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Assurance maladie / Health Insurance

Franc, C., et al. (2016). "Supplemental Health Insurance and Healthcare Consumption—A Dynamic Approach to Moral Hazard." *Health Economics* 25(12): 1582-1598.

<http://dx.doi.org/10.1002/hec.3271>

We analyze the existence and persistence of moral hazard over time to test the assumption of pent-up demand. We consider the effects of supplemental health insurance provided by a private insurer when added to compulsory public insurance that is already supplemented by private insurance. Using original panel data from a French mutuelle, we study the influence of insurance on all of the dimensions of healthcare expenditures: (1) the probability of using health care, (2) the number of uses conditional on use, and (3) the per unit cost of care. To conduct this study, we control, to the extent possible, for endogeneity because of adverse selection using the characteristics of our panel data. Our study allows us to confirm a positive and significant effect of the extra complementary health insurance on healthcare consumption, primarily in terms of the probability of using care. More interestingly, our results show that these effects are principally transitory mainly for the probability of using dental care and optical care and depend on income. Finally, we show that individuals did not postpone health care before enrollment. Copyright © 2015 John Wiley & Sons, Ltd.

Higuera, L. et Prada, S. I. (2016). "Barrier to Access or Cost Share? Coinsurance and Dental-Care Utilization in Colombia." *Appl Health Econ Health Policy* 14(5): 569-578.

<http://link.springer.com/article/10.1007%2Fs40258-016-0251-4>

BACKGROUND: Copayments, deductibles, and coinsurance, are elements of health-care systems to make prices salient for the insured. Individuals may respond differently to cost sharing, according to the type of care they seek; dental care, as a combination of both acute and elective care, is an ideal setting to study the effects of cost-sharing mechanisms on utilization. **OBJECTIVE:** To test how coinsurance affects dental-care utilization in a middle-income country context. **METHODS:** This study uses policy variations in the Colombian health-care system to analyze changes in dental-care utilization due to different levels of coinsurance. We used matching procedures to balance observed differences in pre-treatment variables between those who face coinsurance (non-policy holders, or beneficiaries) and those who don't (policyholders). We use zero-inflated negative binomial models for the count of visits and two-part models for total expenditures, and test for unobservable confounders with random-effect models and instrumental variables. **RESULTS:** Individuals who face coinsurance are less likely to have any dental-care utilization, at a relatively small scale. Facing coinsurance does not correlate with changes in total expenditures. Falsification tests with dental-care visits exempt from coinsurance show no statistically distinguishable changes in utilization. Random-effect models and instrumental variable models show results similar to the main specification. **CONCLUSIONS:** Cost-sharing policies in Colombia seem to be well designed because they don't represent an important barrier to dental-care access.

Le Meur-Baudry, V. et Barthélémy, J. (2016). "Protection sociale complémentaire : choix de l'organisme assureur et transparence." *Droit Social*(4): 376.

Etat de santé / Health Status

Guilleminault, L., et al. (2016). "[Seasonality in asthma: Impact and treatments]." *Presse Med* 45(11): 1005-1018.

The role of seasons should be taken into account in the management of asthma. The environment varies between seasons and it is well documented that asthma is modulated by environment. Viruses cause asthma exacerbations peak, in winter, in adults while the peak is present in September in children. Allergens are probably a less powerful source of asthma exacerbation than viruses but pollen

involvement in spring and summer and dust mites in autumn are indisputable. Air pollutants, present in summer during the hottest periods, are also highly involved in asthma exacerbations. Indoor air pollution, in winter, is also implicated in asthma disease. All these environmental factors are synergistic and increase the risk of asthma exacerbation. Therapies should be adapted to each season depending on environmental factors potentially involved in the asthma disease.

Hôpital / Hospitals

Figueroa, J. F., et al. (2016). "Association between the Value-Based Purchasing pay for performance program and patient mortality in US hospitals: observational study." *BMJ* 353.

<http://www.bmj.com/content/bmj/353/bmj.i2214.full.pdf>

Objective To determine the impact of the Hospital Value-Based Purchasing (HVBP) program—the US pay for performance program introduced by Medicare to incentivize higher quality care—on 30 day mortality for three incentivized conditions: acute myocardial infarction, heart failure, and pneumonia. **Design** Observational study. **Setting** 4267 acute care hospitals in the United States: 2919 participated in the HVBP program and 1348 were ineligible and used as controls (44 in general hospitals in Maryland and 1304 critical access hospitals across the United States). **Participants** 2 430 618 patients admitted to US hospitals from 2008 through 2013. **Main outcome measures** 30 day risk adjusted mortality for acute myocardial infarction, heart failure, and pneumonia using a patient level linear spline analysis to examine the association between the introduction of the HVBP program and 30 day mortality. Non-incentivized, medical conditions were the comparators. A secondary outcome measure was to determine whether the introduction of the HVBP program was particularly beneficial for a subgroup of hospital—poor performers at baseline—that may benefit the most. **Results** Mortality rates of incentivized conditions in hospitals participating in the HVBP program declined at –0.13% for each quarter during the preintervention period and –0.03% point difference for each quarter during the post-intervention period. For non-HVBP hospitals, mortality rates declined at –0.14% point difference for each quarter during the preintervention period and –0.01% point difference for each quarter during the post-intervention period. The difference in the mortality trends between the two groups was small and non-significant (difference in difference in trends –0.03% point difference for each quarter, 95% confidence interval –0.08% to 0.13% point difference, P=0.35). In no subgroups of hospitals was HVBP associated with better outcomes, including poor performers at baseline. **Conclusions** Evidence that HVBP has led to lower mortality rates is lacking. Nations considering similar pay for performance programs may want to consider alternative models to achieve improved patient outcomes.

Fusco, M., et al. "Individual and hospital-related determinants of potentially inappropriate admissions emerging from administrative records." *Health Policy* 120(11): 1304-1312.

<http://dx.doi.org/10.1016/j.healthpol.2016.09.015>

We examined individual and organizational determinants of potentially avoidable admissions. We used administrative records and specific quality of care indicators. Personal determinants were: age, schooling, Barthel dependency level and comorbidities. Organizational determinants were: wards' complexity and efficiency.

Gey-Coué, M. (2016). "La place des usagers dans le GHT." *Gestions hospitalières*(559): 510-512.

Hirtzlin, I. (2016). "Le paiement à l'épisode de soins en chirurgie aux Etats-Unis." *Gestions hospitalières*(558): 416-421.

Karmann, A. et Roesel, F. (2016). "Hospital Policy and Productivity – Evidence from German States." *Health Economics*: Ahead of print

<http://dx.doi.org/10.1002/hec.3447>

Total factor productivity (TFP) growth allows for additional healthcare services under restricted resources. We examine whether hospital policy can stimulate hospital TFP growth. We exploit variation across German federal states in the period 1993–2013. State governments decide on hospital capacity planning (number of hospitals, departments, and beds), ownership, medical students, and hospital investment funding. We show that TFP growth in German hospital care reflects quality improvements rather than increases in output volumes. Second-stage regression results indicate that reducing the length of stay is generally a proper way to foster TFP growth. The effects of other hospital policies depend on the reimbursement scheme: Under activity-based (German Diagnosis-related Group) hospital funding, scope-related policies (privatization and specialization) come with TFP growth. Under fixed daily rate funding, scale matters to TFP (hospital size and occupancy rates). Differences in capitalization in East and West Germany allow to show that deepening capital may enhance TFP growth if capital is scarce. We also show that there is less scope for hospital policies after large-scale restructurings of the hospital sector. Copyright © 2016 John Wiley & Sons, Ltd.

Kaur, R., et al. (2016). "Hospital Postacute Care Referral Networks: Is Referral Concentration Associated with Medicare-Style Bundled Payments?" Health Serv Res.

OBJECTIVE: To evaluate whether Medicare-style bundled payments are lower or higher for beneficiaries discharged from hospitals with postacute care (PAC) referrals concentrated among fewer PAC providers. DATA SOURCE: Medicare Part A and Part B claim (2008-2012) for all beneficiaries residing in any of 17 market areas: the Provider of Service file, the Healthcare Cost Report Information System, and the Dartmouth Atlas. STUDY DESIGN: An observational study in which hospitals were distinguished according to PAC referral concentration, which is the tendency to utilize fewer rather than more PAC providers. We tested the hypothesis that higher referral concentration would be associated with total Medicare bundled payments. DATA COLLECTION/EXTRACTION METHODS: The data represent a convenience sample of market areas that were defined by the locations of grantees from the ONC Beacon Community Program. PRINCIPAL FINDINGS: The four most-used PAC providers accounted for an average of 60 percent of patients discharged from hospitals in the sample. Regression analysis suggested that higher referral concentration was associated with lower Medicare costs per bundle. CONCLUSIONS: Hospitals that tend to use fewer PAC providers may lead to lower costs for payers such as Medicare. The study results reinforce the importance of limited networks for PAC services under bundling arrangements for hospital and PAC payments.

Kifmann, M. et Siciliani, L. (2016). "Average-Cost Pricing and Dynamic Selection Incentives in the Hospital Sector." Health Economics: Ahead of print.

<http://dx.doi.org/10.1002/hec.3451>

This study investigates dynamic incentives to select patients for hospitals that are remunerated according to a prospective payment system of the diagnosis-related group (DRG) type. Using a model with patients differing in severity within a DRG, we show that price dynamics depend on the extent of hospital altruism and the relation between patients' severity and benefit. Upwards and downwards price movements over time are both possible. In a steady state, DRG prices are unlikely to give optimal incentives to treat patients. Depending on the level of altruism, too few or too many patients are treated. DRG pricing may also give incentives to treat low-severity patients even though high-severity patients should be treated. Copyright © 2016 John Wiley & Sons, Ltd.

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." The European Journal of Public Health 26(6): 935-939.

<http://eurpub.oxfordjournals.org/content/eurpub/26/6/935.full.pdf>

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.

Lammers, E. J., et al. (2016). "Physician EHR Adoption and Potentially Preventable Hospital Admissions among Medicare Beneficiaries: Panel Data Evidence, 2010–2013." *Health Services Research* 51(6): 2056-2075.

<http://dx.doi.org/10.1111/1475-6773.12586>

Objective: To test for correlation between the growth in adoption of ambulatory electronic health records (EHRs) in the United States during 2010–2013 and hospital admissions and readmissions for elderly Medicare beneficiaries with at least one of four common ambulatory care–sensitive conditions (ACSCs). Data Sources: SK&A Information Services Survey of Physicians, American Hospital Association General Survey and Information Technology Supplement; and the Centers for Medicare & Medicaid Services Chronic Conditions Data Warehouse Geographic Variation Database for 2010 through 2013. Study Design: Fixed effects model estimated the relationship between hospital referral region (HRR) level measures of physician EHR adoption and ACSC admissions and readmissions. Analyzed rates of admissions and 30-day readmissions per beneficiary at the HRR level (restricting the denominator to beneficiaries in our sample), adjusted for differences across HRRs in Medicare beneficiary age, gender, and race. Calculated physician EHR adoption rates as the percentage of physicians in each HRR who report using EHR in ambulatory care settings. Principal Findings: Each percentage point increase in market-level EHR adoption by physicians is correlated with a statistically significant decline of 1.06 ACSC admissions per 10,000 beneficiaries over the study period, controlling for the overall time trend as well as market fixed effects and characteristics that changed over time. This finding implies 26,689 fewer ACSC admissions in our study population during 2010 to 2013 that were related to physician ambulatory EHR adoption. This represents 3.2 percent fewer ACSC admissions relative to the total number of such admissions in our study population in 2010. We found no evidence of a correlation between EHR use, by either physicians or hospitals, and hospital readmissions at either the market level or hospital level. Conclusions: This study extends knowledge about EHRs' relationship with quality of care and utilization. The results suggest a significant association between EHR use in ambulatory care settings and ACSC admissions that is consistent with policy goals to improve the quality of ambulatory care for patients with chronic conditions. The null findings for readmissions support the need for improved interoperability between ambulatory care EHRs and hospital EHRs to realize improvements in readmissions.

Lard-Huchet, B. (2016). "GHT : et maintenant, comment construire ?" *Gestions Hospitalières*(558): 446-448.

Plaisier, I., et al. "Developments in home-care use. Policy and changing community-based care use by independent community-dwelling adults in the Netherlands." *Health Policy* 121(1): 82-89.

<http://dx.doi.org/10.1016/j.healthpol.2016.11.006>

Community-based care in the Netherlands did not increase between 2004 and 2011. The role of income in care use seemed to have increased. The difference in care use between single and multiple-person households widened. Care use by (elderly) older persons also appears to have increased. Developments in care use are in line with the policy deployed.

Rahman, M., et al. (2016). "Is a Skilled Nursing Facility's Rehospitalization Rate a Valid Quality Measure?" *Health Services Research* 51(6): 2158-2175.

<http://dx.doi.org/10.1111/1475-6773.12603>

Objective: To determine whether the observed differences in the risk-adjusted rehospitalization rates across skilled nursing facilities (SNFs) reflect true differences or merely differences in patient severity. **Settings:** Elderly Medicare beneficiaries newly admitted to an SNF following hospitalization. **Study Design:** We used 2009–2012 Medicare data to calculate SNFs' risk-adjusted rehospitalization rate. We then estimated the effect of these rehospitalization rates on the rehospitalization of incident patients in 2013, using an instrumental variable (IV) method and controlling for patient's demographic and clinical characteristics and residential zip code fixed effects. We used the number of empty beds in a patient's proximate SNFs during hospital discharge to create the IV. **Principal Findings:** The risk-adjusted rehospitalization rate varies widely; about one-quarter of the SNFs have a rehospitalization rate lower than 17 percent, and for one-quarter, it is higher than 23 percent. All the IV models result in a robust finding that an increase in a SNF's rehospitalization rate of 1 percentage point over the period 2009–2012 leads to an increase in a patient's likelihood of rehospitalization by 0.8 percentage points in 2013. **Conclusions:** Treatment in SNFs with historically low rehospitalization causally reduces a patient's likelihood of rehospitalization. Observed differences in rehospitalization rates reflect true differences and are not an artifact of selection.

Reuter, P. G., et al. (2016). "[Place of doctors and medicine in our society. What the names given to hospitals reveal]." *Presse Med* 45(9): 791-792.

Sagan, A., et al. "The 2015 emergency care reform in Poland: Some improvements, some unmet demands and some looming conflicts." *Health Policy* 120(11): 1220-1225.

<http://dx.doi.org/10.1016/j.healthpol.2016.09.009>

This article follows the format of Health Reform Monitor articles. It describes the introduction of the 2015 emergency care reform in Poland. It analyses the key stakeholders position, the policy process and the reform content. The 2015 Act does not meet the key demands of medical rescuers. The 2015 Act and its implementing legislation may create tensions between medical rescuers and nurses.

Sutherland, J. M., et al. "Paying for volume: British Columbia's experiment with funding hospitals based on activity." *Health Policy* 120(11): 1322-1328.

<http://dx.doi.org/10.1016/j.healthpol.2016.09.010>

Activity-based funding for hospitals was introduced in British Columbia, Canada, in 2010. There were increases in the volume of inpatient surgical activity. There were no changes in measures of hospital quality. Small magnitude and short term reforms were unlikely to change hospitals' behaviors.

Van den Heede, K. et Van de Voorde, C. (2016). "Interventions to reduce emergency department utilisation: A review of reviews." *Health Policy* 120 (12) : 1337-1349

OBJECTIVE: To describe policy interventions that have the objective to reduce ED use and to estimate their effectiveness. **METHODS:** Narrative review by searching three electronic databases for scientific literature review papers published between 2010 and October 2015. The quality of the included studies was assessed with AMSTAR, and a narrative synthesis of the retrieved papers was applied. **RESULTS:** Twenty-three included publications described six types of interventions: (1) cost sharing; (2) strengthening primary care; (3) pre-hospital diversion (including telephone triage); (4) coordination; (5) education and self-management support; (6) barriers to access emergency departments. The high number of interventions, the divergent methods used to measure outcomes and the different populations complicate their evaluation. Although approximately two-thirds of the primary studies showed reductions in ED use for most interventions the evidence showed contradictory results. **CONCLUSION:** Despite numerous publications, evidence about the effectiveness of interventions that aim to reduce ED use remains insufficient. Studies on more homogeneous patient groups with a

clearly described intervention and control group are needed to determine for which specific target group what type of intervention is most successful and how the intervention should be designed. The effective use of ED services in general is a complex and multi-factorial problem that requires integrated interventions that will have to be adapted to the specific context of a country with a feedback system to monitor its (un-)intended consequences. Yet, the co-location of GP posts and emergency departments seems together with the introduction of telephone triage systems the preferred interventions to reduce inappropriate ED visits while case-management might reduce the number of ED attendances by frequent ED users.

Wargon, M. (2016). "GHT et pratiques médicales." *Gestions hospitalières*(559): 490-492.

Inégalités de santé / Health Inequalities

Hollander, A.-C., et al. (2016). "Refugee migration and risk of schizophrenia and other non-affective psychoses: cohort study of 1.3 million people in Sweden." *BMJ* 352.

<http://www.bmj.com/content/bmj/352/bmj.i1030.full.pdf>

Objective To determine whether refugees are at elevated risk of schizophrenia and other non-affective psychotic disorders, relative to non-refugee migrants from similar regions of origin and the Swedish-born population. **Design** Cohort study of people living in Sweden, born after 1 January 1984 and followed from their 14th birthday or arrival in Sweden, if later, until diagnosis of a non-affective psychotic disorder, emigration, death, or 31 December 2011. **Setting** Linked Swedish national register data. **Participants** 1 347 790 people, including people born in Sweden to two Swedish-born parents (1 191 004; 88.4%), refugees (24 123; 1.8%), and non-refugee migrants (132 663; 9.8%) from four major refugee generating regions: the Middle East and North Africa, sub-Saharan Africa, Asia, and Eastern Europe and Russia. **Main outcome measures** Cox regression analysis was used to estimate adjusted hazard ratios for non-affective psychotic disorders by refugee status and region of origin, controlling for age at risk, sex, disposable income, and population density. **Results** 3704 cases of non-affective psychotic disorder were identified during 8.9 million person years of follow-up. The crude incidence rate was 38.5 (95% confidence interval 37.2 to 39.9) per 100 000 person years in the Swedish-born population, 80.4 (72.7 to 88.9) per 100 000 person years in non-refugee migrants, and 126.4 (103.1 to 154.8) per 100 000 person years in refugees. Refugees were at increased risk of psychosis compared with both the Swedish-born population (adjusted hazard ratio 2.9, 95% confidence interval 2.3 to 3.6) and non-refugee migrants (1.7, 1.3 to 2.1) after adjustment for confounders. The increased rate in refugees compared with non-refugee migrants was more pronounced in men (likelihood ratio test for interaction χ^2 (df=2) z=13.5; P=0.001) and was present for refugees from all regions except sub-Saharan Africa. Both refugees and non-refugee migrants from sub-Saharan Africa had similarly high rates relative to the Swedish-born population. **Conclusions** Refugees face an increased risk of schizophrenia and other non-affective psychotic disorders compared with non-refugee migrants from similar regions of origin and the native-born Swedish population. Clinicians and health service planners in refugee receiving countries should be aware of a raised risk of psychosis in addition to other mental and physical health inequalities experienced by refugees.

Maass, R., et al. (2016). "The impact of neighborhood social capital on life satisfaction and self-rated health: A possible pathway for health promotion?" *Health & Place* 42: 120-128.

<http://www.sciencedirect.com/science/article/pii/S1353829216301745>

Neighborhood social capital has repeatedly been linked to favorable health-outcomes and life satisfaction. However, it has been questioned whether it's impact on health has been over-rated. We aim to investigate relationships between neighborhood social capital and self-rated health (SRH) and life satisfaction (LS) respectively, both directly and indirectly mediated via Sense of Coherence and self-esteem. Based on a cross-sectional population-survey (N=865) in a medium size Norwegian municipality, we specified a structural equation model (SEM) including the above-listed variables, while controlling for gender, age, education, income, and employment status. The applied model

explains more variance in LS (46%) than in SRH (23%). Social capital has a stronger impact on life satisfaction than on health. The indirect pathway via SOC had the highest impact on life satisfaction, but no significant relationship to SRH. Self-rated health was more tightly linked to personal background variables. Enhancing social capital in the neighborhood might be a beneficial strategy to promote life satisfaction, as well as strengthening sense of coherence even in healthy communities

Palencia, L., et al. (2017). "Gender Policies and Gender Inequalities in Health in Europe: Results of the SOPHIE Project." *Int J Health Serv* 47(1): 61-82.

The aim of this article is to explain the results of the SOPHIE project regarding the effect of gender policies on gender inequalities in health in Europe. We start with the results of a systematic review on how gender regimes and gender equality policies at the country level impact women's health and gender inequalities in health. Then, we report on three empirical analyses on the relationship between different family policy models existing in Europe and gender inequalities in health. Finally we present four case studies on specific examples of gender policies or determinants of gender inequalities in health. The results show that policies that support women's participation in the labor force and decrease their burden of care, such as public services and support for families and entitlements for fathers, are related to lower levels of gender inequality in terms of health. In addition, public services and benefits for disabled and dependent people can reduce the burden placed on family caregivers and hence improve their health. In the context of the current economic crisis, gender equality policies should be maintained or improved.

Phillips, R. L., et al. (2016). "How Other Countries Use Deprivation Indices-And Why The United States Desperately Needs One." *Health Aff (Millwood)* 35(11): 1991-1998.

Integrating public health and medicine to address social determinants of health is essential to achieving the Triple Aim of lower costs, improved care, and population health. There is intense interest in the United States in using social determinants of health to direct clinical and community health interventions, and to adjust quality measures and payments. The United Kingdom and New Zealand use data representing aspects of material and social deprivation from their censuses or from administrative data sets to construct indices designed to measure socioeconomic variation across communities, assess community needs, inform research, adjust clinical funding, allocate community resources, and determine policy impact. Indices provide these countries with comparable data and serve as a universal language and tool set to define organizing principles for population health. In this article we examine how these countries develop, validate, and operationalize their indices; explore their use in policy; and propose the development of a similar deprivation index for the United States.

Porthé, V., et al. "Changes in access to health care for immigrants in Catalonia during the economic crisis: Opinions of health professionals and immigrant users." *Health Policy* 120(11): 1293-1303.

<http://dx.doi.org/10.1016/j.healthpol.2016.09.005>

Changes in migrants' access to healthcare during the economic crisis are analyzed. First comprehensive analysis from health professionals and immigrants viewpoint. Results show aggravation of pre-existing utilization barriers and new barriers. Barriers to enter the system relate to changes on entitlements and procedures. Changes affect especially migrants and contradict the equity principles of the NHS.

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

<http://eurpub.oxfordjournals.org/content/eurpub/26/6/992.full.pdf>

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.

Methodologie – Statistique / Methodology - Statistics

Damen, J. A. A. G., et al. (2016). "Prediction models for cardiovascular disease risk in the general population: systematic review." *BMJ* 353.

<http://www.bmj.com/content/bmj/353/bmj.i2416.full.pdf>

Objective To provide an overview of prediction models for risk of cardiovascular disease (CVD) in the general population. Design Systematic review. Data sources Medline and Embase until June 2013. Eligibility criteria for study selection Studies describing the development or external validation of a multivariable model for predicting CVD risk in the general population. Results 9965 references were screened, of which 212 articles were included in the review, describing the development of 363 prediction models and 473 external validations. Most models were developed in Europe (n=167, 46%), predicted risk of fatal or non-fatal coronary heart disease (n=118, 33%) over a 10 year period (n=209, 58%). The most common predictors were smoking (n=325, 90%) and age (n=321, 88%), and most models were sex specific (n=250, 69%). Substantial heterogeneity in predictor and outcome definitions was observed between models, and important clinical and methodological information were often missing. The prediction horizon was not specified for 49 models (13%), and for 92 (25%) crucial information was missing to enable the model to be used for individual risk prediction. Only 132 developed models (36%) were externally validated and only 70 (19%) by independent investigators. Model performance was heterogeneous and measures such as discrimination and calibration were reported for only 65% and 58% of the external validations, respectively. Conclusions : There is an excess of models predicting incident CVD in the general population. The usefulness of most of the models remains unclear owing to methodological shortcomings, incomplete presentation, and lack of external validation and model impact studies. Rather than developing yet another similar CVD risk prediction model, in this era of large datasets, future research should focus on externally validating and comparing head-to-head promising CVD risk models that already exist, on tailoring or even combining these models to local settings, and investigating whether these models can be extended by addition of new predictors.

Médicaments / Pharmaceuticals

Bognar, K., et al. (2016). "The role of imperfect surrogate endpoint information in drug approval and reimbursement decisions." *J Health Econ* 51: 1-12.

Approval of new drugs is increasingly reliant on "surrogate endpoints," which correlate with but

imperfectly predict clinical benefits. Proponents argue surrogate endpoints allow for faster approval, but critics charge they provide inadequate evidence. We develop an economic framework that addresses the value of improvement in the predictive power, or "quality," of surrogate endpoints, and clarifies how quality can influence decisions by regulators, payers, and manufacturers. For example, the framework shows how lower-quality surrogates lead to greater misalignment of incentives between payers and regulators, resulting in more drugs that are approved for use but not covered by payers. Efficient price-negotiation in the marketplace can help align payer incentives for granting access based on surrogates. Higher-quality surrogates increase manufacturer profits and social surplus from early access to new drugs. Since the return on better quality is shared between manufacturers and payers, private incentives to invest in higher-quality surrogates are inefficiently low.

McCoy, R. G., et al. (2016). "The Method for Performance Measurement Matters: Diabetes Care Quality as Measured by Administrative Claims and Institutional Registry." *Health Services Research* 51(6): 2206-2220.

<http://dx.doi.org/10.1111/1475-6773.12453>

Objectives: Performance measurement is used by health care providers, payers, and patients. Historically accomplished using administrative data, registries are used increasingly to track and improve care. We assess how measured diabetes care quality differs when calculated using claims versus registry. Data Sources/Study Setting: Cross-sectional analysis of administrative claims and electronic health records (EHRs) of patients in a multispecialty integrated health system in 2012 (n = 368,883). Study Design: We calculated percent of patients attaining glycohemoglobin <8.0 percent, LDL cholesterol <100 mg/dL, blood pressure <140/90 mmHg, and nonsmoking (D4) in cohorts, identified by Medicare Accountable Care Organization/Minnesota Community Measures (ACO-MNCM; claims-based), Healthcare Effectiveness Data and Information Set (HEDIS; claims-based), and registry (EHR-based). Data Collection/Extraction Methods: Claims were linked to EHR to create a dataset of performance-eligible patients. Principal Findings: ACO-MNCM, HEDIS, and registry identified 6,475, 6,989, and 6,425 measurement-eligible patients. Half were common among the methods; discrepancies were due to attribution, age restriction, and encounter requirements. D4 attainment was lower in ACO-MNCM (36.09 percent) and HEDIS (37.51 percent) compared to registry (43.74 percent) cohorts. Conclusions: Registry- and claims-based performance measurement methods identify different patients, resulting in different rates of quality metric attainment with implications for innovative population health management.

McIntosh, T., et al. (2016). "Influences on prescribing decision-making among non-medical prescribers in the United Kingdom: systematic review." *Family Practice* 33(6): 572-579.

<http://fampra.oxfordjournals.org/content/33/6/572.abstract>

Background. Suitably qualified non-medical healthcare professionals may now prescribe medicines. Prescribing decision-making can be complex and challenging; a number of influences have been identified among medical prescribers but little appears to be known about influences among non-medical prescribers (NMPs). Objective. To critically appraise, synthesize and present evidence on the influences on prescribing decision-making among supplementary and independent NMPs in the UK. Methods. The systematic review included all studies between 2003 and June 2013. Included studies researched the prescribing decision-making of supplementary and independent NMPs practising in the UK; all primary and secondary study designs were considered. Studies were assessed for quality and data extracted independently by two researchers, and findings synthesized using a narrative approach. Results. Following duplicates exclusion, 886 titles, 349 abstracts and 40 full studies were screened. Thirty-seven were excluded leaving three for quality assessment and data extraction. While all studies reported aspects of prescribing decision-making, this was not the primary research aim for any. Studies were carried out in primary care almost exclusively among nurse prescribers (n = 67). Complex influences were evident such as experience in the role, the use of evidence-based guidelines and peer support and encouragement from doctors; these helped participants to feel more knowledgeable and confident about their prescribing decisions. Opposing influences included prioritization of experience and concern about complications over evidence base, and peer conflict. Conclusion. While there is a limited evidence base on NMPs' prescribing decision-making, it appears that this is complex with

NMPs influenced by many and often opposing factors.

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." *The European Journal of 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. <http://eurpub.oxfordjournals.org/content/eurpub/26/6/916.full.pdf>

Oberlander, J. "The End of Obamacare." *New England Journal of Medicine* 0(0): Ahead of print
<http://www.nejm.org/doi/full/10.1056/NEJMp1614438>

Osborn, R., et al. (2016). "In New Survey Of Eleven Countries, US Adults Still Struggle With Access To And Affordability Of Health Care." *Health Affairs* 35(12): 2327-2336.
<http://content.healthaffairs.org/content/35/12/2327.abstract>

Surveys of patients' experiences with health care services can reveal how well a country's health system is meeting the needs of its population. Using data from a 2016 survey conducted in eleven countries—Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States—we found that US adults reported poor health and well-being and were the most likely to experience material hardship. The United States trailed other countries in making health care affordable and ranked poorly on providing timely access to medical care (except specialist care). In all countries, shortfalls in patient engagement and chronic care management were reported, and at least one in five adults experienced a care coordination problem. Problems were often particularly acute for low-income adults. Overall, the Netherlands performed at the top of the eleven-country range on most measures of access, engagement, and coordination.

Rigby, E. et Hatch, M. E. (2016). "Incorporating Economic Policy Into A 'Health-In-All-Policies' Agenda." *Health Aff (Millwood)* 35(11): 2044-2052.

Recognizing the health effects of nonhealth policies, scholars and others seeking to improve Americans' health have advocated the implementation of a culture of health—which would call attention to and prioritize health as a key outcome of policy making across all levels of government and in the private sector. Adopting this "health-in-all-policies" lens, policy makers are paying increasing attention to health impacts as they debate policies in areas such as urban planning, housing, and transportation. Yet the health impacts of economic policies that shape the distribution of income and wealth are often overlooked. Pooling data from all fifty states for the period 1990-2010,

we provide a broad portrait of how economic policies affect health. Overall, we found better health outcomes in states that enacted higher tax credits for the poor or higher minimum wage laws and in states without a right-to-work law that limits union power. Notably, these policies focus on increasing the incomes of low-income and working-class families, instead of on shaping the resources available to wealthier individuals. Incorporating these findings into a health-in-all-policies agenda will require leadership from the health sector, including a willingness to step into core and polarizing debates about redistribution.

Sinnott, S.-J., et al. "The international generalisability of evidence for health policy: A cross country comparison of medication adherence following policy change." *Health Policy* 121(1): 27-34.

<http://dx.doi.org/10.1016/j.healthpol.2016.10.009>

How generalisable is evidence for health policy making across health systems, in particular evidence for prescription copayments? We addressed this question by studying two similar copayment policies in two health systems. We assessed the impact of each policy on adherence. These two similar copayment policies did not invoke similar responses in adherence to medications. Nuanced differences between the health systems and the patients within them may affect differences in impact of policies. Before applying evidence from one health system to another, critical questions about local applicability are key to maximising its utility.

Vainieri, M., et al. "How to set challenging goals and conduct fair evaluation in regional public health systems. Insights from Valencia and Tuscany Regions." *Health Policy* 120(11): 1270-1278.

<http://dx.doi.org/10.1016/j.healthpol.2016.09.011>

We propose a method to define what is challenging in setting goals. We propose a method to define what is fair in goal assessment. These methods can help regional health care systems to improve performance. These methods can help regional health care systems to reduce variability. These methods were successfully applied in two European Regions which adopted different governance models.

Politique publique / Public Policy

Spach, M. (2016). "Enjeux économiques et politiques publiques de lutte contre la consommation nocive d'alcool." *Santé Publique* 28(4): 461-486.

Objectif : Analyser le poids du marché alcoolier sur la mise en place de politiques publiques volontaristes, au travers d'une revue de la littérature critique des politiques publiques de lutte contre l'abus d'alcool. Méthode : Une recherche documentaire et une analyse des données économique du marché alcoolier en France ont été réalisées. Le panorama des politiques publiques de lutte contre l'abus d'alcool a été élaboré d'un point de vue historique, en distinguant les politiques de lutte contre l'ivresse, de protection des populations vulnérables, de lutte contre l'alcoolémie au volant ou encore en milieu professionnel. Résultats : Les politiques publiques de lutte contre l'abus d'alcool visent principalement à diminuer les conséquences nocives de l'alcool survenant à l'issue d'un épisode de consommation (accident de la route, accidents de la voie publique, etc.), en négligeant les conséquences de long terme (cancer, cirrhose, etc.). De plus, tandis que la taxation figure parmi les outils de santé publique les plus efficaces pour diminuer le coût que l'alcool fait supporter à la société, l'État exerce une protection législative et fiscale sur les boissons alcooliques françaises. En particulier, le vin bénéficie d'une taxation inférieure aux autres alcools dont le titre alcoométrique volumique est supérieur (eaux-de-vie, liqueurs, etc.). Une explication quant à l'orientation des politiques publiques de lutte contre l'abus d'alcool réside dans le poids économique de l'alcool. Conclusion : Au regard de la mortalité engendrée par l'abus d'alcool, l'engagement de la France dans une politique publique volontariste est nécessaire. Dans ce sens, une politique de taxation de l'alcool selon la quantité d'alcool contenue, l'instauration d'un prix-plancher du gramme d'alcool ou encore l'augmentation des

taxes sur l'alcool sont autant de politiques à considérer en vue d'infléchir la mortalité liée à l'alcool.

Soins de santé primaires / Primary Health Care

Allen, T., et al. (2016). "Does the proportion of pay linked to performance affect the job satisfaction of general practitioners?" *Soc Sci Med* 173: 9-17.

There is concern that pay-for-performance (P4P) can negatively affect general practitioners (GPs) by reducing their autonomy, increasing their wage dispersion or eroding their intrinsic motivation. This is especially a concern for the Quality and Outcomes Framework (QOF), a highly powered P4P scheme for UK GPs. The QOF affected all GPs but the exposure of their income to P4P varied. GPs did not know their level of exposure before the QOF was introduced and could not choose or manage it. We examine whether changes in GPs' job satisfaction before and after the introduction of the QOF in 2004 were correlated with the proportion of their income that became exposed to P4P. We use data on 1920 GPs observed at three time points spanning the introduction of the QOF; 2004, 2005 and 2008. We estimate the effect of exposure to P4P using a continuous difference-in-differences model. We find no significant effects of P4P exposure on overall job satisfaction or 12 additional measures of working lives in either the short or longer term. The level of exposure to P4P does not harm job satisfaction or other aspects of working lives. Policies influencing the exposure of income to P4P are unlikely to alter GP job satisfaction subject to final income remaining constant.

Cambon, B., et al. (2016). "Quality of qualitative studies centred on patients in family practice: a systematic review." *Family Practice* 33(6): 580-587.

<http://fampra.oxfordjournals.org/content/33/6/580.abstract>

Background. Qualitative research is often used in the field of general medicine. Our objective was to evaluate the quality of published qualitative studies conducted using individual interviews or focus groups centred on patients monitored in general practice. Methods. We have undertaken a review of the literature in the PubMed and Embase databases of articles up to February 2014. The selection criteria were qualitative studies conducted using individual interviews or focus groups, centred on patients monitored in general practice. The articles chosen were analysed and evaluated using a score established from the Relevance, Appropriateness, Transparency and Soundness (RATS) grid. Results. The average score of the 52 studies chosen was 28 out of 42. The criteria least often present were the description of the patients who chose not to participate in the study, the justification of the end of data collection, the discussion of the influence of the researchers and the discussion of the confidentiality of the data. The criteria most frequently described were an explicit research question, justified and in relation to existing knowledge, the agreement of the ethical committee and the presence of quotations. The number of studies and the score increased from year-to-year. The score was independent of the impact factor of the journal. Conclusions. Even though the qualitative research was published in reviews with a low impact factor, our results suggest that this research responded to the quality criteria of the RATS grid. The evaluation scored using RATS could be useful for authors or reviewers and for literature reviews.

Gjesdal, S., et al. (2016). "GP consultations for common mental disorders and subsequent sickness certification: register-based study of the employed population in Norway." *Family Practice* 33(6): 656-662.

<http://fampra.oxfordjournals.org/content/33/6/656.abstract>

Background. Challenges related to work are in focus when employed people with common mental disorders (CMDs) consult their GPs. Many become sickness certified and remain on sick leave over time. Objectives. To investigate the frequency of new CMD episodes among employed patients in Norwegian general practice and subsequent sickness certification. Methods. Using a national claims register, employed persons with a new episode of CMD were included. Sickness certification, sick leave over 16 days and length of absences were identified. Patient- and GP-related predictors for the

different outcomes were assessed by means of logistic regression. Results. During 1 year 2.6% of employed men and 4.2% of employed women consulted their GP with a new episode of CMD. Forty-five percent were sickness certified, and 24 percent were absent over 16 days. Thirty-eight percent had depression and 19% acute stress reaction, which carried the highest risk for initial sickness certification, 75%, though not for prolonged absence. Men and older patients had lower risk for sickness certification, but higher risk for long-term absence. Conclusion. Better knowledge of factors at the workplace detrimental to mental health, and better treatment for depression and stress reactions might contribute to timely return of sickness absentees.

Imbaud, C., et al. (2016). "Le développement de centres de santé pluridisciplinaires de proximité en Allemagne : les Medizinische Versorgungszentren. ». ." *Santé Publique* 28(5): 555-568.

Les Medizinische Versorgungszentren (MVZ) sont des centres de santé de proximité pluridisciplinaires de petite taille nés en Allemagne en 2004. L'article décrit le processus d'émergence des MVZ, leur rôle dans le paysage global et compare leur organisation et leur fonctionnement aux modèles français des centres de santé (CS) et des maisons de santé pluriprofessionnelles (MSP). L'étude a été réalisée à partir de bibliographie et de 14 visites et entretiens. Les MVZ ont pour origine les « polikliniks » de l'ex-Allemagne de l'Est. Ils sont créés majoritairement par des médecins libéraux ou des hôpitaux et caractérisés par l'obligation de réunir une équipe de médecins pluridisciplinaires. Depuis 2004, leur nombre ne fait qu'augmenter. Ils prennent des formes variées aussi bien par les activités qu'ils proposent, par leur taille, que par leur lieu d'implantation. Les MVZ offrent une médecine de proximité, facilitent l'accès aux soins coordonnés de premier et second recours et permettent aux hôpitaux de développer des activités de spécialité en ambulatoire. Ils proposent également une médecine centrée patient en favorisant la coordination pluridisciplinaire et pluriprofessionnelle en interne et en externe entre les différents acteurs de soins. L'exemple des MVZ ouvre une réflexion sur les évolutions envisageables de l'organisation des spécialistes libéraux et de la structuration de l'offre hospitalière en France alors que les MSP se tournent principalement vers la médecine de premier recours et que les centres de santé de spécialités sont peu développés.

Larsson, L. G., et al. "Primary care managers' perceptions of their capability in providing care planning to patients with complex needs." *Health Policy* 121(1): 58-65.

<http://dx.doi.org/10.1016/j.healthpol.2016.11.010>

Care planning is a process where patient's needs and interventions are determined. Managers' perception of care planning was dominated by non-cooperation and separation. Care planning was not a priority for actors in primary care.

Leonardsen, A.-C. L., et al. (2016). "General practitioners' perspectives on referring patients to decentralized acute health care." *Family Practice* 33(6): 709-714.

<http://fampra.oxfordjournals.org/content/33/6/709.abstract>

Background. Municipality acute wards (MAWs) have recently been introduced in Norway. Their mandate is to provide treatment for patients who otherwise would have been hospitalized. Even though GPs are key stakeholders, little is known about how they perceive referring patients to these wards. The aim of this study was to investigate GPs' perspectives on factors relevant for their decision-making when referring patients to MAWs. Methods. We used a qualitative approach, conducting semi-structured interviews with 23 GPs from five different MAW catchment areas in the southeastern part of Norway. The data were analysed using thematic analysis. Results. The GPs experienced challenges in deciding which patients were suitable for treatment at a MAW, including whether patients could be regarded as medically clarified, and whether these services were sufficient and safe. GPs were also under pressure from several other stakeholders when deciding where to refer their patients. Moreover, the MAWs were viewed not merely as an alternative to hospitals, but also as a service in addition to hospitals. Conclusion. This study improves our understanding of how GPs experience decentralized acute health care services, by identifying factors that influence and challenge their

referral decisions. For these services to be used as intended in the collaboration reform, integrating the perspectives of GPs in the development and implementation of these services may be beneficial.

Levaillant, M. (2016). "Les études médicales, un enjeu de santé publique." *Gestions hospitalières*(559): 493-495.

Lin, T.-Y., et al. "The effectiveness of a pay for performance program on diabetes care in Taiwan: A nationwide population-based longitudinal study." *Health Policy* 120(11): 1313-1321.

<http://dx.doi.org/10.1016/j.healthpol.2016.09.014>

The long-term effect of P4P program on DM patient's prognoses is positive. Dose response relationship was found between level of P4P participation and mortality. Provider's incentives in policy can be effective in guarding patient's prognosis.

Liu, H., et al. (2017). "The Impact of Using Mid-level Providers in Face-to-Face Primary Care on Health Care Utilization." *Medical Care* 55(1): 12-18.

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

[medicalcare/Fulltext/2017/01000/The_Impact_of_Using_Mid_level_Providers_in.3.aspx](http://journals.lww.com/lww-medicalcare/Fulltext/2017/01000/The_Impact_of_Using_Mid_level_Providers_in.3.aspx)

Background: There has been concern that greater use of nurse practitioners (NP) and physician assistants (PA) in face-to-face primary care may increase utilization and spending. Objective: To evaluate a natural experiment within Kaiser Permanente in Georgia in the use of NP/PA in primary care. Study Design: From 2006 through early 2008 (the preperiod), each NP or PA was paired with a physician to manage a patient panel. In early 2008, NPs and PAs were removed from all face-to-face primary care. Using the 2006–2010 data, we applied a difference-in-differences analytic approach at the clinic level due to patient triage between a NP/PA and a physician. Clinics were classified into 3 different groups based on the percentage of visits by NP/PA during the preperiod: high (over 20% in-person primary care visits attended by NP/PAs), medium (5%–20%), and low (<5%) NP/PA model clinics. Measures: Referrals to specialist physicians; emergency department visits and inpatient admissions; and advanced diagnostic imaging services. Results: Compared with the low NP/PA model, the high NP/PA model and the medium NP/PA model were associated with 4.9% and 5.1% fewer specialist referrals, respectively ($P < 0.05$ for both estimates); the high NP/PA model and the medium NP/PA model also showed fewer hospitalizations and emergency department visits and fewer advanced diagnostic imaging services, but none of these was statistically significant. Conclusions: We find no evidence to support concerns that under a physician's supervision, NPs and PAs increase utilization and spending.

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." *The European Journal of 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.
<http://eurpub.oxfordjournals.org/content/eurpub/26/6/927.full.pdf>

Mehrotra, A., et al. (2016). "Patients Who Choose Primary Care Physicians Based On Low Office Visit Price Can Realize Broader Savings." *Health Affairs* 35(12): 2319-2326.

<http://content.healthaffairs.org/content/35/12/2319.abstract>

Price transparency initiatives encourage patients to save money by choosing physicians with a relatively low price per office visit. Given that the price of such visits represents a small fraction of total spending, the extent of the savings from choosing such physicians has not been clear. Using a national sample of commercial claims data, we compared the care received by patients of high- and low-price primary care physicians. The median price for an established patient's office visit was \$60 among low-price physicians and \$86 among high-price physicians (price was calculated as reimbursement plus out-of-pocket spending). Patients of low-price physicians also received, on average, relatively low-price lab tests, imaging, and other procedures. Total spending per year among patients cared for by low-price physicians was \$690 less than spending among patients cared for by high-price physicians. There were no consistent differences in patients' use of services between high- and low-price physicians. Despite modest differences in physicians' office visit prices, patients of low-price physicians had substantively lower overall spending, compared to patients of high-price physicians.

Mokrzycka, A., et al. "The 2014 primary health care reform in Poland: Short-term fixes instead of a long-term strategy." *Health Policy* 120(11): 1226-1232.

<http://dx.doi.org/10.1016/j.healthpol.2016.07.012>

The reform allowed pediatricians and internal medicine specialists to provide primary health care (PHC) services that would be reimbursed by the National Health Fund. The reform provides a short-term fix to the low number of physicians with a specialization in family medicine. A long-term strategy is missing to assure the provision of high quality PHC for the ageing population.

Mundt, M. P. et Swedlund, M. P. (2016). "A human factors systems approach to understanding team-based primary care: a qualitative analysis." *Family Practice* 33(6): 721-726.

<http://fampra.oxfordjournals.org/content/33/6/721.abstract>

Background. Research shows that high-functioning teams improve patient outcomes in primary care. However, there is no consensus on a conceptual model of team-based primary care that can be used to guide measurement and performance evaluation of teams. Objective. To qualitatively understand whether the Systems Engineering Initiative for Patient Safety (SEIPS) model could serve as a framework for creating and evaluating team-based primary care. Methods. We evaluated qualitative interview data from 19 clinicians and staff members from 6 primary care clinics associated with a large Midwestern university. All health care clinicians and staff in the study clinics completed a survey of their communication connections to team members. Social network analysis identified key informants for interviews by selecting the respondents with the highest frequency of communication ties as reported by their teammates. Semi-structured interviews focused on communication patterns, team climate and teamwork. Results. Themes derived from the interviews lent support to the SEIPS model components, such as the work system (Team, Tools and Technology, Physical Environment, Tasks and Organization), team processes and team outcomes. Conclusions. Our qualitative data support the SEIPS model as a promising conceptual framework for creating and evaluating primary care teams. Future studies of team-based care may benefit from using the SEIPS model to shift clinical practice to high functioning team-based primary care.

Oosterink, J. J., et al. (2016). "Interprofessional communication between oncologic specialists and general practitioners on end-of-life issues needs improvement." *Family Practice* 33(6): 727-732.

<http://fampra.oxfordjournals.org/content/33/6/727.abstract>

Background. Timely end-of-life (EOL) discussions between patients and physicians are considered essential for high-quality EOL care, but research shows that these discussions frequently do not occur or occur late. In oncology, one barrier for timely EOL discussions is poor collaboration between oncologic specialists and GPs. **Objective.** To explore interprofessional communication and coordination between oncologic specialists and GPs on EOL discussions. **Methods.** We conducted in-depth interviews with 16 GPs and 14 oncologic specialists. Interviews were recorded, transcribed verbatim and analysed using qualitative content analysis. **Results.** EOL discussions were primarily considered the role of the GP, but oncologists' perceptions of their own roles in discussing EOL issues varied. Interprofessional coordination on who discusses what and when was mostly absent. Interprofessional communication of EOL issues usually proceeded using the patient as intermediary. This functioned well but only if three essential conditions were met: the specialist being realistic to patients about limits of treatment, informing the GP adequately and the GP being proactive in initiating EOL issues in time. However, when these conditions were absent, timely EOL discussions did not seem to occur. **Conclusions.** EOL discussions are rarely a subject of direct interprofessional communication and mainly proceed through the patient as intermediary. For implementation of EOL discussions into regular care, earlier interprofessional communication and coordination is needed, particularly if barriers for such discussions occur.

Orozco-Beltrán, D., et al. (2016). "Management and referral of patients with severe and poorly controlled asthma in primary care." *Family Practice* 33(6): 678-683.

<http://fampra.oxfordjournals.org/content/33/6/678.abstract>

Background. Over 50% of treated patients with asthma in Europe are not well controlled. Their management in primary health care (PHC) differs from that in specialized care, and there is no real coordination between the two. **Objectives.** To identify barriers and solutions to improving the management of patients with severe and poorly controlled asthma and the communication between specialists and PHC, and to reach a consensus on the criteria for referral patients. **Methods.** An observational study using a modified Delphi technique. About 79 physicians from PHC, pneumology and allergy fields from different Spanish regions were invited to participate via an online questionnaire. Consensus was reached on an item when more than two-thirds of the panel members scored within the 3-point category (1–3 or 7–9) containing the median and the interquartile range of answers had to be ≤ 4 points. **Results.** Response rate: 52%. After the second round, consensus items were 40 (62.5%): of which 37 in agreement and 3 in disagreement. Around 92.68% of respondents agreed that it would be useful to incorporate questionnaires for asthma control into PHC computer-based searches. About 100% of participants agreed that clear consensus criteria between PHC and specialists must be determined to decide when a patient with asthma is referred from PHC to specialist or vice versa. Ten of the proposed criteria reached consensus agreement. **Conclusion.** The failure to use guidelines and specific questionnaires for asthma control in PHC is one reason why there is underdiagnosis and poor control of asthma. Some strategies to improve the asthma care management emerged from the survey results.

Systèmes de santé / Health Systems

Sanderson, M., et al. (2017). "The regulation of competition in the National Health Service (NHS): what difference has the Health and Social Care Act 2012 made?" *Health Econ Policy Law* 12(1): 1-19.

This article examines the impact of the Health and Social Care Act 2012 on the regulation of competition in the English National Health Service (NHS), by focussing on the change it marked from a

system of sector-specific regulation to one which is clearly based in competition law. It has been suggested that the Act and its associated reforms would significantly alter accountability in the NHS, and would change decisions from the remit of public policy to that of the law. To assess the impact the Act has had in practice, the article compares the interpretation of the rules regarding competition in the NHS by the regulators of competition immediately before, and following, the passing of the Act. It argues that, whilst the reforms have the potential significantly to alter the way competition in the NHS is regulated, the impact of the reforms in this area is limited by the development of systems within the NHS to manage and resolve issues internally where possible.

Wu, F. M., et al. (2016). "Assessing Differences between Early and Later Adopters of Accountable Care Organizations Using Taxonomic Analysis." *Health Services Research* 51(6): 2318-2329.
<http://dx.doi.org/10.1111/1475-6773.12473>

Objective: To compare early and later adopters of the accountable care organization (ACO) model, using the taxonomy of larger, integrated system; smaller, physician-led; and hybrid ACOs. Data sources: The National Survey of ACOs, Waves 1 and 2. Study design: Cluster analysis using the two-step clustering approach, validated using discriminant analysis. Wave 2 data analyzed separately to assess differences from Wave 1 and then data pooled across waves. Findings: Compared to early ACOs, later adopter ACOs included a greater breadth of provider group types and a greater proportion self-reported as integrated delivery systems. When data from the two time periods were combined, a three-cluster solution similar to the original cluster solution emerged. Of the 251 ACOs, 31.1 percent were larger, integrated system ACOs; 45.0 percent were smaller physician-led ACOs; and 23.9 percent were hybrid ACOs—compared to 40.1 percent, 34.0 percent, and 25.9 percent from Wave 1 clusters, respectively. Conclusions: While there are some differences between ACOs formed prior to August 2012 and those formed in the following year, the three-cluster taxonomy appears to best describe the types of ACOs in existence as of July 2013. The updated taxonomy can be used by researchers, policy makers, and health care organizations to support evaluation and continued development of ACOs.

Technologies médicales – E-santé / Medical Technologies –E-Health

De Rosis, S. et Barsanti, S. "Patient satisfaction, e-health and the evolution of the patient: ;general practitioner relationship: Evidence from an Italian survey." *Health Policy* 120(11): 1279-1292.
<http://dx.doi.org/10.1016/j.healthpol.2016.09.012>

The e-health user is mainly young, healthy and literate, showing a digital divide in the opportunities of health promotion through the ICT. Internet use for health purposes is affected by experience and satisfaction with the healthcare system, but not with the GPs. Being satisfied with GPs' involvement in decision-making is a key factor affecting the patient behaviour of sharing e-health findings with the GP. In the patient' web' physician triangulation, GPs play an important role in improving the appropriateness of the Internet use.

Durupt, M., et al. (2016). "La télémédecine en zones rurales : représentations et expériences de médecins généralistes." *Santé Publique* 28(4): 487-497.

Hofer, F., et al. (2016). "Cost-Utility Analysis of Telemonitoring Interventions for Patients with Chronic Obstructive Pulmonary Disease (COPD) in Germany." *Appl Health Econ Health Policy* 14(6): 691-701.

BACKGROUND: Chronic obstructive pulmonary disease (COPD) poses major challenges for health care systems. Previous studies suggest that telemonitoring could be effective in preventing hospitalisations and hence reduce costs. OBJECTIVE: The aim was to evaluate whether telemonitoring interventions for COPD are cost-effective from the perspective of German statutory sickness funds. METHODS: A cost-utility analysis was conducted using a combination of a Markov model and a decision tree.

Telemonitoring as add-on to standard treatment was compared with standard treatment alone. The

model consisted of four transition stages to account for COPD severity, and a terminal stage for death. Within each cycle, the frequency of exacerbations as well as outcomes for 2015 costs and quality adjusted life years (QALYs) for each stage were calculated. Values for input parameters were taken from the literature. Deterministic and probabilistic sensitivity analyses were conducted. RESULTS: In the base case, telemonitoring led to an increase in incremental costs (euro866 per patient) but also in incremental QALYs (0.05 per patient). The incremental cost-effectiveness ratio (ICER) was thus euro17,410 per QALY gained. A deterministic sensitivity analysis showed that hospitalisation rate and costs for telemonitoring equipment greatly affected results. The probabilistic ICER averaged euro34,432 per QALY (95 % confidence interval 12,161-56,703). CONCLUSION: We provide evidence that telemonitoring may be cost-effective in Germany from a payer's point of view. This holds even after deterministic and probabilistic sensitivity analyses.

Salisbury, C., et al. (2016). "Telehealth for patients at high risk of cardiovascular disease: pragmatic randomised controlled trial." *BMJ* 353.

Objective To assess whether non-clinical staff can effectively manage people at high risk of cardiovascular disease using digital health technologies. **Design** Pragmatic, multicentre, randomised controlled trial. **Setting** 42 general practices in three areas of England. **Participants** Between 3 December 2012 and 23 July 2013 we recruited 641 adults aged 40 to 74 years with a 10 year cardiovascular disease risk of 20% or more, no previous cardiovascular event, at least one modifiable risk factor (systolic blood pressure ≥ 140 mm Hg, body mass index ≥ 30 , current smoker), and access to a telephone, the internet, and email. **Participants** were individually allocated to intervention (n=325) or control (n=316) groups using automated randomisation stratified by site, minimised by practice and baseline risk score. **Interventions** Intervention was the Healthlines service (alongside usual care), comprising regular telephone calls from trained lay health advisors following scripts generated by interactive software. Advisors facilitated self management by supporting participants to use online resources to reduce risk factors, and sought to optimise drug use, improve treatment adherence, and encourage healthier lifestyles. The control group comprised usual care alone. **Main outcome measures** The primary outcome was the proportion of participants responding to treatment, defined as maintaining or reducing their cardiovascular risk after 12 months. Outcomes were collected six and 12 months after randomisation and analysed masked. **Participants** were not masked. **Results** 50% (148/295) of participants in the intervention group responded to treatment compared with 43% (124/291) in the control group (adjusted odds ratio 1.3, 95% confidence interval 1.0 to 1.9; number needed to treat=13); a difference possibly due to chance (P=0.08). The intervention was associated with reductions in blood pressure (difference in mean systolic -2.7 mm Hg (95% confidence interval -4.7 to -0.6 mm Hg), mean diastolic -2.8 (-4.0 to -1.6 mm Hg); weight -1.0 kg (-1.8 to -0.3 kg), and body mass index -0.4 (-0.6 to -0.1) but not cholesterol -0.1 (-0.2 to 0.0), smoking status (adjusted odds ratio 0.4, 0.2 to 1.0), or overall cardiovascular risk as a continuous measure (-0.4 , -1.2 to 0.3). The intervention was associated with improvements in diet, physical activity, drug adherence, and satisfaction with access to care, treatment received, and care coordination. One serious related adverse event occurred, when a participant was admitted to hospital with low blood pressure. **Conclusions** This evidence based telehealth approach was associated with small clinical benefits for a minority of people with high cardiovascular risk, and there was no overall improvement in average risk. The Healthlines service was, however, associated with improvements in some risk behaviours, and in perceptions of support and access to care. **Trial registration** Current Controlled Trials ISRCTN 27508731. <http://www.bmj.com/content/bmj/353/bmj.i2647.full.pdf>

Sorbets, E. (2016). "[E-health and treatment adherence]." *Presse Med* 45(10): 856-858.

The medico-economic implications of poor drug compliance are such that improving the adherence could have a considerable impact in terms of public health. Technological tools from the digital revolution are now at the service of health: the connected health. There are already numerous, more or less sophisticated, and many more are under development. Data from the literature suggest that these tools could provide real benefits including improving patient compliance. The digital revolution has changed our daily lives. It will certainly revolutionize the practice of medicine.

Travail et santé / Occupational Health

Dyrstad, K., et al. (2016). "Sick of waiting: Does waiting for elective treatment cause sickness absence?" *Health Policy*. 120 (12) : 1383-1388

Sickness absence represents a substantial cost in most of Western Europe, whether the insurance scheme is public or private. The objective of this study was to analyse whether waiting time for elective treatment in specialist health care is associated with the length of individual sickness absence in Norway. To estimate the association between waiting time and the duration of sick leave, we used data from the working population aged 18-67 years in 2010-2012. The files combined register data from The Norwegian Patient Registry with individual characteristics and sickness absence data from Statistics Norway, and was analysed using zero-truncated negative binomial regression. We found that about one in four employees who had one or more spells of sick leave in the period, was also waiting for consultation or treatment in specialist health care. Yet, the length of the waiting period had no substantial effect on the length of sickness absence (i.e., less than 0.1% reduction). Therefore, while measures to reduce waiting times for hospital treatment in many instances could be beneficial for the individual patient, such policies would probably not have any substantial impact on the national sickness absence rate.

Pagetti, L., et al. (2016). "Retour à l'emploi après un accident de travail : une coordination entre médecin du travail et médecin-conseil d'assurance est-elle possible ?" *Santé Publique*(5): 603-612.

Médecin du travail et médecin-conseil d'assurance ont chacun un rôle propre à jouer dans le décours de la prise en charge d'un accident de travail et leur interaction est au centre du processus administratif et clinique de retour au travail. Nous avons voulu analyser les freins et facilitateurs de cette collaboration dans le contexte belge. La méthode utilisée était une étude qualitative par entretiens individuels dirigés auprès d'un échantillon de médecins-conseils d'assurance et de médecins du travail exerçant en Belgique francophone. Cet échantillon a été choisi pour représenter toutes les compagnies d'assurance et la plupart des services de prévention et protection opérant sur le territoire. Le guide d'entretien a été élaboré de manière à explorer les différentes dimensions du modèle RDIC (Resource Dependence Institutional Collaboration) de collaboration entre professionnels. Cette étude a permis de mettre en évidence les freins entravant la collaboration et qui sont de l'ordre de la perception mutuelle des deux professions, de la méconnaissance du contexte de travail de l'autre profession, du manque de ressources indépendantes entravant la volonté de collaboration (temps suffisant, honoraires). Des éléments facilitateurs ont aussi été mis en évidence : une volonté de collaboration des médecins du travail, une attitude positive sur la capacité à coopérer, ainsi que des propositions d'améliorations immédiates de certains facteurs. La collaboration entre ces deux professions avait été très peu étudiée auparavant, les résultats mis au jour ici fournissent des pistes d'amélioration pouvant être appliquées à court ou à moyen terme. Ceci permettrait aux deux catégories de médecins d'être plus efficaces et structurés dans la prise en charge des accidents de travail et de leurs conséquences en matière d'incapacité de travail.

Susser, P. et Ziebarth, N. R. (2016). "Profiling the U.S. Sick Leave Landscape: Presenteeism among Females." *Health Services Research* 51(6): 2305-2317.

<http://dx.doi.org/10.1111/1475-6773.12471>

Objective: To profile the sick leave landscape in the United States. Data Sources: The 2011 Leave Supplement of the American Time Use Survey. Study Design: Bivariate and multivariate analyses to identify (i) employees without sick pay coverage and (ii) employees who attend work sick. Principal Findings: Sixty-five percent of full-time employees have sick pay coverage. Coverage rates are below 20 percent for employees with hourly wages below \$10, part-time employees, and employees in the hospitality and leisure industry. Conclusion: Each week, up to 3 million U.S. employees go to work sick. Females, low-income earners, and those aged 25 to 34 years have a significantly elevated risk of

presenteeism behavior.

Vahid Shahidi, F., et al. (2016). "Does social policy moderate the impact of unemployment on health? A multilevel analysis of 23 welfare states." *The European Journal of 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. %U <http://eurpub.oxfordjournals.org/content/eurpub/26/6/1017.full.pdf>

Vigoureux, S., et al. (2016). "Occupational, social and medical characteristics of early prenatal leave in France." *The European Journal of Public Health* 26(6): 1022-1027.

Background: In France, most women of childbearing age work. The prenatal leave law in France protects women during pregnancy and their employment. We aimed to describe how long before delivery women stopped working and analyse the association between occupational, social and medical factors and early prenatal leave (before 24 weeks' gestation). Methods: The sample was extracted from the 2010 French National Perinatal Survey. Women were interviewed in French maternity units during a 1-week period. We focused on all women with a singleton live birth who were working during pregnancy (n = 10 149). Women were interviewed between delivery and discharge to collect information on employment, date of leave, sociodemographic and medical characteristics. Results: Among women who worked during pregnancy, 27.5% reported early occupational leave (before 24 weeks' gestation). Early occupational leave was more frequent among women with unstable jobs (fixed-term vs. non-fixed-term contract: adjusted odds ratio OR = 1.60 [95% confidence interval 1.40–1.84]) and with less-qualified occupational categories (manual workers vs. managers and upper-intellectual positions: OR = 2.96 [2.30–3.82]), even after adjusting for sociodemographic and other employment characteristics. Women with a pathological or at risk pregnancy left work earlier than other women. After stratification on type of pregnancy there was still a higher rate of early leave for women with less qualified occupational group. Conclusion: In France, social vulnerability of pregnant women, linked to low sociodemographic situation or low occupational categories, is associated with early leave during pregnancy, even after stratification on type of pregnancy. <http://eurpub.oxfordjournals.org/content/eurpub/26/6/1022.full.pdf>

Vieillessement / Ageing

Laaksonen, M., et al. (2016). "Sickness allowance trajectories preceding disability retirement: a register-based retrospective study." *The European Journal of Public Health* 26(6): 1050-1055. <http://eurpub.oxfordjournals.org/content/eurpub/26/6/1050.full.pdf>

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.

Vrhovec, J. et Tajnikar, M. "Population ageing and healthcare demand: The case of Slovenia."

Health Policy **120**(11): 1329-1336.

<http://dx.doi.org/10.1016/j.healthpol.2016.09.007>

The effects of population ageing on healthcare demand in Slovenia were investigated. A model for forecasting healthcare demand was developed. Healthcare demand is expected to increase for four major types of healthcare services. The forecast increases are significant, especially for hospital services. Specific disease groups have a larger effect on healthcare demand.