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Assurance maladie / Health Insurance

Handel B.R. (2013). Adverse Selection and Inertia in Health Insurance Markets: When Nudging Hurts. *American Economic Review*, 103 (7) : 2643-2682.

Abstract: This paper investigates consumer inertia in health insurance markets, where adverse selection is a potential concern. We leverage a major change to insurance provision that occurred at a large firm to identify substantial inertia, and develop and estimate a choice model that also quantifies risk preferences and ex ante health risk. We use these estimates to study the impact of policies that nudge consumers toward better decisions by reducing inertia. When aggregated, these improved individual-level choices substantially ex-acerbate adverse selection in our setting, leading to an overall reduction in.

Gunther F., Paul J.R., Ali S., Rainer S. (2013). Does health insurance improve health? *Journal of Health Economics*, 32 (6) : 1043-1056.

Abstract: In 2004, a community-based insurance (CBI) scheme was introduced in Nouna health district, Burkina Faso. We use six years of panel data to evaluate the welfare and health impact of the insurance scheme exploring the random rollout of the program as exogenous source of variation. The average reductions in health expenditure among insurance enrollees are small. The insurance scheme induced a temporary increase in mortality among older community members.

Allen H., Baicker K., Taubman S., Wright B., Finkelstein A. (2013). The Oregon health insurance experiment: when limited policy resources provide research opportunities. *J Health Polit.Policy Law*, 38 (6) : 1183-1192.

Abstract: In 2008 Oregon allocated access to its Medicaid expansion program, Oregon Health Plan Standard, by drawing names from a waiting list by lottery. The lottery was chosen by policy makers and stakeholders as the preferred way to allocate limited resources. At the same time, it also gave rise to the Oregon Health Insurance Experiment: an unprecedented opportunity to do a randomized evaluation - the gold standard in medical and scientific research - of the impact of expanding Medicaid. In this article we provide historical context for Oregon's decision to conduct a lottery, discuss the importance of randomized controlled designs for policy evaluation, and describe some of the practical challenges in successfully capitalizing on the research opportunity presented by the Oregon lottery through public-academic partnerships. Since policy makers will always face tough choices about how to distribute scarce resources, we urge thoughtful consideration of the opportunities to incorporate randomization that can substantially improve the evidence available to inform policy decisions without compromising policy goals.

Economie de la santé / Health Economics

Maynard A. (2013). Health care rationing: doing it better in public and private health care systems. *J Health Polit.Policy Law*, 38 (6) : 1103-1127.

Abstract: All public and private health care systems ration patient access to care. The private sector rations access to consumers who are willing and able to pay. The poor and disadvantaged have limited access to care and inadequate income protection. In public health systems, care is provided on the basis of "need," that is, the comparative cost-effectiveness of competing treatments. This results in patients being deprived of care if treatments are clinically effective but not cost-effective. Rationing health care is ubiquitous. In both types of systems physicians have discretion to deviate from these rationing principles. This has created inefficient variations in clinical practice. These are difficult to

resolve because of the lack of transparency of costs and patient outcomes and perverse incentives. The failure to remove universal inefficiency in a period of economic austerity sharpens awareness of rationing. Hopes of greater efficiency are largely faith based. Competing ideologues from the left and the right continue to offer evidence for free solutions to long-established problems. Inefficiency is unethical, as it deprives potential patients of care from which they could benefit. Reducing inefficiency is essential but difficult. The universal challenge is to decide who shall live when all will die in a world of scarce resources.

Etat de santé / Health Status

Dahlin J., Harkonen J. (2013). Cross-national differences in the gender gap in subjective health in Europe: Does country-level gender equality matter? *Soc Sci Med*, 98 24-28.

Abstract: Multiple studies have found that women report being in worse health despite living longer. Gender gaps vary cross-nationally, but relatively little is known about the causes of comparative differences. Existing literature is inconclusive as to whether gender gaps in health are smaller in more gender equal societies. We analyze gender gaps in self-rated health (SRH) and limiting longstanding illness (LLI) with five waves of European Social Survey data for 191,104 respondents from 28 countries. We use means, odds ratios, logistic regressions, and multilevel random slopes logistic regressions. Gender gaps in subjective health vary visibly across Europe. In many countries (especially in Eastern and Southern Europe), women report distinctly worse health, while in others (such as Estonia, Finland, and Great Britain) there are small or no differences. Logistic regressions ran separately for each country revealed that individual-level socioeconomic and demographic variables explain a majority of these gaps in some countries, but contribute little to their understanding in most countries. In yet other countries, men had worse health when these variables were controlled for. Cross-national variation in the gender gaps exists after accounting for individual-level factors. Against expectations, the remaining gaps are not systematically related to societal-level gender inequality in the multilevel analyses. Our findings stress persistent cross-national variability in gender gaps in health and call for further analysis.

Géographie de la santé / Geography of Health

Wang L., Hu W. (2013). Immigrant health, place effect and regional disparities in Canada. *Soc Sci Med*, 98 8-17.

Abstract: The paper addresses a critically important area in Canadian immigration and health from both a social and a spatial perspective. It employs multilevel and contextual approaches to examine the social determinants of immigrant health as well as the place effects on self-reported health at a regional and neighborhood scale. The data come from the raw microdata file of the 2005-10 Canadian Community Health Survey (a random national health survey) and the publicly available Canadian Marginalization index based on the 2006 Census. Three populations are compared: Canadian-born, overall foreign-born, and Chinese immigrants. The results suggest various degrees of association between self-reported health, individual and lifestyle behavioral characteristics, and neighborhood material deprivation and ethnic concentration in census tracts. These factors contribute differently to the reported health of Chinese immigrants, Canada's largest recent immigrant group. A healthy immigrant effect is partially evident in the overall foreign-born population, but appears to be relatively weak in Chinese immigrants. For all groups, neighborhood deprivation moderately increases the likelihood of reporting poor health. Ethnic concentration negatively affects self-rated health, with the exception of the slight protective effect of Chinese-specific ethnic density in census tracts. The multilevel models reveal significant area inequalities across Census Metropolitan Areas/Census

Agglomerations in risk of reporting unhealthy status, with greater magnitude in the foreign-born population. The vast regional variations in health among Chinese immigrants should be interpreted carefully due to the group's heavy concentration in large cities. The study contributes to the literature on ethnicity and health by systematically incorporating neighborhood contextual effects in modeling the social determinants of immigrant health status. It fills a gap in the literature on neighborhoods and health by focusing on ethnically disparate groups rather than on the general population. By revealing regional disparities in health, the paper adds a spatial perspective to the work on immigrant health.

Hôpital / Hospitals

Schwach V. (2013). Une prospective des soins de suite et de réadaptation. *Gestions hospitalières*, (530) : 528-537.

Abstract: Les soins de suite et de réadaptation (SSR) constituent un secteur sans doute modeste au regard de l'activité hospitalière dans son ensemble et qui a fait jusqu'ici l'objet d'une attention limitée. Pourtant, fort de quelque 90 000 à 100 000 lits, il constitue un maillon utile. La présente réflexion concerne une dimension importante : la prospective. À partir de la mise en mouvement de l'ensemble du système de santé et particulièrement de l'hôpital en raison des évolutions réglementaires et surtout de la pression économique, il est utile de réfléchir au futur. Car, inévitablement, il faudra s'adapter. Il importe alors d'identifier les facteurs susceptibles de forger l'activité de demain.

Mauro M., Cardamone E., Cavallaro G., Minvielle E., Rania F., Sicotte C., Trotta A. (2013). Teaching hospital performance: Towards a community of shared values? *Social Science & Medicine*, 101 (0) : 107-112.

Abstract: This paper explores the performance dimensions of Italian teaching hospitals (THs) by considering the multiple constituent model approach, using measures that are subjective and based on individual ideals and preferences. Our research replicates a study of a French TH and deepens it by adjusting it to the context of an Italian TH. The purposes of this research were as follows: to identify emerging views on the performance of teaching hospitals and to analyze how these views vary among hospital stakeholders. We conducted an in-depth case study of a TH using a quantitative survey method. The survey uses a questionnaire based on Parsons' social system action theory, which embraces the major models of organizational performance and covers three groups of internal stakeholders: physicians, caregivers and administrative staff. The questionnaires were distributed between April and September 2011. The results confirm that hospital performance is multifaceted and includes the dimensions of efficiency, effectiveness and quality of care, as well as organizational and human features. There is a high degree of consensus among all observed stakeholder groups about these values, and a shared view of performance is emerging. Our research provides useful information for defining management priorities to improve the performance of THs.

Holmns T.H., Islam M.K., Kjerstad E. (2013). Interdependency between social care and hospital care: the case of hospital length of stay. *The European Journal of Public Health*, 23 (6) : 927-933.

Abstract: Background: Poor co-ordination and collaboration have been identified by many governments as a major and growing weakness of their health care systems. Better integrated care for the elderly individuals is one field of particular importance. In this study, we ask to what extent local authorities social care services create cost externalities by prolonging hospital length of stay (LOS) because of inadequate service capacity and/or service quality. Methods: The data set is constructed by merging in-patient data from the Norwegian Patient Register with Statistics Norway local authority variables for the period from 2007 to 2009. The sample includes 386 000 observations of in-patients aged 67 years. Using the quantile regression (QR) technique, we analyse the impact of social care services along the entire distribution of LOS. The QR estimates are compared with ordinary least square estimates (OLS). Patient variables in the analyses include age, gender and

case-mix variables. Hospital and time-fixed effects are also controlled for variables. Results: More resources to the social care services give shorter LOS, and the QR analysis shows that resources matter more for patients in the long tail of the distribution compared with those in the lower quantiles. LOS is longer for patients with change of residence after discharge from hospital compared with those patients that do not change residence. Conclusions: Increased supply of social care services contributes to a reduction in aggregate societal costs of treatment and nursing of elderly patients by shortening comparatively costly hospital LOS.

Borda-Olivas A., Fernandez-Navarro P., Otero-Garcia L., Sanz-Barbero B. (2013). Rurality and avoidable hospitalization in a Spanish region with high population dispersion. *The European Journal of Public Health*, 23 (6) : 946-951.

Abstract: Background: This study analyses the association between rurality and local rate of avoidable hospitalizations in a Spanish region with high population dispersion. Methods: Ecological study using a municipality in the region of Castile and Leon (Spain) as the spatial unit of analysis. The variables used to operationalize rurality included the following: distance to hospital, population density, mean socio-economic level and percentage of the population aged >65 years. We calculated relative risk (RR) and 95% confidence intervals (CI) using the conditional autoregressive spatial model proposed by Besag, York and Mollié, with explanatory variables. Results: The number of avoidable hospitalizations was 9923 or 4.5% of all admissions. The age- and gender-adjusted avoidable hospitalization rate was 4.06 per 1000 persons. Spatial analysis showed that two variables, distance from municipality of residence to reference hospital and percentage of population aged >65 years were inversely associated with risk for avoidable hospitalization [RR=0.996 (95% CI 0.993-0.999) and RR=0.989 (95% CI 0.982-.996), respectively]. Conclusions: It is important to determine whether these lower avoidable hospitalization rates reflect an adequate level of accessibility and quality of primary care health services for rural populations or, in the contrary, they reveal access barriers to hospital care.

De Bruijne M.C., Van Rosse F., Uiters E., Droomers M.I., Suurmond J., Stronks K., Essink-Bot M.L. (2013). Ethnic variations in unplanned readmissions and excess length of hospital stay: a nationwide record-linked cohort study. *The European Journal of Public Health*, 23 (6) : 964-971.

Abstract: Background: Studies in the USA have shown ethnic inequalities in quality of hospital care, but in Europe, this has never been analysed. We explored variations in indicators of quality of hospital care by ethnicity in the Netherlands. Methods: We analysed unplanned readmissions and excess length of stay (LOS) across ethnic groups in a large population of hospitalized patients over an 11-year period by linking information from the national hospital discharge register, the Dutch population register and socio-economic data. Data were analysed with stepwise logistic regression. Results: Ethnic differences were most pronounced in older patients: all non-Western ethnic groups > 45 years had an increased risk for excess LOS compared with ethnic Dutch patients, with odds ratios (ORs) (adjusted for case mix) varying from 1.05 [95% confidence intervals (95% CI) 1.02-1.08] for other non-Western patients to 1.14 (95% CI 1.07-1.22) for Moroccan patients. The risk for unplanned readmission in patients >45 years was increased for Turkish (OR 1.24, 95% CI 1.18-1.30) and Surinamese patients (OR 1.11, 95% CI 1.07-1.16). These differences were explained partially, although not substantially, by differences in socio-economic status. Conclusion: We found significant ethnic variations in unplanned readmissions and excess LOS. These differences may be interpretable as shortcomings in the quality of hospital care delivered to ethnic minority patients, but exclusion of alternative explanations (such as differences in patient- and community-level factors, which are outside hospitals control) requires further research. To quantify potential ethnic inequities in hospital care in Europe, we need empirical prospective cohort studies with solid quality outcomes such as adverse event rates.

Davies S.M., Saynina O., McDonald K.M., Baker L.C. (2013). Limitations of using same-hospital readmission metrics. *Int J Qual. Health Care*, 25 (6) : 633-639.

Abstract: OBJECTIVE: To quantify the limitations associated with restricting readmission metrics to same-hospital only readmission. DESIGN: Using 2000-2009 California Office of Statewide Health Planning and Development Patient Discharge Data Nonpublic file, we identified the proportion of 7-, Pôle documentation de l'Irdes / Irdes Documentation centre - Safon M.-O., Suhard V. Page 10 sur 26

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15- and 30-day readmissions occurring to the same hospital as the initial admission using All-cause Readmission (ACR) and 3M Corporation Potentially Preventable Readmissions (PPR) Metric. We examined the correlation between performance using same and different hospital readmission, the percent of hospitals remaining in the extreme deciles when utilizing different metrics, agreement in identifying outliers and differences in longitudinal performance. Using logistic regression, we examined the factors associated with admission to the same hospital. RESULTS: 68% of 30-day ACR and 70% of 30-day PPR occurred to the same hospital. Abdominopelvic procedures had higher proportions of same-hospital readmissions (87.4-88.9%), cardiac surgery had lower (72.5-74.9%) and medical DRGs were lower than surgical DRGs (67.1 vs. 71.1%). Correlation and agreement in identifying high- and low-performing hospitals was weak to moderate, except for 7-day metrics where agreement was stronger ($r = 0.23-0.80$, Kappa = 0.38-0.76). Agreement for within-hospital significant ($P < 0.05$) longitudinal change was weak (Kappa = 0.05-0.11). Beyond all patient refined-diagnostic related groups, payer was the most predictive factor with Medicare and Medical patients having a higher likelihood of same-hospital readmission (OR 1.62, 1.73). CONCLUSIONS: Same-hospital readmission metrics are limited for all tested applications. Caution should be used when conducting research, quality improvement or comparative applications that do not account for readmissions to other hospitals.

Wright P.N., Tan G., Iliffe S., Lee D. (2014). The impact of a new emergency admission avoidance system for older people on length of stay and same-day discharges. *Age and Ageing*, 43 (1) : 116-121.

Abstract: Background: unplanned hospital admissions of older patients continue to attract the attention of UK policymakers, advisors and media. Reducing the number and length of stay (LOS) of these admissions has the potential to save NHS substantial costs while reducing iatrogenic risks. Some NHS trusts have introduced geriatric admission-avoidance systems, but evidence of their effectiveness is lacking. In September 2010, The Royal Free Hospital and Haverstock Healthcare Ltd, a GP provider organisation, introduced an admission-avoidance system for patients aged 70 or over: the Triage and Rapid Elderly Assessment Team (TREAT). Objective: to measure the effect of TREAT on LOS and the rate of same-day discharges (an inverse measure of admission rate). Setting: TREAT was based in the Accident and Emergency (A&E) department of the Royal Free Hospital, London. Design: a pre- and post-retrospective cohort study comparing the 5,416 emergency geriatric admissions in the 12 months preceding the introduction of TREAT with the 5,370 emergency geriatric admissions in the 12 months following. Emergency geriatric admissions were divided into TREAT-matching and residual (non-matching) cohorts from hospital provider spell records, using the Healthcare Resource Group (HRG), treatment function and patient classification of the TREAT admissions. LOS and same-day discharge rates were measured over the pre- and post-TREAT periods: for the TREAT-matching cohort; for the residual cohort of emergency geriatric admissions; and for all emergency geriatric admissions. Intervention: TREAT is a system of care combining early Accident and Emergency (A&E)-based senior doctor review, Comprehensive Geriatric Assessment (CGA), therapist assessment and supported discharge; post-discharge supported recovery; and a rapid access geriatric "hot-clinic". TREAT was supported by a post-acute care enablement (PACE) team, providing short-term nursing support immediately following discharge. Results: TREAT accepted 593 geriatric admissions over a 12-month period, of which 32.04% were discharged on the day of admission. The mean LOS was 4.41 days, and the median LOS was 1 day. After the introduction of TREAT, mean LOS reduced by 18.16% (1.78 days, $P < 0.001$) for TREAT-matching admissions; by 11.65% (1.13 days, $P < 0.001$) for all emergency geriatric admissions; and by 1.08% (0.11 days, $P = 0.065$) for the residual population. Over the same period, the percentage of admissions resulting in same-day discharges increased from 12.26 to 16.23% (OR: 1.386, 95% CI: 1.203-1.597, $P < 0.001$) for TREAT-matching admissions, but for the residual population fell from 15.01 to 9.77% (OR: 0.613, $P < 0.001$, 95% CI: 0.737-0.509). Conclusions: TREAT appears to have reduced avoidable emergency geriatric admissions, and to have shortened LOS for all emergency geriatric admissions. It aims to address the King's Fund's call for an overall system of care rather than lots of discrete processes through "better design and co-ordination of services following the needs of older people". The ease of set-up lends itself to replication and testing in clinical and cost-effectiveness studies. Further studies are needed to measure the impact of TREAT on re-admission rates, patient outcomes and satisfaction.

Evans S.J., Sayers M., Mitnitski A., Rockwood K. (2014). The risk of adverse outcomes in hospitalized older patients in relation to a frailty index based on a comprehensive geriatric assessment. *Age and Ageing*, 43 (1) : 127-132.

Abstract: Background: prognostication for frail older adults is complex, especially when they become seriously ill. Objectives: to test the measurement properties, especially the predictive validity, of a frailty index based on a comprehensive geriatric assessment (FI-CGA) in an acute care setting in relation to the risk of death, length of stay and discharge destination. Design and setting: prospective cohort study. Inpatient medical units in a teaching, acute care hospital. Subjects: individuals on inpatient medical units in a hospital, n = 752, aged 75+ years, were evaluated on their first hospital day; to test reliability, a subsample (n = 231) was seen again on Day 3. Measurements: all frailty data collected routinely as part of a CGA were used to create the FI-CGA. Mortality data were reviewed from hospital records, claims data, Social Security Death Index and interviews with Discharge Managers. Results: thirty-day mortality was 93 (12.4%; 95% confidence interval (CI) = 10-15%) of whom 52 died in hospital. The risk of dying increased with each 0.01 increment in the FI-CGA: hazard ratio (HR) = 1.05, (95% CI = 1.04-1.07). People who were discharged home had the lowest admitting mean FI-CGA = 0.38 (-|standard deviation 0.11) compared with those who died, FI-CGA = 0.51 (-|0.12) or were discharged to nursing home, FI-CGA = 0.49 (-|0.11). Likewise, increasing FI-CGA values on admission were significantly associated with a longer length of hospital stay. Conclusions: frailty, measured by the FI-CGA, was independently associated with a higher risk of death and other adverse outcomes in older people admitted to an acute care hospital.

Inégalités de santé / Health Inequalities

Desprès C. (2013). Significations du renoncement aux soins : une analyse anthropologique. *Sciences sociales et Santé*, 31 (2) : 71-96.

Abstract: Le renoncement aux soins, concept récemment introduit dans les enquêtes de l'Institut de recherche et de documentation en économie de la santé (IRDES), constitue aujourd'hui un indicateur d'évaluation des politiques publiques, notamment en termes d'équité d'accès aux soins. Non définie par les décideurs et les enquêteurs, cette notion fait l'objet de diverses définitions de la part des experts. Cet article vise à les clarifier, puis à analyser les significations attribuées par les non-experts, sujets potentiels des enquêtes, et désignées comme significations profanes. Nous nous sommes appuyés sur des entretiens approfondis en mobilisant les concepts et les méthodes anthropologiques. Les résultats montrent d'abord l'absence du « renoncement aux soins » dans le langage ordinaire. Une fois introduit, il fait l'objet de représentations variées. Nous distinguons deux catégories, le renoncement-refus et le renoncement-barrière, renvoyant à des significations différentes mais articulées entre elles. Ces différentes significations sont mobilisées de manière variable en fonction, notamment, des expériences vécues dans les parcours de soins, des modalités de questionnement, du contexte d'énonciation.

Musso S. (2013). A propos des façonnements sociaux du renoncement aux soins : commentaire. *Sciences sociales et Santé*, 31 (2) : 97-102.

Abstract: Dans son voyage au cœur de la « crise » en France par l'expérience des contrats intérimaires de femme de ménage et la restitution qu'elle y a consacré, Florence Aubenas livre, dans *Le quai de Ouistreham*, un chapitre dont le titre, *Les dents*, fait transition avec les derniers paragraphes de l'article de C. Desprès. Il y est question de Marilou, jeune femme vivant de ces contrats précaires, que l'auteur a rencontrée en faisant des ménages avec elle dans la région de Caen. Marilou « a mal aux dents, elle a toujours eu mal aux dents. Dans ces cas-là, le dentiste lui semble la plus périlleuse des solutions. Trop compliqué, trop douloureux, trop cher, une idée d'un autre monde en somme...

Lang T. (2013). "On ne peut pas se contenter d'accumuler des données d'observation pour réduire les inégalités". *Santé en action (La)*, (425) : 19-20.

Abstract: Formé aux sciences « dures », Thierry Lang est devenu un spécialiste des inégalités sociales de santé et s'est peu à peu intéressé aux sciences humaines et à la recherche interventionnelle. Initiateur du programme de recherche interventionnelle AAPRISS, il raconte son parcours de chercheur. Pour que les interventions visant à réduire les inégalités soient efficaces, il plaide pour un « *faire ensemble* » avec les décideurs et les acteurs de terrain. Et pour que les chercheurs travaillent en interdisciplinarité.

(2013). Renoncement aux soins : pas seulement financiers. *Revue Prescrire*, 33 (362) : 944.

Neutens T., Vyncke V., De Winter D., Willems S. (2013). Neighborhood differences in social capital in Ghent (Belgium): a multilevel approach. *International Journal of Health Geographics*, 12 (1) : 52.

Abstract: BACKGROUND: Little research has focused on the spatial distribution of social capital, despite social capital's rising popularity in health research and policy. This study examines the neighborhood differences in social capital and the determinants that explain these differences. METHODS: Five components of neighborhood social capital are identified by means of factor and reliability analyses using data collected in the cross-sectional SWING study from 762 inhabitants in 42 neighbourhoods in the city of Ghent (Belgium). Neighborhood differences in social capital are explored using hierarchical linear models with cross-level interactions. RESULTS: Significant neighborhood differences are found for social cohesion, informal social control and social support, but not for social leverage and generalized trust. Our findings suggest that neighborhood social capital depends on both characteristics of individuals living in the neighborhood (attachment to neighborhood) and characteristics of the neighborhood itself (deprivation and residential turnover). Our analysis further shows that neighborhood deprivation reinforces the negative effect of declining neighborhood attachment on social cohesion and informal social control. CONCLUSIONS: This study foregrounds the importance of contextual effects in encouraging neighborhood social capital. Given the importance of neighborhood-level characteristics, it can be anticipated social capital promoting initiatives are likely to be more effective when tailored to specific areas. Second, our analyses show that not all forms of social capital are influenced by contextual factors to the same extent, implying that changes in neighborhood characteristics are conducive to, say, trust while leaving social support unaffected. Finally, our analysis has demonstrated that complex interrelationships between individual- and neighborhood-level variables exist, which are often overlooked in current work.

Essink-Bot M.L., Lamkaddem M., Jellema P., Nielsen S.S., Stronks K. (2013). Interpreting ethnic inequalities in healthcare consumption: a conceptual framework for research. *The European Journal of Public Health*, 23 (6) : 922-926.

Abstract: Background: The increasing diversity of the Western-European population demands identification of potential ethnic healthcare inequities. We developed a framework that helps researchers in interpreting ethnic inequalities in healthcare consumption in equity terms. From this framework, we develop recommendations for the design of future studies. Methods: The framework was developed by analysing three typical studies on ethnic inequalities in healthcare consumption with respect to the potential of interpreting their results as healthcare inequities. Results: Analysing the effects of ethnic variations in healthcare consumption on health outcomes provides important clues about the presence of potential ethnic healthcare inequities. Interpretation of ethnic variations in healthcare consumption as potentially inequitable requires appropriate adjustment for medical need for healthcare, patient preferences and treatment adherence. Because of the central position of medical need, studies need to be disease-specific and based on standardized assessment of risk factors and disease characteristics. A longitudinal study design is necessary to prevent reverse causation. Conclusion: The framework shows that ethnic inequalities in healthcare consumption can be justified if healthcare received meets the need for healthcare in all groups and is in accordance with informed patient preferences. It also shows that ethnic equality in healthcare consumption may hide healthcare inequities. We recommend further research on ethnic healthcare inequities using multi-ethnic cohort designs combined with linkage to healthcare registries. We also recommend research to identify clinically relevant ethnic differences in disease profiles and optimization of treatment regimens.

Vikum E., Bjorngaard J.H., Westin S., Krokstad S. (2013). Socio-economic inequalities in Norwegian health care utilization over 3 decades: the HUNT Study. *The European Journal of Public Health*, 23 (6) : 1003-1010.

Abstract: Background: The aim of this study was to investigate socio-economic inequalities in health care utilization from the 1980s and through the last 3 decades in a Norwegian county population. Methods: Altogether, 166 758 observations of 97 251 individuals during surveys in 1984–86 (83% eligible responses), 1995–97 (51% eligible responses) and 2006–08 (50% eligible responses) of the total population of adults (≥ 20 years) from Nord-trøndelag county in Norway were included. Health care utilization was measured as at least one visit to general practitioner (GP), hospital outpatient services and inpatient care in the past year. Socio-economy was measured by both education and income and rescaled to measure relative indexes of inequality (RII). Relative and absolute inequalities were estimated from multilevel logistic regression. Estimates were adjusted for age, sex, municipality size and self-reported health. Results: GP utilization was higher among individuals with higher education in 1984–86. Among men the RII was 0.54 (CI: 0.48–0.62), and among women RII was 0.67 (CI: 0.58–0.77). In 2006–08, the corresponding RII was 1.31 (CI: 1.13–1.52) for men and 1.00 (CI: 0.85–1.18) for women, indicating higher or equal GP utilization among those with lower education, respectively. The corresponding RIIs for outpatient consultations were 0.58 (CI: 0.49–0.68) for men and 0.40 (CI: 0.34–0.46) for women in 1984–86, and 0.53 (CI: 0.46–0.62) for men and 0.47 (CI: 0.41–0.53) for women in 2006–08. Conclusion: Through the last 3 decades, the previous socio-economic differences in GP utilization have diminished. Despite this, highly educated people were more prone to utilize hospital outpatient consultations throughout the period 1984–2008.

Simons A.M., Groffen D.A., Bosma H. (2013). Socio-economic inequalities in all-cause mortality in Europe: an exploration of the role of heightened social mobility. *The European Journal of Public Health*, 23 (6) : 1010-1012.

Abstract: The larger than expected socio-economic inequalities in health in more egalitarian countries might be explained by a heightened social mobility in these countries. Therefore, the aim of this explorative study was to examine the associations between country-level social mobility, income inequality and socio-economic differences in all-cause mortality, using country-level secondary data from 12 European countries. Both income equality and social mobility were found to be associated with larger socio-economic differences in mortality, particularly in women. These findings suggest that social mobility and income equality, beside their shiny side of improving population health, might have a shady side of increasing socio-economic health inequalities.

Bien B, McKee KJ, Döhner H, Triantafillou J, Lamura G, Doroszkiewicz H, Krevers B, Kofahl C. (2013). Disabled older people' use of health and social care services and their unmet care needs in six European countries. *The European Journal of Public Health*, 23 (6) : 1032-1038.

Abstract: Background: The national health and social care systems in Europe remain poorly integrated with regard to the care needs of older persons. The present study examined the range of health and social care services used by older people and their unmet care needs, across six European countries. Methods: Family carers of older people were recruited in six countries via a standard protocol. Those providing care for disabled older people ($n = 2629$) provided data on the older persons' service use over a 6-month period, and their current unmet care needs. An inventory of 21 services common to all six countries was developed. Analyses considered the relationship between older peoples' service use and unmet care needs across countries. Results: Older people in Greece, Italy and Poland used mostly health-oriented services, used fewer services overall and also demonstrated a higher level of unmet care needs when compared with the other countries. Older people in the United Kingdom, Germany and Sweden used a more balanced profile of socio-medical services. A negative relationship was found between the number of different services used and the number of different areas of unmet care needs across countries. Conclusions: Unmet care needs in older people are particularly high in European countries where social service use is low, and where there is a lack of balance in the use of health and social care services. An expansion of social care services in these countries might be the most effective strategy for reducing unmet needs in disabled older people.

Tallarek Nee Grimm M.J., Helgesen M.K., Fosse E. (2013). Reducing social inequities in health in Norway: Concerted action at state and local levels? *Health Policy*, 113 (3) : 228-235.

Abstract: Norwegian national policies have been distinguished by their focus on equity, contributing to comprehensive policies to reduce the social inequities in health (SIH). The newly adopted Public health act, which aims at reducing the SIH, endorses these acknowledgements while highlighting the importance of municipalities as the key actors in public health. Municipal obligations include inter-sectoral policies for health, health impact assessments (HIA), and the development of local health overviews. Against the background of a system of local autonomy in Norway, this article illuminates whether, and how, municipal public health policies reflect national priorities. Our data are based on one qualitative study, combining document content analysis and expert interviews conducted in 2011, and one quantitative questionnaire sent to municipal chief administrative officers in 2011. Our findings indicate a divide between national and municipal public health strategies. Many municipalities focus on life-style and health-care related measures. Only few municipalities acknowledge the social determinants of health and have implemented HIA and health overviews. Arguing for the importance of concerted multi-level action to reduce the SIH, we need to better understand the gap between national and municipal approaches. We thus suggest further research to illuminate the challenges and success factors faced at local levels.

Médicaments / Pharmaceuticals

Clerc P., Le Breton J. (2013). Prescription médicamenteuse et polyopathologies chroniques. *Sciences sociales et Santé*, 31 (3) : 71-101.

Abstract: Dans un contexte de dépenses de santé croissantes, de scandales pharmaceutiques, d'émergence de patients polyopathologiques chroniques, la prescription des médecins généralistes est régulièrement remise en cause. Mais la gestion au quotidien du patient polyopathologique par ces praticiens est mal connue. Nous avons donc réunis 60 médecins généralistes, pendant une journée, pour, d'une part, réfléchir sur leur pratique et, d'autre part, discuter en groupes de pairs autour de diagnostics et de prescriptions réelles de patients polyopathologiques chroniques. Les résultats présentés ici montrent le réseau complexe qui se noue en arrière fond de la relation médecin-malade dans ce contexte. La conclusion est qu'il ne sera pas possible d'améliorer la prise en charge de ces patients en ambulatoire sans une réorganisation majeure du système de soins et un changement culturel dans la coopération entre professionnels de santé.

Letourny A. (2013). Les contraintes d'une profession médicale. *Sciences sociales et Santé*, 31 (3) : 103-111.

Abstract: L'article de P. Clerc et J. Le Breton analyse ce que disent les médecins généralistes de la prescription médicamenteuse des patients polyopathologiques. Le thème qu'ils abordent est incontestablement pertinent, car il représente à la fois un enjeu économique - pour l'Assurance maladie - et un enjeu de santé publique - pour les patients concernés.

(2013). La fabrique des DCI. 3e partie : des obstacles à la portée universelle des DCI. *Revue Prescrire*, 33 (362) : 936-942.

San Miguel L., Baeten R., Remmen R., Busse R., Gil J., Knai C., Maikinen M., Rubert G., McKee M. (2013). Obstacles to the recognition of medical prescriptions issued in one EU country and presented in another. *The European Journal of Public Health*, 23 (6) : 972-974.

Abstract: A study involving the presentation of 192 Belgian or Finnish prescriptions in pharmacies in five other member states was undertaken to assess whether, as envisaged by European Union law, prescriptions issued in one member state are dispensed by pharmacists in another and to identify

factors that influence such decisions. Overall, pharmacists were willing to dispense in 108 cases. Detailed results show important differences depending on the country where prescriptions are presented and whether prescriptions were written by International Nonproprietary Name and in English, as opposed to prescriptions written by brand in a national language.

Danzon P., Towse A., Mestre-Ferrandiz J. (2013). Value-based differential pricing, efficient prices for drugs in a global context. *Health Economics*, Ahead of pub.

Abstract: This paper analyzes pharmaceutical pricing between and within countries to achieve second-best static and dynamic efficiency. We distinguish countries with and without universal insurance, because insurance undermines patients' price sensitivity, potentially leading to prices above second-best efficient levels. In countries with universal insurance, if each payer unilaterally sets an incremental cost-effectiveness ratio (ICER) threshold based on its citizens' willingness-to-pay for health; manufacturers price to that ICER threshold; and payers limit reimbursement to patients for whom a drug is cost-effective at that price and ICER, then the resulting price levels and use within each country and price differentials across countries are roughly consistent with second-best static and dynamic efficiency. These value-based prices are expected to differ cross-nationally with per capita income and be broadly consistent with Ramsey optimal prices. Countries without comprehensive insurance avoid its distorting effects on prices but also lack financial protection and affordability for the poor. Improving pricing efficiency in these self-pay countries includes improving regulation and consumer information about product quality and enabling firms to price discriminate within and between countries.

Sommet A., Georgel B., Poutrain J.C., Oustric S., Bourrel R., Montastruc J.L., Birebent J. (2013). [Generic substitution in primary care in 2011: Differences according to pharmacological classes?]. *Rev Epidemiol Santé Publique*, 61 (6) : 539-544.

Abstract: BACKGROUND: Generic substitution has been permitted for several years in France and is promoted in order to reduce health expenditures. However, reluctance concerning use of generic drugs exists for different reasons: suspicions about their efficacy and/or safety, differences in content (excipients) and discussions about bioequivalency. The aim of our study was to determine whether or not the substitution ratio differs according to pharmacological classes used in primary care. METHODS: We conducted a descriptive study in the French Health Insurance Database using reimbursement data on drugs prescribed and delivered in the Midi-Pyrenees administrative district between March 2010 and March 2011. We selected different pharmacological classes largely used in primary care. For each class, a substitution ratio was calculated (DDD of generics delivered/DDD of brand name plus generics). A Chi(2) test was used in order to detect a difference between these substitution ratios. RESULTS: The global substitution ratio was 72.32%. Values varied from 28.36% for thyroid hormones to 90.39% for antibiotics, with significant statistical difference ($P < 0.001$). The substitution ratio was less than 50% for thyroid hormones (28.36%) and antiepileptics (45.28%). Higher substitution ratios were observed for protein pump inhibitors (88.81%), statins (87.81%), antidepressors (87.37%) and diuretics (86.1%). CONCLUSION: This study highlights major differences in terms of the generic substitution ratio between different pharmacological classes. This difference can be explained in part by published guidelines. Further studies are needed to ascertain the precise point of view of patients, general practitioners and pharmacists concerning this issue.

Babar Z.U., Lessing C., Mace C., Bissell K. (2013). The availability, pricing and affordability of three essential asthma medicines in 52 low- and middle-income countries. *PharmacoEconomics*, 31 (11) : 1063-1082.

Abstract: BACKGROUND: Almost 300 million people suffer from asthma, yet many in low- and middle-income countries have difficulty accessing essential asthma medicines. Availability, price and affordability of medicines are likely to affect access. Very few studies have included asthma medicines, particularly inhaled corticosteroids, in these countries. Reflections about international reference prices (IRPs) are generally absent from pricing studies, yet some IRPs may be masking the extent of access problems. OBJECTIVES: Our objective was to determine the availability, pricing and affordability of beclometasone, budesonide and salbutamol, the three asthma medicines on the World Health Organization's Model List of Essential Medicines (EML) in selected low- and middle-income countries and to reflect on the appropriateness of using IRPs. METHODS: A cross-sectional pricing

survey was conducted in 52 countries. Data were collected on country demographics including national currency, \$US exchange rate and daily wage of the lowest-paid unskilled government worker. Pricing and availability data were collected for salbutamol, beclometasone and budesonide in two private retail pharmacies, the national procurement centre and a main public hospital. RESULTS: Availability was particularly poor for corticosteroids, and worse in national procurement centres and main hospitals. The surveyed strength of beclometasone was only on the EML of ten countries. Considerable variability was found in pricing and affordability across countries. Procurement systems appeared largely inefficient when Asthma Drug Facility prices were applied as references. Some countries appear to be subsidising asthma medicines, making them free or less expensive for patients, while other countries are applying very high margins, which can significantly increase the price for patients unless a reimbursement system exists. CONCLUSIONS: Findings raise important policy concerns. Availability of inhaled corticosteroids is poor; many EMLs are not updated; IRPs can be misleading; health systems and patients are paying more than necessary for asthma medicines, which are unaffordable for many patients in many countries.

Drummond M. (2013). Twenty years of using economic evaluations for drug reimbursement decisions: what has been achieved? *J Health Polit. Policy Law*, 38 (6) : 1081-1102.

Abstract: The objective of this article is to examine the impact of economic evaluation on the reimbursement process for pharmaceuticals. The changes in the structure of reimbursement policies necessary to incorporate economic evaluation have been accomplished without major difficulty in most jurisdictions. However, several methodological differences in international guidelines for economic evaluation exist, only some of which can easily be justified. A number of beneficial changes in reimbursement processes have also been observed, such as a trend toward requiring the measurement of more meaningful clinical end points and increased engagement between manufacturers, drug regulators, and payers. A consistent finding in studies of reimbursement decisions is that economic considerations have been influential, second only to the strength of the clinical evidence for the drug of interest. The impact of economic evaluation on the allocation of health care resources is hard to ascertain because little is known about the extent to which reimbursement decisions actually lead to changes in health care practice. However, there is evidence that economic evaluation has assisted price negotiations and enabled reimbursement agencies to target drugs to those patients who will benefit the most.

Levaggi R. (2014). Pricing schemes for new drugs: A welfare analysis. *Social Science & Medicine*, 102 (0) : 69-73.

Abstract: Abstract Drug price regulation is acquiring increasing significance in the investment choices of the pharmaceutical sector. The overall objective is to determine an optimal trade-off between the incentives for innovation, consumer protection, and value for money. However, price regulation is itself a source of distortion. In this study, we examine the welfare properties of listing through a bargaining process and value-based pricing schemes. The latter are superior instruments to uncertain listing processes for maximising total welfare, but the distribution of the benefits between consumers and the industry depends on rate of rebate chosen by the regulator. However, through an appropriate choice, it is always possible to define a value-based pricing scheme with risk sharing, which both consumers and the industry prefer to an uncertain bargaining process.

McMahon C.G., Cahir C.A., Kenny R.A., Bennett K. (2014). Inappropriate prescribing in older fallers presenting to an Irish emergency department. *Age and Ageing*, 43 (1) : 44-50.

Abstract: Background: certain medications increase falls risk in older people. Objective: to assess if prescribing modification occurs in older falls presenting to an emergency department (ED). Design: before-and-after design: presentation to ED with a fall as the index event. Subjects: over 70's who presented to ED with a fall over a 4-year period. Methods: dispensed medication in the 12 months pre- and post-fall was identified using a primary care reimbursement services pharmacy claims database. Screening Tool of Older Person's PIP (STOPP) and Beers prescribing criteria were applied to identify potentially inappropriate prescribing (PIP). Polypharmacy was defined as four or more regular medicines. Psychotropic medication was identified using the WHO Anatomical Therapeutic Chemical classification system. Changes in prescribing were compared using McNemar's test (significance $P <$

0.05).Results: One thousand sixteen patients were eligible for analysis; 53.1% had at least one STOPP criteria pre-fall with no change post-fall (53.7%, $P = 0.64$). Beers criteria were identified in 44.0% pre-fall, with no change post-fall (41.5%, $P = 0.125$). The most significant individual indicators to change were neuroleptics, which decreased from 17.5 to 14.7% ($P = 0.02$) and long-acting benzodiazepines decreased from 10.7 to 8.6% ($P = 0.005$). Polypharmacy was observed in 63% and was strongly predictive of PIP, OR 4.0 (95% CI 3.0, 5.32). A high prevalence of psychotropic medication was identified pre-fall: anxiolytics (15.7%), antidepressants (26%), hypnotics (30%). New initiation of anxiolytics and hypnotics occurred in 9% and 15%, respectively, post-fall.Conclusion: a significant prevalence of PIP was observed in older fallers presenting to the ED. No substantial improvements in PIP occurred in the 12 months post-fall, suggesting the need for focused intervention studies to be undertaken in this area.

Méthodologie – Statistique / Methodology – Statistics

Blangiardo M., Cameletti M., Baio G., Rue H. (2013). Spatial and spatio-temporal models with R-INLA. *Spatial and Spatio-temporal Epidemiology*, 7 (0) : 39-55.

Abstract: Abstract During the last three decades, Bayesian methods have developed greatly in the field of epidemiology. Their main challenge focuses around computation, but the advent of Markov Chain Monte Carlo methods (MCMC) and in particular of the WinBUGS software has opened the doors of Bayesian modelling to the wide research community. However model complexity and database dimension still remain a constraint. Recently the use of Gaussian random fields has become increasingly popular in epidemiology as very often epidemiological data are characterised by a spatial and/or temporal structure which needs to be taken into account in the inferential process. The Integrated Nested Laplace Approximation (INLA) approach has been developed as a computationally efficient alternative to MCMC and the availability of an R package (R-INLA) allows researchers to easily apply this method. In this paper we review the INLA approach and present some applications on spatial and spatio-temporal data.

Demarest S., Van der Heyden J., Charafeddine R., Tafforeau J., Van Oyen H., Van Hal G. (2013). Socio-economic differences in participation of households in a Belgian national health survey. *The European Journal of Public Health*, 23 (6) : 981-985.

Abstract: Background: Socio-economic inequalities in health survey participation can jeopardize the extrapolation of the survey findings to the total population. Earlier research, based on aggregated data, showed that in Belgium less-educated people with poor health were less likely to participate in a health survey. In this article, the association by socio-economic status and household non-response in a health survey is examined. Methods: A linkage between the Belgian Health Survey 2001 with Census 2001 enabled us to evaluate the participation by socio-economic status. Results: We observed that the socio-economic position was a determinant of health survey participation: participation rate was significantly lower in households with a lower socio-economic profile. Conclusion: Socio-economic inequalities in participation can introduce a bias in the health survey findings. Strategies targeting improvement of the participation of lower socio-economic groups need to be considered.

Bekker-Grob E., Rose J., Bliemer M. (2013). A Closer Look at Decision and Analyst Error by Including Nonlinearities in Discrete Choice Models: Implications on Willingness-to-Pay Estimates Derived from Discrete Choice Data in Healthcare. *PharmacoEconomics*, 31 (12) : 1169-1183.

Abstract: Background : Most researchers in health economics cite random utility theory (RUT) when analysing discrete choice experiments (DCEs). Under RUT, the error term is associated with the

analyst's inability to properly capture the true choice processes of the respondent as well as the inconsistency or mistakes arising from the respondent themselves. Under such assumptions, it stands to reason that analysts should explore more complex nonlinear indirect utility functions, than currently used in healthcare, to strive for better estimates of preferences in healthcare. Objective : To test whether complex indirect utility functions decrease error variance for models that either implicitly (i.e. the multinomial logit (MNL) model) or explicitly (i.e. entropy multinomial logit (EMNL) model) account for error variance in health(care)-related DCEs; and to determine the impact of complex indirect utility functions on willingness-to-pay (WTP) measures. Methods: Using data from DCEs aimed at healthcare-related decisions, we empirically compared (1) complex and simple indirect utility specifications in terms of goodness of fit, (2) their impact on WTP measures, including confidence intervals (CIs) based on the Delta method, the Krinsky and Robb-procedure, and Bootstrapping, and (3) MNL and EMNL model results. Results : Complex indirect utility functions had a better model fit than simple specifications ($p < 0.05$). WTP estimates were quite similar across alternative specifications. The Delta method produced the most narrow CIs. The EMNL model showed that respondents apply simplifying strategies when answering DCE questions. Conclusion : Complex indirect utility functions reduce error arisen from researchers, which can have important implications for measures in healthcare such as the WTP, whereas EMNL provides insights into the behaviour of respondents when answering DCEs. Understanding how respondents answer DCE questions may allow researchers to construct DCEs that minimise scale differences, so that the decision error made across respondents is more homogeneous and therefore taken out as additional noise in the data. Hence, better estimates of preferences in healthcare can be provided.

Colonna M., Sauleau E.A. (2013). How to interpret and choose a Bayesian spatial model and a Poisson regression model in the context of describing small area cancer risks variations. *Rev Epidemiol Santé Publique*, 61 (6) : 559-567.

Abstract: BACKGROUND: The statistical Bayesian approach is widely used in disease mapping and Poisson regression. Results differ depending on the underlying hypothesis. Our objective is to give a comprehensive presentation of the tools that can be used to interpret results and choose between the different hypotheses. Data from the Isere cancer registry (France) illustrate this presentation. METHOD: We consider, first, Bayesian models for disease mapping. Classic heterogeneity (Potthoff-Whithinghill statistic) and spatial autocorrelation tests (Moran statistic) of the SIRs, the DIC criteria of the different Bayesian models and finally the comparison of the empirical variance of the unstructured and structured heterogeneity components of the BYM model are considered. The last two criteria are considered for Bayesian Poisson regression including a covariate. Mapping the components of the BYM model with a covariate is also considered. RESULTS: Four cancer sites (prostate, lung, colon-rectum and bladder) in men diagnosed during the 1998-2007 period are used to illustrate our presentation. We show that the different criteria used to interpret and to choose a model give coherent results. CONCLUSION: A relevant interpretation of results is a necessary step in choosing the best-adapted Bayesian model. This choice is easy to make with criteria such as the DIC. The comparison of the empirical variance of the unstructured and structured heterogeneity components of the BYM model is also informative.

Politique de santé / Health Policy

Vayssette P. (2013). PLFSS 2014 : des expérimentations. *Réseaux, Santé et Territoires*, (52) : 8-9.

Abstract: Le projet de loi de financement de la sécurité sociale pour 2014 prolonge et annonce des nouvelles expérimentations figurant dans la Stratégie nationale de santé : nouveaux modes de rémunération, financement des protocoles de coopération, financement de la télémédecine en ambulatoire, parcours de soins, création d'un sous-Ondam...

(2013). Stratégie nationale de santé 2013-2023. *Réseaux, Santé et Territoires*, (52) : 10-11.

Paez A., Esita J., Newbold K.B., Heddle N.M., Blake J.T. (2013). Exploring resource allocation and alternate clinic accessibility landscapes for improved blood donor turnout. *Applied Geography*, 45 (0) : 89-97.

Abstract: Abstract An important goal for blood agencies, especially in the context of aging populations, is to ensure the sufficiency of the blood supply. Of the eligible population, only a small proportion donates. A question therefore is how to expand the donor base. Previous research has shown that accessibility to clinics positively associates with donor turnout. Since accessibility depends on the allocation of resources to clinic sites it provides a policy handle to facilitate donor participation. Generation and examination of clinic accessibility landscapes can be part of a strategy to increase donor turnout. The research uses donor and clinic databases provided by Canadian Blood Services for calendar year 2008. Donor numbers were aggregated at the level of Dissemination Areas for the city of Toronto, Canada, and complemented with socio-economic and demographic information from the Census. Multivariate statistical analysis confirms the positive association between number of donors and accessibility, calculated using a two-step floating approach. The model becomes the objective function in a heuristic search procedure (genetic algorithms) to investigate the potential effect on donor turnout of allocation of resources to clinics. The results of the analysis indicate that the current number of donors is at the lower end of the range of solutions obtained from generating accessibility landscapes. Gains in the total number of estimated donors range between 1% and 22%. An advantage of generating several solutions is the possibility of examining the magnitude of change required, in terms of the (re-)allocation of resources to clinics. Detailed examination of the results can assist decision-makers to evaluate the trade-offs between the magnitude of the change required and the potential payoff. Given current trends, there is a need for planning to ensure that the supply of blood is sufficient. Even small gains can make an important difference between a sufficient blood supply and shortages. The approach presented here to generate clinic accessibility landscapes constitutes a useful tool for blood agencies to explore scenarios for increasing their donor base.

Danyang L., Zackary H., Kurt S. (2013). Increasing organ donation via changes in the default choice or allocation rule. *Journal of Health Economics*, 32 (6) : 1117-1129.

Abstract: We design a laboratory experiment to measure the relative effectiveness of potential policy changes that target increasing donor registration. We focus on two policy proposals: the opt-out system and the priority rule. Both the opt-out system and the priority rule have a positive impact on donor registration. The priority rule outperforms the opt-out system, while the opt-out system generates approximately 80% of the gain achieved under the priority rule. The combination of the opt-out system and the priority rule generates the highest registration rate.

Vazquez M.L., Terraza-Nunez R., Hernandez S., Vargas I., Bosch L., Gonzalez A., Pequeno S., Cantos R., Martinez J.I., Lopez L.A. (2013). Are migrants health policies aimed at improving access to quality healthcare? An analysis of Spanish policies. *Health Policy*, 113 (3) : 236-246.

Abstract: Although until April 2012, all Spanish citizens regardless of their origin, residence status and work situation were entitled to health care, available evidence suggested inadequate access for immigrants. Following the Aday and Andersen model, we conducted an analysis of policy elements that affect immigrants' access to health care in Spain, based on documentary analysis of national policies and selected regional policies related to migrant health care. Selected documents were (a) laws and plans in force at the time containing migrant health policies and (b) evaluations. The analysis included policy principles, objectives, strategies and evaluations. Results show that the national and regional policies analyzed are based on the principle that health care is a right granted to immigrants by law. These policies include strategies to facilitate access to health care, reducing barriers for entry to the system, for example simplifying requirements and raising awareness, but mostly they address the necessary qualities for services to be able to attend to a more diverse population, such as the adaptation of resources and programs, or improved communication and training. However, limited planning was identified in terms of their implementation, necessary resources and evaluation. In conclusion, the policies address relevant barriers of access for migrants and signal improvements in the health system's responsiveness, but reinforcement is required in order for them to be effectively implemented.

Prévention / Prevention

Mackenbach J.P., Lingsma H.F., Van Ravesteyn N.T., Kamphuis C.B.M. (2013). The population and high-risk approaches to prevention: quantitative estimates of their contribution to population health in the Netherlands, 1970-2010. *The European Journal of Public Health*, 23 (6) : 909-915.

Abstract: Background: To compare the contribution of “population” and “high-risk” approaches to prevention, with regard to their impact on population health in the Netherlands between 1970 and 2010. Methods: Preventive interventions that have had an impact on mortality and morbidity rates were identified using published evaluation studies and routinely collected mortality and morbidity data. These interventions were then classified into population versus high-risk approaches, depending on whether they were targeted to groups identified on the basis of their risk of disease. Results: In the period 1970-2010, 22 new preventive interventions were introduced, which altogether avoided about 16000 deaths and several hundred thousand disease cases per year in the Netherlands. Tobacco control and road safety measures had the largest impact. Preventive interventions based on a high-risk approach, such as hypertension detection and control and cancer screening, accounted for approximately one quarter of the total health gain. Conclusions: In the period 1970-2010, considerably larger health gains have been achieved with the population approach than with the high-risk approach to prevention. National prevention policies should make judicious use of these complementary approaches to maximize health gain.

Prévision – Evaluation

Hoefman R., Exel J., Brouwer W. (2013). How to Include Informal Care in Economic Evaluations. In : *PharmacoEconomics. PharmacoEconomics*, 31 (12) : 1105-1119.

Abstract: Economic evaluations of health interventions aim to support decision making in healthcare. To effectively do so, evaluations need to include all relevant costs and effects of an intervention. Informal care provided by family or friends is an important element of care for many patients, but can have a profound impact on the health and well-being of carers. Therefore, informal care should be considered in economic evaluations of health interventions. Different methods to do so exist. This paper provides an overview of state-of-the-art methods available for this purpose, illustrated with practical examples. Since the choice of measurement and valuation technique depends on the type and perspective of the economic evaluation, this paper supports researchers in choosing the appropriate techniques to include informal care in their economic evaluation of a health intervention. We discuss the different approaches to measuring and valuing informal care, covering both partial and full valuation methods, allowing inclusion as costs or effects.

Makai P., Brouwer W.B.F., Koopmanschap M.A., Stolk E.A., Nieboer A.P. (2014). Quality of life instruments for economic evaluations in health and social care for older people: A systematic review. *Social Science & Medicine*, 102 (0) : 83-93.

Abstract: Abstract Gaining health may not be the main goal of healthcare services aimed at older people, which may (also) seek to improve wellbeing. This emphasizes the need of finding appropriate outcome measures for economic evaluation of such services, particularly in long-term care, capturing more than only health-related quality of life (HrQol). This review assesses the usefulness of HrQol and wellbeing instruments for economic evaluations specifically aimed at older people, focusing on generic and preference-based questionnaires measuring wellbeing in particular. We systematically searched six databases and extracted instruments used to assess HrQol and wellbeing outcomes. Instruments

were compared based on their usefulness for economic evaluation of services aimed at older people (dimensions measured, availability of utility scores, extent of validation). We identified 487 articles using 34 generic instruments: 22 wellbeing (two of which were preference-based) and 11 HrQoL instruments. While standard HrQoL instruments measure physical, social and psychological dimensions, wellbeing instruments contain additional dimensions such as purpose in life and achievement, security, and freedom. We found four promising wellbeing instruments for inclusion in economic evaluation: Ferrans and Powers QLI and the WHO-QoL OLD, ICECAP-O and the ASCOT. Ferrans and Powers QLI and the WHO-QoL OLD are widely validated but lack preference-weights while for ICECAP-O and the ASCOT preference-weights are available, but are less widely validated. Until preference-weights are available for the first two instruments, the ICECAP-O and the ASCOT currently appear to be the most useful instruments for economic evaluations in services aimed at older people. Their limitations are that (1) health dimensions may be captured only partially and (2) the instruments require further validation. Therefore, we currently recommend using the ICECAP-O or the ASCOT alongside the EQ-5D or SF-6D when evaluating interventions aimed at older people.

Soins de santé primaires / Primary Health Care

Baret C. (2013). Les défis de la gestion du changement dans les organisations de santé : commentaire. *Sciences sociales et Santé*, 31 (2) : 65-69.

Abstract: Dans un contexte de dépenses de santé croissantes, de scandales pharmaceutiques, d'émergence de patients polypathologiques chroniques, la prescription des médecins généralistes est régulièrement remise en cause. Mais la gestion au quotidien du patient polypathologique par ces praticiens est mal connue. Nous avons donc réunis 60 médecins généralistes, pendant une journée, pour, d'une part, réfléchir sur leur pratique et, d'autre part, discuter en groupes de pairs autour de diagnostics et de prescriptions réelles de patients polypathologiques chroniques. Les résultats présentés ici montrent le réseau complexe qui se noue en arrière fond de la relation médecin-malade dans ce contexte. La conclusion est qu'il ne sera pas possible d'améliorer la prise en charge de ces patients en ambulatoire sans une réorganisation majeure du système de soins et un changement culturel dans la coopération entre professionnels de santé.

(2013). Expérimentations Paerpa : premiers actes. *Réseaux, Santé et Territoires*, (52) : 12.

Abstract: La première phase des expérimentations Paerpa (Personnes âgées en risque de perte d'autonomie) était d'installer la gouvernance du projet. Ce processus est bien avancé pour les cinq premiers projets portés par les agences régionales de santé (ARS) Centre, Ile-de-France, Lorraine, Midi-Pyrénées et Pays-de-la-Loire. Le lancement officiel passe par la signature d'une convention territoriale.

Brennan N., Barnes R., Calnan M., Corrigan O., Dieppe P., Entwistle V. (2013). Trust in the health-care provider-patient relationship: a systematic mapping review of the evidence base. *Int J Qual. Health Care*, 25 (6) : 682-688.

Abstract: PURPOSE: Trust is important for patients and may be used as an indicator and potential 'marker' for how patients evaluate the quality of health care. The review aimed to classify the current evidence base on trust in the patient-provider relationship in order to identify strengths and weaknesses and to point towards areas for future research. DATA SOURCES: Nine electronic databases were searched from 2004 onwards using text and subject heading keywords relating to 'trust' and 'health care' and 'relationships'. STUDY SELECTION: Abstracts were identified for empirical studies carried out in health-care settings that explicitly examined trust or reported trust-related findings as a secondary outcome. Data extraction Two review authors assessed the relevance of abstracts and extracted data relating to year published, country of study, clinical specialty, STUDY DESIGN: and participants. RESULTS OF DATA SYNTHESIS: Five hundred and ninety-six abstracts were included. Most reported on patients' trust in providers; were carried out in the USA; collected data in family care or oncology/palliative care settings; used questionnaires and interviews and elicited

patients' perspectives. Only one study explicitly set out to examine providers' trust in patients and <5% of included studies reported on providers' trust in patients. CONCLUSION: Providers' trust in patients remains a neglected area on the trust research agenda. Empirical studies examining the factors that influence providers' trust in patients and how this might affect the quality of care and patient health-related behaviours are urgently needed to readdress this imbalance. Further exploration of this area using observational methods is recommended.

Cramm J.M., Nieboer A.P. (2013). High-quality chronic care delivery improves experiences of chronically ill patients receiving care. *Int J Qual. Health Care*, 25 (6) : 689-695.

Abstract: OBJECTIVE: Investigate whether high-quality chronic care delivery improved the experiences of patients. DESIGN: This study had a longitudinal design. SETTING AND PARTICIPANTS: We surveyed professionals and patients in 17 disease management programs targeting patients with cardiovascular diseases, chronic obstructive pulmonary disease, heart failure, stroke, comorbidity and eating disorders. MAIN OUTCOME MEASURES: Patients completed questionnaires including the Patient Assessment of Chronic Illness Care (PACIC) [T1 (2010), 2637/4576 (58%); T2 (2011), 2314/4330 (53%)]. Professionals' Assessment of Chronic Illness Care (ACIC) scores [T1, 150/274 (55%); T2, 225/325 (68%)] were used as a context variable for care delivery. We used two-tailed, paired t-tests to investigate improvements in chronic illness care quality and patients' experiences with chronic care delivery. We employed multilevel analyses to investigate the predictive role of chronic care delivery quality in improving patients' experiences with care delivery. RESULTS: Overall, care quality and patients' experiences with chronic illness care delivery significantly improved. PACIC scores improved significantly from 2.89 at T1 to 2.96 at T2 and ACIC-S scores improved significantly from 6.83 at T1 to 7.18 at T2. After adjusting for patients' experiences with care delivery at T1, age, educational level, marital status, gender and mental and physical quality of life, analyses showed that the quality of chronic care delivery at T1 ($P < 0.001$) and changes in care delivery quality ($P < 0.001$) predicted patients' experiences with chronic care delivery at T2. CONCLUSION: This research showed that care quality and changes therein predict more positive experiences of patients with various chronic conditions over time.

Cousin G., Schmid M.M., Jaunin-Stalder N. (2013). Finding the right interactional temperature: Do colder patients need more warmth in physician communication style? *Soc Sci Med*, 98 18-23.

Abstract: Being aware of which communication style should be adopted when facing more difficult patients is important for physicians; it can help prevent patient reactions of dissatisfaction, mistrust, or non-adherence that can be detrimental to the process of care. Past research suggests that less agreeable patients are especially critical towards, and reactive to, their physician's communication style, compared to more agreeable patients. On the basis of the literature, we hypothesized that less agreeable patients would react more negatively than agreeable patients to lower levels of affiliativeness (i.e., warmth, friendliness) in the physicians, in terms of satisfaction with the physician, trust in the physician, and determination to adhere to the treatment. Thirty-six general practitioners (20 men/16 women) working in their own practice in Switzerland were filmed while interacting with 69 patients (36 men/33 women) of different ages ($M = 50.7$; $SD = 18.19$; range: 18-84) and presenting different medical problems (e.g., back pain, asthma, hypertension, diabetes). After the medical interview, patients filled in questionnaires measuring their satisfaction with the physician, their trust in the physician, their determination to adhere to the treatment, and their trait of agreeableness. Physician affiliativeness was coded on the basis of the video recordings. Physician gender and dominance, patient gender and age, as well as the gravity of the patient's medical condition were introduced as control variables in the analysis. Results confirmed our hypothesis for satisfaction and trust, but not for adherence; less agreeable patients reacted more negatively (in terms of satisfaction and trust) than agreeable patients to lower levels of affiliativeness in their physicians. This study suggests that physicians should be especially attentive to stay warm and friendly with people low in agreeableness because those patients' satisfaction and trust might be more easily lowered by a cold or distant physician communication style.

Systèmes de santé / Health Systems

Atanasova E., Pavlova M., Moutafova E., Rechel B., Groot W. (2013). Out-of-pocket payments for health care services in Bulgaria: financial burden and barrier to access. *The European Journal of Public Health, 23* (6) : 916-922.

Abstract: Background: In recent years, Bulgaria has increasingly relied on out-of-pocket payments as one of the main sources of health care financing. However, it is largely unknown whether the official patient charges, combined with informal payments, are affordable for the population. Our study aimed to explore the scale of out-of-pocket payments for health care services and their affordability. Methods: Data were collected in two nationally representative surveys, conducted in Bulgaria in 2010 and 2011, using face-to-face interviews based on a standardized questionnaire. To select respondents, a multi-stage random probability method was used. The questionnaire included questions on the out-of-pocket payments for health care services used by the respondent during the preceding 12 months. Results: In total, 75.7% (2010) and 84.0% (2011) of outpatient service users reported to have paid out-of-pocket, with 12.6% (2010) and 9.7% (2011) of users reporting informal payments. Of those who had used inpatient services, 66.5% (2010) and 63.1% (2011) reported to have made out-of-pocket payments, with 31.8% (2010) and 18.3% (2011) reporting to have paid informally. We found large inability to pay indicated by the need to borrow money and/or forego services. Regression analysis showed that the inability to pay is especially pronounced among those with poor health status and chronic diseases and those on low household incomes. Conclusion: The high level of both formal and informal out-of-pocket payments for health care services in Bulgaria poses a considerable burden for households and undermines access to health services for poorer parts of the population.

Hoffmann K., Stein K.V., Maier M., Rieder A., Dorner T.E. (2013). Access points to the different levels of health care and demographic predictors in a country without a gatekeeping system. Results of a cross-sectional study from Austria. *The European Journal of Public Health, 23* (6) : 933-939.

Abstract: Background: The challenges for health care systems are evident both in terms of costs and of healthy life expectancy. It was the aim of this study to assess the access points towards the different levels of care and predictors for consulting a specialist without having consulted a general practitioner (GP), a common way of access to the Austrian health care system, a system without gatekeeping function. Method: The database used for this analysis was the Austrian Health Interview Survey 2006GÇ07, with data from 15 474 people. Statistical analyses included descriptive statistics as well as multivariate logistic regression models. Results: In the 12 months before the survey, 78.8% consulted a GP, 67.4% consulted a specialist, 18.6% visited an outpatient department and 22.8% had a hospital stay at least once. Overall, 15.1% visited a specialist, 8.5% an outpatient department and 8.1% a hospital without consulting a GP concomitantly. One of the main reasons for direct specialist use was a preventive check-up visit. Tertiary education and migration background increased significantly the chance of having been to a specialist without GP contact for both sexes. Conclusion: The overall access rates for specialists as well as the access rates for specialist without GP consultations were high. The findings point into the direction of a benefit through a structurally supported advocacy role for primary health care professionals. The knowledge gained could contribute to the health policy debate on the importance of coordination and continuity with special respect to demographic factors showing the importance of target-group-specific interventions.

Glorioso V., Subramanian S.V. (2013). Equity in Access to Health Care Services in Italy. *Health Services Research, Ahead of pub.*

Abstract: Objective To provide new evidence on whether and how patterns of health care utilization deviate from horizontal equity in a country with a universal and egalitarian public health care system: Italy. Data Sources Secondary analysis of data from the Health Conditions and Health Care Utilization Survey 2005, conducted by the Italian National Institute of Statistics on a probability sample of the noninstitutionalized Italian population. Study Design Using multilevel logistic regression, we investigated how the probability of utilizing five health care services varies among individuals with equal health status but different SES. Data Collection/Extraction Respondents aged 18 or older at the Pôle documentation de l'Irdes / Irdes Documentation centre - Safon M.-O., Suhard V.

interview time (n=103,651). Principal Findings Overall, we found that use of primary care is inequitable in favor of the less well-off, hospitalization is equitable, and use of outpatient specialist care, basic medical tests, and diagnostic services is inequitable in favor of the well-off. Stratifying the analysis by health status, however, we found that the degree of inequity varies according to health status. Conclusions Despite its universal and egalitarian public health care system, Italy exhibits a significant degree of SES-related horizontal inequity in health services utilization.

Van Der Wees P.J., Zaslavsky A.M., Ayanian J.Z. (2013). Improvements in health status after massachusetts health care reform. *Milbank Q*, 91 (4) : 663-689.

Abstract: CONTEXT: Massachusetts enacted health care reform in 2006 to expand insurance coverage and improve access to health care. The objective of our study was to compare trends in health status and the use of ambulatory health services before and after the implementation of health reform in Massachusetts relative to that in other New England states. METHODS: We used a quasi-experimental design with data from the Behavioral Risk Factor Surveillance System from 2001 to 2011 to compare trends associated with health reform in Massachusetts relative to that in other New England states. We compared self-reported health and the use of preventive services using multivariate logistic regression with difference-in-differences analysis to account for temporal trends. We estimated predicted probabilities and changes in these probabilities to gauge the differential effects between Massachusetts and other New England states. Finally, we conducted subgroup analysis to assess the differential changes by income and race/ethnicity. FINDINGS: The sample included 345,211 adults aged eighteen to sixty-four. In comparing the periods before and after health care reform relative to those in other New England states, we found that Massachusetts residents reported greater improvements in general health (1.7%), physical health (1.3%), and mental health (1.5%). Massachusetts residents also reported significant relative increases in rates of Pap screening (2.3%), colonoscopy (5.5%), and cholesterol testing (1.4%). Adults in Massachusetts households that earned up to 300% of the federal poverty level gained more in health status than did those above that level, with differential changes ranging from 0.2% to 1.3%. Relative gains in health status were comparable among white, black, and Hispanic residents in Massachusetts. CONCLUSIONS: Health care reform in Massachusetts was associated with improved health status and the greater use of some preventive services relative to those in other New England states, particularly among low-income households. These findings may stem from expanded insurance coverage as well as innovations in health care delivery that accelerated after health reform.

Travail et santé / Occupational Health

Fantoni-Quinton S. (2013). Le système de santé au travail pourrait-il exister sans (in)aptitude ?

Droit Social, (12) : 1023-1030.

Jane G., Louise H.N. (2013). Useful beautiful minds. An analysis of the relationship between schizophrenia and employment. *Journal of Health Economics*, 32 (6) : 1066-1076.

Abstract: We examine the relationship between schizophrenia and employment. We show a considerable drop in the employment rate for people with schizophrenia six years before the first treatment at a psychiatric facility. After the first treatment, the employment rate stabilizes at 18%. The difference in the employment rate in 2007 for siblings with and without schizophrenia is estimated at 67%. The difference in the employment rate remains unchanged when we apply a sibling fixed effects approach.

Webber D.A., Bjelland M.J. (2013). The impact of work-limiting disability on labor force participation. *Health Economics*, Ahead of pub.

Abstract: According to the justification hypothesis, non-employed individuals may over-report their level of work limitation, leading to biased census/survey estimates of the prevalence of severe disabilities and the associated labor force participation rate. For researchers studying policies which impact the disabled or elderly (e.g., Supplemental Security Income, Disability Insurance, and Early Retirement), this could lead to significant bias in key parameters of interest. Using the American Community Survey, we examine the potential for both inflated and deflated reported disability status and generate a general index of disability, which can be used to reduce the bias of these self-reports in other studies. We find that at least 4.8 million individuals have left the labor force because of a work-limiting disability, at least four times greater than the impact implied by our replication of previous models.

Vieillessement / Aging

Bousquet J., Hajjam J., Piette F., Jean-Bart B., Wlosik C., Robine J.M., Iglesia-Gomez M. (2013). [The French reference sites of the European Innovation Partnership on active and healthy ageing]. *Presse Med*, 42 (12) : 1558-1561.

Cesari M., Gambassi G., Abellan van Kan G., Vellas B. (2014). The frailty phenotype and the frailty index: different instruments for different purposes. *Age and Ageing*, 43 (1) : 10-12.

Abstract: The integration of frailty measures in clinical practice is crucial for the development of interventions against disabling conditions in older persons. The frailty phenotype (proposed and validated by Fried and colleagues in the Cardiovascular Health Study) and the Frailty Index (proposed and validated by Rockwood and colleagues in the Canadian Study of Health and Aging) represent the most known operational definitions of frailty in older persons. Unfortunately, they are often wrongly considered as alternatives and/or substitutables. These two instruments are indeed very different and should rather be considered as complementary. In the present paper, we discuss about the designs and rationals of the two instruments, proposing the correct ways for having them implemented in the clinical setting.

Rechel B. (2014). Health and care in ageing societies: a new international approach. *Age and Ageing*, 43 (1) : 148.