaviour, and perceptions of the environment. Using a large, representative sample from the UKHLS, Newcomers demonstrate significantly lower mental and physical health, reduced car commuting, and a higher likelihood of liking their neighbourhood. Area deprivation, urbanicity, household income, and age emerge as influential moder-

ators with i.e. Newcomers in affluent areas experiencing lower physical health than Settled Residents, and rural Newcomers expressing less neighbourhood satisfaction. Our findings highlight that Newcomers' perceptions of their environment diverge and environmental influences vary among population segments, potentially impacting related health behaviours such as active travel. Furthermore, residential relocation introduces Newcomers with distinct characteristics into areas, affecting the context in which potential population health interventions aiming to influence health behaviours operate. This necessitates a deeper understanding of what influences reactions to the environment as well as ongoing adaptation of environmental interventions to respond to changing contexts within the same location over time.

Superior Medical Resources or Geographic Proximity? The Joint Effects of Regional Medical Resource Disparity, Geographic Distance, and Cultural Differences on Online Medical Consultation

LIU X. ET BEN LIU Q.

2024

Social Science & Medicine 350 : 116911.

https://doi.org/10.1016/j.socscimed.2024.116911

Online medical consultation platforms enable patients to seek health advice from physicians across geographic regions. In this study, we analyze patterns of online consultation between patients and physicians. We examine the joint effects of regional medical resource disparity, geographic distance, and cultural differences between patients and physicians on patients' decisions about which physicians they consult online. Using a unique dataset of city-to-city tuples based on 813,684 online consultation records and combining it with region-level data from multiple external sources, we find that while regional medical resource disparity drives patients from medically disadvantaged regions to seek online consultations with physicians from medically advantaged regions, geographic distance and cultural differences tend to constrain these consultations. We also find that cultural differences can amplify the impact of regional medical resource disparity, whereas geographic distance may lessen this effect. Further, we discover that the constraining effect of geographic distance is partly due to the online-to-offline nature of online medical consultations. Moreover, additional analyses suggest that physicians' online reputation and information about physicians' participation on the platform can help alleviate the negative effects of geographic distance and cultural differences. These findings hold significant implications for the allocation of medical resources and the formulation of healthcare policies.

Rurality, Healthcare and Crises: Investigating Experiences, Differences, and Changes to Medical Care for People Living in Rural Areas

MACLAREN A. S., LOCOCK L., SKEA Z., *et al.*

2024

Health & Place 87: 103217.

https://doi.org/10.1016/j.healthplace.2024.103217

Healthcare provision in rural areas is a global challenge, characterised by a dispersed patient population, difficulties in the recruitment and retention of healthcare professionals and a physical distance from hospital care. This research brings together both public and doctor perspectives to explore the experience of healthcare across rural Scotland, against the backdrop of contemporary crises, including a global pandemic and extreme weather events. We draw on two studies on rural healthcare provision to understand how healthcare services have been experienced, changed and might move on after periods of short- and longer-term change caused by such crises. We highlight the importance of communicating service changes to aid in setting healthcare expectations and advocate a mixed approach to the introduction of digital solutions to best balance access to services in rural areas with the challenges of digital connectivity and literacy.

Does Better Than Expected Life Expectancy in Areas of Disadvantage Indicate Health Resilience? Stakeholder Perspectives and Possible Explanations

MEAD R., RINALDI C., MCGILL E., *et al.*

2024

Health & Place 87: 103242.

https://doi.org/10.1016/j.healthplace.2024.103242

Some places have better than expected health trends despite being disadvantaged in other ways. Thematic analysis of qualitative data from stakeholders (N = 25) in two case studies of disadvantaged local authorities the North West and South East of England assessed explanations for the localities' apparent health resil-

ience. Participants identified ways of working that might contribute to improved life expectancy, such as partnering with third sector, targeting and outcome driven action. Stakeholders were reluctant to assume credit for better-than-expected health outcomes. External factors such as population change, national politics and finances were considered crucial. Local public health stakeholders regard their work as important but unlikely to cause place-centred health resilience.

Handicap

Disability

▶ Psychological Distress and Mental Health Diagnoses in Adults by Disability and Functional Difficulty Status: Findings from the 2021 National Health Interview Survey

KOENIG J., MCLEAN K. J. ET BISHOP L.

2024

Disability and Health Journal: 101641 [In Press]

https://doi.org/10.1016/j.dhjo.2024.101641

Background Evidence suggests that disabled people have worse mental health than non-disabled people, but the degree to which disability contributes to mental health is unclear. Objective This paper uses 2021 National Health Interview Survey (NHIS) data to estimate the association between disability and depression and anxiety diagnoses as well as psychological distress among adults. Methods We calculated disability population prevalence and mental health diagnoses and associated symptoms among 28,534 NHIS respondents. Logistic regressions estimated the odds of depression or anxiety diagnoses and recent psychological distress, controlling for disability and mental health diagnoses. We measured disability using binary and continuum measures of functional disability with the Washington Group Short Set on Functioning. Results Disabled people have significantly greater odds of both depression and anxiety diagnoses compared to non-disabled people. Those with high functional disability have 552% greater odds of an anxiety diagnosis (95% CI: 5.61 – 7.58; p<0.01) and 697% greater odds of a depression diagnosis (95% CI: 6.97 – 9.12; p<0.01) compared to those with no functional disability. Similarly, those with any level of functional disability are more likely to have elevated psychological distress in the past 30 days compared to those with no functional disability. Conclusions Findings support the idea that mental health is worse for disabled people compared to non-disabled people, with increasing functional disability associated with worse mental health. This suggests that mental health is not being adequately addressed for those with the greatest functional disability. Future work should seek to better understand the systemic causes of disparities.

▶ Personal Assistance, Independent Living, and People with Disabilities: An International Systematic Review (2013-2023)

RIOBÓO-LOIS B., FRIEIRO P., GONZÁLEZ-RODRÍGUEZ R., *et al.*

2024

Disability and Health Journal: 101630. [In Press]

https://doi.org/10.1016/j.dhjo.2024.101630

Background The article discusses the contribution of personal assistance for the independent living of people with disabilities. This right is evolving at different speeds internationally, presents controversial aspects, and is under continuous debate. Objective To synthesize the evidence relating to the promotion of self-determination and independent living through personal assistance. Methods A systematic review was conducted following Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines. A search for relevant literature published was conducted during March 2023 across nine databases. The findings of the included studies were coded and analyzed via inductive content analysis. Results 26 articles were included, mostly qualitative, from four different continents. The analysis revealed six different key themes. The social framework highlighted the influence of international agreements and disability activism on cultural shifts in understanding disability. Secondly, healthy relationships and life or service

expectations were emphasized. Key agents included users, personal assistants, family members, service providers, and other professionals. Personal assistants' work context explored ethical dilemmas, training, and working rights. Decision-making about personal assistance involved factors like lack of information, access requirements, and funding. Lastly, the implications underscored the positive impact of personal assistance on independent living, while identifying threats, and best practices for improvement. Conclusions This systematic review was the first to explore the promotion of independent living of people with disabilities through personal assistance schemes and highlights the need for governments to prioritize and coordinate efforts to ensure access for all, emphasizing the ethical imperative to progress toward social justice.

▶ Medicare, Medicaid, and Dual Enrollment for Adults with Intellectual and Developmental Disabilities

RUBENSTEIN E., TEWOLDE S., LEVINE A. A., *et al.*
2024
Health Services Research 59(3): e14287.
https://doi.org/10.1111/1475-6773.14287

Abstract Objective Given high rates of un- and underemployment among disabled people, adults with intellectual and developmental disabilities rely on Medicaid, Medicare, or both to pay for healthcare. Many disabled adults are Medicare eligible before the age of 65 but little is known as to why some receive Medicare services while others do not. We described the duration of Medicare enrollment for adults with intellectual and developmental disabilities in 2019 and then compared demographics by enrollment type (Medicare-only, Medicaid-only, dual-enrolled). Additionally, we examined the percent in each enrollment type by state, and differences in enrollment type for those with Down syndrome. Data Sources and Study Setting 2019 Medicare and Medicaid claims data for all adults (≥18 years) in the US with claim codes for intellectual disability, Down syndrome, or autism at any time between 2011 and 2019. Study Design Administrative claims cohort. Data Collection and Abstraction Methods Data were from the Transformed Medicaid Statistical Information System Analytic Files and Medicare Beneficiary Summary files. Principle Findings In 2019, Medicare insured 582,868 adults with identified intellectual disability, autism, or Down syndrome. Of 582,868 Medicare beneficiaries, 149,172 were Medicare only and 433,396 were dual-enrolled. Most Medicare enrollees were enrolled as child dependents (61.5%) Medicaid-only enrollees (N = 819,256) were less likely to be white non-Hispanic (58.5% white non-Hispanic vs. 72.9% white non-Hispanic in dual-enrolled), more likely to be Hispanic (19.6% Hispanic vs. 9.2% Hispanic in dual-enrolled) and were younger (mean 34.2 years vs. 50.5 years dual-enrolled). Conclusion There is heterogeneity in public insurance enrollment which is associated with state and disability type. Action is needed to ensure all are insured in the program that works for their healthcare needs.

Hôpital
Hospital

▶ New Evidence on the Impacts of Cross-Market Hospital Mergers on Commercial Prices and Measures of Quality

ARNOLD D. R., KING J. S., FULTON B. D., *et al.*
2024
Health Services Research 1-13.
https://doi.org/10.1111/1475-6773.14291

Abstract Objective To examine the impact of "cross-market" hospital mergers on prices and quality and the extent to which serial acquisitions contribute to any measured effects. Data Sources 2009–2017 commercial claims from the Health Care Cost Institute (HCCI) and quality measures from Hospital Compare. Study Design Event study models in which the treated group consisted of hospitals that acquired hospitals further than 50 miles, and the control group was hospitals that were not part of any merger activity (as a target or acquirer) during the study period. Data Extraction Methods We extracted data for 214 treated hospitals and 955 control hospitals. Principal Findings Six years after acquisition, cross-market hos-

pital mergers had increased acquirer prices by 12.9% (CI: 0.6%–26.6%) relative to control hospitals, but had no discernible impact on mortality and readmission rates for heart failure, heart attacks and pneumonia. For serial acquirers, the price effect increased to 16.3% (CI: 4.8%–29.1%). For all acquisitions, the price effect was 21.8% (CI: 4.6%–41.7%) when the target's market share was greater than the acquirer's market share versus 9.7% (CI: –0.5% to 20.9%) when the opposite was true. The magnitude of the price effect was similar for out-of-state and in-state cross-market mergers. Conclusions Additional evidence on the price and quality effects of cross-market mergers is needed at a time when over half of recent hospital mergers have been cross-market. To date, no hospital mergers have been challenged by the Federal Trade Commission on cross-market grounds. Our study is the third to find a positive price effect associated with cross-market mergers and the first to show no quality effect and how serial acquisitions contribute to the price effect. More research is needed to identify the mechanism behind the price effects we observe and analyze price effect heterogeneity.

Hospital Competition and Health Outcomes: Evidence from Acute Myocardial Infarction Admissions in Germany

BAYINDIR E. E., JAMALABADI S., MESSERLE R., *et al.*

2024

Social Science & Medicine: 349 :116910.

https://doi.org/10.1016/j.socscimed.2024.116910

Countries increasingly rely on competition among hospitals to improve health outcomes. However, there is limited empirical evidence on the effect of competition on health outcomes in Germany. We examined the effect of hospital competition on quality of care, which is assessed using health outcomes (risk-adjusted in-hospital and post-hospitalization mortality and cardiac-related readmissions), focusing on acute myocardial infarction (AMI) treatment. We obtained data on all hospital utilizations and mortality of 13.2% of the population from a large statutory health insurer and all AMI admission records from Diagnosis-Related Groups Statistic from 2015-19. We constructed the measures of hospital competition, which mitigates the possibility of endogeneity bias. The relationships between health outcomes and competition measures are estimated using linear probability models. Intense competition was associated with lower quality of care in terms of mortality and cardiac-related readmissions. Patients treated in hospitals facing high competition were 0.9 (1.2) percentage points more likely to die within 90 days (2 years) of admission, and 1.4 (1.6) percentage points more likely to be readmitted within 90 days (2 years) of discharge than patients treated in hospitals facing low competition. Our results indicate that hospital competition does not lead to better health outcomes for AMI patients in Germany. Therefore, additional measures are necessary to achieve quality improvement.

Interventions and Hospital Characteristics Associated with Patient Experience: An Update of the Evidence

BECKETT M. K., QUIGLEY D. D., LEHRMAN W. G., *et al.*

2024

Medical Care Research and Review 81(3): 195–208.

https://doi.org/10.1177/10775587231223292

Patient experience is a key hospital quality measure. We review and characterize the literature on interventions, care and management processes, and structural characteristics associated with better inpatient experiences as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Prior reviews identified several promising interventions. We update these previous efforts by including more recent peer-reviewed literature and expanding the review's scope to include observational studies of HCAHPS measures with process measures and structural characteristics. We used PubMed to identify U.S. English-language peer-reviewed articles published in 2017 to 2020 and focused on hospital patient experience. The two HCAHPS domains for which we found the fewest potential quality improvement interventions were Communication with Doctors and Quietness. We identified several modifiable processes that could be rigorously evaluated in the future, including electronic health record patient engagement functionality, care management processes, and nurse-to-patient ratios. We describe implications for future policy, practice, and research.

LFSS pour 2024 : la réforme du financement des établissements de santé répond-elle aux enjeux ?

BONNIEU-MILOT P., PLANEL M. P. ET VARNIER F.

2024

Revue de droit sanitaire et social 2024(2).

La LFSS pour 2024 procède à une réforme des modalités de financement des établissements de santé. Cette réforme illustre la recherche d'un modèle de financement qui réponde à l'évolution des besoins et des modes de prise en charge, dans le prolongement de réflexions visant à sortir du « tout T2A » . Elle propose une inflexion vers un modèle mixte mêlant des activités financées à la tarification et des prises en charge spécifiques avec une meilleure prise en compte des données populationnelles. Cette réflexion doit être élargie à d'autres problématiques comme les modalités de financement de l'investissement ou la participation des assurés.

Effect on Hospital Incentive Payments and Quality Performance of a Hospital Pay for Performance (P4P) Programme in Belgium

BROUWERS J., SEYS D., CLAESSENS F., *et al.*

2024

Journal of Healthcare Quality Research 39(3): 147-154.

https://doi.org/10.1016/j.jhqr.2024.02.005

Background Belgium initiated a hospital pay for performance (P4P) programme after a decade of fixed bonus budgets for "quality and safety contracts". This study examined the effect of P4P on hospital incentive payments, performance on quality measures, and the association between changes in quality performance and incentive payments over time. Methods The Belgian government provided information on fixed bonus budgets in 2013–2017 and hospital incentive payments as well as hospital performance on quality measures for the P4P programmes in 2018–2020. Descriptive analyses were conducted to map the financial repercussion between the two systems. A difference-in-difference analysis evaluated the association between quality indicator performance and received incentive payments over time. Results Data from 87 acute-care hospitals were analyzed. In the transition to a P4P programme, 29% of hospitals received lower incentive payments per bed. During the P4P years, quality performance scores increased yearly for 55% of hospitals and decreased yearly for 5% of hospitals. There was a significant larger drop in incentive payments for hospitals that scored above median with the start of the P4P programme. Conclusions The transition from fixed bonus budgets for quality efforts to a new incentive payment in a P4P programme has led to more hospitals being financially impacted, although the effect is marginal given the small P4P budget. Quality indicators seem to improve over the years, but this does not correlate with an increase in reward per bed for all hospitals due to the closed nature of the budget.

Un rapport de la Cour des comptes sur les établissements de santé publics et privés très idéologique

GRIMALDI A.

2024

Les Tribunes de la santé 79(1): 79-82.

https://doi.org/10.1684/seve1.2024.7

Cost, Quality, and Utilization After Hospital-Physician and Hospital-Post Acute Care Vertical Integration: A Systematic Review

HARRIS A., PHILBIN S., POST B., *et al.*

2024

Medical Care Research and Review 6: 10775587241247682.

https://doi.org/10.1177/10775587241247682

Vertical integration of health systems—the common ownership of different aspects of the health care system—continues to occur at increasing rates in the United States. This systematic review synthesizes recent evidence examining the association between two types of vertical integration—hospital-physician (n = 43 studies) and hospital-post-acute care (PAC; n = 10 studies)—and cost, quality, and health services utilization. Hospital-physician integration is associated with higher health care costs, but the effect on quality and health services utilization remains unclear. The effect of hospital-PAC integration on these three outcomes is ambiguous, particularly when focusing on hospital-SNF integration. These findings should raise some concern among policymakers about the trajectory of affordable, high-quality health care in the presence of increasing hospital-physician vertical integration but perhaps not hospital-PAC integration.

Rural Hospitals Experienced More Patient Volume Variability Than Urban Hospitals During the COVID-19 Pandemic, 2020–21

JIANG H.J., MOSHER HANKE R., *et al.*

2024

Health Affairs 43(5): 641-650.
https://doi.org/10.1377/hlthaff.2023.00678

Fluctuations in patient volume during the COVID-19 pandemic may have been particularly concerning for rural hospitals. We examined hospital discharge data from the Healthcare Cost and Utilization Project State Inpatient Databases to compare data from the COVID-19 pandemic period (March 8, 2020–December 31, 2021) with data from the prepandemic period (January 1, 2017–March 7, 2020). Changes in average daily medical volume at rural hospitals showed a dose-response relationship with community COVID-19 burden, ranging from a 13.2 percent decrease in patient volume in periods of low transmission to a 16.5 percent increase in volume in periods of high transmission. Overall, about 35 percent of rural hospitals experienced fluctuations exceeding 20 percent (in either direction) in average daily total volume, in contrast to only 13 percent of urban hospitals experiencing similar magnitudes of changes. Rural hospitals with a large change in average daily volume were more likely to be smaller, government-owned, and critical access hospitals and to have significantly lower operating margins. Our findings suggest that rural hospitals may have been more vulnerable operationally and financially to volume shifts during the pandemic, which warrants attention because of the potential impact on these hospitals' long-term sustainability.

Managing Surges in Demand: A Grounded Conceptual Framework of Surge Management Capability

LARSON J. D., LAI A. Y., DEPUCCIO M. J., *et al.*

2024

Medical Care Research and Review 81(3): 245–258.
https://10.1177/10775587241226485

Surge management is important to hospital operations, yet surge literature has mostly focused on the addition of resources (e.g., 25% more beds) during events like pandemics. Such views are limiting, as meeting surge demands requires hospitals to engage in practices tailored to a surge's unique contingencies. We argue that a dynamic view of surge management should include surge management capability, which refers to how resources are deployed to respond to surge contingencies. To understand this capability, we qualitatively studied five hospital systems experiencing multiple surges due to COVID-19 between April 2020 and March 2022. We develop a framework showing that managing surges involves preserving capacity, expanding capacity, smoothing capacity demand, and enabling surge management. We contribute to surge literature by identifying practices hospitals can adopt to address surges and offering a better understanding of surge conditions (e.g., degree of novelty) that make some surge management practices more appropriate than others.

Association Between Physician–Hospital Integration and Inpatient Care Delivery in Accountable Care Organizations: An Instrumental Variable Analysis

LIN M.-Y., HANCHATE A. D., FRAKT A. B., *et al.*

2024

Health Services Research 1-11
https://doi.org/10.1111/1475-6773.14311

Abstract Objective To investigate the relationship between physician–hospital integration within accountable care organizations (ACOs) and inpatient care utilization and expenditure. Data Sources The primary data were Massachusetts All-Payer Claims Database (2009–2013). Study Setting Fifteen provider organizations that entered a commercial ACO contract with a major private payer in Massachusetts between 2009 and 2013. Study Design Using an instrumental variable approach, the study compared inpatient care delivery between patients of ACOs demonstrating high versus low integration. We measured physician–hospital integration within ACOs by the proportion of primary care physicians in an ACO who billed for outpatient services with a place-of-service code indicating employment or practice ownership by a hospital. The study sample comprised non-elderly adults who had continuous insurance coverage and were attributed to one of the 15 ACOs. Outcomes of interest included total medical expenditure during an episode of inpatient care, length of stay (LOS) of the index hospitalization, and 30-day readmission. An inpatient episode was defined as 30, 45, and 60 days from the admission date. Data Collection/Extraction Methods Not applicable. Principal Findings The study examined 33,535 admissions from patients served by the 15 ACOs. Average medical expenditure within 30 days of admission was $24,601, within 45 days was $26,447,

and within 60 days was $28,043. Average LOS was 3.5 days, and 5.4% of patients were readmitted within 30 days. Physician–hospital integration was associated with a 10.6% reduction in 30-day expenditure (95% CI, –15.1% to –5.9%). Corresponding estimates for 45 and 60 days were – 9.7% (95%CI, –14.2% to –4.9%) and – 9.6% (95%CI, –14.3% to –4.7%). Integration was associated with a 15.7% decrease in LOS (95%CI, –22.6% to –8.2%) but unrelated to 30-day readmission rate. Conclusions Our instrumental variable analysis shows physician–hospital integration with ACOs was associated with reduced inpatient spending and LOS, with no evidence of elevated readmission rates.

▶ A More Complete Measure of Vertical Integration Between Physicians and Hospitals

LUO Q., BLACK B., MAGID D. J., *et al.*

2024

Health Services Research 1-11

https://doi.org/10.1111/1475-6773.14314

Abstract Objective To develop an accurate and reproducible measure of vertical integration between physicians and hospitals (defined as hospital or health system employment of physicians), which can be used to assess the impact of integration on healthcare quality and spending. Data Sources and Study Setting We use multiple data sources including from the Internal Revenue Service, the Centers for Medicare and Medicaid Services, and others to determine the Tax Identification Numbers (TINs) that hospitals and physicians use to bill Medicare for services, and link physician billing TINs to hospital-related TINs. Study Design We developed a new measure of vertical integration, based on the TINs that hospitals and physicians use to bill Medicare, using a broad set of sources for hospital-related TINs. We considered physicians as hospital-employed if they bill Medicare primarily or exclusively using hospital-related TINs. We assessed integration status for all physicians who billed Medicare from 1999 to 2019. We compared this measure with others used in the existing literature. We conducted a simulation study which highlights the importance of accurately identifying integrated physicians when study the effects of integration. Data Collection/Extraction Methods We extracted physician and hospital-related TINs from multiple sources, emphasizing specificity (a small proportion of nonintegrated physicians identified as integrated). Principal Findings We identified 12,269 hospital-related TINs, used for billing by 546,775 physicians. We estimate that the percentage of integrated physicians rose from 19% in 1999 to 43% in 2019. Our approach identifies many additional physician practices as integrated; a simpler TIN measure, comparable with prior work, identifies only 30% (3877) of the TINs we identify. A service location measure, used in prior work, has both many false positives and false negatives. Conclusion We developed a new measure of hospital-physician integration. This measure is reproducible and identifies many additional physician practices as integrated.

Inégalités de santé

Health Inequalities

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

AKALIN N.

2024

Social Science & Medicine 348: 116822.

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

A growing body of scholarship examines the varying impact of legal status and race on accessing healthcare. However, a notable gap persists in comprehending the supplementary mechanisms that hinder immigrants' pathway to seek care. Drawing on ethnographic observations in various clinical settings and in-depth interviews with 28 healthcare professionals and 12 documented Haitian immigrants in a city in Upstate New York, between 2019 and 2021, I demonstrate the tension between the conceptualization and implementation of inclusive care practices by healthcare providers. I argue that the mere expansion and adoption of inclusive discourse among providers do not inherently ensure equity and the removal of barriers to health-

care access. This work contributes to the social study of medicine and race and ethnic studies by introducing the innovative concept of "immigrant-blind." Through this concept, the research sheds light on how providers' conceptualization of inclusivity proclaims medical encounters to be devoid of stratifications and rationalizes their practices which mask the profound impact of immigration status and immigration on immigrant health. Furthermore, these practices reinforce existing divisions within care settings and medical encounters, where immigration laws and enforcement practices operate and further exacerbate stratifications. By examining providers' uninformed implementation of culturally competent care practices, the findings reveal that providers stigmatize and essentialize immigrants during medical encounters. This highlights the imperative for a more nuanced and informed approach to healthcare provision, where genuine inclusivity is upheld, and barriers to access are dismantled to foster equitable and dignified healthcare experiences for all.

Social Risk Factors and Racial and Ethnic Disparities in Health Care Resource Utilization Among Medicare Advantage Beneficiaries with Psychiatric Disorders

COOK B. L., RASTEGAR J. ET PATEL N.

2024

Medical Care Research and Review 81(3): 209–222.

https://doi.org/10.1177/1077558723122258

The intersection of social risk and race and ethnicity on mental health care utilization is understudied. This study examined disparities in health care treatment, adjusting for clinical need, among 25,780 Medicare Advantage beneficiaries with a diagnosis of a psychiatric disorder. We assessed contributions to disparities from racial and ethnic differences in the composition and returns of social risk variables. Black and Hispanic beneficiaries had lower rates of mental health outpatient visits than Whites. Assessing composition, Black and Hispanic beneficiaries experienced greater financial, food, and housing insecurity than White beneficiaries, factors associated with greater mental health treatment. Assessing returns, food insecurity was associated with an exacerbation of Hispanic-White disparities. Health care systems need to address the financial, food and housing insecurity of racial and ethnic minority groups with psychiatric disorder. Accounting for racial and ethnic differences in social risk adjustment-based payment reforms has significant implications for provider reimbursement and outcomes.

A Longitudinal Perspective to Migrant Health: Unpacking the Immigrant Health Paradox in Germany

FERRARA A., GRINDEL C. ET BRUNORI C.

2024

Social Science & Medicine: 116976. [In press]

https://doi.org/10.1016/j.socscimed.2024.116976

Previous research finds that recent immigrants are healthier than the native-born, while more established immigrants exhibit worse health, suggesting a process of unhealthy assimilation. However, previous literature is mostly based on cross-sectional data or on longitudinal analyses similarly failing to disentangle individual-level variation from between-individual confounding. Moreover, previous longitudinal studies are often limited in their study of different health outcomes (few and mostly subjective health), populations (sometimes only elderly individuals), time periods (short panels) and geographical contexts (mostly Australia, Canada and USA). We address these limitations by comparing the health trajectories of adult immigrants and natives in Germany over extended periods, using data from years 2002-2021 of the German Socio-Economic Panel (SOEP), and investigating a wide range of health outcomes, including self-assessed physical and mental health measures, diagnosed illnesses, and health behaviors. We employ a longitudinal approach that stratifies immigrants by age at arrival, and compares them to natives of the same age. This allows us to estimate both Hierarchical Linear Models and more rigorous Fixed Effects models to further address confounding. Cross-sectionally, we confirm previous literature's findings: recent immigrants are healthier than natives and established immigrants. Longitudinally, we find support for the unhealthy assimilation hypothesis concerning subjective health and mental health, but not for the others health indicators or behaviors. We interpret these findings as possible evidence of immigrants' reduced access to timely health care and emphasize the need for greater longitudinal research investigating migrant gaps in various health outcomes.

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

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

2024

Journal of Healthcare Quality Research 39(3): 139-146.

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

Introduction and objective A low socioeconomic status (SES) has been associated with poor health results. The present study aimed to investigate if SES of older patients attending the emergency department is associated with the use of healthcare resources and outcomes. Patients and methods Observational, retrospective study including consecutive patients 65 years or older admitted to the emergency department. Variables at baseline, index episode, and follow-up were recorded. SES was measured using an indirect theoretical index and patients were categorised into two groups according to whether they lived in a neighbourhood with a low or high SES. Primary outcomes included hospitalisation after the emergency department visit and prolonged hospitalisation (>7 days) at index episode. Secondary outcomes included emergency department re-consultant and hospital admission in the following 3 months after the index episode, and all-cause mortality after long-term follow-up. Logistic regression and cumulative hazards regression models were used to investigate associations between SES and outcomes.

Effects of Communicating Health Disparities Using Social Comparison Framing: A Comprehensive Review

LIU J. ET NIEDERDEPPE J.

2024

Social Science & Medicine 348: 116808.

https://doi.org/10.1016/j.socscimed.2024.116808

Communicating health disparities in mass and social media has typically taken the form of comparing disease risks and outcomes between two or more social groups, a strategy known as social comparison framing. This comprehensive review examined the design and results of 17 studies from 15 peer-reviewed journal articles about the effects of social comparison framing of health disparities. Most studies focus on race-based disparities across a variety of health topics. For individual-level outcomes, social comparison tends to reduce perceived disease risks for the lower disease prevalence group while prompting negative emotions and yielding inconsistent impact on health behavioral intentions among members of the higher prevalence group. For societal-level outcomes, social comparison often has either null or polarizing effects on support for policies to address these disparities that vary by racial identity/attitudes of the respondents. Studies also find that racial comparisons trigger lower levels of support for policy remedies relative to economic, educational, or geographic comparisons. We conclude that social comparison framing of health disparities, in the absence of broader discussion of the social and structural causes of these disparities, is more likely to incur negative consequences. We propose several possible strategies to communicate health disparity information more effectively.

Socioeconomic Deprivation, Health and Access to Healthcare Among Millennials

MARTÍNEZ-JIMÉNEZ M., HOLLINGSWORTH B. ET ZUCCHELLI E.

2024

Social Science & Medicine: 351: 116961.

https://doi.org/10.1016/j.socscimed.2024.116961

This study estimates and decomposes components of different measures of inequality in health and healthcare use among millennial adolescents, a sizeable cohort of individuals at a critical stage of life. Administrative data from the UK Hospital Episode Statistics are linked to Next Steps, a survey collecting information about millennials born between 1989 and 1990, providing a uniquely comprehensive source of health and socioeconomic variables. Socioeconomic inequalities in psychological distress, long-term illness and the use of emergency and outpatient hospital care are measured using a corrected concentration index. Shapley-Shorrocks decomposition techniques are employed to measure the relative contributions of childhood socioeconomic circumstances to adolescents' health and healthcare inequality of opportunity. Results show that income-related deprivation contributes to significant inequalities in mental and physical health among adolescents aged between 15 and 17 years old. There are also pro-rich inequalities in the use of specific outpatient hospital services (e.g., orthodontic and mental healthcare), while pro-poor

disparities are found in the use of emergency care services. Regional and parental circumstances are leading factors in influencing inequality of opportunity in the use of hospital care among adolescents. These findings shed light on the main drivers of health inequalities during an important stage of human development and have potentially important implications on human capital formation across the life-cycle.

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

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

2024

Social Science & Medicine 348: 116806.

https://doi.org/10.1016/j.socscimed.2024.116806

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

Differences Across the Lifespan Between Females and Males in the Top 20 Causes of Disease Burden Globally: A Systematic Analysis of the Global Burden of Disease Study 2021

PATWARDHAN V., GIL G. F., ARRIETA A., *et al.*

2024

The Lancet Public Health 9(5): e282-e294.

https://doi.org/10.1016/S2468-2667(24)00053-7

Background Sex and gender shape health. There is a growing body of evidence focused on comprehensively and systematically examining the magnitude, persistence, and nature of differences in health between females and males. Here, we aimed to quantify differences in the leading causes of disease burden between females and males across ages and geographies.

The Problematic Nature of Existing Explanations for Differential Immigrant Mortality: Insights from a Comparative Cross-National Systematic Review and Meta-Analysis

ROELFS D. J. ET SHOR E.

2024

Social Science & Medicine 349: 116897.

https://doi.org/10.1016/j.socscimed.2024.116897

Empirical studies in multiple disciplines have frequently observed an immigrant mortality advantage. Yet, questions remain regarding the possible mechanisms underlying this phenomenon. We obtained data from 61 studies of relative immigrant mortality from single origin-destination country pairings, providing information on immigrants from 77 origin countries. We systematically review the arguments made in these studies about origin-country factors that might influence immigrant mortality and then use meta-analyses to examine the veracity of these arguments. We find that most existing origin-country explanations for immigrant mortality patterns (e.g., health behaviors, genetic characteristics, environmental conditions, and socioeconomic conditions) are problematic or insufficient when accounting for differential mortality by origin country. We identify non-comparative analyses and geographic aggregation as the two major obsta-

cles to understanding the mechanisms underlying the immigrant mortality advantage. We conclude by advocating for a risk-factor-based, cross-national approach.

Trapped in Vicious Cycles: Unraveling the Health Experiences and Needs of Adults Living with Socioeconomic Insecurity

VERRA S. E., POELMAN M. P., MUDD A. L., *et al.*

2024

Archives of Public Health 82(1): 51.

https://doi.org/10.1186/s13690-024-01281-w

This study explores the role of health in daily life and needs of Dutch adults (aged 25–49) experiencing one or more forms of socioeconomic insecurity stemming from their financial, housing, or employment situations.

Médicaments

Pharmaceuticals

Covid-19 Psychological Distress: Analysis of Antipsychotic Drugs' Use in an Italian Population Sample

FERRARA F., CAPUOZZO M., TRAMA U., *et al.*

2024

Annales Pharmaceutiques Françaises [In Press]

https://doi.org/10.1016/j.pharma.2024.04.007

Background: The current pandemic, in addition to putting a strain on healthcare systems and global economies, has exacerbated psychiatric problems and undermined the mental health of many individuals. In an Italian cohort, this phenomenon has been assessed through a retrospective study aimed at evaluating the consumption and costs of antipsychotic drugs between 2020 and 2022.

Transparence, liens et conflits d'intérêts : quels enjeux pour les professionnels de santé, les entreprises du médicament et les décideurs dans leurs interactions

MOUTEL G.

2024

Sève : Les Tribunes de la santé 79(1): 35-40.

https://doi.org/10.1684/seve1.2024.4

Les liens de travail entre les entreprises du médicament et les professionnels de santé sont essentiels à la vie scientifique et aux progrès en santé. La mise en commun de leurs expertises respectives permet de poursuivre un même objectif : améliorer la prise en charge des patients grâce au progrès thérapeutique. Les liens d'intérêts ne doivent en aucune façon être confondus avec des conflits et doivent en être clairement distingués. Différents dispositifs ont été mis en place depuis 1993 pour encadrer les pratiques, prévenir les conflits d'intérêts et promouvoir le principe de transparence. Le Codeem, Comité d'éthique et de déontologie des entreprises du médicament, est un acteur central dans la régulation de ces enjeux.

En 2024, toujours rien à attendre de la visite médicale des firmes pharmaceutiques

PRESCRIRE

2024

Sève : Les Tribunes de la santé 79(1): 45-50.

https://10.1684/seve1.2024.11

La Haute autorité de santé (HAS) française a publié un rapport concernant les interactions entre les professionnels de santé et les firmes, via notamment la visite médicale. Elle constate que l'exposition des professionnels à ces interactions est précoce, omniprésente et mondiale. Selon la synthèse méthodique d'études publiées entre 2004 et 2018 réalisée par la HAS, l'information transmise par la visite médicale est de mauvaise qualité ; et les professionnels de santé

manquent d'esprit critique et de formation pour en discerner les influences sur leur pratique. Diverses tentatives de régulation ont été mises en place dans certains pays pour limiter les conséquences sur les soins. Elles n'ont pas été concluantes jusque-là. La façon la plus efficace pour limiter les influences de la visite médicale des firmes sur la prescription et la dispensation des médicaments reste encore de ne pas recevoir de visiteurs médicaux.

Are Web-Based Valuation Surveys for Preference-Based Measures as Reliable as Face-To-Face Surveys? TTO, DCE and DCE with Duration

SHIROIWA T. ET FUKUDA T.

2024

Applied Health Economics and Health Policy 22(3): 391-400.

https://link.springer.com/article/10.1007/s40258-023-00865-x

Valuation surveys of preference-based measures are typically conducted face-to-face or on web panels. In this survey, we considered whether face-to-face and online surveys were reliable using three tasks: composite time trade-off (cTTO), discrete choice experiment (DCE), and DCE with duration.

A Review of Current Approaches to Evaluating and Reimbursing New Medicines in a Subset of OECD Countries

ZOZAYA N., VILLASECA J., FERNÁNDEZ I., *et al.*

2024

Applied Health Economics and Health Policy 22(3): 297-313.

https://doi.org/10.1007/s40258-023-00865-x

The aim of this study was to review the current evaluation and funding processes for new drugs in different developed countries, to provide a comparative framework with detailed, homogeneous, and up-to-date information.

Méthodologie-Statistiques

Methodology-Statistics

Extending Intersectional Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy (MAIHDA) to Study Individual Longitudinal Trajectories, with Application to Mental Health in the UK

BELL A., EVANS C., HOLMAN D., *et al.*

2024

Social Science & Medicine: 351 :116955.

https://doi.org/10.1016/j.socscimed.2024.116955

The intersectional Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy (MAIHDA) approach is gaining prominence in health sciences and beyond, as a robust quantitative method for identifying intersectional inequalities in a range of individual outcomes. However, it has so far not been applied to longitudinal data, despite the availability of such data, and growing recognition that intersectional social processes and determinants are not static, unchanging phenomena. Drawing on intersectionality and life course theories, we develop a longitudinal version of the intersectional MAIHDA approach, allowing the analysis not just of intersectional inequalities in static individual differences, but also of life course trajectories. We discuss the conceptualisation of intersectional groups in this context: how they are changeable over the life course, appropriate treatment of generational differences, and relevance of the age-period-cohort identification problem. We illustrate the approach with a study of mental health using United Kingdom Household Longitudinal Study data (2009-2021). The results reveal important differences in trajectories between generations and intersectional strata, and show that trajectories are partly multiplicative but mostly additive in their intersectional inequalities. This article provides an important and much needed methodological contribution, enabling rigorous quantitative, longitudinal, intersectional analyses in social epidemiology and beyond.

Performance of Health Care Service Area Definitions for Capturing Variation in Inpatient Care and Social Determinants of Health

CROOK H., HORTA M., MICHELSON K. A., *et al.*

2024

Health Services Research : 1-10

https://doi.org/10.1111/1475-6773.14312

Abstract Objective To quantify the degree to which health care service area (HCSA) definitions captured hospitalizations and heterogeneity in social determinants of health (SDOH). Data Sources and Study Setting Geospatial data from the Centers for Medicare and Medicaid Services, the Census Bureau, and the Dartmouth Institute. Drive-time isochrones from MapBox. Area Deprivation Index (ADI) data. 2017 inpatient discharge data from Arizona, Florida, Iowa, Maryland, Nebraska, New Jersey, New York, and Wisconsin, State Emergency Department Databases and State Inpatient Databases, Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality; and Fee-For-Service Medicare data in 48 states. Study Design Cross-sectional, descriptive analysis. Data Collection/Extraction Methods The capture rate was the percentage of inpatient discharges occurring in the same HCSA as the hospital. We compared capture rates for each HCSA definition for different populations and by hospital type. We measured SDOH heterogeneity using the coefficient of variation of the ADI among ZIP codes within each HCSA. Principal Findings HCSA definitions captured a wide range of inpatient discharges, ranging from 20% to 50% for Public Use Microdata Areas (PUMAs) to 93%–97% for Metropolitan Statistical Areas (MSAs). Three-quarters of inpatient discharges were from facilities within the same county as the patient's residential ZIP code, while nearly two-thirds were within the same Hospital Service Area. From the hospital perspective, 74.7% of inpatient discharges originated from within a 30-min drive and 90.1% within a 60-min drive. Capture rates were the lowest for teaching hospitals. PUMAs and drive-time-based HCSAs encompassed more homogenous populations while MSAs, Commuting Zones, and Hospital Referral Regions captured the most variation. Conclusions The proportion of hospital discharges captured by each HCSA varied, with MSAs capturing the highest proportion of discharges and PUMAs capturing the lowest. Additionally, researchers face a trade-off between capture rate and population homogeneity when deciding which HCSA to use.

Quality- and Productivity-Adjusted Life Years: from QALYs to PALYs and Beyond

HANSEN K. S., MORENO-TERNERO J. D. ET ØSTERDAL L. P.

2024

Journal of Health Economics: 95: 102885.

https://doi.org/10.1016/j.jhealeco.2024.102885

We develop a unified framework for the measurement and valuation of health and productivity. Within this framework, we characterize evaluation functions allowing for compromises between the classical quality-adjusted life years (QALYs) and its polar productivity-adjusted life years (PALYs). Our framework and characterization results provide a new normative basis for the economic evaluation of health care interventions, as well as occupational health and safety policies, aimed to impact both health and productivity of individuals.

Comparing Preferences for Disease Profiles: A Discrete Choice Experiment from a US Societal Perspective

JOHNSTON K. M., AUDHYA I. F., DUNNE J., *et al.*

2024

Applied Health Economics and Health Policy 22(3): 343-352.

https://doi.org/10.1007/s40258-023-00869-7

There is increasing interest in expanding the elements of value to be considered when making health policy decisions. To help inform value frameworks, this study quantified preferences for disease attributes in a general public sample and examined which combination of attributes (disease profiles) are considered most important for research and treatment.

Methods for Health Workforce Projection Model: Systematic Review and Recommended Good Practice Reporting Guideline

LEE J. T., CRETTENDEN I., TRAN M., *et al.*

2024

Human Resources for Health 22(1): 25.

https://doi.org/10.1186/s12960-024-00895-z

Health workforce projection models are integral components of a robust healthcare system. This research aims to review recent advancements in methodology and approaches for health workforce projection models and proposes a set of good practice reporting guidelines.

Simplified Methods for Modelling Dependent Parameters in Health Economic Evaluations: A Tutorial

XIE X., SCHAINK A. K., LIU S., *et al.*

2024

Applied Health Economics and Health Policy 22(3): 331-341.
https://doi.org/10.1007/s40258-024-00874-4

In health economic evaluations, model parameters are often dependent on other model parameters. Although methods exist to simulate multivariate normal (MVN) distribution data and estimate transition probabilities in Markov models while considering competing risks, they are technically challenging for health economic modellers to implement. This tutorial introduces easily implementable applications for handling dependent parameters in modelling.

Politique de santé

Health Policy

La Haute Autorité de santé : l'indépendance d'une autorité publique scientifique

COLLET L., FONTY A., GELLI R., *et al.*

2024

Sève : Les Tribunes de la santé 79(1): 25-34.
https://doi.org/10.1684/seve1.2024.3

Pour répondre à une défiance des citoyens à l'encontre de l'État et de ses administrations publiques, la France a mis en place de nombreuses autorités indépendantes : autorités administratives ou autorités publiques selon leurs statuts respectifs. Cette approche extensive n'est d'ailleurs pas restée sans critiques, du Parlement comme des publicistes. Au sein de cet ensemble, la Haute Autorité de santé (HAS) occupe une place à part qui tient autant aux circonstances historiques de sa création qu'à son statut, à ses missions ou au large périmètre qu'elle embrasse. La HAS est la seule parmi toutes les autorités publiques administratives dont toutes les missions relèvent du secteur de la santé. Sa création est apparue nécessaire en raison de la défiance vis-à-vis des administrations publiques, d'une part et de la succession de crises sanitaires qui rappellent la nécessité de disposer d'une expertise en santé indépendante, d'autre part. Pour garantir pleinement cette indépendance, la HAS veille à répondre aux principes en matière de déontologie et de transparence.

Do Social Protection Programmes Affect the Burden of Breast and Cervical Cancer? A Systematic Review

GABRIELLI L., ALVIM MATOS S. M., LUÍSA PATRÃO A., *et al.*

2024

Health Policy OPEN: 6: 100122.
https://doi.org/10.1016/j.hpopen.2024.100122

Background Socioeconomic conditions are strongly associated with breast and cervical cancer incidence and mortality patterns; therefore, social protection programmes (SPPs) might impact these cancers. This study aimed to evaluate the effect of SPPs on breast and cervical cancer outcomes and their risk/protective factors. Methods Five databases were searched for articles that assessed participation in PPS and the incidence, survival, mortality (primary outcomes), screening, staging at diagnosis and risk/protective factors (secondary outcomes) for these cancers. Only peer-reviewed quantitative studies of women receiving SPPs compared to eligible women not receiving benefits were included. Independent reviewers selected articles, assessed eligibility, extracted data, and assessed the risk of bias. A harvest plot represents the included studies and shows the direction of effect, sample size and risk of bias. Findings Of 17,080 documents retrieved, 43 studies were included in the review. No studies evaluated the primary outcomes. They all examined the relationship between SPPs and screening, as well as risk and protective factors. The harvest plot showed that in lower risk of bias studies, participants of SPPs had lower weight and fertility, were older at sexual debut, and breastfed their infants for longer. Interpretation No studies have

yet assessed the effect of SPPs on breast and cervical cancer incidence, survival, or mortality; nevertheless, the existing evidence suggests positive impacts on risk and protective factors

Is the EU Steering National Social and Health Policy Making? A Case-Study on Finland's National Reform

HEINONEN N., KOIVUSALO M., KESKIMÄKI I., *et al.*

2024

Health Policy: 105078. [In press]

https://doi.org/10.1016/j.healthpol.2024.105078

As part of the European Semester, Finland received country-specific recommendations (CSRs) in 2013–2020 that encouraged the reform of national social and health services. These recommendations were part of efforts to balance public finances and implement public-sector structural reforms. Finland has been struggling to reform the national social and health care system since 2005. Only on 1 January 2023 did the new wellbeing services counties become liable for organizing social, health, and rescue services. Studying the CSRs for Finland enables us to understand better what genuinely occurs at the EU member state level. This data-driven case study aims to disclose the relevance of the European Semester for Finland in the pursuit of a national social and health system reform. The mixed-method approach is based on the research tradition of governance, and the study contains features of data sourcing and methodological triangulation. Empirically, the research material consists of Finland's official policy documents and anonymous semi-structured elite interviews. The study highlights that although the received CSRs on the need to restructure social and health services corresponded to Finland's views, their influence to national reform efforts was limited. The CSRs were administered according to the established formal routines, but separately from the national reform preparations. The CSRs, however, delivered implicit steering, which were considered to affect social and health policy making in various ways.

Lessons Learned from a Global Analysis of Priority Setting Practices in Pandemic Response Planning

KAPIRIRI L. ET ESSUE B. M.

2024

Health Policy: 144: 105075.

https://doi.org/10.1016/j.healthpol.2024.105075

The Impact of Raising Alcohol Taxes on Government Tax Revenue: Insights from Five European Countries

MANTHEY J., GOBIŅA I., ISAJEVA L., *et al.*

2024

Applied Health Economics and Health Policy 22(3): 363-374.

https://doi.org/10.1007/s40258-024-00873-5

Reducing the affordability of alcoholic beverages by increasing alcohol excise taxation can lead to a reduction in alcohol consumption but the impact on government alcohol excise tax revenue is poorly understood. This study aimed to (a) describe cross-country tax revenue variations and (b) investigate how changes in taxation were related to changes in government tax revenue, using data from Estonia, Germany, Latvia, Lithuania and Poland.

Prévention

Prevention

De l'intérêt de l'État à tirer les leçons de la crise sanitaire, considérée comme un moment responsabilisant les acteurs du dernier kilomètre. Le cas des chefs de centre de vaccination

STROEYMEYT L.

2024

Sève : Les Tribunes de la santé 79(1): 65-74.
https://doi.org/10.1684/seve1.2024.10

Réponse à la crise sanitaire qui a débuté en mars 2020 en France, la campagne vaccinale contre la Covid-19 a conduit à la vaccination de plus de 50 000 000 de personnes en moins d'un an. Élaborée en quelques mois, cette campagne est démesurée par les enjeux (scientifiques, industriels, techniques, humains et financiers), les moyens mobilisés et les finalités visées. Elle a mobilisé 130 000 vaccinateurs répartis dans près de 2 000 centres, véritable service public d'urgence du dernier kilomètre. Dans un climat de crise aiguë où les administrations, les procédures, les décisions, etc. sont en évolution constante, les chefs de centre ont assuré le déploiement effectif d'une politique publique exceptionnelle. Le présent article propose d'étudier leur expérience de la campagne pour identifier les points forts et les marges d'amélioration en général et en gestion de crise en particulier de l'État en matière d'anticipation, de pilotage et de préparation. En mobilisant les sciences sociales d'horizons variés (science politique, sociologie des organisations et des politiques publiques, etc.) et sur la base de données qualitative et quantitative riche et inédite, les résultats démontrent que la crise est un moment « limite » qui met en lumière les forces et les faiblesses des parties prenantes. Les conclusions opérationnelles soulignent l'intérêt à donner plus de responsabilités aux cadres intermédiaires. Note aux lecteurs Cet article s'inspire d'un travail (« rapport individuel d'expertise ») réalisé en 2023 dans le cadre de la scolarité à l'Institut national du service public (ex- ENA). La méthodologie retenue s'appuie à la fois sur une approche qualitative (entretiens semi- directifs, témoignages, RETEX locaux, documentations ministérielles, expérience personnelle au sein de la Task Force Vaccination) et sur une approche quantitative (données en open data, réponses à un questionnaire envoyé aux 2 000 chefs de centre et données de plateformes de recherche d'emploi).

Psychiatrie

Psychiatry

Psychological Therapies for Depression in Older Adults Residing in Long-Term Care Settings

DAVISON T. E., BHAR S., WELLS Y., *et al.*

2024

Cochrane Database of Systematic Reviews(3).
https://doi.org/10.1002/14651858.CD013059.pub2

- Background Depression is common amongst older people residing in long-term care (LTC) facilities. Currently, most residents treated for depression are prescribed antidepressant medications, despite the potential availability of psychological therapies that are suitable for older people and a preference amongst many older people for non-pharmacological treatment approaches. Objectives To assess the effect of psychological therapies for depression in older people living in LTC settings, in comparison with treatment as usual, waiting list control, and non-specific attentional control; and to compare the effectiveness of different types of psychological therapies in this setting. methods. Given the ageing population and projected increase in older people requiring LTC, high-quality clinical trials on the effectiveness of treatments for depression are urgently required. How up to date is this evidence? The literature search was completed in October 2021.

Partnership Building for Scale-Up in the Veteran Sponsorship Initiative: Strategies for Harnessing Collaboration to Accelerate Impact in Suicide Prevention

FINLEY E. P., FRANKFURT S. B., KAMDAR N., *et al.*

2024

Health Services Research 1-11

https://doi.org/10.1111/1475-6773.14309

Abstract Objective To evaluate the implementation and trust-building strategies associated with successful partnership formation in scale-up of the Veteran Sponsorship Initiative (VSI), an evidence-based suicide prevention intervention enhancing connection to U.S. Department of Veterans Affairs (VA) and other resources during the military-to-civilian transition period. Data Sources and Study Setting Scaling VSI nationally required establishing partnerships across VA, the U.S. Department of Defense (DoD), and diverse public and private Veteran-serving organizations. We assessed partnerships formalized with a signed memorandum during pre- and early implementation periods (October 2020–October 2022). To capture implementation activities, we conducted 39 periodic reflections with implementation team members over the same period. Study Design We conducted a qualitative case study evaluating the number of formalized VSI partnerships alongside directed qualitative content analysis of periodic reflections data using Atlas.ti 22.0. Data Collection/Extraction Methods We first independently coded reflections for implementation strategies, following the Expert Recommendations for Implementing Change (ERIC) taxonomy, and for trust-building strategies, following the Theoretical Model for Trusting Relationships and Implementation; a second round of inductive coding explored emergent themes associated with partnership formation. Principal Findings During this period, VSI established 12 active partnerships with public and non-profit agencies. The VSI team reported using 35 ERIC implementation strategies, including building a coalition and developing educational and procedural documents, and trust-building strategies including demonstrating competence and credibility, frequent interactions, and responsiveness. Cultural competence in navigating DoD and VA and accepting and persisting through conflict also appeared to support scale-up. Conclusions VSI's partnership-formation efforts leveraged a variety of implementation strategies, particularly around strengthening stakeholder interrelationships and refining procedures for coordination and communication. VSI implementation activities were further characterized by an intentional focus on trust-building over time. VSI's rapid scale-up highlights the value of partnership formation for achieving coordinated interventions to address complex problems.

Hospitalisation en service médico-psychologique régional : réflexion autour de l'évolution du projet de soin aux détenus

HETTÉ J., GREGORY-DELCAMPE C., DUCHARLET-NGOM V., *et al.*

2024

L'information psychiatrique 100(4): 225-230.

https://doi.org/10.1684/ipe.2024.2704

Parmi les vingt-six services médico-psychologiques régionaux de France, celui de Poitiers fait état d'une longue expérience de prise en charge des patients détenus en provenance des établissements pénitentiaires de la région, en proposant depuis toujours des soins en hospitalisation de jour. Récemment, le service a fait évoluer son fonctionnement d'hôpital de jour sur le modèle et dans l'esprit d'une unité de psychiatrie générale, notamment par un système de portes (cellules) ouvertes. Cette évolution a nécessité une réflexion sur les relations entre les patients détenus, les soignants et les surveillants pénitentiaires. Elle a également permis, sous certaines conditions, l'accès des femmes détenues à l'hospitalisation, ce qui constitue une des premières expériences françaises en la matière.

Équipes mobiles à destination de mineurs confiés à l'aide sociale à l'enfance : modalités d'intervention, intérêt et difficultés rencontrées

KOMPÉ A. T.

2024

L'information psychiatrique 100(4): 253-259.

https://doi.org/10.1684/ipe.2024.2708

Dans un souci de mieux répondre aux difficultés des mineurs confiés à l'Aide sociale à l'enfance aux parcours chaotiques et de soutenir les professionnels de ces institutions, des équipes mobiles se sont déployées en Gironde selon des modalités que nous allons vous décrire au travers d'une vignette clinique. Soigner et fluidifier le réseau de partenaires autour du jeune est notre souci, la promotion de l'acculturation notre préoccupation, la pédagogie clinique notre levier d'action.

Ainsi après une présentation des actions menées, nous ferons ressortir les intérêts d'un tel dispositif tout en analysant les freins rencontrés et les perspectives de recherches qui se dessinent.

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

SPEARING J.

2024

Health Economics :1-28.

https://doi.org/10.1002/hec.4835

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

Delayed Discharge in Inpatient Psychiatric Care: A Systematic Review

TEALE A.-L., MORGAN C., JENKINS T. A., *et al.*

2024

International Journal of Mental Health Systems 18(1): 14.

https://doi.org/10.1186/s13033-024-00635-9

Delayed discharge is problematic. It is financially costly and can create barriers to delivering best patient care, by preventing return to usual functioning and delaying admissions of others in need. This systematic review aimed to collate existing evidence on delayed discharge in psychiatric inpatient settings and to develop understanding of factors and outcomes of delays in these services.

The Transition Towards Community-Based Mental Health Care in the European Union: Current Realities and Prospects

VANDONI M., D'AVANZO B. ET BARBATO A.

2024

Health Policy: 144 : 105081.

https://doi.org/10.1016/j.healthpol.2024.105081

The shift of mental health care from mental institutions to community-based services has been implemented differentially throughout the EU. However, because a comprehensive overview of the current mental health provision in member states is lacking, it is challenging to compare services across nations. This study investigates the extent of implementation of community-based mental health services within the EU using data collected from the WHO Mental Health Atlas. Results show that, although great cross-country variation exists in the implementation of community-based services, mental hospitals remain the prominent model of care in most countries. A few countries endorsed a balanced care model, with the co-occurrence of community services and mental hospitals. However, missing data, low quality of data and different service definitions hamper the possibility of a thorough analysis of the status on deinstitutionalization. Although policies on the closing and downsizing of mental institutions have been endorsed by the EU, the strong presence of mental hospitals slows down the shift towards community-based mental health care. This study highlights the need for an international consensus on definitions and a harmonization of indicators on mental health services. Together with the commitment of member states to improve the quality of data reporting, leadership must emerge to ensure quality monitoring of mental health-related data, which will help advance research, policies and practices.

Soins de santé primaires

Primary Health care

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

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

2024

Health Services Research 59(3): e14303.

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

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

Médecins libéraux et systèmes de santé. Observations à partir de droits d'ailleurs

BADEL M.

2024

Revue de droit sanitaire et social 2024(2): 230-239.

L'appréciation du système de santé français conduit souvent à porter le regard au- delà des frontières, généralement pour souligner la situation ô combien avantageuse de nos médecins libéraux et leur grande liberté par rapport à leurs confrères étrangers. Mais pour autant qu'ils soient exacts, les exemples cités à cette fin, parcellaires, ne permettent pas de rendre compte de la réalité des autres systèmes. Qu'il s'agisse des modalités d'exercice de leur art, de leur rétribution, du suivi des patients, ces marqueurs des systèmes de santé ne peuvent en effet être analysés sans être mis en perspective les uns avec les autres, car seule leur combinaison permet d'avoir une vue complète et réaliste de la situation de ceux qui en sont les protagonistes : les médecins et les patients (extrait du texte).

The Hidden Work of General Practitioners: An Ethnography

BARNARD R., SPOONER S., HUBMANN M., *et al.*

2024

Social Science & Medicine: 350 : 116922.

https://doi.org/10.1016/j.socscimed.2024.116922

High quality primary care is a foundational element of effective health services. Internationally, primary care physicians (general practitioners (GPs), family doctors) are experiencing significant workload pressures. How non-patient-facing work contributes to these pressures and what constitutes this work is poorly understood and often unrecognised and undervalued by patients, policy makers, and even clinicians engaged in it. This paper examines non-patient-facing work ethnographically, informed by practice theory, the Listening Guide, and empirical ethics. Ethnographic observations (104 hours), in-depth interviews (n = 16; 8 with GPs and 8 with other primary care staff) and reflexive workshops were conducted in two general practices in England.

Our analysis shows that 'hidden work' was integral to direct patient care, involving diverse clinical practices such as: interpreting test results; crafting referrals; and accepting interruptions from clinical colleagues. We suggest the term 'hidden care work' more accurately reflects the care-ful nature of this work, which was laden with ambiguity and clinical uncertainty. Completing hidden care work outside of expected working hours was normalised, creating feelings of inefficiency, and exacerbating workload pressure. Pushing tasks forward into an imagined future (when conditions might allow its completion) commonly led to overspill into GPs' own time. GPs experienced tension between their desire to provide safe, continuous, 'caring' care and the desire to work a manageable day, in a context of increasing demand and burgeoning complexity.

L'encadrement pluriel de la liberté d'installation des professionnels de santé par les conventions nationales

COLLET C.

2024

Revue de droit sanitaire et social 2024(2): 202-209.

Cet article interroge les manifestations interventionnisme de la médicale dans le champ d'installation. Par principe, l'accès au conventionnement des professionnels de libéraux en France comme dans des systèmes assurantiels. Depuis le début des années cependant, s'est développée une réglementation relative au conventionnement stricte pour certaines ainsi en est- il des professions d'infirmière, de sage- femme, masseur- kinésithérapeute et récemment, de chirurgien- dentiste. Pour les médecins, la forte opposition du corps médical à la restriction de d'installation, laquelle cristallise pourtant autour d'elle l'enjeu de l'accès aux soins, ne permet pour l'heure à la convention médicale de n'être qu'incitative à leur égard. Pour répondre à l'enjeu de l'attractivité de la médecine libérale sur les territoires déficitaires, l'accompagnement à l'installation semble être une voie prometteuse.

Indépendance, liens et conflits d'intérêts à l'heure des coopérations interprofessionnelles

ESCOBEDO P.

2024

Sève : Les Tribunes de la santé 79(1): 41-44.

https://doi.org/10.1684/seve1.2024.2

L'indépendance professionnelle du médecin fonde la confiance du patient envers le praticien. L'institution ordinale en est garante, alors que cette indépendance est d'autant plus menacée, à l'heure de l'évolution rapide des modalités d'exercices et des coopérations professionnelles. L'institution a ainsi une vigilance toute particulière et fait en sorte que, dans ses missions, les médecins gardent les moyens nécessaires pour l'exercer. Deux situations plus particulièrement seront envisagées en lien avec l'indépendance professionnelle, les situations de liens et conflits d'intérêts, et le compérage. Les situations de liens et conflits d'intérêts peuvent influencer les décisions médicales. Une vigilance particulière est préconisée dans les domaines de l'information, de l'assurance, du contrôle et de l'expertise médicale. Le compérage lui, constitue un risque toujours d'actualité, et a justifié un encadrement des coopérations interprofessionnelles. Les contrats signés par les médecins représentent un outil essentiel en ce domaine, ils doivent préciser les moyens mis en œuvre, notamment au sein des coopérations professionnelles, pour que l'indépendance professionnelle puisse s'exercer au bénéfice du patient.

Restrictiveness of Medicare Advantage Provider Networks Across Physician Specialties

FEYMAN Y., FIGUEROA J., GARRIDO M., *et al.*

2024

Health Services Research 1-8

https://doi.org/10.1111/1475-6773.14308

Abstract Objective The objective was to measure specialty provider networks in Medicare Advantage (MA) and examine associations with market factors. Data Sources and Study Setting We relied on traditional Medicare (TM) and MA prescription drug event data from 2011 to 2017 for all Medicare beneficiaries in the United States as well as data from the Area Health Resources File. Study Design Relying on a recently developed and validated prediction model, we calculated the provider network restrictiveness of MA contracts for nine high-prescribing specialties.

We characterized network restrictiveness through an observed-to-expected ratio, calculated as the number of unique providers seen by MA beneficiaries divided by the number expected based on the prediction model. We assessed the relationship between network restrictiveness and market factors across specialties with multivariable linear regression. Data Collection/ Extraction Methods Prescription drug event data for a 20% random sample of beneficiaries enrolled in prescription drug coverage from 2011 to 2017. Principal Findings Provider networks in MA varied in restrictiveness. OB-Gynecology was the most restrictive with enrollees seeing 34.5% (95% CI: 34.3%–34.7%) as many providers as they would absent network restrictions; cardiology was the least restrictive with enrollees seeing 58.6% (95% CI: 58.4%–58.8%) as many providers as they otherwise would. Factors associated with less restrictive networks included the county-level TM average hierarchical condition category score (0.06; 95% CI: 0.04–0.07), the county-level number of doctors per 1000 population (0.04; 95% CI: 0.02–0.05), the natural log of local median household income (0.03; 95% CI: 0.007–0.05), and the parent company's market share in the county (0.16; 95% CI: 0.13–0.18). Rurality was a major predictor of more restrictive networks (–0.28; 95% CI: –0.32 to –0.24). Conclusions Our findings suggest that rural beneficiaries may face disproportionately reduced access in these networks and that efforts to improve access should vary by specialty.

▶ It's a Jungle Out There: Understanding Physician Payment and Its Role in Group Dynamics

GIFFORD R., MOLLEMAN E. ET VAN DER VAART T.

2024

Social Science & Medicine 350: 116945.

https://doi.org/10.1016/j.socscimed.2024.116945

Although collaboration between healthcare professionals is essential for the delivery of effective, efficient, and high-quality care, it remains an ongoing and critical challenge across health systems. As a result, many countries are experimenting with innovative payment and employment models. The literature tends to focus on improving collaboration across organizational and sectoral boundaries, and largely ignores potential barriers to collaborative work between members of the same profession within a single organization. Despite intergroup dynamics and professional boundaries having been shown to restrict patient flow and collaboration between specialties, studies have so far tended to overlook the potential effects of differentiated organizational and payment models on physicians' behaviors and intergroup dynamics. In the present study, we seek to unpack the influence of physicians' payment and employment models on their collaborative behaviors and on intergroup dynamics between specialties, adding to the current scholarship on physician payment and employment by considering how physicians' view and act in response to different structural arrangements. The findings suggest that adopting hybrid models, in which physicians are employed or paid differently within the same organization or practice, creates a bifurcation of the profession whereby physicians across different models are perceived to behave differently and have conflicting professional values. These models are perceived to inhibit collaboration between physicians and complicate hospital governance, restricting the ability to move towards new models of care delivery. These findings can be used as a basis for future work that aims to unpack the reality of physician payment and offer important insights for policies surrounding physician employment.

▶ Devenir infirmier en pratique avancée : les dimensions subjectives d'une mobilité discrète au sein du groupe infirmier

GIRAUD F. ET MORALDO D.

2024

Formation emploi 165(1): 43-63.

https://doi.org/10.4000/formationemploi.12266

En 2018, la loi de modernisation du système de santé crée le diplôme d'infirmier en pratique avancée (IPA), nouveau segment professionnel, entre les médecins et les infirmiers diplômés d'État (IDE). Cet article s'intéresse à la manière dont les infirmiers en exercice, de façon socialement différenciée, d'une part, choisissent de reprendre des études contraignantes pour obtenir ce diplôme ; d'autre part, s'approprient ce nouveau diplôme dans leur manière de vivre la pratique infirmière. Il montre notamment que si, objectivement, l'obtention du diplôme IPA s'apparente à une mobilité « sur place », « horizontale » ou « discrète », subjectivement, elle peut être appréhendée tout autrement par certains : comme une véritable « mobilité verticale » et comme l'entrée dans un nouveau métier.

Migration and Professional Mobility: Rural Attraction and Retention of South African Educated Physicians

HADLEY A.

2024

Social Science & Medicine: 350:116884.
https://doi.org/10.1016/j.socscimed.2024.116884

Rural communities in Alberta, Canada have faced physician shortages for decades. Attracting internationally educated physicians, including many South African physicians, is one way to address this problem. While much of the research on international medical graduates (IMGs) focuses on the push and pull of attraction and retention, I situate the decision to stay as a matter of geographic and professional mobility, all within a life course perspective. More specifically, I explore physicians' decisions to migrate from South Africa to rural Alberta and the impact of professional mobility on their migrations. To understand the processes, I collected data via semi-structured virtual interviews with 29 South African educated generalist/family physicians with experience in rural Alberta. Research was guided by abductive grounded theory and data was analysed using open thematic coding. I found that South African educated physicians made the decision to leave South Africa and to come to Canada to pursue prestige and opportunity they perceived to be inaccessible in South Africa. However, physicians were limited to perceived low prestige work as rural generalists, while they understood that more prestigious work was reserved for Canadian educated physicians. Physicians who remained in rural communities brought their aspirations to life, or achieved upward professional mobility in rural communities, through focused clinical and administrative opportunities. The decision to leave rural communities was often a matter of lifestyle and burnout over prestige.

Les conflits d'intérêts en médecine ou la mise en transparence des dynamiques d'influence industrielle

HAURAY B.

2024

Sève :Les Tribunes de la santé 79(1): 15-23.
https://doi.org/10.1684/seve1.2024.1

Depuis le milieu du 20e siècle, une catégorie sociale, le conflit d'intérêts, s'est imposée pour penser l'influence des laboratoires pharmaceutiques au sein de la médecine : appliquée d'abord aux enjeux d'expertise, elle a été ensuite mobilisée pour penser les biais des publications scientifiques, avant de viser les multiples facettes de la présence des industriels de la pharmacie dans la vie du monde médical. Le succès de cette catégorie traduit plusieurs processus sociaux : la place importante prise par les professionnels de santé dans la société, des doutes sur une hétéronomie créée par leurs liens de plus en plus manifestes avec des acteurs économiques, un mouvement de démocratisation sanitaire (mise en cause de l'autorité médicale, mobilisation de collectifs et d'associations), et des tentatives de restaurer la confiance par des régulations de ces conflits d'intérêts. Si cette diffusion a permis de mettre en œuvre des politiques visant à limiter les situations de conflits d'intérêts, elle s'est souvent traduite par l'instauration de différentes politiques de mises en transparence des dynamiques d'influence.

Investing in Child Health Through Alternative Payment Models: Lessons from North Carolina Integrated Care for Kids

JAMES G., KASPER E., WONG C. A., *et al.*

2024

Medical Care Research and Review 81(3): 259–270.
https://doi.org/10.1177/10775587231217178

Pediatric value-based payment reform has been hindered by limited return on investment (ROI) for child-focused measures and the accrual of financial benefits to non-health care sectors. States participating in the federally-funded Integrated Care for Kids (InCK) models are required to design child-centered alternative payment models (APMs) for Medicaid-enrolled children. The North Carolina InCK pediatric APM launched in January 2023 and includes innovative measures focused on school readiness and social needs. We interviewed experts at NC Medicaid managed care organizations, NC Medicaid, and actuaries with pediatric value-based payment experience to assess the NC InCK APM design process and develop strategies for future child-focused value-based payment reform. Key principles emerging from conversations included: accounting for payer priorities and readiness to implement measures; impact of data uncertainty on investment in novel measures; misalignment of a short-term ROI framework with whole child health measures; and state levers like mandates and financial incentives to promote implementation.

Healthcare Utilisation by Diabetic Patients in Denmark: The Role of Primary Care in Reducing Emergency Visits

LAUDICELLA M., DONNI P. ET PRETE V.

2024

Health Policy: 145 105079.
https://doi.org/10.1016/j.healthpol.2024.105079

Improving the management of diabetic patients is receiving increasing attention in the health policy agenda due to increasing prevalence in the population and raising pressure on healthcare resources. This paper examines the determinants of healthcare services utilisation in patients with type-2 diabetes, investigating the potential substitution effect of general practice visits on the utilisation of emergency department visits. By using rich longitudinal data from Denmark and a bivariate econometric model, our analysis highlights primary care services that are more effective in preventing emergency department visits and socioeconomic groups of patients with a weak substitution response. Our results suggest that empowering primary care services, such as preventive assessment visits, may contribute to reducing emergency department visits significantly. Moreover, special attention should be devoted to vulnerable groups, such as patients from low socioeconomic background and older patients, who may find more difficult achieving a large substitution response.

Loneliness Impact on Healthcare Utilization in Primary Care: A Retrospective Study

MIRA J. J., TORRES D., GIL V., *et al.*

2024

Journal of Healthcare Quality Research [In press]
https://doi.org/10.1016/j.jhqr.2024.04.001

Background An increased number of patients seek help for loneliness in primary care. Objective To analyze whether loneliness was associated with a higher utilization of healthcare facilities. Methods Observational, retrospective study based on the review of routinely coded data in the digital medical record system in a random sample of patients aged 65 or older, stratified by population size of their residence area. A minimum sample size was estimated at 892 medical records. Loneliness was defined as the negative feeling that arises when there is a mismatch between the quantity and quality of a person's social relationships and those, they desire. Thirty-three primary care nurses (30 females and 3 males) were reviewing the data. Results A total of 932 medical records of patients were reviewed (72% belonged to female patients). Of these, 657 individuals were living alone (71.9%). DeJong Scale average scores was 8.9 points (SD 3.1, 95CI 8.6–9.1). The average annual attendance to primary care ranged from 12.2 visits per year in the case of family practice, 10.7 nurse, 0.7 social workers. The average number of home visits was 3.2, and the urgent consultations attended at health centers were 1.5 per year. Higher feelings of loneliness were associated with extreme values in the frequency of healthcare resource usage. Compared to their peers of the same age, the additional healthcare resource consumption amounted to €802.18 per patient per year. Conclusion Loneliness is linked to higher healthcare resource usage in primary care, with individuals experiencing poorer physical and mental health utilizing these resources up to twice as much as their peers of the same age.

Physician Group Practices Accrued Large Bonuses Under Medicare's Bundled Payment Model, 2018–20

SHASHIKUMAR, S.A., CHOPRA Z.

2024

Health Affairs 43(5): 623-631.
https://doi.org/10.1377/hlthaff.2023.00915

The Bundled Payments for Care Improvement Advanced Model (BPCI-A), a voluntary Alternative Payment Model for Medicare, incentivizes hospitals and physician group practices to reduce spending for patient care episodes below preset target prices. The experience of physician groups in BPCI-A is not well understood. We found that physician groups earned $421 million in incentive payments during BPCI-A's first four performance periods (2018–20). Target prices were positively associated with bonuses, with a mean reconciliation payment of $139 per episode in the lowest decile of target prices and $2,775 in the highest decile. In the first year of the COVID-19 pandemic, mean bonuses increased from $815 per episode to $2,736 per episode. These findings suggest that further policy changes, such as improving target price accuracy and refining participation rules, will be important as the Centers for Medicare and Medicaid Services continues to expand BPCI-A and develop other bundled payment models.

Systèmes de santé

Health Systems

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

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

2024

Social Science & Medicine 348: 116801.

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

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

The Impact of Medicaid Accountable Care Organizations on Health Care Utilization, Quality Measures, Health Outcomes and Costs from 2012 to 2023: A Scoping Review

HOLM J., PAGÁN J. A. ET SILVER D.

2024

Medical Care Research and Review 0(0): 10775587241241984.

https://doi.org/10.1177/10775587241241984

Most of the evidence regarding the success of ACOs is from the Medicare program. This review evaluates the impacts of ACOs within the Medicaid population. We identified 32 relevant studies published between 2012 and 2023 which analyzed the association of Medicaid ACOs and health care utilization (n = 21), quality measures (n = 18), health outcomes (n = 10), and cost reduction (n = 3). The results of our review regarding the effectiveness of Medicaid ACOs are mixed. Significant improvements included increased primary care visits, reduced admissions, and reduced inpatient stays. Cost reductions were reported in a few studies, and savings were largely dependent on length of attribution and years elapsed after ACO implementation. Adopting the ACO model for the Medicaid population brings some different challenges from those with the Medicare population, which may limit its success, particularly given differences in state Medicaid programs.

Local Level Economic Evaluation: What Is It? What Is Its Value? Is It Sustainable?

KARNON J., PARTINGTON A., GRAY J., *et al.*

2024

Applied Health Economics and Health Policy 22(3): 273-281.

https://doi.org/10.1007/s40258-023-00847-z

In Australia, local health services with allocated budgets manage public hospital services for defined geographical areas. The authors were embedded in a local health service for around 2 years and undertook a range of local level economic evaluations for

which three decision contexts were defined: intervention development, post-implementation and prioritisation. Despite difficulties in estimating opportunity costs and in the relevance of portfolio-based prioritisation approaches, economic evaluation added value to local decision-making. Development-focused (ex ante) economic evaluations used expert elicitation and calibration methods to synthesise published evidence with local health systems data to evaluate interventions to prevent hospital acquired complications. The use of economic evaluation facilitated the implementation of interventions with additional resource requirements. Decision analytic models were used alongside the implementation of larger scale, more complex service interventions to estimate counterfactual patient pathways, costs and outcomes, providing a transparent alternative to the statistical analyses of intervention effects, which were subject to high risk of bias. Economic evaluations of more established services had less impact due to data limitations and lesser executive interest. Prioritisation-focused economic evaluations compared costs, outcomes and processes of care for defined patient populations across alternative local health services to identify, understand and quantify the effects of unwarranted variation to inform priority areas for improvement within individual local health services. The sustained use of local level economic evaluation could be supported by embedding health economists in local continuous improvement units, perhaps with an initial focus on supporting the development and evaluation of prioritised new service interventions. Shared resources and critical mass are important, which could be facilitated through groups of embedded economists with joint appointments between different local health services and the same academic institution.

Travail et santé

Occupational Health

▶ Trajectories of Job Insecurity and the Probability of Poorer Mental Health Among Prime Working-Age Australian Women and Men

ERVIN J., LAMONTAGNE T., TAOUK Y., *et al.*
2024
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Precarious and insecure employment arrangements are important social determinants of health. Prior evidence has consistently found perceived job insecurity to be associated with poorer mental health. Nonetheless, several key under-researched areas remain in the existing evidence base. This study addresses some of these gaps by examining trajectories of job (in)security and assessing the effect of various persistent job security trajectories on subsequent mental health of both men and women. Utilising 15 waves of data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey, we employed group-based trajectory modelling (GBTM) to identify trajectories of job (in) security through men and women's prime working years (from baseline age of 28-38yrs to 41-51yrs) across 14 years (waves 5-18), before subsequently examining the associations between these estimated trajectories and mental health at wave 19 (aged 42-52yrs). We identified four distinct trajectories of job (in)security for both men and women: persistently secure, becoming more secure, becoming less secure, and persistently insecure. Examining the association between these trajectories and mental health, we found that chronic exposure to any amount of persistent job insecurity (improving, worsening or persistently insecure) is detrimental to the mental health of both men and women. Furthermore, a somewhat incremental or dose dependant effect was found, with persistent job insecurity associated with the largest declines in mental health scores. Given mental health disorders are a substantial cause of disability globally, our study provides evidence that developing policy and practice interventions to reduce job insecurity (as an increasingly recognised and highly modifiable social determinant of mental health) has considerable potential to enact positive population health improvements.

Inégalités de genre face à l'inaptitude au travail

GABORIAU M.

2024

Travail, genre et sociétés 51(1): 45-64.

https://doi.org/10.3917/tgs.051.0045

À partir d'une enquête sociologique au sein de la Ville de Paris, cet article propose d'objectiver statistiquement et d'analyser qualitativement les inégalités sociales et genrées en matière de reconnaissance d'inaptitude pour raison de santé dans la fonction publique. Il s'agit en particulier de comprendre la surreprésentation des femmes de service et du care parmi les agent·es déclaré·es inaptes, en l'étudiant au regard de leurs activités de travail particulièrement pénibles mais peu reconnues comme telles, de leurs statuts d'emploi plus souvent précaires et de leurs trajectoires socio-professionnelles plus décousues. La reconnaissance d'inaptitude semble fonctionner comme un pis-aller et constituer un statut de relégation pour les femmes qui ne bénéficient pas de droits plus protecteurs et/ou de ressources (protections statutaires ou collectives, retraite anticipée pour pénibilité), leur permettant de faire face au dispositif ou de s'en détourner quand elles ont plus à y perdre qu'à y gagner.

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 télétravail 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.

Vieillissement

Aging

Does Assisted Living Provide Assistance and Promote Living?

ZIMMERMAN S., STONE R., *et al.*

2024

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Assisted living has promised assistance and quality of living to older adults for more than eighty years. It is the largest residential provider of long-term care in the United States, serving more than 918,000 older adults as of 2018. As assisted living has evolved, the needs of residents have become more challenging; staffing shortages have worsened; regulations have become complex; the need for consumer support, education, and advocacy has grown; and financing and accessibility have become insufficient. Together, these factors have limited the extent to which today's assisted living adequately provides assistance and promotes living, with negative consequences for aging in place and well-being. This Commentary provides recommendations in four areas to help assisted living meet its promise: workforce; regulations and government; consumer needs and roles; and financing and accessi-

bility. Policies that may be helpful include those that would increase staffing and boost wages and training; establish staffing standards with appropriate skill mix; promulgate state regulations that enable greater use of third-party services; encourage uniform data reporting; provide funds supporting family involvement; make community disclosure statements more accessible; and offer owners and operators incentives to facilitate access for consumers with fewer resources. Attention to these and other recommendations may help assisted living live up to its name.

Burnout Among Nursing Home Care Aides and the Effects on Resident Outcomes

GRUNEIR A., CHAMBERLAIN S. A., JENSEN C., *et al.*
2024
Medical Care Research and Review 81(3): 233–244.
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While burnout among health care workers has been well studied, little is known about the extent to which burnout among health care workers impacts the outcomes of their care recipients. To test this, we used a multi-year (2014–2020) survey of care aides working in approximately 90 nursing homes (NHs); the survey focused on work–life measures, including the Maslach Burnout Inventory (MBI) and work-unit identifier. Resident Assessment Instrument Minimum Data Set (RAI-MDS 2.0) data were obtained on all residents in the sampled NHs during this time and included a unit identifier for each resident. We used multi-level models to test associations between the MBI emotional exhaustion and cynicism sub-scales reported by care aides and the resident outcomes of antipsychotics without indication, depressive symptoms, and responsive behaviors among residents on units. In 2019/2020, our sample included 3,547 care aides and 10,117 residents in 282 units. The mean frequency of emotional exhaustion and cynicism across units was 43% and 50%, respectively. While residents frequently experienced antipsychotics without indication 1,852 (18.3%), depressive symptoms 2,089 (20.7%), and responsive behaviors 3,891 (38.5%), none were found to be associated with either emotional exhaustion or cynicism among care aides.

Mortality Risk Following End-Of-Life Caregiving: A Population-Based Analysis of Hospice Users and Their Families

HOLLINGSHAUS M., SMITH K. R., MEEKS H., *et al.*
2024
Social Science & Medicine 348: 116781.
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Experiencing the death of a family member and providing end-of-life caregiving can be stressful on families – this is well-documented in both the caregiving and bereavement literatures. Adopting a linked-lived theoretical perspective, exposure to the death and dying of one family member could be conceptualized as a significant life stressor that produces short and long-term health consequences for surviving family members. This study uses familial-linked administrative records from the Utah Population Database to assess how variations in family hospice experiences affect mortality risk for surviving spouses and children. A cohort of hospice decedents living in Utah between 1998 and 2016 linked to their spouses and adult children (n = 37,271 pairs) provides an ideal study population because 1) hospice typically involves family members in the planning and delivery of end-of-life care, and 2) hospice admission represents a conscious awareness and acknowledgment that the decedent is entering an end-of-life experience. Thus, hospice duration (measured as the time between admission and death) is a precise measure of the family's exposure to an end-of-life stressor. Linking medical records, vital statistics, and other administrative microdata to describe decedent-kin pairs, event-history models assessed how hospice duration and characteristics of the family, including familial network size and coresidence with the decedent, were associated with long-term mortality risk of surviving daughters, sons, wives (widows), and husbands (widowers). Longer hospice duration increased mortality risk for daughters and husbands, but not sons or wives. Having other family members in the state was protective, and living in the same household as the decedent prior to death was a risk factor for sons. We conclude that relationship type and sex likely modify the how of end-of-life stressors (i.e., potential caregiving demands and bereavement experiences) affect health because of normative gender roles. Furthermore, exposure to dementia deaths may be particularly stressful, especially for women.

Mental Health in Nursing Homes: The Role of Immigration in the Long-Term Care Workforce

JUN H. ET GRABOWSKI D. C.

2024

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https://doi.org/10.1016/j.socscimed.2024.116978

One-fourth of nursing home residents are diagnosed with anxiety disorders and approximately half live with depression. Nursing homes have long struggled with staffing shortages, and the lack of care has further heightened the risk of poor mental health. A key solution to both problems could be immigration. Prior studies have documented how immigrant labor could strengthen the long-term care workforce. We add to this picture by exploring the impact of immigrant inflows on the mental health outcomes of nursing home residents. Using a nationally representative dataset and a shift-share instrumental variable approach, we find empirical evidence that immigration reduces diagnoses of depression and anxiety, the use of antidepressant and antianxiety drugs, and self-assessed symptoms of depression. The results are robust to several sensitivity tests. We further find that the effect is more substantial in facilities with lower direct care staff hours per resident and with likely more immigrants without citizenship. Language barriers tend to be a minor issue when providing essential care. The findings suggest that creating a policy framework that directs immigrant labor to the long-term care sector can mutually benefit job-seeking immigrants and nursing home residents.

Long-Run Consequences of Informal Elderly Care and Implications of Public Long-Term Care Insurance

KORFHAGE T. ET FISCHER-WECKEMANN B.

2024

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https://doi.org/10.1016/j.jhealeco.2024.102884

We estimate a dynamic structural model of labor supply, retirement, and informal caregiving to study short and long-term costs of informal caregiving in Germany. Incorporating labor market frictions and the German tax and benefit system, we find that in the absence of Germany's public long-term insurance scheme, informal elderly care has adverse and persistent effects on labor market outcomes and, thus, negatively affects lifetime earnings and future pension benefits. These consequences of caregiving are heterogeneous and depend on age, previous earnings, and institutional regulations. Policy simulations suggest that while public long-term care insurance policies are fiscally costly and induce negative labor market effects, they can largely offset the personal costs of caregiving and increase welfare, especially for low-income individuals.

Exploring Social Network Typologies and Their Impact on Health and Mental Well-Being in Older Adults: Evidence from JAGES

TORRES Z., OLIVER A., TOMÁS J. M., *et al.*

2024

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Background The types of social networks, their prevalence, and their relationship to health outcomes in older age have been different across countries and cultures. Most of the literature has focused on USA or in European countries and little is known about the social network typologies among older adults from Japan. This study aimed to identify these patterns of social network typologies and examine the differences in sociodemographic and related to health variables. Methods 23894 participants from the JAGES project (2019), aged 65 or older (M = 74.74, DT = 6.39) from Japan. Statistical analyses included Latent Profile Analysis (LPA) followed by ANOVAs, Chi square and multinomial logistic regressions tests to compare the profiles. Results Four profiles were identified: family (66.9%), spouse (16.6%), diverse (14.5%), and neighbor/others (1.9%). The profiles differ statistically ($p < 0.001$) in all sociodemographic characteristics and in the means of depression, loneliness, self-perceived health, and happiness. Compared with the "family" network, younger men, with fewer chronic illnesses but higher levels of depression and loneliness were more likely to be in the "spouse" profile, older women with lower socioeconomic status, but less lonely and happier in the "diverse" profile and adults who still working, have lower socioeconomic status and are less happy into the "neighbors/others" group. Discussion We discuss the differences between the profiles found, the potential differences with previous studies and the specific cultural Japanese nuances that may explain the characteristics of the network types founded.

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