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Assurance maladie

Burke, S. A., et al. (2016). "From universal health insurance to universal healthcare? The shifting health policy landscape in Ireland since the economic crisis." *Health Policy* 120(3): 235-240.

Ireland experienced one of the most severe economic crises of any OECD country. In 2011, a new government came to power amidst unprecedented health budget cuts. Despite a retrenchment in the ability of health resources to meet growing need, the government promised a universal, single-tiered health system, with access based solely on medical need. Key to this was introducing universal free GP care by 2015 and Universal Health Insurance from 2016 onwards. Delays in delivering universal access and a new health minister in 2014 resulted in a shift in language from 'universal health insurance' to 'universal healthcare'. During 2014 and 2015, there was an absence of clarity on what government meant by universal healthcare and divergence in policy measures from their initial intent of universalism. Despite the rhetoric of universal healthcare, years of austerity resulted in poorer access to essential healthcare and little extension of population coverage. The Irish health system is at a critical juncture in 2015, veering between a potential path to universal healthcare and a system, overwhelmed by years of austerity, which maintains the status quo. This paper assesses the gap between policy intent and practice and the difficulties in implementing major health system reform especially while emerging from an economic crisis.

Lindner, S. (2016). "How Do Unemployment Insurance Benefits Affect the Decision to Apply for Social Security Disability Insurance?" *Journal of Human Resources* 51(1): 62-94.

<http://jhr.uwpress.org/content/51/1/62.abstract>

This paper examines whether Unemployment Insurance (UI) benefits affect the decision to apply for Social Security Disability Insurance (DI). Using data from the Survey of Income and Benefits matched to administrative records on DI applications, I find that higher UI benefits reduce applications for DI. This substitution effect is imprecisely estimated but economically significant, implying that a \$1.00 increase in UI benefits reduces DI expenditures by 15 cents. Recognizing this cost-saving effect would increase the optimal UI benefit level by more than 20 percent for coefficients of relative risk aversion ranging from two to five.

Muir, G. and J. Anant (2016). "Promoting Triple Value Healthcare in Countries with Universal Healthcare." *HealthcarePapers* 15(3): 42-48.

<https://www.longwoods.com/content/24473>

Verma and Bhatia (2016) have made an important case for Canada to embrace the Institute for Healthcare Improvement (IHI) Triple Aim. In England, the National Health Service (NHS) has certainly benefited from the Triple Aim, but a different approach has developed, reflecting the difference in health services between the United States and the UK. The principal difference is that the NHS, like all universal healthcare systems, has an explicit and legally required commitment to cover the needs of the whole population within a defined and finite budget. For this reason, we have been working to not only improve the quality and safety of services, learning greatly from IHI, but also maximize value for individuals and populations.

Shrivastava, S., et al. (2016). « Moving toward the universal health coverage: A strategy to expedite health equity." *Journal of Medical Society* 30(1): 70-71

Among the multiple goals set in the field of health for the nations and the general population, ensuring universal health coverage (UHC) is of extreme priority. Globally, it has been anticipated, that by achieving UHC, it will not only help to negate social inequity, but even aid the stakeholders in their mission to ensure sustainable development and minimize poverty, especially in middle- and low-income nations. The findings of a recently released report have suggested that close to 400 million people were devoid of one of the essential health services, and hence there is an indispensable need

to expand the reach of health services. In conclusion, the scope of UHC is much more than just health, set with a primary objective of extending quality assured essential health services in order to improve the health standards of the beneficiaries, without compromising the financial status of the family. Thus, by moving toward UHC, it will help nations to achieve equity and social inclusion.

Economie de la santé

Agade A., et al. (2016). "Diabète : quel coût pour l'assurance maladie en 2012, par poste de dépense et par région ?" *Diabetes & Metabolism* 42(S1).

Objectif : Réalisée sur la population du régime général en France (59 millions d'individus), cette étude estime le coût du diabète pour l'Assurance maladie, aux niveaux national et régional, en distinguant notamment les remboursements spécifiques à la prise en charge du diabète (antidiabétiques, HbA1c, matériel d'injection et de surveillance, hospitalisations pour diabète, consultations d'endocrinologie, etc.) des autres dépenses mobilisées pour la prise en charge de cette pathologie et de ses complications. Matériels et Méthodes : Un algorithme appliqué aux données du SNIIRAM (Système National d'Information Inter-Régimes de l'Assurance Maladie) repère une personne diabétique sur la base d'au moins trois remboursements d'antidiabétiques en 2012, ou en 2011, ou si elle est exonérée au titre d'une Affection de Longue Durée diabète en 2012. Les postes de dépenses spécifiques au diabète sont affectés intégralement au coût de cette pathologie. Pour les postes de dépenses non-spécifiques, le surcroît de remboursements versé aux patients diabétiques est mesuré par modélisation par rapport aux témoins d'âge et sexe comparables. Une comparaison régionale des dépenses moyennes remboursées par patient est également effectuée en contrôlant sur l'âge et le sexe. Résultats : La population diabétique représentait 5 % de la population assurée par le régime général (qui couvre 86 % de la population) en 2012. La dépense remboursée pour la prise en charge du diabète et de ses complications s'élevait à 10 milliards d'euros, soit 8 % des remboursements totaux versés à toute la population. Les remboursements spécifiques au diabète représentaient 20 % des dépenses totales pour diabète et le surcroît de remboursements pour les autres postes de dépenses non spécifiques, 80 %. Les séjours hospitaliers (tous motifs) représentaient une part importante du coût global du diabète (22 %). La dépense moyenne par patient était estimée à 3 400 €, avec des disparités régionales (3 040 € à 5 080 €) liées aux caractéristiques des patients (insulinothérapie) et à leur recours aux soins (hospitalier). Conclusions : Cette étude identifie les postes de dépenses, en particulier hospitalières mais aussi non spécifiques du diabète, qui représentent un enjeu dans le cadre de la prise en charge du diabète et de ses complications, et leur variabilité régionale.

Charbonnel B., et al. (2016). "Coût du diabète de type 2 en France." *Diabetes & Metabolism* 42(S1): P. A1-A109.

Objectif : Estimer les coûts directs de prise en charge du diabète de type 2 (DT2) en France, en 2013, en distinguant la consommation totale des ressources utilisées pour les patients DT2 des coûts directement attribuables au diabète et ses complications. Patients et Méthodes - Les données sont issues de la base EGB (Echantillon Généraliste des Bénéficiaires), échantillon aléatoire de ≈600 000 patients enregistrés dans la base de données de l'assurance maladie. Les patients DT2 ont été identifiés à partir de leurs consommations de médicaments hypoglycémisants, de l'existence d'un statut ALD pour diabète et/ou d'un code diagnostic diabète au cours d'une hospitalisation. Les coûts directs ont été estimés selon une perspective collective. Le fardeau du DT2 a été évalué en comparant les coûts des dépenses de santé observées chez les patients DT2 versus une population témoin appariée sur l'âge, le sexe et la région de résidence. Résultats - L'analyse a été réalisée dans l'ensemble de la population DT2, soit 25 987 patients (âge moyen 67,5 ans (SD 12,5), 53,9 % d'hommes) appariée à un groupe témoin de 76 406 sujets non diabétiques et présents dans la base en 2013. Les dépenses annuelles totales de santé par patient s'élevaient à 6 506 € (SD 10 106) dans la population DT2 versus 3 668 € (SD 6 954) pour les témoins (X1,8). Parmi les patients diabétiques, les

postes de dépenses les plus élevés étaient les hospitalisations (33,2 % des dépenses totales), les dépenses de pharmacie ou produits dérivés en ville (23,8 %), auxiliaires médicaux (13,5 %), consultations ou actes médicaux en ville (11,5 %). Peu de différences de coûts étaient observées parmi les patients traités par monothérapie, bithérapie ou multithérapie (respectivement : 4,779, 4,555, 4,75 € par patient). En revanche, les dépenses de santé étaient beaucoup plus élevées chez les patients traités par insuline versus ceux sans insuline (12,88 € versus 4,84 €). - Conclusions - En extrapolant à l'ensemble de la population de DT2 en France, les coûts directs totaux du DT2 en 2013 ont été estimés à plus de 9 milliards € en France. Cette estimation met en évidence le fardeau économique considérable que cette pathologie impose à la société.

Eckardt, M., et al. (2016). "Analysis of Health Care Costs in Elderly Patients with Multiple Chronic Conditions Using a Finite Mixture of Generalized Linear Models." *Health Economics*: Ahead of print

<http://dx.doi.org/10.1002/hec.3334>

In this paper we analysed healthcare costs in a sample of elderly patients suffering from multimorbidity. On the one hand, multimorbid individuals consume a disproportionately large share of healthcare resources. On the other hand, the patient specific number and combination of co-occurring single diseases result in inhomogeneous data leading to biased estimates when using traditional regression techniques. Therefore, we applied a mixture of regressions in order to control for unobserved heterogeneity focussing on the identification of multimorbidity patterns. We used a subsample of N = 1050 patients from a multicentre prospective cohort study of randomly selected multimorbid primary care patients aged 65 to 85 years in Germany (ISRCTN 89818205) who completed a detailed questionnaire on healthcare utilization during the 6-month period preceding the interview. Disease combinations of 1047 were included. We detected four different groups of patients with regard to total costs. These groups corresponded largely to findings from the epidemiological literature. The effect of the presence of an additional disease on costs differed between groups. Moreover, two diametrically opposed cost trends were detected with respect to the number of co-occurring diseases. While in one group costs increased with the number of co-occurring diseases, in a second group cost tended to decrease. Copyright © 2016 John Wiley & Sons, Ltd.

Hellsten, E., et al. (2016). "New pricing approaches for bundled payments: Leveraging clinical standards and regional variations to target avoidable utilization." *Health Policy* 120(3): 316-326.

OBJECTIVES: Develop pricing models for bundled payments that draw inputs from clinician-defined best practice standards and benchmarks set from regional variations in utilization. **DATA:** Health care utilization and claims data for a cohort of incident Ontario ischemic and hemorrhagic stroke episodes. Episodes of care are created by linking incident stroke hospitalizations with subsequent health service utilization across multiple datasets. **STUDY DESIGN:** Costs are estimated for episodes of care and constituent service components using setting-specific case mix methodologies and provincial fee schedules. Costs are estimated for five areas of potentially avoidable utilization, derived from best practice standards set by an expert panel of stroke clinicians. Alternative approaches for setting normative prices for stroke episodes are developed using measures of potentially avoidable utilization and benchmarks established by the best performing regions. **PRINCIPAL FINDINGS:** There are wide regional variations in the utilization of different health services within episodes of stroke care. Reconciling the best practice standards with regional utilization identifies significant amounts of potentially avoidable utilization. Normative pricing models for stroke episodes result in increasingly aggressive redistributions of funding. **CONCLUSIONS:** Bundled payment pilots to date have been based on the costs of historical service patterns, which effectively 'bake in' unwarranted and inefficient variations in utilization. This study demonstrates the feasibility of novel clinically informed episode pricing approaches that leverage these variations to target reductions in potentially avoidable utilization.

Sherry, T. B. (2016). "A Note on the Comparative Statics of Pay-for-Performance in Health Care." *Health Economics* 25(5): 637-644.

<http://dx.doi.org/10.1002/hec.3169>

Pay-for-performance (P4P) is a widely implemented quality improvement strategy in health care that has generated much enthusiasm, but only limited empirical evidence to support its effectiveness. Researchers have speculated that flawed program designs or weak financial incentives may be to blame, but the reason for P4P's limited success may be more fundamental. When P4P rewards multiple services, it creates a special case of the well-known multitasking problem, where incentives to increase some rewarded activities are blunted by countervailing incentives to focus on other rewarded activities: these incentives may cancel each other out with little net effect on quality. This paper analyzes the comparative statics of a P4P model to show that when P4P rewards multiple services in a setting of multitasking and joint production, the change in both rewarded and unrewarded services is generally ambiguous. This result contrasts with the commonly held intuition that P4P should increase rewarded activities. Copyright © 2015 John Wiley & Sons, Ltd.

Tuppin, P., et al. (2016) "Consommations de soins des bénéficiaires de la couverture maladie universelle complémentaire (CMUC) ou de l'aide pour une complémentaire santé (ACS) en 2012." *Revue d'Épidémiologie et de Santé Publique* 64 (2)

<http://www.sciencedirect.com/science/article/pii/S0398762016000869>

Position du problème L'objectif était de comparer la consommation de soins des assurés ayant bénéficié d'un des deux dispositifs d'assurance santé disponibles pour les assurés avec de faibles ressources (CMUC, couverture maladie universelle complémentaire, et pour ceux au-dessus du plafond l'ACS, aide pour une complémentaire santé), entre eux et aux assurés sans dispositifs. Méthodes À partir du Système national d'information inter-régimes de l'Assurance maladie (Sniiram), les assurés du régime général (> 60 ans) avec une ouverture de droits en 2012 ont été sélectionnés. Les pathologies ont été identifiées par des algorithmes incluant les affections de longue durée, les diagnostics hospitaliers ou des médicaments. Les groupes homogènes en hôpital de court séjour ont été rassemblés en domaines d'activité. Des risques relatifs (RR) standardisés pour le sexe et l'âge ont été calculés. Résultats Le nombre de bénéficiaires de la CMUC était de 4,4 millions (9,6 %) et de 732 000 (1,6 %) pour l'ACS (pourcentage de femmes : 56 % et 54 %, âge moyen 24 ans et 29 ans ; chez les autres assurés 52 % et 30 ans). Les assurés avec une CMUC ou l'ACS avaient plus souvent une maladie cardiovasculaire (RR = 1,4 et 2,1 respectivement) ou un diabète (RR = 2,2 ; 2,4). Leurs taux d'hospitalisation standardisés étaient significativement plus élevés (18 % ; 17 %, RR = 1,3 ; 1,4), particulièrement pour les domaines « toxicologie, intoxications, alcool » (RR = 3,8 ; 4,0), psychiatrie (RR = 2,8 ; 4,1), pneumologie (RR = 1,9 ; 2,3) et maladies infectieuses (RR = 1,9 ; 2,7). Par rapport aux bénéficiaires de la CMUC, ceux de l'ACS avaient plus fréquemment un cancer (RR = 1,5), une maladie cardiovasculaire (RR = 1,5), neurologique ou dégénérative (RR = 2,7), psychiatrique (RR = 2,6), métabolique héréditaire (RR = 1,9), ou une mucoviscidose (RR = 1,6) mais aussi une allocation adulte handicapé (20%, 4%). La valeur de ces RR pour les ACS chutait après l'exclusion de ceux avec une allocation adulte handicapé. Conclusion La fréquence des pathologies et hospitalisations des assurés bénéficiant de l'ACS est proche de celle des assurés avec une CMUC, voire parfois supérieure. En accord avec la littérature, ces deux populations ont plus souvent une consommation de soins pour des pathologies chroniques et peuvent faire l'objet d'actions de prévention et de dépistage afin d'améliorer leur état de santé et leur recours aux soins.

Varabyova, Y. and J. M. Muller (2016). "The efficiency of health care production in OECD countries: A systematic review and meta-analysis of cross-country comparisons." *Health Policy* 120(3): 252-263.

There has been an ongoing interest in the analysis and comparison of the efficiency of health care systems using nonparametric and parametric applications. The objective of this study was to review the current state of the literature and to synthesize the findings on health system efficiency in OECD countries. We systematically searched five electronic databases through August 2014 and identified 22 studies that analyzed the efficiency of health care production at the country level. We summarized these studies with view on their sample, methods, and utilized variables. We developed and applied a checklist of 14 items to assess the quality of the reviewed studies along four dimensions: reporting,

external validity, bias, and power. Moreover, to examine the internal validity of findings we meta-analyzed the efficiency estimates reported in 35 models from ten studies. The qualitative synthesis of the literature indicated large differences in study designs and methods. The meta-analysis revealed low correlations between country rankings suggesting a lack of internal validity of the efficiency estimates. In conclusion, methodological problems of existing cross-country comparisons of the efficiency of health care systems draw into question the ability of these comparisons to provide meaningful guidance to policy-makers.

Etat de santé / Health Status

(2016). "Trends in adult body-mass index in 200 countries from 1975 to 2014: a pooled analysis of 1698 population-based measurement studies with 19.2 million participants." *The Lancet* **387**(10026): 1377-1396.

Jusot F. (2016). "L'évolution favorable de l'espérance de vie correspond-elle à une augmentation du bien-être lié à la santé ?" *Médecine Sciences* **32**: 231-232.

<http://www.medecinesciences.org/articles/medsci/pdf/2016/03/medsci20163203p231.pdf>

Stockwell, T., et al. (2016). "Do "Moderate" Drinkers Have Reduced Mortality Risk? A Systematic Review and Meta-Analysis of Alcohol Consumption and All-Cause Mortality." *J Stud Alcohol Drugs* **77**(2): 185-198.

OBJECTIVE: Previous meta-analyses of cohort studies indicate a J-shaped relationship between alcohol consumption and all cause mortality, with reduced risk for low-volume drinkers. However, low-volume drinkers may appear healthy only because the "abstainers" with whom they are compared are biased toward ill health. The purpose of this study was to determine whether misclassifying former and occasional drinkers as abstainers and other potentially confounding study characteristics underlie observed positive health outcomes for low volume drinkers in prospective studies of all-cause mortality. METHOD: A systematic review and meta-regression analysis of studies investigating alcohol use and mortality risk after controlling for quality-related study characteristics was conducted in a population of 3,998,626 individuals, among whom 367,103 deaths were recorded. RESULTS: Without adjustment, meta-analysis of all 87 included studies replicated the classic J-shaped curve, with low-volume drinkers (1.3-24.9 g ethanol per day) having reduced mortality risk (RR = 0.86, 95% CI [0.83, 0.90]). Occasional drinkers (<1.3 g per day) had similar mortality risk (RR = 0.84, 95% CI [0.79, 0.89]), and former drinkers had elevated risk (RR = 1.22, 95% CI [1.14, 1.31]). After adjustment for abstainer biases and quality-related study characteristics, no significant reduction in mortality risk was observed for low-volume drinkers (RR = 0.97, 95% CI [0.88, 1.07]). Analyses of higher-quality bias-free studies also failed to find reduced mortality risk for low-volume alcohol drinkers. Risk estimates for occasional drinkers were similar to those for low- and medium-volume drinkers. CONCLUSIONS: Estimates of mortality risk from alcohol are significantly altered by study design and characteristics. Meta-analyses adjusting for these factors find that low-volume alcohol consumption has no net mortality benefit compared with lifetime abstention or occasional drinking. These findings have implications for public policy, the formulation of low-risk drinking guidelines, and future research on alcohol and health.

Géographie de la santé/ Geography of Health

Brunat, M. and V. Fargeon (2015). "Accessibilité et organisation des soins de premier recours." *Journal de Gestion et d'Economie Médicales* **33**(3): 175-189.

<http://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2015-3-page-175.htm>

da Silva, N., et al. (2015). "Les liens entre la performance médicale et la composition de la patientèle : Une étude économétrique sur les médecins d'Ile-de-France." *Journal de Gestion et d'Economie Médicales* **33**(3): 191-214.

<http://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2015-3-page-191.htm>

Mercier, G., et al. (2015). "Variations géographiques des taux d'hospitalisations potentiellement évitables en France." *Journal de Gestion et d'Economie Médicales* **33**(3): 161-173.

<http://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2015-3-page-161.htm>

Weil, M. (2016). "[Urban planning, health and public policy]." *Rev Epidemiol Santé Publique*.

Hôpital / Hospitals

Barros, P. and G. Braun (2016). "Upcoding in a National Health Service: the evidence from Portugal." *Health Economics*: Ahead of print.

<http://dx.doi.org/10.1002/hec.3335>

For many years, evidence from the USA has pointed out to the existence of upcoding in management practices. Upcoding is defined as classifying patients in diagnosis-related groups codes associated with larger payments. The incentive for upcoding is not restricted to private providers of care.

Conceptually, any patient classification system that is used for payment purposes may be vulnerable to this sort of strategic behaviour by providers. We document here that upcoding occurs in a National Health Service where public hospitals have their payment (budget) tied to the classification of treatment episodes. Using diagnosis-related groups data from Portugal, we found that the practice of upcoding has been used in the hospitals in a way leading to larger budgets (age of patients plays a key role). The effect is quantitatively small. Copyright © 2016 John Wiley & Sons, Ltd.

Larochelle, J.L., and D. Ehrmann Feldmann (2016). "Impact of Type of Medical Specialist Involvement in Chronic Illness Care on Emergency Department Use." *Healthcare Policy* **11**(3): 54-66.

<http://www.longwoods.com/content/24536>

Objectives: Medical specialist physicians may act as either consultants or co-managers for patients managed in primary care settings. We assessed whether the type of specialist involvement affected emergency department (ED) use for patients with chronic diseases.

Methods: In total, 709 primary care patients with arthritis, chronic obstructive pulmonary disease, diabetes or congestive heart failure were followed for one year using survey and administrative data. Multivariate logistic regressions were used to compare all-cause ED use according to specialist involvement (none, co-manager or consultant). Results: In total, 240 (34%) patients visited the ED. ED use did not differ between those with specialist involvement and those without it, either as co-managers (adjusted OR = 1.06, 95% CI = [0.61, 1.85]) or consultants (adjusted OR = 0.97, 95% CI = [0.63, 1.50]). Discussion: The type of specialist involvement is not associated with all-cause ED use in primary care patients with chronic diseases. Indications for co-management should be further investigated.

Or, Z., et al. (2016). "La pertinence des pratiques d'hospitalisation : une analyse des écarts départementaux de prostatectomies." *Revue économique* **67**(2): 337-354.

<http://www.cairn.info/revue-economique-2016-2-page-337.htm>

Cet article analyse les variations territoriales de pratiques de prostatectomies en France. Nous recourons à une modélisation multiniveau permettant de distinguer la variabilité liée à deux niveaux

géographiques : le département et la région. Nos résultats montrent que les taux de prostatectomies standardisés (pour 100 000 hommes) varient de manière significative entre les départements. Les écarts interdépartementaux sont expliqués notamment par la densité d'urologues libéraux dans le département ainsi que par l'offre de soins hospitaliers (disponibilité des lits de chirurgie et de personnels soignants) au niveau régional une fois contrôlés par le revenu et les taux de mortalité par départements.

Pierru, F. (2016). "[Hospital and public health: An improbable encounter. A political sociology reflecting on non-decision making in the French health system]." Rev Epidémiol Santé Publique : Ahead of print.

Schüssler-Fiorenza Rose, S. M., et al. (2016). "Potentially Avoidable Hospitalizations among People at Different Activity of Daily Living Limitation Stages." Health Services Research: Ahead of print. <http://dx.doi.org/10.1111/1475-6773.12484>

Objective To determine whether higher activity of daily living (ADL) limitation stages are associated with increased risk of hospitalization, particularly for ambulatory care sensitive (ACS) conditions. Data Source Secondary data analysis, including 8,815 beneficiaries from 2005 to 2006 Medicare Current Beneficiary Survey (MCBS). Study Design ADL limitation stages (0-IV) were determined at the end of 2005. Hospitalization rates were calculated for 2006 and age adjusted using direct standardization. Multivariate negative binomial regression, adjusting for baseline demographic and health characteristics, with the outcome hospitalization count was performed to estimate the adjusted rate ratio of ACS and non-ACS hospitalizations for beneficiaries with ADL stages > 0 compared to beneficiaries without limitations. Data Collection Baseline ADL stage and health conditions were assessed using 2005 MCBS data and count of hospitalization determined using 2006 MCBS data. Principal Findings Referenced to stage 0, the adjusted rate ratios (95 percent confidence interval) for stage I to stage IV ranged from 1.9 (1.4–2.5) to 4.1 (2.2–7.8) for ACS hospitalizations compared with from 1.6 (1.3–1.9) to 1.8 (1.4–2.5) for non-ACS hospitalizations. Conclusions Hospitalization rates for ACS conditions increased more dramatically with ADL limitation stage than did rates for non-ACS conditions. Adults with ADL limitations appear particularly vulnerable to potentially preventable hospitalizations for conditions typically manageable in ambulatory settings.

Sinsky, C. A. (2016). "Helicopters and Hospitalizations: Getting the Primary Care That We Invest In." Ann Intern Med 164(5): 370-371.

Zuckerman, R. B., et al. (2016). "Readmissions, Observation, and the Hospital Readmissions Reduction Program." N Engl J Med. : Feb. 24.

Background The Hospital Readmissions Reduction Program, which is included in the Affordable Care Act (ACA), applies financial penalties to hospitals that have higher-than-expected readmission rates for targeted conditions. Some policy analysts worry that reductions in readmissions are being achieved by keeping returning patients in observation units instead of formally readmitting them to the hospital. We examined the changes in readmission rates and stays in observation units over time for targeted and nontargeted conditions and assessed whether hospitals that had greater increases in observation-service use had greater reductions in readmissions. Methods We compared monthly, hospital-level rates of readmission and observation-service use within 30 days after hospital discharge among Medicare elderly beneficiaries from October 2007 through May 2015. We used an interrupted time-series model to determine when trends changed and whether changes differed between targeted and nontargeted conditions. We assessed the correlation between changes in readmission rates and use of observation services after adoption of the ACA in March 2010. Results We analyzed data from 3387 hospitals. From 2007 to 2015, readmission rates for targeted conditions declined from 21.5% to 17.8%, and rates for nontargeted conditions declined from 15.3% to 13.1%. Shortly after passage of the ACA, the readmission rate declined quickly, especially for targeted conditions, and then continued to fall at a slower rate after October 2012 for both targeted and nontargeted conditions. Stays in observation units for targeted conditions increased from 2.6% in 2007 to 4.7% in 2015, and rates for

nontargeted conditions increased from 2.5% to 4.2%. Within hospitals, there was no significant association between changes in observation-unit stays and readmissions after implementation of the ACA. Conclusions Readmission trends are consistent with hospitals' responding to incentives to reduce readmissions, including the financial penalties for readmissions under the ACA. We did not find evidence that changes in observation-unit stays accounted for the decrease in readmissions.

Inégalités de santé / Health Inequalities

Cambois, E. (2016). "[Social inequalities in health less pronounced in women than in men: A question of measurements?]." Rev Epidémiol Santé Publique : **64(S2) : 65-75.**

Giuntella, O. and L. Stella (2016). "The Acceleration of Immigrant Unhealthy Assimilation." Health Economics:Ahead of print.
<http://dx.doi.org/10.1002/hec.3331>

It is well known that immigrants tend to be healthier than US natives and that this advantage erodes with time spent in the USA. However, we know less about the heterogeneity of these trajectories among arrival cohorts. Recent studies have shown that later arrival cohorts of immigrants have lower entry wages and experience less economic assimilation. In this paper, we investigate whether similar cohort effects can be observed in the weight assimilation of immigrants in the USA. Focusing on obesity, we show that more recent immigrant cohorts arrive with higher obesity rates and experience a faster 'unhealthy assimilation' in terms of weight gain. Copyright © 2016 John Wiley & Sons, Ltd.

Ancelet, A. and M.H. Depret (2016). "Le renoncement aux soins chez les femmes enceintes : une analyse empirique à partir de l'Enquête nationale périnatale. ." Revue d'Épidémiologie et de Santé Publique **64(P. S97).**

Raynault, M. F. and D. Cote (2016). "[Social policies and social inequalities in health: The Quebec early childhood centres program]." Rev Epidemiol Santé Publique : **64(S2) : 87-95.**

Soler, L. G. (2016). "[Nutrition policies: What possible impacts on health inequalities?]." Rev Epidémiol Santé Publique : **64(S2) : 55-60.**

Tuppin, P. and P. O. Blotiere (2012). "[Hospitalization rates for immigrant-related illness among individuals with low income and full health insurance coverage in France, 2009]." Bull Soc Pathol Exot **105(2): 79-85.**

Complementary Universal Health Insurance (CMUC) which provides free access to health care has been available in France since 2000 for people with an annual income less than 60% of the poverty threshold. Hospitalization rates in 2009 for common diseases among immigrants were compared between beneficiaries of the general scheme under the age of 60 years with (4.5 millions) or without CMUC (34.1 millions) in 2008 and still alive at the end of the year. Data were derived from the French national health insurance reimbursements and short-stay hospital discharge databases. Age - and sex-adjusted hospitalization rates and relative risk significantly greater overall hospitalization rates (17.5% vs 13.2%) (males RR= 2.0, female RR 2.3) and each parasitic diseases (RR = 2.1), which include viral diseases and fevers of unknown origin (1.1/1000, RR =1.6), septicaemia (0.4/1000, RR = 2.2), HIV infection (0.7/1000, RR = 3.5), other infectious and parasitic diseases (0.7/1000, RR= 2.5) and, more precisely, measles (2.7/1000, RR = 5.0). Hospitalization for sickle cell disease (3%, RR = 4.5) were also more frequent as also for lead poisoning (0.12/1000, RR = 5.2). In this low-income population with free access to health care, hospitalizations were higher for many diseases that are targets for prevention and screening actions. This is the case for immigrant with CMUC coverage arriving in

France and when they travel to their country of origin.

Médicaments / Pharmaceuticals

Csete, J., et al. (2016) "Public health and international drug policy." *The Lancet* 387(10026): 1427-1480.
[http://dx.doi.org/10.1016/S0140-6736\(16\)00619-X](http://dx.doi.org/10.1016/S0140-6736(16)00619-X)

Rousseau, A., et al. (2016). "[Inappropriate prescription and administration of medications in 10 nursing homes in Alsace, France]." *Rev Epidemiol Santé Publique* : 64(S2) : 95-101.

BACKGROUND: Medication care is a complicated process in nursing homes. The aim of the study was to offer an overview of inappropriate medication prescription and administration practices in nursing homes in Alsace in order to propose improvement actions to remedy the weaknesses identified. METHODS: This study was conducted prospectively in 10 nursing homes under contract with community pharmacies in Alsace. The practices of prescription were examined to determine the prevalence of potentially inappropriate medications, inappropriate and contraindicated medication associations. Crushing and opening practices were also assessed, daily treatment costs were calculated. RESULTS: Two hundred and eighty-four residents were included (age: 87.1+/-5.6years). The average number of drugs per resident was 8.1+/-4.0 (daily treatment cost: 4.19+/-5.21euro). On average, 1.5 drugs+/-1.4 per prescription were considered as potentially inappropriate (daily treatment cost: 0.49+/-0.76euro). The contraindication associations concerned 8 % of prescriptions and involved potentially inappropriate drugs in 60 % of cases. Inappropriate associations mainly concerned nervous system drugs. Thirty-three residents were taking more than 2 psychotropic drugs; 23 had more than one benzodiazepine. Regarding drug administration, practices differed from one nursing home to another. Crushing was performed in 8 nursing homes. It concerned 20 residents (7 %) and 69 drugs. In 50 %, the crushing decision was made by nurses without physician or pharmacist supervision. Fifty-seven percent of crushed drugs had a formulation which did not allow crushing (n=39 drugs). The analysis of those items led to the proposal of improvement actions. CONCLUSION: This study pointed out inappropriate medication practices. Tracking tools for inappropriate clinical practices could be operated by physicians, pharmacists and nursing teams through coordinated multidisciplinary approaches.

Steinman, M. A. (2016). "Polypharmacy-Time to Get Beyond Numbers." *JAMA Intern Med.* 21 Mar.

Stroka, M. A. (2015). "Drug overprescription in nursing homes: an empirical evaluation of administrative data." *The European Journal of Health Economics* 17(3): 257-267.
<http://dx.doi.org/10.1007/s10198-015-0676-y>

A widely discussed shortcoming of long-term care in nursing homes for the elderly is the inappropriate or suboptimal drug utilization, particularly of psychotropic drugs. Using administrative data from the largest sickness fund in Germany, this study was designed to estimate the effect of institutionalization on the drug intake of the frail elderly. Difference-in-differences propensity score matching techniques were used to compare drug prescriptions for the frail elderly who entered a nursing home with those who remained in the outpatient care system; findings suggest that nursing home residents receive more doses of antipsychotics, antidepressants, and analgesics. The potential overprescription correlates with estimated drug costs of about €87 million per year.

Tsaprantzi, A. V., et al. (2016). "The Impact of Information on Doctors' Attitudes Toward Generic Drugs." *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 53 : 1-8.
<http://inq.sagepub.com/content/53/0046958016637791.abstract>

The objective of this study is to assess the impact of information on doctors' attitudes and perceptions

toward generics. A cross-sectional survey based on a specially designed 21-item questionnaire was conducted. The survey involved doctors of different specialties working in a public hospital in Greece. The analysis includes descriptive and inferential statistics, reliability and validity tests, as well as structural equation modeling to evaluate the causal model. Statistical analysis was accomplished by using SPSS 20 and Amos 20. A total of 134 questionnaires out of 162 were received, providing a response rate of 82.71%. A number of significant associations were found between information and perceptions about generic medicines with demographic characteristics. It seems that the provision of quality information on generic drugs influences doctors' attitudes and prescription practices toward generic drugs. This is not a static process but a rather dynamic issue involving information provision policies for strengthening the proper doctors' attitudes toward generic drugs.

Wise, J. (2016). "Hospitals and GPs are offered incentives to reduce antibiotic prescribing." *BMJ* 352. <http://www.bmj.com/content/bmj/352/bmj.i1499.full.pdf>

GPs and hospitals in England will be given incentives to reduce the number of antibiotics they prescribe, in an effort to tackle the growing problem of antibiotic resistance. NHS England announced that, from April 2016, clinical commissioning groups (CCGs) will receive extra funding if they reduce the number of antibiotics prescribed in primary care either by 4% or down to the average performance level of 2013-14. The incentive is part ...

Méthodologie – Statistique / Methodology - Statistics

Delavallade, C. (2016). "Quality Health Care and Willingness to Pay for Health Insurance Retention: A Randomized Experiment in Kolkata Slums." *Health Economics*: Ahead of print. <http://dx.doi.org/10.1002/hec.3337>

The low quality of health care in developing countries reduces the poor's incentives to use quality health services and their demand for health insurance. Using data from a field experiment in India, I show that randomly offering insurance policyholders a free preventive checkup with a qualified doctor has a twofold effect: receiving this additional benefit raises willingness to pay to renew health insurance by 53%, doubling the likelihood of hypothetical renewal; exposed individuals are 10 percentage points more likely to consult a qualified practitioner when ill after the checkup. Both effects are concentrated on poorer households. There is no effect on health knowledge and healthcare spending. This suggests that exposing insured households to quality preventive care can be a cost-effective way of raising the demand for quality health care and retaining policyholders in the insurance scheme. Copyright © 2016 John Wiley & Sons, Ltd.

Kunz, J. S. and R. Winkelmann (2016). "An Econometric Model of Healthcare Demand With Nonlinear Pricing." *Health Economics*: Ahead of print. <http://dx.doi.org/10.1002/hec.3343>

From 2004 to 2012, the German social health insurance levied a co-payment for the first doctor visit in a calendar quarter. We develop a new model for estimating the effect of such a co-payment on the individual number of visits per quarter. The model combines a one-time increase in the otherwise constant hazard rate determining the timing of doctor visits with a difference-in-differences strategy to identify the reform effect. An extended version of the model accounts for a mismatch between reporting period and calendar quarter. Using data from the German Socio-Economic Panel, we do not find an effect of the co-payment on demand for doctor visits. Copyright © 2016 John Wiley & Sons, Ltd.

Stollenwerk, B., et al. (2015). "Cost-of-illness studies based on massive data: a prevalence-based, top-down regression approach." *The European Journal of Health Economics* 17(3): 235-244.

<http://dx.doi.org/10.1007/s10198-015-0667-z>

Despite the increasing availability of routine data, no analysis method has yet been presented for cost-of-illness (COI) studies based on massive data. We aim, first, to present such a method and, second, to assess the relevance of the associated gain in numerical efficiency. We propose a prevalence-based, top-down regression approach consisting of five steps: aggregating the data; fitting a generalized additive model (GAM); predicting costs via the fitted GAM; comparing predicted costs between prevalent and non-prevalent subjects; and quantifying the stochastic uncertainty via error propagation. To demonstrate the method, it was applied to aggregated data in the context of chronic lung disease to German sickness funds data (from 1999), covering over 7.3 million insured. To assess the gain in numerical efficiency, the computational time of the innovative approach has been compared with corresponding GAMs applied to simulated individual-level data. Furthermore, the probability of model failure was modeled via logistic regression. Applying the innovative method was reasonably fast (19 min). In contrast, regarding patient-level data, computational time increased disproportionately by sample size. Furthermore, using patient-level data was accompanied by a substantial risk of model failure (about 80 % for 6 million subjects). The gain in computational efficiency of the innovative COI method seems to be of practical relevance. Furthermore, it may yield more precise cost estimates.

Politique de santé / Health Policy

Agrawal, S. and D. Brown (2016). "The Physician Payments Sunshine Act--Two Years of the Open Payments Program." *N Engl J Med* **374**(10): 906-909.

Casassus, B. "France passes wide-ranging health reforms." *The Lancet* **387**(10021): 831-832.
[http://dx.doi.org/10.1016/S0140-6736\(16\)00554-7](http://dx.doi.org/10.1016/S0140-6736(16)00554-7)

Nelson, J. P. and A. D. McNall (2016). "Alcohol prices, taxes, and alcohol-related harms: A critical review of natural experiments in alcohol policy for nine countries." *Health Policy* **120**(3): 264-272.

OBJECTIVE: Evidence for alcohol-price policy relies heavily on aggregate econometric studies for the United States. Prior reviews of prices and alcohol-related harms include only a few studies based on natural experiments. This study provides a comprehensive review of natural experiments for a wide variety of harms from studies published during 2003 to 2015. We examine policy changes that importantly affected alcohol taxes and prices, and related changes in availability. **METHODS:** Forty-five studies met inclusion criteria, covering nine countries: Australia, Denmark, Finland, Hong Kong, Iceland, Russia, Sweden, Switzerland, and United States. Some studies cover more than one harm or country, and there are 69 outcomes for review. Summaries are provided for five outcome groups: alcohol-related mortality and hospitalizations; assaults and other crime; drink-driving; intoxication; and survey-indexes for dependency. The review notes both positive/mixed results and negative/null results. **RESULTS:** Findings indicate that changes in taxes and prices have selective effects on harms. Mortality outcomes are positive for liver disease and older persons, especially in Finland and Russia. Mostly null results for assaults and drink-driving are found for five countries. Intoxication results for Nordic countries are mixed for selective subpopulations. Results for survey indexes are mixed, with no strong pattern of outcomes within or across countries. **CONCLUSION:** Prior reviews stress taxes as a comprehensive and cost-effective intervention for addressing alcohol-related harms. A review of natural experiments indicates the confidence placed on this measure is too high, and natural experiments in alcohol policy had selective effects on various subpopulations.

Richard, W. and W. C. Hon. Douglas (2016). "System-Level Reform in Healthcare Delivery for Patients and Populations Living With Chronic Disease." *HealthcarePapers* **15**(Special Issue): 67-

73.

<http://www.longwoods.com/content/24508>

Healthcare in Canada has generally not kept pace with the evolving needs of patients since the creation of Medicare in the 1960s. Budgets for hospitals, physicians and prescription drugs make up the bulk of spending in health, despite the need for better prevention and management of chronic disease, the needed expansion of home-based care services and the call for reform of front-line primary care. Over the past decade, a number of Canadian health authorities have adopted the US-based Institute for Healthcare Improvement Triple Aim philosophy (better population health, better patient experience and better per capita cost of care) in order to build system-level change. The Atlantic Healthcare Collaboration was one attempt to initiate system-level reform in healthcare delivery for patients living with chronic disease.

Prévention / Prevention

Andler, R., et al. (2015). "Electronic cigarette use in France in 2014." International Journal of Public Health 61(2): 159-165.

<http://dx.doi.org/10.1007/s00038-015-0773-9>

The aim of this study was to investigate electronic cigarette use in France with a special focus on its relationship with tobacco smoking.

Bouckaert, N. and E. Schokkaert (2015). "Differing types of medical prevention appeal to different individuals." The European Journal of Health Economics 17(3): 317-337.

<http://dx.doi.org/10.1007/s10198-015-0709-6>

We analyze participation in medical prevention with an expected utility model that is sufficiently rich to capture diverging features of different prevention procedures. The predictions of the model are not rejected with data from SHARE. A decrease in individual health decreases participation in breast cancer screening and dental prevention and increases participation in influenza vaccination, cholesterol screening, blood pressure screening, and blood sugar screening. Positive income effects are most pronounced for dental prevention. Increased mortality risk is an important predictor in the model for breast cancer screening, but not for the other procedures. Targeted screening and vaccination programs increase participation.

Farrell, L. C., et al. (2016). "Socio-economic divergence in public opinions about preventive obesity regulations: Is the purpose to 'make some things cheaper, more affordable' or to 'help them get over their own ignorance'?" Social Science & Medicine 154: 1-8.

<http://www.sciencedirect.com/science/article/pii/S0277953616300831>

The potential for regulatory measures to address escalating rates of obesity is widely acknowledged in public health circles. Many advocates support regulations for their potential to reduce health inequalities, in light of the well-documented social gradient in obesity. This paper examines how different social groups understand the role of regulations and other public health interventions in addressing obesity. Drawing upon focus group data from a metropolitan city in southern Australia, we argue that implementing obesity regulations without attention to the ways in which disadvantaged communities problematise obesity may lead to further stigmatisation of this key target population. Tuana's work on the politics of ignorance, and broader literature on classed asymmetries of power, provides a theoretical framework to demonstrate how middle class understandings of obesity align with dominant 'obesity epidemic' discourses. These position obese people as lacking knowledge; underpinning support for food labelling and mandatory nutrition education for welfare recipients as well as food taxes. In contrast, disadvantaged groups emphasised the potential for a different set of

interventions to improve material circumstances that constrain their ability to act upon existing health promotion messages, while also describing priorities of everyday living that are not oriented to improving health status. Findings demonstrate how ignorance is produced as an explanation for obesity, widely replicated in political settings and mainstream public health agendas. This politics of ignorance and its logical reparation serve to reproduce power relations in which particular groups are constructed as lacking capacity to act on knowledge, whilst maintaining others in privileged positions of knowing.

Hudon, C., et al. (2016). "The Chronic Disease Self-Management Program: the experience of frequent users of health care services and peer leaders." *Family Practice* 33(2): 167-171.
<http://fampra.oxfordjournals.org/content/33/2/167.abstract>

Background. Large amount of evidence supports the contribution of the Stanford Chronic Disease Self-Management Program (CDSMP) to a global chronic disease management strategy. However, many studies have suggested further exploring of the factors influencing acceptance and completion of participants in this program. Objective. This study aimed to describe and examine factors associated with acceptance and completion rates of the CDSMP among frequent users of health care services, and to highlight the experience of patients and peer leaders who facilitated the program. Methods. A descriptive design with mixed sequential data was used. Acceptance and completion rates were calculated and their relationship with patient characteristics was examined in regression analysis (n = 167). Interviews were conducted among patients who accepted (n = 11) and refused (n = 13) to participate and with the program coordinator. Focus groups were held with the seven peer leaders who facilitated the program. Data were analysed using thematic analysis. Results. Of the 167 patients invited, 60 (36%) accepted to participate in the program. Group format was the most frequent reason to decline the invitation to participate. Twenty-eight participants (47%) completed the program. Participants who dropped out during the program raised different reasons such as poor health and too much heterogeneity among participants. Factors such as location, schedule, content, group composition and facilitation were considered as important elements contributing to the success of the program. Conclusion. The CDSMP could therefore be considered as a self-management support option for this vulnerable clientele, while taking measures to avoid too much heterogeneity among participants to improve completion rates.

Kaye Phillips, C. A. and E.-J. Keesa (2016). "Evaluating a Chronic Disease Management Improvement Collaboration: Lessons in Design and Implementation Fundamentals." *HealthcarePapers* 15(Special Issue): 80-89.
<http://www.longwoods.com/content/24505>

For the Canadian Foundation for Healthcare Improvement (CFHI), the Atlantic Healthcare Collaboration (AHC) was a pivotal opportunity to build upon its experience and expertise in delivering regional change management training and to apply and refine its evaluation and performance measurement approach. This paper reports on its evaluation principles and approach, as well as the lessons learned as CFHI diligently coordinated and worked with improvement project (IP) teams and a network of stakeholders to design and undertake a suite of evaluative activities. The evaluation generated evidence and learnings about various elements of chronic disease prevention and management (CDPM) improvement processes, individual and team capacity building and the role and value of CFHI in facilitating tailored learning activities and networking among teams, coaches and other AHC stakeholders.

Michael, V. (2016). "A Collaborative Approach to a Chronic Care Problem: An Academic Mentor's Point of View." *HealthcarePapers* 15(Special Issue): 74-79.
<http://www.longwoods.com/content/24543>

The Atlantic Healthcare Collaboration for Innovation and Improvement in Chronic Disease (AHC) represents a social experiment of sorts. The AHC provided a platform to integrate regions, health issues, healthcare systems, providers and individuals/families living with chronic disease. As such, the scope of the AHC was very broad, providing a rich learning environment but also risking biting off

more than it could chew. I participated in this experiment as an academic mentor to three of the improvement projects (IPs) with Health PEI, Central Health and Western Health and also was a member of the IP extended team at Nova Scotia Health Authority (formerly Capital Health) in Nova Scotia. My professional contribution was from the perspective of health behaviour change – change at the level of the patient and family living with chronic disease, at the level of the healthcare provider working within an expert-based, siloed system, and at the level of the healthcare system – the managers and decision-makers.

Petticrew, M., et al. (2016). "[Same words, different meanings: How epidemiological terminology struggles with population health intervention research]." *Rev Epidémiol Santé Publique* : **64(S2) : 43-54.**

Public health research differs from clinical epidemiological research in that its focus is primarily on the population level social and structural determinants of individual health and the interventions that might ameliorate them, rather than having a primary focus on individual-level risks. It is typically concerned with the proximal and distal causes of health problems, and their location within complex systems, more than with single exposures. Thus, epidemiological terms and concepts may have very different implications when used in the context of population health. This paper considers some key differences in relation to terms like 'population', 'baseline', 'control group' 'outcome' and 'adverse effects'. Even the concept of an 'intervention' often needs careful handling. The paper concludes that there is a need for an expanded, and more realistic use of these terms in the population health intervention research context.

Pichetti, S., et al. (2016). "[Access to care and prevention for people with disabilities in France: Analysis based on data from the 2008 French health and disabilities households surveys (Handicap-Santé-Ménages)]." *Rev Epidémiol Santé Publique* : **64(S2) : 79-94.**

BACKGROUND: Using data from the 2008 French health and disabilities households surveys, this study examines the use of three types of routine medical care (dental, ophthalmological and gynecological care) and four preventive services (cervical cancer screening, breast cancer screening, colon cancer screening and vaccination against hepatitis B) both for people with disabilities and for those without. Two definitions of disability were retained: (1) functional limitations (motor, cognitive, visual or hearing limitations) and (2) administrative recognition of disability. METHODS: For each type of care, binary logistic regression was used to test whether access to care is influenced by any of the disability indicators as well as by other explanatory variables. Two set of explanatory variables were included successively: (1) sociodemographic variables such as age, gender as well as a proxy variable representing medical needs and (2) socioeconomic variables such as level of education, household income per consumption unit, supplementary health insurance coverage, co-payment exemption and geographic variables. RESULTS: Persons reporting functional limitations are less likely to access to all types of care, in a proportion that varies between 5 to 27 points, compared to persons without functional limitations, except for eye care for which no gap is observed. The same results are obtained for persons reporting an administrative recognition of disability, and more precisely for those who benefit from the Disability allowance for adults (Allocation adulte handicapé [AAH]). After adding the social variables to the model, problems of access to health care decrease significantly, showing that disabled persons' social situation tends to reduce their access to care. CONCLUSION: This study reveals, for a broad range of care, a negative differential access to care for persons reporting functional limitations compared to those without limitations which is confirmed when identifying disability through administrative recognition. Furthermore, it also discusses factors explaining these differentials. It highlights the role of the social situation of disabled people as an additional barrier to already limited access to healthcare.

Schang, L., et al. (2016). "Explaining differences in stakeholder take up of disease management programmes: A comparative analysis of policy implementation in Austria and Germany." *Health Policy* **120(3): 281-292.**

PURPOSE: Understanding why policies to improve care for people with chronic conditions fail to be implemented is a pressing issue in health system reform. We explore reasons for the relatively high uptake of disease management programmes (DMPs) in Germany, in contrast to low uptake in Austria. We focus on the motivation, information and power of key stakeholder groups (payers, physician associations, individual physicians and patients). **METHODS:** We conducted a comparative stakeholder analysis using qualitative data from interviews (n=15 in Austria and n=26 in Germany), legal documents and media reports. **RESULTS:** Stakeholders in Germany appeared to have systematically stronger motivation, exposure to more positive information about DMPs and better ability to implement DMPs than their counterparts in Austria. Policy in Austria focused on financial incentives to physicians only. In Germany, limited evidence about the quality improvement and cost savings potential of DMPs was mitigated by strong financial incentives to sickness funds but proved a fundamental obstacle in Austria. **CONCLUSIONS:** Efforts to promote DMPs should seek to ensure the cooperation of payers and patients, not just physicians, using a mix of financial and non-financial instruments suited to the context. A singular focus on financially incentivising providers is unlikely to stimulate uptake of DMPs.

Prévision – Evaluation / Prevision - Evaluation

Berndt, N., et al. (2015). "Economic evaluation of a telephone- and face-to-face-delivered counseling intervention for smoking cessation in patients with coronary heart disease." *The European Journal of Health Economics* 17(3): 269-285.

<http://dx.doi.org/10.1007/s10198-015-0677-x>

This study examined the cost-effectiveness and cost-utility of two smoking cessation counseling interventions differing in their modality for patients diagnosed with coronary heart disease from a societal perspective.

Psychiatrie / Psychiatry

Frasquilho, D., et al. (2016). "Mental health outcomes in times of economic recession: a systematic literature review." *BMC Public Health* 16(1): 115.

BACKGROUND: Countries in recession experience high unemployment rates and a decline in living conditions, which, it has been suggested, negatively influences their populations' health. The present review examines the recent evidence of the possible association between economic recessions and mental health outcomes. **METHODS:** Literature review of records identified through Medline, PsycINFO, SciELO, and EBSCO Host. Only original research papers, published between 2004 and 2014, peer-reviewed, non-qualitative research, and reporting on associations between economic factors and proxies of mental health were considered. **RESULTS:** One-hundred-one papers met the inclusion criteria. The evidence was consistent that economic recessions and mediators such as unemployment, income decline, and unmanageable debts are significantly associated with poor mental wellbeing, increased rates of common mental disorders, substance-related disorders, and suicidal behaviours. **CONCLUSION:** On the basis of a thorough analysis of the selected investigations, we conclude that periods of economic recession are possibly associated with a higher prevalence of mental health problems, including common mental disorders, substance disorders, and ultimately suicidal behaviour. Most of the research is based on cross-sectional studies, which seriously limits causality inferences. Conclusions are summarised, taking into account international policy recommendations concerning the cost-effective measures that can possibly reduce the occurrence of negative mental health outcomes in populations during periods of economic recession.

Soins de santé primaires / Primary Health Care

(2016). "The Landscape Of Physician Practice." *Health Aff (Millwood)* **35**(3): 388-389.

The landscape of physician practice is changing. The number of physicians describing themselves as independent practice owners declined from 62 percent in 2008 to 35 percent in 2014, according to the 2014 Survey of American Physicians conducted by the Physicians Foundation. Over 70 percent of physicians would still choose to be a physician if they could do their career over, but many have important concerns. Over 80 percent report that they are overextended or at full capacity and that nonclinical paperwork takes up about 20 percent of their time. Only 10 percent of physicians interviewed in 2014 were very optimistic about the future of the medical profession.

Antoun, J. (2016). "Electronic mail communication between physicians and patients: a review of challenges and opportunities." *Family Practice* **33(2): 121-126.**

<http://fampra.oxfordjournals.org/content/33/2/121.abstract>

Although promising benefits hold for email communication between physicians and patients in terms of lowering the costs of health care while maintaining or improving the quality of disease management and health promotion, physician use of email with patients is still low and lags behind the willingness of patients to communicate with their physicians through email. There is also a discrepancy between physicians' willingness and actual practice of email communication. Several factors may explain these discrepancies. They include physicians differ in their experience and attitude towards information technology; some may not be convinced that patients appreciate, need and can communicate by email with their doctors; others are still waiting for robust evidence on service performance and efficiency in addition to patient satisfaction and outcome that support such practice; and many are reluctant to do so because of perceived barriers. This report is a review of the literature on the readiness for and adoption of physician-patient email communication, and how can challenges be or have been addressed. The need for Governmental support and directives for email communication to move forward is iterated, and opportunities for future research are pointed out.

Bishop, T. F., et al. (2016). "Care Management Processes Used Less Often For Depression Than For Other Chronic Conditions In US Primary Care Practices." *Health Aff (Millwood)* **35(3): 394-400.**

Primary care physicians play an important role in the diagnosis and management of depression. Yet little is known about their use of care management processes for depression. Using national survey data for the period 2006-13, we assessed the use of five care management processes for depression and other chronic illnesses among primary care practices in the United States. We found significantly less use for depression than for asthma, congestive heart failure, or diabetes in 2012-13. On average, practices used fewer than one care management process for depression, and this level of use has not changed since 2006-07, regardless of practice size. In contrast, use of diabetes care management processes has increased significantly among larger practices. These findings may indicate that US primary care practices are not well equipped to manage depression as a chronic illness, despite the high proportion of depression care they provide. Policies that incentivize depression care management, including additional quality metrics, should be considered.

Bridget L. Ryan, Judy Belle Brown, and H. Brian (2016). "Examining Primary Healthcare Performance through a Triple Aim Lens." *Healthcare Policy* **11(3): 19-31.**

<http://www.longwoods.com/product/24521>

Purpose: This study sought to apply a Triple Aim framework to the measurement and evaluation of primary healthcare (PHC) team performance. Methods: Triple Aim components were populated with 10 dimensions derived from survey and health administrative data for 17 Family Health Teams (FHTs)

in Ontario, Canada. Bivariate analyses and rankings of sites examined the relationships among dimensions and among Triple Aim components. Results: Readily available measures to fully populate the Triple Aim framework were lacking in FHTs. Within sites, there was little consistency in performance across the Triple Aim components (health, patient experience and cost). Conclusions: More and better measures are needed that can be readily used to examine the Triple Aim performance in PHC teams. FHTs, in this study, are partially achieving Triple Aim goals; however, there was a lack of consistency in performance. It is essential to collect appropriate measures and attend to performance across all components of the Triple Aim.

de Boer, W. E. L., et al. (2016). "Expectation of sickness absence duration: a review on statements and methods used in guidelines in Europe and North America." *The European Journal of Public Health* 26(2): 306-311.

<http://eurpub.oxfordjournals.org/content/eurpub/26/2/306.full.pdf>

Background: Certifying physicians play a key role in the management of sickness absence and are often provided with guidelines. Some of these guidelines contain statements on expected sickness absence duration, according to diagnosis. We were interested in exploring the evidence base of these statements. Methods: We identified guidelines through a survey of EUMASS members and a literature search of the Internet and PubMed. We extracted the statements and methods from the guidelines. We compared: diagnoses that were addressed, expected durations and development processes followed. Next, we presented our findings to the developers, to afford them an opportunity to comment and/or correct any misinterpretations. Results: We identified 4 guidelines from social insurance institutions (France, Serbia, Spain and Sweden) and 4 guidelines from private organisations (1 Netherlands, 3 US). Guidelines addressed between 63 and some 63000 health conditions (ICD 10 codes). Health conditions overlapped among guidelines. Direct comparison is hampered by differences in coding (ICD 9 or 10) and level of aggregation (three or four digit, clustering of diseases and treatment situations). Expectations about duration are defined as minimum, maximum, and optimum or mean or median and percentile distribution, stratified to age and work requirements. In a sample of 5 diagnoses we found overlap in expected duration but also differences. Guidelines are developed differently, pragmatic expert consensus being used most, supplemented with data on sickness absence from different registers, other guidelines and non-systematic literature reviews. The effectiveness of these guidelines has not yet been formally evaluated. Conclusions: Expectations about duration of sickness absence by diagnosis are expressed in several guidelines. The expectations are difficult to compare, their evidence base is unclear and their effectiveness needs to be established.

Freund, T., et al. (2016). "Medical Assistant-Based Care Management for High-Risk Patients in Small Primary Care Practices: A Cluster Randomized Clinical Trial." *Ann Intern Med* 164(5): 323-330.

BACKGROUND: Patients with multiple chronic conditions are at high risk for potentially avoidable hospitalizations, which may be reduced by care coordination and self-management support. Medical assistants are an increasingly available resource for patient care in primary care practices. OBJECTIVE: To determine whether protocol-based care management delivered by medical assistants improves care in patients at high risk for future hospitalization in primary care. DESIGN: Two-year cluster randomized clinical trial. (Current Controlled Trials: ISRCTN56104508). SETTING: 115 primary care practices in Germany. PATIENTS: 2076 patients with type 2 diabetes, chronic obstructive pulmonary disease, or chronic heart failure and a likelihood of hospitalization in the upper quartile of the population, as predicted by an analysis of insurance data. INTERVENTION: Protocol-based care management, including structured assessment, action planning, and monitoring delivered by medical assistants, compared with usual care. MEASUREMENTS: All-cause hospitalizations at 12 months (primary outcome) and quality-of-life scores (12-Item Short Form Health Survey [SF-12] and EuroQol instrument [EQ-5D]). RESULTS: Included patients had an average of 4 co-occurring chronic conditions. All-cause hospitalizations did not differ between groups at 12 months (risk ratio [RR], 1.01 [95% CI, 0.87 to 1.18]) and 24 months (RR, 0.98 [CI, 0.85 to 1.12]). Quality of life (differences, 1.16 [CI, 0.24 to 2.08] on SF-12 physical component and 1.68 [CI, 0.60 to 2.77] on SF-12 mental component) and general health (difference on EQ-5D, 0.03 [CI, 0.00 to 0.05]) improved significantly at 24 months.

Intervention costs totaled \$10 per patient per month. LIMITATION: Small number of primary care practices and low intensity of intervention. CONCLUSION: This low-intensity intervention did not reduce all-cause hospitalizations but showed positive effects on quality of life at reasonable costs in high-risk multimorbid patients. PRIMARY FUNDING SOURCE: AOK Baden-Wurtemberg and AOK Bundesverband.

Freund, T., et al. (2011). "Primary care practice-based care management for chronically ill patients (PraCMan): study protocol for a cluster randomized controlled trial [ISRCTN56104508]." *Trials* 12: 163.

BACKGROUND: Care management programmes are an effective approach to care for high risk patients with complex care needs resulting from multiple co-occurring medical and non-medical conditions. These patients are likely to be hospitalized for a potentially "avoidable" cause. Nurse-led care management programmes for high risk elderly patients showed promising results. Care management programmes based on health care assistants (HCAs) targeting adult patients with a high risk of hospitalisation may be an innovative approach to deliver cost-efficient intensified care to patients most in need. **METHODS/DESIGN:** PraCMan is a cluster randomized controlled trial with primary care practices as unit of randomisation. The study evaluates a complex primary care practice-based care management of patients at high risk for future hospitalizations. Eligible patients either suffer from type 2 diabetes mellitus, chronic obstructive pulmonary disease, chronic heart failure or any combination. Patients with a high likelihood of hospitalization within the following 12 months (based on insurance data) will be included in the trial. During 12 months of intervention patients of the care management group receive comprehensive assessment of medical and non-medical needs and resources as well as regular structured monitoring of symptoms. Assessment and monitoring will be performed by trained HCAs from the participating practices. Additionally, patients will receive written information, symptom diaries, action plans and a medication plan to improve self-management capabilities. This intervention is addition to usual care. Patients from the control group receive usual care. Primary outcome is the number of all-cause hospitalizations at 12 months follow-up, assessed by insurance claims data. Secondary outcomes are health-related quality of life (SF12, EQ5D), quality of chronic illness care (PACIC), health care utilisation and costs, medication adherence (MARS), depression status and severity (PHQ-9), self-management capabilities and clinical parameters. Data collection will be performed at baseline, 12 and 24 months (12 months post-intervention). **DISCUSSION:** Practice-based care management for high risk individuals involving trained HCAs appears to be a promising approach to face the needs of an aging population with increasing care demands.

Looman, W. M., et al. (2016). "Cost-effectiveness of the 'Walcheren Integrated Care Model' intervention for community-dwelling frail elderly." *Family Practice* 33(2): 154-160.
<http://fampra.oxfordjournals.org/content/33/2/154.abstract>

Background. An important aim of integrated care for frail elderly is to generate more cost-effective health care. However, empirical research on the cost-effectiveness of integrated care for community-dwelling frail elderly is limited. **Objective.** This study reports on the cost-effectiveness of the Walcheren Integrated Care Model (WICM) after 12 months from a societal perspective. **Methods.** The design of this study was quasi-experimental. In total, 184 frail elderly patients from 3 GP practices that implemented the WICM were compared with 193 frail elderly patients of 5 GP practices that provided care as usual. Effects were determined by health-related quality of life (EQ-5D questionnaire). Costs were assessed based on questionnaires, GP files, time registrations and reports from multidisciplinary meetings. Average costs and effects were compared using t-tests. The incremental cost-effectiveness ratio (ICER) was calculated, and bootstrap methods were used to determine its reliability. **Results.** Neither the WICM nor care as usual resulted in a change in health-related quality of life. The average total costs of the WICM were higher than care as usual (17089 euros versus 15189 euros). The incremental effects were 0.00, whereas the incremental costs were 1970 euros, indicating an ICER of 412450 euros. **Conclusions.** The WICM is not cost-effective, and the costs per quality-adjusted life year are high. The costs of the integrated care intervention do not outweigh the limited effects on health-related quality of life after 12 months. More analyses of the cost-effectiveness of integrated care for community-dwelling frail elderly are recommended as well as consideration of the specific costs and

effects.

Rose, S., et al. (2016). "Variation In Accountable Care Organization Spending And Sensitivity To Risk Adjustment: Implications For Benchmarking." *Health Aff (Millwood)* 35(3): 440-448.

Spending targets (or benchmarks) for accountable care organizations (ACOs) participating in the Medicare Shared Savings Program must be set carefully to encourage program participation while achieving fiscal goals and minimizing unintended consequences, such as penalizing ACOs for serving sicker patients. Recently proposed regulatory changes include measures to make benchmarks more similar for ACOs in the same area with different historical spending levels. We found that ACOs vary widely in how their spending levels compare with those of other local providers after standard case-mix adjustments. Additionally adjusting for survey measures of patient health meaningfully reduced the variation in differences between ACO spending and local average fee-for-service spending, but substantial variation remained, which suggests that differences in care efficiency between ACOs and local non-ACO providers vary widely. Accordingly, measures to equilibrate benchmarks between high- and low-spending ACOs—such as setting benchmarks to risk-adjusted average fee-for-service spending in an area—should be implemented gradually to maintain participation by ACOs with high spending. Use of survey information also could help mitigate perverse incentives for risk selection and upcoding and limit unintended consequences of new benchmarking methodologies for ACOs serving sicker patients.

Sirdifield, C., et al. (2016). "Comparing importance and performance from a patient perspective in English general practice: a cross-sectional survey." *Family Practice* 33(2): 179-185.

<http://fampra.oxfordjournals.org/content/33/2/179.abstract>

Background. Patient experience and satisfaction are important indicators of quality in health care. Little is known about where to prioritize efforts to improve patient satisfaction. **Objectives.** To investigate patient satisfaction with primary care, as part of the Quality and Costs of Primary Care in Europe study in England, identifying areas where improvements could be made from patients' perspectives. **Methods.** We conducted a questionnaire survey of general practice patients in three English regions. Patient Values questionnaires assessed what patients thought was important, and Patient Experience questionnaires rated performance of primary care. Fifteen attributes of care were compared using Importance Performance Analysis, a method that simultaneously represents data on importance and performance of a service, enabling identification of its strengths and weaknesses. **Results.** Patients rated both 'relational' and 'functional' aspects of care as important. Satisfaction with general practice could be improved by concentrating on specific aspects of access (ensuring that patients know how to access out-of-hours services and find it easy to get an appointment), and one aspect of empowerment (after their visit, patients feel able to cope better with their health problem/illness). However, for other attributes (e.g. proximity of the practice to a patient's house or, a short waiting time when contacting the practice), investing additional resources is not likely to increase patient satisfaction. **Conclusion.** Attributes needing most improvement concerned access to primary care and patient empowerment. More research is needed to identify how to improve access without generating unnecessary additional demand or compromising continuity of care.

Tynkkynen, L. K., et al. (2016). "Expanding choice of primary care in Finland: much debate but little change so far." *Health Policy* 120(3): 227-234.

"Putting the patient in the driver's seat" is one of the top issues on the health policy agenda in Finland. One of the means believed to promote patient empowerment and patient centeredness is the introduction and further expansion of choice policies with accompanying competition between public and private service providers. However, the Finnish health care system has a highly decentralized administration with multiple funding sources and three different types of providers that people can seek primary care from (municipal health centers, occupational health care services, and private sector providers). This complicates the implementation of choice at the level of primary health care. In this paper, we describe the current policy debates and initiatives promoting the expansion of the choice of primary care provider in Finland. We examine the legislation and policies that have

contributed to the current, complex service system in Finland. In light of this examination, we critically discuss the current debate on choice policies as well as the introduction of choice in the context of primary health care.

Weir, D. L., et al. (2016). "The Interplay Between Continuity of Care, Multimorbidity, and Adverse Events in Patients With Diabetes." *Medical Care* 54(4): 386-393.

<http://journals.lww.com/lww->

[medicalcare/Fulltext/2016/04000/The Interplay Between Continuity of Care,.8.aspx](http://journals.lww.com/lww-medicalcare/Fulltext/2016/04000/The_Interplay_Between_Continuity_of_Care,.8.aspx)

Objectives: To evaluate the impact of continuity of care and multimorbidity on health outcomes in patients with diabetes. **Research Design:** Using a US claims database of insured patients, we identified those with incident diabetes between 2004 and 2008 and followed them until death, disenrollment, or December 31, 2010. Continuity of care was defined using Breslau's Usual Provider of Continuity (UPC; proportion of visits to the usual or predominant provider within 2 y of diabetes diagnosis). Multivariable logistic regression was used to determine the association between UPC in the first 2 years after diabetes diagnosis and subsequent 1-year composite primary outcome of all-cause hospitalization or death in year 3 in patients with/without multimorbidity. **Results:** Of the 285,231 patients with incident diabetes, 74% had multimorbidity; their average age was 53 years (SD=10.5) and 49% were female. A total of 77,270 (27%) individuals had a mean $UPC \geq 75\%$ in the first 2 years. During year 3 of follow-up, 33,632 (12%) patients died or were hospitalized for any cause. Greater continuity of care ($UPC \geq 75\%$) was associated with reduced risk of subsequent death or hospitalization [7.2% vs. 13.5%; adjusted odds ratio (aOR)=0.72; 95% CI, 0.70–0.75]. Although multimorbidity was independently associated with an increased risk of our primary composite endpoint (13.4% vs. 7.2%; aOR=1.26; 95% CI, 1.21–1.30), the association between greater continuity and better outcomes was similar in those with multimorbidity (aOR=0.71; 95% CI, 0.69–0.71) as in those without (aOR=0.75; 95% CI, 0.71–0.80). **Conclusions:** In patients with incident diabetes, greater continuity of care is associated with improved outcomes, irrespective of whether or not they have multimorbidity.

White, E. S., et al. (2016). "Fifty years of longitudinal continuity in general practice: a retrospective observational study." *Family Practice* 33(2): 148-153.

<http://fampra.oxfordjournals.org/content/33/2/148.abstract>

Background. Continuity of care has been defined as relational continuity between patient and doctor and longitudinal continuity describing the duration of the relationship. Measurement of longitudinal continuity alone is associated with outcomes including patient satisfaction, medical costs, hospital admissions and mortality. **Methods.** In one UK general practice, records were searched for patients with continuous registration for 50 or more years. Characteristics of these patients were analysed for age, gender, social deprivation, partner registration and length of registration. Trends in numbers and proportions of this group over the previous 14 years were determined. A comparison group of patients, aged 50 or more, and registered in the same practice within the last 2–4 years, was identified. **Results.** Patients registered for 50 years or more with a median registration of 56.2 years numbered 190 out of a population of 8420 (2.3%). These patients increased in number by 35.3% (1.7–2.3%) over 14 consecutive years. There were no differences between groups for GP consultation rate, number of repeat medications and hospital use, despite the significantly higher prevalence of multimorbidity, depression and diabetes in patients with high continuity. **Conclusions.** This is the first report of 50-year continuity in general practice. Numbers of such patients and proportions are increasing. Longitudinal continuity is easily measured in general practice and associated with important clinical outcomes.

Zuvekas, S. H. and J. W. Cohen (2016). "Fee-For-Service, While Much Maligned, Remains The Dominant Payment Method For Physician Visits." *Health Aff (Millwood)* 35(3): 411-414.

Recent concerted efforts have sought to shift provider payment away from fee-for-service and toward risk-based alternatives. Despite these efforts, fee-for-service not only remains the dominant payment method but has continued to grow, with nearly 95 percent of all physician office visits in 2013 reimbursed in this fashion.

Système de santé / Health Systems

Karanikolos, M., et al. (2016). "Access to care in the Baltic States: did crisis have an impact?" *The European Journal of Public Health* **26**(2): 236-241.
<http://eurpub.oxfordjournals.org/content/eurpub/26/2/236.full.pdf>

Background: In 2009, brief but deep economic crisis profoundly affected the three Baltic States: Estonia, Latvia and Lithuania. In response, all three countries adopted severe austerity measures with the shared goal of containing rising deficits, but employing different methods. **Aims:** In this article, we analyze the impact of the economic crisis and post-crisis austerity measures on health systems and access to medical services in the three countries. **Methods:** We use the EU-SILC data to analyze trends in unmet medical need in 2005–2012, and apply log-binomial regression to calculate the risk of unmet medical need in the pre- and post- crisis period. **Results:** Between 2009 and 2012 unmet need has increased significantly in Latvia (OR: 1.24, 95% confidence interval (CI): 1.15–1.34) and Estonia (OR: 1.98, 95% CI: 1.72–2.27), but not Lithuania (OR: 0.84, 95% CI: 0.69–1.04). The main drivers of increased unmet need were inability to afford care in Latvia and long waiting lists in Estonia. **Conclusion:** The impact of the crisis on access to care in the three countries varied, as did the austerity measures affecting their health systems. Estonia and Latvia experienced worsening access to care, largely exacerbating already existing barriers. The example of Lithuania suggests that deterioration in access is not inevitable, once health policies prioritise maintenance and availability of existing services, or if there is room for reducing existing inefficiencies. Moreover, better financial preparedness of health systems in Estonia and Lithuania achieved some protection of the population from increasing unmet need due to the rising cost of medical care.

Steffen, M. (2016). "Universalism, Responsiveness, Sustainability--Regulating the French Health Care System." *N Engl J Med* **374**(5): 401-405.

Travail et santé / Occupational Health

Fiori, F., et al. (2016). "Employment insecurity and mental health during the economic recession: An analysis of the young adult labour force in Italy." *Soc Sci Med* **153**: 90-98.

BACKGROUND AND OBJECTIVE: A growing body of scientific literature highlights the negative consequences of employment insecurity on several life domains. This study focuses on the young adult labour force in Italy, investigating the relationship between employment insecurity and mental health and whether this has changed after years of economic downturn. It enhances understanding by addressing differences in mental health according to several employment characteristics; and by exploring the role of respondents' economic situation and educational level. **DATA AND METHODS:** Data from a large-scale, nationally representative health survey are used to estimate the relationship between employment insecurity and the Mental Health Inventory (MHI), by means of multiple linear regressions. **RESULTS AND CONCLUSIONS:** The study demonstrates that employment insecurity is associated with poorer mental health. Moreover, neither temporary workers nor unemployed individuals are a homogeneous group. Previous job experience is important in differentiating the mental health risks of unemployed individuals; and the effects on mental health vary according to occupational status and to the amount of time spent in a condition of insecurity. Further, the experience of financial difficulties partly explains the relationship between employment insecurity and mental health; and different mental health outcomes depend on respondents' educational level. Lastly, the risks of reporting poorer mental health were higher in 2013 than in 2005.

Giraud, M., et al. (2016). "Occupational injuries in times of labour market flexibility: the different stories of employment-secure and precarious workers." *BMC Public Health* 16(1): 150.

BACKGROUND: The relationship between labour market flexibility, job insecurity and occupational injuries is not univocal. The literature generally focuses on the temporary character of work arrangements rather than on the precariousness of careers. The aim of this paper is to identify, without defining a priori what a precarious career is, the most common professional profiles of young people who entered the labour market in the 2000s and to correlate them with occupational injury risks. **METHODS:** Using the Whip-Salute database, which combines individual work and health histories, we selected the subjects under 30 years of age whose first appearance in the database is dated after 2000. The occupational history of each individual between 2000 and 2005 was described according to 6 variables (type of entry contract, number of contracts, number of jobs, economic activities, work intensity and duration of the longest period of non-employment). Workers were grouped into homogeneous categories using cluster analysis techniques, which enable to identify different career profiles. Injury rates were calculated for each cluster, and compared within and between the groups. **RESULTS:** We selected 56,760 workers in the study period, who were classified in 6 main career profiles. About 1/3 of the subjects presented an employment-secure career profile, while about 45 % of them were classified into 3 clusters showing precarious career profiles with different work intensities. Precarious workers present significantly higher injury rates than those with secure careers, with an increase in risk between 24 and 57 % (< 0.05). The comparison of injury rates at the beginning and at the end of the study period revealed a significant decrease in all clusters, but the gap between secure and precarious workers remained wide. **CONCLUSIONS:** Cluster analysis allowed to identify career patterns with clearly different characteristics. A positive association between injury risk and the level of career fragmentation was found. The association cannot be fully interpreted in a causal way, since reversed causality and selection processes may be in action. However the study indicates a disadvantage for precarious workers, who face significantly higher risks of both minor and severe injuries.

Jeon, S.-H. (2016). "The Long-Term Effects of Cancer on Employment and Earnings." *Health Economics: Ahead of print*.
<http://dx.doi.org/10.1002/hec.3342>

The study examines long-term effects of cancer on the work status and annual earnings of cancer survivors who had a strong attachment to the labor market prior to their cancer diagnosis. We use linkage data combining Canadian 1991 Census microdata with administrative records from the Canadian Cancer Registry, the Vital Statistics Registry and longitudinal personal income tax records. We estimate changes in the magnitude of cancer effects during the first 3 years following the year of the diagnosis using a large sample of cancer survivors diagnosed at ages 25 to 61. The comparison group consists of similar workers never diagnosed with cancer. The empirical strategy combines coarsened exact matching and regression models to deal with observed and unobserved differences between the cancer and comparison groups. The results show moderate negative cancer effects on work status and annual earnings. Over the 3-year period following the year of the diagnosis, the probability of working is 5 percentage points lower for cancer survivors than for the comparison group, and their earnings are 10% lower. Our findings also suggest that the effects of cancer on labor market outcomes differ for high and low survival rate cancer categories. Copyright © 2016 John Wiley & Sons, Ltd.

Kaspersen, S. L., et al. (2016). "Health and unemployment: 14 years of follow-up on job loss in the Norwegian HUNT Study." *The European Journal of Public Health* 26(2): 312-317.
<http://eurpub.oxfordjournals.org/content/eurpub/26/2/312.full.pdf>

Background: Many studies have investigated how unemployment influences health, less attention has been paid to the reverse causal direction; how health may influence the risk of becoming unemployed.

We prospectively investigated a wide range of health measures and subsequent risk of unemployment during 14 years of follow-up. Methods: Self-reported health data from 36 249 participants in the Norwegian HUNT2 Study (1995–1997) was linked by a personal identification number to the National Insurance Database (1992–2008). Exact dates of unemployment were available. Cox's proportional hazard models were used to estimate hazard ratios (HR) for the association of unemployment with several health measures. Adjustment variables were age, gender, education, marital status, occupation, lifestyle and previous unemployment. Results: Compared to reporting no conditions/symptoms, having ≥ 3 chronic somatic conditions (HR 1.78, 95% CI 1.46–2.17) or high symptom levels of anxiety and depression (HR 1.57, 95% CI 1.35–1.83) increased the risk of subsequent unemployment substantially. Poor self-rated health (HR 1.36, 95% CI 1.24–1.51), insomnia (HR 1.19, 95% CI 1.09–1.32), gastrointestinal symptoms (HR 1.17, 95% CI 1.08–1.26), high alcohol consumption (HR 1.17, 95% CI 0.95–1.44) and problematic use of alcohol measured by the CAGE questionnaire (HR 1.32, 95% CI 1.17–1.48) were also associated with increased risk of unemployment. Conclusion: People with poor mental and physical health are at increased risk of job loss. This contributes to poor health amongst the unemployed and highlights the need for policy focus on the health and welfare of out of work individuals, including support preparing them for re-employment.

Rugulies, R., et al. (2016). "Workplace social capital and risk of long-term sickness absence. Are associations modified by occupational grade?" *Eur J Public Health* 26(2): 328-333.

BACKGROUND: Workplace social capital (WSC) is an emerging topic among both work environment professionals and researchers. We examined (i) whether high WSC protected against risk of long-term sickness absence (LTSA) in a random sample of the Danish workforce during a 1-year follow-up and (ii) whether the association of WSC with sickness absence was modified by occupational grade. METHODS: We measured WSC by self-report in a cohort of 3075 employees and linked responses to a national register of sickness absence. We calculated hazard ratios (HRs) and 95% confidence intervals (CIs) of onset of LTSA (≥ 21 days), adjusted for covariates. We stratified analyses by occupational grade and examined if there was an interaction effect of WSC and occupational grade. RESULTS: A one standard deviation higher WSC score predicted a reduced risk of sickness absence after adjustment for sociodemographic variables, prevalent health problems and health behaviours (HR = 0.85, 95% CI = 0.74-0.99). The HR was attenuated and lost statistical significance after further adjustment for occupational grade (HR = 0.90, 95% CI = 0.78-1.04). When stratified by occupational grade, high WSC predicted a decreased risk of sickness absence among higher grade workers (HR = 0.61, 95% CI = 0.44-0.84) but not among lower grade workers (HR = 0.98, 95% CI = 0.83-1.15). The interaction effect of WSC and occupational grade was statistically significant (HR = 0.97, 95% CI = 0.95-0.99). CONCLUSION: High WSC might reduce risk of LTSA. However, the protective effect appears to be limited to workers of higher occupational grade.

Vieillesse / Ageing

Petriwskyj, A., et al. (2016). "What Health and Aged Care Culture Change Models Mean for Residents and Their Families: A Systematic Review." *The Gerontologist* 56(2): e12-e20.
<http://gerontologist.oxfordjournals.org/content/56/2/e12.abstract>

Purpose of the Study: A range of commercialized programs are increasingly being adopted which involve broad culture change within care organizations to implement person-centered care. These claim a range of benefits for clients; however, the published evidence for client and family outcomes from culture change is inconclusive and the evidence for these specific models is difficult to identify. The purpose of this review was to identify and evaluate the peer-reviewed evidence regarding consumer outcomes for these subscription-based models. Design and Methods: The review followed the Joanna Briggs Institute procedure. The review considered peer-reviewed literature that reported on studies conducted with health and aged care services, their staff, and consumers, addressed subscription-based person-centered culture change models, and were published in English up to and

including 2015. The review identified 19 articles of sufficient quality that reported evidence relating to consumer outcomes and experience. Results: Resident outcomes and family and resident satisfaction and experiences were mixed. Findings suggest potential benefits for some outcomes, particularly related to quality of life and psychiatric symptoms, staff engagement, and functional ability. Although residents and families identified some improvements in residents' lives, both also identified problematic aspects of the change related to staff adjustment and staff time. Implications: Outcomes for these models are at best comparable with traditional care with limited suggestions that they result in poorer outcomes and sufficient potential for benefits to warrant further investigation. Although these models may have the potential to benefit residents, the implementation of person-centered principles may affect the outcomes.

Sadana, R., et al. (2016). "Healthy Ageing: Raising Awareness of Inequalities, Determinants, and What Could Be Done to Improve Health Equity." *The Gerontologist* 56(Suppl 2): S178-S193.

http://gerontologist.oxfordjournals.org/content/56/Suppl_2/S178.abstract

Purpose of the Study: Social and scientific discourses on healthy ageing and on health equity are increasingly available, yet from a global perspective limited conceptual and analytical work connecting both has been published. This review was done to inform the WHO World Report on Ageing and Health and to inform and encourage further work addressing both healthy aging and equity. Design and Methods: We conducted an extensive literature review on the overlap between both topics, privileging publications from 2005 onward, from low-, middle-, and high-income countries. We also reviewed evidence generated around the WHO Commission on Social Determinants of Health, applicable to ageing and health across the life course. Results: Based on data from 194 countries, we highlight differences in older adults' health and consider three issues: First, multilevel factors that contribute to differences in healthy ageing, across contexts; second, policies or potential entry points for action that could serve to reduce unfair differences (health inequities); and third, new research areas to address the cause of persistent inequities and gaps in evidence on what can be done to increase healthy ageing and health equity. Implications: Each of these areas warrant in depth analysis and synthesis, whereas this article presents an overview for further consideration and action.

Van Eeno, L., et al. (2016). "Substantial between-country differences in organising community care for older people in Europe—a review." *The European Journal of Public Health* 26(2): 213-219.

<http://eurpub.oxfordjournals.org/content/eurpub/26/2/213.full.pdf>

Background: The European population is aging. The main drivers of public spending on health care for people of 65 years and older are hospital admission and admission to long-term care facilities. High quality community care can be a cost-effective and quality solution to respond to the impact of ageing populations on health-care systems. It is unclear how well countries are equipped to provide affordable and quality community care. The aim of this article is to describe and compare community care delivery with care-dependent older people in Europe. Methods: This study is conducted within the European Union-financed IBenC project [Identifying best practices for care-dependent elderly by Benchmarking Costs and outcomes of community care (FP7)] in which six European countries are involved. To compare the community care delivery with care-dependent older people in these countries, we performed a systematic comparison of macro indicators using metadata complemented with data from multinational surveys. Results: Data on the following dimensions are described and compared: population of the country, governmental expenditures on health, sources of community health services funding, governmental vision and regulation on community care, community care organisations and care professionals, eligibility criteria for and equity in receiving care and the involvement of informal care. Conclusion: Because of the variations in the European community care contexts, the growing demand for community care as a cost-effective and quality solution to the care burden of aging populations will have country-specific impacts. When learning from other countries' best practices, in addition to researchers, policy makers should take full account of local and national care contexts.