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Veille scientifique
en économie de la santé

Janvier 2018

Sommaire en français

Watch on
Health Economics Literature

January 2018

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Institut de recherche et documentation en économie de la santé

Présentation

Cette publication mensuelle, réalisée par les documentalistes de l'Irdes, rassemble de façon thématique les résultats de la veille documentaire sur les systèmes et les politiques de santé ainsi que sur l'économie de la santé : articles, littérature grise, ouvrages, rapports…

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www.irdes.fr/documentation/veille-bibliographique-en-economie-de-la-sante.html

Veille scientifique en économie de la santé

Directeur de la publication Denis Raynaud
Documentalistes Marie-Odile Safon
Véronique Suhard
Maquette & Mise en pages Franck-Séverin Clérembault
Mise en ligne web Aude Sirvain
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Institut de recherche et documentation en économie de la santé
117bis rue Manin - 75019 Paris • Tél. : 01 53 93 43 00 • www.irdes.fr

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Assurance maladie

La bataille de l'Obamacare et ses leçons pour la France

MEUNIER F.

2017

Esprit (11): 106-114.

https://www.cairn.info/revue-esprit-2017-11-page-106.htm

La saga de l'Obamacare rebondit. Le Congrès américain, dominé par le Parti républicain, n'est pas arrivé depuis l'élection de Donald Trump à abolir le Affordable Care Act, la loi sur l'assurance maladie universelle aux États-Unis, dite Obamacare. Aux termes d'atermoiements, de tentatives avortées, de pressions sur les membres du Congrès, l'évidence est apparue : les Républicains ne disposent d'aucune proposition sérieuse de remplacement pour la loi emblématique de la présidence Obama. Se défaire de cette loi sans accord sur un nouveau système a fait peur à beaucoup. D'autant plus qu'il est difficile de toucher un élément partiel de cette loi sans tout mettre à terre. C'est exactement ce qu'a compris Donald Trump. Au moment où j'écris, il vient, dans une sorte de politique du pire, de prendre deux ordonnances qui, si elles étaient appliquées, paralyseraient la loi, forçant le Congrès à légiférer à nouveau.

Estimating the Effects of Health Insurance and Other Social Programs on Poverty Under the Affordable Care Act

REMLER D. K., *et al.*

2017

Health Aff (Millwood) 36(10): 1828-1837.

The effects of health insurance on poverty have been difficult to ascertain because US poverty measures have not taken into account the need for health care and the value of health benefits. We developed the first US poverty measure to include the need for health insurance and to count health insurance benefits as resources available to meet that need-in other words, a health-inclusive poverty measure. We estimated the direct effects of health insurance benefits on health-inclusive poverty for people younger than age sixty-five, comparing the impacts of different health insurance programs and of nonhealth means-tested cash and in-kind benefits, refundable tax credits, and nonhealth social insurance programs. Private health insurance benefits reduced poverty by 3.7 percentage points. Public health insurance benefits (from Medicare, Medicaid, and Affordable Care Act premium subsidies) accounted for nearly one-third of the overall poverty reduction from public benefits. Poor adults with neither children nor a disability experienced little poverty relief from public programs, and what relief they did receive came mostly from premium subsidies and other public health insurance benefits. Medicaid had a larger effect on child poverty than all nonhealth means-tested benefits combined.

E-santé

Chapitre 2. Utilisation des Big Data en santé : le cas des objets connectés

BROUARD B.

2017

Journal International de Bioéthique 28(3): 27-30.

https://www.cairn.info/revue-journal-international-de-bioethique-2017-3-page-27.htm

Selon le rapport « The Internet of Things Market », le nombre d'objets connectés devrait être de 68 milliards en 2020. De plus, en 2012, le total des données stockées dans le monde était de 500 petabytes. Après la course à la puissance de calcul puis au développement des réseaux, l'enjeu réside désormais dans le stockage de ces données dans le « cloud », mais aussi et surtout, à libérer leur accès (open data) et à les traiter rapidement et en masse (Big Data). L'utilisation de ces données à bon escient est un enjeu majeur pour la recherche et la santé publique.

E-Health in Switzerland: The Laborious Adoption of the Federal Law on Electronic Health Records (EHR) and Health Information Exchange (HIE) Networks

DE PIETRO C. ET FRANCETIC I.

2017/11

Health Policy: Ahead of print.

Within the framework of a broader e-health strategy launched a decade ago, in 2015 Switzerland passed a new federal law on patients' electronic health records (EHR). The reform requires hospitals to adopt interoperable EHRs to facilitate data sharing and cooperation among healthcare providers, ultimately contributing to improvements in quality of care and efficiency in the health system. Adoption is voluntary for ambulatories and private practices, that may however be pushed towards EHRs by patients. The latter have complete discretion in the choice of the health information to share. Moreover, careful attention is given to data security issues. Despite good intentions, the high institutional and organisational fragmentation of the Swiss healthcare system, as well as the lack of full agreement with stakeholders on some critical points of the reform, slowed the process of adoption of the law. In particular, pilot projects made clear that the participation of ambulatories is doomed to be low unless appropriate incentives are put in place. Moreover, most stakeholders point at the strategy proposed to finance technical implementation and management of EHRs as a major drawback. After two years of intense preparatory work, the law entered into force in April 2017.

Chapitre 6. Les dispositions de la loi de modernisation de notre système de santé relatives aux données de santé

DEVILLIER N.

2017

Journal International de Bioéthique 28(3): 57-61.

https://www.cairn.info/revue-journal-international-de-bioethique-2017-3-page-57.htm

La loi sur la modernisation de notre système de santé adoptée en 2016 étend le champ du secret médical en créant le dossier médical partagé (DMP) du patient. Tous les professionnels de santé intervenant dans le parcours de soin ont accès aux informations qui y sont renseignées. Le patient y accède par un site Internet dédié. Les décrets d'application de ce dispositif fixent les modalités de ce partage et encadrent la création de ce traitement automatisé de données à caractère personnel. Enfin, la loi créée un accès ouvert et sécurisé aux données de santé dans l'intérêt de la collectivité. Cet open data en santé est placé sous la gouvernance de l'Institut national des données de santé.

Using Mobile Apps to Communicate Vaccination Records: A City-Wide Evaluation with a National Immunization App, Maternal Child Registry and Public Health Authorities

ATKINSON K.M., *et al.*

2017

Healthcare Quarterly 20(3): 41-46.

http://www.longwoods.com/product/25289

Medicine is experiencing a paradigm shift, where patients are increasingly involved in the management of their health data. We created a mobile app which permitted parental reporting of immunization status to public health authorities. We describe app use as a proxy for feasibility and acceptability as well as data utility for public health surveillance. The evaluation period ran from April 27, 2015, to April 18, 2017, during which time 2,653 unique children's records were transmitted, containing 36,105 vaccinations. Our findings suggest that mobile immunization reporting is feasible and may be an acceptable complement to existing reporting methods. Measures of data utility suggest that mobile reporting could enable more accurate assessments of vaccine coverage.

Chapitre 4. La gouvernance des Big data utilisées en santé, un enjeu national et international

RIAL-SEBBAG E.

2017

Journal International de Bioéthique 28(3): 39-50.

https://www.cairn.info/revue-journal-international-de-bioethique-2017-3-page-39.htm

L'utilisation des données de santé est de plus en plus considérée comme un enjeu central pour la recherche mais également pour le soin. La génération de ces données est une valeur ajoutée pour la conduite d'études à grande échelle, elle est même considérée comme une (r)évolution dans la méthodologie de la recherche ou encore la médecine personnalisée. Plusieurs facteurs ont influencé l'accélération de l'utilisation des données de santé (progrès de la génétique, de la technologie, diversification des sources) conduisant à re-questionner les principes juridiques posés pour la protection des données de santé tant en droit français qu'en droit européen. En effet, premièrement, la production de masse (Big Data) de données dans le champ de la santé influe sur la quantité et la qualité des données venant dès lors reconfigurer les outils de protection de la vie privée en insistant sur le risque informationnel. Deuxièmement, l'utilisation de ces données repose quant à elle sur des principes fondamentaux existants tout en soulevant de nouveaux challenges pour leur gouvernance.

La télémédecine dans la loi de financement de la sécurité sociale pour 2017

SIMON P.

2017/09-10

Techniques Hospitalières(765): 6p.

Le programme Expérimentations de télémédecine pour l'amélioration du parcours en santé (Etapes) préfigure le financement des pratiques professionnelles de télémédecine dans le droit commun de la sécurité sociale. Cet article présente ce programme initié dans la Loi de financement de la sécurité sociale pour 2017.

Économie de la santé

How Much Do Cancer Specialists Earn? A Comparison of Physician Fees and Remuneration in Oncology and Radiology in High-Income Countries

BOYLE S., *et al.*

2017

Health Policy : Ahead of print.

http://dx.doi.org/10.1016/j.healthpol.2017.11.003

Higher spending on healthcare in the USA is driven by higher physician fees. The oncology consultation fee is three times greater, chemotherapy four times. There is a three to fourfold variation in fees for ultrasound and CT scans. Physician earnings in the USA are greater in oncology and radiology. Canadian specialists earn considerably more than their European counterparts.

A Method to Simulate Incentives for Cost Containment Under Various Cost Sharing Designs: An Application to a First-Euro Deductible and a Doughnut Hole

CATTEL D., *et al.*

2017

Eur J Health Econ 18 (8): 987-1000.

Many health insurance schemes include deductibles to provide consumers with cost containment incentives (CCI) and to counteract moral hazard. Policymakers are faced with choices on the implementation of a specific cost sharing design. One of the guiding principles in this decision process could be which design leads to the strongest CCI. Despite the vast amount of literature on the effects of cost sharing, the relative effects of specific cost sharing designs-e.g., a traditional deductible versus a doughnut hole-will mostly be absent for a certain context. This papers aims at developing a simulation model to approximate the relative effects of different deductible modalities on the CCI. We argue that the CCI depends on the probability that healthcare expenses end up in the deductible range and the expected healthcare expenses given that they end up in the deductible range. Our empirical application shows that different deductible modalities result in different CCIs and that the CCI under a certain modality differs across risk-groups.

Improving Risk Equalization for Individuals with Persistently High Costs: Experiences from the Netherlands

EIJKENAAR F. ET VAN VLIET R.

2017

Health Policy 121(11): 1169-1176.

Risk-equalization (RE) models in competitive health insurance markets have become increasingly sophisticated. However, these models still have important imperfections. A specific problem in the Netherlands is that insurers are insufficiently compensated for individuals who can persistently be found in the right-end tail of the cost distribution. The goal of this study is to explore and evaluate options for improving compensation for persistently high-cost individuals in the Dutch basic health insurance. Prescription drugs claims (2012) and administrative data on costs and risk-characteristics (2010-2013) for the entire Dutch population are used to identify high-cost individuals and evaluate improvement options. These options - including new risk-classes and a form of risk-sharing - are evaluated in terms of insurers' incentives for risk-selection and efficiency. Although this study provides useful insights in the possibilities for improving RE-models for persistently high-cost individuals, improving compensation remains challenging and dependent on the ongoing debate regarding coverage and reimbursement of expensive drugs.

▶ Combined Social and Private Health Insurance Versus Catastrophic Out of Pocket Payments for Private Hospital Care in Greece

GRIGORAKIS N., *et al.*

2017

Int J Health Econ Manag. : Ahead of print.

The high level of out of pocket (OOP) payments constitutes a major concern for Greece and several other European and OECD countries as a result of the significant down turning of their public health finances due to the 2008 financial crisis. The basic objective of this study is to provide empirical evidence on the effect of combining social health insurance (SHI) and private health insurance (PHI) on OOP payments. Further, this study examines the catastrophic impact of OOP payments on insured's welfare using the incidence and intensity methodological approach of measuring catastrophic health care expenditures. Conducting a cross-sectional survey in Greece in 2013, we find that the combination of SHI-PHI has a strong negative influence on insured OOP payments for inpatient health care in private hospitals. Furthermore, our results indicate that SHI coverage is not sufficient by itself to manage with this issue. Moreover, we find that poor people present a greater tendency to incur catastrophic OOP expenditures for hospital health care in private providers. Drawing evidence from Greece, a country with huge fiscal problems that has suffered the consequences of the economic crisis more than any other, could be a starting point for policymakers to consider the perspective of SHI-PHI co-operation against OOP payments more seriously.

▶ How Do Performance-Based Financing Programmes Measure Quality of Care? A Descriptive Analysis of 68 Quality Checklists from 28 Low- and Middle-Income Countries

JOSEPHSON E., *et al.*

2017

Health Policy Plan 32(8): 1120-1126.

This paper seeks to systematically describe the length and content of quality checklists used in performance-based financing programmes, their similarities and differences, and how checklists have evolved over time. We compiled a list of supply-side, health facility-based performance-based financing (PBF) programmes in low- and lower middle-income countries based on a document review. We then solicited PBF manuals and quality checklists from implementers and donors of these PBF mechanisms. We entered each indicator from each quality checklist into a database verbatim in English, and translated into English from French where appropriate, and categorized each indicator according to the Donabedian framework and an author-derived categorization. We extracted 8,490 quality indicators from 68 quality checklists across 32 PBF implementations in 28 countries. On average, checklists contained 125 indicators; within the same program, checklists tend to grow as they are updated.

▶ Effect of Incentive Payments on Chronic Disease Management and Health Services Use in British Columbia, Canada: Interrupted Time Series Analysis

LAVERGNE M. R., *et al.*

2017

Health Policy : Ahead of print.

We studied the effects of incentive payments to primary care physicians for the care of patients with diabetes, hypertension, and Chronic Obstructive Pulmonary Disease (COPD) in British Columbia, Canada. We used linked administrative health data to examine monthly primary care visits, continuity of care, laboratory testing, pharmaceutical dispensing, hospitalizations, and total health care spending. We examined periods two years before and two years after each incentive was introduced, and used segmented regression to assess whether there were changes in level or trend of outcome measures across all eligible patients following incentive introduction, relative to pre-intervention periods. We observed no increases in primary care visits or continuity of care after incentives were introduced. Rates of ACR testing and antihypertensive dispensing increased among patients with hypertension, but none of the other modest increases in laboratory testing or prescriptions dispensed reached statistical significance. Rates of hospitalizations for stroke and heart failure among patients with hypertension fell relative to pre-intervention patterns, while hospitalizations for COPD increased. Total hospitalizations and hospitalizations via the emergency department did not change. Health care spending increased for patients with hypertension. This large-scale incentive scheme for primary care physicians showed some positive effects for patients with hypertension, but we observe no similar changes in patient management, reductions in hospitalizations, or changes in spending for patients with diabetes and COPD.

Improving Care and Lowering Costs: Evidence and Lessons from a Global Analysis of Accountable Care Reforms

MCCLELLAN M., *et al.*

2017

Health Aff (Millwood) 36(11): 1920-1927.

Policy makers and providers are under increasing pressure to find innovative approaches to achieving better health outcomes as efficiently as possible. Accountable care, which holds providers accountable for results rather than specific services, is emerging in many countries to support such care innovations. However, these reforms are challenging and complex to implement, requiring significant policy and delivery changes. Despite global interest, the evidence on how to implement accountable care successfully remains limited. To improve the evidence base and increase the likelihood of success, we applied a comprehensive framework for assessing accountable care implementation to three promising reforms outside the United States. The framework relates accountable care policy reforms to the competencies of health care organizations and their health policy environments to facilitate qualitative comparisons of innovations and factors that influence success. We present emerging lessons to guide future implementation and evaluation of accountable care reforms to improve access to and the quality and affordability of care.

Does Health Insurance Reduce Out-Of-Pocket Expenditure? Heterogeneity Among China's Middle-Aged and Elderly

ZHANG A., *et al.*

2017

Soc Sci Med 190: 11-19.

China's recent healthcare reforms aim to provide fair and affordable health services for its huge population. In this paper, we investigate the association between China's health insurance and out-of-pocket (OOP) healthcare expenditure. We further explore the heterogeneity in this association. Using data of 32,387 middle-aged and elderly individuals drawn from the 2011 and 2013 waves of China Health and Retirement Longitudinal Study (CHARLS), we report five findings. First, having health insurance increases the likelihood of utilizing healthcare and reduces inpatient OOP expenditure. Second, healthcare benefits are distributed unevenly: while low- and medium-income individuals are the main beneficiaries with reduced OOP expenditure, those faced with very high medical bills are still at risk, owing to limited and shallow coverage in certain aspects. Third, rural migrants hardly benefit from having health insurance, suggesting that institutional barriers are still in place. Fourth, health insurance does not increase patient visits to primary care facilities; hospitals are still the main provider of healthcare. Nonetheless, there is some evidence that patients shift from higher-tier to lower-tier hospitals. Last, OOP spending on pharmaceuticals is reduced for inpatient care but not for outpatient care, suggesting that people rely on inpatient care to obtain reimbursable drugs, putting further pressure on the already overcrowded hospitals.

État de santé

Not Feeling Well ... True or Exaggerated? Self-Assessed Health as a Leading Health Indicator

BECCHETTI L., *et al.*

2017

Health Econ. : Ahead of print.

We provide original, international evidence documenting that self-assessed health (SAH) is a leading health indicator, that is, a significant predictor of future changes in health conditions, in a large sample of Europeans aged above 50 and living in 13 different countries. We find that, after controlling for attrition bias, lagged SAH is significantly and negatively correlated with changes in the number of chronic diseases, net of the correlations with levels, and changes in sociodemographic factors and health styles, country and regional health system effects, and declared symptoms. Illness-specific estimates document that lagged SAH significantly correlates with arthritis, cholesterol, and lung diseases (and weakly so with ulcer, hypertension, and cataracts) and has a significant correlation with the probability of contracting cancer. Interpretations and policy implications of our findings are discussed in the paper.

Childhood Environmental Harshness Predicts Coordinated Health and Reproductive Strategies: A Cross-Sectional Study of a Nationally Representative Sample from France

MELL H., *et al.*

2018

Evolution and Human Behavior 39(1):1-8.

http://dx.doi.org/10.1016/j.evolhumbehav.2017.08.006

There is considerable variation in health and reproductive behaviours within and across human populations. Drawing on principles from Life History Theory, psychosocial acceleration theory predicts that individuals developing in harsh environments decrease their level of somatic investment and accelerate their reproductive schedule. Although there is consistent empirical support for this general prediction, most studies have focused on a few isolated life history traits and few have investigated the way in which individuals apply life strategies across reproductive and somatic domains to produce coordinated behavioural responses to their environment. In our study, we thus investigate the impact of childhood environmental harshness on both reproductive strategies and somatic investment by applying structural equation modeling (SEM) to cross-sectional survey data obtained in a representative sample of the French population (n = 1015, age: 19-87years old, both genders). This data allowed us to demonstrate that (i) inter-individual variation in somatic investment (e.g. effort in looking after health) and reproductive timing (e.g. age at first birth) can be captured by a latent fast-slow continuum, and (ii) faster strategies along this continuum are predicted by higher childhood harshness. Overall, our results support the existence of a fast-slow continuum and highlight the relevance of the life history approach for understanding variations in reproductive and health related behaviours.

Self-Rated Health, Generalized Trust, and the Affordable Care Act: A US Panel Study, 2006-2014

MEWES J. ET GIORDANO G. N.

2017

Soc Sci Med 190: 48-56.

Previous research shows that generalized trust, the belief that most people can be trusted, is conducive to people's health. However, only recently have longitudinal studies suggested an additional reciprocal pathway from health back to trust. Drawing on a diverse body of literature that shows how egalitarian social policy contributes to the promotion of generalized trust, we hypothesize that this other 'reverse' pathway could be sensitive to health insurance context. Drawing on nationally representative US panel data from the General Social Survey, we examine whether the Affordable Care Act of 2010 could have had influence on the deteriorating impact of worsening self-rated health (SRH) on generalized trust. Firstly, using two-wave panel data (2008-2010, N = 1403) and employing random effects regression models, we show that a lack of health insurance coverage negatively determines generalized trust in the United States. However, this association is attenuated when additionally controlling for (perceived) income inequality. Secondly, utilizing data from two separate three-wave panel studies from the US General Social Survey (2006-10; N = 1652; 2010-2014; N = 1187), we employ fixed-effects linear regression analyses to control for unobserved heterogeneity from time-invariant factors. We demonstrate that worsening SRH was a stronger predictor for a decrease in generalized trust prior (2006-2010) to the implementation of the Affordable Care Act. Further, the negative effect of fair/poor SRH seen in the 2006-2010 data becomes attenuated in the 2010-2014 panel data

▶ How Strongly Related Are Health Status and Subjective Well-Being? Systematic Review and Meta-Analysis

NGAMABA K. H., *et al.*

2017

Eur J Public Health 27(5): 879-885.

Health status is widely considered to be closely associated with subjective well-being (SWB), yet this assumption has not been tested rigorously. The aims of this first systematic review and meta-analysis are to examine the association between health status and SWB and to test whether any association is affected by key operational and methodological factors. A systematic search (January 1980-April 2017) using Web of Science, Medline, Embase, PsycInfo and Global health was conducted according to Cochrane and PRISMA guidelines. Meta-analyses using a random-effects model were performed. Twenty nine studies were included and the pooled effect size of the association between health status and SWB was medium, statistically significant and positive (pooled r = 0.347, 95% CI = 0.309-0.385; Q = 691.51, I2 = 94.99%, P < 0.001). However, the association was significantly stronger: (i) when SWB was operationalised as life satisfaction (r = 0.365) as opposed to happiness (r = 0.307); (ii) among studies conducted in developing countries (r = 0.423) than it was in developed countries (r = 0.336) and (iii) when multiple items were used to assess health status and SWB (r = 0.353) as opposed to single items (r = 0.326). Conclusion: Improving people's health status may be one means by which governments can improve the SWB of their citizens. Life satisfaction might be preferred to happiness as a measure of SWB because it better captures the influence of health status.

Géographie de la santé

▶ Junior Doctors' Medical Specialty and Practice Location Choice: Simulating Policies to Overcome Regional Inequalities

RAMOS P., *et al.*

2017

Eur J Health Econ 18(8): 1013-1030.

There are nowadays over 1 million Portuguese who lack a primary care physician. By applying a discrete choice experiment to a large representative sample of Portuguese junior doctors (N = 503) in 2014, we provide an indication that this shortage may be addressed with a careful policy design that mixes pecuniary and non-pecuniary incentives for these junior physicians. According to our simulations, a policy that includes such incentives may increase uptake of general practitioners (GPs) in rural areas from 18% to 30%. Marginal wages estimated from our model are realistic and close to market prices: an extra hour of work would require an hourly wage of 16.5euro; moving to an inland rural setting would involve an increase in monthly income of 1.150euro (almost doubling residents' current income); a shift to a GP career would imply an 849euro increase in monthly income. Additional opportunities to work outside the National Health Service overcome an income reduction of 433euro. Our simulation predicts that an income increase of 350euro would lead to a 3 percentage point increase in choice probability, which implies an income elasticity of 3.37, a higher estimation compared to previous studies.

▶ Determining Geographic Accessibility of Family Physician and Nurse Practitioner Services in Relation to the Distribution of Seniors Within Two Canadian Prairie Provinces

SHAH T. I., *et al.*

2017

Soc Sci Med 194: 96-104.

Equitable access and distribution of health care services for rural and remote populations is a substantial challenge for health workforce planners and policy makers. Geospatial examination of access to health care considers both need and supply dimensions together to determine spatial access scores which contribute to a greater understanding of potential inequity in accessibility. This geospatial investigation explores geographic variation in accessibility to primary health care services utilizing combined access scores for family physicians and nurse practitioner services in urban and rural communities in the Canadian Prairie provinces of Saskatchewan and Alberta. An index of access scores was developed using a floating catchment area framework and a census subdivision geographic unit. Information about family physician and nurse practitioner practice locations and spatial population data were obtained from the Canadian Institute for Health Information and Statistics Canada respectively. This study contributes to health services research by exploration of combined access scores for family physician and nurse practitioner services in relation to the distribution of seniors. These findings provide insight into which areas may be in need of increased primary health care services with a focus on both of these health professional groups. The findings of this research will serve as a foundational model for future expansion of the methods to other health care provider groups and to other population health need indicators provincially and nationally.

Handicap

▶ Collaborative Design of a Health Care Experience Survey for Persons with Disability

LEZZONI L. I., *et al.*

2017

Disability and Health Journal 10(2): 231-239.

http://www.sciencedirect.com/science/article/pii/S193665741730002X

When assessing results of health care delivery system reforms targeting persons with disability, quality metrics must reflect the experiences and perspectives of this population. For persons with disability and researchers to develop collaboratively a survey that addresses critical quality questions about a new Massachusetts health care program for persons with disability dually-eligible for Medicare and Medicaid. Persons with significant physical disability or serious mental health diagnoses participated fully in all research activities, including co-directing the study, co-moderating focus groups, performing qualitative analyses, specifying survey topics, cognitive interviewing, and refining survey language. Several sources informed survey development, including key informant interviews, focus groups, and cognitive testing. Analyses by collaborators with disability identified 29 questions for persons with physical disability and 38 for persons with mental health diagnoses. After cognitive testing, the final survey includes questions on topics ranging from independent living principles to health care delivery system concerns. The Persons with Disabilities Quality Survey (PDQ-S) captures specific quality concerns of Massachusetts residents with physical or mental health disability about an integrated health plan. PDQ-S requires further testing elsewhere to determine its value for quality assessment more generally and to other populations with disability.

▶ De la vulnérabilité et du droit des usagers de notre système de santé

OLLIVET C.

2017

Gérontologie et société 39(154): 109-119.

https://www.cairn.info/revue-gerontologie-et-societe-2017-3-page-109.htm

Aborder le vieillissement cognitif, et en particulier les syndromes démentiels, avec le prisme des droits de l’Homme permet d’attirer l’attention sur les privations de droits et sur les restrictions abusives de liberté dont sont victimes les personnes âgées en difficulté cognitive. Cela conduit aussi à se demander si le cadre de référence que constituent les droits de l’Homme ne pourrait pas permettre de définir un projet ou une ambition, et aider à penser ce que serait une véritable prise en compte par la société des citoyens qui vivent avec des troubles cognitifs. Le prisme des droits de l’Homme invite ainsi à considérer la maladie d’Alzheimer et les maladies apparentées comme des handicaps cognitifs évolutifs, et à envisager leur prise en charge et leur accompagnement d'après le modèle de la réhabilitation ou de la compensation. Parallèlement à cette évolution conceptuelle, on constate que le droit international et certaines législations nationales commencent à s'adapter afin que la protection des personnes vulnérables ne se fasse pas au détriment de leurs droits et libertés. Et loin que la référence aux droits de l'Homme emporte avec elle une anthropologie individualiste, on observe au contraire l'émergence d'une conception relationnelle de l'autonomie, où les aidants – qu'ils soient familiaux, bénévoles ou professionnels – jouent un rôle central pour rendre effectifs les droits fondamentaux et faire en sorte que soit respectée l'inaliénable dignité des personnes. Ce numéro est coordonné par Fabrice Gzil (Docteur en philosophie, responsable du pôle Soutien à la recherche et à l'innovation sociale, Fondation Médéric Alzheimer).

▶ Disability, Residential Environment and Social Participation: Factors Influencing Daily Mobility of Persons Living in Residential Care Facilities in Two Regions of France

RAPEGNO N. ET RAVAUD J.-F.

2017

BMC Health Services Research 17(1): 683.

https://doi.org/10.1186/s12913-017-2602-8

Despite the context of individualization of public policies and promotion of independent living, residential care facilities (RCFs) (called "établissements médico-sociaux" in France) still represent the main system used by disabled people. Through a study of their daily mobility, this article proposes a geographical approach to the examination of factors influencing the social participation of disabled persons with motor impairments who live in residential care facilities.

▶ Welfare Reform Act de 2012, fusion des minima sociaux britanniques et prestations handicap

VELCHE D.

2017

Revue française des affaires sociales(3): 109-128.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-3-page-109.htm

Instituant le « crédit universel » fusionnant divers minima sociaux, la loi britannique de réforme de l'assistance sociale adoptée en 2012 affecte les personnes handicapées, directement d'abord par l'absorption progressive de la principale prestation handicap non contributive et sous conditions de ressources, indirectement ensuite par l'incidence d'autres prestations sociales en cours d'extinction, prestations qui souvent prévoyaient divers suppléments handicap. La même réforme rend plus stricte l'attribution des aides à la vie indépendante non incluses dans le crédit universel. À cela s'ajoute l'adoption d'un plafonnement du total des prestations accordées à une même famille. Ces décisions, mises en œuvre dans un contexte généralisé de coupes budgétaires, inquiètent les personnes handicapées et leurs proches. Peuvent-ils craindre une paupérisation ?

Hôpital

▶ The Political Economy of Diagnosis-Related Groups

BERTOLI P. ET GREMBI V.

2017

Soc Sci Med 190: 38-47.

A well-established political economic literature has shown as multi-level governance affects the inefficiency of public expenditures. Yet, this expectation has not been empirically tested on health expenditures. We provide a political economy interpretation of the variation in the prices of 6 obstetric DRGs using Italy as a case study. Italy offers a unique institutional setting since its 21 regional governments can decide whether to adopt the national DRG system or to adjust/waive it. We investigate whether the composition and characteristics of regional governments do matter for the average DRG level and, if so, why. To address both questions, we first use a panel fixed effects model exploiting the results of 66 elections between 2000 and

2013 (i.e., 294 obs) to estimate the link between DRGs and the composition and characteristics of regional governments. Second, we investigate these results exploiting the implementation of a budget constraint policy through a difference-in-differences framework. The incidence of physicians in the regional government explains the variation of DRGs with low technological intensity, such as normal newborn, but not of those with high technological intensity, as severely premature newborn.

The Impact of Introducing a New Hospital Financing System (DRGs) in Poland on Hospitalisations for Atherosclerosis: An Interrupted Time Series Analysis (2004-2012)

BUCZAK-STEC E., *et al.*

2017

Health Policy 121(11): 1186-1193.

Hospital payment based on diagnosis-related groups (DRGs) was introduced in Poland in July 2008. We evaluate the impact of this policy on the frequency of hospitalisation for atherosclerosis in internal medicine units of district hospitals and non-public hospitals in Poland. Data were collected between 2004 and 2012 from each district and non-public hospital participating in the General Hospital Morbidity Study (165 hospitals in total). Atherosclerosis was defined using the ICD-10 code I70. Hospitalisation patterns were examined using interrupted time series with segmented regression analysis. We conclude that implementation of a DRG-based system in Poland was associated with substantial increases in atherosclerosis hospitalisation rates. Failing to take into account this change in financing and not accounting for long-term trends in hospitalisation rates may result in inaccurate epidemiological data.

L'impact de la T2A sur la gestion des établissements publics de santé

BURNEL P.

2017

Journal de gestion et d'économie médicales 35(2): 67-79.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-2-page-67.htm

Le présent article a pour objet de faire un point, après 12 ans de mise en œuvre, sur les effets induits par la tarification à l'activité (T2A) sur la gestion et l'organisation des établissements publics de santé (EPS). Il met en évidence, en s'appuyant sur la littérature, que les effets attendus en termes d'efficience ne se sont que partiellement réalisés. Les EPS n'ont pas révisé en profondeur leurs processus et leurs organisations se contentant de mesures d'ajustement sur les charges variables. Il s'ensuit une dégradation des conditions de travail et une perte de sens qui affecte les personnels soignants et, parfois médicaux. Pour dépasser ces limites, cet article explore les voies d'un approche réellement médico-économique centrée sur la refonte des processus de prise en charge en se fondant sur ce qui motive l'action des personnels soignants : les dynamiques du progrès médical qui offre des opportunités nouvelles et la recherche de l'amélioration de la qualité des soins.

GHT : de la collection d'individus au groupe solidaire. Un pari gagnant/gagnant pour l'hôpital

CHAPUIS C. ET VIELFAURE-CHAPUIS M.

2017/08-09

Gestions hospitalières(568): 406-408.

La loi du 26 janvier 2016 a créé les groupements hospitaliers de territoire (GHT), afin de permettre une égalité d'accès aux soins sur un territoire de santé. Les hôpitaux concernés par ces GHT ont dû s'inscrire dans un partage de vision de l'offre de soins de territoire nécessitant une analyse récursive afin de structurer un projet médico-soignant fonctionnant en réseau. Mais les établissements sont-ils prêts ? Tel est le questionnement de cet article.

Avoidable Hospitalization Among Migrants and Ethnic Minority Groups: A Systematic Review

DALLA ZUANNA T., *et al.*

2017

Eur J Public Health 27(5): 861-868.

The numbers of migrants living in Europe are growing rapidly, and has become essential to assess their access to primary health care (PHC). Avoidable Hospitalization (AH) rates can reflect differences across migrant and ethnic minority groups in the performance of PHC. We aimed to conduct a systematic review of all published studies on AH comparing separately migrants with natives or different racial/ethnic groups, in Europe and elsewhere. We ran a systematic search for original articles indexed in primary electronic databases on AH among migrants or ethnic minorities. Most of the studies (91%) used a cross-sectional design. The exposure variable was defined in almost all articles by ethnicity, race, or a combination of the two; country of birth was only used in one Australian study. Most of the studies found significant differences in overall AH rates, with minorities (mainly Black and Hispanics) showing higher rates than non-Hispanic Whites. Conclusions: AH has been used, mostly in the US, to compare different racial/ethnic groups, while it has never been used in Europe to assess migrants' access to PHC. Studies comparing AH rates between migrants and natives in European settings can be helpful in filling this lack of evidence.

▶ Insights from the Design and Implementation of a Single-Entry Model of Referral for Total Joint Replacement Surgery: Critical Success Factors and Unanticipated Consequences

DAMANI Z., *et al.*

2017

Health Policy : Ahead of print.

http://dx.doi.org/10.1016/j.healthpol.2017.10.006

The Winnipeg Central Intake Service (WCIS) employs single-entry, centralized intake and triage. The WCIS streamlined processes; improved referrals, patient care, and monitoring of outcomes. Challenges included low initial understanding, participation, and slow uptake. Unanticipated consequences included incorrect perceptions, increased referral volume, incomplete information sharing. Recommendations for successful implementation: early communication, clear processes, physician leadership, greater patience

▶ Hospitalization in French Forensic Units: Results of a Patient Satisfaction Survey

DE LABROUHE D., *et al.*

2017

Rev Epidemiol Sante Publique 65(4): 285-294.

In France, special full-time inpatient hospital units (UHSA) have been created for inmates with psychiatric disorders. Since they were established in 2010, the quality of care in such units has not been studied. Particularly, no patient satisfaction survey has been conducted yet. The main objective of this study was to assess the patients' satisfaction about their hospitalization in UHSA. A descriptive study has been performed in two hospitals (UHSA of Villejuif and UHSA of Lille-Seclin). From February to May 2015, 125 adult patients were included, at the end of their hospitalization (voluntary or involuntary psychiatric care) in UHSA. The patient's satisfaction was assessed by a psychiatrist who did not participate in patient care with a 16-item scale exploring three areas (quality of care, quality of information provided and UHSA functioning and organization). The items were evaluated with a visual numeric scale (1 to 10). This study demonstrates that patients hospitalized in UHSA are satisfied. Given the relationship between patient satisfaction and compliance, these structures could therefore have an important medical interest for inmates with psychiatric disorders. However, these results need to be replicated in a study involving all the UHSA of France.

▶ Using Weighted Hospital Service Area Networks to Explore Variation in Preventable Hospitalization

FALSTER M. O., *et al.*

2017

Health Serv Res. : Ahead of print.

The aim of this study is to demonstrate the use of multiple-membership multilevel models, which analytically structure patients in a weighted network of hospitals, for exploring between-hospital variation in preventable hospitalizations. The study is based on a cohort of 267,014 people aged over 45 in NSW, Australia. Patterns of patient flow were used to create weighted hospital service area networks (weighted-HSANs) to 79 large public hospitals of admission. Multiple-membership multilevel models on rates of preventable hospitalization, modeling participants structured within weighted-HSANs, were contrasted with models clustering on 72 hospital service areas (HSAs) that assigned participants to a discrete geographic region. We conclude that multiple-membership multilevel models can analytically capture information lost on patient attribution when creating discrete health care catchments. Weighted-HSANs have broad potential application in health services research and can be used across methods for creating patient catchments.

Long-Term Care Provision, Hospital Bed Blocking, and Discharge Destination for Hip Fracture and Stroke Patients

GAUGHAN J., *et al.*

2017

Int J Health Econ Manag 17(3): 311-331.

We examine the relationship between long-term care supply (care home beds and prices) and (i) the probability of being discharged to a care home and (ii) length of stay in hospital for patients admitted to hospital for hip fracture or stroke. Using patient level data from all English hospitals and allowing for a rich set of demographic and clinical factors, we find no association between discharge destination and long-term care beds supply or prices. We do, however, find evidence of bed blocking: hospital length of stay for hip fracture patients discharged to a care home is shorter in areas with more long-term care beds and lower prices. Length of stay is over 30% shorter in areas in the highest quintile of care home beds supply compared to those in the lowest quintile.

Agreement Between Hospital Discharge Diagnosis Codes and Medical Records to Identify Metastatic Colorectal Cancer and Associated Comorbidities in Elderly Patients

GOUVERNEUR A., *et al.*

2017

Rev Epidemiol Sante Publique 65(4): 321-325.

Quality of coding to identify cancers and comorbidities through the French hospital diagnosis database (Programme de médicalisation des systèmes d'information, PMSI) has been little investigated. Agreement between medical records and PMSI database was evaluated regarding metastatic colorectal cancer (mCRC) and comorbidities. From 01/01/2013 to 06/30/2014, 74 patients aged≥65years at mCRC diagnosis were identified in Bordeaux teaching hospital. Data on mCRC and comorbidities were collected from medical records. All diagnosis codes (main, related and associated) registered into the PMSI were extracted. Agreement between sources was evaluated using the percent agreement for mCRC and the kappa (kappa) statistic for comorbidities. Agreement for primary CRC and mCRC was higher using all types of diagnosis codes instead of the main one exclusively (respectively 95 % vs. 53 % for primary CRC and 91 % vs. 24 % for mCRC). Agreement was substantial (kappa 0.65) for cardiovascular diseases, notably atrial fibrillation (kappa 0.77) and hypertension (kappa 0.68). It was moderate for psychiatric disorders (kappa 0.49) and respiratory diseases (kappa 0.48), although chronic obstructive pulmonary disease had a good agreement (kappa 0.75). These results are reassuring with regard to detection through PMSI of mCRC if all types of diagnosis codes are considered and useful to better choose comorbidities in elderly mCRC patients that could be well identified through hospital diagnosis codes.

Le financement des établissements de santé par la Tarification à l'Activité : impasses et pistes de solutions

HIRTZLIN I.

2017

Journal de gestion et d'économie médicales 35(2): 81-92.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-2-page-81.htm

La tarification basée sur l'activité médicale reposant sur les diagnostics principaux des patients a d'abord été expérimentée par le dispositif Medicare, puis généralisée aux États Unis, avant de se diffuser à la plupart des pays d'Europe de l'Ouest, y compris la France, où elle a pris le nom de Tarification à l'activité à partir de 2008. L'efficience attendue du dispositif repose sur le principe de la concurrence par comparaison. La T2A connaît aujourd'hui des remises en cause liées aux limites de l'application pratique des principes incitatifs théoriques. Des pistes de solutions sont explorées dans cet article. Leur objectif est de réintroduire une composante économique dans le calcul des coûts et de tarifer en fonction des bonnes pratiques. Par ailleurs, comme la prise en charge du patient s'insère dans un établissement de santé il convient de tenir compte de ses contraintes productives et de son organisation.

Hospital Postacute Care Referral Networks: Is Referral Concentration Associated with Medicare-Style Bundled Payments

KAUR R., *et al.*

2017

Health Serv Res 52(6): 2079-2098.

The aim of this paper is 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. 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. The study design consists in 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. The study concludes that hospitals that tend to use fewer PAC providers may lead to lower costs for payers such as Medicare. Morever, the study results reinforce the importance of limited networks for PAC services under bundling arrangements for hospital and PAC payments.

Do Reduced Hospital Mortality Rates Lead to Increased Utilization of Inpatient Emergency Care? A Population-Based Cohort Study

LAUDICELLA M., *et al.*

2017

Health Serv Res: Ahead of print.

The aim of this study is to measure the impact of the improvement in hospital survival rates on patients' subsequent utilization of unplanned (emergency) admissions. Data is based on unplanned admissions occurring in all acute hospitals of the National Health Service in England between 2000 and 2009, including 286,027 hip fractures, 375,880 AMI, 387,761 strokes, and 9,966,246 any cause admissions. Unplanned admissions experienced by patients within 28 days, 1 year, and 2 years of discharge from the index admission are modeled as a function of hospital risk-adjusted survival rates using patient-level probit and negative binomial models. Identification is also supported by an instrumental variable approach and placebo test. The improvement in hospital survival rates that occurred between 2000 and 2009 explains 37.3 percent of the total increment in unplanned admissions observed over the same period. The success of hospitals in improving survival from unplanned admissions can be an important contributory factor to the increase in subsequent admissions.

Maternity Services for Rural and Remote Australia: Barriers to Operationalising National Policy

LONGMAN J., *et al.*

2017

Health Policy 121(11): 1161-1168.

In Australia, many small birthing units have closed in recent years, correlating with adverse outcomes including a rise in the number of babies born before arrival to hospital. Concurrently, a raft of national policy and planning documents promote continued provision of rural and remote maternity services, articulating a strategic intent for services to provide responsive, woman-centred care as close as possible to a woman's home. The aims of this paper are to contribute to an explanation of why this strategic intent is not realised, and to investigate the utility of an evidence based planning tool (the Toolkit) to assist with planning services to realise this intent.

Hospital-At-Home Integrated Care Programme for the Management of Disabling Health Crises in Older Patients: Comparison with Bed-Based Intermediate Care

MAS M. A., *et al.*

2017

Age Ageing 46(6): 925-931.

The aims of this study is to analyse the clinical impact of a home-based Intermediate Care model in the Catalan health system, comparing it with usual bed-based care. Design: quasi-experimental longitudinal study. Setting: hospital Municipal de Badalona and El Carme Intermediate Care Hospital, Badalona, Catalonia, Spain. We included older patients with medical and orthopaedic disabling health crises in need of Comprehensive Geriatric Assessment (CGA) and rehabilitation. At the end, clinical characteristics were similar between home-based and bed-based groups. Acute stay was shorter in home group: 6.1 (5.3-6.9) versus 11.2 (10.5-11.9) days, P < 0.001. The home-based scheme showed better results on functional resolution 79.1% (versus 75.2%), OR 1.62 (1.09-2.41) and on favourable crisis resolution 73.8% (versus 69.6%), OR 1.54 (1.06-2.22), with shorter length of intervention, with a reduction of -5.72 (-9.75 and -1.69) days. We conclude that the extended CGA-based hospital-at-home programme was associated with shorter stay and favourable clinical outcomes. Future studies might test this intervention to the whole Catalan integrated care system.

▶ Evaluation of Minimum Volume Standards for Surgery in the Netherlands (2003-2017): A Successful Policy

MESMAN R., *et al.*

2017

Health Policy 121(12): 1263-1273.

The purpose of this paper is to evaluate the introduction and implications of minimum volume standards for surgery in Dutch health care from 2003 to 2017 and formulate policy lessons for other countries. Three eras were identified, representing a trust-and-control cycle in keeping with changing roles of different stakeholders in Dutch context. Based on the Dutch experience, the following lessons can be useful for other health care systems: 1. professionals should be in the lead in the development of national quality standards, 2. external pressure can be helpful for professionals to take the initiative and 3. volume remains a controversial quality measure. Future research and policies should focus on the underlying mechanism of volume-outcome relationships and overall effects of volume-based policies.

▶ PMSI, T2A et gestion interne

MOISDON J. C.

2017

Journal de gestion et d'économie médicales 35(2): 51-66.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-2-page-51.htm

▶ Des coûts aux tarifs par pathologie. Les enseignements d'une tentative de transposition de la T2A au système de financement hospitalier belge

RUYSSEN M., *et al.*

2017

Journal de gestion et d'économie médicales 35(2): 93-108.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-2-page-93.htm

Un des objectifs essentiels du PMSI et ensuite de la T2A était l'amélioration du management des établissements de santé. Pourtant, des investigations dans le système hospitalier montrent que les effets de ces nouveaux instruments sur l'organisation des hôpitaux ont été de faible ampleur et que les raisons d'un tel phénomène sont notamment liées à la complexité du dispositif de financement et aux caractéristiques intrinsèques du fonctionnement d'un hôpital. Le nouveau financement a moins conduit à une augmentation de l'efficience qu'à une répartition plus équitable d'une enveloppe globale et un gain en autonomie stratégique des établissements. Ces observations conduisent à des réflexions sur les relations entre économie et gestion et sur les apprentissages qui vont se révéler nécessaires dans les évolutions qui sont prévues à l'heure actuelle pour les modalités de financement des hôpitaux.

▶ Should I Stay or Should I Go? Hospital Emergency Department Waiting Times and Demand

SIVEY P.

2017

Health Econ. : Ahead of print

In the absence of the price mechanism, hospital emergency departments rely on waiting times, alongside prioritisation mechanisms, to restrain demand and clear the market. This paper estimates by how much the number of treatments demanded is reduced by a higher waiting time. I use variation in waiting times for low-urgency patients caused by rare and resource-intensive high-urgency patients to estimate the relationship. I find that when waiting times are higher, more low-urgency patients are deterred from treatment and leave the hospital during the waiting period without being treated. The waiting time elasticity of demand for low-urgency patients is approximately -0.25 and is highest for the lowest-urgency patients.

▶ Restricted Health Care Entitlements for Child Migrants in Europe and Australia

STUBBE OSTERGAARD L., *et al.*

2017

Eur J Public Health 27(5): 869-873.

More than 300 000 asylum seeking children were registered in Europe alone during 2015. In this study, we examined entitlements for health care for these and other migrant children in Europe and Australia in a framework based on United Nations Convention of the Rights of the Child (UNCRC). The study is founded on a survey to child health professionals, NGO's and European Ombudspersons for Children in 30 EU/EEA countries and Australia, supplemented by desktop research of official documents. Migrant children were categorised as asylum seekers and irregular/undocumented migrants. Five countries (France, Italy, Norway, Portugal and Spain) explicitly entitle all migrant children, irrespective of legal status, to receive equal health care to that of its nationals. Sweden and Belgium entitle equal care to asylum seekers and irregular non-EU migrants, while entitlements for EU migrants are unclear. Twelve European countries have limited entitlements to health care for asylum seeking children, including Germany that stands out as the country with the most restrictive health care policy for migrant children. In Australia entitlements for health care are restricted for asylum seeking children in detention and for irregular migrants. The needs of irregular migrants from other EU countries are often overlooked in European health care policy. We conclude that putting pressure on governments to honour the obligations of the UNCRC and explicitly entitle all children equal rights to health care can be an important way of advocating for better access to primary and preventive care for asylum seeking and undocumented children in Australia and the EU.

▶ ISQUA17-3302: The Association Between Hospitals-Community Continuity of Care Patients with Chronic Disease and Clinical Outcomes

ZIMLICHMAN E., *et al.*

2017

International Journal for Quality in Health Care 29(suppl_1): 14-15.

http://dx.doi.org/10.1093/intqhc/mzx125.19

Transition of the patient from one physician to another throughout the therapeutic process; particularly in the transition from hospital to community, is a known weak point in the provision of safe, high quality care. The phenomenon is more prominent in patients with chronic illnesses, in light of the fact that these patients are usually receiving numerous medications and that their care is more fragmented. These patients therefore require closer supervision in disease management. Efforts are being made in Israel by the Health Funds to improve the maintenance of continuous treatment. The goals of this study were to evaluate the level of care continuity in chronic disease patients from four Health Funds, hospitalized at one medical center. Second, we have set out to learn about the association between maintaining continuity and clinical outcomes.

Inégalités de santé

▶ Geographical Inequalities in Health in a Time of Austerity: Baseline Findings from the Stockton-On-Tees Cohort Study

BHANDARI R., *et al.*

2017

Health Place 48: 111-122.

Stockton-on-Tees has the highest geographical inequalities in health in England with the life expectancy at birth gap between the most and deprived neighbourhoods standing at over 17 years for men and 11 years for women. In this study, we provide the first detailed empirical examination of this geographical health divide by: estimating the gap in physical and general health (as measured by EQ. 5D, EQ. 5D-VAS and SF8PCS) between the most and least deprived areas; using a novel statistical technique to examining the causal role of compositional and contextual factors and their interaction; and doing so in a time of economic recession and austerity. Using a stratified random sampling technique, individual-level survey data was combined with secondary data sources and analysed using multi-level models with 95% confidence intervals obtained from nonparametric bootstrapping. The main findings indicate that there is a significant gap in health between the two areas, and that compositional level material factors, contextual factors and their interaction appear to be the major explanations of this gap. Contrary to the dominant policy discourse in this area, individual behavioural and psychosocial factors did not make a significant contribution towards explaining health inequalities in the study area. The findings are discussed in relation to geographical theories of health inequalities and the context of austerity.

A Systematic Literature Review on the Use and Outcomes of Maternal and Child Healthcare Services by Undocumented Migrants in Europe

DE JONG L., *et al.*

2017

Eur J Public Health 27(6): 990-997.

Undocumented migrants, in particular pregnant women and their newborns, constitute a particularly vulnerable group of migrants. The aim of this study was to systematically review the academic literature on the use and outcomes of maternal and child healthcare by undocumented migrants in the European Union (EU) and European Free Trade Association (EFTA) countries. The databases, MEDLINE, Embase, CINAHL Plus, Global Health and Popline were searched for the period 2007 to 2017. Overall, the quantitative studies found that undocumented women underutilised essential maternal and child healthcare services, and experienced worse health outcomes. Qualitative studies supported these results, indicating that undocumented migrants were hesitant to use services due to a lack of knowledge and fear of deportation. Studies included in the review covered 10 of 32 EU or EFTA countries, making a European comparison impossible. Despite major methodological differences between included studies, the results of this review indicate that the status of undocumented migrants exacerbates known health risks and hampers service use.

Multimorbidity and Immigrant Status: Associations with Area of Origin and Length of Residence in Host Country

GIMENO-FELIU L. A., *et al.*

2017

Family Practice 34(6): 662-666.

http://dx.doi.org/10.1093/fampra/cmx048

Multimorbidity is a growing phenomenon in primary care, and knowledge of the influence of social determinants on its evolution is vital. The aim of this study was to understand the relationship between multimorbidity and immigration, taking into account length of residence in the host country and area of origin of the immigrant population. Cross-sectional retrospective study of all adult patients registered within the public health service of Aragon, Spain (N = 1092279; 144238 were foreign-born), based on data from the EpiChron Cohort. Age-standardized prevalence rates of multimorbidity were calculated. Different models of binary logistic regressions were conducted to study the association between multimorbidity, immigrant status and length of residence in the host country. Prevalence of multimorbidity is lower among foreign-borns as compared with native-borns, but increases rapidly with length of residence in the host country. However, the progressive development of multimorbidity among immigrants varies widely depending on area of origin. These findings provide important insight into the health care needs of specific population groups and may help minimize the negative impact of multimorbidity among the most vulnerable groups.

Health and Mortality Patterns Among Migrants in France

KHLAT M. ET GUILLOT M.

2017

University of Pennsylvania: 35p.

http://repository.upenn.edu/psc_publications/8/

Research on migrants' health and mortality has been lagging in France, by comparison with other European countries with shorter immigration histories. This lag has been related to the predominance in France of the modèle d'intégration républicaine (republican model of integration), according to which the state disregards criteria such as race, ethnicity or religion when interacting with individuals, in order to guarantee equal treatment for all (Oberti, 2008). Given the strong links between the state and the statistical system, the dividing line has long been limited to the basic distinction between foreigners and French citizens (Safi, 2007).

▶ The Impact of Minimum Wages on Population Health: Evidence from 24 OECD Countries

LENHART O.

2016

Eur J Health Econ. : Ahead of print.

This study examines the relationship between minimum wages and several measures of population health by analyzing data from 24 OECD countries for a time period of 31 years. Specifically, I test for health effects as a result of within-country variations in the generosity of minimum wages, which are measured by the Kaitz index. The paper finds that higher levels of minimum wages are associated with significant reductions of overall mortality rates as well as in the number of deaths due to outcomes that have been shown to be more prevalent among individuals with low socioeconomic status (e.g., diabetes, disease of the circulatory system, stroke). A 10% point increase of the Kaitz index is associated with significant declines in death rates and an increase in life expectancy of 0.44 years. Furthermore, I provide evidence for potential channels through which minimum wages impact population health by showing that more generous minimum wages impact outcomes such as poverty, the share of the population with unmet medical needs, the number of doctor consultations, tobacco consumption, calorie intake, and the likelihood of people being overweight.

▶ Health of Newly Arrived Immigrants in Canada and the United States: Differential Selection on Health

LU Y., *et al.*

2017

Health Place 48: 1-10.

Canada and the U.S. are two major immigrant-receiving countries characterized by different immigration policies and health care systems. The present study examines whether immigrant health selection, or the «healthy immigrant effect», differs by destination and what factors may account for differences in immigrant health selection. We use 12 years of U.S. National Health Interview Survey and Canadian Community Health Survey data to compare the risks of overweight/obesity and chronic health conditions among new immigrants in the two countries. Results suggest a more positive health selection of immigrants to Canada than the U.S. Specifically, newly arrived U.S. immigrants are more likely to be overweight or obese and have serious chronic health conditions than their Canadian counterparts. The difference in overweight/obesity was explained by differences in source regions and educational levels of immigrants across the two countries. But this is not the case for serious chronic conditions. These results suggest that immigration-related policies can potentially shape immigrant health selection.

▶ Nordic Paradox, Southern Miracle, Eastern Disaster: Persistence of Inequalities in Mortality in Europe

MACKENBACH J. P.

2017

Eur J Public Health 27(suppl_4): 14-17.

http://dx.doi.org/10.1093/eurpub/ckx160

The persistence of socioeconomic inequalities in health, despite all that has been done to reduce social and economic inequalities in many European countries, is one of the great disappointments of public health. In this paper, I summarize the results of a series of studies into the explanation of variations and trends in inequalities in mortality in three European regions: the Nordic countries with their puzzlingly large inequalities in mortality, Southern European countries with their miraculously small inequalities in mortality and Central and Eastern European countries in which inequalities in mortality have disastrously exploded since the early 1990 s. The results of these studies show that inequalities in mortality are remarkably variable and dynamic, which suggests that it may be possible to reduce them if we exploit the entry-points for policy that these studies have also identified, such as poverty, smoking, excessive alcohol consumption and lack of access to health care. At the same time, another lesson is that health inequalities are influenced in sometimes unexpected ways by factors that are not under our control, and that we cannot expect to eliminate these health inequalities soon.

Health and Access to Health Care of 18-25 Years Old People Not in Employment, Education or Training (NEETs) Attending the French 'Missions Locales'

ROBERT S., *et al.*

2017

Rev Epidemiol Sante Publique 65(4): 265-276.

In France, «missions locales» are public assistance units for young people aged 16-25 years not in employment, education or training (NEET). The health status of the more than 1.5 million young adults attending these units annually is unknown. The purpose of this study was to describe the health status and health care use of this population in comparison with the general population of the same age. The Presaje survey was conducted in 2011 on a randomized sample of 1453 young adults aged 18-25 years who attended five «missions locales» in mainland France. Data were analyzed and compared with those of participants of the same age interviewed in a French national health survey (Barometre Sante 2010, n = 2899) and in a regional cohort (SIRS, n = 204) conducted in the Greater Paris area, both in 2010. Careful attention must be given to the young NEET population. Many of these youths are not familiar with health care services despite their important health care needs. Integrating health services into the «missions locales» may help detect health problems in this population, facilitating links to care.

Austerity and Health: The Impact in the UK and Europe

STUCKLER D., *et al.*

2017

Eur J Public Health 27(suppl_4): 18-21.

Austerity measures-reducing social spending and increasing taxation-hurts deprived groups the most. Less is known about the impact on health. In this short review, we evaluate the evidence of austerity's impact on health, through two main mechanisms: a 'social risk effect' of increasing unemployment, poverty, homelessness and other socio-economic risk factors (indirect), and a 'healthcare effect' through cuts to healthcare services, as well as reductions in health coverage and restricting access to care (direct). We distinguish those impacts of economic crises from those of austerity as a response to it. Where possible, data from across Europe will be drawn upon, as well as more extensive analysis of the UK's austerity measures performed by the authors of this review.

Undocumented and Documented Migrants with Chronic Diseases in Family Practice in the Netherlands

VAN DE SANDE J. S. O. ET VAN DEN MUIJSENBERGH M. E. T. C.

2017

Family Practice 34(6): 649-655.

http://dx.doi.org/10.1093/fampra/cmx032

Undocumented migrants (UM) face many barriers in accessing healthcare. It is unknown how these affect the care of UM with chronic diseases in general practices. In the Netherlands, a General practitioner (GP) is the gatekeeper to the healthcare system and primary care provider for UM. The aim of this study is to get insight into GP care for chronic diseases in UM compared with documented migrants (DM). A survey study of medical records of UM and DM in five general practices in the Netherlands with extensive experience in caring for UM. UM and DM were matched for gender, age and region of origin. Consultation rates, values of HbA1C, blood pressure, spirometry, number of referrals and medicine prescriptions were compared in all people with cardiovascular disease, diabetes or asthma/ COPD. We conclude that undocumented migrants with chronic diseases in general practices in the Netherlands that are experienced in caring for UM receive to a large extent equitable care compared to documented migrants.

The Dark Side of Social Capital: A Systematic Review of the Negative Health Effects of Social Capital

VILLALONGA-OLIVES E. ET KAWACHI I.

2017

Soc Sci Med 194: 105-127.

There is a growing literature demonstrating the health benefits of social capital (defined as the resources accessed through social connections). However, social capital is also acknowledged to be a «double-edged» phenomenon, whose effects on health are not always positive. We sought to systematically review studies that have found a negative (i.e. harmful) association between social capital and health outcomes. Our objective was to classify the different types of negative effects, following a framework originally proposed by Portes. (1998). We conducted a literature search in Pubmed, Embase and PsychInfo. We identified 3530 manuscripts. After detailed review, we included 44 articles in our systematic review. There are at least two negative consequences of social capital besides the classification proposed by Portes: behavioral contagion and cross-level interactions between social cohesion and individual characteristics. When leveraging the concept of social capital for health promotion interventions, researchers need to take account of these potential «downsides» for health outcomes.

Médicaments

Endogenous Versus Exogenous Generic Reference Pricing for Pharmaceuticals

ANTONANZAS F., *et al.*

2017

Int J Health Econ Manag 17(4): 413-432.

In this paper we carry out a vertical differentiation duopoly model applied to pharmaceutical markets to analyze how endogenous and exogenous generic reference pricing influence competition between generic and branded drugs producers. Unlike the literature, we characterize for the exogenous case the equilibrium prices for all feasible relevant reference prices. Competition is enhanced after the introduction of a reference pricing system. We also compare both reference pricing systems on welfare grounds, assuming two different objective functions for health authorities: (i) standard social welfare and (ii) gross consumer surplus net of total pharmaceutical expenditures. We show that regardless of the objective function, health authorities will never choose endogenous reference pricing. When health authorities are paternalistic, the exogenous reference price that maximizes standard social welfare is such that the price of the generic drug is the reference price while the price of the branded drug is higher than the reference price. When health authorities are not paternalistic, the optimal exogenous reference price is such that the price of the branded drug is the reference price while the price of the generic drug is lower than the reference price.

A Review of International Coverage and Pricing Strategies for Personalized Medicine and Orphan Drugs

DEGTIAR I.

2017

Health Policy 121(12): 1240-1248.

Personalized medicine and orphan drugs share many characteristics-both target small patient populations, have uncertainties regarding efficacy and safety at payer submission, and frequently have high prices. Given personalized medicine's rising importance, this review summarizes international coverage and pricing strategies for personalized medicine and orphan drugs as well as their impact on therapy development incentives, payer budgets, and therapy access and utilization. PubMed, Health Policy Reference Center, EconLit, Google Scholar, and references were searched through February 2017 for articles presenting primary data. The conclusion is as following : as more personalized medicine and orphan drugs enter the market, registries can provide better quality evidence on their efficacy and safety. Payers need systematic assessment strategies that are communicated with more transparency. Further studies are necessary to compare the implications of different payer approaches.

Socialisation non professionnelle et logiques de prescription médicale. Commentaire

GELLY M.

2017

Sciences sociales et santé 35(3): 71-79.

https://www.cairn.info/revue-sciences-sociales-et-sante-2017-3-page-71.htm

L'élaboration des normes de bonnes pratiques médicales a fait l'objet de nombreux travaux sociologiques, à la suite de la recherche socio-historique d'Harry Marks sur l'émergence de la « médecine des preuves » au cours du XXe siècle (Marks, 1999). Il s'agit d'un mouvement scientifique qui consiste à détacher les pratiques médicales des préférences personnelles des médecins pour tel ou tel traitement et à les adosser aux résultats d'essais cliniques. D'autres courants sociologiques existent. L'objectif de cet article est de présenter ces différentes approches, qui mettent en évidence la complexité de la prescription médicale.

Physicians' and Pharmacists' Perceptions on Real-Time Drug Utilization Review System: A Nationwide Survey

LEE S. M., *et al.*

2017

Int J Qual Health Care 29(5): 634-641.

The aims of this paper is to identify healthcare providers' experience and satisfaction for the drug utilization review (DUR) system, their impact on prescription changes following alerts, and difficulties experienced in the system by surveying primary healthcare centers and pharmacies. The analysis is based on a c cross-sectional nationwide survey. Approximately 2000 institutions were selected for the survey by a simple random sampling of nationwide primary healthcare centers and community pharmacy approximately practices, and 358 replied. The study concludes that, although most surveyed physicians and pharmacists receive the alerts, some do not or reported that they would not follow the alerts. To increase adherence, the DUR system should be improved to ensure a preferential and intensive approach to detecting potentially high-risk drug combinations.

Cost Analysis and Cost-Benefit Analysis of a Medication Review with Follow-Up Service in Aged Polypharmacy Patients

MALET-LARREA A., *et al.*

2017

Eur J Health Econ 18(9): 1069-1078.

Drug related problems have a significant clinical and economic burden on patients and the healthcare system. Medication review with follow-up (MRF) is a professional pharmacy service aimed at improving patient's health outcomes through an optimization of the medication. The aims of this paper is to ascertain the economic impact of the MRF service provided in community pharmacies to aged polypharmacy patients comparing MRF with usual care, by undertaking a cost analysis and a cost-benefit analysis. The economic evaluation was based on a cluster randomized controlled trial. The analysis included 1403 patients (IG: n = 688 vs CG: n = 715). The cost analysis showed that the MRF saved 97 euro per patient in 6 months. Extrapolating data to 1 year and assuming a fee for service of 22 euro per patient-month, the estimated savings were 273 euro per patient-year. The cost-benefit ratio revealed that for every 1 euro invested in MRF, a benefit of 3.3 euro to 6.2 euro was obtained. The MRF provided health benefits to patients and substantial cost savings to the NHS. Investment in this service would represent an efficient use of healthcare resources.

Gouverner (par) les prix. La fixation des prix des médicaments remboursés en France

NOUGUEZ É. ET BENOÎT C.

2017

Revue française de sociologie 58(3): 399-424.

https://www.cairn.info/revue-francaise-de-sociologie-2017-3-page-399.htm

Cet article examine la fixation des prix des médicaments remboursés par l'État, en France, depuis ses origines au sortir de la Seconde Guerre mondiale jusqu'au milieu des années 2010. Nous analysons les formes successives prises par cette politique, de l'administration unilatérale des prix mise en place de 1948 aux années 1980 à leur négociation dans le cadre de conventions entre un Comité interministériel et les industriels à partir du milieu des années 1990. Nous défendons la thèse selon laquelle ce contrôle des prix par l'État articule deux types de gouvernement du marché : un gouvernement des valeurs, visant à apprécier les médicaments à partir de principes de justice sociale (promouvoir la santé publique, respecter l'équilibre des dépenses d'Assurance maladie, favoriser la recherche et développement et l'emploi industriel); un gouvernement des conduites, visant à apprécier les médicaments à partir de considérations de justesse marchande (s'assurer que les prix établis orientent les conduites des industriels et des acteurs du marché dans le sens de l'intérêt général). Loin d'aller de soi, la détermination du « juste prix » donne alors lieu à des affrontements, au sein du Comité économique des produits de santé et dans les négociations entre le Comité et les industriels, entre des acteurs porteurs de conceptions plurielles et antagonistes de la justice sociale et de la justesse marchande.

Méthodologie – Statistique

▶ Using Cancer Case Identification Algorithms in Medico-Administrative Databases: Literature Review and First Results from the REDSIAM Tumors Group Based on Breast, Colon, and Lung Cancer

BOUSQUET P. J., *et al.*

2017

Rev Epidemiol Sante Publique 65 Suppl 4: S236-S242.

The development and use of healthcare databases accentuates the need for dedicated tools, including validated selection algorithms of cancer diseased patients. As part of the development of the French National Health Insurance System data network REDSIAM, the tumor taskforce established an inventory of national and internal published algorithms in the field of cancer. This work aims to facilitate the choice of a best-suited algorithm. A non-systematic literature search was conducted for various cancers. Results are presented for lung, breast, colon, and rectum. Medline, Scopus, the French Database in Public Health, Google Scholar, and the summaries of the main French journals in oncology and public health were searched for publications until August 2016. This study illustrates the complexity of cancer detection through sole reliance on healthcare databases and the lack of validated algorithms specifically designed for this purpose. Studies that standardize and facilitate validation of these algorithms should be developed and promoted.

▶ Promoting the Use of the French National Health Database (SNIIRAM)

GOLDBERG M.

2017

Rev Epidemiol Sante Publique 65 Suppl 4: S141-S143.

Cet éditorial présente le Système national d'information interrégimes de l'assurance maladie (SNIIRAM), bases de données médico-administratives nationales, centralisées et gérées par des organismes publics. Ces bases couvrent l'ensemble de la population dans différents domaines stratégiques de la santé publique. Elles sont alimentées par le dispositif de remboursement des soins des différents régimes de l'assurance maladie (données de consommation interégimes ou DCIR) et par le programme de médicalisation du système d'information des hôpitaux (PMSI).

▶ Perinatal Health and Medical Administrative Data: What Uses, Which Stakeholders, What the Issues for Birth Data? - Special REDSIAM

SERFATY A., *et al.*

2017

Rev Epidemiol Sante Publique 65 Suppl 4: S209-S219.

The uses of medical administrative data (MAD/BDMA) emerged in perinatal health following the work on regionalization of very pre-term birth. They have become more numerous since the late 2000s. The objective of this article is to take stock of the existing work carried out within the REDSIAM-perinatality group, on MAD/BDMA and their uses for the period of «birth». The studied MADs are the Hospital Discharge Data (PMSI) and the French national health database (SNIIRAM). The material includes knowledge shared by the members of the REDSIAM-perinatality group, scientific references and gray literature. The BDMA, including the PMSI and the SNIIRAM, are used and relevant in Perinatal health with the rise of health networks, the territorialisation of health, in an increased demand for quality of care. Their use will increase the reliability of the data collected and an inscription in the validation studies, more and more numerous in the field of BDMA. The algorithms need to be more finely compiled, validated and enhanced.

▶ Standardization of Physical Measurements in European Health Examination Surveys- Experiences from the Site Visits

TOLONEN H., *et al.*

2017

Eur J Public Health 27(5): 886-891.

Health examination surveys (HESs) provide valuable data on health and its determinants at the population level. Comparison of HES results within and between countries and over time requires measurements which are free of bias due to differences in or adherence to measurement procedures and/or measurement devices: In the European HES (EHES) Pilot Project, 12 countries conducted a pilot HES in 2010-11 using standardized measurement protocols and centralized training. External evaluation visits (site visits) were performed by the EHES Reference Centre staff to evaluate the success of standardization and quality of data collection. The EHES protocols to standardize HES measurements and procedures for collection of blood samples are feasible in cross-country settings. The prerequisite for successful standardization is adequate training. External and internal evaluation activities during the survey fieldwork are also needed to monitor compliance to standards.

Politique de santé

▶ Développer la recherche en services de santé

BENAMOUZIG D. ET ALLA F.

2017/10

Questions de santé publique(33): 8p.

http://www.iresp.net/files/2017/10/IReSP-n--33.Web_.pdf

Les systèmes de santé européens sont confrontés à des transformations majeures des modes de prise en charge. Cette transition épidémiologique se double d'une transition organisationnelle et plus largement sociale. Ces changements exigent des nouvelles connaissances et de nouvelles évaluations plus précises des services de santé, souvent situées et comparatives.

▶ An Innovative Approach to Participatory Health Policy Development in Bulgaria: The Conception and First Achievements of the Partnership for Health

DIMOVA A., *et al.*

2017

Health Policy: Ahead of print.

The Bulgarian Partnership for Health was established in 2015 as a new forum for health policy formulation and discussion. The Partnership presents a new approach of structured and sustained stakeholder involvement to overcome the lack of public participation in health policy development and implementation. Constituted as a permanent consultative body to the Council of Ministers, the Partnership engages a wide variety of stakeholders and professionals to shape and improve health policies. The shared governance of the Partnership between the Minister of Health and a patient organisation supports the elaboration of legislative acts based on the stakeholders' collaboration in priority areas. The governance and organisational structure of the Partnership assures capacity building, fast mobilisation of experts, continuity of stakeholder involvement, and increased responsibility in health policy development and implementation. This type of participatory approach may help reconcile initially opposing positions and foster reforms often impeded by political antagonism. Persisting challenges are a rather slow process of policy development and different perceptions of key concepts among the stakeholders. As policy-making in many countries in Eastern Europe suffers from political distrust, the Partnership's approach of involving experts - and not only politicians - could provide inspiration also to other countries, which have struggled with inconsistency of health policies pursued by different governments.

▶ Effectiveness of UK Provider Financial Incentives on Quality of Care: A Systematic Review

MANDAVIA R., *et al.*

2017

Br J Gen Pract 67(664): e800-e815.

Provider financial incentives are being increasingly adopted to help improve standards of care while promoting efficiency. The aim of this study is to review the UK evidence on whether provider financial incentives are an effective way of improving the quality of health care. Systematic review of UK evidence, undertaken in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) recommendations. MEDLINE and Embase databases were searched in August 2016. Original articles that assessed the relationship between UK provider financial incentives and a quantitative measure of quality of health care were included. We conclude that the effects of UK provider financial incentives on healthcare quality are unclear. Owing to this uncertainty and their significant costs, use of them may be counterproductive to their goal of improving healthcare quality and efficiency. UK policymakers should be cautious when implementing these incentives - if used, they should be subject to careful long-term monitoring and evaluation. Further research is needed to assess whether provider financial incentives represent a cost-effective intervention to improve the quality of care delivered in the UK.

▶ Socioeconomic Differences in the Pathways to Diagnosis of Coronary Heart Disease: A Qualitative Study

SCHRODER S. L., *et al.*

2017

Eur J Public Health 27(6): 1055-1060.

Socioeconomic inequalities in coronary heart disease (CHD)-related morbidity and mortality are well explored. However, less is known about the causes of inequalities in CHD treatment. In this qualitative study, we explored socioeconomic differences in the pathways to diagnosis of CHD. The data originated from 38 semi-structured interviews with older CHD patients, aged 59-80 years, conducted at the university hospital in Halle, Germany, between November 2014 and April 2015. We analysed the narratives related to the time before CHD was confirmed by coronary angiography electively or urgently. We found no socioeconomic differences in the urgent pathway. However, along the elective pathway, only low-SES patients reported receiving assistance from a general practitioner in accessing a cardiologist. Socioeconomic differences in CHD diagnosis were mainly apparent before patients sought healthcare. These differences were more pronounced when CHD was electively diagnosed due to chronic symptoms rather than urgently diagnosed due to acute symptoms. To address socioeconomic differences, general practitioners should focus on any indication of symptoms and interpretation mentioned by low-SES patients, and coordinate these patients' pathways to diagnosis while emphasizing the seriousness of CHD.

▶ Does Public Reporting Influence Quality, Patient and Provider's Perspective, Market Share and Disparities? A Review

VUKOVIC V., *et al.*

2017

Eur J Public Health 27(6): 972-978.

http://dx.doi.org/10.1093/eurpub/ckx145

Public reporting (PR) of healthcare (HC) provider's quality was proposed as a public health instrument for providing transparency and accountability in HC. Our aim was to assess the impact of PR on five main domains: quality improvement; patient choice, service utilization and market share; provider's perspective; patient experience; and unintended consequences. PubMed, Scopus, ISI WOS, and EconLit databases were searched to identify studies investigating relationships between PR and five main domains, published up to April 1, 2016. Our research covering different outcomes and settings reported that PR is associated with changes in HC provider's behavior and can influence market share. Unintended consequences are a concern of PR and should be taken into account when allocating HC resources. The experiences collected in this paper could give a snapshot about the impact of PR on a HC user's perception of the providers' quality of care, helping them to make empowered choices.

Politique sociale

▶ Compte personnel d'activité et éthique du care : une révolution sociale et philosophique à mener

DELAURENS D.

2017/08-09

Gestions hospitalières(568): 409-412.

Le système de protection sociale français doit évoluer en raison de son inadéquation avec la société contemporaine et de l'essoufflement de son modèle économique. Deux outils sont disponibles pour réaliser cette transformation : sur le plan pratique, le compte personnel d'activité (CPA) entré discrètement en vigueur le 1er janvier 2017 ; sur le plan théorique, le courant philosophique de l'éthique du care.

Psychiatrie

▶ The Psychiatric Hospital Discharge Database (RIM-P): An Essential Tool for the Surveillance of Hospitalization After a Suicide Attempt

CHAN CHEE C. ET PAGET L. M.

2017

Rev Epidemiol Sante Publique 65(5): 349-359.

Epidemiological surveillance of suicide attempts is essential for monitoring indicator trends in the evaluation of prevention actions. As part of this surveillance, analysis of data from hospitalization for suicide attempts is particularly useful. For the first time, data from two national hospital discharge databases, the « Programme de médicalisation des systèmes d'information en médecine, chirurgie, obstétrique » (PMSI-MCO) and the « Recueil d'information médicalisé en psychiatrie » (RIM-P) have been analyzed jointly. All patients aged 10 or more hospitalized in 2012 in medicine, surgery or psychiatry departments in metropolitan France have were included. We conclude that improvement of the epidemiological surveillance of suicide attempts requires a systematic coding of hospitalizations in psychiatry as well as in medicine and surgery. Data from hospitalization in psychiatry yield a more precise identification of psychiatric co-morbidities associated with suicide attempts. The frequent presence of mental problems associated with suicide attempts should encourage clinicians to search for these symptoms systematically as soon as possible after admission of the patient.

▶ A Systemic Approach to Understanding Mental Health and Services

COHEN M.

2017

Soc Sci Med 191: 1-8.

In the UK mental health and associated NHS services face considerable challenges. This paper aims to form an understanding both of the complexity of context in which services operate and the means by which services have sought to meet these challenges. Systemic principles as have been applied to public service organisations with reference to interpersonal relations, the wider social culture and its manifestation in service provision. The analysis suggests that the wider culture has shaped service demand and the approaches adopted by services resulting in a number of unintended consequences, reinforcing loops, increased workload demands and the limited value of services. The systemic modelling of this situation provides a necessary overview prior to future policy development. The paper concludes that mental health and attendant services requires a systemic understanding and a whole system approach to reform.

Labey, M. et Noël, C. « Les soins sans contrainte : politique d'organisation d'un pôle de psychiatrie intégré dans la cité. . » INFORMATION PSYCHIATRIQUE (L') 93(7) : 563-567.

Le pôle de santé mentale des villes de Ronchin, Faches-Thumesnil, Lesquin, Lezennes, Hellemmes et Mons-en-Barœul est engagé depuis 40 ans dans des pratiques visant à réduire la contrainte et développer les soins ambulatoires. La politique d'action est fondée sur les valeurs du rétablissement et la valorisation du savoir expérientiel. Le souci de la réduction de la contrainte apparaît en premier lieu à travers les conditions d'accueil en hospitalisation avec un objectif d'absence d'isolement et de contention. Ce dispositif sous tendu par une organisation propre à l'unité s'inscrit dans la conception générale de l'offre de soin sur le modèle de la santé mentale communautaire.

▶ Changes in Behaviors and Indicators of Mental Health Between 2006 and 2010 in the French Working Population

MALARD L., *et al.*

2017

Rev Epidemiol Sante Publique 65(4): 309-320.

The 2008 economic crisis may have had an impact on mental health but the studies on this topic are sparse, in particular among the working population. However, mental health at work is a crucial issue involving substantial costs and consequences. The aim of the study was to assess changes in behaviors and indicators of mental health in the French working population between 2006 and 2010, and to explore the differential changes according to age, origin, occupation, activity sector, public/private sector, self-employed/employee status and work contract. The data came from the prospective national representative Santé et itinéraire professionnel (SIP) survey, including a sample of 5600 French workers interviewed in 2006 and 2010. The behaviors and indicators of mental health studied were excessive alcohol consumption, smoking, sleep problems (sleep disorders and/or insufficient sleep duration), psychotropic drug use (antidepressants, anxiolytics and/or hypnotics), and poor self-reported health. We conclude that prevention policies should consider that behavior and indicators of mental health may deteriorate in times of economic crisis, especially among some sub-groups of the working population, such as young workers and workers with a permanent contract. These changes might foreshadow a forthcoming increase in mental disorders.

▶ ISQUA17-2402 : Co Designing Patient-Centred Care Using Participation Action Research: The Epilepsy Partnership (EPIC) Project

VARLEY J., *et al.*

2017

International Journal for Quality in Health Care 29(suppl_1): 8-9.

http://dx.doi.org/10.1093/intqhc/mzx125.8

"Co-design", "Co-creation","Co-production" are concepts currently used by those promoting innovation to improve the quality, safety and integration of healthcare services. They reflect an approach where the consumer and the provider of a service/product work in partnership to make things happen in a meaningful way. Such collaboration is inherent in models of patient-centred healthcare. Patient-centred care (PCC) is a core value in heath service reform that recognises people within the full context of their lives not just their health condition. PCC promotes partnerships between healthcare practitioners, patients and their families to ensure that correct and responsive clinical decisions are made. The National Clinical Care Programme for Epilepsy in Ireland is conducting a project which aims to create co-design teams of those who receive and those who deliver health services to work together on devising services that can realise the promise of patient-centre care.

Soins de santé primaires

▶ The Influence of Registered Nurses and Nurse Practitioners on Patient Experience with Primary Care: Results from the Canadian QUALICO-PC Study

AMMI M., *et al.*

2017

Health Policy: Ahead of print.

Nurses, whether registered nurses (RNs) or nurse practitioners (NPs), are becoming key providers of primary care services. While evidence for the influence of NPs on patient experience in primary care is mounting, this is less so for RNs. We use the Canadian component of the international Quality and Costs of Primary Care 2013/14 survey to investigate the mechanisms by which nurses can affect patients' experience in primary care, focusing on accessibility and appropriateness of care. The data allow us to distinguish between family practice RNs, specialised RNs and NPs, and covers all types of patients visiting a primary care clinic in a variety of contexts in all Canadian provinces. In addition to the types of nurses and full-time equivalent (FTE) numbers, we explore the role of nurse autonomy and collaboration. Our regression results show that one of the most important predictors of patient experience is the collaboration between health professionals, whereas nurse staffing in terms of FTE numbers has little influence by itself. Different types of nurses influence different dimensions of accessibility, and the association between patient experience and nurse staffing depends on the number of physicians in the clinic. Our results can inform decision-makers on how to strengthen primary care provision, and particularly in Canadian context, the adaptation of the recently implemented interprofessional primary care teams.

▶ High Levels of Capitation Payments Needed to Shift Primary Care Toward Proactive Team and Nonvisit Care

BASU S., *et al.*

2017

Health Aff (Millwood) 36(9): 1599-1605.

Capitated payments in the form of fixed monthly payments to cover all of the costs associated with delivering primary care could encourage primary care practices to transform the way they deliver care. Using a microsimulation model incorporating data from 969 US practices, we sought to understand whether shifting to team- and non-visit-based care is financially sustainable for practices under traditional fee-for-service, capitated payment, or a mix of the two. Practice revenues and costs were computed for fee-for-service payments and a range of capitated payments, before and after the substitution of team- and non-visit-based services for low-complexity in-person physician visits. The substitution produced financial losses for simulated practices under fee-for-service payment of $42,398 per full-time-equivalent physician per year; however, substitution produced financial gains under capitated payment in 95 percent of cases, if more than 63 percent of annual payments were capitated. Shifting to capitated payment might create an incentive for practices to increase their delivery of team- and non-visit-based primary care, if capitated payment levels were sufficiently high.

▶ Postponing a General Practitioner Visit: Describing Social Differences in Thirty-One European Countries

DETOLLENAERE J., *et al.*

2017

Health Serv Res 52(6): 2099-2120.

The aims of this study is to describe social differences in postponing a general practitioner visit in 31 European countries and to explore whether primary care strength is associated with postponement rates. Between October 2011 and December 2013, the multicountry QUALICOPC study collected data on 61,931 patients and 7,183 general practitioners throughout Europe. Access to primary care was measured by asking the patients whether they postponed a general practitioner visit in the past year. Social differences were described according to patients' self-rated household income, education, ethnicity, and gender. This paper concludes that, despite the universal and egalitarian goals of health care systems, access to general practitioner care in Europe is still determined by patients' socioeconomic status (self-rated household income and education) and migration background.

Les modes de paiements à la coordination : État des lieux et pistes pour une application en France

GIRAULT A., *et al.*

2017

Journal de gestion et d'économie médicales 35(2): 109-127.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-2-page-109.htm

L'émergence de nouveaux modes de paiement occupe une place majeure dans la transformation du système de soins, notamment en France, les « paiements à la coordination » qui retiennent l'attention des pouvoirs publics, désireux d'améliorer la coordination des soins. L'objectif de ce travail est de dresser un état des lieux de ces paiements et de proposer des pistes pour leur mise en œuvre dans le contexte français. Ce travail se base sur une revue intégrative de la littérature à partir des bases de données Medline, Econlit et Cochrane. Peu de preuves robustes peuvent, pour le moment, être portées au crédit de ces paiements, malgré quelques signes prometteurs. Les papiers sélectionnés concernaient en grande majorité des expériences aux Etats-Unis.

Professional Healthcare Regulation and Practice: The Case of Medicine in Britain

MIKE S.

2017

HealthcarePapers 16(4): 25-29.

http://www.longwoods.com/product/25205

This contribution comments selectively on the themes of the lead paper by Wilkie and Tzountzouris (2017) on aspects of Canadian healthcare regulation that impact on the crucial agenda of public protection. In a more skeptical sociopolitical climate in the modern world, these authors particularly highlight the need to ensure professional attitudes and behaviours enhance and sustain safe patient care - using the recent stance on professionalism of the College of Medical Laboratory Technologists of Ontario as an illustration of good practice. It is argued, though, that this important analysis could be sharpened further both academically and practically with greater awareness of the theoretical complexity surrounding this area and by drawing more fully on comparative international exemplars - particularly in relation to medicine in Britain, on which this paper focuses. The commentary concludes by noting that - notwithstanding its many merits - the lead paper could usefully show greater recognition of cognate research on health regulation in the Canadian context and, as British research has clearly indicated, professional impediments to the translation of formally designated regulatory frameworks into practice on the ground. In addition, there needs to be more awareness of the impact of the wider environment in which physicians and other healthcare professionals operate.

Managing Multimorbidity: Profiles of Integrated Care Approaches Targeting People with Multiple Chronic Conditions in Europe

RIJKEN M., *et al.*

2018

Health Policy: 122(1): 44-52.

In response to the growing populations of people with multiple chronic diseases, new models of care are currently being developed in European countries to better meet the needs of these people. This paper aims to describe the occurrence and characteristics of various types of integrated care practices in European countries that target people with multimorbidity. Data were analysed from multimorbidity care practices participating in the Innovating care for people with multiple chronic conditions (ICARE4EU) project, covering all 28EU Member States, Iceland, Norway and Switzerland. A total of 112 practices in 24 countries were included: 65 focus on patients with any combination of chronic diseases, 30 on patients with a specific chronic disease with all kinds of comorbidities and 17 on patients with a combination of specific chronic diseases. Practices that focus on a specific index disease or a combination of specific diseases are less extensive regarding the type, breadth and degree of integration than practices that focus on any combination of diseases. The latter type is more often seen in countries where more disciplines, e.g. community nurses, physiotherapists, social workers, work in the same primary care practice as the general practitioners. Non-disease specific practices put more emphasis on patient involvement and provide more comprehensive care, which are important preconditions for person-centered multimorbidity care.

Patient-Centered Medical Home Implementation and Improved Chronic Disease Quality: A Longitudinal Observational Study

ROSLAND A. M., *et al.*

2017

Health Serv Res: Ahead of print.

The objectives of this study is to examine associations between clinics' extent of patient-centered medical home (PCMH) implementation and improvements in chronic illness care quality. The analysis is based on data from 808 Veterans Health Administration (VHA) primary care clinics nationwide implementing the Patient Aligned Care Teams (PACT) PCMH initiative, begun in 2010. The design consists in clinic-level longitudinal observational study of clinics that received training and resources to implement PACT. Clinics varied in the extent they had PACT components in place by 2012. The study concludes that Veterans Health Administration primary care clinics with the most PCMH components in place in 2012 had greater improvements in several chronic disease quality measures in 2009-2013 than the lowest PCMH clinics.

Good, Better, Best? A Comprehensive Comparison of Healthcare Providers' Performance: An Application to Physiotherapy Practices in Primary Care

STEENHUIS S., *et al.*

2017

Health Policy : Ahead of print.

Most payment methods in healthcare stimulate volume-driven care, rather than value-driven care. Value-based payment methods such as Pay-For-Performance have the potential to reduce costs and improve quality of care. Ideally, outcome indicators are used in the assessment of providers' performance. The aim of this paper is to describe the feasibility of assessing and comparing the performances of providers using a comprehensive set of quality and cost data. We had access to unique and extensive datasets containing individual data on PROMs, PREMs and costs of physiotherapy practices in Dutch primary care. We merged these datasets at the patient-level and compared the performances of these practices using case-mix corrected linear regression models. Several significant differences in performance were detected between practices. These results can be used by both physiotherapists, to improve treatment given, and insurers to support their purchasing decisions. The study demonstrates that it is feasible to compare the performance of providers using PROMs and PREMs. However, it would take an extra effort to increase usefulness and it remains unclear under which conditions this effort is cost-effective. Healthcare providers need to be aware of the added value of registering outcomes to improve their quality. Insurers need to facilitate this by designing value-based contracts with the right incentives. Only then can payment methods contribute to value-based healthcare and increase value for patients.

Relevant Models and Elements of Integrated Care for Multi-Morbidity: Results of a Scoping Review

STRUCKMANN V., *et al.*

2017

Health Policy : Ahead of print.

In order to provide adequate care for the growing group of persons with multi-morbidity, innovative integrated care programmes are appearing. The aims of the current scoping review were to i) identify relevant models and elements of integrated care for multi-morbidity and ii) to subsequently identify which of these models and elements are applied in integrated care programmes for multi-morbidity. Most models and elements found in the literature focus on integrated care in general and do not explicitly focus on multi-morbidity. In line with this, most programmes identified in the literature build on the CCM. A comprehensive framework that better accounts for the complexities resulting from multi-morbidity is needed.

Patient-Centeredness of Integrated Care Programs for People with Multimorbidity. Results from the European ICARE4EU Project

VAN DER HEIDE I., *et al.*

2017

Health Policy : Ahead of print.

This paper aims to support the implementation of patient-centered care for people with multimorbidity in Europe, by providing insight into ways in which patient-centeredness is currently shaped in integrated care programs for people with multimorbidity in European countries. In 2014, expert organizations in 31 European countries identified 200 integrated care practices ('programs') in 25 countries of which 123 were included in our study. Managers of 112 programs from 24 countries completed a questionnaire about characteristics and results of the program, including questions on elements of patient-centeredness. Eight programs that were considered especially innovative or promising were analyzed in depth. The study concludes that, in many European countries, innovative approaches are applied to increase patient-centeredness of care for people with multimorbidity. To assess their potential benefits and conditions for implementation, thorough process and outcome evaluations of programs are urgently needed.

▶ Enhancing the Relationship Between Regulators and Their Profession

ZUBIN A.

2017

HealthcarePapers 16(4): 50-54.

Regulators face unique pressures to balance competing priorities related to patient safety, public accountability, and practitioners' expectations. Historically, the collegial model of self-regulation has been used as a tool for risk management, to recognize the importance of profession- and context-specific judgment in complex, ambiguous clinical situations. Increasingly, as public accountability concerns have grown dominant within regulatory bodies, this collegial model has shifted toward a more antagonistic relationship between the regulators and the regulated. Wilkie and Tzountzouris (2017) highlight one profession's journey toward embedding professionalism within regulatory practices and policies through application of a right-touch regulatory philosophy. Given the complexity of regulatory work, this shift required significant strategic and deliberative thinking. The challenges of facilitating this sort of cultural shift in the role of a regulator are significant, but so too are the potential gains associated with a more engaged relationship between regulators and their practitioners.

Systèmes de santé

▶ Patterns of Collaboration Among Health Care and Social Services Providers in Communities with Lower Health Care Utilization and Costs

BREWSTER A. L., *et al.*

2017

Health Serv Res. : Ahead of print.

The aims of this study is to understand how health care providers and social services providers coordinate their work in communities that achieve relatively low health care utilization and costs for older adults. The analysis is based on sixteen Hospital Service Areas (HSAs) in the United States. We conducted a qualitative study of HSAs with performance in the top or bottom quartiles nationally across three key outcomes: ambulatory care sensitive hospitalizations, all-cause risk-standardized readmission rates, and average reimbursements per Medicare beneficiary. We selected 10 higher performing HSAs and six lower performing HSAs for inclusion in the study. We conclude that the collaborative approaches used by higher performing communities, if spread, may be able to improve outcomes elsewhere.

▶ Switching Gains and Health Plan Price Elasticities: 20 Years of Managed Competition Reforms in the Netherlands

DOUVEN R., *et al.*

2017

Eur J Health Econ. : Ahead of print.

In this paper we estimate health plan price elasticities and financial switching gains for consumers over a 20-year period in which managed competition was introduced in the Dutch health insurance market. The period is characterized by a major health insurance reform in 2006 to provide health insurers with more incentives and tools to compete, and to provide consumers with a more differentiated choice of products. Prior to the reform, in the period 1995-2005, we find a low number of switchers, between 2 and 4% a year, modest average total switching gains of 2 million euros per year and short-term health plan price elasticities ranging from -0.1 to -0.4. The major reform in 2006 resulted in an all-time high switching rate of 18%, total switching gains of 130 million euros, and a high short-term price elasticity of -5.7. During 2007-2015 switching rates returned to lower levels, between 4 and 8% per year, with total switching gains in the order of 40 million euros per year on average. Total switching gains could have been 10 times higher if all consumers had switched to one of the cheapest plans. We find short-term price elasticities ranging between -0.9 and -2.2. Our estimations suggest substantial consumer inertia throughout the entire period, as we find degrees of choice persistence ranging from about 0.8 to 0.9.

▶ Long-Term Effects of Managed Care

KAUER L.

2017

Health Econ 26(10): 1210-1223.

Managed care (MC) plans have been introduced to curb the ever increasing health care costs. Many previous studies on effectiveness lacked a long-term perspective; hence, the sustainability of (possible) savings remains unclear. Moreover, because of their incentives, MC plans are susceptible to under-provision of care. Most of these possibly negative effects can only be observed in the long-term. This paper analyzes the long-term effects of MC plans on cost savings, mortality, and the use of service, using administrative data from a large Swiss health insurer. The identification is based on a propensity-score matching approach, where individuals who enter an MC plan are compared over 10 years to individuals who remain in a standard fee-for-service plan. Cost savings are substantial and sustainable, and the mortality rate is lower in MC plans. Cost savings are driven by fewer consultations and fewer days in hospital care, although the probability of visiting a provider at least once per year is similar or even higher for persons in MC plans.

▶ Is Canadian Healthcare Affordable? A Comparative Analysis of the Canadian Healthcare System from 2004 to 2014

LESLEY J.J., *et al.*

2017

Healthcare Policy 13(1): 43-58.

The objective of this paper is to compare cost-related non-adherence (CRNA), serious problems paying medical bills and average annual out-of-pocket cost over time in five countries. Repeated cross-sectional analysis of the Commonwealth Fund International Health Policy survey from 2004 to 2014. Responses were compared between Canada, the UK, Australia, New Zealand and the US. Compared to the UK, respondents in Canada, Australia and New Zealand were two to three times and respondents in the US were eight times more likely to experience CRNA; these odds remained stable over time. From 2004 to 2014, Canadian respondents paid US $852-1,767 out-of-pocket for care. The US reported the largest risks of serious problems paying for care (13-18.5%), highest out-of-pocket costs (US $2,060-3,319) and greatest rise in expenditures

▶ The New Frontier of Strategic Alliances in Health Care: New Partnerships Under Accountable Care Organizations

LEWIS V. A., *et al.*

2017

Soc Sci Med 190: 1-10.

Accountable care organizations (ACOs) and similar reforms aim to improve coordination between health care providers; however, due to the fragmented nature of the US health care system, successful coordination will hinge in large part on the ability of health care organizations to successfully partner across organizational boundaries. Little is known about new partnerships formed under the ACO model. We use mixed methods data from the National Survey of ACOs, Medicare ACO performance data and interviews with executive leaders across 31 ACOs to examine the prevalence, characteristics, and capabilities of partnership ACOs and why and how ACO partnerships form. Our findings suggests that the success of the ACO model will hinge in large part upon the success of new partnerships, with important implications for understanding ACO readiness and capabilities, the relatively small savings achieved to date by ACO programs, and the path to providers bearing more risk for population health management. In addition, ACO partnerships may provide an important window to monitor a potential wave of health care consolidation or, in contrast, a new model of independent providers successfully coordinating patient care.

▶ Structural Integration and Performance of Inter-Sectoral Public Health-Related Policy Networks: An Analysis Across Policy Phases

PETERS D., *et al.*

2017

Health Policy 121(12): 1296-1302.

Inter-sectoral policy networks may be effective in addressing environmental determinants of health with interventions. However, contradictory results are reported on relations between structural network characteristics (i.e., composition and integration) and network performance, such as addressing environmental determinants of health. This study examines these relations in different phases of the policy process. A multiple-case study was performed on four public health-related policy networks. The results suggest that, to address environmental determinants of health, sub-networks should be inter-sectorally composed in the policy development rather than in the intervention development and implementation phases, and that policy development actors should have the opportunity to connect with other actors, without strong direction from a central actor.

Travail et santé

▶ Harder, Better, Faster ... yet Stronger? Working Conditions and Self-Declaration of Chronic Diseases

DEFEBVRE E.

2017

Health Econ. : Ahead of print.

The role played by working conditions in worker health status has been widely acknowledged in the literature in general but has received less attention in economics, due to the inherent statistical biases and lack of data available to determine the role of simultaneous and chronic exposures. This study aims to estimate the causal impact of detrimental working conditions on the self-declaration of chronic diseases in France. Using a rebuilt retrospective lifelong panel and defining indicators for physical and psychosocial strains, I implement a mixed econometric strategy that relies on difference-in-differences and matching methods to take into account for selection biases as well as unobserved heterogeneity. For men and women, I find deleterious effects of both types of working conditions on the declaration of chronic diseases after exposure, with varying patterns of impacts according to the nature and magnitude of the strains. These results provide insights into the debate on legal retirement age postponement and justify not only policies being enacted early in individuals' careers in order to prevent subsequent midcareer health repercussions, but also schemes that are more focused on psychosocial risk factors.

▶ Short-Run and Long-Run Effects of Unemployment on Suicides: Does Welfare Regime Matter

GAJEWSKI P. ET ZHUKOVSKA K.

2017

Eur J Public Health 27(6): 1030-1042.

Disentangling the immediate effects of an unemployment shock from the long-run relationship has a strong theoretical rationale. Different economic and psychological forces are at play in the first moment and after prolonged unemployment. This study suggests a diverse impact of short- and long-run unemployment on suicides in liberal and social-democratic countries. We take a macro-level perspective and simultaneously estimate the short- and long-run relationships between unemployment and suicide, along with the speed of convergence towards the long-run relationship after a shock, in a panel of 10 high-income countries. We also account for unemployment benefit spending, the share of the population aged 15-34, and the crisis effects. We conclude that a generous welfare system seems efficient at preventing unemployment-related suicides in the long run, but societies in social-democratic countries might be less psychologically immune to sudden negative changes in their professional lives compared with people in liberal countries. Accounting for the different short- and long-run effects could thus improve our understanding of the unemployment-suicide link.

Working Conditions in the Explanation of Occupational Inequalities in Sickness Absence in the French SUMER Study

NIEDHAMMER I., *et al.*

2017

Eur J Public Health 27(6): 1061-1068.

Explanations of social inequalities in sickness absence are lacking in the literature. Our objectives were to evaluate the contribution of various occupational exposures in explaining these inequalities in a national representative sample of employees. : The study was based on the cross-sectional sample of the SUMER 2010 survey that included 46 962 employees, 26 883 men and 20 079 women. Both sickness absence spells and days within the last 12 months, as health indicators, were studied. Occupation was used as a marker of social position. The study included both psychosocial work factors (variables related to the classical job strain model, psychological demands, decision latitude, social support and understudied variables related to reward, job insecurity, job promotion, esteem, working time/hours and workplace violence) and occupational exposures of chemical, biological, physical and biomechanical nature. Strong occupational differences were found for sickness absence spells and days and for exposure to most work factors.

Vieillissement

Trajectories of Long-Term Care in 28 EU Countries: Evidence from a Time Series Analysis

GIANINO M. M., *et al.*

2017

Eur J Public Health : Ahead of print.

This study aims to confirm whether an increase in the number of elderly people and a worsening in the auto-evaluation of the general health state and in the limitation of daily activities result in increases in the offered services (beds in residential LTC facilities), in the social and healthcare expenditure and, consequently, in the percentage of LTC users. This study used a pooled, cross-sectional, time series design focusing on 28 European countries from 2004 to 2015. The indicators considered are: population aged 65 years and older; self-perceived health (bad and very bad) and long-standing limitations in usual activities; social protection benefits (cash and kind); LTC beds in institutions; LTC recipients at home and in institutions; healthcare expenditures and were obtained from the Organization for Economic Co-operation and Development and Eurostat. This paper concludes that demographic, societal, health changes could considerably affect LTC needs and services, resulting in higher LTC related costs. Thus, knowledge of LTC expenditures and the demand for services could be useful for healthcare decision makers.

What Works in Implementation of Integrated Care Programs for Older Adults with Complex Needs? A Realist Review

KIRST M., *et al.*

2017

Int J Qual Health Care 29(5): 612-624.

A realist review of the evaluative evidence was conducted on integrated care (IC) programs for older adults to identify key processes that lead to the success or failure of these programs in achieving outcomes such as reduced healthcare utilization, improved patient health, and improved patient and caregiver experience. International academic literature was searched in 12 indexed, electronic databases and gray literature through internet searches, to identify evaluative studies. A total of 65 articles, representing 28 IC programs, were included in the review. This review included a wide range of international evidence, and identified key processes for successful implementation of IC programs that should be considered by program planners, leaders and evaluators.

Older Americans Were Sicker and Faced More Financial Barriers to Health Care Than Counterparts in Other Countries

OSBORN R., *et al.*

2017

Health Aff (Millwood) : Ahead of print.

https://www.ncbi.nlm.nih.gov/pubmed/29140737

High-income countries are grappling with the challenge of caring for aging populations, many of whose members have chronic illnesses and declining capacity to manage activities of daily living. The 2017 Commonwealth Fund International Health Policy Survey of Older Adults in eleven countries showed that US seniors were sicker than their counterparts in other countries and, despite universal coverage under Medicare, faced more financial barriers to health care. The survey's findings also highlight economic hardship and mental health problems that may affect older adults' health, use of care, and outcomes. They show that in some countries, one in five elderly people have unmet needs for social care services-a gap that can undermine health. New to the survey is a focus on the «high-need» elderly (those with multiple chronic conditions or functional limitations), who reported high rates of emergency department use and care coordination failures. Across all eleven countries, many high-need elderly people expressed dissatisfaction with the quality of health care they had received.

Multimorbidity Care Model: Recommendations from the Consensus Meeting of the Joint Action on Chronic Diseases and Promoting Healthy Ageing Across the Life Cycle (JA-CHRODIS)

PALMER K., *et al.*

2017

Health Policy : Ahead of print.

Patients with multimorbidity have complex health needs but, due to the current traditional disease-oriented approach, they face a highly fragmented form of care that leads to inefficient, ineffective, and possibly harmful clinical interventions. There is limited evidence on available integrated and multidimensional care pathways for multimorbid patients. An expert consensus meeting was held to develop a framework for care of multimorbid patients that can be applied across Europe, within a project funded by the European Union; the Joint Action on Chronic Diseases and Promoting Healthy Ageing across the Life Cycle (JA-CHRODIS). The experts included a diverse group representing care providers and patients, and included general practitioners, family medicine physicians, neurologists, geriatricians, internists, cardiologists, endocrinologists, diabetologists, epidemiologists, psychologists, and representatives from patient organizations. Sixteen components across five domains were identified (Delivery of Care; Decision Support; Self Management Support; Information Systems and Technology; and Social and Community Resources). Due to the lack of evidence-based recommendations specific to multimorbid patients, this care model needs to be assessed and validated in different European settings to examine specifically how multimorbid patients will benefit from this care model, and whether certain components have more importance than others.

Quelle planification anticipée des soins pour les personnes malades d'Alzheimer

RIGAUX N. ET CARBONNELLE S.

2017

Gérontologie et société 39(54): 121-133.

https://www.cairn.info/revue-gerontologie-et-societe-2017-3-page-121.htm

La préoccupation pour le renforcement de la qualité de vie et de l'autonomie des personnes atteintes de démence de type Alzheimer est portée depuis plusieurs années en Belgique par la Fondation Roi Baudouin. Elle s'est concrétisée en 2013-2014 par le soutien de 12 projets-pilotes en Flandre, en Wallonie et à Bruxelles, contribuant à mettre en œuvre des démarches concrètes de planification anticipée des soins (Advance Care Planning, ACP). Faisant partie de l'équipe de chercheuses chargée du suivi des projets, nous décrirons d'abord la diversité des approches possibles d'ACP en ramenant celles-ci à deux pôles idéal-typiques, l'un visant la production de documents contraignants portant sur les décisions médicales de fin de vie, l'autre concevant l'ACP comme un processus de dialogue avec la personne et ses proches à propos des valeurs et des préférences au jour le jour de la personne malade, sans être nécessairement formalisé.

Nous situerons ensuite ces deux pôles dans la perspective des questions soulevées dans la littérature européenne, pour interroger la pertinence de différentes modalités d'ACP. Baliser ainsi le champ du débat est important à l'heure où le droit au consentement du patient, fût-il dément, cherche à se concrétiser dans ces dispositifs d'ACP.

Income-Rich and Wealth-Poor? The Impact of Measures of Socio-Economic Status in the Analysis of the Distribution of Long-Term Care Use Among Older People

RODRIGUES R., *et al.*

2017

Health Econ: Ahead of print.

This article aims to investigate the impact of using 2 measures of socio-economic status on the analysis of how informal care and home care use are distributed among older people living in the community. Using data from the Survey of Health, Ageing and Retirement in Europe for 14 European countries, we estimate differences in corrected concentration indices for use of informal care and home care, using equivalised household net income and equivalised net worth (as a proxy for wealth). We also calculate horizontal inequity indices using both measures of socio-economic status and accounting for differences in need. The findings show that using wealth as a ranking variable results, as a rule, in a less pro-poor inequality of use for both informal and home care. Once differences in need are controlled for (horizontal inequity), wealth still results in a less pro-poor distribution for informal care, in comparison with income, whereas the opposite is observed for home care. Possible explanations for these differences and research and policy implications are discussed.

Explaining the Impact of Poverty on Old-Age Frailty in Europe: Material, Psychosocial and Behavioural Factors

STOLZ E., *et al.*

2017

Eur J Public Health 27(6): 1003-1009.

Previous research found poverty to be associated with adverse health outcomes among older adults but the factors that translate low economic resources into poor physical health are not well understood. The goal of this analysis was to assess the impact of material, psychosocial, and behavioural factors as well as education in explaining the poverty-health link. In total, 28 360 observations from 11 390 community-dwelling respondents (65+) in the Survey of Health, Ageing and Retirement in Europe (2004-13, 10 countries) were analysed. Results stress the role of material and particularly psychosocial factors such as perceived control and social isolation, whereas the role of health behaviour was negligible. We suggest to strengthen social policy and public health efforts in order to fight poverty and its deleterious health effects from early age on as well as to broaden the scope of interventions with regard to psychosocial factors.

New Horizons in Multimorbidity in Older Adults

YARNALL A. J., *et al.*

2017

Age Ageing 46(6): 882-888.

The concept of multimorbidity has attracted growing interest over recent years, and more latterly with the publication of specific guidelines on multimorbidity by the National Institute for Health and Care Excellence (NICE). Increasingly it is recognised that this is of particular relevance to practitioners caring for older adults, where multimorbidity may be more complex due to the overlap of physical and mental health disorders, frailty and polypharmacy. The overlap of frailty and multimorbidity in particular is likely to be due to the widespread health deficit accumulation, leading in some cases to functional impairment. The NICE guidelines identify 'target groups' who may benefit from a tailored approach to care that takes their multimorbidity into account, and make a number of research recommendations. Management includes a proactive individualised assessment and care plan, which improves quality of life by reducing treatment burden, adverse events, and unplanned or uncoordinated care.

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La bataille de l'Obamacare et ses leçons pour la France

MEUNIER F.

2017

Esprit (11): 106-114.

https://www.cairn.info/revue-esprit-2017-11-page-106.htm

La saga de l'Obamacare rebondit. Le Congrès américain, dominé par le Parti républicain, n'est pas arrivé depuis l'élection de Donald Trump à abolir le Affordable Care Act, la loi sur l'assurance maladie universelle aux États-Unis, dite Obamacare. Aux termes d'atermoiements, de tentatives avortées, de pressions sur les membres du Congrès, l'évidence est apparue : les Républicains ne disposent d'aucune proposition sérieuse de remplacement pour la loi emblématique de la présidence Obama. Se défaire de cette loi sans accord sur un nouveau système a fait peur à beaucoup. D'autant plus qu'il est difficile de toucher un élément partiel de cette loi sans tout mettre à terre. C'est exactement ce qu'a compris Donald Trump. Au moment où j'écris, il vient, dans une sorte de politique du pire, de prendre deux ordonnances qui, si elles étaient appliquées, paralyseraient la loi, forçant le Congrès à légiférer à nouveau.

Estimating the Effects of Health Insurance and Other Social Programs on Poverty Under the Affordable Care Act

REMLER D. K., *et al.*

2017

Health Aff (Millwood) 36(10): 1828-1837.

The effects of health insurance on poverty have been difficult to ascertain because US poverty measures have not taken into account the need for health care and the value of health benefits. We developed the first US poverty measure to include the need for health insurance and to count health insurance benefits as resources available to meet that need-in other words, a health-inclusive poverty measure. We estimated the direct effects of health insurance benefits on health-inclusive poverty for people younger than age sixty-five, comparing the impacts of different health insurance programs and of nonhealth means-tested cash and in-kind benefits, refundable tax credits, and nonhealth social insurance programs. Private health insurance benefits reduced poverty by 3.7 percentage points. Public health insurance benefits (from Medicare, Medicaid, and Affordable Care Act premium subsidies) accounted for nearly one-third of the overall poverty reduction from public benefits. Poor adults with neither children nor a disability experienced little poverty relief from public programs, and what relief they did receive came mostly from premium subsidies and other public health insurance benefits. Medicaid had a larger effect on child poverty than all nonhealth means-tested benefits combined.

E-health

Chapitre 2. Utilisation des Big Data en santé : le cas des objets connectés

BROUARD B.

2017

Journal International de Bioéthique 28(3): 27-30.

https://www.cairn.info/revue-journal-international-de-bioethique-2017-3-page-27.htm

Selon le rapport « The Internet of Things Market », le nombre d'objets connectés devrait être de 68 milliards en 2020. De plus, en 2012, le total des données stockées dans le monde était de 500 petabytes. Après la course à la puissance de calcul puis au développement des réseaux, l'enjeu réside désormais dans le stockage de ces données dans le « cloud », mais aussi et surtout, à libérer leur accès (open data) et à les traiter rapidement et en masse (Big Data). L'utilisation de ces données à bon escient est un enjeu majeur pour la recherche et la santé publique.

E-Health in Switzerland: The Laborious Adoption of the Federal Law on Electronic Health Records (EHR) and Health Information Exchange (HIE) Networks

DE PIETRO C. ET FRANCETIC I.

2017/11

Health Policy: Ahead of print.

Within the framework of a broader e-health strategy launched a decade ago, in 2015 Switzerland passed a new federal law on patients' electronic health records (EHR). The reform requires hospitals to adopt interoperable EHRs to facilitate data sharing and cooperation among healthcare providers, ultimately contributing to improvements in quality of care and efficiency in the health system. Adoption is voluntary for ambulatories and private practices, that may however be pushed towards EHRs by patients. The latter have complete discretion in the choice of the health information to share. Moreover, careful attention is given to data security issues. Despite good intentions, the high institutional and organisational fragmentation of the Swiss healthcare system, as well as the lack of full agreement with stakeholders on some critical points of the reform, slowed the process of adoption of the law. In particular, pilot projects made clear that the participation of ambulatories is doomed to be low unless appropriate incentives are put in place. Moreover, most stakeholders point at the strategy proposed to finance technical implementation and management of EHRs as a major drawback. After two years of intense preparatory work, the law entered into force in April 2017.

Chapitre 6. Les dispositions de la loi de modernisation de notre système de santé relatives aux données de santé

DEVILLIER N.

2017

Journal International de Bioéthique 28(3): 57-61.

https://www.cairn.info/revue-journal-international-de-bioethique-2017-3-page-57.htm

La loi sur la modernisation de notre système de santé adoptée en 2016 étend le champ du secret médical en créant le dossier médical partagé (DMP) du patient. Tous les professionnels de santé intervenant dans le parcours de soin ont accès aux informations qui y sont renseignées. Le patient y accède par un site Internet dédié. Les décrets d'application de ce dispositif fixent les modalités de ce partage et encadrent la création de ce traitement automatisé de données à caractère personnel. Enfin, la loi créée un accès ouvert et sécurisé aux données de santé dans l'intérêt de la collectivité. Cet open data en santé est placé sous la gouvernance de l'Institut national des données de santé.

Using Mobile Apps to Communicate Vaccination Records: A City-Wide Evaluation with a National Immunization App, Maternal Child Registry and Public Health Authorities

ATKINSON K.M., *et al.*

2017

Healthcare Quarterly 20(3): 41-46.

http://www.longwoods.com/product/25289

Medicine is experiencing a paradigm shift, where patients are increasingly involved in the management of their health data. We created a mobile app which permitted parental reporting of immunization status to public health authorities. We describe app use as a proxy for feasibility and acceptability as well as data utility for public health surveillance. The evaluation period ran from April 27, 2015, to April 18, 2017, during which time 2,653 unique children's records were transmitted, containing 36,105 vaccinations. Our findings suggest that mobile immunization reporting is feasible and may be an acceptable complement to existing reporting methods. Measures of data utility suggest that mobile reporting could enable more accurate assessments of vaccine coverage.

Chapitre 4. La gouvernance des Big data utilisées en santé, un enjeu national et international

RIAL-SEBBAG E.

2017

Journal International de Bioéthique 28(3): 39-50.

https://www.cairn.info/revue-journal-international-de-bioethique-2017-3-page-39.htm

L'utilisation des données de santé est de plus en plus considérée comme un enjeu central pour la recherche mais également pour le soin. La génération de ces données est une valeur ajoutée pour la conduite d'études à grande échelle, elle est même considérée comme une (r)évolution dans la méthodologie de la recherche ou encore la médecine personnalisée. Plusieurs facteurs ont influencé l'accélération de l'utilisation des données de santé (progrès de la génétique, de la technologie, diversification des sources) conduisant à re-questionner les principes juridiques posés pour la protection des données de santé tant en droit français qu'en droit européen. En effet, premièrement, la production de masse (Big Data) de données dans le champ de la santé influe sur la quantité et la qualité des données venant dès lors reconfigurer les outils de protection de la vie privée en insistant sur le risque informationnel. Deuxièmement, l'utilisation de ces données repose quant à elle sur des principes fondamentaux existants tout en soulevant de nouveaux challenges pour leur gouvernance.

▶ La télémédecine dans la loi de financement de la sécurité sociale pour 2017

SIMON P.

2017/09-10

Techniques Hospitalières(765): 6p.

Le programme Expérimentations de télémédecine pour l'amélioration du parcours en santé (Etapes) préfigure le financement des pratiques professionnelles de télémédecine dans le droit commun de la sécurité sociale. Cet article présente ce programme initié dans la Loi de financement de la sécurité sociale pour 2017.

Health Economics

▶ How Much Do Cancer Specialists Earn? A Comparison of Physician Fees and Remuneration in Oncology and Radiology in High-Income Countries

BOYLE S., *et al.*

2017

Health Policy : Ahead of print.

http://dx.doi.org/10.1016/j.healthpol.2017.11.003

Higher spending on healthcare in the USA is driven by higher physician fees. The oncology consultation fee is three times greater, chemotherapy four times. There is a three to fourfold variation in fees for ultrasound and CT scans. Physician earnings in the USA are greater in oncology and radiology. Canadian specialists earn considerably more than their European counterparts.

▶ A Method to Simulate Incentives for Cost Containment Under Various Cost Sharing Designs: An Application to a First-Euro Deductible and a Doughnut Hole

CATTEL D., *et al.*

2017

Eur J Health Econ 18 (8): 987-1000.

Many health insurance schemes include deductibles to provide consumers with cost containment incentives (CCI) and to counteract moral hazard. Policymakers are faced with choices on the implementation of a specific cost sharing design. One of the guiding principles in this decision process could be which design leads to the strongest CCI. Despite the vast amount of literature on the effects of cost sharing, the relative effects of specific cost sharing designs-e.g., a traditional deductible versus a doughnut hole-will mostly be absent for a certain context. This papers aims at developing a simulation model to approximate the relative effects of different deductible modalities on the CCI. We argue that the CCI depends on the probability that healthcare expenses end up in the deductible range and the expected healthcare expenses given that they end up in the deductible range. Our empirical application shows that different deductible modalities result in different CCIs and that the CCI under a certain modality differs across risk-groups.

▶ Improving Risk Equalization for Individuals with Persistently High Costs: Experiences from the Netherlands

EIJKENAAR F. ET VAN VLIET R.

2017

Health Policy 121(11): 1169-1176.

Risk-equalization (RE) models in competitive health insurance markets have become increasingly sophisticated. However, these models still have important imperfections. A specific problem in the Netherlands is that insurers are insufficiently compensated for individuals who can persistently be found in the right-end tail of the cost distribution. The goal of this study is to explore and evaluate options for improving compensation for persistently high-cost individuals in the Dutch basic health insurance. Prescription drugs claims (2012) and administrative data on costs and risk-characteristics (2010-2013) for the entire Dutch population are used to identify high-cost individuals and evaluate improvement options. These options - including new risk-classes and a form of risk-sharing - are evaluated in terms of insurers' incentives for risk-selection and efficiency. Although this study provides useful insights in the possibilities for improving RE-models for persistently high-cost individuals, improving compensation remains challenging and dependent on the ongoing debate regarding coverage and reimbursement of expensive drugs.

▶ Combined Social and Private Health Insurance Versus Catastrophic Out of Pocket Payments for Private Hospital Care in Greece

GRIGORAKIS N., *et al.*

2017

Int J Health Econ Manag. : Ahead of print.

The high level of out of pocket (OOP) payments constitutes a major concern for Greece and several other European and OECD countries as a result of the significant down turning of their public health finances due to the 2008 financial crisis. The basic objective of this study is to provide empirical evidence on the effect of combining social health insurance (SHI) and private health insurance (PHI) on OOP payments. Further, this study examines the catastrophic impact of OOP payments on insured's welfare using the incidence and intensity methodological approach of measuring catastrophic health care expenditures. Conducting a cross-sectional survey in Greece in 2013, we find that the combination of SHI-PHI has a strong negative influence on insured OOP payments for inpatient health care in private hospitals. Furthermore, our results indicate that SHI coverage is not sufficient by itself to manage with this issue. Moreover, we find that poor people present a greater tendency to incur catastrophic OOP expenditures for hospital health care in private providers. Drawing evidence from Greece, a country with huge fiscal problems that has suffered the consequences of the economic crisis more than any other, could be a starting point for policymakers to consider the perspective of SHI-PHI co-operation against OOP payments more seriously.

▶ How Do Performance-Based Financing Programmes Measure Quality of Care? A Descriptive Analysis of 68 Quality Checklists from 28 Low- and Middle-Income Countries

JOSEPHSON E., *et al.*

2017

Health Policy Plan 32(8): 1120-1126.

This paper seeks to systematically describe the length and content of quality checklists used in performance-based financing programmes, their similarities and differences, and how checklists have evolved over time. We compiled a list of supply-side, health facility-based performance-based financing (PBF) programmes in low- and lower middle-income countries based on a document review. We then solicited PBF manuals and quality checklists from implementers and donors of these PBF mechanisms. We entered each indicator from each quality checklist into a database verbatim in English, and translated into English from French where appropriate, and categorized each indicator according to the Donabedian framework and an author-derived categorization. We extracted 8,490 quality indicators from 68 quality checklists across 32 PBF implementations in 28 countries. On average, checklists contained 125 indicators; within the same program, checklists tend to grow as they are updated.

▶ Effect of Incentive Payments on Chronic Disease Management and Health Services Use in British Columbia, Canada: Interrupted Time Series Analysis

LAVERGNE M. R., *et al.*

2017

Health Policy : Ahead of print.

We studied the effects of incentive payments to primary care physicians for the care of patients with diabetes, hypertension, and Chronic Obstructive Pulmonary Disease (COPD) in British Columbia, Canada. We used linked administrative health data to examine monthly primary care visits, continuity of care, laboratory testing, pharmaceutical dispensing, hospitalizations, and total health care spending. We examined periods two years before and two years after each incentive was introduced, and used segmented regression to assess whether there were changes in level or trend of outcome measures across all eligible patients following incentive introduction, relative to pre-intervention periods. We observed no increases in primary care visits or continuity of care after incentives were introduced. Rates of ACR testing and antihypertensive dispensing increased among patients with hypertension, but none of the other modest increases in laboratory testing or prescriptions dispensed reached statistical significance. Rates of hospitalizations for stroke and heart failure among patients with hypertension fell relative to pre-intervention patterns, while hospitalizations for COPD increased. Total hospitalizations and hospitalizations via the emergency department did not change. Health care spending increased for patients with hypertension. This large-scale incentive scheme for primary care physicians showed some positive effects for patients with hypertension, but we observe no similar changes in patient management, reductions in hospitalizations, or changes in spending for patients with diabetes and COPD.

Improving Care and Lowering Costs: Evidence and Lessons from a Global Analysis of Accountable Care Reforms

MCCLELLAN M., *et al.*

2017

Health Aff (Millwood) 36(11): 1920-1927.

Policy makers and providers are under increasing pressure to find innovative approaches to achieving better health outcomes as efficiently as possible. Accountable care, which holds providers accountable for results rather than specific services, is emerging in many countries to support such care innovations. However, these reforms are challenging and complex to implement, requiring significant policy and delivery changes. Despite global interest, the evidence on how to implement accountable care successfully remains limited. To improve the evidence base and increase the likelihood of success, we applied a comprehensive framework for assessing accountable care implementation to three promising reforms outside the United States. The framework relates accountable care policy reforms to the competencies of health care organizations and their health policy environments to facilitate qualitative comparisons of innovations and factors that influence success. We present emerging lessons to guide future implementation and evaluation of accountable care reforms to improve access to and the quality and affordability of care.

Does Health Insurance Reduce Out-Of-Pocket Expenditure? Heterogeneity Among China's Middle-Aged and Elderly

ZHANG A., *et al.*

2017

Soc Sci Med 190: 11-19.

China's recent healthcare reforms aim to provide fair and affordable health services for its huge population. In this paper, we investigate the association between China's health insurance and out-of-pocket (OOP) healthcare expenditure. We further explore the heterogeneity in this association. Using data of 32,387 middle-aged and elderly individuals drawn from the 2011 and 2013 waves of China Health and Retirement Longitudinal Study (CHARLS), we report five findings. First, having health insurance increases the likelihood of utilizing healthcare and reduces inpatient OOP expenditure. Second, healthcare benefits are distributed unevenly: while low- and medium-income individuals are the main beneficiaries with reduced OOP expenditure, those faced with very high medical bills are still at risk, owing to limited and shallow coverage in certain aspects. Third, rural migrants hardly benefit from having health insurance, suggesting that institutional barriers are still in place. Fourth, health insurance does not increase patient visits to primary care facilities; hospitals are still the main provider of healthcare. Nonetheless, there is some evidence that patients shift from higher-tier to lower-tier hospitals. Last, OOP spending on pharmaceuticals is reduced for inpatient care but not for outpatient care, suggesting that people rely on inpatient care to obtain reimbursable drugs, putting further pressure on the already overcrowded hospitals.

Health Status

Not Feeling Well ... True or Exaggerated? Self-Assessed Health as a Leading Health Indicator

BECCHETTI L., *et al.*

2017

Health Econ. : Ahead of print.

We provide original, international evidence documenting that self-assessed health (SAH) is a leading health indicator, that is, a significant predictor of future changes in health conditions, in a large sample of Europeans aged above 50 and living in 13 different countries. We find that, after controlling for attrition bias, lagged SAH is significantly and negatively correlated with changes in the number of chronic diseases, net of the correlations with levels, and changes in sociodemographic factors and health styles, country and regional health system effects, and declared symptoms. Illness-specific estimates document that lagged SAH significantly correlates with arthritis, cholesterol, and lung diseases (and weakly so with ulcer, hypertension, and cataracts) and has a significant correlation with the probability of contracting cancer. Interpretations and policy implications of our findings are discussed in the paper.

Childhood Environmental Harshness Predicts Coordinated Health and Reproductive Strategies: A Cross-Sectional Study of a Nationally Representative Sample from France

MELL H., *et al.*

2018

Evolution and Human Behavior 39(1):1-8.

http://dx.doi.org/10.1016/j.evolhumbehav.2017.08.006

There is considerable variation in health and reproductive behaviours within and across human populations. Drawing on principles from Life History Theory, psychosocial acceleration theory predicts that individuals developing in harsh environments decrease their level of somatic investment and accelerate their reproductive schedule. Although there is consistent empirical support for this general prediction, most studies have focused on a few isolated life history traits and few have investigated the way in which individuals apply life strategies across reproductive and somatic domains to produce coordinated behavioural responses to their environment. In our study, we thus investigate the impact of childhood environmental harshness on both reproductive strategies and somatic investment by applying structural equation modeling (SEM) to cross-sectional survey data obtained in a representative sample of the French population (n = 1015, age: 19-87years old, both genders). This data allowed us to demonstrate that (i) inter-individual variation in somatic investment (e.g. effort in looking after health) and reproductive timing (e.g. age at first birth) can be captured by a latent fast-slow continuum, and (ii) faster strategies along this continuum are predicted by higher childhood harshness. Overall, our results support the existence of a fast-slow continuum and highlight the relevance of the life history approach for understanding variations in reproductive and health related behaviours.

Self-Rated Health, Generalized Trust, and the Affordable Care Act: A US Panel Study, 2006-2014

MEWES J. ET GIORDANO G. N.

2017

Soc Sci Med 190: 48-56.

Previous research shows that generalized trust, the belief that most people can be trusted, is conducive to people's health. However, only recently have longitudinal studies suggested an additional reciprocal pathway from health back to trust. Drawing on a diverse body of literature that shows how egalitarian social policy contributes to the promotion of generalized trust, we hypothesize that this other 'reverse' pathway could be sensitive to health insurance context. Drawing on nationally representative US panel data from the General Social Survey, we examine whether the Affordable Care Act of 2010 could have had influence on the deteriorating impact of worsening self-rated health (SRH) on generalized trust. Firstly, using two-wave panel data (2008-2010, N = 1403) and employing random effects regression models, we show that a lack of health insurance coverage negatively determines generalized trust in the United States. However, this association is attenuated when additionally controlling for (perceived) income inequality. Secondly, utilizing data from two separate three-wave panel studies from the US General Social Survey (2006-10; N = 1652; 2010-2014; N = 1187), we employ fixed-effects linear regression analyses to control for unobserved heterogeneity from time-invariant factors. We demonstrate that worsening SRH was a stronger predictor for a decrease in generalized trust prior (2006-2010) to the implementation of the Affordable Care Act. Further, the negative effect of fair/poor SRH seen in the 2006-2010 data becomes attenuated in the 2010-2014 panel data

▶ How Strongly Related Are Health Status and Subjective Well-Being? Systematic Review and Meta-Analysis

NGAMABA K. H., *et al.*

2017

Eur J Public Health 27(5): 879-885.

Health status is widely considered to be closely associated with subjective well-being (SWB), yet this assumption has not been tested rigorously. The aims of this first systematic review and meta-analysis are to examine the association between health status and SWB and to test whether any association is affected by key operational and methodological factors. A systematic search (January 1980-April 2017) using Web of Science, Medline, Embase, PsycInfo and Global health was conducted according to Cochrane and PRISMA guidelines. Meta-analyses using a random-effects model were performed. Twenty nine studies were included and the pooled effect size of the association between health status and SWB was medium, statistically significant and positive (pooled r = 0.347, 95% CI = 0.309-0.385; Q = 691.51, I2 = 94.99%, P < 0.001). However, the association was significantly stronger: (i) when SWB was operationalised as life satisfaction (r = 0.365) as opposed to happiness (r = 0.307); (ii) among studies conducted in developing countries (r = 0.423) than it was in developed countries (r = 0.336) and (iii) when multiple items were used to assess health status and SWB (r = 0.353) as opposed to single items (r = 0.326). Conclusion: Improving people's health status may be one means by which governments can improve the SWB of their citizens. Life satisfaction might be preferred to happiness as a measure of SWB because it better captures the influence of health status.

Geography of Health

▶ Junior Doctors' Medical Specialty and Practice Location Choice: Simulating Policies to Overcome Regional Inequalities

RAMOS P., *et al.*

2017

Eur J Health Econ 18(8): 1013-1030.

There are nowadays over 1 million Portuguese who lack a primary care physician. By applying a discrete choice experiment to a large representative sample of Portuguese junior doctors (N = 503) in 2014, we provide an indication that this shortage may be addressed with a careful policy design that mixes pecuniary and non-pecuniary incentives for these junior physicians. According to our simulations, a policy that includes such incentives may increase uptake of general practitioners (GPs) in rural areas from 18% to 30%. Marginal wages estimated from our model are realistic and close to market prices: an extra hour of work would require an hourly wage of 16.5euro; moving to an inland rural setting would involve an increase in monthly income of 1.150euro (almost doubling residents' current income); a shift to a GP career would imply an 849euro increase in monthly income. Additional opportunities to work outside the National Health Service overcome an income reduction of 433euro. Our simulation predicts that an income increase of 350euro would lead to a 3 percentage point increase in choice probability, which implies an income elasticity of 3.37, a higher estimation compared to previous studies.

▶ Determining Geographic Accessibility of Family Physician and Nurse Practitioner Services in Relation to the Distribution of Seniors Within Two Canadian Prairie Provinces

SHAH T. I., *et al.*

2017

Soc Sci Med 194: 96-104.

Equitable access and distribution of health care services for rural and remote populations is a substantial challenge for health workforce planners and policy makers. Geospatial examination of access to health care considers both need and supply dimensions together to determine spatial access scores which contribute to a greater understanding of potential inequity in accessibility. This geospatial investigation explores geographic variation in accessibility to primary health care services utilizing combined access scores for family physicians and nurse practitioner services in urban and rural communities in the Canadian Prairie provinces of Saskatchewan and Alberta. An index of access scores was developed using a floating catchment area framework and a census subdivision geographic unit. Information about family physician and nurse practitioner practice locations and spatial population data were obtained from the Canadian Institute for Health Information and Statistics Canada respectively. This study contributes to health services research by exploration of combined access scores for family physician and nurse practitioner services in relation to the distribution of seniors. These findings provide insight into which areas may be in need of increased primary health care services with a focus on both of these health professional groups. The findings of this research will serve as a foundational model for future expansion of the methods to other health care provider groups and to other population health need indicators provincially and nationally.

Disability

▶ Collaborative Design of a Health Care Experience Survey for Persons with Disability

LEZZONI L. I., *et al.*

2017

Disability and Health Journal 10(2): 231-239.

http://www.sciencedirect.com/science/article/pii/S193665741730002X

When assessing results of health care delivery system reforms targeting persons with disability, quality metrics must reflect the experiences and perspectives of this population. For persons with disability and researchers to develop collaboratively a survey that addresses critical quality questions about a new Massachusetts health care program for persons with disability dually-eligible for Medicare and Medicaid. Persons with significant physical disability or serious mental health diagnoses participated fully in all research activities, including co-directing the study, co-moderating focus groups, performing qualitative analyses, specifying survey topics, cognitive interviewing, and refining survey language. Several sources informed survey development, including key informant interviews, focus groups, and cognitive testing. Analyses by collaborators with disability identified 29 questions for persons with physical disability and 38 for persons with mental health diagnoses. After cognitive testing, the final survey includes questions on topics ranging from independent living principles to health care delivery system concerns. The Persons with Disabilities Quality Survey (PDQ-S) captures specific quality concerns of Massachusetts residents with physical or mental health disability about an integrated health plan. PDQ-S requires further testing elsewhere to determine its value for quality assessment more generally and to other populations with disability.

▶ De la vulnérabilité et du droit des usagers de notre système de santé

OLLIVET C.

2017

Gérontologie et société 39(154): 109-119.

https://www.cairn.info/revue-gerontologie-et-societe-2017-3-page-109.htm

Aborder le vieillissement cognitif, et en particulier les syndromes démentiels, avec le prisme des droits de l’Homme permet d’attirer l’attention sur les privations de droits et sur les restrictions abusives de liberté dont sont victimes les personnes âgées en difficulté cognitive. Cela conduit aussi à se demander si le cadre de référence que constituent les droits de l’Homme ne pourrait pas permettre de définir un projet ou une ambition, et aider à penser ce que serait une véritable prise en compte par la société des citoyens qui vivent avec des troubles cognitifs. Le prisme des droits de l’Homme invite ainsi à considérer la maladie d’Alzheimer et les maladies apparentées comme des handicaps cognitifs évolutifs, et à envisager leur prise en charge et leur accompagnement d'après le modèle de la réhabilitation ou de la compensation. Parallèlement à cette évolution conceptuelle, on constate que le droit international et certaines législations nationales commencent à s'adapter afin que la protection des personnes vulnérables ne se fasse pas au détriment de leurs droits et libertés. Et loin que la référence aux droits de l'Homme emporte avec elle une anthropologie individualiste, on observe au contraire l'émergence d'une conception relationnelle de l'autonomie, où les aidants – qu'ils soient familiaux, bénévoles ou professionnels – jouent un rôle central pour rendre effectifs les droits fondamentaux et faire en sorte que soit respectée l'inaliénable dignité des personnes. Ce numéro est coordonné par Fabrice Gzil (Docteur en philosophie, responsable du pôle Soutien à la recherche et à l'innovation sociale, Fondation Médéric Alzheimer).

▶ Disability, Residential Environment and Social Participation: Factors Influencing Daily Mobility of Persons Living in Residential Care Facilities in Two Regions of France

RAPEGNO N. ET RAVAUD J.-F.

2017

BMC Health Services Research 17(1): 683.

https://doi.org/10.1186/s12913-017-2602-8

Despite the context of individualization of public policies and promotion of independent living, residential care facilities (RCFs) (called "établissements médico-sociaux" in France) still represent the main system used by disabled people. Through a study of their daily mobility, this article proposes a geographical approach to the examination of factors influencing the social participation of disabled persons with motor impairments who live in residential care facilities.

▶ Welfare Reform Act de 2012, fusion des minima sociaux britanniques et prestations handicap

VELCHE D.

2017

Revue française des affaires sociales(3): 109-128.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-3-page-109.htm

Instituant le « crédit universel » fusionnant divers minima sociaux, la loi britannique de réforme de l'assistance sociale adoptée en 2012 affecte les personnes handicapées, directement d'abord par l'absorption progressive de la principale prestation handicap non contributive et sous conditions de ressources, indirectement ensuite par l'incidence d'autres prestations sociales en cours d'extinction, prestations qui souvent prévoyaient divers suppléments handicap. La même réforme rend plus stricte l'attribution des aides à la vie indépendante non incluses dans le crédit universel. À cela s'ajoute l'adoption d'un plafonnement du total des prestations accordées à une même famille. Ces décisions, mises en œuvre dans un contexte généralisé de coupes budgétaires, inquiètent les personnes handicapées et leurs proches. Peuvent-ils craindre une paupérisation ?

Hospitals

▶ The Political Economy of Diagnosis-Related Groups

BERTOLI P. ET GREMBI V.

2017

Soc Sci Med 190: 38-47.

A well-established political economic literature has shown as multi-level governance affects the inefficiency of public expenditures. Yet, this expectation has not been empirically tested on health expenditures. We provide a political economy interpretation of the variation in the prices of 6 obstetric DRGs using Italy as a case study. Italy offers a unique institutional setting since its 21 regional governments can decide whether to adopt the national DRG system or to adjust/waive it. We investigate whether the composition and characteristics of regional governments do matter for the average DRG level and, if so, why. To address both questions, we first use a panel fixed effects model exploiting the results of 66 elections between 2000 and

2013 (i.e., 294 obs) to estimate the link between DRGs and the composition and characteristics of regional governments. Second, we investigate these results exploiting the implementation of a budget constraint policy through a difference-in-differences framework. The incidence of physicians in the regional government explains the variation of DRGs with low technological intensity, such as normal newborn, but not of those with high technological intensity, as severely premature newborn.

▶ The Impact of Introducing a New Hospital Financing System (DRGs) in Poland on Hospitalisations for Atherosclerosis: An Interrupted Time Series Analysis (2004-2012)

BUCZAK-STEC E., *et al.*

2017

Health Policy 121(11): 1186-1193.

Hospital payment based on diagnosis-related groups (DRGs) was introduced in Poland in July 2008. We evaluate the impact of this policy on the frequency of hospitalisation for atherosclerosis in internal medicine units of district hospitals and non-public hospitals in Poland. Data were collected between 2004 and 2012 from each district and non-public hospital participating in the General Hospital Morbidity Study (165 hospitals in total). Atherosclerosis was defined using the ICD-10 code I70. Hospitalisation patterns were examined using interrupted time series with segmented regression analysis. We conclude that implementation of a DRG-based system in Poland was associated with substantial increases in atherosclerosis hospitalisation rates. Failing to take into account this change in financing and not accounting for long-term trends in hospitalisation rates may result in inaccurate epidemiological data.

▶ L'impact de la T2A sur la gestion des établissements publics de santé

BURNEL P.

2017

Journal de gestion et d'économie médicales 35(2): 67-79.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-2-page-67.htm

Le présent article a pour objet de faire un point, après 12 ans de mise en œuvre, sur les effets induits par la tarification à l'activité (T2A) sur la gestion et l'organisation des établissements publics de santé (EPS). Il met en évidence, en s'appuyant sur la littérature, que les effets attendus en termes d'efficience ne se sont que partiellement réalisés. Les EPS n'ont pas révisé en profondeur leurs processus et leurs organisations se contentant de mesures d'ajustement sur les charges variables. Il s'ensuit une dégradation des conditions de travail et une perte de sens qui affecte les personnels soignants et, parfois médicaux. Pour dépasser ces limites, cet article explore les voies d'un approche réellement médico- économique centrée sur la refonte des processus de prise en charge en se fondant sur ce qui motive l'action des personnels soignants : les dynamiques du progrès médical qui offre des opportunités nouvelles et la recherche de l'amélioration de la qualité des soins.

▶ GHT : de la collection d'individus au groupe solidaire. Un pari gagnant/gagnant pour l'hôpital

CHAPUIS C. ET VIELFAURE-CHAPUIS M.

2017/08-09

Gestions hospitalières(568): 406-408.

La loi du 26 janvier 2016 a créé les groupements hospitaliers de territoire (GHT), afin de permettre une égalité d'accès aux soins sur un territoire de santé. Les hôpitaux concernés par ces GHT ont dû s'inscrire dans un partage de vision de l'offre de soins de territoire nécessitant une analyse récursive afin de structurer un projet médico-soignant fonctionnant en réseau. Mais les établissements sont-ils prêts ? Tel est le questionnement de cet article.

▶ Avoidable Hospitalization Among Migrants and Ethnic Minority Groups: A Systematic Review

DALLA ZUANNA T., *et al.*

2017

Eur J Public Health 27(5): 861-868.

The numbers of migrants living in Europe are growing rapidly, and has become essential to assess their access to primary health care (PHC). Avoidable Hospitalization (AH) rates can reflect differences across migrant and ethnic minority groups in the performance of PHC. We aimed to conduct a systematic review of all published studies on AH comparing separately migrants with natives or different racial/ethnic groups, in Europe and elsewhere. We ran a systematic search for original articles indexed in primary electronic databases on AH among migrants or ethnic minorities. Most of the studies (91%) used a cross-sectional design. The exposure variable was defined in almost all articles by ethnicity, race, or a combination of the two; country of birth was only used in one Australian study. Most of the studies found significant differences in overall AH rates, with minorities (mainly Black and Hispanics) showing higher rates than non-Hispanic Whites. Conclusions: AH has been used, mostly in the US, to compare different racial/ethnic groups, while it has never been used in Europe to assess migrants' access to PHC. Studies comparing AH rates between migrants and natives in European settings can be helpful in filling this lack of evidence.

▶ Insights from the Design and Implementation of a Single-Entry Model of Referral for Total Joint Replacement Surgery: Critical Success Factors and Unanticipated Consequences

DAMANI Z., *et al.*

2017

Health Policy : Ahead of print.

http://dx.doi.org/10.1016/j.healthpol.2017.10.006

The Winnipeg Central Intake Service (WCIS) employs single-entry, centralized intake and triage. The WCIS streamlined processes; improved referrals, patient care, and monitoring of outcomes. Challenges included low initial understanding, participation, and slow uptake. Unanticipated consequences included incorrect perceptions, increased referral volume, incomplete information sharing. Recommendations for successful implementation: early communication, clear processes, physician leadership, greater patience

▶ Hospitalization in French Forensic Units: Results of a Patient Satisfaction Survey

DE LABROUHE D., *et al.*

2017

Rev Epidemiol Sante Publique 65(4): 285-294.

In France, special full-time inpatient hospital units (UHSA) have been created for inmates with psychiatric disorders. Since they were established in 2010, the quality of care in such units has not been studied. Particularly, no patient satisfaction survey has been conducted yet. The main objective of this study was to assess the patients' satisfaction about their hospitalization in UHSA. A descriptive study has been performed in two hospitals (UHSA of Villejuif and UHSA of Lille-Seclin). From February to May 2015, 125 adult patients were included, at the end of their hospitalization (voluntary or involuntary psychiatric care) in UHSA. The patient's satisfaction was assessed by a psychiatrist who did not participate in patient care with a 16-item scale exploring three areas (quality of care, quality of information provided and UHSA functioning and organization). The items were evaluated with a visual numeric scale (1 to 10). This study demonstrates that patients hospitalized in UHSA are satisfied. Given the relationship between patient satisfaction and compliance, these structures could therefore have an important medical interest for inmates with psychiatric disorders. However, these results need to be replicated in a study involving all the UHSA of France.

▶ Using Weighted Hospital Service Area Networks to Explore Variation in Preventable Hospitalization

FALSTER M. O., *et al.*

2017

Health Serv Res. : Ahead of print.

The aim of this study is to demonstrate the use of multiple-membership multilevel models, which analytically structure patients in a weighted network of hospitals, for exploring between-hospital variation in preventable hospitalizations. The study is based on a cohort of 267,014 people aged over 45 in NSW, Australia. Patterns of patient flow were used to create weighted hospital service area networks (weighted-HSANs) to 79 large public hospitals of admission. Multiple-membership multilevel models on rates of preventable hospitalization, modeling participants structured within weighted-HSANs, were contrasted with models clustering on 72 hospital service areas (HSAs) that assigned participants to a discrete geographic region. We conclude that multiple-membership multilevel models can analytically capture information lost on patient attribution when creating discrete health care catchments. Weighted-HSANs have broad potential application in health services research and can be used across methods for creating patient catchments.

Long-Term Care Provision, Hospital Bed Blocking, and Discharge Destination for Hip Fracture and Stroke Patients

GAUGHAN J., *et al.*

2017

Int J Health Econ Manag 17(3): 311-331.

We examine the relationship between long-term care supply (care home beds and prices) and (i) the probability of being discharged to a care home and (ii) length of stay in hospital for patients admitted to hospital for hip fracture or stroke. Using patient level data from all English hospitals and allowing for a rich set of demographic and clinical factors, we find no association between discharge destination and long-term care beds supply or prices. We do, however, find evidence of bed blocking: hospital length of stay for hip fracture patients discharged to a care home is shorter in areas with more long-term care beds and lower prices. Length of stay is over 30% shorter in areas in the highest quintile of care home beds supply compared to those in the lowest quintile.

Agreement Between Hospital Discharge Diagnosis Codes and Medical Records to Identify Metastatic Colorectal Cancer and Associated Comorbidities in Elderly Patients

GOUVERNEUR A., *et al.*

2017

Rev Epidemiol Sante Publique 65(4): 321-325.

Quality of coding to identify cancers and comorbidities through the French hospital diagnosis database (Programme de médicalisation des systèmes d'information, PMSI) has been little investigated. Agreement between medical records and PMSI database was evaluated regarding metastatic colorectal cancer (mCRC) and comorbidities. From 01/01/2013 to 06/30/2014, 74 patients aged≥65years at mCRC diagnosis were identified in Bordeaux teaching hospital. Data on mCRC and comorbidities were collected from medical records. All diagnosis codes (main, related and associated) registered into the PMSI were extracted. Agreement between sources was evaluated using the percent agreement for mCRC and the kappa (kappa) statistic for comorbidities. Agreement for primary CRC and mCRC was higher using all types of diagnosis codes instead of the main one exclusively (respectively 95 % vs. 53 % for primary CRC and 91 % vs. 24 % for mCRC). Agreement was substantial (kappa 0.65) for cardiovascular diseases, notably atrial fibrillation (kappa 0.77) and hypertension (kappa 0.68). It was moderate for psychiatric disorders (kappa 0.49) and respiratory diseases (kappa 0.48), although chronic obstructive pulmonary disease had a good agreement (kappa 0.75). These results are reassuring with regard to detection through PMSI of mCRC if all types of diagnosis codes are considered and useful to better choose comorbidities in elderly mCRC patients that could be well identified through hospital diagnosis codes.

Le financement des établissements de santé par la Tarification à l'Activité : impasses et pistes de solutions

HIRTZLIN I.

2017

Journal de gestion et d'économie médicales 35(2): 81-92.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-2-page-81.htm

La tarification basée sur l'activité médicale reposant sur les diagnostics principaux des patients a d'abord été expérimentée par le dispositif Medicare, puis généralisée aux États Unis, avant de se diffuser à la plupart des pays d'Europe de l'Ouest, y compris la France, où elle a pris le nom de Tarification à l'activité à partir de 2008. L'efficience attendue du dispositif repose sur le principe de la concurrence par comparaison. La T2A connaît aujourd'hui des remises en cause liées aux limites de l'application pratique des principes incitatifs théoriques. Des pistes de solutions sont explorées dans cet article. Leur objectif est de réintroduire une composante économique dans le calcul des coûts et de tarifer en fonction des bonnes pratiques. Par ailleurs, comme la prise en charge du patient s'insère dans un établissement de santé il convient de tenir compte de ses contraintes productives et de son organisation.

Hospital Postacute Care Referral Networks: Is Referral Concentration Associated with Medicare-Style Bundled Payments

KAUR R., *et al.*

2017

Health Serv Res 52(6): 2079-2098.

The aim of this paper is 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. 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. The study design consists in 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. The study concludes that hospitals that tend to use fewer PAC providers may lead to lower costs for payers such as Medicare. Morever, the study results reinforce the importance of limited networks for PAC services under bundling arrangements for hospital and PAC payments.

Do Reduced Hospital Mortality Rates Lead to Increased Utilization of Inpatient Emergency Care? A Population-Based Cohort Study

LAUDICELLA M., *et al.*

2017

Health Serv Res: Ahead of print.

The aim of this study is to measure the impact of the improvement in hospital survival rates on patients' subsequent utilization of unplanned (emergency) admissions. Data is based on unplanned admissions occurring in all acute hospitals of the National Health Service in England between 2000 and 2009, including 286,027 hip fractures, 375,880 AMI, 387,761 strokes, and 9,966,246 any cause admissions. Unplanned admissions experienced by patients within 28 days, 1 year, and 2 years of discharge from the index admission are modeled as a function of hospital risk-adjusted survival rates using patient-level probit and negative binomial models. Identification is also supported by an instrumental variable approach and placebo test. The improvement in hospital survival rates that occurred between 2000 and 2009 explains 37.3 percent of the total increment in unplanned admissions observed over the same period. The success of hospitals in improving survival from unplanned admissions can be an important contributory factor to the increase in subsequent admissions.

Maternity Services for Rural and Remote Australia: Barriers to Operationalising National Policy

LONGMAN J., *et al.*

2017

Health Policy 121(11): 1161-1168.

In Australia, many small birthing units have closed in recent years, correlating with adverse outcomes including a rise in the number of babies born before arrival to hospital. Concurrently, a raft of national policy and planning documents promote continued provision of rural and remote maternity services, articulating a strategic intent for services to provide responsive, woman-centred care as close as possible to a woman's home. The aims of this paper are to contribute to an explanation of why this strategic intent is not realised, and to investigate the utility of an evidence based planning tool (the Toolkit) to assist with planning services to realise this intent.

Hospital-At-Home Integrated Care Programme for the Management of Disabling Health Crises in Older Patients: Comparison with Bed-Based Intermediate Care

MAS M. A., *et al.*

2017

Age Ageing 46(6): 925-931.

The aims of this study is to analyse the clinical impact of a home-based Intermediate Care model in the Catalan health system, comparing it with usual bed-based care. Design: quasi-experimental longitudinal study. Setting: hospital Municipal de Badalona and El Carme Intermediate Care Hospital, Badalona, Catalonia, Spain. We included older patients with medical and orthopaedic disabling health crises in need of Comprehensive Geriatric Assessment (CGA) and rehabilitation. At the end, clinical characteristics were similar between home-based and bed-based groups. Acute stay was shorter in home group: 6.1 (5.3-6.9) versus 11.2 (10.5-11.9) days, P < 0.001. The home-based scheme showed better results on functional resolution 79.1% (versus 75.2%), OR 1.62 (1.09-2.41) and on favourable crisis resolution 73.8% (versus 69.6%), OR 1.54 (1.06-2.22), with shorter length of intervention, with a reduction of -5.72 (-9.75 and -1.69) days. We conclude that the extended CGA-based hospital-at-home programme was associated with shorter stay and favourable clinical outcomes. Future studies might test this intervention to the whole Catalan integrated care system.

Evaluation of Minimum Volume Standards for Surgery in the Netherlands (2003-2017): A Successful Policy

MESMAN R., *et al.*

2017

Health Policy 121(12): 1263-1273.

The purpose of this paper is to evaluate the introduction and implications of minimum volume standards for surgery in Dutch health care from 2003 to 2017 and formulate policy lessons for other countries. Three eras were identified, representing a trust-and-control cycle in keeping with changing roles of different stakeholders in Dutch context. Based on the Dutch experience, the following lessons can be useful for other health care systems: 1. professionals should be in the lead in the development of national quality standards, 2. external pressure can be helpful for professionals to take the initiative and 3. volume remains a controversial quality measure. Future research and policies should focus on the underlying mechanism of volume-outcome relationships and overall effects of volume-based policies.

PMSI, T2A et gestion interne

MOISDON J. C.

2017

Journal de gestion et d'économie médicales 35(2): 51-66.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-2-page-51.htm

Des coûts aux tarifs par pathologie. Les enseignements d'une tentative de transposition de la T2A au système de financement hospitalier belge

RUYSSEN M., *et al.*

2017

Journal de gestion et d'économie médicales 35(2): 93-108.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-2-page-93.htm

Un des objectifs essentiels du PMSI et ensuite de la T2A était l'amélioration du management des établissements de santé. Pourtant, des investigations dans le système hospitalier montrent que les effets de ces nouveaux instruments sur l'organisation des hôpitaux ont été de faible ampleur et que les raisons d'un tel phénomène sont notamment liées à la complexité du dispositif de financement et aux caractéristiques intrinsèques du fonctionnement d'un hôpital. Le nouveau financement a moins conduit à une augmentation de l'efficience qu'à une répartition plus équitable d'une enveloppe globale et un gain en autonomie stratégique des établissements. Ces observations conduisent à des réflexions sur les relations entre économie et gestion et sur les apprentissages qui vont se révéler nécessaires dans les évolutions qui sont prévues à l'heure actuelle pour les modalités de financement des hôpitaux.

Should I Stay or Should I Go? Hospital Emergency Department Waiting Times and Demand

SIVEY P.

2017

Health Econ. : Ahead of print

In the absence of the price mechanism, hospital emergency departments rely on waiting times, alongside prioritisation mechanisms, to restrain demand and clear the market. This paper estimates by how much the number of treatments demanded is reduced by a higher waiting time. I use variation in waiting times for low-urgency patients caused by rare and resource-intensive high-urgency patients to estimate the relationship. I find that when waiting times are higher, more low-urgency patients are deterred from treatment and leave the hospital during the waiting period without being treated. The waiting time elasticity of demand for low-urgency patients is approximately -0.25 and is highest for the lowest-urgency patients.

Restricted Health Care Entitlements for Child Migrants in Europe and Australia

STUBBE OSTERGAARD L., *et al.*

2017

Eur J Public Health 27(5): 869-873.

More than 300 000 asylum seeking children were registered in Europe alone during 2015. In this study, we examined entitlements for health care for these and other migrant children in Europe and Australia in a framework based on United Nations Convention of the Rights of the Child (UNCRC). The study is founded on a survey to child health professionals, NGO's and European Ombudspersons for Children in 30 EU/EEA countries and Australia, supplemented by desktop research of official documents. Migrant children were categorised as asylum seekers and irregular/undocumented migrants. Five countries (France, Italy, Norway, Portugal and Spain) explicitly entitle all migrant children, irrespective of legal status, to receive equal health care to that of its nationals. Sweden and Belgium entitle equal care to asylum seekers and irregular non-EU migrants, while entitlements for EU migrants are unclear. Twelve European countries have limited entitlements to health care for asylum seeking children, including Germany that stands out as the country with the most restrictive health care policy for migrant children. In Australia entitlements for health care are restricted for asylum seeking children in detention and for irregular migrants. The needs of irregular migrants from other EU countries are often overlooked in European health care policy. We conclude that putting pressure on governments to honour the obligations of the UNCRC and explicitly entitle all children equal rights to health care can be an important way of advocating for better access to primary and preventive care for asylum seeking and undocumented children in Australia and the EU.

ISQUA17-3302: The Association Between Hospitals-Community Continuity of Care Patients with Chronic Disease and Clinical Outcomes

ZIMLICHMAN E., *et al.*

2017

International Journal for Quality in Health Care 29(suppl_1): 14-15.

http://dx.doi.org/10.1093/intqhc/mzx125.19

Transition of the patient from one physician to another throughout the therapeutic process; particularly in the transition from hospital to community, is a known weak point in the provision of safe, high quality care. The phenomenon is more prominent in patients with chronic illnesses, in light of the fact that these patients are usually receiving numerous medications and that their care is more fragmented. These patients therefore require closer supervision in disease management. Efforts are being made in Israel by the Health Funds to improve the maintenance of continuous treatment. The goals of this study were to evaluate the level of care continuity in chronic disease patients from four Health Funds, hospitalized at one medical center. Second, we have set out to learn about the association between maintaining continuity and clinical outcomes.

Health Inequalities

Geographical Inequalities in Health in a Time of Austerity: Baseline Findings from the Stockton-On-Tees Cohort Study

BHANDARI R., *et al.*

2017

Health Place 48: 111-122.

Stockton-on-Tees has the highest geographical inequalities in health in England with the life expectancy at birth gap between the most and deprived neighbourhoods standing at over 17 years for men and 11 years for women. In this study, we provide the first detailed empirical examination of this geographical health divide by: estimating the gap in physical and general health (as measured by EQ. 5D, EQ. 5D-VAS and SF8PCS) between the most and least deprived areas; using a novel statistical technique to examining the causal role of compositional and contextual factors and their interaction; and doing so in a time of economic recession and austerity. Using a stratified random sampling technique, individual-level survey data was combined with secondary data sources and analysed using multi-level models with 95% confidence intervals obtained from nonparametric bootstrapping. The main findings indicate that there is a significant gap in health between the two areas, and that compositional level material factors, contextual factors and their interaction appear to be the major explanations of this gap. Contrary to the dominant policy discourse in this area, individual behavioural and psychosocial factors did not make a significant contribution towards explaining health inequalities in the study area. The findings are discussed in relation to geographical theories of health inequalities and the context of austerity.

A Systematic Literature Review on the Use and Outcomes of Maternal and Child Healthcare Services by Undocumented Migrants in Europe

DE JONG L., *et al.*

2017

Eur J Public Health 27(6): 990-997.

Undocumented migrants, in particular pregnant women and their newborns, constitute a particularly vulnerable group of migrants. The aim of this study was to systematically review the academic literature on the use and outcomes of maternal and child healthcare by undocumented migrants in the European Union (EU) and European Free Trade Association (EFTA) countries. The databases, MEDLINE, Embase, CINAHL Plus, Global Health and Popline were searched for the period 2007 to 2017. Overall, the quantitative studies found that undocumented women underutilised essential maternal and child healthcare services, and experienced worse health outcomes. Qualitative studies supported these results, indicating that undocumented migrants were hesitant to use services due to a lack of knowledge and fear of deportation. Studies included in the review covered 10 of 32 EU or EFTA countries, making a European comparison impossible. Despite major methodological differences between included studies, the results of this review indicate that the status of undocumented migrants exacerbates known health risks and hampers service use.

Multimorbidity and Immigrant Status: Associations with Area of Origin and Length of Residence in Host Country

GIMENO-FELIU L. A., *et al.*

2017

Family Practice 34(6): 662-666.

http://dx.doi.org/10.1093/fampra/cmx048

Multimorbidity is a growing phenomenon in primary care, and knowledge of the influence of social determinants on its evolution is vital. The aim of this study was to understand the relationship between multimorbidity and immigration, taking into account length of residence in the host country and area of origin of the immigrant population. Cross-sectional retrospective study of all adult patients registered within the public health service of Aragon, Spain (N = 1092279; 144238 were foreign-born), based on data from the EpiChron Cohort. Age-standardized prevalence rates of multimorbidity were calculated. Different models of binary logistic regressions were conducted to study the association between multimorbidity, immigrant status and length of residence in the host country. Prevalence of multimorbidity is lower among foreign-borns as compared with native-borns, but increases rapidly with length of residence in the host country. However, the progressive development of multimorbidity among immigrants varies widely depending on area of origin. These findings provide important insight into the health care needs of specific population groups and may help minimize the negative impact of multimorbidity among the most vulnerable groups.

Health and Mortality Patterns Among Migrants in France

KHLAT M. ET GUILLOT M.

2017

University of Pennsylvania: 35p.

http://repository.upenn.edu/psc_publications/8/

Research on migrants' health and mortality has been lagging in France, by comparison with other European countries with shorter immigration histories. This lag has been related to the predominance in France of the modèle d'intégration républicaine (republican model of integration), according to which the state disregards criteria such as race, ethnicity or religion when interacting with individuals, in order to guarantee equal treatment for all (Oberti, 2008). Given the strong links between the state and the statistical system, the dividing line has long been limited to the basic distinction between foreigners and French citizens (Safi, 2007).

▶ The Impact of Minimum Wages on Population Health: Evidence from 24 OECD Countries

LENHART O.

2016

Eur J Health Econ. : Ahead of print.

This study examines the relationship between minimum wages and several measures of population health by analyzing data from 24 OECD countries for a time period of 31 years. Specifically, I test for health effects as a result of within-country variations in the generosity of minimum wages, which are measured by the Kaitz index. The paper finds that higher levels of minimum wages are associated with significant reductions of overall mortality rates as well as in the number of deaths due to outcomes that have been shown to be more prevalent among individuals with low socioeconomic status (e.g., diabetes, disease of the circulatory system, stroke). A 10% point increase of the Kaitz index is associated with significant declines in death rates and an increase in life expectancy of 0.44 years. Furthermore, I provide evidence for potential channels through which minimum wages impact population health by showing that more generous minimum wages impact outcomes such as poverty, the share of the population with unmet medical needs, the number of doctor consultations, tobacco consumption, calorie intake, and the likelihood of people being overweight.

▶ Health of Newly Arrived Immigrants in Canada and the United States: Differential Selection on Health

LU Y., *et al.*

2017

Health Place 48: 1-10.

Canada and the U.S. are two major immigrant-receiving countries characterized by different immigration policies and health care systems. The present study examines whether immigrant health selection, or the «healthy immigrant effect», differs by destination and what factors may account for differences in immigrant health selection. We use 12 years of U.S. National Health Interview Survey and Canadian Community Health Survey data to compare the risks of overweight/obesity and chronic health conditions among new immigrants in the two countries. Results suggest a more positive health selection of immigrants to Canada than the U.S. Specifically, newly arrived U.S. immigrants are more likely to be overweight or obese and have serious chronic health conditions than their Canadian counterparts. The difference in overweight/obesity was explained by differences in source regions and educational levels of immigrants across the two countries. But this is not the case for serious chronic conditions. These results suggest that immigration-related policies can potentially shape immigrant health selection.

▶ Nordic Paradox, Southern Miracle, Eastern Disaster: Persistence of Inequalities in Mortality in Europe

MACKENBACH J. P.

2017

Eur J Public Health 27(suppl_4): 14-17.

http://dx.doi.org/10.1093/eurpub/ckx160

The persistence of socioeconomic inequalities in health, despite all that has been done to reduce social and economic inequalities in many European countries, is one of the great disappointments of public health. In this paper, I summarize the results of a series of studies into the explanation of variations and trends in inequalities in mortality in three European regions: the Nordic countries with their puzzlingly large inequalities in mortality, Southern European countries with their miraculously small inequalities in mortality and Central and Eastern European countries in which inequalities in mortality have disastrously exploded since the early 1990 s. The results of these studies show that inequalities in mortality are remarkably variable and dynamic, which suggests that it may be possible to reduce them if we exploit the entry-points for policy that these studies have also identified, such as poverty, smoking, excessive alcohol consumption and lack of access to health care. At the same time, another lesson is that health inequalities are influenced in sometimes unexpected ways by factors that are not under our control, and that we cannot expect to eliminate these health inequalities soon.

Health and Access to Health Care of 18-25 Years Old People Not in Employment, Education or Training (NEETs) Attending the French 'Missions Locales'

ROBERT S., *et al.*

2017

Rev Epidemiol Sante Publique 65(4): 265-276.

In France, «missions locales» are public assistance units for young people aged 16-25 years not in employment, education or training (NEET). The health status of the more than 1.5 million young adults attending these units annually is unknown. The purpose of this study was to describe the health status and health care use of this population in comparison with the general population of the same age. The Presaje survey was conducted in 2011 on a randomized sample of 1453 young adults aged 18-25 years who attended five «missions locales» in mainland France. Data were analyzed and compared with those of participants of the same age interviewed in a French national health survey (Barometre Sante 2010, n = 2899) and in a regional cohort (SIRS, n = 204) conducted in the Greater Paris area, both in 2010. Careful attention must be given to the young NEET population. Many of these youths are not familiar with health care services despite their important health care needs. Integrating health services into the «missions locales» may help detect health problems in this population, facilitating links to care.

Austerity and Health: The Impact in the UK and Europe

STUCKLER D., *et al.*

2017

Eur J Public Health 27(suppl_4): 18-21.

Austerity measures-reducing social spending and increasing taxation-hurts deprived groups the most. Less is known about the impact on health. In this short review, we evaluate the evidence of austerity's impact on health, through two main mechanisms: a 'social risk effect' of increasing unemployment, poverty, homelessness and other socio-economic risk factors (indirect), and a 'healthcare effect' through cuts to healthcare services, as well as reductions in health coverage and restricting access to care (direct). We distinguish those impacts of economic crises from those of austerity as a response to it. Where possible, data from across Europe will be drawn upon, as well as more extensive analysis of the UK's austerity measures performed by the authors of this review.

Undocumented and Documented Migrants with Chronic Diseases in Family Practice in the Netherlands

VAN DE SANDE J. S. O. ET VAN DEN MUIJSENBERGH M. E. T. C.

2017

Family Practice 34(6): 649-655.

http://dx.doi.org/10.1093/fampra/cmx032

Undocumented migrants (UM) face many barriers in accessing healthcare. It is unknown how these affect the care of UM with chronic diseases in general practices. In the Netherlands, a General practitioner (GP) is the gatekeeper to the healthcare system and primary care provider for UM. The aim of this study is to get insight into GP care for chronic diseases in UM compared with documented migrants (DM). A survey study of medical records of UM and DM in five general practices in the Netherlands with extensive experience in caring for UM. UM and DM were matched for gender, age and region of origin. Consultation rates, values of HbA1C, blood pressure, spirometry, number of referrals and medicine prescriptions were compared in all people with cardiovascular disease, diabetes or asthma/ COPD. We conclude that undocumented migrants with chronic diseases in general practices in the Netherlands that are experienced in caring for UM receive to a large extent equitable care compared to documented migrants.

The Dark Side of Social Capital: A Systematic Review of the Negative Health Effects of Social Capital

VILLALONGA-OLIVES E. ET KAWACHI I.

2017

Soc Sci Med 194: 105-127.

There is a growing literature demonstrating the health benefits of social capital (defined as the resources accessed through social connections). However, social capital is also acknowledged to be a «double-edged» phenomenon, whose effects on health are not always positive. We sought to systematically review studies that have found a negative (i.e. harmful) association between social capital and health outcomes. Our objective was to classify the different types of negative effects, following a framework originally proposed by Portes. (1998). We conducted a literature search in Pubmed, Embase and PsychInfo. We identified 3530 manuscripts. After detailed review, we included 44 articles in our systematic review. There are at least two negative consequences of social capital besides the classification proposed by Portes: behavioral contagion and cross-level interactions between social cohesion and individual characteristics. When leveraging the concept of social capital for health promotion interventions, researchers need to take account of these potential «downsides» for health outcomes.

Pharmaceuticals

Endogenous Versus Exogenous Generic Reference Pricing for Pharmaceuticals

ANTONANZAS F., *et al.*

2017

Int J Health Econ Manag 17(4): 413-432.

In this paper we carry out a vertical differentiation duopoly model applied to pharmaceutical markets to analyze how endogenous and exogenous generic reference pricing influence competition between generic and branded drugs producers. Unlike the literature, we characterize for the exogenous case the equilibrium prices for all feasible relevant reference prices. Competition is enhanced after the introduction of a reference pricing system. We also compare both reference pricing systems on welfare grounds, assuming two different objective functions for health authorities: (i) standard social welfare and (ii) gross consumer surplus net of total pharmaceutical expenditures. We show that regardless of the objective function, health authorities will never choose endogenous reference pricing. When health authorities are paternalistic, the exogenous reference price that maximizes standard social welfare is such that the price of the generic drug is the reference price while the price of the branded drug is higher than the reference price. When health authorities are not paternalistic, the optimal exogenous reference price is such that the price of the branded drug is the reference price while the price of the generic drug is lower than the reference price.

A Review of International Coverage and Pricing Strategies for Personalized Medicine and Orphan Drugs

DEGTIAR I.

2017

Health Policy 121(12): 1240-1248.

Personalized medicine and orphan drugs share many characteristics-both target small patient populations, have uncertainties regarding efficacy and safety at payer submission, and frequently have high prices. Given personalized medicine's rising importance, this review summarizes international coverage and pricing strategies for personalized medicine and orphan drugs as well as their impact on therapy development incentives, payer budgets, and therapy access and utilization. PubMed, Health Policy Reference Center, EconLit, Google Scholar, and references were searched through February 2017 for articles presenting primary data. The conclusion is as following : as more personalized medicine and orphan drugs enter the market, registries can provide better quality evidence on their efficacy and safety. Payers need systematic assessment strategies that are communicated with more transparency. Further studies are necessary to compare the implications of different payer approaches.

Socialisation non professionnelle et logiques de prescription médicale. Commentaire

GELLY M.

2017

Sciences sociales et santé 35(3): 71-79.

https://www.cairn.info/revue-sciences-sociales-et-sante-2017-3-page-71.htm

L'élaboration des normes de bonnes pratiques médicales a fait l'objet de nombreux travaux sociologiques, à la suite de la recherche socio- historique d'Harry Marks sur l'émergence de la « médecine des preuves » au cours du XXe siècle (Marks, 1999). Il s'agit d'un mouvement scientifique qui consiste à détacher les pratiques médicales des préférences personnelles des médecins pour tel ou tel traitement et à les adosser aux résultats d'essais cliniques. D'autres courants sociologiques existent. L'objectif de cet article est de présenter ces différentes approches, qui mettent en évidence la complexité de la prescription médicale.

Physicians' and Pharmacists' Perceptions on Real-Time Drug Utilization Review System: A Nationwide Survey

LEE S. M., *et al.*

2017

Int J Qual Health Care 29(5): 634-641.

The aims of this paper is to identify healthcare providers' experience and satisfaction for the drug utilization review (DUR) system, their impact on prescription changes following alerts, and difficulties experienced in the system by surveying primary healthcare centers and pharmacies. The analysis is based on a c cross-sectional nationwide survey. Approximately 2000 institutions were selected for the survey by a simple random sampling of nationwide primary healthcare centers and community pharmacy approximately practices, and 358 replied. The study concludes that, although most surveyed physicians and pharmacists receive the alerts, some do not or reported that they would not follow the alerts. To increase adherence, the DUR system should be improved to ensure a preferential and intensive approach to detecting potentially high-risk drug combinations.

Cost Analysis and Cost-Benefit Analysis of a Medication Review with Follow-Up Service in Aged Polypharmacy Patients

MALET-LARREA A., *et al.*

2017

Eur J Health Econ 18(9): 1069-1078.

Drug related problems have a significant clinical and economic burden on patients and the healthcare system. Medication review with follow-up (MRF) is a professional pharmacy service aimed at improving patient's health outcomes through an optimization of the medication. The aims of this paper is to ascertain the economic impact of the MRF service provided in community pharmacies to aged polypharmacy patients comparing MRF with usual care, by undertaking a cost analysis and a cost-benefit analysis. The economic evaluation was based on a cluster randomized controlled trial. The analysis included 1403 patients (IG: n = 688 vs CG: n = 715). The cost analysis showed that the MRF saved 97 euro per patient in 6 months. Extrapolating data to 1 year and assuming a fee for service of 22 euro per patient-month, the estimated savings were 273 euro per patient-year. The cost-benefit ratio revealed that for every 1 euro invested in MRF, a benefit of 3.3 euro to 6.2 euro was obtained. The MRF provided health benefits to patients and substantial cost savings to the NHS. Investment in this service would represent an efficient use of healthcare resources.

Gouverner (par) les prix. La fixation des prix des médicaments remboursés en France

NOUGUEZ É. ET BENOÎT C.

2017

Revue française de sociologie 58(3): 399-424.

https://www.cairn.info/revue-francaise-de-sociologie-2017-3-page-399.htm

Cet article examine la fixation des prix des médicaments remboursés par l'État, en France, depuis ses origines au sortir de la Seconde Guerre mondiale jusqu'au milieu des années 2010. Nous analysons les formes successives prises par cette politique, de l'administration unilatérale des prix mise en place de 1948 aux années 1980 à leur négociation dans le cadre de conventions entre un Comité interministériel et les industriels à partir du milieu des années 1990. Nous défendons la thèse selon laquelle ce contrôle des prix par l'État articule deux types de gouvernement du marché : un gouvernement des valeurs, visant à apprécier les médicaments à partir de principes de justice sociale (promouvoir la santé publique, respecter l'équilibre des dépenses d'Assurance maladie, favoriser la recherche et développement et l'emploi industriel) ; un gouvernement des conduites, visant à apprécier les médicaments à partir de considérations de justesse marchande (s'assurer que les prix établis orientent les conduites des industriels et des acteurs du marché dans le sens de l'intérêt général). Loin d'aller de soi, la détermination du « juste prix » donne alors lieu à des affrontements, au sein du Comité économique des produits de santé et dans les négociations entre le Comité et les industriels, entre des acteurs porteurs de conceptions plurielles et antagonistes de la justice sociale et de la justesse marchande.

Methodology - Statistics

▶ Using Cancer Case Identification Algorithms in Medico-Administrative Databases: Literature Review and First Results from the REDSIAM Tumors Group Based on Breast, Colon, and Lung Cancer

BOUSQUET P. J., *et al.*

2017

Rev Epidemiol Sante Publique 65 Suppl 4: S236-S242.

The development and use of healthcare databases accentuates the need for dedicated tools, including validated selection algorithms of cancer diseased patients. As part of the development of the French National Health Insurance System data network REDSIAM, the tumor taskforce established an inventory of national and internal published algorithms in the field of cancer. This work aims to facilitate the choice of a best-suited algorithm. A non-systematic literature search was conducted for various cancers. Results are presented for lung, breast, colon, and rectum. Medline, Scopus, the French Database in Public Health, Google Scholar, and the summaries of the main French journals in oncology and public health were searched for publications until August 2016. This study illustrates the complexity of cancer detection through sole reliance on healthcare databases and the lack of validated algorithms specifically designed for this purpose. Studies that standardize and facilitate validation of these algorithms should be developed and promoted.

▶ Promoting the Use of the French National Health Database (SNIIRAM)

GOLDBERG M.

2017

Rev Epidemiol Sante Publique 65 Suppl 4: S141-S143.

Cet éditorial présente le Système national d'information interrégimes de l'assurance maladie (SNIIRAM), bases de données médico-administratives nationales, centralisées et gérées par des organismes publics. Ces bases couvrent l'ensemble de la population dans différents domaines stratégiques de la santé publique. Elles sont alimentées par le dispositif de remboursement des soins des différents régimes de l'assurance maladie (données de consommation interégimes ou DCIR) et par le programme de médicalisation du système d'information des hôpitaux (PMSI).

▶ Perinatal Health and Medical Administrative Data: What Uses, Which Stakeholders, What the Issues for Birth Data? - Special REDSIAM

SERFATY A., *et al.*

2017

Rev Epidemiol Sante Publique 65 Suppl 4: S209-S219.

The uses of medical administrative data (MAD/BDMA) emerged in perinatal health following the work on regionalization of very pre-term birth. They have become more numerous since the late 2000s. The objective of this article is to take stock of the existing work carried out within the REDSIAM-perinatality group, on MAD/BDMA and their uses for the period of «birth». The studied MADs are the Hospital Discharge Data (PMSI) and the French national health database (SNIIRAM). The material includes knowledge shared by the members of the REDSIAM-perinatality group, scientific references and gray literature. The BDMA, including the PMSI and the SNIIRAM, are used and relevant in Perinatal health with the rise of health networks, the territorialisation of health, in an increased demand for quality of care. Their use will increase the reliability of the data collected and an inscription in the validation studies, more and more numerous in the field of BDMA. The algorithms need to be more finely compiled, validated and enhanced.

▶ Standardization of Physical Measurements in European Health Examination Surveys-Experiences from the Site Visits

TOLONEN H., *et al.*

2017

Eur J Public Health 27(5): 886-891.

Health examination surveys (HESs) provide valuable data on health and its determinants at the population level. Comparison of HES results within and between countries and over time requires measurements which are free of bias due to differences in or adherence to measurement procedures and/or measurement devices: In the European HES (EHES) Pilot Project, 12 countries conducted a pilot HES in 2010-11 using standardized measurement protocols and centralized training. External evaluation visits (site visits) were performed by the EHES Reference Centre staff to evaluate the success of standardization and quality of data collection. The EHES protocols to standardize HES measurements and procedures for collection of blood samples are feasible in cross-country settings. The prerequisite for successful standardization is adequate training. External and internal evaluation activities during the survey fieldwork are also needed to monitor compliance to standards.

Health Policy

▶ Développer la recherche en services de santé

BENAMOUZIG D. ET ALLA F.

2017/10

Questions de santé publique(33): 8p.

http://www.iresp.net/files/2017/10/IReSP-n--33.Web_.pdf

Les systèmes de santé européens sont confrontés à des transformations majeures des modes de prise en charge. Cette transition épidémiologique se double d'une transition organisationnelle et plus largement sociale. Ces changements exigent des nouvelles connaissances et de nouvelles évaluations plus précises des services de santé, souvent situées et comparatives.

▶ An Innovative Approach to Participatory Health Policy Development in Bulgaria: The Conception and First Achievements of the Partnership for Health

DIMOVA A., *et al.*

2017

Health Policy: Ahead of print.

The Bulgarian Partnership for Health was established in 2015 as a new forum for health policy formulation and discussion. The Partnership presents a new approach of structured and sustained stakeholder involvement to overcome the lack of public participation in health policy development and implementation. Constituted as a permanent consultative body to the Council of Ministers, the Partnership engages a wide variety of stakeholders and professionals to shape and improve health policies. The shared governance of the Partnership between the Minister of Health and a patient organisation supports the elaboration of legislative acts based on the stakeholders' collaboration in priority areas. The governance and organisational structure of the Partnership assures capacity building, fast mobilisation of experts, continuity of stakeholder involvement, and increased responsibility in health policy development and implementation. This type of participatory approach may help reconcile initially opposing positions and foster reforms often impeded by political antagonism. Persisting challenges are a rather slow process of policy development and different perceptions of key concepts among the stakeholders. As policy-making in many countries in Eastern Europe suffers from political distrust, the Partnership's approach of involving experts - and not only politicians - could provide inspiration also to other countries, which have struggled with inconsistency of health policies pursued by different governments.

Effectiveness of UK Provider Financial Incentives on Quality of Care: A Systematic Review

MANDAVIA R., *et al.*

2017

Br J Gen Pract 67(664): e800-e815.

Provider financial incentives are being increasingly adopted to help improve standards of care while promoting efficiency. The aim of this study is to review the UK evidence on whether provider financial incentives are an effective way of improving the quality of health care. Systematic review of UK evidence, undertaken in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) recommendations. MEDLINE and Embase databases were searched in August 2016. Original articles that assessed the relationship between UK provider financial incentives and a quantitative measure of quality of health care were included. We conclude that the effects of UK provider financial incentives on healthcare quality are unclear. Owing to this uncertainty and their significant costs, use of them may be counterproductive to their goal of improving healthcare quality and efficiency. UK policymakers should be cautious when implementing these incentives - if used, they should be subject to careful long-term monitoring and evaluation. Further research is needed to assess whether provider financial incentives represent a cost-effective intervention to improve the quality of care delivered in the UK.

Socioeconomic Differences in the Pathways to Diagnosis of Coronary Heart Disease: A Qualitative Study

SCHRODER S. L., *et al.*

2017

Eur J Public Health 27(6): 1055-1060.

Socioeconomic inequalities in coronary heart disease (CHD)-related morbidity and mortality are well explored. However, less is known about the causes of inequalities in CHD treatment. In this qualitative study, we explored socioeconomic differences in the pathways to diagnosis of CHD. The data originated from 38 semi-structured interviews with older CHD patients, aged 59-80 years, conducted at the university hospital in Halle, Germany, between November 2014 and April 2015. We analysed the narratives related to the time before CHD was confirmed by coronary angiography electively or urgently. We found no socioeconomic differences in the urgent pathway. However, along the elective pathway, only low-SES patients reported receiving assistance from a general practitioner in accessing a cardiologist. Socioeconomic differences in CHD diagnosis were mainly apparent before patients sought healthcare. These differences were more pronounced when CHD was electively diagnosed due to chronic symptoms rather than urgently diagnosed due to acute symptoms. To address socioeconomic differences, general practitioners should focus on any indication of symptoms and interpretation mentioned by low-SES patients, and coordinate these patients' pathways to diagnosis while emphasizing the seriousness of CHD.

Does Public Reporting Influence Quality, Patient and Provider's Perspective, Market Share and Disparities? A Review

VUKOVIC V., *et al.*

2017

Eur J Public Health 27(6): 972-978.

http://dx.doi.org/10.1093/eurpub/ckx145

Public reporting (PR) of healthcare (HC) provider's quality was proposed as a public health instrument for providing transparency and accountability in HC. Our aim was to assess the impact of PR on five main domains: quality improvement; patient choice, service utilization and market share; provider's perspective; patient experience; and unintended consequences. PubMed, Scopus, ISI WOS, and EconLit databases were searched to identify studies investigating relationships between PR and five main domains, published up to April 1, 2016. Our research covering different outcomes and settings reported that PR is associated with changes in HC provider's behavior and can influence market share. Unintended consequences are a concern of PR and should be taken into account when allocating HC resources. The experiences collected in this paper could give a snapshot about the impact of PR on a HC user's perception of the providers' quality of care, helping them to make empowered choices.

Social Policy

Compte personnel d'activité et éthique du care : une révolution sociale et philosophique à mener

DELAURENS D.

2017/08-09

Gestions hospitalières(568): 409-412.

Le système de protection sociale français doit évoluer en raison de son inadéquation avec la société contemporaine et de l'essoufflement de son modèle économique. Deux outils sont disponibles pour réaliser cette transformation : sur le plan pratique, le compte personnel d'activité (CPA) entré discrètement en vigueur le 1er janvier 2017 ; sur le plan théorique, le courant philosophique de l'éthique du care.

Psychiatry

The Psychiatric Hospital Discharge Database (RIM-P): An Essential Tool for the Surveillance of Hospitalization After a Suicide Attempt

CHAN CHEE C. ET PAGET L. M.

2017

Rev Epidemiol Sante Publique 65(5): 349-359.

Epidemiological surveillance of suicide attempts is essential for monitoring indicator trends in the evaluation of prevention actions. As part of this surveillance, analysis of data from hospitalization for suicide attempts is particularly useful. For the first time, data from two national hospital discharge databases, the « Programme de médicalisation des systèmes d'information en médecine, chirurgie, obstétrique » (PMSI-MCO) and the « Recueil d'information médicalisé en psychiatrie » (RIM-P) have been analyzed jointly. All patients aged 10 or more hospitalized in 2012 in medicine, surgery or psychiatry departments in metropolitan France have were included. We conclude that improvement of the epidemiological surveillance of suicide attempts requires a systematic coding of hospitalizations in psychiatry as well as in medicine and surgery. Data from hospitalization in psychiatry yield a more precise identification of psychiatric co-morbidities associated with suicide attempts. The frequent presence of mental problems associated with suicide attempts should encourage clinicians to search for these symptoms systematically as soon as possible after admission of the patient.

A Systemic Approach to Understanding Mental Health and Services

COHEN M.

2017

Soc Sci Med 191: 1-8.

In the UK mental health and associated NHS services face considerable challenges. This paper aims to form an understanding both of the complexity of context in which services operate and the means by which services have sought to meet these challenges. Systemic principles as have been applied to public service organisations with reference to interpersonal relations, the wider social culture and its manifestation in service provision. The analysis suggests that the wider culture has shaped service demand and the approaches adopted by services resulting in a number of unintended consequences, reinforcing loops, increased workload demands and the limited value of services. The systemic modelling of this situation provides a necessary overview prior to future policy development. The paper concludes that mental health and attendant services requires a systemic understanding and a whole system approach to reform.

Labey, M. et Noël, C. « Les soins sans contrainte : politique d'organisation d'un pôle de psychiatrie intégré dans la cité. . » INFORMATION PSYCHIATRIQUE (L') 93(7) : 563-567.

Le pôle de santé mentale des villes de Ronchin, Faches-Thumesnil, Lesquin, Lezennes, Hellemmes et Mons-en-Barœul est engagé depuis 40 ans dans des pratiques visant à réduire la contrainte et développer les soins ambulatoires. La politique d'action est fondée sur les valeurs du rétablissement et la valorisation du savoir expérientiel. Le souci de la réduction de la contrainte apparaît en premier lieu à travers les conditions d'accueil en hospitalisation avec un objectif d'absence d'isolement et de contention. Ce dispositif sous tendu par une organisation propre à l'unité s'inscrit dans la conception générale de l'offre de soin sur le modèle de la santé mentale communautaire.

▶ Changes in Behaviors and Indicators of Mental Health Between 2006 and 2010 in the French Working Population

MALARD L., *et al.*

2017

Rev Epidemiol Sante Publique 65(4): 309-320.

The 2008 economic crisis may have had an impact on mental health but the studies on this topic are sparse, in particular among the working population. However, mental health at work is a crucial issue involving substantial costs and consequences. The aim of the study was to assess changes in behaviors and indicators of mental health in the French working population between 2006 and 2010, and to explore the differential changes according to age, origin, occupation, activity sector, public/private sector, self-employed/employee status and work contract. The data came from the prospective national representative Santé et itinéraire professionnel (SIP) survey, including a sample of 5600 French workers interviewed in 2006 and 2010. The behaviors and indicators of mental health studied were excessive alcohol consumption, smoking, sleep problems (sleep disorders and/or insufficient sleep duration), psychotropic drug use (antidepressants, anxiolytics and/or hypnotics), and poor self-reported health. We conclude that prevention policies should consider that behavior and indicators of mental health may deteriorate in times of economic crisis, especially among some sub-groups of the working population, such as young workers and workers with a permanent contract. These changes might foreshadow a forthcoming increase in mental disorders.

▶ ISQUA17-2402 : Co Designing Patient-Centred Care Using Participation Action Research: The Epilepsy Partnership (EPIC) Project

VARLEY J., *et al.*

2017

International Journal for Quality in Health Care 29(suppl_1): 8-9.

http://dx.doi.org/10.1093/intqhc/mzx125.8

"Co-design", "Co-creation","Co-production" are concepts currently used by those promoting innovation to improve the quality, safety and integration of healthcare services. They reflect an approach where the consumer and the provider of a service/product work in partnership to make things happen in a meaningful way. Such collaboration is inherent in models of patient-centred healthcare. Patient-centred care (PCC) is a core value in heath service reform that recognises people within the full context of their lives not just their health condition. PCC promotes partnerships between healthcare practitioners, patients and their families to ensure that correct and responsive clinical decisions are made. The National Clinical Care Programme for Epilepsy in Ireland is conducting a project which aims to create co-design teams of those who receive and those who deliver health services to work together on devising services that can realise the promise of patient-centre care.

Primary Health Care

The Influence of Registered Nurses and Nurse Practitioners on Patient Experience with Primary Care: Results from the Canadian QUALICO-PC Study

AMMI M., *et al.*

2017

Health Policy: Ahead of print.

Nurses, whether registered nurses (RNs) or nurse practitioners (NPs), are becoming key providers of primary care services. While evidence for the influence of NPs on patient experience in primary care is mounting, this is less so for RNs. We use the Canadian component of the international Quality and Costs of Primary Care 2013/14 survey to investigate the mechanisms by which nurses can affect patients' experience in primary care, focusing on accessibility and appropriateness of care. The data allow us to distinguish between family practice RNs, specialised RNs and NPs, and covers all types of patients visiting a primary care clinic in a variety of contexts in all Canadian provinces. In addition to the types of nurses and full-time equivalent (FTE) numbers, we explore the role of nurse autonomy and collaboration. Our regression results show that one of the most important predictors of patient experience is the collaboration between health professionals, whereas nurse staffing in terms of FTE numbers has little influence by itself. Different types of nurses influence different dimensions of accessibility, and the association between patient experience and nurse staffing depends on the number of physicians in the clinic. Our results can inform decision-makers on how to strengthen primary care provision, and particularly in Canadian context, the adaptation of the recently implemented interprofessional primary care teams.

High Levels of Capitation Payments Needed to Shift Primary Care Toward Proactive Team and Nonvisit Care

BASU S., *et al.*

2017

Health Aff (Millwood) 36(9): 1599-1605.

Capitated payments in the form of fixed monthly payments to cover all of the costs associated with delivering primary care could encourage primary care practices to transform the way they deliver care. Using a microsimulation model incorporating data from 969 US practices, we sought to understand whether shifting to team- and non-visit-based care is financially sustainable for practices under traditional fee-for-service, capitated payment, or a mix of the two. Practice revenues and costs were computed for fee-for-service payments and a range of capitated payments, before and after the substitution of team- and non-visit-based services for low-complexity in-person physician visits. The substitution produced financial losses for simulated practices under fee-for-service payment of $42,398 per full-time-equivalent physician per year; however, substitution produced financial gains under capitated payment in 95 percent of cases, if more than 63 percent of annual payments were capitated. Shifting to capitated payment might create an incentive for practices to increase their delivery of team- and non-visit-based primary care, if capitated payment levels were sufficiently high.

Postponing a General Practitioner Visit: Describing Social Differences in Thirty-One European Countries

DETOLLENAERE J., *et al.*

2017

Health Serv Res 52(6): 2099-2120.

The aims of this study is to describe social differences in postponing a general practitioner visit in 31 European countries and to explore whether primary care strength is associated with postponement rates. Between October 2011 and December 2013, the multicountry QUALICOPC study collected data on 61,931 patients and 7,183 general practitioners throughout Europe. Access to primary care was measured by asking the patients whether they postponed a general practitioner visit in the past year. Social differences were described according to patients' self-rated household income, education, ethnicity, and gender. This paper concludes that, despite the universal and egalitarian goals of health care systems, access to general practitioner care in Europe is still determined by patients' socioeconomic status (self-rated household income and education) and migration background.

Les modes de paiements à la coordination : État des lieux et pistes pour une application en France

GIRAULT A., *et al.*

2017

Journal de gestion et d'économie médicales 35(2): 109-127.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-2-page-109.htm

L'émergence de nouveaux modes de paiement occupe une place majeure dans la transformation du système de soins, notamment en France, les « paiements à la coordination » qui retiennent l'attention des pouvoirs publics, désireux d'améliorer la coordination des soins. L'objectif de ce travail est de dresser un état des lieux de ces paiements et de proposer des pistes pour leur mise en œuvre dans le contexte français. Ce travail se base sur une revue intégrative de la littérature à partir des bases de données Medline, Econlit et Cochrane. Peu de preuves robustes peuvent, pour le moment, être portées au crédit de ces paiements, malgré quelques signes prometteurs. Les papiers sélectionnés concernaient en grande majorité des expériences aux Etats-Unis.

Professional Healthcare Regulation and Practice: The Case of Medicine in Britain

MIKE S.

2017

HealthcarePapers 16(4): 25-29.

http://www.longwoods.com/product/25205

This contribution comments selectively on the themes of the lead paper by Wilkie and Tzountzouris (2017) on aspects of Canadian healthcare regulation that impact on the crucial agenda of public protection. In a more skeptical sociopolitical climate in the modern world, these authors particularly highlight the need to ensure professional attitudes and behaviours enhance and sustain safe patient care - using the recent stance on professionalism of the College of Medical Laboratory Technologists of Ontario as an illustration of good practice. It is argued, though, that this important analysis could be sharpened further both academically and practically with greater awareness of the theoretical complexity surrounding this area and by drawing more fully on comparative international exemplars - particularly in relation to medicine in Britain, on which this paper focuses. The commentary concludes by noting that - notwithstanding its many merits - the lead paper could usefully show greater recognition of cognate research on health regulation in the Canadian context and, as British research has clearly indicated, professional impediments to the translation of formally designated regulatory frameworks into practice on the ground. In addition, there needs to be more awareness of the impact of the wider environment in which physicians and other healthcare professionals operate.

Managing Multimorbidity: Profiles of Integrated Care Approaches Targeting People with Multiple Chronic Conditions in Europe

RIJKEN M., *et al.*

2018

Health Policy: 122(1): 44-52.

In response to the growing populations of people with multiple chronic diseases, new models of care are currently being developed in European countries to better meet the needs of these people. This paper aims to describe the occurrence and characteristics of various types of integrated care practices in European countries that target people with multimorbidity. Data were analysed from multimorbidity care practices participating in the Innovating care for people with multiple chronic conditions (ICARE4EU) project, covering all 28EU Member States, Iceland, Norway and Switzerland. A total of 112 practices in 24 countries were included: 65 focus on patients with any combination of chronic diseases, 30 on patients with a specific chronic disease with all kinds of comorbidities and 17 on patients with a combination of specific chronic diseases. Practices that focus on a specific index disease or a combination of specific diseases are less extensive regarding the type, breadth and degree of integration than practices that focus on any combination of diseases. The latter type is more often seen in countries where more disciplines, e.g. community nurses, physiotherapists, social workers, work in the same primary care practice as the general practitioners. Non-disease specific practices put more emphasis on patient involvement and provide more comprehensive care, which are important preconditions for person-centered multimorbidity care.

Patient-Centered Medical Home Implementation and Improved Chronic Disease Quality: A Longitudinal Observational Study

ROSLAND A. M., *et al.*

2017

Health Serv Res: Ahead of print.

The objectives of this study is to examine associations between clinics' extent of patient-centered medical home (PCMH) implementation and improvements in chronic illness care quality. The analysis is based on data from 808 Veterans Health Administration (VHA) primary care clinics nationwide implementing the Patient Aligned Care Teams (PACT) PCMH initiative, begun in 2010. The design consists in clinic-level longitudinal observational study of clinics that received training and resources to implement PACT. Clinics varied in the extent they had PACT components in place by 2012. The study concludes that Veterans Health Administration primary care clinics with the most PCMH components in place in 2012 had greater improvements in several chronic disease quality measures in 2009-2013 than the lowest PCMH clinics.

Good, Better, Best? A Comprehensive Comparison of Healthcare Providers' Performance: An Application to Physiotherapy Practices in Primary Care

STEENHUIS S., *et al.*

2017

Health Policy : Ahead of print.

Most payment methods in healthcare stimulate volume-driven care, rather than value-driven care. Value-based payment methods such as Pay-For-Performance have the potential to reduce costs and improve quality of care. Ideally, outcome indicators are used in the assessment of providers' performance. The aim of this paper is to describe the feasibility of assessing and comparing the performances of providers using a comprehensive set of quality and cost data. We had access to unique and extensive datasets containing individual data on PROMs, PREMs and costs of physiotherapy practices in Dutch primary care. We merged these datasets at the patient-level and compared the performances of these practices using case-mix corrected linear regression models. Several significant differences in performance were detected between practices. These results can be used by both physiotherapists, to improve treatment given, and insurers to support their purchasing decisions. The study demonstrates that it is feasible to compare the performance of providers using PROMs and PREMs. However, it would take an extra effort to increase usefulness and it remains unclear under which conditions this effort is cost-effective. Healthcare providers need to be aware of the added value of registering outcomes to improve their quality. Insurers need to facilitate this by designing value-based contracts with the right incentives. Only then can payment methods contribute to value-based healthcare and increase value for patients.

Relevant Models and Elements of Integrated Care for Multi-Morbidity: Results of a Scoping Review

STRUCKMANN V., *et al.*

2017

Health Policy : Ahead of print.

In order to provide adequate care for the growing group of persons with multi-morbidity, innovative integrated care programmes are appearing. The aims of the current scoping review were to i) identify relevant models and elements of integrated care for multi-morbidity and ii) to subsequently identify which of these models and elements are applied in integrated care programmes for multi-morbidity. Most models and elements found in the literature focus on integrated care in general and do not explicitly focus on multi-morbidity. In line with this, most programmes identified in the literature build on the CCM. A comprehensive framework that better accounts for the complexities resulting from multi-morbidity is needed.

Patient-Centeredness of Integrated Care Programs for People with Multimorbidity. Results from the European ICARE4EU Project

VAN DER HEIDE I., *et al.*

2017

Health Policy : Ahead of print.

This paper aims to support the implementation of patient-centered care for people with multimorbidity in Europe, by providing insight into ways in which patient-centeredness is currently shaped in integrated care programs for people with multimorbidity in European countries. In 2014, expert organizations in 31 European countries identified 200 integrated care practices ('programs') in 25 countries of which 123 were included in our study. Managers of 112 programs from 24 countries completed a questionnaire about characteristics and results of the program, including questions on elements of patient-centeredness. Eight programs that were considered especially innovative or promising were analyzed in depth. The study concludes that, in many European countries, innovative approaches are applied to increase patient-centeredness of care for people with multimorbidity. To assess their potential benefits and conditions for implementation, thorough process and outcome evaluations of programs are urgently needed.

▶ Enhancing the Relationship Between Regulators and Their Profession

ZUBIN A.

2017

HealthcarePapers 16(4): 50-54.

Regulators face unique pressures to balance competing priorities related to patient safety, public accountability, and practitioners' expectations. Historically, the collegial model of self-regulation has been used as a tool for risk management, to recognize the importance of profession- and context-specific judgment in complex, ambiguous clinical situations. Increasingly, as public accountability concerns have grown dominant within regulatory bodies, this collegial model has shifted toward a more antagonistic relationship between the regulators and the regulated. Wilkie and Tzountzouris (2017) highlight one profession's journey toward embedding professionalism within regulatory practices and policies through application of a right-touch regulatory philosophy. Given the complexity of regulatory work, this shift required significant strategic and deliberative thinking. The challenges of facilitating this sort of cultural shift in the role of a regulator are significant, but so too are the potential gains associated with a more engaged relationship between regulators and their practitioners.

Health systems

▶ Patterns of Collaboration Among Health Care and Social Services Providers in Communities with Lower Health Care Utilization and Costs

BREWSTER A. L., *et al.*

2017

Health Serv Res. : Ahead of print.

The aims of this study is to understand how health care providers and social services providers coordinate their work in communities that achieve relatively low health care utilization and costs for older adults. The analysis is based on sixteen Hospital Service Areas (HSAs) in the United States. We conducted a qualitative study of HSAs with performance in the top or bottom quartiles nationally across three key outcomes: ambulatory care sensitive hospitalizations, all-cause risk-standardized readmission rates, and average reimbursements per Medicare beneficiary. We selected 10 higher performing HSAs and six lower performing HSAs for inclusion in the study. We conclude that the collaborative approaches used by higher performing communities, if spread, may be able to improve outcomes elsewhere.

▶ Switching Gains and Health Plan Price Elasticities: 20 Years of Managed Competition Reforms in the Netherlands

DOUVEN R., *et al.*

2017

Eur J Health Econ. : Ahead of print.

In this paper we estimate health plan price elasticities and financial switching gains for consumers over a 20-year period in which managed competition was introduced in the Dutch health insurance market. The period is characterized by a major health insurance reform in 2006 to provide health insurers with more incentives and tools to compete, and to provide consumers with a more differentiated choice of products. Prior to the reform, in the period 1995-2005, we find a low number of switchers, between 2 and 4% a year, modest average total switching gains of 2 million euros per year and short-term health plan price elasticities ranging from -0.1 to -0.4. The major reform in 2006 resulted in an all-time high switching rate of 18%, total switching gains of 130 million euros, and a high short-term price elasticity of -5.7. During 2007-2015 switching rates returned to lower levels, between 4 and 8% per year, with total switching gains in the order of 40 million euros per year on average. Total switching gains could have been 10 times higher if all consumers had switched to one of the cheapest plans. We find short-term price elasticities ranging between -0.9 and -2.2. Our estimations suggest substantial consumer inertia throughout the entire period, as we find degrees of choice persistence ranging from about 0.8 to 0.9.

Long-Term Effects of Managed Care

KAUER L.

2017

Health Econ 26(10): 1210-1223.

Managed care (MC) plans have been introduced to curb the ever increasing health care costs. Many previous studies on effectiveness lacked a long-term perspective; hence, the sustainability of (possible) savings remains unclear. Moreover, because of their incentives, MC plans are susceptible to under-provision of care. Most of these possibly negative effects can only be observed in the long-term. This paper analyzes the long-term effects of MC plans on cost savings, mortality, and the use of service, using administrative data from a large Swiss health insurer. The identification is based on a propensity-score matching approach, where individuals who enter an MC plan are compared over 10 years to individuals who remain in a standard fee-for-service plan. Cost savings are substantial and sustainable, and the mortality rate is lower in MC plans. Cost savings are driven by fewer consultations and fewer days in hospital care, although the probability of visiting a provider at least once per year is similar or even higher for persons in MC plans.

Is Canadian Healthcare Affordable? A Comparative Analysis of the Canadian Healthcare System from 2004 to 2014

LESLEY J.J., *et al.*

2017

Healthcare Policy 13(1): 43-58.

The objective of this paper is to compare cost-related non-adherence (CRNA), serious problems paying medical bills and average annual out-of-pocket cost over time in five countries. Repeated cross-sectional analysis of the Commonwealth Fund International Health Policy survey from 2004 to 2014. Responses were compared between Canada, the UK, Australia, New Zealand and the US. Compared to the UK, respondents in Canada, Australia and New Zealand were two to three times and respondents in the US were eight times more likely to experience CRNA; these odds remained stable over time. From 2004 to 2014, Canadian respondents paid US $852-1,767 out-of-pocket for care. The US reported the largest risks of serious problems paying for care (13-18.5%), highest out-of-pocket costs (US $2,060-3,319) and greatest rise in expenditures

The New Frontier of Strategic Alliances in Health Care: New Partnerships Under Accountable Care Organizations

LEWIS V. A., *et al.*

2017

Soc Sci Med 190: 1-10.

Accountable care organizations (ACOs) and similar reforms aim to improve coordination between health care providers; however, due to the fragmented nature of the US health care system, successful coordination will hinge in large part on the ability of health care organizations to successfully partner across organizational boundaries. Little is known about new partnerships formed under the ACO model. We use mixed methods data from the National Survey of ACOs, Medicare ACO performance data and interviews with executive leaders across 31 ACOs to examine the prevalence, characteristics, and capabilities of partnership ACOs and why and how ACO partnerships form. Our findings suggests that the success of the ACO model will hinge in large part upon the success of new partnerships, with important implications for understanding ACO readiness and capabilities, the relatively small savings achieved to date by ACO programs, and the path to providers bearing more risk for population health management. In addition, ACO partnerships may provide an important window to monitor a potential wave of health care consolidation or, in contrast, a new model of independent providers successfully coordinating patient care.

▶ Structural Integration and Performance of Inter-Sectoral Public Health-Related Policy Networks: An Analysis Across Policy Phases

PETERS D., *et al.*

2017

Health Policy 121(12): 1296-1302.

Inter-sectoral policy networks may be effective in addressing environmental determinants of health with interventions. However, contradictory results are reported on relations between structural network characteristics (i.e., composition and integration) and network performance, such as addressing environmental determinants of health. This study examines these relations in different phases of the policy process. A multiple-case study was performed on four public health-related policy networks. The results suggest that, to address environmental determinants of health, sub-networks should be inter-sectorally composed in the policy development rather than in the intervention development and implementation phases, and that policy development actors should have the opportunity to connect with other actors, without strong direction from a central actor.

Occupational Health

▶ Harder, Better, Faster ... yet Stronger? Working Conditions and Self-Declaration of Chronic Diseases

DEFEBVRE E.

2017

Health Econ. : Ahead of print.

The role played by working conditions in worker health status has been widely acknowledged in the literature in general but has received less attention in economics, due to the inherent statistical biases and lack of data available to determine the role of simultaneous and chronic exposures. This study aims to estimate the causal impact of detrimental working conditions on the self-declaration of chronic diseases in France. Using a rebuilt retrospective lifelong panel and defining indicators for physical and psychosocial strains, I implement a mixed econometric strategy that relies on difference-in-differences and matching methods to take into account for selection biases as well as unobserved heterogeneity. For men and women, I find deleterious effects of both types of working conditions on the declaration of chronic diseases after exposure, with varying patterns of impacts according to the nature and magnitude of the strains. These results provide insights into the debate on legal retirement age postponement and justify not only policies being enacted early in individuals' careers in order to prevent subsequent midcareer health repercussions, but also schemes that are more focused on psychosocial risk factors.

▶ Short-Run and Long-Run Effects of Unemployment on Suicides: Does Welfare Regime Matter

GAJEWSKI P. ET ZHUKOVSKA K.

2017

Eur J Public Health 27(6): 1030-1042.

Disentangling the immediate effects of an unemployment shock from the long-run relationship has a strong theoretical rationale. Different economic and psychological forces are at play in the first moment and after prolonged unemployment. This study suggests a diverse impact of short- and long-run unemployment on suicides in liberal and social-democratic countries. We take a macro-level perspective and simultaneously estimate the short- and long-run relationships between unemployment and suicide, along with the speed of convergence towards the long-run relationship after a shock, in a panel of 10 high-income countries. We also account for unemployment benefit spending, the share of the population aged 15-34, and the crisis effects. We conclude that a generous welfare system seems efficient at preventing unemployment-related suicides in the long run, but societies in social-democratic countries might be less psychologically immune to sudden negative changes in their professional lives compared with people in liberal countries. Accounting for the different short- and long-run effects could thus improve our understanding of the unemployment-suicide link.

▶ Working Conditions in the Explanation of Occupational Inequalities in Sickness Absence in the French SUMER Study

NIEDHAMMER I., *et al.*

2017

Eur J Public Health 27(6): 1061-1068.

Explanations of social inequalities in sickness absence are lacking in the literature. Our objectives were to evaluate the contribution of various occupational exposures in explaining these inequalities in a national representative sample of employees. : The study was based on the cross-sectional sample of the SUMER 2010 survey that included 46 962 employees, 26 883 men and 20 079 women. Both sickness absence spells and days within the last 12 months, as health indicators, were studied. Occupation was used as a marker of social position. The study included both psychosocial work factors (variables related to the classical job strain model, psychological demands, decision latitude, social support and understudied variables related to reward, job insecurity, job promotion, esteem, working time/hours and workplace violence) and occupational exposures of chemical, biological, physical and biomechanical nature. Strong occupational differences were found for sickness absence spells and days and for exposure to most work factors.

Ageing

▶ Trajectories of Long-Term Care in 28 EU Countries: Evidence from a Time Series Analysis

GIANINO M. M., *et al.*

2017

Eur J Public Health : Ahead of print.

This study aims to confirm whether an increase in the number of elderly people and a worsening in the auto-evaluation of the general health state and in the limitation of daily activities result in increases in the offered services (beds in residential LTC facilities), in the social and healthcare expenditure and, consequently, in the percentage of LTC users. This study used a pooled, cross-sectional, time series design focusing on 28 European countries from 2004 to 2015. The indicators considered are: population aged 65 years and older; self-perceived health (bad and very bad) and long-standing limitations in usual activities; social protection benefits (cash and kind); LTC beds in institutions; LTC recipients at home and in institutions; healthcare expenditures and were obtained from the Organization for Economic Co-operation and Development and Eurostat. This paper concludes that demographic, societal, health changes could considerably affect LTC needs and services, resulting in higher LTC related costs. Thus, knowledge of LTC expenditures and the demand for services could be useful for healthcare decision makers.

▶ What Works in Implementation of Integrated Care Programs for Older Adults with Complex Needs? A Realist Review

KIRST M., *et al.*

2017

Int J Qual Health Care 29(5): 612-624.

A realist review of the evaluative evidence was conducted on integrated care (IC) programs for older adults to identify key processes that lead to the success or failure of these programs in achieving outcomes such as reduced healthcare utilization, improved patient health, and improved patient and caregiver experience. International academic literature was searched in 12 indexed, electronic databases and gray literature through internet searches, to identify evaluative studies. A total of 65 articles, representing 28 IC programs, were included in the review. This review included a wide range of international evidence, and identified key processes for successful implementation of IC programs that should be considered by program planners, leaders and evaluators.

Older Americans Were Sicker and Faced More Financial Barriers to Health Care Than Counterparts in Other Countries

OSBORN R., *et al.*

2017

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https://www.ncbi.nlm.nih.gov/pubmed/29140737

High-income countries are grappling with the challenge of caring for aging populations, many of whose members have chronic illnesses and declining capacity to manage activities of daily living. The 2017 Commonwealth Fund International Health Policy Survey of Older Adults in eleven countries showed that US seniors were sicker than their counterparts in other countries and, despite universal coverage under Medicare, faced more financial barriers to health care. The survey's findings also highlight economic hardship and mental health problems that may affect older adults' health, use of care, and outcomes. They show that in some countries, one in five elderly people have unmet needs for social care services-a gap that can undermine health. New to the survey is a focus on the «high-need» elderly (those with multiple chronic conditions or functional limitations), who reported high rates of emergency department use and care coordination failures. Across all eleven countries, many high-need elderly people expressed dissatisfaction with the quality of health care they had received.

Multimorbidity Care Model: Recommendations from the Consensus Meeting of the Joint Action on Chronic Diseases and Promoting Healthy Ageing Across the Life Cycle (JA-CHRODIS)

PALMER K., *et al.*

2017

Health Policy : Ahead of print.

Patients with multimorbidity have complex health needs but, due to the current traditional disease-oriented approach, they face a highly fragmented form of care that leads to inefficient, ineffective, and possibly harmful clinical interventions. There is limited evidence on available integrated and multidimensional care pathways for multimorbid patients. An expert consensus meeting was held to develop a framework for care of multimorbid patients that can be applied across Europe, within a project funded by the European Union; the Joint Action on Chronic Diseases and Promoting Healthy Ageing across the Life Cycle (JA-CHRODIS). The experts included a diverse group representing care providers and patients, and included general practitioners, family medicine physicians, neurologists, geriatricians, internists, cardiologists, endocrinologists, diabetologists, epidemiologists, psychologists, and representatives from patient organizations. Sixteen components across five domains were identified (Delivery of Care; Decision Support; Self Management Support; Information Systems and Technology; and Social and Community Resources). Due to the lack of evidence-based recommendations specific to multimorbid patients, this care model needs to be assessed and validated in different European settings to examine specifically how multimorbid patients will benefit from this care model, and whether certain components have more importance than others.

Quelle planification anticipée des soins pour les personnes malades d'Alzheimer

RIGAUX N. ET CARBONNELLE S.

2017

Gérontologie et société 39(54): 121-133.

https://www.cairn.info/revue-gerontologie-et-societe-2017-3-page-121.htm

La préoccupation pour le renforcement de la qualité de vie et de l'autonomie des personnes atteintes de démence de type Alzheimer est portée depuis plusieurs années en Belgique par la Fondation Roi Baudouin. Elle s'est concrétisée en 2013-2014 par le soutien de 12 projets-pilotes en Flandre, en Wallonie et à Bruxelles, contribuant à mettre en œuvre des démarches concrètes de planification anticipée des soins (Advance Care Planning, ACP). Faisant partie de l'équipe de chercheuses chargée du suivi des projets, nous décrirons d'abord la diversité des approches possibles d'ACP en ramenant celles-ci à deux pôles idéal-typiques, l'un visant la production de documents contraignants portant sur les décisions médicales de fin de vie, l'autre concevant l'ACP comme un processus de dialogue avec la personne et ses proches à propos des valeurs et des préférences au jour le jour de la personne malade, sans être nécessairement formalisé.

Nous situerons ensuite ces deux pôles dans la perspective des questions soulevées dans la littérature européenne, pour interroger la pertinence de différentes modalités d'ACP. Baliser ainsi le champ du débat est important à l'heure où le droit au consentement du patient, fût-il dément, cherche à se concrétiser dans ces dispositifs d'ACP.

Income-Rich and Wealth-Poor? The Impact of Measures of Socio-Economic Status in the Analysis of the Distribution of Long-Term Care Use Among Older People

RODRIGUES R., *et al.*

2017

Health Econ: Ahead of print.

This article aims to investigate the impact of using 2 measures of socio-economic status on the analysis of how informal care and home care use are distributed among older people living in the community. Using data from the Survey of Health, Ageing and Retirement in Europe for 14 European countries, we estimate differences in corrected concentration indices for use of informal care and home care, using equivalised household net income and equivalised net worth (as a proxy for wealth). We also calculate horizontal inequity indices using both measures of socio-economic status and accounting for differences in need. The findings show that using wealth as a ranking variable results, as a rule, in a less pro-poor inequality of use for both informal and home care. Once differences in need are controlled for (horizontal inequity), wealth still results in a less pro-poor distribution for informal care, in comparison with income, whereas the opposite is observed for home care. Possible explanations for these differences and research and policy implications are discussed.

Explaining the Impact of Poverty on Old-Age Frailty in Europe: Material, Psychosocial and Behavioural Factors

STOLZ E., *et al.*

2017

Eur J Public Health 27(6): 1003-1009.

Previous research found poverty to be associated with adverse health outcomes among older adults but the factors that translate low economic resources into poor physical health are not well understood. The goal of this analysis was to assess the impact of material, psychosocial, and behavioural factors as well as education in explaining the poverty-health link. In total, 28 360 observations from 11 390 community-dwelling respondents (65+) in the Survey of Health, Ageing and Retirement in Europe (2004-13, 10 countries) were analysed. Results stress the role of material and particularly psychosocial factors such as perceived control and social isolation, whereas the role of health behaviour was negligible. We suggest to strengthen social policy and public health efforts in order to fight poverty and its deleterious health effects from early age on as well as to broaden the scope of interventions with regard to psychosocial factors.

New Horizons in Multimorbidity in Older Adults

YARNALL A. J., *et al.*

2017

Age Ageing 46(6): 882-888.

The concept of multimorbidity has attracted growing interest over recent years, and more latterly with the publication of specific guidelines on multimorbidity by the National Institute for Health and Care Excellence (NICE). Increasingly it is recognised that this is of particular relevance to practitioners caring for older adults, where multimorbidity may be more complex due to the overlap of physical and mental health disorders, frailty and polypharmacy. The overlap of frailty and multimorbidity in particular is likely to be due to the widespread health deficit accumulation, leading in some cases to functional impairment. The NICE guidelines identify 'target groups' who may benefit from a tailored approach to care that takes their multimorbidity into account, and make a number of research recommendations. Management includes a proactive individualised assessment and care plan, which improves quality of life by reducing treatment burden, adverse events, and unplanned or uncoordinated care.