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Veille bibliographique en économie de la santé / Watch on Health Economics Literature

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Assurance maladie / Health Insurance

Dormont, B. et Péron, M. (2016). "Does Health Insurance Encourage the Rise in Medical Prices? A Test on Balance Billing in France." Health Economics: Ahead of pub).

<http://dx.doi.org/10.1002/hec.3347>

We evaluate the causal impact of an improvement in insurance coverage on patients' decisions to consult physicians who charge more than the regulated fee. We use a French panel data set of 43,111 individuals observed from 2010 to 2012. At the beginning of the period, none of them were covered for balance billing; by the end, 3819 had switched to supplementary insurance contracts that cover balance billing. Using instrumental variables to deal with possible non-exogeneity of the decision to switch, we find evidence that better coverage increases demand for specialists who charge high fees, thereby contributing to the rise in medical prices. People whose coverage improves increased their average amount of balance billing per consultation by 32%. However, the impact of the coverage shock depends on the supply of physicians. For people residing in areas where few specialists charge the regulated fee, better coverage increases not only prices but also the number of consultations, a finding that suggests that balance billing might limit access to care. Conversely, in areas where patients have a genuine choice between specialists who balance bill and those who do not, we find no evidence of a response to better coverage. Copyright © 2016 John Wiley & Sons, Ltd.

Fagnani J. (coor.) et Lestrade, B. (éd.). (2015/10-12). "Les réformes de la protection sociale en Allemagne depuis les années 1990 : enjeux, arbitrages et résultats." Revue Française des Affaires Sociales(4): 1-126.

<https://www.cairn.info/revue-francaise-des-affaires-sociales-2015-4.htm>

Nay, O., et al. "Achieving universal health coverage in France: policy reforms and the challenge of inequalities." The Lancet **387(10034): 2236-2249.**

[http://dx.doi.org/10.1016/S0140-6736\(16\)00580-8](http://dx.doi.org/10.1016/S0140-6736(16)00580-8)

Since 1945, the provision of health care in France has been grounded in a social conception promoting universalism and equality. The French health-care system is based on compulsory social insurance funded by social contributions, co-administered by workers' and employers' organisations under State control and driven by highly redistributive financial transfers. This system is described frequently as the French model. In this paper, the first in The Lancet's Series on France, we challenge conventional wisdom about health care in France. First, we focus on policy and institutional transformations that have affected deeply the governance of health care over past decades. We argue that the health system rests on a diversity of institutions, policy mechanisms, and health actors, while its governance has been marked by the reinforcement of national regulation under the aegis of the State. Second, we suggest the redistributive mechanisms of the health insurance system are impeded by social inequalities in health, which remain major hindrances to achieving objectives of justice and solidarity associated with the conception of health care in France.

Pelster, M., et al. (2016). "Key Aspects of a Sustainable Health Insurance System in Germany." Appl Health Econ Health Policy **14(3): 293-312.**

BACKGROUND: The main goals of health-care systems are to improve the health of the population they serve, respond to people's legitimate expectations, and offer fair financing. As a result, the health system in Germany is subject to continuous adaption as well as public and political discussions about its design. **OBJECTIVE:** This paper analyzes the key challenges for the German health-care system and the underlying factors driving these challenges. We aim to identify possible solutions to put the German health-care system in a better position to face these challenges. **METHODS:** We utilize a broad array of methods to answer these questions, including a review of the published and grey literature on health-care planning in Germany, semi-structured interviews with stakeholders in the system, and an online questionnaire. **RESULTS:** We find that the most urgent (and manageable) aspects that merit

attention are holistic hospital planning, initiatives to increase (administrative) innovation in the health-care system, incentives to increase prevention, and approaches to increase analytical quality assurance. CONCLUSION: We found that hospital planning, innovation, quality control, and prevention, are considered to be the topics most in need of attention in the German health system.

Raisa, B. D. et Audrey, L. (2016). "Funding Long-Term Care in Canada: Who is Responsible for What?" *HealthcarePapers* **15**(4): 36-40.
<http://www.longwoods.com/product/24587>

As Adams and Vanin (2016) have noted, different ways of funding long-term care (LTC) have different implications. Because health is not just healthcare, and LTC is not homogeneous, determining the appropriate public-private mix is complex. We suggest that how issues are framed helps influence policy choices, including who should pay for what, and how things should be financed. In addition, the distribution of expenditures for some services can be highly skewed, affecting the extent to which average cost data are useful in extrapolating their costs. We note that health expenditures fall into multiple categories, each presenting different policy issues. For example, framing LTC as health, as basic costs associated with living or as forced savings (like pensions) affects which funding approaches might be used, and the extent to which changes in the population distribution will affect cost structures. Underlying these discussions are questions of solidarity, and how much we believe that we are our brother's or grandmother's keeper.

Economie de la santé / Health Economics

Cavazza, M., et al. (2016). "Social/economic costs and quality of life in patients with haemophilia in Europe." *Eur J Health Econ* **17 Suppl 1**: 53-65.

OBJECTIVE: The aim of this study was to determine the economic burden from a societal perspective and the health-related quality of life (HRQOL) of patients with haemophilia in Europe. METHODS: We conducted a cross-sectional study of patients with haemophilia from Bulgaria, France, Germany, Hungary, Italy, Spain Sweden and the UK. Data on demographic characteristics, health resource utilisation, informal care, loss of labour productivity and HRQOL were collected from the questionnaires completed by patients or their caregivers. HRQOL was measured with the EuroQol 5-domain (EQ-5D) questionnaire. The costs have been estimated from a societal perspective adopting a bottom-up approach. RESULTS: A total of 401 questionnaires were included in the study, of which 339 were collected from patients with haemophilia and 62 from caregivers. The lowest average annual cost per person was reported in Bulgaria (euro6,660) and the highest in Germany (euro194,490). Our results demonstrate both a large difference from country to country in the average annual cost per patient in 2012 and the driving role of drugs in costs. Drugs represent nearly 90 % of direct healthcare costs in a majority of the countries analysed (Hungary, Italy, Spain and Germany). In Bulgaria, France and Sweden, however, healthcare services (visits, tests and hospitalisations) prevail. Costs are also shown to differ between children and adults. The mean EQ-5D index score for adult patients was 0.69 and mean EQ-5D VAS was 66.6. The mean EQ-5D index score for carers was 0.87 and mean EQ-5D VAS was 75.5. In the disability score, 60 % showed no disability and measuring caregiver burden with the Zarit Index produced an overall mean score of 25.3. CONCLUSION: We have shown that haemophilia is associated with a substantial economic burden and impaired HRQOL. Studies on cost of illness and HRQOL are important for haemophilia as the future of this disease is likely to change with the development of new innovative treatments. The introduction of these treatments will most likely impact future costs related to haemophilia.

Cavazza, M., et al. (2016). "Social/economic costs and health-related quality of life in patients with Duchenne muscular dystrophy in Europe." *Eur J Health Econ* **17 Suppl 1**: 19-29.

OBJECTIVE: The aim of this study was to determine the economic burden from a societal perspective

and the health-related quality of life (HRQOL) of patients with Duchenne muscular dystrophy (DMD) in Europe. METHODS: We conducted a cross-sectional study of patients with DMD from Bulgaria, France, Germany, Hungary, Italy, Spain, Sweden, and the UK. Data on demographic characteristics, healthcare resource utilization, informal care, labor productivity losses, and HRQOL were collected from the questionnaires completed by patients or their caregivers. HRQOL was measured with the EuroQol 5-domain (EQ-5D) questionnaire. Costs have been estimated from a societal perspective adopting a bottom-up approach. RESULTS: A total of 422 questionnaires were included in the study; 268 of which were collected from patients with DMD and 154 from caregivers. The average annual cost per person in 2012 ranged from euro7657 in Hungary to euro58,704 in France. Direct non-healthcare costs are the main component of whole costs and informal care is the main driver of non-healthcare costs. Costs are also shown to differ between children and adults. With regard to HRQOL of adult patients, the EQ-5D VAS score and EQ-5D index scores were 50.5 and 0.24, respectively. The corresponding EQ-5D VAS and EQ-5D index scores for caregivers were 74.7 and 0.71, respectively. CONCLUSIONS: We have estimated the average annual cost per patient with DMD in eight European countries adopting a social perspective, and to our knowledge this is the first study with such a wide perspective. The results on costs show a considerable gap between Eastern and Western European countries. Non-healthcare costs range from 64 to 89 % of overall costs and informal care is to a great extent the main driver of this cost category. The HRQOL of people with DMD is much lower than that of the general population.

Chevreur, K., et al. (2016). "Social/economic costs and health-related quality of life in patients with cystic fibrosis in Europe." *Eur J Health Econ* 17 Suppl 1: 7-18.

OBJECTIVES: Our goal was to provide data on the economic burden and health-related quality of life (HRQOL) of patients with cystic fibrosis (CF) and their caregivers in Europe. METHODS: A cross-sectional study was carried out on adults and children with CF in eight European countries. Patients completed an anonymous questionnaire regarding their socio-demographic characteristics, use of healthcare services and presence of a caregiver. Costs were calculated with a bottom-up approach using unit costs from each participating country, and HRQOL was assessed using EQ-5D. The principal caregiver also answered a questionnaire on their characteristics, HRQOL and burden. RESULTS: A total of 905 patients with CF was included (399 adults and 506 children). The total average annual cost per patient varied from euro21,144 in Bulgaria to euro53,256 in Germany. Adults had higher direct healthcare costs than children, but children had much higher informal care costs ($P < 0.0001$). Total costs increased with patients' level of dependence. In adults, mean utility fell between 0.640 and 0.870, and the visual analogue scale ranged from 46.0 to 69.7. There was no difference in caregiver HRQOL regardless of whether they cared for an adult or a child. However, caregivers who looked after a child had a significantly higher burden ($P = 0.0013$). CONCLUSIONS: Our study highlights the burden of CF in terms of costs and decreased HRQOL for both patients and their caregivers throughout Europe.

Hallberg, S., et al. (2016). "Healthcare costs associated with cardiovascular events in patients with hyperlipidemia or prior cardiovascular events: estimates from Swedish population-based register data." *Eur J Health Econ* 17(5): 591-601.

OBJECTIVES: To estimate healthcare costs of new cardiovascular (CV) events (myocardial infarction, unstable angina, revascularization, ischemic stroke, transient ischemic attack, heart failure) in patients with hyperlipidemia or prior CV events. METHODS: A retrospective population-based cohort study was conducted using Swedish national registers and electronic medical records. Patients with hyperlipidemia or prior CV events were stratified into three cohorts based on CV risk level: history of major cardiovascular disease (CVD), coronary heart disease (CHD) risk-equivalent, and low/unknown risk. Propensity score matching was applied to compare patients with new events to patients without new events for estimation of incremental costs of any event and by event type. RESULTS: A CV event resulted in increased costs over 3 years of follow-up, with the majority of costs occurring in the 1st year following the event. The mean incremental cost of patients with a history of major CVD ($n = 6881$) was euro8588 during the 1st year following the event. This was similar to that of CHD risk-equivalent patients ($n = 3226$; euro6663) and patients at low/unknown risk ($n = 2497$; euro8346). Ischemic stroke

resulted in the highest 1st-year cost for patients with a history of major CVD and CHD risk-equivalent patients (euro 10,194 and euro 9823, respectively); transient ischemic attack in the lowest (euro 3917 and euro 4140). Incremental costs remained elevated in all cohorts during all three follow-up years, with costs being highest in the major CVD history cohort. CONCLUSIONS: Healthcare costs of CV events are substantial and vary considerably by event type. Incremental costs remain elevated for several years after an event.

Lopez-Bastida, J., et al. (2016). "Social/economic costs and health-related quality of life in patients with rare diseases in Europe." *Eur J Health Econ* 17 Suppl 1: 1-5.

Mokdad, A. H., et al. (2016). "Global burden of diseases, injuries, and risk factors for young people's health during 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013." *Lancet*. : Ahead of pub

BACKGROUND: Young people's health has emerged as a neglected yet pressing issue in global development. Changing patterns of young people's health have the potential to undermine future population health as well as global economic development unless timely and effective strategies are put into place. We report the past, present, and anticipated burden of disease in young people aged 10-24 years from 1990 to 2013 using data on mortality, disability, injuries, and health risk factors. METHODS: The Global Burden of Disease Study 2013 (GBD 2013) includes annual assessments for 188 countries from 1990 to 2013, covering 306 diseases and injuries, 1233 sequelae, and 79 risk factors. We used the comparative risk assessment approach to assess how much of the burden of disease reported in a given year can be attributed to past exposure to a risk. We estimated attributable burden by comparing observed health outcomes with those that would have been observed if an alternative or counterfactual level of exposure had occurred in the past. We applied the same method to previous years to allow comparisons from 1990 to 2013. We cross-tabulated the quantiles of disability-adjusted life-years (DALYs) by quintiles of DALYs annual increase from 1990 to 2013 to show rates of DALYs increase by burden. We used the GBD 2013 hierarchy of causes that organises 306 diseases and injuries into four levels of classification. Level one distinguishes three broad categories: first, communicable, maternal, neonatal, and nutritional disorders; second, non-communicable diseases; and third, injuries. Level two has 21 mutually exclusive and collectively exhaustive categories, level three has 163 categories, and level four has 254 categories. FINDINGS: The leading causes of death in 2013 for young people aged 10-14 years were HIV/AIDS, road injuries, and drowning (25.2%), whereas transport injuries were the leading cause of death for ages 15-19 years (14.2%) and 20-24 years (15.6%). Maternal disorders were the highest cause of death for young women aged 20-24 years (17.1%) and the fourth highest for girls aged 15-19 years (11.5%) in 2013. Unsafe sex as a risk factor for DALYs increased from the 13th rank to the second for both sexes aged 15-19 years from 1990 to 2013. Alcohol misuse was the highest risk factor for DALYs (7.0% overall, 10.5% for males, and 2.7% for females) for young people aged 20-24 years, whereas drug use accounted for 2.7% (3.3% for males and 2.0% for females). The contribution of risk factors varied between and within countries. For example, for ages 20-24 years, drug use was highest in Qatar and accounted for 4.9% of DALYs, followed by 4.8% in the United Arab Emirates, whereas alcohol use was highest in Russia and accounted for 21.4%, followed by 21.0% in Belarus. Alcohol accounted for 9.0% (ranging from 4.2% in Hong Kong to 11.3% in Shandong) in China and 11.6% (ranging from 10.1% in Aguascalientes to 14.9% in Chihuahua) of DALYs in Mexico for young people aged 20-24 years. Alcohol and drug use in those aged 10-24 years had an annual rate of change of >1.0% from 1990 to 2013 and accounted for more than 3.1% of DALYs. INTERPRETATION: Our findings call for increased efforts to improve health and reduce the burden of disease and risks for diseases in later life in young people. Moreover, because of the large variations between countries in risks and burden, a global approach to improve health during this important period of life will fail unless the particularities of each country are taken into account. Finally, our results call for a strategy to overcome the financial and technical barriers to adequately capture young people's health risk factors and their determinants in health information systems. FUNDING: Bill & Melinda Gates Foundation.

Sen, B., et al. (2016). "Health Expenditure Concentration and Characteristics of High-Cost Enrollees

in CHIP." Inquiry: The Journal of Health Care Organization, Provision, and Financing 53.
<http://ing.sagepub.com/content/53/0046958016645000.abstract>

Devising effective cost-containment strategies in public insurance programs requires understanding the distribution of health care spending and characteristics of high-cost enrollees. The aim was to characterize high-cost enrollees in a state's public insurance program and determine whether expenditure inequality changes over time, or with changes in cost-sharing policies or program eligibility. We use 1999-2011 claims and enrollment data from the Alabama Children's Health Insurance Program, ALL Kids. All children enrolled in ALL Kids were included in our study, including multiple years of enrollment (N = 1,031,600 enrollee-months). We examine the distribution of costs over time, whether this distribution changes after increases in cost sharing and expanded eligibility, patient characteristics that predict high-cost status, and examine health services used by high-cost children to identify what is preventable. The top 10% (1%) of enrollees account for about 65.5% (24.7%) of total program costs. Inpatient and outpatient costs are the largest components of costs incurred by high-cost utilizers. Non-urgent emergency department costs are a relatively small portion. Average expenditure increases over time, particularly after expanded eligibility, and the share of costs incurred by the top 10% and 1% increases slightly. Multivariable logistic regression results indicate that infants and older teens, Caucasian children, and those with chronic conditions are more likely to be high-cost utilizers. Increased cost sharing does not reduce cost concentration or average expenditure among high-cost utilizers. These findings suggest that identifying and targeting potentially preventable costs among high-cost utilizers are called for to help reduce costs in public insurance programs.

Zweifel, P. (2016). "Catastrophic' healthcare expenditure: critique of a problematic concept and a proposal." Eur J Health Econ 17(5): 519-520.

Etat de santé / Health Status

Orsini, M., et al. (2016). "Individual socioeconomic status and breast cancer diagnostic stages: a French case-control study." The European Journal of Public Health 26(3): 445-450.
<http://eurpub.oxfordjournals.org/content/eurpub/26/3/445.full.pdf>

Background: Health inequalities have increased over the last 30 years. Our goal was to investigate the relationship between low individual socioeconomic status and poor breast cancer prognosis. Our hypothesis was: low socioeconomic status patients have a higher risk of being diagnosed with late stage breast cancer than high socioeconomic status ones due to delayed diagnosis. Methods: We conducted a matched case-control study on 619 women with breast cancer, living in the Hérault, a French administrative area. Both Cases and Controls were recruited among invasive cases diagnosed in 2011 and 2012 and treated in Hérault care centers. Cases were defined as patients with advanced stages. Controls were composed of early stage patients. Individual socioeconomic status was assessed using a validated individual score adapted to the French population and health care system. Results: We observed that low socioeconomic status patients have a 2-fold risk of having late stage breast cancer regardless of cancer characteristics and detection mode (screening vs. clinical signs). Conclusion: One reason explaining those results could be that low socioeconomic status patients have less regular follow-up which can lead to later and poorer diagnosis. Follow-up is improved for women with a better awareness of breast cancer. Health policy makers could reduce health inequalities by reducing the delay in breast cancer diagnosis for low socioeconomic status women.

Géographie de la santé / Geography of Health

Lin, B.-C., et al. (2016). "Spatial decision on allocating automated external defibrillators (AED) in communities by multi-criterion two-step floating catchment area (MC2SFCA)." International Journal of Health Geographics 15(1): 1-14.

The occurrence of out-of-hospital cardiac arrest (OHCA) is a critical life-threatening event which frequently warrants early defibrillation with an automated external defibrillator (AED). The optimization of allocating a limited number of AEDs in various types of communities is challenging. We aimed to propose a two-stage modeling framework including spatial accessibility evaluation and priority ranking to identify the highest gaps between demand and supply for allocating AEDs.

Meyer, S., et al. (2016). "Model-based testing for space–time interaction using point processes: An application to psychiatric hospital admissions in an urban area." Spatial and Spatio-temporal Epidemiology 17: 15-25.

<http://www.sciencedirect.com/science/article/pii/S187758451530006X>

Spatio-temporal interaction is inherent to cases of infectious diseases and occurrences of earthquakes, whereas the spread of other events, such as cancer or crime, is less evident. Statistical significance tests of space–time clustering usually assess the correlation between the spatial and temporal (transformed) distances of the events. Although appealing through simplicity, these classical tests do not adjust for the underlying population nor can they account for a distance decay of interaction. We propose to use the framework of an endemic–epidemic point process model to jointly estimate a background event rate explained by seasonal and areal characteristics, as well as a superposed epidemic component representing the hypothesis of interest. We illustrate this new model-based test for space–time interaction by analysing psychiatric inpatient admissions in Zurich, Switzerland (2007–2012). Several socio-economic factors were found to be associated with the admission rate, but there was no evidence of general clustering of the cases.

Hôpital / Hospitals

Aldridge, C., et al. (2016). "Weekend specialist intensity and admission mortality in acute hospital trusts in England: a cross-sectional study." Lancet: Ahead of pub.

BACKGROUND: Increased mortality rates associated with weekend hospital admission (the so-called weekend effect) have been attributed to suboptimum staffing levels of specialist consultants. However, evidence for a causal association is elusive, and the magnitude of the weekend specialist deficit remains unquantified. This uncertainty could hamper efforts by national health systems to introduce 7 day health services. We aimed to examine preliminary associations between specialist intensity and weekend admission mortality across the English National Health Service. **METHODS:** Eligible hospital trusts were those in England receiving unselected emergency admissions. On Sunday June 15 and Wednesday June 18, 2014, we undertook a point prevalence survey of hospital specialists (consultants) to obtain data relating to the care of patients admitted as emergencies. We defined specialist intensity at each trust as the self-reported estimated number of specialist hours per ten emergency admissions between 0800 h and 2000 h on Sunday and Wednesday. With use of data for all adult emergency admissions for financial year 2013-14, we compared weekend to weekday admission risk of mortality with the Sunday to Wednesday specialist intensity ratio within each trust. We stratified trusts by size quintile. **FINDINGS:** 127 of 141 eligible acute hospital trusts agreed to participate; 115 (91%) trusts contributed data to the point prevalence survey. Of 34 350 clinicians surveyed, 15 537 (45%) responded. Substantially fewer specialists were present providing care to emergency admissions on Sunday (1667 [11%]) than on Wednesday (6105 [42%]). Specialists present on Sunday spent 40% more time caring for emergency patients than did those present on Wednesday (mean 5.74 h [SD 3.39] vs 3.97 h [3.31]); however, the median specialist intensity on Sunday was only 48% (IQR 40-58) of that on Wednesday. The Sunday to Wednesday intensity ratio was less than 0.7 in 104 (90%) of the contributing trusts. Mortality risk among patients admitted at weekends was higher

than among those admitted on weekdays (adjusted odds ratio 1.10, 95% CI 1.08-1.11; $p < 0.0001$). There was no significant association between Sunday to Wednesday specialist intensity ratios and weekend to weekday mortality ratios ($r = -0.042$; $p = 0.654$). INTERPRETATION: This cross-sectional analysis did not detect a correlation between weekend staffing of hospital specialists and mortality risk for emergency admissions. Further investigation is needed to evaluate whole-system secular change during the implementation of 7 day services. Policy makers should exercise caution before attributing the weekend effect mainly to differences in specialist staffing. FUNDING: National Institute for Health Research Health Services and Delivery Research Programme.

Basu, J., et al. (2016). "Hospital Readmission Rates in U.S. States: Are Readmissions Higher Where More Patients with Multiple Chronic Conditions Cluster?" *Health Serv Res* 51(3): 1135-1151.

RESEARCH OBJECTIVE: This study examines small area variations in readmission rates to assess whether higher readmission rate in an area is associated with higher clusters of patients with multiple chronic conditions. STUDY DESIGN: The study uses hospital discharge data of adult (18+) patients in 6 U.S. states for 2009 from the Healthcare Cost and Utilization Project of the Agency for Healthcare Research and Quality, linked to contextual and provider data from Health Resources and Services Administration. A multivariate cross sectional design at primary care service area (PCSA) level is used. PRINCIPAL FINDINGS: Adjusting for area characteristics, the readmission rates were significantly higher in PCSAs having higher proportions of patients with 2-3 chronic conditions and those with 4+ chronic conditions, compared with areas with a higher concentration of patients with 0-1 chronic conditions. CONCLUSIONS: Using small area analysis, the study shows that areas with higher concentration of patients with increased comorbid conditions are more likely to have higher readmission rates.

Bray, B. D., et al. (2016). "Weekly variation in health-care quality by day and time of admission: a nationwide, registry-based, prospective cohort study of acute stroke care." *Lancet: Ahead of pub.*

BACKGROUND: Studies in many health systems have shown evidence of poorer quality health care for patients admitted on weekends or overnight than for those admitted during the week (the so-called weekend effect). We postulated that variation in quality was dependent on not only day, but also time, of admission, and aimed to describe the pattern and magnitude of variation in the quality of acute stroke care across the entire week. METHODS: We did this nationwide, registry-based, prospective cohort study using data from the Sentinel Stroke National Audit Programme. We included all adult patients (aged >16 years) admitted to hospital with acute stroke (ischaemic or primary intracerebral haemorrhage) in England and Wales between April 1, 2013, and March 31, 2014. Our outcome measure was 30 day post-admission survival. We estimated adjusted odds ratios for 13 indicators of acute stroke-care quality by fitting multilevel multivariable regression models across 42 4-h time periods per week. FINDINGS: The study cohort comprised 74 307 patients with acute stroke admitted to 199 hospitals. Care quality varied across the entire week, not only between weekends and weekdays, with different quality measures showing different patterns and magnitudes of temporal variation. We identified four patterns of variation: a diurnal pattern (thrombolysis, brain scan within 12 h, brain scan within 1 h, dysphagia screening), a day of the week pattern (stroke physician assessment, nurse assessment, physiotherapy, occupational therapy, and assessment of communication and swallowing by a speech and language therapist), an off-hours pattern (door-to-needle time for thrombolysis), and a flow pattern whereby quality changed sequentially across days (stroke-unit admission within 4 h). The largest magnitude of variation was for door-to-needle time within 60 min (range in quality 35-66% [16/46-232/350]; coefficient of variation 18.2). There was no difference in 30 day survival between weekends and weekdays (adjusted odds ratio 1.03, 95% CI 0.95-1.13), but patients admitted overnight on weekdays had lower odds of survival (0.90, 0.82-0.99). INTERPRETATION: The weekend effect is a simplification, and just one of several patterns of weekly variation occurring in the quality of stroke care. Weekly variation should be further investigated in other health-care settings, and quality improvement should focus on reducing temporal variation in quality and not only the weekend effect. FUNDING: None.

Brewster, A. L., et al. (2016). "What Works in Readmissions Reduction: How Hospitals Improve

Performance." *Medical Care* **54**(6): 600-607.

Background: Hospitals across the United States are pursuing strategies to reduce avoidable readmissions but the evidence on how best to accomplish this goal is mixed, with no specific clinical practice shown to reduce readmissions consistently. Changes to hospital organizational practices, a key component of context, also may be critical to improving performance on readmissions, but this has not been studied. Objective: The aim of this study was to understand how high-performing hospitals improved risk-stratified readmission rates, and whether their changes to clinical practices and organizational practices differed from low-performing hospitals. Design: This was a qualitative study of 10 hospitals in which readmission rates had decreased (n=7) or increased (n=3). Participants: A total of 82 hospital staff drawn from hospitals that had participated in the State Action on Avoidable Readmissions quality improvement initiative. Results: High-performing hospitals were distinguished by several organizational practices that facilitated readmissions reduction, that is, collective habits of action or interpretation shared by organization members. First, high-performing hospitals reported focused efforts to improve collaboration across hospital departments. Second, they helped postacute providers improve care by sharing the hospital's clinical and quality improvement expertise and data. Third, high performers enthusiastically engaged in trial and error learning to reduce readmissions. Fourth, they emphasized that readmissions represented bad outcomes for patients, de-emphasizing the role of financial penalties. Both high-performing and low-performing hospitals had implemented most clinical practice changes commonly recommended to reduce readmissions. Conclusions: Our findings highlight several organizational practices that hospitals may be able to use to enhance the effectiveness of their readmissions reduction efforts.

Clark, D. E., et al. (2016). "A Multistate Model Predicting Mortality, Length of Stay, and Readmission for Surgical Patients." *Health Serv Res* **51(3): 1074-1094.**

OBJECTIVE: Simultaneously evaluate postoperative mortality, length of stay (LOS), and readmission. DATA SOURCE: National Surgical Quality Improvement Program (NSQIP). DESIGN: Retrospective cohort. METHODS: Data from elective general surgical patients were obtained from the 2012 NSQIP Participant Use File. For each postoperative day, each patient's state was classified as index hospitalization, discharged home, discharged to long-term care (LTC), readmitted, or dead. Transition rates were estimated using exponential regression, assuming constant rates for specified time periods. These estimates were combined into a multistate model, simulated results of which were compared to observed outcomes. FINDINGS: Age, comorbidities, more complex procedures, and longer index LOS were associated with lower rates of discharge home and higher rates of death, discharge to LTC, and readmission. The longer patients had been discharged, the less likely they were to die or be readmitted. The model predicted 30-day mortality 0.38 percent (95 percent CI: 0.36-0.41), index LOS 2.85 days (95 percent CI: 2.83-2.86), LTC discharge 2.76 percent (95 percent CI: 2.69-2.82), and readmissions 5.53 percent (95 percent CI: 5.43-5.62); observed values were 0.39 percent, 2.82 days, 2.87 percent, and 5.70 percent, respectively. CONCLUSIONS: Multistate models can simultaneously predict postoperative mortality, LOS, discharge destination, and readmissions, which allows multidimensional comparison of surgical outcomes.

Dupont, B., et al. (2016). "Groupe de recherche sur l'impact des recompositions et des coopérations hospitalières IRC : quels critères d'évaluation pour les futurs GHT ?" *Gestions Hospitalières*(554): 136-163.

Figuerola, J. F., et al. (2016). "Association between the Value-Based Purchasing pay for performance program and patient mortality in US hospitals: observational study." *BMJ* **353.
<http://www.bmj.com/content/bmj/353/bmj.i2214.full.pdf>**

Objective: To determine the impact of the Hospital Value-Based Purchasing (HVBP) program—the US pay for performance program introduced by Medicare to incentivize higher quality care—on 30 day mortality for three incentivized conditions: acute myocardial infarction, heart failure, and pneumonia. Design: Observational study. Setting: 4267 acute care hospitals in the United States: 2919 participated

in the HVBP program and 1348 were ineligible and used as controls (44 in general hospitals in Maryland and 1304 critical access hospitals across the United States). Participants 2 430 618 patients admitted to US hospitals from 2008 through 2013. Main outcome measures 30 day risk adjusted mortality for acute myocardial infarction, heart failure, and pneumonia using a patient level linear spline analysis to examine the association between the introduction of the HVBP program and 30 day mortality. Non-incentivized, medical conditions were the comparators. A secondary outcome measure was to determine whether the introduction of the HVBP program was particularly beneficial for a subgroup of hospital—poor performers at baseline—that may benefit the most. Results: Mortality rates of incentivized conditions in hospitals participating in the HVBP program declined at -0.13% for each quarter during the preintervention period and -0.03% point difference for each quarter during the post-intervention period. For non-HVBP hospitals, mortality rates declined at -0.14% point difference for each quarter during the preintervention period and -0.01% point difference for each quarter during the post-intervention period. The difference in the mortality trends between the two groups was small and non-significant (difference in difference in trends -0.03% point difference for each quarter, 95% confidence interval -0.08% to 0.13% point difference, $P=0.35$). In no subgroups of hospitals was HVBP associated with better outcomes, including poor performers at baseline. Conclusions: Evidence that HVBP has led to lower mortality rates is lacking. Nations considering similar pay for performance programs may want to consider alternative models to achieve improved patient outcomes.

Paul, E. et al (2016). "Coopération public/privé : dossier." *Gestions Hospitalières*(554): 164-191.

Rush, K. L., et al. (2016). "Older Adults' Risk Practices From Hospital to Home: A Discourse Analysis." *The Gerontologist* 56(3): 494-503.

Purpose: To understand risk-related practices of older adults returning home posthospitalization. Research Design: Qualitative methods informed by critical discourse theory, designed to uncover linkages between broader social practices and peoples' talk and stories, were used. Methods: Eight older adults, screened as high-risk from an inpatient cardiology unit, and six partners were interviewed face-to-face within three weeks of discharge. A discourse analysis of participants' accounts of risk was conducted: the cultural and social understandings or conceptual frameworks used to understand risk were identified. Results: Ableism, a discourse in our society that privileges abledness, was found to permeate the data. Participants underscored that being abled was normal and being disabled was abnormal. Ableism, as a discourse or conceptual framework, compelled participants to appear and act abled, or to perform "compulsory abledness." That, in turn, produced their responses to risk: a pressure to preserve ableist identities created internal and external tensions related to objects and situations of risk and forced participants to use strategies to diminish and minimize risk. Participants created a new response—a position of "liminality" or in-between—where their accounts portrayed them as neither abled nor disabled. This discourse of liminality allowed them to reconcile tensions associated with risk. Implications: Critical discourse analysis sheds new light on older adults' risk practices. This approach challenges accepted ways of acting and thinking about what constitutes risk and produces possibilities for alternate ways of representing the same reality.

Inégalités de santé / Health Inequalities

Alegría, M., et al. (2016). "Removing Obstacles To Eliminating Racial And Ethnic Disparities In Behavioral Health Care." *Health Affairs* 35(6): 991-999.

Despite decades of research, racial and ethnic disparities in behavioral health care persist. The Affordable Care Act expanded access to behavioral health care, but many reform initiatives fail to consider research about racial/ethnic minorities. Mistaken assumptions that underlie the expansion of behavioral health care run the risk of replicating existing service disparities. Based on a review of relevant literature and numerous observational and field studies with minority populations, we

identified the following three mistaken assumptions: Improvement in health care access alone will reduce disparities, current service planning addresses minority patients' preferences, and evidence-based interventions are readily available for diverse populations. We propose tailoring the provision of care to remove obstacles that minority patients face in accessing treatment, promoting innovative services that respond to patients' needs and preferences, and allowing flexibility in evidence-based practice and the expansion of the behavioral health workforce. These proposals should help meet the health care needs of a growing racial/ethnic minority population.

Allik, M., et al. (2016). "Developing a new small-area measure of deprivation using 2001 and 2011 census data from Scotland." *Health & Place* 39: 122-130.

Material deprivation contributes to inequalities in health; areas of high deprivation have higher rates of ill-health. How deprivation is measured has a great impact on its explanatory power with respect to health. We compare previous deprivation measures used in Scotland and propose a new deprivation measure using the 2001 and 2011 Scottish census data. We calculate the relative index of inequality (RII) for self-reported health and mortality. While across all age groups different deprivation measures provide similar results, the assessment of health inequalities among those aged 20–29 differs markedly according to the deprivation measure. In 2011 the RII for long-term health problem for men aged 20–24 was only 0.71 (95% CI 0.60–0.83) using the Carstairs score, but 1.10 (0.99–1.21) for the new score and 1.13 (1.03–1.24) for the income domain of Scottish Index of Multiple Deprivation (SIMD). The RII for mortality in that age group was 1.25 (0.89–1.58) for the Carstairs score, 1.69 (1.35–2.02) for the new measure and 1.76 (1.43–2.08) for SIMD. The results suggest that researchers and policy makers should consider the suitability of deprivation measures for different social groups.

Alvarez-Galvez, J. (2016). "Measuring the effect of ethnic and non-ethnic discrimination on Europeans' self-rated health." *International Journal of Public Health* 61(3): 367-374.

The study of perceived discrimination based on race and ethnic traits belongs to a long-held tradition in this field, but recent studies have found that non-ethnic discrimination based on factors such as gender, disability or age is also a crucial predictor of health outcomes.

Bleser, W. K., et al. (2016). "Racial/Ethnic Disparities in Influenza Vaccination of Chronically Ill US Adults: The Mediating Role of Perceived Discrimination in Health Care." *Medical Care* 54(6): 570-577.

Background: Despite well-established programs, influenza vaccination rates in US adults are well below federal benchmarks and exhibit well-documented, persistent racial and ethnic disparities. The causes of these disparities are multifactorial and complex, though perceived racial/ethnic discrimination in health care is 1 hypothesized mechanism. Objectives: To assess the role of perceived discrimination in health care in mediating influenza vaccination RACIAL/ETHNIC disparities in chronically ill US adults (at high risk for influenza-related complications). Research Design: We utilized 2011–2012 data from the Aligning Forces for Quality Consumer Survey on health and health care (n=8127), nationally representative of chronically ill US adults. Logistic regression marginal effects examined the relationship between race/ethnicity and influenza vaccination, both unadjusted and in multivariate models adjusted for determinants of health service use. We then used binary mediation analysis to calculate and test the significance of the percentage of this relationship mediated by perceived discrimination in health care. Results: Respondents reporting perceived discrimination in health care had half the uptake as those without discrimination (32% vs. 60%, P=0.009). The change in predicted probability of vaccination given perceived discrimination experiences (vs. none) was large but not significant in the fully adjusted model (–0.185; 95% CI, –0.385, 0.014). Perceived discrimination significantly mediated 16% of the unadjusted association between race/ethnicity and influenza vaccination, though this dropped to 6% and lost statistical significance in multivariate models. Conclusions: The causes of persistent racial/ethnic disparities are complex and a single explanation is unlikely to be sufficient. We suggest reevaluation in a larger cohort as well as potential directions for future research.

Clarke, A. et Ispording, I. E. (2016). "Language Barriers and Immigrant Health." Health Economics: Ahead of pub.

We study the impact of language deficiency on the health status of childhood migrants to Australia. Our identification strategy relies on a quasi-experiment comparing immigrants arriving at different ages and from different linguistic origins. In the presence of considerable non-classical measurement error in self-reported language proficiency, our results provide lower and upper bounds for a strong negative effect of English deficiency on health of between one half and a full standard deviation in the health score. Copyright © 2016 John Wiley & Sons, Ltd.

Farré, L. (2016). "New evidence on the healthy immigrant effect." Journal of Population Economics 29(2): 365-394.

This paper presents new evidence that immigrants have better health than natives upon arrival to their destination. It analyzes a very interesting episode in international migration, namely the exodus of Ecuadorians in the aftermath of the economic collapse in the late 1990s. More than 600,000 Ecuadorians from 1999 to 2005 left their homeland, most relocating in Spain. Using information from the birth certificate data, the paper compares the birth outcomes of immigrant women in Spain not only to that of natives at destination, but to that of natives in Ecuador and immigrants from other nationalities in Spain. These comparisons suggest that the better health at birth of children born to immigrants from Ecuador partly responds to the selection of healthier women into migration.

Marmot, M. et Bell, R. (2016). "Social inequalities in health: a proper concern of epidemiology." Ann Epidemiol 26(4): 238-240.

Social inequalities are a proper concern of epidemiology. Epidemiological thinking and modes of analysis are central, but epidemiological research is one among many areas of study that provide the evidence for understanding the causes of social inequalities in health and what can be done to reduce them. Understanding the causes of health inequalities requires insights from social, behavioral and biological sciences, and a chain of reasoning that examines how the accumulation of positive and negative influences over the life course leads to health inequalities in adult life. Evidence that the social gradient in health can be reduced should make us optimistic that reducing health inequalities is a realistic goal for all societies.

Marton, J., et al. (2016). "Does Medicaid Managed Care Help Equalize Racial and Ethnic Disparities in Utilization?" Health Serv Res 51(3): 872-891.

OBJECTIVE: To estimate the impact of different forms of Medicaid managed care (MMC) delivery on racial and ethnic disparities in utilization. DATA SOURCE: Longitudinal, administrative data on 101,649 children in Kentucky continuously enrolled in Medicaid between January 1997 and June 1999. Outcomes considered are monthly professional, outpatient, and inpatient utilization. STUDY DESIGN: We apply an intent-to-treat, instrumental variables analysis using the staggered geographic implementation of MMC to create treatment and control groups of children. PRINCIPAL FINDINGS: The implementation of MMC reduced monthly professional visits by a smaller degree for non-whites than whites (3.8 percentage points vs. 6.2 percentage points), thereby helping to equalize the initial racial/ethnic disparity in utilization. The Passport MMC program in the Louisville-centered region statistically significantly reduced disparities for professional visits (closing the gap by 8.0 percentage points), while the Kentucky Health Select MMC program in the Lexington-centered region did not. No substantive impact on disparities was found for either outpatient or inpatient utilization in either program. CONCLUSIONS: We find evidence that MMC has the possibility to reduce racial/ethnic disparities in professional utilization. More work is needed to determine which managed care program characteristics drive this result.

Ro, A., et al. (2016). "An examination of health selection among U.S. immigrants using multi-national data." Soc Sci Med 158: 114-121.

While migrants are widely believed to be positively selected on health, there has been very little empirical exploration of the actual health differential between migrants and non-migrants. This paper explored: 1) the extent of health selection by comparing US immigrants from 19 sending countries to their non-migrating counterparts still residing in the countries of origin; 2) country-level correlates of health selection; and 3) whether country-level health selection accounted for differences in self-rated health between immigrants and US-born Whites. We combined nationally-representative international data with data from US immigrants from the 2003-2007 Current Population Survey. The health selectivity measure was the Net Difference Index (NDI), which compares the distribution of self-rated health between migrants and non-migrants. We calculated Spearman correlation and bivariate regression coefficients between the NDI and economic, health, distance, and migration characteristics of the sending countries. We used generalized estimating equation models to examine the association between country-level health selection and immigrants' current self-rated health. We found immigrants from South America to show the most positive health selection. Health selection was significantly correlated with visa mode of entry, where family networks decrease, but work-related networks increase health selection. There was little evidence that country-level health selection explained differences in the self-rated health of US immigrants relative to US-born Whites. Our findings do not support the idea that country-level health selection underlies the "healthy immigrant effect".

Médicaments / Pharmaceuticals

Benkimoun, P. (2016). "French drug agency was not wrong to allow deadly trial, review says." *BMJ* 353.
<http://www.bmj.com/content/bmj/353/bmj.i2774.full.pdf>

The French national drug agency was not wrong to authorise a drug trial that left one volunteer dead and four with severe neurological side effects, concludes the final report of an official review published on 23 May.¹ However, the Agence Nationale de Sécurité du Médicament (ANSM) should have asked for more details about the escalation of doses described in the protocol, the report said, and it criticised errors made by the company that conducted the trial. Media commentators and the barrister representing the family of the volunteer, Guillaume Molinet, who died on 17 January after participating in the first in humans phase I clinical trial of the experimental compound BIA-10-2474, had argued that the agency should not have given the go-ahead to test the drug in humans, because neurological adverse

Gros, O. (2016). "Médicaments, trou de la sécu et loi du marché." *Revue Projet* 351(2): 83-89.
<http://www.cairn.info/revue-projet-2016-2-page-83.htm>

Michel-Lepage, A. et Ventelou, B. (2015). "The true impact of the French pay-for-performance program on physicians' benzodiazepines prescription behavior." *Eur J Health Econ*.

OBJECTIVES: The French pay-for-performance (P4P) contract CAPI implemented by the national health insurance included a target-goal which aims at reducing benzodiazepines prescriptions. In this investigation, we would like to assess whether: (1) the general practitioners (GPs) having signed P4P contract obtain better results regarding the target-goal than non-signatories; (2) (part of) this progression is due to the CAPI contract itself (tentative measurement of a "causal effect"); (3) (part of) the money spent on this P4P incentive can be self-financed with the amount of pharmaceuticals saved. **METHODS:** We matched cross-sectional and longitudinal data including 4622 French GPs from June 2011 to December 2012. A treatment effect model using instrumental variables was performed to take into account potential self-selection issue in signing. After having identified the NET impact of the P4P, we calculate the cost of an avoided benzodiazepines treatment. **RESULTS:** In our study, GPs who have signed the CAPI contract (36 % of the sample) are more numerous in achieving

benzodiazepines target goal than non-signatories: 90.7 vs. 85.5 %. After controlling for the self-selection bias, the propensity of GPs to achieve the benzodiazepines target is only 0.31 % higher for signatories than for their non-signing counterparts-estimate for June 2012, which yields a statistically significant gap. Our economic analysis demonstrates that the CAPI contract does not allow savings, but presents in 2012 a NET cost of 93.6<euro> per avoided benzodiazepines treatment (291<euro> in 2011). CONCLUSIONS: The P4P contract has a positive but modest impact on the achievement of GPs regarding benzodiazepines indicator.

Méthodologie – Statistique / Methodology - Statistique

Delnord, M., et al. (2016). "Linking databases on perinatal health: a review of the literature and current practices in Europe." *The European Journal of Public Health* 26(3): 422-430.

Background: International comparisons of perinatal health indicators are complicated by the heterogeneity of data sources on pregnancy, maternal and neonatal outcomes. Record linkage can extend the range of data items available and thus can improve the validity and quality of routine data. We sought to assess the extent to which data are linked routinely for perinatal health research and reporting. Methods: We conducted a systematic review of the literature by searching PubMed for perinatal health studies from 2001 to 2011 based on linkage of routine data (data collected continuously at various time intervals). We also surveyed European health monitoring professionals about use of linkage for national perinatal health surveillance. Results: 516 studies fit our inclusion criteria. Denmark, Finland, Norway and Sweden, the US and the UK contributed 76% of the publications; a further 29 countries contributed at least one publication. Most studies linked vital statistics, hospital records, medical birth registries and cohort data. Other sources were specific registers for: cancer (70), congenital anomalies (56), ART (19), census (19), health professionals (37), insurance (22) prescription (31), and level of education (18). Eighteen of 29 countries (62%) reported linking data for routine perinatal health monitoring. Conclusion: Research using linkage is concentrated in a few countries and is not widely practiced in Europe. Broader adoption of data linkage could yield substantial gains for perinatal health research and surveillance.

Fichera, E., et al. (2016). "How do individuals' health behaviours respond to an increase in the supply of health care? Evidence from a natural experiment." *Social Science & Medicine* 159: 170-179.

The efficacy of the management of long-term conditions depends in part on whether healthcare and health behaviours are complements or substitutes in the health production function. On the one hand, individuals might believe that improved health care can raise the marginal productivity of their own health behaviour and decide to complement health care with additional effort in healthier behaviours. On the other hand, health care can lower the cost of unhealthy behaviours by compensating for their negative effects. Individuals may therefore reduce their effort in healthier lifestyles. Identifying which of these effects prevails is complicated by the endogenous nature of treatment decisions and individuals' behavioural responses. We explore whether the introduction in 2004 of the Quality and Outcomes Framework (QOF), a financial incentive for family doctors to improve the quality of healthcare, affected the population's weight, smoking and drinking behaviours by applying a sharp regression discontinuity design to a sample of 32,102 individuals in the Health Survey for England (1997–2009). We find that individuals with the targeted health conditions improved their lifestyle behaviours. This complementarity was only statistically significant for smoking, which reduced by 0.7 cigarettes per person per day, equal to 18% of the mean. We investigate whether this change was attributable to the QOF by testing for other discontinuity points, including the introduction of a smoking ban in 2007 and changes to the QOF in 2006. We also examine whether medication and smoking cessation advice are potential mechanisms and find no statistically significant discontinuities for these aspects of health care supply. Our results suggest that a general improvement in healthcare generated by provider incentives can have positive unplanned effects on patients' behaviours.

Li, L. et Rothwell, P. M. (2016). "Biases in detection of apparent "weekend effect" on outcome with administrative coding data: population based study of stroke." *BMJ* 353.
<http://www.bmj.com/content/bmj/353/bmj.i2648.full.pdf>

Objectives: To determine the accuracy of coding of admissions for stroke on weekdays versus weekends and any impact on apparent outcome. Design: Prospective population based stroke incidence study and a scoping review of previous studies of weekend effects in stroke. Setting: Primary and secondary care of all individuals registered with nine general practices in Oxfordshire, United Kingdom (OXVASC, the Oxford Vascular Study). Participants All patients with clinically confirmed acute stroke in OXVASC identified with multiple overlapping methods of ascertainment in 2002-14 versus all acute stroke admissions identified by hospital diagnostic and mortality coding alone during the same period. Main outcomes measures Accuracy of administrative coding data for all patients with confirmed stroke admitted to hospital in OXVASC. Difference between rates of "false positive" or "false negative" coding for weekday and weekend admissions. Impact of inaccurate coding on apparent case fatality at 30 days in weekday versus weekend admissions. Weekend effects on outcomes in patients with confirmed stroke admitted to hospital in OXVASC and impacts of other potential biases compared with those in the scoping review. Results Among 92 728 study population, 2373 episodes of acute stroke were ascertained in OXVASC, of which 826 (34.8%) mainly minor events were managed without hospital admission, 60 (2.5%) occurred out of the area or abroad, and 195 (8.2%) occurred in hospital during an admission for a different reason. Of 1292 local hospital admissions for acute stroke, 973 (75.3%) were correctly identified by administrative coding. There was no bias in distribution of weekend versus weekday admission of the 319 strokes missed by coding. Of 1693 admissions for stroke identified by coding, 1055 (62.3%) were confirmed to be acute strokes after case adjudication. Among the 638 false positive coded cases, patients were more likely to be admitted on weekdays than at weekends (536 (41.0%) v 102 (26.5%); $P < 0.001$), partly because of weekday elective admissions after previous stroke being miscoded as new stroke episodes (267 (49.8%) v 26 (25.5%); $P < 0.001$). The 30 day case fatality after these elective admissions was lower than after confirmed acute stroke admissions (11 (3.8%) v 233 (22.1%); $P < 0.001$). Consequently, relative 30 day case fatality for weekend versus weekday admissions differed ($P < 0.001$) between correctly coded acute stroke admissions and false positive coding cases. Results were consistent when only the 1327 emergency cases identified by "admission method" from coding were included, with more false positive cases with low case fatality (35 (14.7%)) being included for weekday versus weekend admissions (190 (19.5%) v 48 (13.7%), $P < 0.02$). Among all acute stroke admissions in OXVASC, there was no imbalance in baseline stroke severity for weekends versus weekdays and no difference in case fatality at 30 days (adjusted odds ratio 0.85, 95% confidence interval 0.63 to 1.15; $P = 0.30$) or any adverse "weekend effect" on modified Rankin score at 30 days (0.78, 0.61 to 0.99; $P = 0.04$) or one year (0.76, 0.59 to 0.98; $P = 0.03$) among incident strokes. Conclusion Retrospective studies of UK administrative hospital coding data to determine "weekend effects" on outcome in acute medical conditions, such as stroke, can be undermined by inaccurate coding, which can introduce biases that cannot be reliably dealt with by adjustment for case mix.

Muhlbacher, A. et Johnson, F. R. (2016). "Choice Experiments to Quantify Preferences for Health and Healthcare: State of the Practice." *Appl Health Econ Health Policy* 14(3): 253-266.

Stated-preference methods increasingly are used to quantify preferences in health economics, health technology assessment, benefit-risk analysis and health services research. The objective of stated-preference studies is to acquire information about trade-off preferences among treatment outcomes, prioritization of clinical decision criteria, likely uptake or adherence to healthcare products and acceptability of healthcare services or policies. A widely accepted approach to eliciting preferences is discrete-choice experiments. Patient, physician, insurer or general-public respondents choose among constructed, experimentally controlled alternatives described by decision-relevant features or attributes. Attributes can represent complete health states, sets of treatment outcomes or characteristics of a healthcare system. The observed pattern of choice reveals how different respondents or groups of respondents implicitly weigh, value and assess different characteristics of treatments, products or services. An important advantage of choice experiments is their foundation in

microeconomic utility theory. This conceptual framework provides tests of internal validity, guidance for statistical analysis of latent preference structures, and testable behavioural hypotheses. Choice experiments require expertise in survey-research methods, random-utility theory, experimental design and advanced statistical analysis. This paper should be understood as an introduction to setting up a basic experiment rather than an exhaustive critique of the latest findings and procedures. Where appropriate, we have identified topics of active research where a broad consensus has not yet been established.

Shiroiwa, T., et al. (2016). "Societal Preferences for Interventions with the Same Efficiency: Assessment and Application to Decision Making." *Appl Health Econ Health Policy* 14(3): 375-385.

BACKGROUND AND OBJECTIVES: Although quality-adjusted life-years (QALYs) may not completely reflect the value of a healthcare technology, it remains unclear how to adjust the cost per QALY threshold. First, the present study compares two survey methods of measuring people's preferences for a specific healthcare technology when each choice has the same efficiency. The second objective was to consider how this information regarding preferences could be used in decision making. **METHODS:** We conducted single-attribute (budget allocation) and multi-attribute (discrete-choice) experiments to survey public medical care preferences. Approximately 1000 respondents were sampled for each experiment. Six questions were prepared to address the attributes included in the study: (a) age; (b) objective of care; (c) disease severity; (d) prior medical care; (e) cause of disease; and (f) disease frequency. For the discrete-choice experiment (a) age, (b) objective of care, (c) disease severity, and (d) prior medical care were orthogonally combined. All assumed medical care had the same costs and incremental cost-effectiveness ratio (ICER; cost per life-year or QALY). We also calculated the preference-adjusted threshold (PAT) to reflect people's preferences in a threshold range. **RESULTS:** The results of both experiments revealed similar preferences: intervention for younger patients was strongly preferred, followed by interventions for treatment and severe disease states being preferred, despite the same cost per life-year or QALY. The single-attribute experiment revealed that many people prefer an option in which resources are equally allocated between two interventions. Marginal PATs were calculated for age, objective of care, disease severity, and prior medical care. **CONCLUSION:** The single- and multi-attribute experiments revealed similar preferences. PAT can reflect people's preferences within the decision-maker's threshold range in a numerical manner.

Squires, H., et al. (2016). "A systematic literature review of the key challenges for developing the structure of public health economic models." *International Journal of Public Health* 61(3): 289-298.

To identify the key methodological challenges for public health economic modelling and set an agenda for future research.

Politique de santé / Health Policy

Devalois, B. et Puybasset, L. (2016). "[New Act concerning end of life: Impact for medical practice?]." *Presse Med* 45(4 Pt 1): 414-421.

New French 2016' Act recognizes 3 new rights for patients at the end of their life: right to die without futilities, right to have their wishes respected and right to be comfortable in all circumstances. Medical acts must not be continued in an unreasonable way. Futility is defined by useless, disproportionate or without another aim than an artificial life sustaining acts. For patients who cannot tell their wishes, a withdrawing or withholding decision of life sustaining treatments can be taken with a collegiate process. Doctors must always care about patient comfort with palliative care. Artificial hydration and nutrition can be considered as futile. Patients can write advanced directives or design

confidence person to attest their wishes if they should be unable to do it. Doctors must respect advanced directives, except in emergency cases or if there are inappropriate. In such cases, the decision not to respect advanced directives must be taken collegially. Sedation is a therapeutic solution to alleviate refractory suffering for patients at the end of life, even if there is a risk to shorten their life, if the aim is to make patient comfortable and if it is the only way to achieve this goal. A specific right to deep and continuous sedation until death is created, only for patients with a short life prognosis (for hours to days). It is an exceptional practice with very strict conditions including a collegiate deliberation including non-medical team members. If they wish, patients at the end of life should be cared at home with comfort treatments if needed. Referent doctor must inform patients about their rights. An initial and continuous formation on this field is required. For every decision, it is important to keep a record in the patient chart. If not, it will be a fault.

French, M. T., et al. (2016). "Key Provisions of the Patient Protection and Affordable Care Act (ACA): A Systematic Review and Presentation of Early Research Findings." Health Services Research: Ahead of pub.

Objectives To conduct a systematic literature review of selected major provisions of the Affordable Care Act (ACA) pertaining to expanded health insurance coverage. We present and synthesize research findings from the last 5 years regarding both the immediate and long-term effects of the ACA. We conclude with a summary and offer a research agenda for future studies. **Study Design** We identified relevant articles from peer-reviewed scholarly journals by performing a comprehensive search of major electronic databases. We also identified reports in the "grey literature" disseminated by government agencies and other organizations. **Principal Findings** Overall, research shows that the ACA has substantially decreased the number of uninsured individuals through the dependent coverage provision, Medicaid expansion, health insurance exchanges, availability of subsidies, and other policy changes. Affordability of health insurance continues to be a concern for many people and disparities persist by geography, race/ethnicity, and income. Early evidence also indicates improvements in access to and affordability of health care. All of these changes are certain to ultimately impact state and federal budgets. **Conclusions** The ACA will either directly or indirectly affect almost all Americans. As new and comprehensive data become available, more rigorous evaluations will provide further insights as to whether the ACA has been successful in achieving its goals.

Philippe Fache, C. S. et Étienne, M. (2016). "The Search is on for Coherent Performance Measurement in Healthcare Organizations. Has Quebec Reached a Crossroads?" Healthcare Policy 11(4): 60-69.

Objective:This research looks back at a 10-year period (2004–2014) to understand the development and outlook for healthcare organization performance measurement in the Quebec healthcare system, in an attempt to objectivize relationships within the configuration of its principal institutional actors. **Methods:**This is a qualitative study combining the use of official publications and fieldwork based on 13 semi-directed interviews, conducted in 2014, with informers in key performance measurement positions within the Quebec healthcare system. **Results:** Performance measurement has generated tensions, both internally between different branches of the Department of Health and externally against a strong coalition of external institutional actors, which were defending a shared homogeneous vision of performance. Four major types of political power plays, owing to the power struggles around performance models and indicators, converged around the same implicit issue of the need to attain greater legitimacy in order to impose an authoritative frame of reference.

Prévention / Prévention

Saffer, H., et al. (2016). "A Behavioral Economic Model of Alcohol Advertising and Price." Health Econ 25(7): 816-828.

This paper presents a new empirical study of the effects of televised alcohol advertising and alcohol price on alcohol consumption. A novel feature of this study is that the empirical work is guided by insights from behavioral economic theory. Unlike the theory used in most prior studies, this theory predicts that restriction on alcohol advertising on TV would be more effective in reducing consumption for individuals with high consumption levels but less effective for individuals with low consumption levels. The estimation work employs data from the National Longitudinal Survey of Youth, and the empirical model is estimated with quantile regressions. The results show that advertising has a small positive effect on consumption and that this effect is relatively larger at high consumption levels. The continuing importance of alcohol taxes is also supported. Education is employed as a proxy for self-regulation, and the results are consistent with this assumption. The key conclusion is that restrictions on alcohol advertising on TV would have a small negative effect on drinking, and this effect would be larger for heavy drinkers. Copyright (c) 2015 John Wiley & Sons, Ltd.

Semenza, J. C., et al. (2016). "Public health needs of migrants, refugees and asylum seekers in Europe, 2015: Infectious disease aspects." *Eur J Public Health* 26(3): 372-373.

Psychiatrie / Psychiatry

Baarnhielm, S. (2016). "Refugees' mental health-a call for a public health approach with focus on resilience and cultural sensitivity." *Eur J Public Health* 26(3): 375-376.

Kouvonen, A., et al. (2016). "Changes in psychosocial and physical working conditions and common mental disorders." *The European Journal of Public Health* 26(3): 458-463.

Background: Previous studies on changes in working conditions and mental health are few and have typically focused only on psychosocial working conditions. We assessed the impact of changes in both psychosocial and physical working conditions on common mental disorders (CMDs) in a cohort of midlife and older employees. Methods: Repeat data were derived from the Helsinki Health Study, which is a cohort study on employees of the City of Helsinki, Finland (aged 40–60 years at baseline). Changes in working conditions were assessed between Phase 1 (2000–2002) and Phase 2 (2007). CMD was assessed at Phase 1, Phase 2 and Phase 3 (2012) using the 12-item General Health Questionnaire. In total, 4946 participants (82% women) who were still employed at Phase 2 were available for the analyses. Logistic regression analyses using generalized estimating equations were conducted to examine the association between changes in working conditions and the likelihood of CMD. ORs and their 95% CIs were estimated. Results: After adjustment for sex, age, marital status, health behaviours and obesity; increased and repeated exposure to low job control, high job demands and repetitive movements and repeated exposure to awkward postures and rotation of back were associated with a higher likelihood of CMD at Phases 1–3. Fully adjusted ORs ranged from 1.27 to 2.39 for psychosocial, and from 1.18 to 1.29 for physical working conditions. Conclusions: Repeated and increased exposures to several adverse psychosocial and physical working conditions are associated with a higher likelihood of CMD.

Lindert, J., et al. (2016). "Refugees mental health-A public mental health challenge." *Eur J Public Health* 26(3): 374-375.

Soins de santé primaires / Primary Health Care

DeVoe, J. E., et al. (2016). "Perspectives in Primary Care: A Conceptual Framework and Path for Integrating Social Determinants of Health Into Primary Care Practice." *Ann Fam Med* 14(2):

104-108.

Mayor, S. (2016). "Closure of community pharmacies in deprived areas will increase GP consultations, says report." *BMJ* 353.

<http://www.bmj.com/content/bmj/353/bmj.i2911.full.pdf>

More than one in four people who would usually seek advice on common ailments from their local pharmacy would make an appointment with their GP surgery instead if the pharmacy closed, says a report exploring the potential impact of government funding cuts that are likely to result in pharmacy closures. The authors said that a nationally representative survey

Mooney, H. (2016). "Incentives paid to GPs to improve healthcare have no effect on mortality, study finds." *BMJ* 353.

<http://www.bmj.com/content/bmj/353/bmj.i2882.full.pdf>

The UK Quality and Outcomes Framework (QOF), the world's largest system of payment for performance in primary care, has failed to improve death rates, show the results of a study published in the *Lancet*. The study, carried out by York and Manchester Universities and the University of Michigan in the United States, showed no statistically significant declines in mortality associated with the chronic conditions targeted by the programme, which include cancer, diabetes, and heart disease.

Rimmer, A. (2016). "GPs urge NHS to plan for sudden loss of primary care services." *BMJ* 353.

<http://www.bmj.com/content/bmj/353/bmj.i2907.full.pdf>

Careers GPs have called for the NHS in England to plan for the possibility that large numbers of patients will be left without general practice services at short notice. GPs attending the BMA's conference of local medical committees (LMCs), the bodies that represent GPs at a local level, in London on Friday 20 May voted in favour of a motion calling for "the urgent incorporation of ...

Roland, M. "Does pay-for-performance in primary care save lives?" *The Lancet* : Ahead of pub.

[http://dx.doi.org/10.1016/S0140-6736\(16\)00550-X](http://dx.doi.org/10.1016/S0140-6736(16)00550-X)

Ryan, A. M., et al. "Long-term evidence for the effect of pay-for-performance in primary care on mortality in the UK: a population study." *The Lancet*: Ahead of pub.

[http://dx.doi.org/10.1016/S0140-6736\(16\)00276-2](http://dx.doi.org/10.1016/S0140-6736(16)00276-2)

Introduced in 2004, the UK's Quality and Outcomes Framework (QOF) is the world's largest primary care pay-for-performance programme. We tested whether the QOF was associated with reduced population mortality.

Sharon, J. et Matthew, H. (2016). "A Decade Lost: Primary Healthcare Performance Reporting across Canada under the Action Plan for Health System Renewal." *Healthcare Policy* 11(4): 95-110.

<http://www.longwoods.com/product/24593>

In 2004, Canada's First Ministers committed to reforms that would shape the future of the Canadian healthcare landscape. These agreements included commitments to improved performance reporting within the primary healthcare system. The aim of this paper was to review the state of primary healthcare performance reporting after the public reporting mandate agreed to a decade ago in the Action Plan for Health System Renewal of 2003 expired. A grey literature search was performed to identify reports released by the governmental and independent reporting bodies across Canada. No province, or the federal government, met their performance reporting obligations from the 2004 accords. Although the indicators required to report on in the 2004 Accord no longer reflect the priorities of patients, policy makers and physicians, provinces are also failing to report on these priorities. Canada needs better primary healthcare performance reporting to enable accountability and improvement within and across provinces. Despite the national mandate to improve public health

system reporting, an opportunity to learn from the diverse primary healthcare reforms, underway across Canada for the past decade, has already been lost.

Wood, A., et al. (2016). "The practice manager role and relevance to general practice-based research: a review of the literature." Aust J Prim Health.

Research based in Australian general practice is essential to ensure that health care provided in this setting is evidenced-based and delivered effectively. Research designed for general practice must be feasible and acceptable to general practitioners (GPs) and practice managers (PMs), who are responsible for coordinating practice activities. However, little is known about the PM role and their contribution to research undertaken in general practice. The aim of this systematic review is to examine this role and its relevance to the conduct of general practice-based research. Databases searched (Medline, PubMed, CINAHL and Scopus) identified six relevant studies. One study investigated the role of the PM in general practice-based research and five examined aspects of the PM role. Data about study design, number and type of participants and findings was extracted and managed using a matrix framework. The limited findings suggested PMs are interested in managing research at the practice level. The PM is central to practice communication and coordination but the role varies depending on qualifications, size of practice and expectations of the GPs. This paper highlights the paucity of evidence about the PM role and their contribution to the conduct of research undertaken in general practice. Further investigation is required to gain insights into establishing and managing future research in Australian general practice.

Travail et santé / Occupational Health

Barnay, T. (2015). "Health, work and working conditions: a review of the European economic literature." Eur J Health Econ.

Economists have traditionally been very cautious when studying the interaction between employment and health because of the two-way causal relationship between these two variables: health status influences the probability of being employed and, at the same time, working affects the health status. Because these two variables are determined simultaneously, researchers control endogeneity skews (e.g., reverse causality, omitted variables) when conducting empirical analysis. With these caveats in mind, the literature finds that a favourable work environment and high job security lead to better health conditions. Being employed with appropriate working conditions plays a protective role on physical health and psychiatric disorders. By contrast, non-employment and retirement are generally worse for mental health than employment, and overemployment has a negative effect on health. These findings stress the importance of employment and of adequate working conditions for the health of workers. In this context, it is a concern that a significant proportion of European workers (29 %) would like to work fewer hours because unwanted long hours are likely to signal a poor level of job satisfaction and inadequate working conditions, with detrimental effects on health. Thus, in Europe, labour-market policy has increasingly paid attention to job sustainability and job satisfaction. The literature clearly invites employers to take better account of the worker preferences when setting the number of hours worked. Overall, a specific "flexicurity" (combination of high employment protection, job satisfaction and active labour-market policies) is likely to have a positive effect on health.

Cleeren, K., et al. (2016). "How Business Cycles Affect the Healthcare Sector: A Cross-country Investigation." Health Econ 25(7): 787-800.

The long-term relationship between the general economy and healthcare expenditures has been extensively researched, to explain differences in healthcare spending between countries, but the midterm (i.e., business cycle) perspective has been overlooked. This study explores business cycle sensitivity in both public and private parts of the healthcare sector across 32 countries. Responses to the business cycle vary notably, both across spending sources and across countries. Whereas in some

countries, consumers and/or governments cut back, in others, private and/or public healthcare buyers tend to spend more. We also assess long-term consequences of business cycle sensitivity and show that public cost cutting during economic downturns deflates the mortality rates, whereas private cut backs increase the long-term growth in total healthcare expenditures. Finally, multiple factors help explain variability in cyclical sensitivity. Private cost cuts during economic downturns are smaller in countries with a predominantly publicly funded healthcare system and more preventive public activities. Public cut backs during contractions are smaller in countries that rely more on tax-based resources rather than social health insurances. Copyright (c) 2015 John Wiley & Sons, Ltd.

Hamad, R., et al. (2016). "The Effects of Job Insecurity on Health Care Utilization: Findings from a Panel of U.S. Workers." *Health Serv Res* 51(3): 1052-1073.

OBJECTIVE: To examine the impacts of job insecurity during the recession of 2007-2009 on health care utilization among a panel of U.S. employees. DATA SOURCES/STUDY SETTING: Linked administrative and claims datasets on a panel of continuously employed, continuously insured individuals at a large multisite manufacturing firm that experienced widespread layoffs (N = 9,486). STUDY DESIGN: We employed segmented regressions to examine temporal discontinuities in utilization during 2006-2012. To assess the effects of job insecurity, we compared individuals at high- and low-layoff plants. Because the dataset includes multiple observations for each individual, we included individual-level fixed effects. PRINCIPAL FINDINGS: We found discontinuous increases in outpatient (3.5 visits/month/10,000 individuals, $p = .002$) and emergency (0.4 visits/month/10,000 individuals, $p = .05$) utilization in the panel of all employees. Compared with individuals at low-layoff plants, individuals at high-layoff plants decreased outpatient utilization (-4.0 visits/month/10,000 individuals, $p = .008$), suggesting foregone preventive care, with a marginally significant increase in emergency utilization (0.4 visits/month/10,000 individuals, $p = .08$). CONCLUSIONS: These results suggest changes in health care utilization and potentially adverse impacts on employee health in response to job insecurity during the latest recession. This study contributes to our understanding of the impacts of economic crises on the health of the U.S. working population.

Maruthappu, M., et al. "Economic downturns, universal health coverage, and cancer mortality in high-income and middle-income countries, 1990-2013;2010: a longitudinal analysis."

The Lancet.

[http://dx.doi.org/10.1016/S0140-6736\(16\)00577-8](http://dx.doi.org/10.1016/S0140-6736(16)00577-8)

The global economic crisis has been associated with increased unemployment and reduced public-sector expenditure on health care (PEH). We estimated the effects of changes in unemployment and PEH on cancer mortality, and identified how universal health coverage (UHC) affected these relationships.

Murray, E. T., et al. (2016). "Local area unemployment, individual health and workforce exit: ONS Longitudinal Study." *The European Journal of Public Health* 26(3): 463-469.

<http://eurpub.oxfordjournals.org/content/eurpub/26/3/463.full.pdf>

Background: In many developed countries, associations have been documented between higher levels of area unemployment and workforce exit, mainly for disability pension receipt. Health of individuals is assumed to be the primary driver of this relationship, but no study has examined whether health explains or modifies this relationship. Methods: We used data from 98 756 Office for National Statistics Longitudinal Study members who were aged 40–69 and working in 2001, to assess whether their odds of identifying as sick/disabled or retired in 2011 differed by local authority area unemployment in 2001, change in local area unemployment from 2001 to 2011 and individual reported health in 2001 (self-rated and limiting long-term illness). Results: Higher local area unemployment and worse self-rated health measures in 2001 were independently related to likelihood of identifying as sick-disabled or retired, compared to being in work, 10 years later, after adjusting for socio-demographic covariates. Associations for local area unemployment were stronger for likelihood of identification as sick/disabled compared to retired in 2011. Associations for changes in local area unemployment from 2001 to 2011 were only apparent for likelihood of identifying as

retired. For respondents that identified as sick/disabled in 2011, effects of local area unemployment in 2001 were stronger for respondents who had better self-rated health in 2001. Conclusions: Strategies to retain older workers may be most effective if targeted toward areas of high unemployment. For persons in ill health, local area unemployment interventions alone will not be as efficient in reducing their exit from the workforce.

Schneider, U., et al. (2016). "Long-term sick leave and the impact of a graded return-to-work program: evidence from Germany." *Eur J Health Econ* 17(5): 629-643.

The implementation of a graded return-to-work (RTW) program to reintegrate the long-term sick started in Germany in 1971 and has been manifested in the Social Code Book V since 1989. Based on a return plan by the physician and the insured, participants increase their working hours slowly over a specified period of time. As participants are still classified as incapable of working they still receive sick leave benefits. Using claims data from the Techniker Krankenkasse, the largest German sickness fund, the study aims at identifying participants and analyzing the full return-to-work and the impact of the RTW program. Thereby, we account for socio-economic factors, insurance-based characteristics, and medical and health-related information. We consider a possible selection bias by using individual weights to analyze determinants of length of the sickness absence by applying models for survival analysis (Cox proportional hazard model). As a main result - depending on the central assumption of unconfoundedness - sickness absence is positively related to participation in the RTW program for those with sickness absence longer than 120 days. For mental disorders, our results indicate an even stronger effect. The study results emphasize the need further promotion of this instrument among those insured, physicians and employers, as occupational health management is one key for a successful return-to-work.

Van Aerden, K., et al. (2016). "How does employment quality relate to health and job satisfaction in Europe? A typological approach." *Soc Sci Med* 158: 132-140.

The changing nature of employment in recent decades, due to an increased emphasis on flexibility and competitiveness in European labour markets, compels the need to assess the consequences of contemporary employment situations for workers. This article aims to study the relation between the quality of employment and the health and well-being of European workers, using data from the 2010 European Working Conditions Survey. A typology of employment arrangements, mapping out employment quality in the European labour force, is constructed by means of a Latent Class Cluster Analysis. This innovative approach shows that it is possible to condense multiple factors characterising the employment situation into five job types: Standard Employment Relationship-like (SER-like), instrumental, precarious unsustainable, precarious intensive and portfolio jobs. Binary logistic regression analyses show that, controlling for other work quality characteristics, this employment quality typology is related to self-perceived job satisfaction, general health and mental health. Precarious intensive jobs are associated with the worst and SER-like jobs with the best health and well-being situation. The findings presented in this study indicate that, among European wage workers, flexible and de-standardised employment tends to be related to lower job satisfaction, general health and mental health. The quality of employment is thus identified as an important social determinant of health (inequalities) in Europe.

Vieillessement / Ageing

Blomqvist, K. et Bibsy, C.B. (2016). "Determining the Public/Private Mix: Options for Financing Targeted Universality in Long-Term Care." *Healthcare Papers* 15(4): 25-30.

The way in which we pay for long-term care (LTC) services is going to come under enormous pressure as Canada's baby boomers age. Once baby boomers start to turn 75, in 2021, the demand for LTC services will see a sharp upward trend. A number of independent projections have demonstrated how

this will put pressure on the public finances in coming years. It should be concerning to Canadians that we have not publicly discussed how we will make the tough choices to cope with these pressures. Moreover, it's equally troubling that our provincial LTC systems already are unable to cope with the current level of demand for services, with less than a decade before the first wave of boomers enter age groups where demand for LTC is high, and alternate level of care patients, made up mostly of frail elderly, occupying over 15% of Canadian hospital beds on a daily basis as they await care elsewhere. Although we think it is unlikely that Canadian provinces will add LTC to the list of fully subsidized health services (hospitals and doctors), we should do a better job of targeting the existing public subsidies for LTC and do so while putting LTC financing on a more sustainable footing.

Michel, G. (2016). "Funding for Long-Term Care: Why Public Insurance Makes Sense."

HealthcarePapers **15**(4): 21-24.

Adams and Vanin (2016) build a strong case for public support for private insurance in long-term care. Their main argument is that public coverage is not politically feasible. I start with summing up and criticizing their argument. The gist of my criticism is that the success of their plan requires some kind of selection (not everybody buys coverage), and selection is precisely why private insurance does not work for long-term care. I then reframe my preferred policy option: a public scheme financed out of a flat rate or sales tax.

Owen, A. et Sharon, V. (2016). "Funding Long-Term Care in Canada: Issues and Options."

HealthcarePapers **15**(4): 7-19.

Canada's aging population is likely to result in increased health and long-term care (LTC) costs. It is estimated that between 2012 and 2046, LTC cost liability could reach almost \$1.2 trillion. Many Canadians are unaware of the potential burden of LTC expenditures, and there is no consensus on who should pay for them. There are four possible options: (1) general tax revenues; (2) social insurance (employer/employee contributions); (3) private purchase of LTC insurance; and (4) private savings. This paper reviews these options as they have materialized to date in Canada and other countries. Despite the growing acuity of this issue, it seems unlikely that a universal, publicly funded approach to LTC will emerge in Canada. It is clear that federal and provincial/territorial governments must continue to explore policy options for LTC funding including public education, prevention and mitigation strategies and provision for tax-sheltered savings specifically for LTC.