

Reproduction sur d'autres sites interdite mais lien vers le document accepté :
<http://www.irdes.fr/documentation/veille-bibliographique-en-economie-de-la-sante.html>

Any and all reproduction is prohibited but direct link to the document is accepted:
<http://www.irdes.fr/english/documentation/watch-on-health-economics-literature.html>

DOC VEILLE

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

10 mars 2017 / March the 10th, 2017

Réalisée par le centre de documentation de l'Irdes, Doc Veille, publication bi-mensuelle, rassemble de façon thématique les résultats de la veille documentaire en économie de la santé : articles, littérature grise, rapports...

Vous pouvez accéder à la version électronique des articles sur notre portail EJS (à l'exception des revues françaises) :

<http://ejournals.ebsco.com/Home.asp> (**Accès réservé à l'Irdes**)

Les autres documents sont soit accessibles en ligne, soit consultables à la documentation (voir mention à la fin de la notice). Aucune photocopie ne sera délivrée par courrier.

Un historique des Doc Veille se trouve sur le web de l'Irdes :

<http://www.irdes.fr/documentation/veille-bibliographique-en-economie-de-la-sante.html>

Produced by the Irdes documentation centre, Doc Veille, a bimonthly publication, presents by theme the latest articles and reports in health economics: both peer-reviewed and grey literature.

You can access to the electronic version of articles on our EJS portal (except for the French journals):

<http://ejournals.ebsco.com/Home.asp> (**Access limited to Irdes team**).

Other documents are accessible online, either available for consultation at the documentation center (see mention at the end of the notice). Requests for photocopies or scans of documents will not be answered. Doc Veille's archives are located on the Irdes website:

<http://www.irdes.fr/english/documentation/watch-on-health-economics-literature.html>

Contacts

Espace documentation : documentation@irdes.fr

Marie-Odile Safon : safon@irdes.fr

Véronique Suhard : suhard@irdes.fr

Sommaire

Sommaire	2
Assurance maladie / Health Insurance	6
Kirby, J. B. et Cohen, J. W. (2017). "Do People with Health Insurance Coverage Who Live in Areas with High Uninsurance Rates Pay More for Emergency Department Visits?"	6
Laaksonen, M., et al. (2016). "Sickness allowance trajectories preceding disability retirement: a register-based retrospective study."	6
Wijnvoord, E. C., et al. (2016). "Health-based risk neutralization in private disability insurance." 6	
Economie de la santé / Health Economics	7
Gifford, B. (2017). "Temporarily Disabled Workers Account For A Disproportionate Share Of Health Care Payments."	7
Habibov, N. et Cheung, A. (2017). "Revisiting informal payments in 29 transitional countries: The scale and socio-economic correlates."	7
Kim, T. J., et al. (2017). "Income, financial barriers to health care and public health expenditure: A multilevel analysis of 28 countries."	7
Lane, H., et al. (2017). "Equity in healthcare resource allocation decision making: A systematic review."	8
Van Esch, T. E. M., et al. "Increased cost sharing and changes in noncompliance with specialty referrals in The Netherlands."	8
Hôpital / Hospital	8
Grimaldi, A. et Vernant, J. P. (2017). "Réflexions sur les modalités de financement des hôpitaux."	8
Johannessen, K. A., et al. (2017). "Assessing physician productivity following Norwegian hospital reform: A panel and data envelopment analysis."	9
Kim, S. J., et al. (2016). "Positive effects of medical staffing on readmission within 30 days after discharge: a retrospective analysis of obstetrics and gynecology data."	9
Sheard, L., et al. (2017). "The Patient Feedback Response Framework - Understanding why UK hospital staff find it difficult to make improvements based on patient feedback: A qualitative study."	9
Inégalités de santé / Health Inequalities	10
De Gelder, R., et al. (2017). "Long-term trends of inequalities in mortality in 6 European countries."	10

Georges-Tarragano, C., et al. (2017). "Soigner les migrants dans les PASS : une pratique spécifique, miroir d'une approche universelle."	10
Graetz, V., et al. (2017). "Utilization of health care services by migrants in Europe-a systematic literature review."	10
Kietzmann, D., et al. (2017). "(Non-)utilization of pre-hospital emergency care by migrants and non-migrants in Germany."	11
Pirhonen, L., et al. "Effects of person-centred care on health outcomes. A randomized controlled trial in patients with acute coronary syndrome."	11
Quick, A., et al. (2017). "Does involvement in a cohort study improve health and affect health inequalities? A natural experiment."	11
Reus-Pons, M., et al. (2016). "Differences in mortality between groups of older migrants and older non-migrants in Belgium, 2001-09."	11
Vuillermoz, C., et al. (2016). "Mortality among homeless people in France, 2008-10."	12
Médicaments / Pharmaceuticals	12
Moustgaard, H., et al. (2016). "A longitudinal study of educational differences in antidepressant use before and after hospital care for depression."	12
Politique de santé / Health Policy	13
Azzopardi-Muscat, N., et al. (2016). "Policy challenges and reforms in small EU member state health systems: a narrative literature review."	13
Canasse, S. (2017/01). "Au-delà du « cure » et du « care »."	13
Downey, L. E., et al. (2017). "Clinical Pathways, Claims Data, And Measuring Quality."	13
Jones, C. M., et al. (2017). "Adapting public policy theory for public health research: A framework to understand the development of national policies on global health."	13
McNamara, C. (2017). "Trade liberalization and social determinants of health: A state of the literature review."	14
Siciliani, L., et al. "Policies towards hospital and GP competition in five European countries." ...	14
Prévention / Prevention	14
Willis, C. D., et al. (2017) "Exploring the unanticipated effects of multi-sectoral partnerships in chronic disease prevention."	14
Prévision – Evaluation / Prevision - Evaluation	14
Kuehnle, D. et Wunder, C. (2017). "The Effects of Smoking Bans on Self-Assessed Health: Evidence from Germany."	14
Psychiatrie / Psychiatry	15

Dey, M. et Jorm, A. F. (2017). "Social determinants of mental health service utilization in Switzerland."	15
Odier, B. (2017). "La description des traitements ambulatoires : vers une typologie."	15
Soins de santé primaires / Primary Health Care	15
Harris, J. E., et al. (2017). "Allocation of Residency Training Positions in Spain: Contextual Effects on Specialty Preferences."	15
Maier, C. B. et Aiken, L. H. (2016). "Task shifting from physicians to nurses in primary care in 39 countries: a cross-country comparative study."	15
Shin, S., et al. (2017). "Do Capitation-based Reimbursement Systems Underfund Tertiary Healthcare Providers? Evidence from New Zealand."	16
Timmons, E. J. "The effects of expanded nurse practitioner and physician assistant scope of practice on the cost of Medicaid patient care."	16
Systèmes de santé / Health Systems	16
Barros, P. P. "Competition policy for health care provision in Portugal."	16
Brekke, K. R. et Straume, O. R. "Competition policy for health care provision in Norway."	16
Choné, P. "Competition policy for health care provision in France."	17
Kifmann, M. "Competition policy for health care provision in Germany."	17
Travail et santé / Occupational Health	17
Blinder, V., et al. (2017). "Women With Breast Cancer Who Work For Accommodating Employers More Likely To Retain Jobs After Treatment."	17
Buchmueller, T. C. et Valletta, R. G. (2017). "Work, Health, And Insurance: A Shifting Landscape For Employers And Workers Alike."	17
Goldman, T. R. (2017). "Working With A Chronic Disease."	18
Jeon, S. H. et Pohl, R. V. (2017). "Health and work in the family: Evidence from spouses' cancer diagnoses."	18
Jinnett, K., et al. (2017). "Chronic Conditions, Workplace Safety, And Job Demands Contribute To Absenteeism And Job Performance."	18
Vahid Shahidi, F., et al. (2016). "Does social policy moderate the impact of unemployment on health? A multilevel analysis of 23 welfare states."	18
Wang, M., et al. (2016). "Morbidity and suicide mortality following sick leave in relation to changes of social insurance regulations in Sweden."	19
Viellissement / Ageing	19

Kaschowitz, J. et Brandt, M. (2017). "Health effects of informal caregiving across Europe: A longitudinal approach." 19

Assurance maladie / Health Insurance

Kirby, J. B. et Cohen, J. W. (2017). "Do People with Health Insurance Coverage Who Live in Areas with High Uninsurance Rates Pay More for Emergency Department Visits?" Health Serv Res.

OBJECTIVE: To investigate the relationship between the percent uninsured in a county and expenditures associated with the typical emergency department visit. **DATA SOURCES:** The Medical Expenditure Panel Survey linked to county-level data from the American Community Survey, the Healthcare Cost and Utilization Project, and the Area Health Resources Files. **STUDY DESIGN:** We use a nationally representative sample of emergency department visits that took place between 2009 and 2013 to estimate the association between the percent uninsured in counties and the amount paid for a typical visit. Final estimates come from a diagnosis-level fixed-effects model, with additional controls for a wide variety of visit, individual, and county characteristics. **PRINCIPAL FINDINGS:** Among those with private insurance, we find that an increase of 1 percentage point in the county uninsurance rate is associated with a \$20 increase in the mean emergency department payment. No such association is observed among visits covered by other insurance types. **CONCLUSIONS:** Results provide tentative evidence that the costs associated with high uninsurance rates spill over to those with insurance, but future research needs to replicate these findings with longitudinal data and methods before drawing causal conclusions. Recent data on changes in area uninsurance rates following the ACA's insurance expansions and subsequent changes in emergency department expenditures afford a valuable opportunity to do this.

Laaksonen, M., et al. (2016). "Sickness allowance trajectories preceding disability retirement: a register-based retrospective study." Eur J Public Health 26(6): 1050-1055.

OBJECTIVES: To identify subgroups of disability retirees with different pre-retirement sickness allowance histories and to examine whether the diagnosis of disability pension and socio-demographic variables discriminate these subgroups. **METHODS:** The data included all Finnish residents aged 30-64 years who were granted a full disability pension in 2011 (N = 17 208). Sickness allowance trajectories during the preceding 10 years were searched using latent trajectory analysis. Multinomial logistic regression analysis was used to explore determinants of the trajectories. **RESULTS:** Six distinct sickness allowance trajectories were identified. Four large subgroups with a long sickness allowance period during the final pre-retirement year were found, characterized by increasing (29% of retirees), early high (21%), stable low (24%) or stable high (16%) sickness allowance histories. In addition, two small subgroups (6 and 4%) with only a little sickness allowance during the final year were identified. The diagnosis of disability pension strongly influenced assignment to the trajectory groups. Women were more likely to have followed the stable high or the early high sickness allowance trajectory. Older age strongly increased but being a lower non-manual employee or self-employed decreased the probability of belonging to the two small trajectory groups. Long-term unemployment slightly increased belonging to the stable low trajectory and was strongly associated with the small subgroups with little or no sickness allowance during the final year preceding retirement. **CONCLUSIONS:** Different pre-retirement sickness allowance trajectories can be found. Assignment to the trajectories differed by the diagnosis of disability pension but associations with socio-demographic variables were weak.

Wijnvoord, E. C., et al. (2016). "Health-based risk neutralization in private disability insurance." Eur J Public Health 26(6): 1045-1049.

BACKGROUND: Exclusions are used by insurers to neutralize higher than average risks of sickness absence (SA). However, differentiating risk groups according to one's medical situation can be seen as discrimination against people with health problems in violation of a 2006 United Nations convention. The objective of this study is to investigate whether the risk of SA of insured persons with exclusions added to their insurance contract differs from the risk of persons without exclusions. **METHODS:** A

dynamic cohort of 15 632 applicants for private disability insurance at a company insuring only college and university educated self-employed in the Netherlands. Mean follow-up was 8.94 years. Duration and number of SA periods were derived from insurance data to calculate the hazard of SA periods and of recurrence of SA periods. RESULTS: Self-employed with an exclusion added to their insurance policy experienced a higher hazard of one or more periods of SA and on average more SA days than self-employed without an exclusion. CONCLUSION: Persons with an exclusion had a higher risk of SA than persons without an exclusion. The question to what extent an individual should benefit from being less vulnerable to disease and SA must be addressed in a larger societal context, taking other aspects of health inequality and solidarity into account as well.

Economie de la santé / Health Economics

Gifford, B. (2017). "Temporarily Disabled Workers Account For A Disproportionate Share Of Health Care Payments." *Health Affairs* 36(2): 245-249.

<http://content.healthaffairs.org/content/36/2/245.abstract>

About one in four employees in a cohort of 408,000 US workers took a temporary leave of absence from work because of illness or injury in the period 2008–12. They accounted for nearly 60 percent (about \$6.5 billion) of total worker health care and disability payments. This finding underscores the importance of workplace care management, lifestyle management, and health and safety efforts to prevent disability leaves.

Habibov, N. et Cheung, A. (2017). "Revisiting informal payments in 29 transitional countries: The scale and socio-economic correlates." *Soc Sci Med* 178: 28-37.

This study assesses informal payments (IPs) in 29 transitional countries using a fully comparable household survey. The countries of the former Soviet Union, especially those in the Caucasus and Central Asia, exhibit the highest scale of IPs, followed by Southern Europe, and then Eastern Europe. The lowest and the highest scale of IPs were in Slovenia (2.7%) and Azerbaijan (73.9%) respectively. We found that being from a wealthier household, experiencing lower quality of healthcare in the form of long waiting times, lack of medicines, absence of personnel, and disrespectful treatment, and having relatives to help when needed, are associated with a higher odds ratio of IPs. Conversely, working for the government is associated with a lower odds ratio of IPs. Living in the countries of the former Soviet Union and in Mongolia is associated with the highest likelihood of IPs, and this is followed by the countries of the Southern Europe. In contrast, living in the countries of Eastern Europe is associated with the lowest likelihood of IPs.

Kim, T. J., et al. (2017). "Income, financial barriers to health care and public health expenditure: A multilevel analysis of 28 countries." *Soc Sci Med* 176: 158-165.

International studies have repeatedly shown that people with lower income are more likely to experience difficulties to access medical services. Less is known on why these relations vary across countries. This study investigates whether the association between income and financial barriers to health care is influenced by national public health expenditures (PHE, in % of total health expenditure). Data from the International Social Survey Programme (2011) was used (28 countries, 23,669 respondents). Financial barriers were assessed by the individual experience of forgone care due to financial reasons. Monthly equivalent household income was included as the main predictor. Other individual-level control variables were age, gender, education, subjective health, insurance coverage and place of living. PHE was considered as a macro-level predictor, adjusted for total health expenditure. Statistically significant associations between income and forgone care were found in 21 of 28 examined countries. Multilevel analyses across countries revealed that people with lower income have a higher likelihood to forgo needed medical care (OR: 3.94, 95%-CI: 2.96-5.24). After adjustments for individual-level covariates, this association slightly decreased (OR: 2.94, 95%-CI: 2.16-3.99). PHE did not moderate the relation between income and forgone care. The linkage between

health system financing and inequalities in access to health care seems to be more complex than initially assumed, pointing towards further research to explore how PHE affects the redistribution of health resources in different health care systems.

Lane, H., et al. (2017). "Equity in healthcare resource allocation decision making: A systematic review." *Social Science & Medicine* 175: 11-27.

<http://www.sciencedirect.com/science/article/pii/S0277953616306827>

Abstract : Objective To identify elements of endorsed definitions of equity in healthcare and classify domains of these definitions so that policy makers, managers, clinicians, and politicians can form an operational definition of equity that reflects the values and preferences of the society they serve. Design Systematic review where verbatim text describing explicit and implicit definitions of equity were extracted and subjected to a thematic analysis. Data sources: The full holdings of the AMED, CINAHL plus, OVID Medline, Scopus, PsychInfo and ProQuest (ProQuest Health & Medical Complete, ProQuest Nursing and Allied Health Source, ProQuest Social Science Journals) were individually searched in April 2015. Eligibility criteria for selecting studies: Studies were included if they provided an original, explicit or implicit definition of equity in regards to healthcare resource allocation decision making. Papers that only cited earlier definitions of equity and provided no new information or extensions to this definition were excluded. Results The search strategy yielded 74 papers appropriate for this review; 60 of these provided an explicit definition of equity, with a further 14 papers discussing implicit elements of equity that the authors endorsed in regards to healthcare resource allocation decision making. Five key themes emerged i) Equalisation across the health service supply/access/outcome chain, ii) Need or potential to benefit, iii) Groupings of equalisation, iv) Caveats to equalisation, and v) Close enough is good enough. Conclusions : There is great inconsistency in definitions of equity endorsed by different authors. Operational definitions of equity need to be more explicit in addressing these five thematic areas before they can be directly applied to healthcare resource allocation decisions.

Van Esch, T. E. M., et al. "Increased cost sharing and changes in noncompliance with specialty referrals in The Netherlands." *Health Policy* 121(2): 180-188.

<http://dx.doi.org/10.1016/j.healthpol.2016.12.001>

Noncompliance increased during the rise of cost sharing. Noncompliance increased most in children and patients with chronic diseases. No one-to-one relationship between increased cost sharing and noncompliance is found.

Hôpital / Hospital

Grimaldi, A. et Vernant, J. P. (2017). "Réflexions sur les modalités de financement des hôpitaux." *Information Psychiatrique (L')* 93(1): 21-26.

Chaque mode de financement de l'hôpital – prix de journée, dotation et tarification à l'activité – a des avantages et des inconvénients. Leur choix devrait être déterminé en fonction de l'activité concernée. Ainsi la T2A est adaptée aux activités standardisées et programmées. Le prix de journée est adapté aux soins palliatifs. La dotation est adaptée aux activités complexes connaissant des modalités de prises en charge rapidement évolutives. C'est le cas notamment des maladies chroniques ou devenant chroniques comme nombre de cancers. Chacune de ces techniques de financement nécessitent des modes de régulation spécifique qui devraient être fixés avec les professionnels. La T2A a été utilisée non pas comme une technique de financement mais comme une politique visant à instaurer dans l'hôpital une gestion privée. Fonctionnant non pas sur le principe éthique du juste soin pour le patient au moindre coût pour la société mais selon le principe commercial de la recherche de la rentabilité pour l'établissement, elle a été généralisée. La concurrence entre établissements était censée permettre l'obtention de la qualité au moindre coût. Le maintien d'un budget national contraint (l'Ondam), le développement des maladies chroniques, la volonté de limiter l'hospitalo-centrisme

conduisent à une critique du « tout T2A » auquel reste attaché le pouvoir managérial qui propose de maintenir la T2A en la complexifiant un peu plus.

Johannessen, K. A., et al. (2017). "Assessing physician productivity following Norwegian hospital reform: A panel and data envelopment analysis." *Social Science & Medicine* 175: 117-126.

<http://www.sciencedirect.com/science/article/pii/S0277953617300084>

Abstract : Background Although health care reforms may improve efficiency at the macro level, less is known regarding their effects on the utilization of health care personnel. Following the 2002 Norwegian hospital reform, we studied the productivity of the physician workforce and the effect of personnel mix on this measure in all nineteen Norwegian hospitals from 2001 to 2013. Methods : We used panel analysis and non-parametric data envelopment analysis (DEA) to study physician productivity defined as patient treatments per full-time equivalent (FTE) physician. Resource variables were FTE and salary costs of physicians, nurses, secretaries, and other personnel. Patient metrics were number of patients treated by hospitalization, daycare, and outpatient treatments, as well as corresponding diagnosis-related group (DRG) scores accounting for differences in patient mix. Research publications and the fraction of residents/FTE physicians were used as proxies for research and physician training. Results : The number of patients treated increased by 47% and the DRG scores by 35%, but there were no significant increases in any of the activity measures per FTE physician. Total DRG per FTE physician declined by 6% (0.05). In the panel analysis, more nurses and secretaries per FTE physician correlated positively with physician productivity, whereas physician salary was neutral. In 2013, there was a 12%–80% difference between the hospitals with the highest and lowest physician productivity in the differing treatment modalities. In the DEA, cost efficiency did not change in the study period, but allocative efficiency decreased significantly. Bootstrapped estimates indicated that the use of physicians was too high and the use of auxiliary nurses and secretaries was too low. Conclusions: Our measures of physician productivity declined from 2001 to 2013. More support staff was a significant variable for predicting physician productivity. Personnel mix developments in the study period were unfavorable with respect to physician productivity.

Kim, S. J., et al. (2016). "Positive effects of medical staffing on readmission within 30 days after discharge: a retrospective analysis of obstetrics and gynecology data." *Eur J Public Health* 26(6): 935-939.

BACKGROUND: Improving quality of care is a major healthcare goal; however, the relationship between limited resources and appropriate healthcare distribution has always been problematic. Planning for resource shortages is important for improving healthcare quality. The aim of our study was to evaluate the effects of manpower planning on improvements in quality of care by estimating the effects of medical staffing on readmission within 30 days after discharge. **METHODS:** We conducted an observational study using 2011-14 National Health Claim data from 692 hospitals and 633 461 admissions. The database included information on uterine (including adnexa) procedures (195 270 cases) and cesarean deliveries (438 191 cases). The outcome variable was readmission within 30 days after discharge. A generalized estimating equation model was used to evaluate associations between readmission and medical staffing. **RESULTS:** The number of doctors and the proportion of registered nurses (RNs) were significantly associated with a lower risk of readmission within 30 days (proportion of RNs, Relative Risk (RR): 0.97, P values: 0.0025; number of doctors, RR: 0.96, P values: <0.0001). The number of nurses (RNs + licensed practical nurses) was not associated with readmission within 30 days (RR: 1.01, P values: <0.0001). **CONCLUSION:** Our results suggested that higher numbers of doctors and higher proportions of RNs were positively correlated with a lower risk of readmission within 30 days. Human resource planning to solve manpower shortages should carefully consider the qualitative aspects of clinical care and include long-term planning.

Sheard, L., et al. (2017). "The Patient Feedback Response Framework - Understanding why UK hospital staff find it difficult to make improvements based on patient feedback: A qualitative study." *Soc Sci Med* 178: 19-27.

Patients are increasingly being asked for feedback about their healthcare experiences. However, healthcare staff often find it difficult to act on this feedback in order to make improvements to services. This paper draws upon notions of legitimacy and readiness to develop a conceptual framework (Patient Feedback Response Framework - PFRF) which outlines why staff may find it problematic to respond to patient feedback. A large qualitative study was conducted with 17 ward based teams between 2013 and 2014, across three hospital Trusts in the North of England. This was a process evaluation of a wider study where ward staff were encouraged to make action plans based on patient feedback. We focus on three methods here: i) examination of taped discussion between ward staff during action planning meetings ii) facilitators notes of these meetings iii) telephone interviews with staff focusing on whether action plans had been achieved six months later. Analysis employed an abductive approach. Through the development of the PFRF, we found that making changes based on patient feedback is a complex multi-tiered process and not something that ward staff can simply 'do'. First, staff must exhibit normative legitimacy - the belief that listening to patients is a worthwhile exercise. Second, structural legitimacy has to be in place - ward teams need adequate autonomy, ownership and resource to enact change. Some ward teams are able to make improvements within their immediate control and environment. Third, for those staff who require interdepartmental co-operation or high level assistance to achieve change, organisational readiness must exist at the level of the hospital otherwise improvement will rarely be enacted. Case studies drawn from our empirical data demonstrate the above. It is only when appropriate levels of individual and organisational capacity to change exist, that patient feedback is likely to be acted upon to improve services.

Inégalités de santé / Health Inequalities

De Gelder, R., et al. (2017). "Long-term trends of inequalities in mortality in 6 European countries."

International Journal of Public Health 62(1): 127-141.

<http://dx.doi.org/10.1007/s00038-016-0922-9>

We aimed to assess whether trends in inequalities in mortality during the period 1970–2010 differed between Finland, Norway, England and Wales, France, Italy (Turin) and Hungary.

Georges-Tarragano, C., et al. (2017). "Soigner les migrants dans les PASS : une pratique spécifique, miroir d'une approche universelle." *Laennec* 65(1): 25-37.

L'afflux massif de réfugiés et de migrants appelle une réponse urgente à leurs besoins sanitaires. Celle-ci est assurée par les Permanences d'accès aux soins de santé médico-sociales (PASS), pour des patients vulnérables. Ces lieux sont un modèle de pratique ouvrant des perspectives à l'ensemble du système de santé français.

Graetz, V., et al. (2017). "Utilization of health care services by migrants in Europe-a systematic literature review." *Br Med Bull*.

INTRODUCTION: Our study reviewed the empirical evidence on the utilization of health care services by migrants in Europe, and on differences in health service utilization between migrants and non-migrants across European countries. SOURCES OF DATA: A systematic literature review was performed, searching the databases Medline, Cinahl and Embase and covering the period from January 2009 to April 2016. The final number of articles included was 39. AREAS OF AGREEMENT: Utilization of accident and emergency services and hospitalizations were higher among migrants compared with non-migrants in most countries for which evidence was available. In contrast, screening and outpatient visits for specialized care were generally used less often by migrants. AREAS OF CONTROVERSY: Utilization of general practitioner services among migrants compared with non-migrants presents a diverging picture. GROWING POINTS: Compared with previous systematic reviews, the results indicate a clearer picture of the differences in health service utilization between migrants and non-migrants in Europe. AREAS TIMELY FOR DEVELOPING RESEARCH: A comprehensive comparison across European countries is impossible because the number of studies is still limited.

Further research should also help to identify barriers regarding the utilization of health care services by migrants.

Kietzmann, D., et al. (2017). "(Non-)utilization of pre-hospital emergency care by migrants and non-migrants in Germany." *International Journal of Public Health* **62**(1): 95-102.
<http://dx.doi.org/10.1007/s00038-016-0904-y>

This study was designed to explore the utilization and non-utilization of pre-hospital emergency care by migrants and non-migrants, and the factors that influence this behaviour.

Pirhonen, L., et al. "Effects of person-centred care on health outcomes. A randomized controlled trial in patients with acute coronary syndrome." *Health Policy* **121**(2): 169-179.
<http://dx.doi.org/10.1016/j.healthpol.2016.12.003>

We employed four different outcomes for measuring health. Effects were estimated controlling for socioeconomic and disease-related variables. Significant effects from person-centred care are found on general self-efficacy. Need for improved knowledge of the cost-effectiveness of person-centred care.

Quick, A., et al. (2017). "Does involvement in a cohort study improve health and affect health inequalities? A natural experiment." *BMC Health Services Research* **17**: 79.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5264453/>

BACKGROUND: Evidence suggests that the process of taking part in health research can improve participants' health, independent of any intended intervention. However, no research has yet explored whether these effects differ across socioeconomic groups. If the effect of mere participation in health research also has a social gradient this could increase health inequalities and bias research results. This study used the Born in Bradford family cohort (BIB) to explore whether simply taking part in BIB had improved participants' health and, if so, whether this effect was mediated by socioeconomic status. **METHODS:** Survey data on self-reported health behaviours were collected between 2007 and 2010 as part of BIB. These were augmented by clinical data on birth weight. Pregnant women on their second pregnancy, joining BIB for the first time formed the control group. Their health was compared to women on their second pregnancy who had both pregnancies within the study, who formed the exposed group. In order to limit the inherent bias in a non-randomised study, propensity score analysis was used, matching on age, ethnicity, education and date of questionnaire. The results were then compared according to mothers' education. **RESULTS:** Of six outcomes tested, only alcohol consumption showed a statistically significant reduction with exposure to BIB (OR: 0.35, 95% CIs 0.13, 0.92). Although effect estimates were larger for women with higher education compared to lower education, these effects were not statistically significant. **CONCLUSIONS:** Despite one significant finding, these results overall are insufficient to conclude that simply taking part in BIB affected participants' health. We recommend that socioeconomic status is considered in future studies testing effects of research participation, and that randomised studies with larger sample sizes are conducted.

Reus-Pons, M., et al. (2016). "Differences in mortality between groups of older migrants and older non-migrants in Belgium, 2001-09." *Eur J Public Health* **26**(6): 992-1000.

BACKGROUND: European societies are rapidly ageing and becoming multicultural. We studied differences in overall and cause-specific mortality between migrants and non-migrants in Belgium specifically focusing on the older population. **METHODS:** We performed a mortality follow-up until 2009 of the population aged 50 and over living in Flanders and the Brussels-Capital Region by linking the 2001 census data with the population and mortality registers. Overall mortality differences were analysed via directly age-standardized mortality rates. Cause-specific mortality differences between non-migrants and various western and non-western migrant groups were analysed using Poisson regression models, controlling for age (model 1) and additionally controlling for socio-economic status

and urban typology (model 2). RESULTS: At older ages, most migrants had an overall mortality advantage relative to non-migrants, regardless of a lower socio-economic status. Specific migrant groups (e.g. Turkish migrants, French and eastern European male migrants and German female migrants) had an overall mortality disadvantage, which was, at least partially, attributable to a lower socio-economic status. Despite the general overall mortality advantage, migrants experienced higher mortality from infectious diseases, diabetes-related causes, respiratory diseases (western migrants), cardiovascular diseases (non-western female migrants) and lung cancer (western female migrants). CONCLUSION: Mortality differences between older migrants and non-migrants depend on cause of death, age, sex, migrant origin and socio-economic status. These differences can be related to lifestyle, social networks and health care use. Policies aimed at reducing mortality inequalities between older migrants and non-migrants should address the specific health needs of the various migrant groups, as well as socio-economic disparities.

Vuillermoz, C., et al. (2016). "Mortality among homeless people in France, 2008-10." *Eur J Public Health* 26(6): 1028-1033.

BACKGROUND: Studies in various countries have shown that homeless people have high mortality levels. The aims of this study concerning the French population were to investigate mortality among the homeless and to study their causes of death in comparison to those of the general population. METHODS: A representative sample of 1145 homeless deaths registered by an association was matched to the national database of medical causes of death using common descriptive variables. Log-binomial regression was used to compare mortality among the homeless to that of the general population. Multiple imputation was used to manage missing causes of deaths. RESULTS: Out of the 1145 registered homeless deaths, 693 were matched to the causes of death database. Homeless deaths were young (average age: 49). Overall, homeless deaths were slightly more frequent during winter. Among all deaths, the probability of being homeless was higher when dying from hypothermia (RR = 6.4), alcohol-related deaths (RR = 1.7), mental disorders, diseases of the digestive and circulatory systems, and undetermined causes (RR from 1.5 to 3.7). CONCLUSION: The homeless died at 49 years old on average compared with 77 in the general population in 2008-10. The health of homeless people should be considered not only in winter periods or in terms of alcohol- or cold-related conditions. This study also highlights the need for more precise data to estimate the mortality risks of the homeless in France.

Médicaments / Pharmaceuticals

Moustgaard, H., et al. (2016). "A longitudinal study of educational differences in antidepressant use before and after hospital care for depression." *Eur J Public Health* 26(6): 1034-1039.

BACKGROUND: Despite social inequalities in depression various studies report small or even reversed social gradients for antidepressant treatment, suggesting unmet need for treatment among those with low social position. However, few studies assess need for treatment or compare longitudinal antidepressant use patterns between socioeconomic groups. METHODS: We used a nationally representative register cohort of Finnish adults with hospital care for depression in 1998-2007 (n = 7249). We compared the prevalence of any use and daily use of antidepressants across educational groups in consecutive 3-month periods up to 5 years before admission and 5 years after discharge, adjusting for important confounders. RESULTS: We found no educational differences in any antidepressant use in the 5 years leading to hospital care for depression but a 3-4 percentage-point higher prevalence among those with high education in the 3-month periods immediately preceding and following hospital care for depression. Furthermore, decline in the prevalence of antidepressant use after discharge was more rapid in low education resulting in a significant 4-6 percentage-point higher prevalence among the highly educated lasting until 2.5 years after discharge. Daily use was significantly more common among the highly educated for a year before admission, immediately after discharge and for 2.5 years thereafter, the excess being 3-8 percentage-points. CONCLUSION: Our results suggest rather equitable access to antidepressant treatment at the time of evident need, i.e.

immediately after discharge from hospital care for depression. However, early discontinuation of treatment as well as below guideline use of antidepressants were more common among the low educated.

Politique de santé / Health Policy

Azzopardi-Muscat, N., et al. (2016). "Policy challenges and reforms in small EU member state health systems: a narrative literature review." *Eur J Public Health* 26(6): 916-922.

BACKGROUND: The EU directive on patients' rights and cross-border care is of particular interest to small states as it reinforces the concept of health system cooperation. An analysis of the challenges faced by small states, as well as a deep evaluation of their health system reform characteristics is timely and justified. This paper identifies areas in which EU level cooperation may bring added value to these countries' health systems. **METHOD:** Literature search is based primarily on PUBMED and is limited to English-language papers published between January 2000 and September 2014. Results of 76 original research papers appearing in peer-reviewed journals are summarised in a literature map and narrative review. **RESULTS:** Primary care, health workforce and medicines emerge as the salient themes in the review. Lack of capacity and small market size are found to be the frequently encountered challenges in governance and delivery of services. These constraints appear to also impinge on the ability of small states to effectively implement health system reforms. The EU appears to play a marginal role in supporting small state health systems, albeit the stimulus for reform associated with EU accession. **CONCLUSIONS:** Small states face common health system challenges which could potentially be addressed through enhanced health system cooperation at EU level. The lessons learned from research on small states may be of relevance to health systems organized at regional level in larger European states.

Canasse, S. (2017/01). "Au-delà du « cure » et du « care »." *Carnets de Santé*(01).

Le « cure » (« guérir ») est l'objet du modèle biomédical. Il a pour but la disparition d'une maladie. Le « care » (« prendre soin ») est l'objet du modèle humaniste. Son but est plus imprécis : il porte sur la prise en compte du « malade » en tant que personne, individu ou sujet.

Downey, L. E., et al. (2017). "Clinical Pathways, Claims Data, And Measuring Quality." *Health Affairs* 36(2): 382-383.

<http://content.healthaffairs.org/content/36/2/382.3.short>

Jones, C. M., et al. (2017). "Adapting public policy theory for public health research: A framework to understand the development of national policies on global health." *Soc Sci Med* 177: 69-77.

National policies on global health appear as one way that actors from health, development and foreign affairs sectors in a country coordinate state action on global health. Next to a burgeoning literature in which international relations and global governance theories are employed to understand global health policy and global health diplomacy at the international level, little is known about policy processes for global health at the national scale. We propose a framework of the policy process to understand how such policies are developed, and we identify challenges for public health researchers integrating conceptual tools from political science. We developed the framework using a two-step process: 1) reviewing literature to establish criteria for selecting a theoretical framework fit for this purpose, and 2) adapting Real-Dato's synthesis framework to integrate a cognitive approach to public policy within a constructivist perspective. Our framework identifies multiple contexts as part of the policy process, focuses on situations where actors work together to make national policy on global health, considers these interactive situations as spaces for observing external influences on policy change and proposes policy design as the output of the process. We suggest that this framework makes three contributions to the conceptualisation of national policy on global health as a research

object. First, it emphasizes collective action over decisions of individual policy actors. Second, it conceptualises the policy process as organised interactive spaces for collaboration rather than as stages of a policy cycle. Third, national decision-making spaces are opportunities for transferring ideas and knowledge from different sectors and settings, and represent opportunities to identify international influences on a country's global health policy. We discuss two sets of challenges for public health researchers using interdisciplinary approaches in policy research.

McNamara, C. (2017). "Trade liberalization and social determinants of health: A state of the literature review." *Social Science & Medicine* 176: 1-13.

<http://www.sciencedirect.com/science/article/pii/S0277953616306852>

The health impacts of trade liberalization are often described in relation to access to medicines, changing dietary patterns, tobacco use and alcohol consumption. The impacts of trade liberalization on the social determinants of health (SDH), are by contrast, less well known. Missing is an account of how liberalizing processes identified across different research areas relate to each other and how the association between trade liberalization and health is conceptualized within each of them, especially with reference to SDH. This paper presents a systematic review which provides a more complete picture of the pathways between trade liberalization and health, with special attention to SDH pathways. This picture captures the interrelationships between different areas of investigation, along with current limitations of our understanding and recommendations for future research.

Siciliani, L., et al. "Policies towards hospital and GP competition in five European countries." *Health Policy* 121(2): 103-110.

<http://dx.doi.org/10.1016/j.healthpol.2016.11.011>

Patients' choice policies are increasingly common. The process to determine hospital tariffs differs across countries. The introduction of GP competition can be controversial. There are innovative examples of selective contracting for patients with chronic conditions. Mergers of private hospitals are cleared in the vast majority of cases.

Prévention / Prevention

Willis, C. D., et al. (2017) "Exploring the unanticipated effects of multi-sectoral partnerships in chronic disease prevention." *Health Policy* 121(2): 158-168.

<http://dx.doi.org/10.1016/j.healthpol.2016.11.019>

Public-private partnerships are important parts of public health efforts to prevent chronic disease. Such partnerships may result in various unexpected effects for participating organizations. These include unexpected access to resources and new capacities in unanticipated domains. These findings may help improve partnership monitoring and evaluation strategies.

Prévision – Evaluation / Prevision - Evaluation

Kuehnle, D. et Wunder, C. (2017). "The Effects of Smoking Bans on Self-Assessed Health: Evidence from Germany." *Health Econ* 26(3): 321-337.

We examine the effects of smoking bans on self-assessed health in Germany taking into account heterogeneities by smoking status, gender and age. We exploit regional variation in the dates of enactment and dates of enforcement across German federal states. Using data from the German Socio-Economic Panel, our difference-in-differences estimates show that non-smokers' health improves, whereas smokers report no or even adverse health effects in response to bans. We find statistically significant health improvements especially for non-smokers living in households with at

least one smoker. Non smokers' health improvements materialise largely with the enactment of smoking bans. Copyright (c) 2016 John Wiley & Sons, Ltd.

Psychiatrie / Psychiatry

Dey, M. et Jorm, A. F. (2017). "Social determinants of mental health service utilization in Switzerland." International Journal of Public Health 62(1): 85-93.
<http://dx.doi.org/10.1007/s00038-016-0898-5>

To investigate whether mental health services utilization in Switzerland is equitably distributed (i.e., predicted only by the need of a person).

Odier, B. (2017). "La description des traitements ambulatoires : vers une typologie." Information Psychiatrique (L) 93(1): 31-38.

L'auteur cherche à montrer que le choix du mode de description de l'activité ambulatoire a une importance stratégique pour l'avenir de la psychiatrie de secteur. Actuellement, la saisie informatisée des actes, décrits selon une nomenclature standard (grille Edgar) conduit à des calculs de totaux d'actes par secteur. Ces décomptes conduisent à évaluer des volumes d'actes qui peuvent être ventilés par catégorie professionnelle, par type d'actes, plus rarement par diagnostic. Ces décomptes d'actes ne soulignent en rien les caractéristiques structurales des centres médico-psychologiques (CMP). En effet l'activité des CMP se distingue de celle de la psychiatrie de ville par sa structure. Dans un CMP et dans la psychiatrie de ville, les taux d'absentéisme, la fréquence des imprévus et le nombre de situations urgentes accueillies et prises en charge sont sans commune mesure. Curieusement les CMP ne se dotent pas en général d'un outil soulignant ces singularités de leur pratique. La description actuelle du travail dans les CMP dissimule de plus la complexité des différentes « formules de soins » proposées au patient. Définir des « formules de soins » qui bénéficient à des effectifs de patients que l'on peut préciser chaque année permet de nommer les traitements et de rendre plus consistantes les prises en charge effectuées en CMP dont les représentations sont aujourd'hui pulvérisées par leur description en miettes.

Soins de santé primaires / Primary Health Care

Harris, J. E., et al. (2017). "Allocation of Residency Training Positions in Spain: Contextual Effects on Specialty Preferences." Health Econ 26(3): 371-386.

In Spain's 'MIR' system, medical school graduates are ranked by their performance on a national exam and then sequentially choose from the available residency training positions. We took advantage of a unique survey of participants in the 2012 annual MIR cycle to analyze preferences under two different choice scenarios: the residency program actually chosen by each participant when it came her turn (the 'real') and the program that she would have chosen if all residency training programs had been available (the 'counterfactual'). Utilizing conditional logit models with random coefficients, we found significant differences in medical graduates' preferences between the two scenarios, particularly with respect to three specialty attributes: work hours/lifestyle, prestige among colleagues, and annual remuneration. In the counterfactual world, these attributes were valued preferentially by those nearer to the top, while in the real world, they were valued preferentially by graduates nearer to the bottom of the national ranking. Medical graduates' specialty preferences, which we conclude, are not intrinsically stable but depend critically on the 'rules of the game'. The MIR assignment system, by restricting choice, effectively creates an externality in which those at the bottom, who have fewer choices, want what those at the top already have. Copyright (c) 2016 John Wiley & Sons, Ltd.

Maier, C. B. et Aiken, L. H. (2016). "Task shifting from physicians to nurses in primary care in 39

countries: a cross-country comparative study." *Eur J Public Health* 26(6): 927-934.

BACKGROUND: Primary care is in short supply in many countries. Task shifting from physicians to nurses is one strategy to improve access, but international research is scarce. We analysed the extent of task shifting in primary care and policy reforms in 39 countries. **METHODS:** Cross-country comparative research, based on an international expert survey, plus literature scoping review. A total of 93 country experts participated, covering Europe, USA, Canada, Australia and New Zealand (response rate: 85.3%). Experts were selected according to pre-defined criteria. Survey responses were triangulated with the literature and analysed using policy, thematic and descriptive methods to assess developments in country-specific contexts. **RESULTS:** Task shifting, where nurses take up advanced roles from physicians, was implemented in two-thirds of countries (N = 27, 69%), yet its extent varied. Three clusters emerged: 11 countries with extensive (Australia, Canada, England, Northern Ireland, Scotland, Wales, Finland, Ireland, Netherlands, New Zealand and USA), 16 countries with limited and 12 countries with no task shifting. The high number of policy, regulatory and educational reforms, such as on nurse prescribing, demonstrate an evolving trend internationally toward expanding nurses' scope-of-practice in primary care. **CONCLUSIONS:** Many countries have implemented task-shifting reforms to maximise workforce capacity. Reforms have focused on removing regulatory and to a lower extent, financial barriers, yet were often lengthy and controversial. Countries early on in the process are primarily reforming their education. From an international and particularly European Union perspective, developing standardised definitions, minimum educational and practice requirements would facilitate recognition procedures in increasingly connected labour markets.

Shin, S., et al. (2017). "Do Capitation-based Reimbursement Systems Underfund Tertiary Healthcare Providers? Evidence from New Zealand." *Health Econ.*

One of the main concerns about capitation-based reimbursement systems is that tertiary institutions may be underfunded due to insufficient reimbursements of more complicated cases. We test this hypothesis with a data set from New Zealand that, in 2003, introduced a capitation system where public healthcare provider funding is primarily based on the characteristics of the regional population. Investigating the funding for all cases from 2003 to 2011, we find evidence that tertiary providers are at a disadvantage compared with secondary providers. The reasons are that tertiary providers not only attract the most complicated, but also the highest number of cases. Our findings suggest that accurate risk adjustment is crucial to the success of a capitation-based reimbursement system. Copyright (c) 2017 John Wiley & Sons, Ltd.

Timmons, E. J. "The effects of expanded nurse practitioner and physician assistant scope of practice on the cost of Medicaid patient care." *Health Policy* 121(2): 189-196.

<http://dx.doi.org/10.1016/j.healthpol.2016.12.002>

Allowing physician assistants to prescribe controlled substances reduces outpatient care cost. This reduction is quite large, ranging from 11.8% to 16.0%. This change is not associated with any changes in care intensity.

Systèmes de santé / Health Systems

Barros, P. P. "Competition policy for health care provision in Portugal." *Health Policy* 121(2): 141-148.
<http://dx.doi.org/10.1016/j.healthpol.2016.12.005>

The role of competition and competition policy in healthcare provision is gaining interest. The scope for competition among healthcare providers within the Portuguese National Health Service is limited. The role of "competition for the market" is more relevant than "competition in the market".

Brekke, K. R. et Straume, O. R. "Competition policy for health care provision in Norway." *Health*

Policy **121**(2): 134-140.

<http://dx.doi.org/10.1016/j.healthpol.2016.11.013>

Standard competition policy plays a limited role in the Norwegian NHS. Competition policy is indirect through reforms introducing provider competition. Examples include patient choice, activity-based funding, and private provider contracting. Evidence for pro-competitive effects is weak and inconclusive. Possible reasons are partial DRG-pricing, dual purchaser-provider role, and consolidation.

Choné, P. "Competition policy for health care provision in France." Health Policy **121(2): 111-118.**

<http://dx.doi.org/10.1016/j.healthpol.2016.11.015>

More than two thousand public and private hospitals operate in France. Government reports argue that activity-based payment and competition impede synergies between hospitals. An important reform coming into effect in January 2016 mandates close cooperation between public hospitals. GP fees are set nationally while many self-employed specialist physicians may overcharge. Government regulation and centralized negotiations tend to be favoured over market mechanisms.

Kifmann, M. "Competition policy for health care provision in Germany." Health Policy **121(2): 119-125.**

<http://dx.doi.org/10.1016/j.healthpol.2016.11.014>

Selective contracting in Germany required financial incentives or mandates to conclude contracts. A key issue of selective contracting is the readjustment of payments for the collective systems. There is evidence that selective contracting has improved quality of care. The evidence on selective contracting points to cost increases, at least in the short run.

Travail et santé / Occupational Health

Blinder, V., et al. (2017). "Women With Breast Cancer Who Work For Accommodating Employers More Likely To Retain Jobs After Treatment." Health Affairs **36(2): 274-281.**

<http://content.healthaffairs.org/content/36/2/274.abstract>

Breast cancer affects one in eight women across the United States, and low-income minority survivors of breast cancer are at increased risk of job loss, compared to higher-income white survivors. Employer accommodations, such as schedule flexibility, have been associated with job retention in higher-income whites, but the role of such accommodations in job retention among low-income minorities is not well understood. We conducted a longitudinal study of 267 employed women ages 18–64 who were undergoing treatment for early-stage breast cancer and spoke English, Chinese, Korean, or Spanish. We categorized patients by income level and by race/ethnicity. The category with the lowest job retention after treatment was low-income women (57 percent). Job retention varied widely by race/ethnicity, ranging from 68 percent among Chinese women to 98 percent among non-Latina whites. Women who had accommodating employers were more than twice as likely to retain their jobs as those without accommodating employers. Low-income women were less likely than higher-income women to have accommodating employers, however. More uniform implementation of accommodations across low- and high-paying jobs could reduce disparities in employment outcomes among workers with a cancer diagnosis. Additional research is needed to better understand the barriers that employers, particularly those with low-income workers, may face in providing accommodations.

Buchmueller, T. C. et Valletta, R. G. (2017). "Work, Health, And Insurance: A Shifting Landscape For Employers And Workers Alike." Health Affairs **36(2): 214-221.**

<http://content.healthaffairs.org/content/36/2/214.abstract>

We examined the complex relationship among work, health, and health insurance, which has been affected by changing demographics and employment conditions in the United States. Stagnation or

deterioration in employment conditions and wages for much of the workforce has been accompanied by the erosion of health outcomes and employer-sponsored insurance coverage. In this article we present data and discuss the research that has established these links, and we assess the potential impact of policy responses to the evolving landscape of work and health. The expansion of insurance availability under the Affordable Care Act may have helped reduce the burden on employers to provide health insurance. However, the act's encouragement of wellness programs has uncertain potential to help contain the rising costs of employer-sponsored health benefits.

Goldman, T. R. (2017). "Working With A Chronic Disease." *Health Affairs* 36(2): 202-205.
<http://content.healthaffairs.org/content/36/2/202.abstract>

As millions of Americans with chronic and serious illnesses continue going to work, their employers are finding new ways to adjust.

Jeon, S. H. et Pohl, R. V. (2017). "Health and work in the family: Evidence from spouses' cancer diagnoses." *J Health Econ* 52: 1-18.

Using Canadian administrative data from multiple sources, we provide the first nationally representative estimates for the effect of spouses' cancer diagnoses on individuals' employment and earnings and on family income. Our identification strategy exploits unexpected health shocks and combines matching with individual fixed effects in a generalized difference-in-differences framework to control for observable and unobservable heterogeneity. While the effect of spousal health shocks on labor supply is theoretically ambiguous, we find strong evidence for a decline in employment and earnings of individuals whose spouses are diagnosed with cancer. We interpret this result as individuals reducing their labor supply to provide care to their sick spouses and to enjoy joint leisure. Family income substantially declines after spouses' cancer diagnoses, suggesting that the financial consequences of such health shocks are considerable.

Jinnett, K., et al. (2017). "Chronic Conditions, Workplace Safety, And Job Demands Contribute To Absenteeism And Job Performance." *Health Affairs* 36(2): 237-244.
<http://content.healthaffairs.org/content/36/2/237.abstract>

An aging workforce, increased prevalence of chronic health conditions, and the potential for longer working lives have both societal and economic implications. We analyzed the combined impact of workplace safety, employee health, and job demands (work task difficulty) on worker absence and job performance. The study sample consisted of 16,926 employees who participated in a worksite wellness program offered by a workers' compensation insurer to their employers—314 large, midsize, and small businesses in Colorado across multiple industries. We found that both workplace safety and employees' chronic health conditions contributed to absenteeism and job performance, but their impact was influenced by the physical and cognitive difficulty of the job. If employers want to reduce health-related productivity losses, they should take an integrated approach to mitigate job-related injuries, promote employee health, and improve the fit between a worker's duties and abilities.

Vahid Shahidi, F., et al. (2016). "Does social policy moderate the impact of unemployment on health? A multilevel analysis of 23 welfare states." *Eur J Public Health* 26(6): 1017-1022.

BACKGROUND: The magnitude of observable health inequalities between the unemployed and their employed counterparts differs considerably across countries. Few attempts have been made to test theoretical explanations for this cross-national variation. Moreover, existing studies suffer from important theoretical and methodological limitations. This study addresses these limitations and investigates whether differences in the generosity of social protection policies and in public attitudes towards those policies explain why unemployment-related health inequalities are steeper in some societies than in others. **METHODS:** Multilevel logistic modelling was used to link contextual-level variables on social protection policies and public attitudes in 23 European countries to individual-level data on self-rated health from the 2012 wave of the European Social Survey. **RESULTS:** The magnitude

of inequalities in self-rated health between the unemployed and their employed counterparts varies significantly across countries as a function of cross-national differences in the level of social protection awarded to the unemployed and the level of public support for the welfare state. **CONCLUSIONS:** The results provide empirical support for the claim that governments can play a more active role in mitigating unemployment-related health inequalities by expanding the generosity and scope of social protection policies. Whether such an expansion of social protection will take place in the current climate of fiscal austerity is a political question whose implications merit the attention of population health scholars.

Wang, M., et al. (2016). "Morbidity and suicide mortality following sick leave in relation to changes of social insurance regulations in Sweden." *Eur J Public Health* 26(6): 1061-1069.

BACKGROUND: Stricter regulations including time limits for sick leave have been introduced in Sweden in 2008, which might have resulted in higher morbidity in those on longer sick-leave spells after the introduction. This study aimed to examine (i) the association between all-cause and diagnosis-specific sickness absence and sick-leave duration with subsequent morbidity and suicide mortality and (ii) differences in socio-demographics and morbidity in individuals on sickness absence regarding changes of social insurance regulations. **METHODS:** A population-based prospective study was conducted of two cohorts of individuals who lived in Sweden, aged between 20 and 64 years at 31 December 2005 (n = 4 477 678) and at 31 December 2008 (n = 4 500 400), respectively. Each of the cohorts was followed regarding inpatient healthcare and suicide. Hazard ratios (HR) and 95% confidence intervals were estimated by Cox regression models. **RESULTS:** In the multivariate analyses, all-cause and diagnosis-specific sickness absence and sick-leave duration showed higher HRs for inpatient care and suicide in both cohorts (range of HR:1.10-2.59). HRs of inpatient care and suicide among individuals with mental sickness absence 2009 were reduced more after controlling for morbidity-related covariates, than such sickness absence in 2006. Individuals with mental and somatic sickness absence and sickness absence > 180 days in 2009 had higher HRs of somatic inpatient care than those on sickness absence in 2006. **CONCLUSIONS:** Diagnosis-specific sickness absence and long-term sickness absence in 2009 might be associated with more severe morbidity or work incapacity than in 2006 due to the stricter regulations.

Vieillessement / Ageing

Kaschowitz, J. et Brandt, M. (2017). "Health effects of informal caregiving across Europe: A longitudinal approach." *Soc Sci Med* 173: 72-80.

Due to an expected increase of people in need of care, sound knowledge about health effects of informal care provision is becoming more and more important. Theoretically, there might be positive as well as negative health effects due to caregiving to relatives. Moreover, we suppose that such health effects differ by national context - since care is differently organized in Europe - and depend on the social setting in which the care relationship takes place. Using data from the Survey of Health, Ageing and Retirement (SHARE, waves 1, 2, 3, and 5) and from the English Longitudinal Study of Ageing (ELSA, waves 2-5) we examined the connection between informal caregiving and self-perceived as well as mental health in a country comparative perspective. Taking advantage of the longitudinal structure of the data, pooled ordinary least squares (OLS) and fixed-effects models (FEM) were estimated. Our results show distinct differences in the relationship between reported health and the provision of informal care depending on whether individuals give care to someone inside or outside the household. Caregivers inside the household reported worse health, caregivers from outside the household reported better health than non-caregivers. We find that this correlation is largely due to selection into caregiving: people in worse health took up care inside while people in better health took up care outside the household. However, in most countries people who started caregiving inside the household experienced a decline in their mental health. This suggests that caregiving inside the household results in psychological stress irrespective of the type of welfare state. The results regarding self-perceived health and caregiving outside the household are less distinct. All in all our

results show that health consequences of caregiving vary not only between different welfare regimes but also between countries of similar welfare state types.