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Veille scientifique
en économie de la santé

Mai .2018

Sommaire en français

Watch on
Health Economics Literature

May 2018

Contents list in English

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Veille scientifique
en économie de la santé

Mai 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

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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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Assurance maladie

La protection des données personnelles comme mode de régulation du big data en protection sociale complémentaire

BERTRAND M.

2017

Revue Française des Affaires Sociales(4): 57-78.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-4-page-57.htm

Le big data constitue un véritable défi pour le système français de protection sociale, fondé sur la mutualisation des risques. Un changement de paradigme est effectivement à l'œuvre avec l'acquisition de données personnelles de plus en plus nombreuses, permettant de réduire l'asymétrie d'information, et de fait l'aléa moral, entre l'assureur et l'assuré. D'une part, la conception du risque s'éloigne progressivement de la notion d'aléa, alors même que le caractère aléatoire est consubstantiel au contrat d'assurance. D'autre part, le modèle traditionnel de protection sociale consistant à atténuer le risque par l'indemnisation du sinistre s'accompagne désormais d'une nouvelle approche préventive. Or, ce changement de paradigme risque d'entraîner une segmentation excessive des risques, susceptible de porter atteinte à la protection des personnes. Si le règlement (UE) n° 2016/679 et la loi n° 2016-1321 pour une République numérique tendent à redonner aux personnes la maîtrise de l'usage de leurs données personnelles, le cadre normatif en vigueur laisse néanmoins apparaître une tension entre diffusion et rétention des données. Ce constat impose alors la recherche d'un nouvel équilibre entre la protection des droits et des libertés des personnes physiques et les enjeux propres au secteur de la protection sociale, à la fois concurrentiel et réglementé.

La complémentaire santé en 2014 : 5 % de non-couverts et 12 % parmi les 20 % les plus pauvres

PERRONNIN M. ET LOUVEL A. C.

2018

Questions d'Économie de la Santé (Irdes) (229)

http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/229-la-complementaire-sante-en-2014.pdf

En 2012 et 2014, près de 5 % des personnes ne bénéficient d'aucune couverture complémentaire santé. Malgré l'existence de dispositifs d'aide pour les plus précaires, l'absence de couverture complémentaire reste souvent liée au revenu. Elle est plus fréquente chez les chômeurs, les inactifs en âge de travailler et les jeunes adultes. Parmi les salariés du secteur privé, près de sept sur dix bénéficient d'une complémentaire santé par le biais de leur employeur. Certaines catégories de salariés, les personnes en Contrat à durée déterminée (CDD), les employés de commerce et les ouvriers non qualifiés sont nettement moins souvent couverts par ce biais. Ayant des taux de couverture élevés, les indépendants, les fonctionnaires et les retraités sont, eux, très majoritairement couverts par des contrats individuels et se déclarent moins souvent bien couverts pour leurs soins que les salariés du secteur privé titulaires d'un contrat collectif.

E-santé – Technologies médicales

Les données au cœur de la stratégie numérique de la branche retraite

BREUIL P. ET VILLARD R.

2017

Revue Française des Affaires Sociales(4): 150-158.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-4-page-150.htm

Ce dernier numéro de la RFAS pour 2017 comprend exclusivement un dossier consacré au big data et à la protection sociale. Il est composé de cinq articles et de six « points de vue ». Les premiers adoptent des angles variés, soit théoriques (notamment lorsqu'il est question de la protection des données personnelles ou de l'anonymisation) soit pratiques, comme celui qui rend compte de l'utilisation de l'intelligence artificielle dans les traitements du cancer. Le premier « point de vue »

fait le point sur big data et statistique publique, les suivants offrent aux lecteurs autant d'exemples d'applications de ces nouvelles techniques de traitement de données « massives » : à la recherche épidémiologique, à l'aide à la décision médicale, à la protection sociale et à la formation professionnelle.

L'e-santé : l'empowerment du patient connecté

CASES A.-S.

2017

Journal de gestion et d'économie médicales 35(4): 137-158.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-4-page-137.htm

L'objectif de cette recherche est de mieux comprendre les apports du numérique dans la sphère médicale avec une approche centrée autour du patient. Aujourd'hui, Internet a transformé la façon dont le patient a accès à l'information santé, ce patient dit « connecté » est de plus en plus informé et devient un acteur de sa santé. Conjointement, certains dispositifs numériques de santé contribuent également à impliquer les patients dans le processus de soin. Aussi, le concept d'empowerment du patient prend tout son sens avec l'arrivée des technologies numériques. Une revue de la littérature relative au concept d'empowerment du client puis du patient a été menée et complétée par deux études qualitatives complémentaires. Il s'agit d'identifier les sources de pouvoir associées au numérique et à l'empowerment du patient ainsi que les bénéfices et les risques de ce gain de pouvoir ressenti par ces derniers.

Apport des nouvelles technologies en résidence seniors : promesse et réalité

CHIRIÉ V.

2017

Gérontologie et société 39

https://www.cairn.info/revue-gerontologie-et-societe-2017-1-page-221.htm

De plus en plus nombreuses, les résidences pour seniors visent les retraités actifs ou fragiles. Alternatives entre le logement habituel et le logement spécialisé, ces résidences réfléchissent à l'intégration de solutions numériques comme facteur décisif de prévention sur les plans de la santé, de la sécurité et du lien social, et mettent en avant ces solutions comme un argument qualité clé de leur offre. Appuyée sur des entretiens pluridisciplinaires auprès de résidents et de professionnels d'une résidence seniors qui valorise son volet numérique, cette étude constate d'une part un écart entre la cible sociologique identifiée et la cible réelle ; d'autre part, elle analyse les usages réels et limités des solutions utilisées dans cette résidence. Des recommandations pour l'intégration des solutions technologiques dans les services de résidences sont proposées en guise de discussion. Cette expérience montre la difficulté d'un usage réellement personnalisé, adapté aux attendus des résidents et en lien avec les offres de services du territoire correspondant à l'implantation de la résidence. En revanche, il n'en ressort pas moins un attendu réel des résidents dans ce domaine, en termes de sécurité, de confort et de lien social et des opportunités de services, qui reste encore à améliorer.

Quelle inférence pour l'épidémiologie à l'heure des big data ?

FALISSARD B.

2017

Revue Française des Affaires Sociales(4): 127-132.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-4-page-127.htm

Cybersécurité : nos données de santé sont-elles en sécurité ?

FROMENTIN V.

2017

Lettre De Galilée (La) (H.S, 3)

Avec 6,4 milliards d'objets déjà connectés, reliés à Internet, et 5,5 millions nouveaux appareils qui sont installés par jour, l'Internet des objets (IoT) constitue une cible de prédilection pour les pirates. Le 21 octobre 2016, la société Dyn aux États-Unis en a fait les frais en essuyant une attaque qui a paralysé de nombreux sites Internet comme CNN, The Guardian, Netflix ou Twitter. Le pirate avait réussi à prendre le contrôle de 100 000 caméras. Avec l'arrivée des voitures connectées, des brosses à dents ou des bracelets connectés, la menace est prise au sérieux par l'Union Européenne. La Haute Autorité de Santé a publié un guide de recommandations pour les applis santé. Faut-il vraiment craindre les objets connectés ?

▶ Telemedical Care and Monitoring for Patients with Chronic Heart Failure Has a Positive Effect on Survival

HEROLD R., *et al.*

2018

Health Serv Res 53(1): 532-555.

Telemedical care and monitoring programs for patients with chronic heart failure have shown beneficial effects on survival in several small studies. The utility in routine care remains unclear. We evaluated a large-sized telemedicine program in a routine care setting, enrolling in total 2,622 patients (54.7 percent male, mean age: 73.7 years) with chronic heart failure. We used reimbursement data from a large statutory health insurance and approached a matched control analysis. In a complex propensity score matching procedure, 3,719 suitable controls (54.2 percent male, mean age: 74.5 years) were matched to 1,943 intervention patients (54.1 percent male, mean age: 74.4 years). The primary endpoint of our analysis was survival after 1 year. Analyses revealed a higher survival probability among subjects of the intervention group compared to controls group after 1 year (adjusted OR: 1.47, CI 95 percent: 1.21-1.80, $p < .001$) and 2 years (adjusted OR: 1.51, CI 95 percent: 1.28-1.77, $p < .001$), respectively. The probabilities to survive after 1 and 2 years were significantly increased in the intervention group. Our findings confirm previous results of controlled trials and importantly indicate that patients with chronic heart failure may benefit from telemonitoring programs in routine care.

▶ 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.

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..

▶ Big data et cancer : le défi

LIVARTOWSKI A., *et al.*

2017

Revue Française des Affaires Sociales(4): 11-25.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-4-page-11.htm

La révolution du big data et de l'intelligence artificielle peut transformer la médecine, et en particulier la lutte contre le cancer. Les grands centres hospitaliers à travers le monde ont un rôle majeur à jouer dans cette transformation car ils concentrent les bases de données les plus riches et les plus proches de la réalité clinique. Dans le domaine de l'aide au diagnostic et de la prédiction de la réponse au traitement, ou afin de mieux déterminer le risque de récidive, le principe consiste à utiliser les technologies de machine learning, de deep learning pour l'analyse automatique des textes, des images et des données de séquençage. Sommes-nous capables d'en extraire des données exploitables pour faire progresser nos connaissances ? Préalable à cette exploitation, de nombreux problèmes doivent être résolus : d'ordre juridique comme l'accès aux données, la question de leur propriété, les problèmes de confidentialité et de consentement du patient, d'ordre technique comme la qualité des données sources, leur interopérabilité et leur intégration. Se poseront ensuite les questions de l'évaluation de ces aides à la décision, et leur appropriation par le monde médical.

Evaluating Barriers to Adopting Telemedicine Worldwide: A Systematic Review

SCOTT KRUSE C., *et al.*

2018

J Telemed Telecare 24(1): 4-12.

https://www.ncbi.nlm.nih.gov/pubmed/29320966

Studies on telemedicine have shown success in reducing the geographical and time obstacles incurred in the receipt of care in traditional modalities with the same or greater effectiveness; however, there are several barriers that need to be addressed in order for telemedicine technology to spread. The aim of this review is to evaluate barriers to adopting telemedicine worldwide through the analysis of published work. The authors conducted a systematic literature review by extracting the data from the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and PubMed (MEDLINE) research databases. The reviewers in this study analysed 30 articles (nine from CINAHL and 21 from Medline) and identified barriers found in the literature. The reviewers identified 33 barriers with a frequency of 100 occurrences through the 30 articles. The study identified the issues with technically challenged staff (11%), followed by resistance to change (8%), cost (8%), reimbursement (5%), age of patient (5%), and level of education of patient (5%). All other barriers occurred at or less than 4% of the time. Telemedicine is not yet ubiquitous, and barriers vary widely. The top barriers are technology-specific and could be overcome through training, change-management techniques, and alternating delivery by telemedicine and personal patient-to-provider interaction. The results of this study identify several barriers that could be eliminated by focused policy. Future work should evaluate policy to identify which one to lever to maximize the results.

Télémédecine : des pratiques innovantes pour l'accès aux soins

SIMON P. ET GAYRARD P.

2017

Actualité et Dossier en Santé Publique(101): 10-55

La télémédecine regroupe des pratiques médicales à distance : téléconsultation, télé-expertise, télésurveillance médicale, téléassistance médicale et régulation. Elle est une réponse aux défis auxquels est confrontée l'offre de soins aujourd'hui. Elle permet la prise en charge au plus près du lieu de vie des patients. C'est un moyen de réorganiser l'offre de soins en améliorant l'accès et la qualité. La Stratégie nationale de santé 2018-2022 donne une nouvelle impulsion à la télémédecine et des financements sont mis en œuvre pour favoriser son développement. Ce dossier spécial de l'ADSP fait un bilan sur le déploiement, les enjeux et les perspectives de la télémédecine en France avec un aperçu sur les expériences étrangères.

L'enjeu de l'anonymisation à l'heure du big data

TANGHE H. ET GIBERT P.-O.

2017

Revue Française des Affaires Sociales(4): 79-93.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-4-page-79.htm

Le système national des données de santé (SNDS) soulève la question de l'« open data santé », et a relancé les réflexions autour de l'anonymisation des données personnelles. La qualification de donnée anonyme représente un véritable enjeu, dans la mesure où elle constitue soit une obligation légale (open data), soit un outil de conformité à la protection des données personnelles. Cependant, à l'ère du big data et des progrès d'analyse des données, il subsiste toujours un risque de ré-identification. Face à une interprétation stricte de l'anonymisation de la part du G29, qui adopte une approche « zéro risque », l'anonymisation nécessite d'être repensée. Alors que la Commission nationale de l'informatique et des libertés (CNIL) s'est vue récemment chargée de publier des référentiels pour la certification des processus d'anonymisation, l'article présente les limites de cette approche trop stricte et principalement établie sur des critères techniques. Il plaide pour une interprétation plus souple de l'anonymisation via la mise en place de seuils de risques prédéfinis selon le contexte, permettant d'évaluer l'anonymat, et le renforcement de mesures juridiques.

Économie de la santé

Impact of the Phased Abolition of Co-Payments on the Utilisation of Selected Prescription Medicines in Wales

ALAM M. F., *et al.*

2018

Health Econ 27(1): 236-243.

We have taken advantage of a natural experiment to measure the impact of the phased abolition of prescription co-payments in Wales. We investigated 3 study periods covering the phased abolition: from £6 to £4, £4 to £3, and £3 to £0. A difference-in-difference modelling was adopted and applied to monthly UK general practice level dispensing data on 14 selected medicines which had the highest percentage of items dispensed subject to a co-payment prior to abolition. Dispensing from a comparator region (North East of England) with similar health and socio-economic characteristics to Wales, and where prescription co-payments continued during the study periods, was used to isolate any non-price effects on dispensing in Wales. Results show a small increase in dispensing of 14 selected medicines versus the comparator. Compared with NE England, monthly average Welsh dispensing was increased by 11.93 items (7.67%; 95% CI [7.2%, 8.1%]), 6.37 items (3.38%; 95% CI [2.9%, 3.7%]) and 9.18 items (4.54%; 95% CI [4.2%, 4.9%]) per practice per 1,000 population during the periods when co-payment was reduced. Price elasticities of the selected medicines utilisation were -0.23, -0.13, and -0.04 in 3 analyses, suggesting the abolition of co-payment had small effect on Welsh dispensing.

Is Health Care Infected by Baumol's Cost Disease? Test of a New Model

ATANDA A., *et al.*

2018

Health Economics: 27(5) : 832-849.

Rising health care costs are a policy concern across the Organisation for Economic Co-operation and Development, and relatively little consensus exists concerning their causes. One explanation that has received revived attention is Baumol's cost disease (BCD). However, developing a theoretically appropriate test of BCD has been a challenge. In this paper, we construct a 2-sector model firmly based on Baumol's axioms. We then derive several testable propositions. In particular, the model predicts that (a) the share of total labor employed in the health care sector and (b) the relative price index of the health and non-health care sectors should both be positively related to economy-wide productivity. The model also predicts that (c) the share of labor in the health sector will be negatively related and (d) the ratio of prices in the health and non-health sectors unrelated, to the demand for non-health services. Using annual data from 28 Organisation for Economic Co-operation and Development countries over the years 1995-2016 and from 14 U.S. industry groups over the years 1947-2015, we find little evidence to support the predictions of BCD once we address spurious correlation due to coincident trending and other econometric issues.

How Does Retirement Affect Healthcare Expenditures? Evidence from a Change in the Retirement Age

BIRO A. ET ELEK P.

2018

Health Economics : 27(5) : 808-818..

Using individual-level administrative panel data from Hungary, we estimate causal effects of retirement on outpatient and inpatient care expenditures and pharmaceutical expenditures. Our identification strategy is based on an increase in the official early retirement age of women, using that the majority of women retire upon reaching that age. According to our descriptive results, people who are working before the early retirement age have substantially lower healthcare expenditures than nonworkers, but the expenditure gap declines after retirement. Our causal estimates from a two-part (hurdle) model show that the shares of women with positive outpatient care, inpatient care, and pharmaceutical expenditures, respectively, decrease by 3.0, 1.4, and 1.3 percentage points in the short run due to retirement. These results are driven by the relatively healthy, by those who spent some time on sick leave and by the less educated. The effect of retirement on the size of positive healthcare expenditures is generally not significant.

Ageing and Healthcare Expenditures: Exploring the Role of Individual Health Status

CARRERAS M., *et al.*

2018

Health Economics : 27(5) : 865-876.

In 1999, Zweifel, Felder, and Meiers questioned conventional wisdom on ageing and healthcare expenditure (HCE). According to these authors, the positive association between age and HCE is due to an increasing age-specific mortality and the high cost of dying. After a weighty academic debate, a new consensus was reached on the importance of proximity to death when analysing HCE. Nevertheless, the influence of individual health status remains unknown. The objective of our study is to analyse the influence individual health status has on HCE, when compared to proximity to death and demographic effects and considering a comprehensive view of healthcare services and costs. We examined data concerning different HCE components of N = 61,473 persons aged 30 to 95 years old. Using 2-part models, we analysed the probability of use and positive HCE. Regardless of the specific group of healthcare services, HCE at the end of life depends mainly on the individual health status. Proximity to death approximates individual morbidity when it is excluded from the model. The inclusion of morbidity generally improves the goodness of fit. These results provide implications for the analysis of ageing population and its impact on HCE that should be taken into account.

National Health Expenditure Projections, 2017-26: Despite Uncertainty, Fundamentals Primarily Drive Spending Growth

CUCKLER G. A., *et al.*

2018

Health Aff (Millwood): 37(3) : 482-492.

Under current law, national health spending is projected to grow 5.5 percent annually on average in 2017-26 and to represent 19.7 percent of the economy in 2026. Projected national health spending and enrollment growth over the next decade is largely driven by fundamental economic and demographic factors: changes in projected income growth, increases in prices for medical goods and services, and enrollment shifts from private health insurance to Medicare that are related to the aging of the population. The recent enactment of tax legislation that eliminated the individual mandate is expected to result in only a small reduction to insurance coverage trends.

The Economic Burden of Diabetes to French National Health Insurance: A New Cost-Of-Illness Method Based on a Combined Medicalized and Incremental Approach

DE LAGASNERIE G., *et al.*

2018

Eur J Health Econ 19(2): 189-201.

A better understanding of the economic burden of diabetes constitutes a major public health challenge in order to design new ways to curb diabetes health care expenditure. The aim of this study was to develop a new cost-of-illness method in order to assess the specific and nonspecific costs of diabetes from a public payer perspective. Using medical and administrative data from the major French national health insurance system covering about 59 million individuals in 2012, we identified people with diabetes and then estimated the economic burden of diabetes. Various methods were used: (a) global cost of patients with diabetes, (b) cost of treatment directly related to diabetes (i.e., 'medicalized approach'), (c) incremental regression-based approach, (d) incremental matched-control approach, and (e) a novel combination of the 'medicalized approach' and the 'incremental matched-control' approach. We identified 3 million individuals with diabetes (5% of the population). The total expenditure of this population amounted to €19 billion, representing 15% of total expenditure reimbursed to the entire population. Of the total expenditure, €10 billion (52%) was considered to be attributable to diabetes care: €2.3 billion (23% of €10 billion) was directly attributable, and €7.7 billion was attributable to additional reimbursed expenditure indirectly related to diabetes (77%). Inpatient care represented the major part of the expenditure attributable to diabetes care (22%) together with drugs (20%) and medical auxiliaries (15%). Antidiabetic drugs represented an expenditure of about €1.1 billion, accounting for 49% of all diabetes-specific expenditure. This study shows the economic impact of the assumption concerning definition of costs on evaluation of the economic burden of diabetes. The proposed new cost-of-illness method provides specific insight for policy-makers to enhance

diabetes management and assess the opportunity costs of diabetes complications' management programs.

Frailty and Healthcare Costs-Longitudinal Results of a Prospective Cohort Study

HAJEK A., *et al.*

2018

Age Ageing 47(2): 233-241.

The aim of this study is to investigate how frailty and frailty symptoms affect healthcare costs in older age longitudinally. Data were gathered from a prospective cohort study in Saarland, Germany (two waves with 3-year interval, n = 1,636 aged 57-84 years at baseline). Frailty was assessed by the five Fried frailty criteria. Frailty was defined as having at least three criteria, the presence of 1-2 criteria as 'pre-frail'. Healthcare costs were quantified based on self-reported healthcare use in the sectors of inpatient treatment, outpatient treatment, professional nursing care and informal care as well as the provision of pharmaceuticals, medical supplies and dental prostheses. While the onset of pre-frailty did not increase (log) total healthcare costs after adjusting for potential confounders including comorbidity, progression from non-frailty to frailty was associated with an increase in total healthcare costs (for example, costs increased by ~54 and 101% if 3 and 4 or 5 symptoms were present, respectively). This association of frailty onset with increased healthcare costs was in particular observed in the inpatient sector and for informal nursing care. Among the frailty symptoms, the onset of exhaustion was associated with an increase in total healthcare costs, whereas changes in slowness, weakness, weight loss and low-physical activity were not significantly associated with an increase in total healthcare costs. Our data stress the economic relevance of frailty in late life. Postponing or reducing frailty might be fruitful in order to reduce healthcare costs.

Modeling Health Care Spending Growth of Older Adults

HATFIELD L. A., *et al.*

2018

Health Serv Res 53(1): 138-155.

This paper aims to forecast out-of-pocket health care spending among older adults. Long-term forecasts allow policy makers to explore potential impacts of policy scenarios, but existing microsimulations do not incorporate details of supplemental insurance coverage and income effects on health care spending. Data sources are based on dynamic microsimulation calibrated to survey and administrative data. We augment Urban Institute's Dynamic Simulation of Income Model (DYNASIM) with modules that incorporate demand responses and economic equilibria, with dynamics driven by exogenous technological change. A lengthy technical appendix provides details of the microsimulation model and economic assumptions for readers interested in applying these techniques. The model projects total out-of-pocket spending (point of care plus premiums) as a share of income for adults aged 65 and older. People with lower incomes and poor health fare worse, despite protections of Medicaid. Spending rises 40 percent from 2012 to 2035 (from 10 to 14 percent of income) for the median beneficiary, but it increases from 5 to 25 percent of income for low-income beneficiaries and from 23 to 29 percent for the near poor who are in fair/poor health. Despite Medicare coverage, near-poor seniors will face out-of-pocket spending that would render them, in practical terms, underinsured.

Impact of Bundled Payments on Hip Fracture Outcomes: A Nationwide Population-Based Study

TUNG Y. C., *et al.*

2017

Int J Qual Health Care: 30 (1) : 23-31

Establishing one price for all bundled services for a particular illness, which has become the key to healthcare reform efforts, is designed to encourage health professionals to coordinate their care for patients. Limited information is available, however, concerning whether bundled payments are associated with changes in patient outcomes. Nationwide longitudinal population-based data were used to examine the effect of bundled payments on hip fracture outcomes. The study is founded on an interrupted time series design with a comparison group, provided by a General acute care hospitals throughout Taiwan. A total of 178 586 hip fracture patients admitted over the period 2007-12 identified from the Taiwan's National Health Insurance Research Database. Bundled payments for hip fractures were implemented in Taiwan in January 2010. The 30-day unplanned readmission and postdischarge

mortality. Segmented generalized estimating equation regression models were used after adjustment for trends, patient, physician and hospital characteristics to assess the effect of bundled payments on 30-day outcomes for hip fracture compared with a reference condition. The 30-day unplanned readmission rate for hip fracture showed a relative decreasing trend after the implementation of bundled payments compared with the trend before the implementation relative to that of the reference condition. This finding might imply that the implementation of bundled payments encourages health professionals to coordinate their care, leading to reduced readmission for hip fracture.

▶ A Systematic Review of Cost-Of-Illness Studies of Multimorbidity

WANG L., *et al.*

2018

Applied Health Economics and Health Policy 16(1): 15-29.

The economic burden of multimorbidity is considerable. This review analyzed the methods of cost-of-illness (COI) studies and summarized the economic outcomes of multimorbidity. A systematic review (2000–2016) was performed, which was registered with Prospero, reported according to PRISMA, and used a quality checklist adapted for COI studies. The inclusion criteria were peer-reviewed COI studies on multimorbidity, whereas the exclusion criterion was studies focusing on an index disease. Extracted data included the definition, measure, and prevalence of multimorbidity; the number of included health conditions; the age of study population; the variables used in the COI methodology; the percentage of multimorbidity vs. total costs; and the average costs per capita. Among the 26 included articles, 14 defined multimorbidity as a simple count of 2 or more conditions. Methodologies used to derive the costs were markedly different. Given different healthcare systems, OOP payments of multimorbidity varied across countries. In the 17 and 12 studies with cut-offs of = 2 and = 3 conditions, respectively, the ratios of multimorbidity to non-multimorbidity costs ranged from 2–16 to 2–10. Among the ten studies that provided cost breakdowns, studies with and without a societal perspective attributed the largest percentage of multimorbidity costs to social care and inpatient care/medicine, respectively. Multimorbidity was associated with considerable economic burden. Synthesising the cost of multimorbidity was challenging due to multiple definitions of multimorbidity and heterogeneity in COI methods. Count method was most popular to define multimorbidity. There is consistent evidence that multimorbidity was associated with higher costs.

Géographie de la santé

▶ Is There a 'Pig Cycle' in the Labour Supply of Doctors? How Training and Immigration Policies Respond to Physician Shortages

CHOJNICKI X. ET MOULLAN Y.

2018

Soc Sci Med 200: 227-237.

Many OECD countries are faced with the considerable challenge of a physician shortage. This paper investigates the strategies that OECD governments adopt and determines whether these policies effectively address these medical shortages. Due to the amount of time medical training requires, it takes longer for an expansion in medical school capacity to have an effect than the recruitment of foreign-trained physicians. Using data obtained from the OECD (2014) and Bhargava et al. (2011), we constructed a unique country-level panel dataset that includes annual data for 17 OECD countries on physician shortages, the number of medical school graduates and immigration and emigration rates from 1991 to 2004. By calculating panel fixed-effect estimates, we find that after a period of medical shortages, OECD governments produce more medical graduates in the long run but in the short term, they primarily recruit from abroad; however, at the same time, certain practising physicians choose to emigrate. Simulation results show the limits of recruiting only abroad in the long term but also highlight its appropriateness for the short term when there is a recurrent cycle of shortages/surpluses in the labour supply of physicians (pig cycle theory).

Handicap

Death, Depression, Disability and Dementia Associated with Self-Reported Hearing Problems: A 25-Year Study

AMIEVA H., *et al.*

2018

J Gerontol A Biol Sci Med Sci. Ahead of print.

Hearing loss in older adults is suspected to play a role in social isolation, depression, disability, lower quality of life and risk of dementia. Such suspected associations still need to be consolidated with additional research. With a particularly long follow-up, this study assessed the relationship between hearing status and four major adverse health events: death, dementia, depression, and disability. Prospective community-based study of 3777 subjects aged ≥ 65 followed-up for 25 years. At baseline, 1289 reported hearing problems and 2290 reported no trouble. The risk of occurrence of the negative outcomes, i.e. death, dementia, depressive symptoms, disability in activities of daily living (ADL) and instrumental ADL (IADL), was assessed with Cox proportional hazards models. Results: Adjusting for numerous confounders, an increased risk of disability and dementia was found for participants reporting hearing problems. An increased risk of depression was found in men reporting hearing problems. In additional exploratory analyses, such associations were not found in those participants using hearing aids. Mortality was not associated with self-reported hearing loss. Our study confirms the strong link between hearing status and the risk of disability, dementia and depression. These results highlight the importance of assessing the consequences of treating hearing loss in elders in further studies.

Hôpital

Groupements hospitaliers de territoire : l'ouverture de la médecine de ville

VIGNERON E.

2017/12

Gestions hospitalières (571): 609-611.

Cet article aborde le rapprochement du groupement hospitalier de territoire avec d'autres secteurs : établissements hospitaliers privés, médico-sociaux, tout particulièrement EHPAD publics et établissements et services médico-sociaux publics pour personnes en situation de handicap et médecine de ville.

Un cas typique d'exécration de soi sous emprise : ou quand la T2A fait s'entretuer les établissements du service public

VIGNERON E.

2017/12

Gestions hospitalières (571): 594-601.

La question d'une autorisation d'angioplastie coronaire à Chalon-sur-Saône est ici analysée sous la forme d'un cas clinique d'organisation sanitaire. La description de ce cas met en lumière l'effet pathogène d'une pensée dominante sur le service public hospitalier. L'auteur propose ensuite une discussion physiopathologique et thérapeutique.

La responsabilité populationnelle à l'hôpital

DOGIMONT R.

Gestions hospitalières (571) : 615-618.

Face à la désertification médicale, au renoncement aux soins pour raisons financières, de mobilité et de délai, aux relations parfois complexes avec la médecine de ville, l'hôpital doit-il rester dans ses murs ? Comment peut-il travailler différemment avec la ville pour fluidifier les parcours de santé ? Peut-il jouer un rôle majeur dans la réduction des inégalités sociales et territoriales à travers la prévention ? L'auteur, directeur du centre hospitalier de Douai, rapport ici la démarche « hors les murs » de son établissement.

▶ Un an après, les facteurs de réussite des GHT

DURAND R.

2017/12

Gestions hospitalières (571): 638-645.

Alors que les groupements hospitaliers de territoire (GHT) ont soufflé leur première bougie et, pour la plupart, porté à leur convention constitutive un projet médical partagé (DMP) et un projet de soins partagé (PSP), la chaire Management des établissements de santé de l'EHESP livre ici une synthèse des exemples et réponses échangés entre professionnels et chercheurs autour de questions managériales prégnantes.

▶ Competition and Quality Indicators in the Health Care Sector: Empirical Evidence from the Dutch Hospital Sector

CROES R. R., *et al.*

2018

Eur J Health Econ 19(1): 5-19.

There is much debate about the effect of competition in healthcare and especially the effect of competition on the quality of healthcare, although empirical evidence on this subject is mixed. The Netherlands provides an interesting case in this debate. The Dutch system could be characterized as a system involving managed competition and mandatory healthcare insurance. Information about the quality of care provided by hospitals has been publicly available since 2008. In this paper, we evaluate the relationship between quality scores for three diagnosis groups and the market power indicators of hospitals. We estimate the impact of competition on quality in an environment of liberalized pricing. For this research, we used unique price and production data relating to three diagnosis groups (cataract, adenoid and tonsils, bladder tumor) produced by Dutch hospitals in the period 2008-2011. We also used the quality indicators relating to these diagnosis groups. We reveal a negative relationship between market share and quality score for two of the three diagnosis groups studied, meaning that hospitals in competitive markets have better quality scores than those in concentrated markets. We therefore conclude that more competition is associated with higher quality scores.

▶ Practice Variation in the Dutch Long-Term Care and the Role of Supply-Sensitive Care: Is Access to the Dutch Long-Term Care Equitable?

DUELL D., *et al.*

2017

Health Econ 26(12): 1728-1742.

Universal access and generous coverage are important goals of the Dutch long-term care (LTC) system. It is a legal requirement that everyone eligible for LTC should be able to receive it. Institutional care (IC) made up for 90% of Dutch LTC spending. To investigate whether access to IC is as equitable as the Dutch government aspires, we explored practice variation in entitlements to IC across Dutch regions. We used a unique dataset that included all individual applications for Dutch LTC in January 2010-December 2013 (N = 3,373,358). This dataset enabled an accurate identification of the need for care. We examined the local variation in the probability of being granted long-term IC and in the intensity of the care granted given that individuals have applied for LTC. We also investigated whether the variation observed was related to differences in the local availability of care facilities. Although our analyses indicated the presence of some practice variation, its magnitude was very small by national and international standards (up to 3%). Only a minor part of the practice variation could be accounted for by local supply differences in care facilities. Overall, we conclude that, unlike many other developed countries, the Dutch system ensured equitable access to long-term IC.

▶ Impact of Health System Affiliation on Hospital Resource Use Intensity and Quality of Care

HENKE R. M., *et al.*

2018

Health Serv Res 53(1): 63-86.

The aims of this study are to assess the impact of hospital affiliation, centralization, and managed care plan ownership on inpatient cost and quality. Inpatient discharges are analysed from 3,957 community hospitals in 44 states and American Hospital Association Annual Survey data from 2010 to 2012. We conducted a retrospective longitudinal regression analysis using hierarchical modeling of discharges clustered within hospitals. Detailed discharge data including costs, length of stay, and patient characteristics from the

Healthcare Cost and Utilization Project State Inpatient Databases were merged with hospital survey data from the American Hospital Association. We conclude that increasing prevalence of health systems and hospital managed care ownership may lead to higher quality but are unlikely to reduce hospital discharge costs. Encouraging participation in innovative payment and delivery reform models, such as accountable care organizations, may be more powerful options.

The Ambiguous Effect of GP Competition: The Case of Hospital Admissions

ISLAM M. K. ET KJERSTAD E.

2017

Health Econ 26(12): 1483-1504.

In the theoretical literature on general practitioner (GP) behaviour, one prediction is that intensified competition induces GPs to provide more services resulting in fewer hospital admissions. This potential substitution effect has drawn political attention in countries looking for measures to reduce the growth in demand for hospital care. However, intensified competition may induce GPs to secure hospital admissions a signal to attract new patients and to keep the already enlisted ones satisfied, resulting in higher admission rates at hospitals. Using both static and dynamic panel data models, we aim to enhance the understanding of whether such relations are causal. Results based on ordinary least square (OLS) models indicate that aggregate inpatient admissions are negatively associated with intensified competition both in the full sample and for the sub-sample patients aged 45 to 69, while outpatient admissions are positively associated. Fixed-effect estimations do not confirm these results though. However, estimations of dynamic models show significant negative (positive) effects of GP competition on aggregate inpatient (outpatient) admissions in the full sample and negative effects on aggregate inpatient admissions and emergency admissions for the sub-sample. Thus, intensified GP competition may reduce inpatient hospital admissions by inducing GPs to provide more services, whereas, the alternative hypothesis seems valid for outpatient admissions.

Association Between Medicare's Mandatory Hospital Value-Based Purchasing Program and Cost Inefficiency

IZÓN G. ET PARDINI C.

2018

Applied Health Economics and Health Policy 16(1): 79-90.

The Patient Protection and Affordable Care Act instituted pay-for-performance programs, including Hospital Value-Based Purchasing (HVBP), designed to encourage hospital quality and efficiency. While these programs have been evaluated with respect to their implications for care quality and financial viability, this is the first study to assess the relationship between hospitals' cost inefficiency and their participation in the programs. We estimate a translog specification of a stochastic cost frontier with controls for participation in the HVBP program and clinical and outcome quality for California hospitals for 2012–2015. The program-participation indicators' parameters imply that participants were more cost inefficient than their peers. Further, the estimated coefficients for summary process of care quality indexes for three health conditions (acute myocardial infarction, pneumonia, and heart failure) suggest that higher quality scores are associated with increased operating costs. The estimated coefficients for the outcome quality variables suggest that future determination of HVBP payment adjustments, which will depend solely on mortality rates as measures of clinical care quality, may not only be aligned with increasing healthcare quality but also reducing healthcare costs.

Hospital Policy and Productivity - Evidence from German States

KARMANN A. ET ROESEL F.

2017

Health Econ 26(12): 1548-1565.

Total factor productivity (TFP) growth allows for additional healthcare services under restricted resources. We examine whether hospital policy can stimulate hospital TFP growth. We exploit variation across German federal states in the period 1993-2013. State governments decide on hospital capacity planning (number of hospitals, departments, and beds), ownership, medical students, and hospital investment funding. We show that TFP growth in German hospital care reflects quality improvements rather than increases in output

volumes. Second-stage regression results indicate that reducing the length of stay is generally a proper way to foster TFP growth. The effects of other hospital policies depend on the reimbursement scheme: Under activity-based (German Diagnosis-related Group) hospital funding, scope-related policies (privatization and specialization) come with TFP growth. Under fixed daily rate funding, scale matters to TFP (hospital size and occupancy rates). Differences in capitalization in East and West Germany allow to show that deepening capital may enhance TFP growth if capital is scarce. We also show that there is less scope for hospital policies after large-scale restructurings of the hospital sector.

Improving Patient Safety for Older People in Acute Admissions: Implementation of the Frailsafe Checklist in 12 Hospitals Across the UK

PAPOUTSI C., *et al.*

2018

Age Ageing 47(2): 311-317.

Checklists are increasingly proposed as a means to enhance safety and quality of care. However, their use has been met with variable levels of success. The Frailsafe project focused on introducing a checklist with the aim to increase completion of key clinical assessments and to facilitate communication for the care of older patients in acute admissions. The aim of this study is to examine the use of the Frailsafe checklist, including potential to contribute to improved safety, quality and reliability of care. 110 qualitative interviews and group discussions with healthcare professionals and other specialties, 172 h of ethnographic observation in 12 UK hospitals and reporting of high-level process data (completion of checklist and relevant frailty assessments). Qualitative analysis followed a thematic and theory-driven approach. Through use of the checklist, hospital teams identified limitations in their existing assessments (e.g. absence of delirium protocols) and practices (e.g. unnecessary catheter use). This contributed to hospitals reporting just 24.0% of sampled patients as having received all clinical assessments across key domains for this population for the duration of the project (1,687/7,021 checklists as fully completed). Staff perceptions and experiences of using the checklist varied significantly, primarily driven by the extent to which the aims of this quality improvement project aligned with local service priorities and pre-existing team communications styles. The Frailsafe checklist highlighted limitations with frailty assessment in acute care and motivated teams to review routine practices. Further work is needed to understand whether and how checklists can be embedded in complex, multidisciplinary care.

Burn out des médecins et autres praticiens hospitaliers

SHADILI G., *et al.*

2018

Information Psychiatrique (L') 94(4).

http://www.jle.com/fr/revues/ipe/e-docs/burn_out_des_medecins_et_autres_praticiens_hospitaliers_311271/article.phtml

Le « burn- out », ou syndrome d'épuisement au travail, est très controversé. Il concerne dans une large mesure les professionnels de santé et notamment les médecins. Il est mésestimé, source de dépression, de suicide, de conduites addictives et d'insatisfaction professionnelle. Le taux de burn- out des médecins français serait compris entre 38 % et 52 % et près d'un quart des médecins (23 %) ne chercheraient pas d'aide s'ils se trouvaient en situation de souffrance psychologique et plus de la moitié (54 %) ne sauraient pas vers qui se tourner. De fait, la France a donc un certain retard dans la prise en charge de ce fléau même si certains proposent qu'il soit reconnu comme maladie professionnelle. Cet article a pour objet d'en définir la clinique et de faire une liste non exhaustive des moyens de préventions et d'accompagnement.

Care Pathways and Healthcare Use of Stroke Survivors Six Months After Admission to an Acute-Care Hospital in France in 2012

TUPPIN P., *et al.*

2016

Rev Neurol (Paris) 172(4-5): 295-306.

Care pathways and healthcare management are not well described for patients hospitalized for stroke. Among the 51 million beneficiaries of the French national health insurance general scheme (77% of the French population), patients hospitalized for a first stroke in 2012 and still alive six months after discharge were included using data from the national health insurance information system (Sniiram). Patient

characteristics were described by discharge destination-home or rehabilitation center (for < 3 months)- and were followed during their first three months back home. A total of 61,055 patients had a first admission to a public or private hospital for stroke (mean age; 72 years, 52% female), 13% died during their stay and 37% were admitted to a stroke management unit. Overall, 40,981 patients were still alive at six months: 33% of them were admitted to a rehabilitation center (mean age: 73 years) and 54% were discharged directly to their home (mean age 67 years). For each group, 45 and 62% had been previously admitted to a stroke unit. Patients discharged to rehabilitation centers had more often comorbidities, 39% were highly physically dependent and 44% were managed in specialized neurology centers. For patients with a cerebral infarction who were directly discharged to their home 76% received at least one antihypertensive drug, 96% an antithrombotic drug and 76% a lipid-lowering drug during the following month. For those with a cerebral hemorrhage, these frequencies were respectively 46, 33 and 28%. For those admitted to a rehabilitation center, more than half had at least one visit with a physiotherapist or a nurse, 15% a speech therapist, 10% a neurologist or a cardiologist and 15% a psychiatrist during the following three months back home (average numbers of visits for those with at least one visit: 23 for physiotherapists and 100 for nurses). Patients who returned directly back home had fewer physiotherapist (30%) or nurse (47%) visits but more medical consultations. The 3-month re-hospitalization rate for patients who were discharged directly to their home was 23% for those who had been admitted to a stroke unit and 25% for the others. In rehabilitation centers, this rate was 10% for patients who stayed < 3 months. These results illustrate the value of administrative databases to study stroke management, care pathways and ambulatory care. These data should be used to improve care pathways, organization, discharge planning and treatments.

Inégalités de santé

A “Healthy Immigrant Effect” or a “Sick Immigrant Effect”? Selection and Policies Matter

CONSTANT A. F., *et al.*

2018

Eur J Health Econ 19(1): 103-121.

Previous literature on a variety of countries has documented a “healthy immigrant effect” (HIE). Accordingly, immigrants arriving in the host country are, on average, healthier than comparable natives. However, their health status dissipates with additional years in the country. HIE is explained through the positive self-selection of healthy immigrants as well as the positive selection, screening and discrimination applied by host countries. In this article we study the health trajectories of immigrants within the context of selection and migration policies. Using SHARE data we examine the HIE, comparing Israel and 16 European countries that have fundamentally different migration policies. Israel has virtually unrestricted open gates for Jewish people around the world, who in turn have ideological rather than economic considerations to move. European countries have selective policies with regards to the health, education and wealth of migrants, who also self-select themselves. Our results provide evidence that (1) immigrants who move to Israel have compromised health and are significantly less healthy than comparable natives. Their health disadvantage persists for up to 20 years of living in Israel, after which they become similar to natives; (2) immigrants who move to Europe have significantly better health than comparable natives. Their health advantage remains positive for many years. Even though during some time lapses they are not significantly different from natives, their health status never becomes worse than that of natives. Our results are important for migration policy and relevant for domestic health policy.

International Migrants’ Use of Emergency Departments in Europe Compared with Non-Migrants’ Use: A Systematic Review

CREDÉ S. H., *et al.*

2018

European Journal of Public Health 28(1): 61-73.

http://dx.doi.org/10.1093/eurpub/ckx057

International migration across Europe is increasing. High rates of net migration may be expected to increase pressure on healthcare services, including emergency services. However, the extent to which immigration creates additional pressure on emergency departments (EDs) is widely debated. This review synthesizes the evidence relating to international migrants' use of EDs in European Economic Area (EEA) countries as compared with that of non-migrants. MEDLINE, EMBASE, CINAHL, The Cochrane Library and The Web of Science were searched for the years 2000–16. Studies reporting on ED service utilization by international immigrants, as compared with non-migrants, were eligible for inclusion. Twenty-two articles (from six host countries) were included. Thirteen of 18 articles reported higher volume of ED service use by immigrants, or some immigrant sub-groups. Migrants were seen to be significantly more likely to present to the ED during unsocial hours and more likely than non-migrants to use the ED for low-acuity presentations. Differences in presenting conditions were seen in 4/7 articles; notably a higher rate of obstetric and gynaecology presentations among migrant women. Conclusions: The principal finding of this review is that migrants utilize the ED more, and differently, to the native populations in EEA countries. The higher use of the ED for low-acuity presentations and the use of the ED during unsocial hours suggest that barriers to primary healthcare may be driving the higher use of these emergency services although further research is needed.

Association Between Cultural Distance and Migrant Self-Rated Health

DETOLLENAERE J., *et al.*

2018

Eur J Health Econ 19(2): 257-266.

We study whether migrant health in Europe is associated with the cultural distance between their host country and country of origin. To this end, we run multilevel regression models on data merging self-rated health and social background of ≥ 3800 migrants from the European Social Survey with an index of cultural distance based on country differences in values, norms and attitudes measured in the World Values Survey. We find that higher levels of cultural distance are associated with worse migrant health. This association is comparable in size with the negative association between health and female (compared with male) gender but less important than the association between health and education level. In addition, this association is less significant among second-generation than first-generation migrants.

Migrant Women Living with HIV in Europe: Are They Facing Inequalities in the Prevention of Mother-To-Child-Transmission of HIV? The European Pregnancy and Paediatric HIV Cohort Collaboration (EPPICC) Study Group in Eurocoord

FAVARATO G., *et al.*

2018

European Journal of Public Health 28(1): 55-60.

In pregnancy early interventions are recommended for prevention of mother-to-child-transmission (PMTCT) of HIV. We examined whether pregnant women who live with HIV in Europe and are migrants encounter barriers in accessing HIV testing and care. Four cohorts within the European Pregnancy and Paediatric HIV Cohort Collaboration provided data for pooled analysis of 11 795 pregnant women who delivered in 2002–12 across ten European countries. We defined a migrant as a woman delivering in a country different from her country of birth and grouped the countries into seven world regions. We compared three suboptimal PMTCT interventions (HIV diagnosis in late pregnancy in women undiagnosed at conception, late anti-retroviral therapy (ART) start in women diagnosed but untreated at conception and detectable viral load (VL) at delivery in women on antenatal ART) in native and migrant women using multivariable logistic regression models. We can conclude that migrant women were more likely to be diagnosed in late pregnancy but once on ART virological response was good. Good access to antenatal care enables the implementation of PMTCT protocols and optimises both maternal and children health outcomes generally.

Gypsy, Roma and Traveller Access to and Engagement with Health Services: A Systematic Review

MCFADDEN A., *et al.*

2018

European Journal of Public Health 28(1): 74-81.

Gypsy, Roma and Traveller people represent the most disadvantaged minority groups in Europe, having the poorest health outcomes. This systematic review addressed the question of how Gypsy, Roma and Traveller people access healthcare and what are the best ways to enhance their engagement with health services. Searches were conducted in 21 electronic databases complemented by a focussed Google search. Studies were included if they had sufficient focus on Gypsy, Roma or Traveller populations; reported data pertinent to healthcare service use or engagement and were published in English from 2000 to 2015. Study findings were analyzed thematically and a narrative synthesis reported. This review provides evidence that Gypsy, Roma and Traveller populations across Europe struggle to exercise their right to healthcare on account of multiple barriers; and related to other determinants of disadvantage such as low literacy levels and experiences of discrimination. Some promising strategies to overcome barriers were reported but the evidence is weak; therefore, rigorous evaluations of interventions to improve access to and engagement with health services for Gypsy, Roma and Traveller people are needed.

▶ Adapting Primary Care for New Migrants: A Formative Assessment

SUCH E., *et al.*

2017

BJGP Open.

http://bjgpopen.org/content/bjgpoa/early/2017/01/10/bjgpopen17X100701.full.pdf

Immigration rates have increased recently in the UK. Migrant patients may have particular needs that are inadequately met by existing primary care provision. In the absence of national guidance, local adaptations are emerging in response to these new demands. This aim of this study is to formatively assess the primary care services offered to new migrants and the ways in which practitioners and practices are adapting to meet need. Online survey and case studies of current practice across primary care were conducted in the UK. Case studies were selected from mainstream and specialist general practice as well as primary care provision in the third sector. Survey results indicated that practitioners focused on working with communities and external agencies and adapting processes of, for example, screening, vaccination, and health checks. Lack of funding was cited most frequently as a barrier to service development (n = 51; 73%). Case studies highlighted the prominence partnership working and of an organisational and practitioner focus on equitable care. Adaptations centred on addressing wider social determinants, trauma, and violence, and additional individual needs; and on delivering culturally-competent care. Despite significant resource constraints, some primary care services are adapting to the needs of new migrants. Many adapted approaches can be characterised as equity-oriented.

▶ Population Health and the Economy: Mortality and the Great Recession in Europe

TAPIA GRANADOS J. A. ET IONIDES E. L.

2017

Health Econ 26(12): e219-e235.

We analyze the evolution of mortality-based health indicators in 27 European countries before and after the start of the Great Recession. We find that in the countries where the crisis has been particularly severe, mortality reductions in 2007-2010 were considerably bigger than in 2004-2007. Panel models adjusted for space-invariant and time-invariant factors show that an increase of 1 percentage point in the national unemployment rate is associated with a reduction of 0.5% ($p < .001$) in the rate of age-adjusted mortality. The pattern of mortality oscillating procyclically is found for total and sex-specific mortality, cause-specific mortality due to major causes of death, and mortality for ages 30-44 and 75 and over, but not for ages 0-14. Suicides appear increasing when the economy decelerates-countercyclically-but the evidence is weak. Results are robust to using different weights in the regression, applying nonlinear methods for detrending, expanding the sample, and using as business cycle indicator gross domestic product per capita or employment-to-population ratios rather than the unemployment rate. We conclude that in the European experience of the past 20 years, recessions, on average, have beneficial short-term effects on mortality of the adult population.

Primary Care for Refugees and Newly Arrived Migrants in Europe: A Qualitative Study on Health Needs, Barriers and Wishes

VAN LOENEN T., *et al.*

2018

European Journal of Public Health 28(1): 82-87.

In order to provide effective primary care for refugees and to develop interventions tailored to them, we must know their needs. Little is known of the health needs and experiences of recently arrived refugees and other migrants throughout their journey through Europe. We aimed to gain insight into their health needs, barriers in access and wishes regarding primary health care. In the spring of 2016, we conducted a qualitative, comparative case study in seven EU countries in a centre of first arrival, two transit centres, two intermediate-stay centres and two longer-stay centres using a Participatory Learning and Action research methodology. A total of 98 refugees and 25 healthcare workers participated in 43 sessions. Transcripts and sessions reports were coded and thematically analyzed by local researchers using the same format at all sites; data were synthesized and further analyzed by two other researchers independently. Results: The main health problems of the participants related to war and to their harsh journey like common infections and psychological distress. They encountered important barriers in accessing healthcare: time pressure, linguistic and cultural differences and lack of continuity of care. They wish for compassionate, culturally sensitive healthcare workers and for more information on procedures and health promotion. Conclusion: Health of refugees on the move in Europe is jeopardized by their bad living circumstances and barriers in access to healthcare. To address their needs, healthcare workers have to be trained in providing integrated, compassionate and cultural competent healthcare.

Médicaments

Un médecin est-il libre de ne pas prescrire un traitement ?

CARTRON D.

2017

Médecine : de la Médecine Factuelle à nos Pratiques 13(10): 466-.

Désormais, il n'est plus rare qu'un patient, adepte de l'internet, vienne consulter son médecin avec le diagnostic et le traitement retrouvés dans ses recherches. Le médecin reste-t-il néanmoins autonome dans sa prescription ?

Diffusion of Innovations Theory, Principles, and Practice

DEARING J. W. ET COX J. G.

2018

Health Aff (Millwood) 37(2): 183-190.

Aspects of the research and practice paradigm known as the diffusion of innovations are applicable to the complex context of health care, for both explanatory and interventionist purposes. This article answers the question, "What is diffusion?" by identifying the parameters of diffusion processes: what they are, how they operate, and why worthy innovations in health care do not spread more rapidly. We clarify how the diffusion of innovations is related to processes of dissemination and implementation, sustainability, improvement activity, and scale-up, and we suggest the diffusion principles that can be readily used in the design of interventions.

Les facteurs influençant la prescription de benzodiazépines hypnotiques pour insomnie chez la personne âgée

STILLMUNKES A., *et al.*

2017

Médecine : De la Médecine Factuelle à nos Pratiques 13(10): 474-479.

En France, les benzodiazépines hypnotiques sont prescrites à 90,5 % par les médecins généralistes. L'objectif de cette étude était de déterminer les facteurs influençant la prescription de benzodiazépines hypnotiques dans l'insomnie transitoire ou chronique chez la per-

sonne de plus de 65 ans non démente en France. Une étude transversale, descriptive, a été basée sur un scénario clinique. Celui-ci a été envoyé aux médecins généralistes du bassin de santé du Lauragais, en Occitanie (France), entre avril et mai 2015. Cinq facteurs modifiaient significativement la prescription des benzodiazépines hypnotiques : l'âge et le sexe du médecin, la réalisation par le praticien lui-même de la prise en charge non médicamenteuse, l'existence de correspondants pour les troubles du sommeil, l'anticipation du sevrage. Des études complémentaires seraient nécessaires pour mieux expliquer ces différents facteurs.

Méthodologie – Statistique

Testing the Impact of Mixed-Mode Designs (Mail and Web) and Multiple Contact Attempts Within Mode (Mail or Web) on Clinician Survey Response

BEEBE T. J., *et al.*

2018

Health Serv Res. Ahead of print.

The aim of this study is to compare response rate and nonresponse bias across two mixed-mode survey designs and two single-mode designs. This experiment was embedded in a clinician survey of knowledge and attitudes regarding HPV vaccination (n = 275). Clinicians were randomly assigned one of two mixed-mode (mail/web or web/mail) or single-mode designs (mail-only/web-only). Differences in response rate and nonresponse bias were assessed. PRINCIPAL Using a multiple-contact protocol increased response, and sending a web survey first provided the more rapid response. Overall, the mixed-mode survey designs generated final response rates approximately 10 percentage points higher than their single-mode counterparts, although only the final response differences between the mail-only and web/mail conditions attained statistical significance (32.1 percent vs. 48 percent, respectively; p = .005). Observed differences did not result in nonresponse bias. Results support mixing modes of survey administration and web-based data collection in a multiple contact survey data collection protocol.

Quelle place pour la data science et les big data au sein de la statistique publique ?

COMBES S. ET GIVORD P.

2017

Revue Française des Affaires Sociales(4): 117-126.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-4-page-117.htm

Le phénomène « big data » fait l'objet de beaucoup d'attention dans un contexte de profusion de données (dont une part croissante est ouverte), de collecte et de traitement facilités par les progrès technologiques et de démocratisation des outils. On utilise classiquement les « 3 V » (volume, variété, vitesse) pour qualifier les big data. Si ces données sont caractérisées en premier lieu par leur volume, elles peuvent être également de nature très variée : numériques, textuelles, photographiques, sonores, vidéos... Enfin, elles peuvent être produites en continu et ainsi générer des flux importants. Avec l'amélioration des infrastructures matérielles et logicielles, notamment s'agissant de la collecte, du stockage et de l'optimisation des calculs, tous ces formats sont devenus exploitables dans des délais raisonnables. Ces nouvelles données peuvent offrir de nouvelles opportunités pour les instituts nationaux de statistiques. Au niveau international (Eurostat et ONU), plusieurs réflexions ont été lancées. Les avantages pressentis de ces sources seraient de réduire les délais de publication de certains indicateurs, d'en augmenter la précision et le degré de finesse de la description qu'ils permettent, et enfin d'enrichir la production statistique, tout en réduisant la charge d'enquête. Mais ces questionnements viennent également alimenter une réflexion plus globale autour du métier de statisticien public : cartographier les données, moderniser les outils, les méthodes statistiques et l'organisation du travail.

Utilisation des réseaux bayésiens comme technique de fouille de données massives – application à des données de recours aux soins

DIMEGLIO C., *et al.*

2017

Revue Française des Affaires Sociales(4): 27-55.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-4-page-27.htm

Les réseaux bayésiens sont utilisés selon deux approches distinctes, reposant sur les mêmes principes d'analyse bayésienne : comme outil de modélisation a priori faisant intervenir les hypothèses du chercheur, ou comme outil de fouille de données, sans hypothèse a priori de la part du chercheur. La première approche a diffusé dans la communauté biomédicale. La seconde provient avant tout de l'intelligence artificielle et n'est à notre connaissance pas utilisée en épidémiologie. Cette application est pourtant prometteuse – notamment dans le cas de données massives – et pourrait permettre la découverte de relations causales insoupçonnées. Cela reste cependant à montrer. Nous avons utilisé les données de 2010 de la cohorte SIRS, reposant sur un échantillon représentatif de la population adulte du Grand Paris. Plusieurs publications en épidémiologie sociale sont fondées sur cette cohorte, dont une étudiant les recours aux soins et les caractéristiques sociales en lien avec ces recours. Nous avons réanalysé les données de cette étude avec différents algorithmes de fouille de données permettant tout d'abord d'identifier automatiquement la structure du réseau bayésien représentant les données (le graphe), et ensuite d'estimer les paramètres du réseau à partir des données. Nous avons comparé les résultats obtenus par fouille de données avec les analyses multivariées classiques et les données de la littérature.. L'analyse multivariée identifie des relations entre variables connues de la littérature. Les analyses par réseau bayésien identifient des relations plus complexes, orientées, entre variables, dont les significations sont simples. La majorité des analyses montre une partition entre variables sociales et variables de recours aux soins. La fouille de données massives par réseau bayésien représente un ensemble de techniques théoriquement bien assises, appliquées avec succès dans différents domaines. Notre exemple de résultats obtenus sur des données connues dans le champ de l'épidémiologie sociale suggère que l'intérêt de ce type d'approche doit être clarifié. En particulier, son utilisation en aveugle paraît, au vu de nos résultats, peu pertinente.

The Impact of the Eligibility Threshold of a French Means-Tested Health Insurance Programme on Doctor Visits: A Regression Discontinuity Analysis

GUTHMULLER S. ET WITTWER J.

2017

Health Econ 26(12): e17-e34.

This paper assesses the impact of eligibility for a free means-tested complementary health insurance plan, called Couverture Maladie Universelle Complémentaire (CMUC), on doctor visits. We use information on the selection rule to qualify for the plan to identify the effect of eligibility and adopt a regression discontinuity approach. Our sample consists of low-income individuals enrolled in the Health Insurance Fund and recipients of social benefits from the Family Allowance Fund of an urban area in Northern France. Our findings do not show significant impacts of the CMUC threshold on the number of doctor visits within the full sample. Among the subsample of adults under 30 years old, however, eligible individuals are more likely to see a specialist and have, on average, significantly more specialist visits than non-eligible individuals. This specific impact of the CMUC cut-off point among young adults may be explained by the fact that young adults are less likely to be covered by a complementary health insurance plan when they are not recipients of the CMUC plan.

Decision Heuristic or Preference? Attribute Non-Attendance in Discrete Choice Problems

HEIDENREICH S., *et al.*

2018

Health Econ 27(1): 157-171.

This paper investigates if respondents' choice to not consider all characteristics of a multiattribute health service may represent preferences. Over the last decade, an increasing number of studies account for attribute non-attendance (ANA) when using discrete choice experiments to elicit individuals' preferences. Most studies assume such behaviour is a heuristic and therefore uninformative. This assumption may result in misleading welfare estimates if ANA reflects preferences. This is the first paper to assess if ANA is a heuristic or genuine preference without relying on respondents' self-stated motivation and the first study to explore this question within a health context. Based on find-

ings from cognitive psychology, we expect that familiar respondents are less likely to use a decision heuristic to simplify choices than unfamiliar respondents. We employ a latent class model of discrete choice experiment data concerned with National Health Service managers' preferences for support services that assist with performance concerns. We present quantitative and qualitative evidence that in our study ANA mostly represents preferences. We also show that wrong assumptions about ANA result in inadequate welfare measures that can result in suboptimal policy advice. Future research should proceed with caution when assuming that ANA is a heuristic.

Quantifying Magnitude of Group-Level Differences in Patient Experiences with Health Care

QUIGLEY D. D., *et al.*

2018

Health Serv Res. Ahead of print.

Review approaches assessing magnitude of differences in patient experience scores between different providers. A systematic literature review was conducted on the period: 2000-2016. Of 812 articles mentioning "CAHPS," "patient experience," "patient satisfaction," "important(ce)," "difference," or "significance," we identified 79 possible articles, yielding 35 for data abstraction. We included 22 articles measuring magnitude of differences in patient experiences. We identified three main ways of estimating magnitude of differences in patient experience scores: (1) by distribution/range of patient experience variable, (2) against external anchor, and (3) comparing a difference in patient experience on one covariate to differences in patient experience on other covariates. We suggest routine estimation of magnitude in patient experience research. More work is needed documenting magnitude of differences between providers to make patient experience data more interpretable and usable.

Identifying Primary Care Pathways from Quality of Care to Outcomes and Satisfaction Using Structural Equation Modeling

RICCI-CABELLO I., *et al.*

2018

Health Serv Res 53(1): 430-449.

The aim of this paper is to study the relationships between the different domains of quality of primary health care for the evaluation of health system performance and for informing policy decision making. A total of 137 quality indicators collected from 7,607 English practices between 2011 and 2012. Indicators were allocated to subdomains of processes of care ("quality assurance," "education and training," "medicine management," "access," "clinical management," and "patient-centered care"), health outcomes ("intermediate outcomes" and "patient-reported health status"), and patient satisfaction. The relationships between the subdomains were hypothesized in a conceptual model and subsequently tested using structural equation modeling. This is the first empirical model to simultaneously provide evidence on the independence of intermediate health care outcomes, patient satisfaction, and health status. The explanatory paths via technical quality clinical management and patient centeredness offer specific opportunities for the development of quality improvement initiatives.

Using Latent Class Analysis to Model Preference Heterogeneity in Health: A Systematic Review

ZHOU M., *et al.*

2018

PharmacoEconomics 36(2): 175-187.

https://doi.org/10.1007/s40273-017-0575-4

Latent class analysis (LCA) has been increasingly used to explore preference heterogeneity, but the literature has not been systematically explored and hence best practices are not understood.

Politique de santé

What's Involved with Wanting to Be Involved? Comparing Expectations For Public Engagement in Health Policy Across Research and Care Contexts

BARG C.J. ET MICHAEL P.-M.

2017

Healthcare Policy 13(2): 40-56.

The objectives of this study are to explore public preferences for involvement in health policy decisions, across the contexts of medical research and healthcare. We e-surveyed a sample of Canadians, categorizing respondents by preferences for decision control: (1) more authority; (2) more input; (3) status quo. Two generalized ordered logistic regressions assessed influences on preferences. The participation rate was 94%; 1,102 completed responses met quality criteria. The dominant preference was for more input (average = 52.0%), followed by status quo (average = 24.9%) and more authority (average = 21.1%), though preferences for more control were higher in healthcare (57.2%) than medical research (46.8%). Preferences for greater control were associated with constructs related to reduced trust in healthcare systems. The public expects health policy to account for public views, but not base decisions primarily on these views. More involvement was expected in healthcare than medical research policy. As opportunities for public involvement in health research grow, we anticipate increased desired involvement.

Scale Effects and Expected Savings from Consolidation Policies of Italian Local Healthcare Authorities

DI NOVI C., *et al.*

2018

Applied Health Economics and Health Policy 16(1): 107-122.

Consolidation is often considered by policymakers as a means to reduce service delivery costs and enhance accountability. The aim of this study was to estimate the potential cost savings that may be derived from consolidation of local health authorities (LHAs) with specific reference to the Italian setting. For our empirical analysis, we use data relating to the costs of the LHAs as reported in the 2012 LHAs' Income Statements published within the New Health Information System (NSIS) by the Ministry of Health. With respect to the previous literature on the consolidation of local health departments (LHDs), which is based on ex-post-assessments on what has been the impact of the consolidation of LHDs on health spending, we use an ex-ante-evaluation design and simulate the potential cost savings that may arise from the consolidation of LHAs. Our results show the existence of economies of scale with reference to a particular subset of the production costs of LHAs, i.e. administrative costs together with the purchasing costs of goods (such as drugs and medical devices) as well as non-healthcare-related services. The research findings of our paper provide practical insight into the concerns and challenges of LHA consolidations and may have important implications for NHS organisation and for the containment of public healthcare expenditure.

Exploring the Interrelationship Between Sport, Health and Social Outcomes in the UK: Implications for Health Policy

DOWNWARD P., *et al.*

2018

European Journal of Public Health 28(1): 99-104.

http://dx.doi.org/10.1093/eurpub/ckx063

Policy agencies are now re-visiting early aspirations that sport, as a form of physical activity, can be an instrument to foster general health and also subjective well-being (SWB). Both of these concepts capture physical and mental health states. SWB also encompasses broader psychological and life satisfaction as well as mood and affect. Past and current policies also identify a link between sport, social capital and SWB. Methods: Structural Equation Modelling (SEM) is undertaken on data from the UK's Taking Part survey to investigate the interrelationships between sport, general health, social capital and SWB. Results: The SEM shows a simultaneous relationship between sport and SWB. The effect is mediated through general health. The results also show that there is no relationship between social capital and sport but a clear relationship between SWB and social capital. From a health policy perspective there should be an emphasis on encouraging greater sport participation, despite the difficulties that this poses, because there is a potential 'multiplier' effect

on SWB and on general health through mediation. The multiplier effect occurs because once someone engages in sport and has their general health and SWB enhanced, then even further sport participation becomes likely, and subsequent general health and SWB, which would comprise both physical and mental health benefits. To target traditional non participants the research suggests that physical activity should be promoted for enjoyment, with health benefits subsequently following.

Expérimentations : le nouveau cadre

VAYSETTE P.

2018

Esop : La Revue Des Soins Primaires(7): 10-11.

La loi de financement pour la sécurité sociale 2018 instaure, dans son article 51, un nouveau cadre pour l'autorisation et la mise en œuvre d'expérimentations dérogatoires. Sont visées à la fois les innovations organisationnelles et de soins. En attendant les textes réglementaires, les expérimentations en cours (PAERPA, enfant à risque d'obésité, etc...) peuvent se poursuivre. Trois types d'expérimentations sont par ailleurs envisagés : un intéressement collectif à des groupements d'acteurs, le paiement à l'épisode de soins, la rémunération collective.

Politique publique

Des rapports d'âge organisationnels : le rôle des dispositifs de gestion

BOUSSARD V.

2017

Gérontologie et société 39 (153): 57-74.

https://www.cairn.info/revue-gerontologie-et-societe-2017-2-page-57.htm

Cet article s'intéresse à la construction sociale des rapports d'âge en entreprise, à partir d'une approche par les dispositifs de gestion de ces dernières (organisation et division du travail, gestion des ressources humaines, gestion financière). Ces dispositifs ne sont pas mis en œuvre pour traiter ou réguler la question des âges ou des relations intra- ou intergénérationnelles, mais celle des qualifications, de la production et des résultats financiers. Pourtant, ils ont une influence indirecte sur les rapports d'âge au travail et les modèles professionnels dans lesquels ils s'insèrent. À partir de deux monographies d'entreprise, il montre que l'articulation des dispositifs de gestion particulière à chaque organisation crée des configurations singulières de rapports d'âge. Les deux cas soulignent que les dispositifs de gestion participent à définir professionnellement l'âge, le rendant relatif. Ils attribuent des positions et offrent des parcours différenciés en fonction de l'âge ou de l'époque d'entrée dans l'emploi. En créant des configurations particulières, ils participent à construire des relations d'âge spécifiques et variables en fonction des organisations. Ainsi, les rapports d'âge, loin d'être de purs produits institutionnels doivent aussi être pensés comme le résultat de formes organisationnelles locales et spécifiques, ancrées plus généralement dans les façons d'organiser, d'encadrer et d'évaluer le travail.

Prévention

What factors predict the passage of state-level e-cigarette regulations?

MACLEAN J. C., *et al.*

Health Econ : 27(5) : 897-907

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3642

E-cigarettes are controversial products. They may help addicted smokers to consume nicotine in a less harmful manner or to quit tobacco cigarettes entirely, but these products may also entice youth into smoking. This controversy complicates e-cigarette regulation as any regulation may lead to health improvements for some populations, and health declines for other populations. Using data from 2007 to 2016, we examine factors that are plausibly linked with U.S. state e-cigarette regulations. We find that less conservative states are more likely to regulate e-cigarettes and that states with stronger tobacco lobbies are less likely to regulate e-cigarettes. This information can help policymakers as they determine how best to promote public health through regulation.

Prévision – Evaluation

Using Health Technology Assessment to Assess the Value of New Medicines: Results of a Systematic Review and Expert Consultation Across Eight European Countries

ANGELIS A., *et al.*

2018

Eur J Health Econ 19(1): 123-152.

Although health technology assessment (HTA) systems base their decision making process either on economic evaluations or comparative clinical benefit assessment, a central aim of recent approaches to value measurement, including value based assessment and pricing, points towards the incorporation of supplementary evidence and criteria that capture additional dimensions of value. The aim of this paper are to study the practices, processes and policies of value-assessment for new medicines across eight European countries and the role of HTA beyond economic evaluation and clinical benefit assessment. A systematic (peer review and grey) literature review was conducted using an analytical framework examining: (1) 'Responsibilities and structure of HTA agencies'; (2) 'Evidence and evaluation criteria considered in HTAs'; (3) 'Methods and techniques applied in HTAs'; and (4) 'Outcomes and implementation of HTAs'. Study countries were France, Germany, England, Sweden, Italy, Netherlands, Poland and Spain. All countries assess similar types of evidence; however, the specific criteria/endpoints used, their level of provision and requirement, and the way they are incorporated (e.g. explicitly vs. implicitly) varies across countries, with their relative importance remaining generally unknown. Incorporation of additional 'social value judgements' (beyond clinical benefit assessment) and economic evaluation could help explain heterogeneity in coverage recommendations and decision-making. More comprehensive and systematic assessment procedures characterised by increased transparency, in terms of selection of evaluation criteria, their importance and intensity of use, could lead to more rational evidence-based decision-making, possibly improving efficiency in resource allocation, while also raising public confidence and fairness.

Involving Members of the Public in Health Economics Research: Insights from Selecting Health States for Valuation to Estimate Quality-Adjusted Life-Year (QALY) Weights

GOODWIN E., *et al.*

2018

Applied Health Economics and Health Policy 16(2) : 187-194

Over recent years, public involvement in health research has expanded considerably. However, public involvement in designing and conducting health economics research is seldom reported. Here we describe the development, delivery and assessment of

an approach for involving people in a clearly defined piece of health economics research: selecting health states for valuation in estimating quality-adjusted life-years (QALYs). This involvement formed part of a study to develop a condition-specific preference-based measure of health-related quality of life, the Multiple Sclerosis Impact Scale (MSIS-8D), and the work reported here relates to the identification of plausible, or realistic, health states for valuation. An Expert Panel of three people with multiple sclerosis (MS) was recruited from a local involvement network, and two health economists designed an interactive task that enabled the Panel to identify health states that were implausible, or unlikely to be experienced.

A Scoping Review of Economic Evaluations Alongside Randomised Controlled Trials of Home Monitoring in Chronic Disease Management

KIDHOLM K. ET KRISTENSEN M.

2018

Applied Health Economics and Health Policy 16(2) : 167-176

Many countries have considered telemedicine and home monitoring of patients as a solution to the demographic challenges that health-care systems face. However, reviews of economic evaluations of telemedicine have identified methodological problems in many studies as they do not comply with guidelines. The aim of this study was to examine economic evaluations alongside randomised controlled trials of home monitoring in chronic disease management and hereby to explore the resources included in the programme costs, the types of health-care utilisation that change as a result of home monitoring and discuss the value of economic evaluation alongside randomised controlled trials of home monitoring on the basis of the studies identified. A scoping review of economic evaluations of home monitoring of patients with chronic disease based on randomised controlled trials and including information on the programme costs and the costs of equipment was carried out based on a Medline (PubMed) search. Nine studies met the inclusion criteria. All studies include both costs of equipment and use of staff, but there is large variation in the types of equipment and types of tasks for the staff included in the costs. Equipment costs constituted 16–73% of the total programme costs. In six of the nine studies, home monitoring resulted in a reduction in primary care or emergency contacts. However, in total, home monitoring resulted in increased average costs per patient in six studies and reduced costs in three of the nine studies. The review is limited by the small number of studies found and the restriction to randomised controlled trials, which can be problematic in this area due to lack of blinding of patients and healthcare professionals and the difficulty of implementing organisational changes in hospital departments for the limited period of a trial. Furthermore, our results may be based on assessments of older telemedicine interventions.

Frailty Index as a Predictor of Mortality: A Systematic Review and Meta-Analysis

KOJIMA G., *et al.*

2018

Age Ageing 47(2): 193-200.

Two popular operational definitions of frailty, the frailty phenotype and Frailty index (FI), are based on different theories. Although FI was shown to be superior in predicting mortality to the frailty phenotype, no meta-analysis on mortality risk according to FI has been found in the literature. Methods: an electronic systematic literature search was conducted in August 2016 using four databases (Embase, Medline, CINAHL and PsycINFO) for prospective cohort studies published in 2000 or later, examining the mortality risk according to frailty measured by FI. A meta-analysis was performed to synthesise pooled mortality risk estimates. Results: of 2,617 studies identified by the systematic review, 18 cohorts from 19 studies were included. Thirteen cohorts showed hazard ratios (HRs) per 0.01 increase in FI, six cohorts showed HRs per 0.1 increase in FI and two cohorts each showed odds ratios (ORs) per 0.01 and 0.1 increase in FI, respectively. All meta-analyses suggested that higher FI was significantly associated with higher mortality risk (pooled HR per 0.01 FI increase = 1.039, 95% CI = 1.033-1.044, $P < 0.001$; pooled HR per 0.1 FI increase = 1.282, 95% CI = 1.258-1.307, $P < 0.001$; pooled OR per 0.01 FI increase = 1.054, 95% CI = 1.040-1.068, $P < 0.001$; pooled OR per 0.1 FI increase = 1.706, 95% CI = 1.547-1.881, $P < 0.001$). Meta-regression analysis among 13 cohorts with HR per 0.01 increase in FI showed that the studies with shorter follow-up periods and with lower female proportion were associated with higher mortality risks by FI. Conclusions: this systematic review and meta-analysis was the first to quantitatively demon-

strate that frailty measured by the FI is a significant predictor of mortality.

▶ The Impact of Regression to the Mean on Economic Evaluation in Quasi-Experimental Pre-Post Studies: The Example of Total Knee Replacement Using Data from the Osteoarthritis Initiative

SCHILLING C., *et al.*

2017

Health Econ 26(12): e35-e51.

Many treatments are evaluated using quasi-experimental pre-post studies susceptible to regression to the mean (RTM). Ignoring RTM could bias the economic evaluation. We investigated this issue using the contemporary example of total knee replacement (TKR), a common treatment for end-stage osteoarthritis of the knee. Data (n = 4796) were obtained from the Osteoarthritis Initiative database, a longitudinal observational study of osteoarthritis. TKR patients (n = 184) were matched to non-TKR patients, using propensity score matching on the predicted hazard of TKR and exact matching on osteoarthritis severity and health-related quality of life (HrQoL). The economic evaluation using the matched control group was compared to the standard method of using the pre-surgery score as the control. Matched controls were identified for 56% of the primary TKRs. The matched control HrQoL trajectory showed evidence of RTM accounting for a third of the estimated QALY gains from surgery using the pre-surgery HrQoL as the control. Incorporating RTM into the economic evaluation significantly reduced the estimated cost effectiveness of TKR and increased the uncertainty. A generalized ICER bias correction factor was derived to account for RTM in cost-effectiveness analysis. RTM should be considered in economic evaluations based on quasi-experimental pre-post studies.

Psychiatrie

▶ Out of Sight but Not Out of Mind: Home Countries' Macroeconomic Volatilities and Immigrants' Mental Health

NGUYEN H. T. ET CONNELLY L. B.

2018

Health Econ 27(1): 189-208.

We provide the first empirical evidence that better economic performances by immigrants' countries of origin, as measured by lower consumer price index (CPI) or higher gross domestic product, improve immigrants' mental health. We use an econometrically-robust approach that exploits exogenous changes in macroeconomic conditions across immigrants' home countries over time and controls for immigrants' observable and unobservable characteristics. The CPI effect is statistically significant and sizeable. Furthermore, the CPI effect diminishes as the time since emigrating increases. By contrast, home countries' unemployment rates and exchange rate fluctuations have no impact on immigrants' mental health.

Soins de santé primaires

▶ La planification des médecins en Europe : une revue de la littérature des modèles de projection

BENAHMED N., *et al.*

2018

Revue d'Épidémiologie et de Santé Publique 66(1): 63-73.

http://www.sciencedirect.com/science/article/pii/S0398762017305011

Position du problème : Les soins de santé représentent un secteur à forte intensité en capital humain dans

lequel les ressources humaines constituent la moitié des dépenses totales. Le nombre de professionnels, ainsi que la répartition de leurs compétences, font donc l'objet d'une attention soutenue de la part des décideurs tant au niveau national qu'au niveau international. L'objectif de cet article est d'analyser les différents modèles européens de projection de l'offre médicale et de la demande en médecins. Méthodes Afin de décrire les outils de projection utilisés pour la planification médicale en Europe, une revue de la littérature grise a été menée. Résultats Les méthodes quantitatives d'évaluation de l'offre médicale reposent généralement sur une modélisation de type « stock and flow » et plus rarement sur une dynamique systémique. Les paramètres inclus dépendent largement de la disponibilité et de la qualité de ces données. Les modélisations des besoins en médecins se limitent à la consommation de soins et n'envisagent que rarement les besoins dans leur globalité ou des objectifs de santé. Outre les méthodes quantitatives, l'« Horizon scanning » est une technique permettant d'apprécier l'évolution de l'offre et de la demande dans un futur incertain à l'aide de techniques qualitatives telles que celles des enquêtes semi-structurées, des panels Delphi ou des« focus group ». Enfin, les modèles de projection de l'offre et de la demande doivent être régulièrement mis à jour pour vérifier la réalisation des hypothèses de travail. De plus, une analyse post-hoc est également nécessaire mais trop rarement réalisée. Conclusion : La planification des ressources humaines médicales est très inégalement implantée en Europe. L'implémentation politique des résultats des exercices de projection est cruciale pour une planification efficace. Cependant des données importantes comme celles relatives à la mobilité entre les États membres sont mal connues, compliquant les politiques de régulation de l'offre médicale. Ces politiques se limitent généralement à la régulation de la formation et n'envisagent que trop rarement la délégation et la substitution. Background : Healthcare is a labor-intensive sector in which half of the expenses are dedicated to human resources. Therefore, policy makers, at national and internal levels, attend to the number of practicing professionals and the skill mix. This paper aims to analyze the European forecasting model for supply and demand of physicians. Methods : To describe the forecasting tools used for physician planning in Europe, a grey literature search was done. Results Quantitative methods for forecasting medical supply rely mainly on stock-and-flow simulations and less often on systemic dynamics. Parameters included in forecasting models exhibit wide variability for data availability and quality. The forecasting of physician needs is limited to healthcare consumption and rarely considers overall needs and service targets. Besides quantitative methods, horizon scanning enables an evaluation of the changes in supply and demand in an uncertain future based on qualitative techniques such as semi-structured interviews, Delphi Panels, or focus groups. Finally, supply and demand forecasting models should be regularly updated. Moreover, post-hoc analyze is also needed but too rarely implemented. Conclusion : Medical human resource planning in Europe is inconsistent. Political implementation of the results of forecasting projections is essential to insure efficient planning. However, crucial elements such as mobility data between Member States are poorly understood, impairing medical supply regulation policies. These policies are commonly limited to training regulations, while horizontal and vertical substitution is less frequently taken into consideration.

Do Financial Incentives Influence GPs' Decisions to Do After-Hours Work? A Discrete Choice Labour Supply Model

BROADWAY B., *et al.*

2017

Health Econ 26(12): e52-e66.

This paper analyses doctors' supply of after-hours care (AHC), and how it is affected by personal and family circumstances as well as the earnings structure. We use detailed survey data from a large sample of Australian General Practitioners (GPs) to estimate a structural, discrete choice model of labour supply and AHC. This allows us to jointly model GPs' decisions on the number of daytime-weekday working hours and the probability of providing AHC. We simulate GPs' labour supply responses to an increase in hourly earnings, both in a daytime-weekday setting and for AHC. GPs increase their daytime-weekday working hours if their hourly earnings in this setting increase, but only to a very small extent. GPs are somewhat more likely to provide AHC if their hourly earnings in that setting increase, but again, the effect is very small and only evident in some subgroups. Moreover, higher earnings in weekday-daytime practice reduce the probability of providing AHC, particularly for men. Increasing GPs' earnings appears to be at best relatively ineffective in encouraging increased provision of AHC and may even prove harmful if incentives are not well targeted.

Factors that Distinguish High-Performing Accountable Care Organizations in the Medicare Shared Savings Program

D'AUNNO T., *et al.*

2018

Health Serv Res 53(1): 120-137.

The aim of this study is to identify factors that promote the effective performance of accountable care organizations (ACOs) in the Medicare Shared Savings Program. Data come from a convenience sample of 16 Medicare Shared Savings ACOs that were organized around large physician groups. We use claims data from the Center for Medicaid and Medicare Services and data from 60 interviews at three high-performing and three low-performing ACOs. Explanatory sequential design, using qualitative data to account for patterns observed in quantitative assessment of ACO performance. A total of 16 ACOs were first rank-ordered on measures of cost and quality of care; we then selected three high and three low performers for site visits; interview data were content-analyzed. Results identify several factors that distinguish high- from low-performing ACOs: (1) collaboration with hospitals; (2) effective physician group practice prior to ACO engagement; (3) trusted, long-standing physician leaders focused on improving performance; (4) sophisticated use of information systems; (5) effective feedback to physicians; and (6) embedded care coordinators. Shorter interventions can improve ACO performance-use of embedded care coordinators and local, regional health information systems; timely feedback of performance data. However, longer term interventions are needed to promote physician-hospital collaboration and skills of physician leaders. CMS and other stakeholders need realistic timelines for ACO performance.

Can You Recommend Me a Good GP? Describing Social Differences in Patient Satisfaction Within 31 Countries

DETOLLENAERE J., *et al.*

2017

Int J Qual Health Care 30(1) : 9-15

This study aims to explore social differences in patient satisfaction of their general practitioner (GP) according to patient's gender, education, household income and ethnicity in Europe. By using multilevel logistic modelling the impact of socioeconomic indicators (i.e. gender, education, household income and ethnicity) on patient satisfaction is estimated. In each model the authors controlled for indicators of person-focused care and strength of the primary care system in 31 European countries. Patients who were sitting in the waiting room of the GP were asked to participate. They filled in the questionnaire after the consultation with the GP. Intervention: Describing social differences in patient satisfaction among European primary care patients. Main Outcome Measure(s): Patient satisfaction. This study confirms previous research and reveals high levels of satisfaction with primary care in Europe. On average, 92.1% of the respondents would recommend their GP to their family or relatives. Variance in patient satisfaction is mostly explained at patient level, ~75% of the variance can be assigned to patient characteristics. Likewise, women, low-income groups and first generation migrants are less satisfied with their GP. Lastly, all indicators of person-focused care are positively associated with patient satisfaction, showing that the more person-focused the care, the higher the satisfaction among the patients. Conclusions: Notwithstanding the high satisfaction rates in Europe, patient satisfaction is still determined by patients' socioeconomic status (gender and household income), migration background and the degree of person-centred care. Therefore, policymakers and health professionals should target these population groups in order to improve the satisfaction rates in their country.

Changes in Access to Primary Care in Europe and Its Patterning, 2007–12: A Repeated Cross-Sectional Study

DIMITROVOVÁ K. ET PERELMAN J.

2018

European Journal of Public Health: Ahead of print

The strengthening of primary care (PC) has been encouraged as a strategy to achieve more efficient and equitable health systems. However, the Great Recession may have reduced access to PC. This paper analyses the change in access to PC and its patterning in 28 European countries between 2007 and 2012. Methods : We used data from the 2007 and 2012 waves of the EU-SILC questionnaire (n = 687 170). The dependent variable was the self-reported access to PC ('easy' vs. 'difficult'). We modelled the access to PC as a function of the year and individual socioeconomic and country-level health system variables, using a mixed effects logistic regression, adjusting for sex, age, civil status, country of birth, chronic condition and

self-reported health. Additionally, we interacted the year with socioeconomic and country-level variables. Results: The probability of reporting difficult access to PC services was 4% lower in 2012, in comparison with 2007 (OR = 0.96, P <; 0.01). People with the lowest educational level (OR = 1.63, P < 0.01), high difficulty to make ends meet (OR = 1.94, P < 0.01) and with material deprivation (OR = 1.25, P <t; 0.01) experienced a significantly higher likelihood of difficult access. The better access in 2012 was significantly higher in people living in countries with higher health expenditures, a greater number of generalist medical practitioners, and with stronger gatekeeping. Conclusion : Access to PC improved between 2007 and 2012, and this improvement was greater for people living in countries with a higher investment in health and PC. However, the poor access amongst low-SE status people was stable over the period.

Can Pay-For-Performance to Primary Care Providers Stimulate Appropriate Use of Antibiotics?

ELLEGARD L. M., *et al.*

2018

Health Econ 27(1): e39-e54.

Antibiotic resistance is a major threat to public health worldwide. As the healthcare sector's use of antibiotics is an important contributor to the development of resistance, it is crucial that physicians only prescribe antibiotics when needed and that they choose narrow-spectrum antibiotics, which act on fewer bacteria types, when possible. Inappropriate use of antibiotics is nonetheless widespread, not least for respiratory tract infections (RTI), a common reason for antibiotics prescriptions. We examine if pay-for-performance (P4P) presents a way to influence primary care physicians' choice of antibiotics. During 2006-2013, 8 Swedish healthcare authorities adopted P4P to make physicians select narrow-spectrum antibiotics more often in the treatment of children with RTI. Exploiting register data on all purchases of RTI antibiotics in a difference-in-differences analysis, we find that P4P significantly increased the share of narrow-spectrum antibiotics. There are no signs that physicians gamed the system by issuing more prescriptions overall.

La médecine générale au défi de la démographie sanitaire

GROSS O.

2018

Médecine : De la Médecine Factuelle à nos Pratiques 13(10): 462-465.

L'engagement des patients comme acteurs de santé est un phénomène mondial et protéiforme. Il est fondé sur le principe selon lequel il participe de l'amélioration de la qualité des soins. Le DUMG de Paris 13 a recours à vingt patients qui disposent d'un statut d'enseignants vacataires et ils y enseignent en binôme avec des médecins dans 90 % des enseignements. La médecine générale s'est trouvée être au sein de l'université, un acteur essentiel dans le développement de la responsabilité sociale de l'université et dans la mise en œuvre de nouvelles pratiques inspirées des principes de la démocratie en santé. De même, en ville, elle développe des nouvelles pratiques favorisant la mise en œuvre d'une démocratie en santé, jusque-là pensée pour l'hôpital. La médecine générale s'impose donc, dans le cadre de la formation médicale et en ville, comme le fer de lance d'une nouvelle forme de la démocratie en santé.

Incentives to Patients Versus Incentives to Health Care Providers: The Users' Perspective

JELOVAC I. ET POLOME P.

2017

Health Econ 26(12): e319-e331.

In theory, health care providers may adapt their professional behavior to the financial incentives resulting from their remuneration. Our research question is whether the users of health care services anticipate such behavior from their general practitioner (GP) and, if they do, what consequences such anticipation has on their preferences regarding financial incentives. Our theoretical model explains users' preferences for one or another incentives scheme, disentangling the financial motives (incentives amounts, wealth) from the behavioral ones (perceived GPs' sensitivity to incentives). We empirically test our theoretical predictions using data from a survey that elicits individual preferences for either patient or provider hypothetical incentives in France. The empirical results confirm the theoretical ones: users tend to prefer incentives to patients rather than to GPs when the amount of GP

incentives is high, when the amount of patient incentives is low, when they anticipate that their GP's medical decisions are affected by financial incentives or when their wealth is high. Otherwise, they prefer their GP to face financial incentives.

Do Capitation-Based Reimbursement Systems Underfund Tertiary Healthcare Providers? Evidence from New Zealand

SHIN S., *et al.*

2017

Health Econ 26(12): e81-e102.

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

Travail et santé

Sickness Benefit Rules and Work Absence: An Empirical Study Based on European Data

CHAUPAIN-GUILLOT S. ET GUILLOT O.

2017

Revue d'économie politique 127(6): 1109-1137.

https://www.cairn.info/revue-d-economie-politique-2017-6-page-1109.htm

À partir des données de l'European Working Conditions Survey de 2010, cette étude s'intéresse aux déterminants des absences au travail pour raisons de santé dans les pays européens. L'accent est mis sur l'impact des règles d'indemnisation des arrêts maladie. Cinq paramètres du système d'indemnisation sont pris en compte : l'obligation ou non de fournir un certificat médical dès le premier jour d'absence, la durée minimale d'affiliation au régime d'assurance sociale, l'existence ou non d'un délai de carence, le niveau d'indemnisation et la durée maximale de versement des indemnités maladie. Les comportements d'absence des salariés sont analysés à l'aide de régressions logistiques multiniveaux. Les résultats montrent que les écarts entre pays dans la probabilité d'absence au travail peuvent en partie s'expliquer par les différences de législation en matière d'indemnisation des arrêts maladie. Le fait que le salaire soit intégralement maintenu par l'employeur en cas de maladie est l'élément le plus déterminant. Comme attendu, dans les pays où cette règle s'applique, la propension à s'absenter est significativement plus élevée.

Bounding the Causal Effect of Unemployment on Mental Health: Nonparametric Evidence from Four Countries

CYGAN-REHM K., *et al.*

2017

Health Econ 26(12): 1844-1861.

An important, yet unsettled, question in public health policy is the extent to which unemployment causally impacts mental health. The recent literature yields varying findings, which are likely due to differences in data, methods, samples, and institutional settings. Taking a more general approach, we provide comparable evidence for four countries with different institutional settings-Australia, Germany, the UK, and the United States-using a nonparametric bounds analysis. Relying on fairly weak and partially testable assumptions, our paper shows that unemployment has a significant negative effect on mental health in all countries. Our results rule out effects larger than a quarter of a standard deviation for Germany and half a standard deviation for the Anglo-Saxon countries. The effect is significant for both men and women and materialises already for short periods of unemployment. Public pol-

icy should hence focus on early prevention of mental health problems among the unemployed.

▶ Predictors of Working Beyond Retirement in Older Workers with and Without a Chronic Disease - Results from Data Linkage of Dutch Questionnaire and Registry Data

DE WIND A., *et al.*

2018

BMC Public Health 18(1): 265.

https://doi.org/10.1186/s12889-018-5151-0

An increasing number of retirees continue to work beyond retirement despite being eligible to retire. As the prevalence of chronic disease increases with age, working beyond retirement may go along with having a chronic disease. Working beyond retirement may be different for retirees with and without chronic disease. We aim to investigate whether demographic, socio-economic and work characteristics, health and social factors predict working beyond retirement, in workers with and without a chronic disease.

▶ Good Jobs, Good Pay, Better Health? The Effects of Job Quality on Health Among Older European Workers

HENSEKE G.

2018

Eur J Health Econ 19(1): 59-73.

Using data from the Survey of Health, Ageing and Retirement in Europe, this study presents new evidence on the effects of job quality on the occurrence of severe acute conditions, the level of cardiovascular risk factors, musculoskeletal disorders, mental health, functional disabilities and self-assessed health among workers aged 50+. By combining intrinsic job quality with job insecurity and pay the study maps out multiple potential pathways through which work may affect health and well-being. Levering longitudinal data and external information on early retirement ages allows for accounting of unobserved heterogeneity, selection bias and reverse causality. The empirical findings suggest that inequities in health correlate with inequities in job quality, though a substantial fraction of these associations reflect time-constant unobserved heterogeneity. Still, there is evidence for genuine protective effects of better jobs on musculoskeletal disorders, mental health and general health. The effect could contribute to a substantial number of avoidable disorders among older workers, despite relatively modest effect sizes at the level of individuals. Mental health, in particular, responds to changes in job quality. Selection bias such as the healthy worker effect does not alter the results. But the influence of job quality on health may be transitional among older workers. An in-depth analysis of health dynamics reveals no evidence for persistence.

▶ Long Term Unemployment, Income, Poverty, and Social Public Expenditure, and Their Relationship with Self-Perceived Health in Spain (2007–2011)

LÓPEZ DEL AMO GONZÁLEZ M. P., *et al.*

2018

BMC Public Health 18(1): 133.

https://doi.org/10.1186/s12889-017-5004-2

There is scant research that simultaneously analyzes the joint effects of long-term unemployment, poverty and public expenditure policies on poorer self-perceived health during the financial crisis. The aim of the study is to analyze the joint relationship between long-term unemployment, social deprivation, and regional social public expenditure on one side, and self-perceived health in Spain (2007–2011) on the other.

▶ Les valeurs des générations au travail : les introuvables différences

SABA T.

2017

Gérontologie et société (39) 153: 27-41.

https://www.cairn.info/revue-gerontologie-et-societe-2017-2-page-27.htm

La cohabitation de travailleurs issus de plusieurs générations sur les lieux de travail semble de nos jours soulever certaines difficultés en gestion des ressources humaines. On prétend que les générations ont des valeurs et des attentes au travail difficilement conciliables. La cohabitation se prolonge puisque les générations plus âgées tardent à quitter le marché du travail ou y reviennent pour occuper des emplois de transition. L'incohérence des modes de gestion des entreprises exacerbe les difficultés qui émergent

de cette cohabitation. Malgré la force des convictions, nous constatons que les chercheurs ont été incapables d'identifier des différences significatives de valeurs entre les générations et d'expliquer si les comportements et les attitudes au travail varient d'une génération à l'autre. Cet article s'attarde à mettre en contexte les études sur les différences de valeurs entre les générations et à présenter les cadres théoriques et analytiques appropriés susceptibles d'expliquer ces différences. Sont discutés les résultats des études qui montrent que les différences générationnelles de valeurs au travail sont un mythe qui est loin de pouvoir être empiriquement démontré.

Vieillissement

Health Services Utilization in Older Adults with Dementia Receiving Care Coordination: The MIND at Home Trial

AMJAD H., *et al.*

2018

Health Serv Res 53(1): 556-579.

The aim of this study is to investigate effects of a novel dementia care coordination program on health services utilization. A total of 303 community-dwelling adults aged ≥70 with a cognitive disorder in Baltimore, Maryland (2008-2011). Single-blind RCT evaluating efficacy of an 18-month care coordination intervention were delivered through community-based nonclinical care coordinators, supported by an interdisciplinary clinical team. Study partners reported acute care/inpatient, outpatient, and home- and community-based service utilization at baseline, 9, and 18 months. From baseline to 18 months, there were no significant group differences in acute care/inpatient or total outpatient services use, although intervention participants had significantly increased outpatient dementia/mental health visits from 9 to 18 months ($p = .04$) relative to controls. Home and community-based support service use significantly increased from baseline to 18 months in the intervention compared to control ($p = .005$). While this dementia care coordination program did not impact acute care/inpatient services utilization, it increased use of dementia-related outpatient medical care and nonmedical supportive community services, a combination that may have helped participants remain at home longer. Future care model modifications that emphasize delirium, falls prevention, and behavior management may be needed to influence inpatient service use.

Le logement et les soins dans le grand âge : briser les silos

DESPRÉS C., *et al.*

2017

Gérontologie et société 39 (152): 107-124.

https://www.cairn.info/revue-gerontologie-et-societe-2017-1-page-107.htm

Au Québec, la population des 80 ans et plus a presque quintuplé entre 1970 et 2010. Si personne ne vieillit de la même façon ni au même rythme, les aînés font inévitablement l'expérience d'un affaiblissement progressif. Un choix difficile qu'ont à prendre les aînés lorsqu'une perte d'autonomie sévère se fait sentir est celui de demeurer dans leur logis ou de déménager. Or, plusieurs dimensions de l'environnement bâti des aînés sont associées à des effets sur leur qualité de vie et leur bien- être. Des actions doivent être entreprises pour assurer que les aînés puissent faire des choix éclairés parmi des options de logis non seulement confortables et sécuritaires, mais jugées désirables. Cela requiert de jeter des ponts entre des univers de recherche et d'intervention diversifiés, soit ceux de la santé, du social et de l'aménagement du cadre bâti. Cette action contribuera à l'intégration de données probantes ainsi qu'à combler les lacunes dans les connaissances, à rapprocher des cultures scientifiques et professionnelles qui n'ont pas l'habitude de travailler ensemble, et à donner une voix aux principaux utilisateurs des connaissances, soit les aînés et leurs proches. Cet article rapporte les résultats d'une collaboration initiée à l'été 2015 entre des chercheurs de trois universités canadiennes du Québec et de l'Alberta et des utilisateurs des connaissances autour de la question de l'habitat et des soins dans le grand âge, dans le but de relever ces nombreux défis.

(Re)construire une approche multidimensionnelle des générations de l'entreprise

JOLIVET A.

2017

Gérontologie et société 39 (153): 45-56.

https://www.cairn.info/revue-gerontologie-et-societe-2017-2-page-45.htm

La loi de 2013 sur le contrat de génération a fait de la génération un nouveau référent des politiques publiques. Pourquoi et comment construire une autre approche des générations en emploi et au travail au sein d'une entreprise ou d'une organisation ? Par ses contours, son contenu mais aussi par les accords ou plans d'action qui ont résulté de l'incitation à négocier, le contrat de génération porte une conception de la notion de génération centrée sur l'âge trop restreinte et peu pertinente. Les travaux de K. Mannheim permettent de proposer une approche locale des générations « de » l'entreprise. Deux exemples couplant démographie du travail et observations du travail sont mobilisés pour montrer les apports d'analyses plus fines des spécificités démographiques locales, des parcours, des collectifs de travail. L'objectif est ainsi de (re)construire une analyse par les générations qui fonde des catégories pertinentes au regard du contexte de l'entreprise, des catégories qui ne sont pas figées par des seuils fixés a priori et qui tiennent compte des situations concrètes de travail et des parcours professionnels des personnes.

Les formes alternatives d'habitat pour les personnes âgées, une comparaison Allemagne-France

LEENHARDT H.

2017

Gérontologie et société 39 (152): 187-206.

https://www.cairn.info/revue-gerontologie-et-societe-2017-1-page-187.htm

Les enjeux de l'adaptation de la société aux évolutions démographiques sont analogues en Allemagne et en France, bien que le vieillissement de la population soit plus accentué en Allemagne. Les deux pays affichent la volonté de permettre aux personnes de vieillir au domicile et de développer des formes alternatives d'habitat pour éviter ou retarder autant que possible une entrée en établissement. Pourtant, ces formes alternatives ne connaissent pas le même essor dans les deux pays. La comparaison Allemagne-France dans ce domaine est-elle possible, que nous enseigne-t-elle ?

Le devenir de l'habitat intergénérationnel : une revisite socio-anthropologique

NÉMOZ S.

2017

Gérontologie et société 39 (152): 207-220.

https://www.cairn.info/revue-gerontologie-et-societe-2017-1-page-207.htm

À la fin du XXe siècle, le « logement intergénérationnel » a été inauguré en Espagne. Au fil des années, la formule a été reprise par d'autres pays européens pour promouvoir l'habitat partagé entre étudiants et retraités. À l'heure où la crise économique perdure en Europe, et ce depuis 2008 suite à l'effondrement de différents systèmes dont celui des prêts hypothécaires accordés aux propriétaires américains, cet article interroge le devenir des cohabitations promues à l'origine par des valeurs de solidarité entre différentes classes d'âge. Dans un premier temps, il s'agit de resituer ce que l'on entend par cohabitation, colocation et logement intergénérationnel. En dehors des formes familiales, les modalités de partage du domicile des personnes âgées avec de plus jeunes, en études supérieures, sont ensuite analysées dans leur diversité et leur évolution par une approche socio-anthropologique. Ce retour sur expériences s'appuie sur la comparaison il y a dix ans des modes d'habiter et de leurs organisations en France et en Espagne (Némoz, 2007), ainsi que sur l'analyse des processus d'institutionnalisation poursuivis depuis lors. Il en ressort une affirmation des enjeux financiers en temps de crise, sans qu'ils ne soient pour autant prometteurs d'une nouvelle économie sociale et solidaire entre les générations. Le paradoxe est dans un troisième temps éclairé au regard d'une approche comparative et réflexive de l'agencement plus large des contraintes et des motivations socio-économiques au cœur de l'innovation résidentielle.

Parcours de soins en phase aiguë de la personne âgée en EHPAD : l'expérience de la région Grand Est

SULTER B. *et al.*, E.

2017/12

Gestions hospitalières(571): 619-628.

Dans un contexte de réorganisation de l'offre de soins qui a impacté tous les établissements hospitaliers, une mission de modernisation de l'offre de soins en Moselle-Est (MISMOE) a été mise en place en janvier 2012 par l'agence régionale de santé pour réfléchir au parcours de la personne âgée. La loi 2015-1776 du 28 décembre 2015 relative à l'adaptation de la société au vieillissement a éclairé la réflexion du groupe de recherche, notamment sur l'aspect « adaptation des politiques publiques », qui s'est ainsi centré sur la personne âgée résidant en Ehpad et a choisi de formaliser une modélisation du parcours de soins en phase aiguë afin qu'il puisse être transposable.

L'entraide générationnelle existe ! Nous l'avons rencontrée

VIALARD F.

2017

Gérontologie et société (39) 153 139-146.

https://www.cairn.info/revue-gerontologie-et-societe-2017-2-page-139.htm

Ce texte présente une expérience concrète d'entraide générationnelle à travers la mobilisation d'un collectif d'agents de la fonction publique, relégués dans un service de la direction régionale du travail où l'atmosphère est pour le moins délétère. L'arrivée de deux collègues plus âgées, au parcours divers, va participer à changer l'équilibre et le collectif va s'organiser pour faire au mieux le travail dévolu, s'appuyant sur les atouts de chacun de ses membres. Il trouvera ainsi la force de se défendre face à des injonctions contradictoires et de protéger les agents de la menace du burn-out.

IRDES

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May 2018

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Health Insurance

La protection des données personnelles comme mode de régulation du big data en protection sociale complémentaire

BERTRAND M.

2017

Revue Française des Affaires Sociales(4): 57-78.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-4-page-57.htm

Le big data constitue un véritable défi pour le système français de protection sociale, fondé sur la mutualisation des risques. Un changement de paradigme est effectivement à l'œuvre avec l'acquisition de données personnelles de plus en plus nombreuses, permettant de réduire l'asymétrie d'information, et de fait l'aléa moral, entre l'assureur et l'assuré. D'une part, la conception du risque s'éloigne progressivement de la notion d'aléa, alors même que le caractère aléatoire est consubstantiel au contrat d'assurance. D'autre part, le modèle traditionnel de protection sociale consistant à atténuer le risque par l'indemnisation du sinistre s'accompagne désormais d'une nouvelle approche préventive. Or, ce changement de paradigme risque d'entraîner une segmentation excessive des risques, susceptible de porter atteinte à la protection des personnes. Si le règlement (UE) n° 2016/679 et la loi n° 2016-1321 pour une République numérique tendent à redonner aux personnes la maîtrise de l'usage de leurs données personnelles, le cadre normatif en vigueur laisse néanmoins apparaître une tension entre diffusion et rétention des données. Ce constat impose alors la recherche d'un nouvel équilibre entre la protection des droits et des libertés des personnes physiques et les enjeux propres au secteur de la protection sociale, à la fois concurrentiel et réglementé.

La complémentaire santé en 2014 : 5 % de non-couverts et 12 % parmi les 20 % les plus pauvres

PERRONNIN M. ET LOUVEL A. C.

2018

Questions d'Économie de la Santé (Irdes) (229)

http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/229-la-complementaire-sante-en-2014.pdf

En 2012 et 2014, près de 5 % des personnes ne bénéficient d'aucune couverture complémentaire santé. Malgré l'existence de dispositifs d'aide pour les plus précaires, l'absence de couverture complémentaire reste souvent liée au revenu. Elle est plus fréquente chez les chômeurs, les inactifs en âge de travailler et les jeunes adultes. Parmi les salariés du secteur privé, près de sept sur dix bénéficient d'une complémentaire santé par le biais de leur employeur. Certaines catégories de salariés, les personnes en Contrat à durée déterminée (CDD), les employés de commerce et les ouvriers non qualifiés sont nettement moins souvent couverts par ce biais. Ayant des taux de couverture élevés, les indépendants, les fonctionnaires et les retraités sont, eux, très majoritairement couverts par des contrats individuels et se déclarent moins souvent bien couverts pour leurs soins que les salariés du secteur privé titulaires d'un contrat collectif.

E-health – Medical technologies

Les données au cœur de la stratégie numérique de la branche retraite

BREUIL P. ET VILLARD R.

2017

Revue Française des Affaires Sociales(4): 150-158.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-4-page-150.htm

Ce dernier numéro de la RFAS pour 2017 comprend exclusivement un dossier consacré au big data et à la protection sociale. Il est composé de cinq articles et de six « points de vue ». Les premiers adoptent des angles variés, soit théoriques (notamment lorsqu'il est question de la protection des données personnelles ou de l'anonymisation) soit pratiques, comme celui qui rend compte de l'utilisation de l'intelligence artificielle dans les traitements du cancer. Le premier « point de vue »

fait le point sur big data et statistique publique, les suivants offrent aux lecteurs autant d'exemples d'applications de ces nouvelles techniques de traitement de données « massives » : à la recherche épidémiologique, à l'aide à la décision médicale, à la protection sociale et à la formation professionnelle.

L'e-santé : l'empowerment du patient connecté

CASES A.-S.

2017

Journal de gestion et d'économie médicales 35(4): 137-158.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-4-page-137.htm

L'objectif de cette recherche est de mieux comprendre les apports du numérique dans la sphère médicale avec une approche centrée autour du patient. Aujourd'hui, Internet a transformé la façon dont le patient a accès à l'information santé, ce patient dit « connecté » est de plus en plus informé et devient un acteur de sa santé. Conjointement, certains dispositifs numériques de santé contribuent également à impliquer les patients dans le processus de soin. Aussi, le concept d'empowerment du patient prend tout son sens avec l'arrivée des technologies numériques. Une revue de la littérature relative au concept d'empowerment du client puis du patient a été menée et complétée par deux études qualitatives complémentaires. Il s'agit d'identifier les sources de pouvoir associées au numérique et à l'empowerment du patient ainsi que les bénéfices et les risques de ce gain de pouvoir ressenti par ces derniers.

Apport des nouvelles technologies en résidence seniors : promesse et réalité

CHIRIÉ V.

2017

Gérontologie et société 39152(1): 221-235.

https://www.cairn.info/revue-gerontologie-et-societe-2017-1-page-221.htm

De plus en plus nombreuses, les résidences pour seniors visent les retraités actifs ou fragiles. Alternatives entre le logement habituel et le logement spécialisé, ces résidences réfléchissent à l'intégration de solutions numériques comme facteur décisif de prévention sur les plans de la santé, de la sécurité et du lien social, et mettent en avant ces solutions comme un argument qualité clé de leur offre. Appuyée sur des entretiens pluridisciplinaires auprès de résidents et de professionnels d'une résidence seniors qui valorise son volet numérique, cette étude constate d'une part un écart entre la cible sociologique identifiée et la cible réelle ; d'autre part, elle analyse les usages réels et limités des solutions utilisées dans cette résidence. Des recommandations pour l'intégration des solutions technologiques dans les services de résidences sont proposées en guise de discussion. Cette expérience montre la difficulté d'un usage réellement personnalisé, adapté aux attendus des résidents et en lien avec les offres de services du territoire correspondant à l'implantation de la résidence. En revanche, il n'en ressort pas moins un attendu réel des résidents dans ce domaine, en termes de sécurité, de confort et de lien social et des opportunités de services, qui reste encore à améliorer.

Quelle inférence pour l'épidémiologie à l'heure des big data ?

FALISSARD B.

2017

Revue Française des Affaires Sociales(4): 127-132.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-4-page-127.htm

Cybersécurité : nos données de santé sont-elles en sécurité ?

FROMENTIN V.

2017

Lettre De Galilée (La) (H.S, 3)

Avec 6,4 milliards d'objets déjà connectés, reliés à Internet, et 5,5 millions nouveaux appareils qui sont installés par jour, l'Internet des objets (IoT) constitue une cible de prédilection pour les pirates. Le 21 octobre 2016, la société Dyn aux États-Unis en a fait les frais en essuyant une attaque qui a paralysé de nombreux sites Internet comme CNN, The Guardian, Netflix ou Twitter. Le pirate avait réussi à prendre le contrôle de 100 000 caméras. Avec l'arrivée des voitures connectées, des brosses à dents ou des bracelets connectés, la menace est prise au sérieux par l'Union Européenne. La Haute Autorité de Santé a publié un guide de recommandations pour les applis santé. Faut-il vraiment craindre les objets connectés ?

Telemedical Care and Monitoring for Patients with Chronic Heart Failure Has a Positive Effect on Survival

HEROLD R., *et al.*

2018

Health Serv Res 53(1): 532-555.

Telemedical care and monitoring programs for patients with chronic heart failure have shown beneficial effects on survival in several small studies. The utility in routine care remains unclear. We evaluated a large-sized telemedicine program in a routine care setting, enrolling in total 2,622 patients (54.7 percent male, mean age: 73.7 years) with chronic heart failure. We used reimbursement data from a large statutory health insurance and approached a matched control analysis. In a complex propensity score matching procedure, 3,719 suitable controls (54.2 percent male, mean age: 74.5 years) were matched to 1,943 intervention patients (54.1 percent male, mean age: 74.4 years). The primary endpoint of our analysis was survival after 1 year. Analyses revealed a higher survival probability among subjects of the intervention group compared to controls group after 1 year (adjusted OR: 1.47, CI 95 percent: 1.21-1.80, $p < .001$) and 2 years (adjusted OR: 1.51, CI 95 percent: 1.28-1.77, $p < .001$), respectively. The probabilities to survive after 1 and 2 years were significantly increased in the intervention group. Our findings confirm previous results of controlled trials and importantly indicate that patients with chronic heart failure may benefit from telemonitoring programs in routine care.

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.

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..

Big data et cancer : le défi

LIVARTOWSKI A., *et al.*

2017

Revue Française des Affaires Sociales(4): 11-25.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-4-page-11.htm

La révolution du big data et de l'intelligence artificielle peut transformer la médecine, et en particulier la lutte contre le cancer. Les grands centres hospitaliers à travers le monde ont un rôle majeur à jouer dans cette transformation car ils concentrent les bases de données les plus riches et les plus proches de la réalité clinique. Dans le domaine de l'aide au diagnostic et de la prédiction de la réponse au traitement, ou afin de mieux déterminer le risque de récidive, le principe consiste à utiliser les technologies de machine learning, de deep learning pour l'analyse automatique des textes, des images et des données de séquençage. Sommes- nous capables d'en extraire des données exploitables pour faire progresser nos connaissances ? Préalable à cette exploitation, de nombreux problèmes doivent être résolus : d'ordre juridique comme l'accès aux données, la question de leur propriété, les problèmes de confidentialité et de consentement du patient, d'ordre technique comme la qualité des données sources, leur interopérabilité et leur intégration. Se poseront ensuite les questions de l'évaluation de ces aides à la décision, et leur appropriation par le monde médical.

Evaluating Barriers to Adopting Telemedicine Worldwide: A Systematic Review

SCOTT KRUSE C., *et al.*

2018

J Telemed Telecare 24(1): 4-12.

https://www.ncbi.nlm.nih.gov/pubmed/29320966

Studies on telemedicine have shown success in reducing the geographical and time obstacles incurred in the receipt of care in traditional modalities with the same or greater effectiveness; however, there are several barriers that need to be addressed in order for telemedicine technology to spread. The aim of this review is to evaluate barriers to adopting telemedicine worldwide through the analysis of published work. The authors conducted a systematic literature review by extracting the data from the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and PubMed (MEDLINE) research databases. The reviewers in this study analysed 30 articles (nine from CINAHL and 21 from Medline) and identified barriers found in the literature. The reviewers identified 33 barriers with a frequency of 100 occurrences through the 30 articles. The study identified the issues with technically challenged staff (11%), followed by resistance to change (8%), cost (8%), reimbursement (5%), age of patient (5%), and level of education of patient (5%). All other barriers occurred at or less than 4% of the time. Telemedicine is not yet ubiquitous, and barriers vary widely. The top barriers are technology-specific and could be overcome through training, change-management techniques, and alternating delivery by telemedicine and personal patient-to-provider interaction. The results of this study identify several barriers that could be eliminated by focused policy. Future work should evaluate policy to identify which one to lever to maximize the results.

Télémédecine : des pratiques innovantes pour l'accès aux soins

SIMON P. ET GAYRARD P.

2017

Actualité et Dossier en Santé Publique(101): 10-55

La télémédecine regroupe des pratiques médicales à distance : téléconsultation, télé-expertise, télésurveillance médicale, téléassistance médicale et régulation. Elle est une réponse aux défis auxquels est confrontée l'offre de soins aujourd'hui. Elle permet la prise en charge au plus près du lieu de vie des patients. C'est un moyen de réorganiser l'offre de soins en améliorant l'accès et la qualité. La Stratégie nationale de santé 2018-2022 donne une nouvelle impulsion à la télémédecine et des financements sont mis en œuvre pour favoriser son développement. Ce dossier spécial de l'ADSP fait un bilan sur le déploiement, les enjeux et les perspectives de la télémédecine en France avec un aperçu sur les expériences étrangères.

L'enjeu de l'anonymisation à l'heure du big data

TANGHE H. ET GIBERT P.-O.

2017

Revue Française des Affaires Sociales(4): 79-93.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-4-page-79.htm

Le système national des données de santé (SNDS) soulève la question de l'« open data santé », et a relancé les réflexions autour de l'anonymisation des données personnelles. La qualification de donnée anonyme représente un véritable enjeu, dans la mesure où elle constitue soit une obligation légale (open data), soit un outil de conformité à la protection des données personnelles. Cependant, à l'ère du big data et des progrès d'analyse des données, il subsiste toujours un risque de ré-identification. Face à une interprétation stricte de l'anonymisation de la part du G29, qui adopte une approche « zéro risque », l'anonymisation nécessite d'être repensée. Alors que la Commission nationale de l'informatique et des libertés (CNIL) s'est vue récemment chargée de publier des référentiels pour la certification des processus d'anonymisation, l'article présente les limites de cette approche trop stricte et principalement établie sur des critères techniques. Il plaide pour une interprétation plus souple de l'anonymisation via la mise en place de seuils de risques prédéfinis selon le contexte, permettant d'évaluer l'anonymat, et le renforcement de mesures juridiques.

Health Economics

Impact of the Phased Abolition of Co-Payments on the Utilisation of Selected Prescription Medicines in Wales

ALAM M. F., *et al.*

2018

Health Econ 27(1): 236-243.

We have taken advantage of a natural experiment to measure the impact of the phased abolition of prescription co-payments in Wales. We investigated 3 study periods covering the phased abolition: from £6 to £4, £4 to £3, and £3 to £0. A difference-in-difference modelling was adopted and applied to monthly UK general practice level dispensing data on 14 selected medicines which had the highest percentage of items dispensed subject to a co-payment prior to abolition. Dispensing from a comparator region (North East of England) with similar health and socio-economic characteristics to Wales, and where prescription co-payments continued during the study periods, was used to isolate any non-price effects on dispensing in Wales. Results show a small increase in dispensing of 14 selected medicines versus the comparator. Compared with NE England, monthly average Welsh dispensing was increased by 11.93 items (7.67%; 95% CI [7.2%, 8.1%]), 6.37 items (3.38%; 95% CI [2.9%, 3.7%]) and 9.18 items (4.54%; 95% CI [4.2%, 4.9%]) per practice per 1,000 population during the periods when co-payment was reduced. Price elasticities of the selected medicines utilisation were -0.23, -0.13, and -0.04 in 3 analyses, suggesting the abolition of co-payment had small effect on Welsh dispensing.

Is Health Care Infected by Baumol's Cost Disease? Test of a New Model

ATANDA A., *et al.*

2018

Health Economics: 27(5) : 832-849.

Rising health care costs are a policy concern across the Organisation for Economic Co-operation and Development, and relatively little consensus exists concerning their causes. One explanation that has received revived attention is Baumol's cost disease (BCD). However, developing a theoretically appropriate test of BCD has been a challenge. In this paper, we construct a 2-sector model firmly based on Baumol's axioms. We then derive several testable propositions. In particular, the model predicts that (a) the share of total labor employed in the health care sector and (b) the relative price index of the health and non-health care sectors should both be positively related to economy-wide productivity. The model also predicts that (c) the share of labor in the health sector will be negatively related and (d) the ratio of prices in the health and non-health sectors unrelated, to the demand for non-health services. Using annual data from 28 Organisation for Economic Co-operation and Development countries over the years 1995-2016 and from 14 U.S. industry groups over the years 1947-2015, we find little evidence to support the predictions of BCD once we address spurious correlation due to coincident trending and other econometric issues.

How Does Retirement Affect Healthcare Expenditures? Evidence from a Change in the Retirement Age

BIRO A. ET ELEK P.

2018

Health Economics : 27(5) : 808-818..

Using individual-level administrative panel data from Hungary, we estimate causal effects of retirement on outpatient and inpatient care expenditures and pharmaceutical expenditures. Our identification strategy is based on an increase in the official early retirement age of women, using that the majority of women retire upon reaching that age. According to our descriptive results, people who are working before the early retirement age have substantially lower healthcare expenditures than nonworkers, but the expenditure gap declines after retirement. Our causal estimates from a two-part (hurdle) model show that the shares of women with positive outpatient care, inpatient care, and pharmaceutical expenditures, respectively, decrease by 3.0, 1.4, and 1.3 percentage points in the short run due to retirement. These results are driven by the relatively healthy, by those who spent some time on sick leave and by the less educated. The effect of retirement on the size of positive healthcare expenditures is generally not significant.

Ageing and Healthcare Expenditures: Exploring the Role of Individual Health Status

CARRERAS M., *et al.*

2018

Health Economics : 27(5) : 865-876.

In 1999, Zweifel, Felder, and Meiers questioned conventional wisdom on ageing and healthcare expenditure (HCE). According to these authors, the positive association between age and HCE is due to an increasing age-specific mortality and the high cost of dying. After a weighty academic debate, a new consensus was reached on the importance of proximity to death when analysing HCE. Nevertheless, the influence of individual health status remains unknown. The objective of our study is to analyse the influence individual health status has on HCE, when compared to proximity to death and demographic effects and considering a comprehensive view of healthcare services and costs. We examined data concerning different HCE components of N = 61,473 persons aged 30 to 95 years old. Using 2-part models, we analysed the probability of use and positive HCE. Regardless of the specific group of healthcare services, HCE at the end of life depends mainly on the individual health status. Proximity to death approximates individual morbidity when it is excluded from the model. The inclusion of morbidity generally improves the goodness of fit. These results provide implications for the analysis of ageing population and its impact on HCE that should be taken into account.

National Health Expenditure Projections, 2017-26: Despite Uncertainty, Fundamentals Primarily Drive Spending Growth

CUCKLER G. A., *et al.*

2018

Health Aff (Millwood): 37(3) : 482-492.

Under current law, national health spending is projected to grow 5.5 percent annually on average in 2017-26 and to represent 19.7 percent of the economy in 2026. Projected national health spending and enrollment growth over the next decade is largely driven by fundamental economic and demographic factors: changes in projected income growth, increases in prices for medical goods and services, and enrollment shifts from private health insurance to Medicare that are related to the aging of the population. The recent enactment of tax legislation that eliminated the individual mandate is expected to result in only a small reduction to insurance coverage trends.

The Economic Burden of Diabetes to French National Health Insurance: A New Cost-Of-Illness Method Based on a Combined Medicalized and Incremental Approach

DE LAGASNERIE G., *et al.*

2018

Eur J Health Econ 19(2): 189-201.

A better understanding of the economic burden of diabetes constitutes a major public health challenge in order to design new ways to curb diabetes health care expenditure. The aim of this study was to develop a new cost-of-illness method in order to assess the specific and nonspecific costs of diabetes from a public payer perspective. Using medical and administrative data from the major French national health insurance system covering about 59 million individuals in 2012, we identified people with diabetes and then estimated the economic burden of diabetes. Various methods were used: (a) global cost of patients with diabetes, (b) cost of treatment directly related to diabetes (i.e., 'medicalized approach'), (c) incremental regression-based approach, (d) incremental matched-control approach, and (e) a novel combination of the 'medicalized approach' and the 'incremental matched-control' approach. We identified 3 million individuals with diabetes (5% of the population). The total expenditure of this population amounted to €19 billion, representing 15% of total expenditure reimbursed to the entire population. Of the total expenditure, €10 billion (52%) was considered to be attributable to diabetes care: €2.3 billion (23% of €10 billion) was directly attributable, and €7.7 billion was attributable to additional reimbursed expenditure indirectly related to diabetes (77%). Inpatient care represented the major part of the expenditure attributable to diabetes care (22%) together with drugs (20%) and medical auxiliaries (15%). Antidiabetic drugs represented an expenditure of about €1.1 billion, accounting for 49% of all diabetes-specific expenditure. This study shows the economic impact of the assumption concerning definition of costs on evaluation of the economic burden of diabetes. The proposed new cost-of-illness method provides specific insight for policy-makers to enhance

diabetes management and assess the opportunity costs of diabetes complications' management programs.

Frailty and Healthcare Costs-Longitudinal Results of a Prospective Cohort Study

HAJEK A., *et al.*

2018

Age Ageing 47(2): 233-241.

The aim of this study is to investigate how frailty and frailty symptoms affect healthcare costs in older age longitudinally. Data were gathered from a prospective cohort study in Saarland, Germany (two waves with 3-year interval, n = 1,636 aged 57-84 years at baseline). Frailty was assessed by the five Fried frailty criteria. Frailty was defined as having at least three criteria, the presence of 1-2 criteria as 'pre-frail'. Healthcare costs were quantified based on self-reported healthcare use in the sectors of inpatient treatment, outpatient treatment, professional nursing care and informal care as well as the provision of pharmaceuticals, medical supplies and dental prostheses. While the onset of pre-frailty did not increase (log) total healthcare costs after adjusting for potential confounders including comorbidity, progression from non-frailty to frailty was associated with an increase in total healthcare costs (for example, costs increased by ~54 and 101% if 3 and 4 or 5 symptoms were present, respectively). This association of frailty onset with increased healthcare costs was in particular observed in the inpatient sector and for informal nursing care. Among the frailty symptoms, the onset of exhaustion was associated with an increase in total healthcare costs, whereas changes in slowness, weakness, weight loss and low-physical activity were not significantly associated with an increase in total healthcare costs. Our data stress the economic relevance of frailty in late life. Postponing or reducing frailty might be fruitful in order to reduce healthcare costs.

Modeling Health Care Spending Growth of Older Adults

HATFIELD L. A., *et al.*

2018

Health Serv Res 53(1): 138-155.

This paper aims to forecast out-of-pocket health care spending among older adults. Long-term forecasts allow policy makers to explore potential impacts of policy scenarios, but existing microsimulations do not incorporate details of supplemental insurance coverage and income effects on health care spending. Data sources are based on dynamic microsimulation calibrated to survey and administrative data. We augment Urban Institute's Dynamic Simulation of Income Model (DYNASIM) with modules that incorporate demand responses and economic equilibria, with dynamics driven by exogenous technological change. A lengthy technical appendix provides details of the microsimulation model and economic assumptions for readers interested in applying these techniques. The model projects total out-of-pocket spending (point of care plus premiums) as a share of income for adults aged 65 and older. People with lower incomes and poor health fare worse, despite protections of Medicaid. Spending rises 40 percent from 2012 to 2035 (from 10 to 14 percent of income) for the median beneficiary, but it increases from 5 to 25 percent of income for low-income beneficiaries and from 23 to 29 percent for the near poor who are in fair/poor health. Despite Medicare coverage, near-poor seniors will face out-of-pocket spending that would render them, in practical terms, underinsured.

Impact of Bundled Payments on Hip Fracture Outcomes: A Nationwide Population-Based Study

TUNG Y. C., *et al.*

2017

Int J Qual Health Care: 30 (1) : 23-31

Establishing one price for all bundled services for a particular illness, which has become the key to health-care reform efforts, is designed to encourage health professionals to coordinate their care for patients. Limited information is available, however, concerning whether bundled payments are associated with changes in patient outcomes. Nationwide longitudinal population-based data were used to examine the effect of bundled payments on hip fracture outcomes. The study is founded on an interrupted time series design with a comparison group, provided by a General acute care hospitals throughout Taiwan. A total of 178 586 hip fracture patients admitted over the period 2007-12 identified from the Taiwan's National Health Insurance Research Database. Bundled payments for hip fractures were implemented in Taiwan in January 2010. The 30-day unplanned readmission and postdischarge

mortality. Segmented generalized estimating equation regression models were used after adjustment for trends, patient, physician and hospital characteristics to assess the effect of bundled payments on 30-day outcomes for hip fracture compared with a reference condition. The 30-day unplanned readmission rate for hip fracture showed a relative decreasing trend after the implementation of bundled payments compared with the trend before the implementation relative to that of the reference condition. This finding might imply that the implementation of bundled payments encourages health professionals to coordinate their care, leading to reduced readmission for hip fracture.

A Systematic Review of Cost-Of-Illness Studies of Multimorbidity

WANG L., *et al.*

2018

Applied Health Economics and Health Policy 16(1): 15-29.

The economic burden of multimorbidity is considerable. This review analyzed the methods of cost-of-illness (COI) studies and summarized the economic outcomes of multimorbidity. A systematic review (2000–2016) was performed, which was registered with Prospero, reported according to PRISMA, and used a quality checklist adapted for COI studies. The inclusion criteria were peer-reviewed COI studies on multimorbidity, whereas the exclusion criterion was studies focusing on an index disease. Extracted data included the definition, measure, and prevalence of multimorbidity; the number of included health conditions; the age of study population; the variables used in the COI methodology; the percentage of multimorbidity vs. total costs; and the average costs per capita. Among the 26 included articles, 14 defined multimorbidity as a simple count of 2 or more conditions. Methodologies used to derive the costs were markedly different. Given different healthcare systems, OOP payments of multimorbidity varied across countries. In the 17 and 12 studies with cut-offs of = 2 and = 3 conditions, respectively, the ratios of multimorbidity to non-multimorbidity costs ranged from 2–16 to 2–10. Among the ten studies that provided cost breakdowns, studies with and without a societal perspective attributed the largest percentage of multimorbidity costs to social care and inpatient care/medicine, respectively. Multimorbidity was associated with considerable economic burden. Synthesising the cost of multimorbidity was challenging due to multiple definitions of multimorbidity and heterogeneity in COI methods. Count method was most popular to define multimorbidity. There is consistent evidence that multimorbidity was associated with higher costs.

Geography of Health

Is There a 'Pig Cycle' in the Labour Supply of Doctors? How Training and Immigration Policies Respond to Physician Shortages

CHOJNICKI X. ET MOULLAN Y.

2018

Soc Sci Med 200: 227-237.

Many OECD countries are faced with the considerable challenge of a physician shortage. This paper investigates the strategies that OECD governments adopt and determines whether these policies effectively address these medical shortages. Due to the amount of time medical training requires, it takes longer for an expansion in medical school capacity to have an effect than the recruitment of foreign-trained physicians. Using data obtained from the OECD (2014) and Bhargava et al. (2011), we constructed a unique country-level panel dataset that includes annual data for 17 OECD countries on physician shortages, the number of medical school graduates and immigration and emigration rates from 1991 to 2004. By calculating panel fixed-effect estimates, we find that after a period of medical shortages, OECD governments produce more medical graduates in the long run but in the short term, they primarily recruit from abroad; however, at the same time, certain practising physicians choose to emigrate. Simulation results show the limits of recruiting only abroad in the long term but also highlight its appropriateness for the short term when there is a recurrent cycle of shortages/surpluses in the labour supply of physicians (pig cycle theory).

Disability

Death, Depression, Disability and Dementia Associated with Self-Reported Hearing Problems: A 25-Year Study

AMIEVA H., *et al.*

2018

J Gerontol A Biol Sci Med Sci. Ahead of print.

Hearing loss in older adults is suspected to play a role in social isolation, depression, disability, lower quality of life and risk of dementia. Such suspected associations still need to be consolidated with additional research. With a particularly long follow-up, this study assessed the relationship between hearing status and four major adverse health events: death, dementia, depression, and disability. Prospective community-based study of 3777 subjects aged ≥ 65 followed-up for 25 years. At baseline, 1289 reported hearing problems and 2290 reported no trouble. The risk of occurrence of the negative outcomes, i.e. death, dementia, depressive symptoms, disability in activities of daily living (ADL) and instrumental ADL (IADL), was assessed with Cox proportional hazards models. Results: Adjusting for numerous confounders, an increased risk of disability and dementia was found for participants reporting hearing problems. An increased risk of depression was found in men reporting hearing problems. In additional exploratory analyses, such associations were not found in those participants using hearing aids. Mortality was not associated with self-reported hearing loss. Our study confirms the strong link between hearing status and the risk of disability, dementia and depression. These results highlight the importance of assessing the consequences of treating hearing loss in elders in further studies.

Hospitals

Groupements hospitaliers de territoire : l'ouverture de la médecine de ville

VIGNERON E.

2017/12

Gestions hospitalières (571): 609-611.

Cet article aborde le rapprochement du groupement hospitalier de territoire avec d'autres secteurs : établissements hospitaliers privés, médico-sociaux, tout particulièrement EHPAD publics et établissements et services médico-sociaux publics pour personnes en situation de handicap et médecine de ville.

Un cas typique d'exécration de soi sous emprise : ou quand la T2A fait s'entretuer les établissements du service public

VIGNERON E.

2017/12

Gestions hospitalières (571): 594-601.

La question d'une autorisation d'angioplastie coronaire à Chalon-sur-Saône est ici analysée sous la forme d'un cas clinique d'organisation sanitaire. La description de ce cas met en lumière l'effet pathogène d'une pensée dominante sur le service public hospitalier. L'auteur propose ensuite une discussion physiopathologique et thérapeutique.

La responsabilité populationnelle à l'hôpital

DOGIMONT R.

Gestions hospitalières (571) : 615-618.

Face à la désertification médicale, au renoncement aux soins pour raisons financières, de mobilité et de délai, aux relations parfois complexes avec la médecine de ville, l'hôpital doit-il rester dans ses murs ? Comment peut-il travailler différemment avec la ville pour fluidifier les parcours de santé ? Peut-il jouer un rôle majeur dans la réduction des inégalités sociales et territoriales à travers la prévention ? L'auteur, directeur du centre hospitalier de Douai, rapport ici la démarche « hors les murs » de son établissement.

▶ Un an après, les facteurs de réussite des GHT

DURAND R.

2017/12

Gestions hospitalières (571): 638-645.

Alors que les groupements hospitaliers de territoire (GHT) ont soufflé leur première bougie et, pour la plupart, porté à leur convention constitutive un projet médical partagé (DMP) et un projet de soins partagé (PSP), la chaire Management des établissements de santé de l'EHESP livre ici une synthèse des exemples et réponses échangés entre professionnels et chercheurs autour de questions managériales prégnantes.

▶ Competition and Quality Indicators in the Health Care Sector: Empirical Evidence from the Dutch Hospital Sector

CROES R. R., *et al.*

2018

Eur J Health Econ 19(1): 5-19.

There is much debate about the effect of competition in healthcare and especially the effect of competition on the quality of healthcare, although empirical evidence on this subject is mixed. The Netherlands provides an interesting case in this debate. The Dutch system could be characterized as a system involving managed competition and mandatory healthcare insurance. Information about the quality of care provided by hospitals has been publicly available since 2008. In this paper, we evaluate the relationship between quality scores for three diagnosis groups and the market power indicators of hospitals. We estimate the impact of competition on quality in an environment of liberalized pricing. For this research, we used unique price and production data relating to three diagnosis groups (cataract, adenoid and tonsils, bladder tumor) produced by Dutch hospitals in the period 2008-2011. We also used the quality indicators relating to these diagnosis groups. We reveal a negative relationship between market share and quality score for two of the three diagnosis groups studied, meaning that hospitals in competitive markets have better quality scores than those in concentrated markets. We therefore conclude that more competition is associated with higher quality scores.

▶ Practice Variation in the Dutch Long-Term Care and the Role of Supply-Sensitive Care: Is Access to the Dutch Long-Term Care Equitable?

DUELL D., *et al.*

2017

Health Econ 26(12): 1728-1742.

Universal access and generous coverage are important goals of the Dutch long-term care (LTC) system. It is a legal requirement that everyone eligible for LTC should be able to receive it. Institutional care (IC) made up for 90% of Dutch LTC spending. To investigate whether access to IC is as equitable as the Dutch government aspires, we explored practice variation in entitlements to IC across Dutch regions. We used a unique dataset that included all individual applications for Dutch LTC in January 2010-December 2013 (N = 3,373,358). This dataset enabled an accurate identification of the need for care. We examined the local variation in the probability of being granted long-term IC and in the intensity of the care granted given that individuals have applied for LTC. We also investigated whether the variation observed was related to differences in the local availability of care facilities. Although our analyses indicated the presence of some practice variation, its magnitude was very small by national and international standards (up to 3%). Only a minor part of the practice variation could be accounted for by local supply differences in care facilities. Overall, we conclude that, unlike many other developed countries, the Dutch system ensured equitable access to long-term IC.

▶ Impact of Health System Affiliation on Hospital Resource Use Intensity and Quality of Care

HENKE R. M., *et al.*

2018

Health Serv Res 53(1): 63-86.

The aims of this study are to assess the impact of hospital affiliation, centralization, and managed care plan ownership on inpatient cost and quality. Inpatient discharges are analysed from 3,957 community hospitals in 44 states and American Hospital Association Annual Survey data from 2010 to 2012. We conducted a retrospective longitudinal regression analysis using hierarchical modeling of discharges clustered within hospitals. Detailed discharge data including costs, length of stay, and patient characteristics from the

Healthcare Cost and Utilization Project State Inpatient Databases were merged with hospital survey data from the American Hospital Association. We conclude that increasing prevalence of health systems and hospital managed care ownership may lead to higher quality but are unlikely to reduce hospital discharge costs. Encouraging participation in innovative payment and delivery reform models, such as accountable care organizations, may be more powerful options.

The Ambiguous Effect of GP Competition: The Case of Hospital Admissions

ISLAM M. K. ET KJERSTAD E.

2017

Health Econ 26(12): 1483-1504.

In the theoretical literature on general practitioner (GP) behaviour, one prediction is that intensified competition induces GPs to provide more services resulting in fewer hospital admissions. This potential substitution effect has drawn political attention in countries looking for measures to reduce the growth in demand for hospital care. However, intensified competition may induce GPs to secure hospital admissions a signal to attract new patients and to keep the already enlisted ones satisfied, resulting in higher admission rates at hospitals. Using both static and dynamic panel data models, we aim to enhance the understanding of whether such relations are causal. Results based on ordinary least square (OLS) models indicate that aggregate inpatient admissions are negatively associated with intensified competition both in the full sample and for the sub-sample patients aged 45 to 69, while outpatient admissions are positively associated. Fixed-effect estimations do not confirm these results though. However, estimations of dynamic models show significant negative (positive) effects of GP competition on aggregate inpatient (outpatient) admissions in the full sample and negative effects on aggregate inpatient admissions and emergency admissions for the sub-sample. Thus, intensified GP competition may reduce inpatient hospital admissions by inducing GPs to provide more services, whereas, the alternative hypothesis seems valid for outpatient admissions.

Association Between Medicare's Mandatory Hospital Value-Based Purchasing Program and Cost Inefficiency

IZÓN G. ET PARDINI C.

2018

Applied Health Economics and Health Policy 16(1): 79-90.

The Patient Protection and Affordable Care Act instituted pay-for-performance programs, including Hospital Value-Based Purchasing (HVBP), designed to encourage hospital quality and efficiency. While these programs have been evaluated with respect to their implications for care quality and financial viability, this is the first study to assess the relationship between hospitals' cost inefficiency and their participation in the programs. We estimate a translog specification of a stochastic cost frontier with controls for participation in the HVBP program and clinical and outcome quality for California hospitals for 2012–2015. The program-participation indicators' parameters imply that participants were more cost inefficient than their peers. Further, the estimated coefficients for summary process of care quality indexes for three health conditions (acute myocardial infarction, pneumonia, and heart failure) suggest that higher quality scores are associated with increased operating costs. The estimated coefficients for the outcome quality variables suggest that future determination of HVBP payment adjustments, which will depend solely on mortality rates as measures of clinical care quality, may not only be aligned with increasing healthcare quality but also reducing healthcare costs.

Hospital Policy and Productivity - Evidence from German States

KARMANN A. ET ROESEL F.

2017

Health Econ 26(12): 1548-1565.

Total factor productivity (TFP) growth allows for additional healthcare services under restricted resources. We examine whether hospital policy can stimulate hospital TFP growth. We exploit variation across German federal states in the period 1993-2013. State governments decide on hospital capacity planning (number of hospitals, departments, and beds), ownership, medical students, and hospital investment funding. We show that TFP growth in German hospital care reflects quality improvements rather than increases in output

volumes. Second-stage regression results indicate that reducing the length of stay is generally a proper way to foster TFP growth. The effects of other hospital policies depend on the reimbursement scheme: Under activity-based (German Diagnosis-related Group) hospital funding, scope-related policies (privatization and specialization) come with TFP growth. Under fixed daily rate funding, scale matters to TFP (hospital size and occupancy rates). Differences in capitalization in East and West Germany allow to show that deepening capital may enhance TFP growth if capital is scarce. We also show that there is less scope for hospital policies after large-scale restructurings of the hospital sector.

Improving Patient Safety for Older People in Acute Admissions: Implementation of the Frailsafe Checklist in 12 Hospitals Across the UK

PAPOUTSI C., *et al.*

2018

Age Ageing 47(2): 311-317.

Checklists are increasingly proposed as a means to enhance safety and quality of care. However, their use has been met with variable levels of success. The Frailsafe project focused on introducing a checklist with the aim to increase completion of key clinical assessments and to facilitate communication for the care of older patients in acute admissions. The aim of this study is to examine the use of the Frailsafe checklist, including potential to contribute to improved safety, quality and reliability of care. 110 qualitative interviews and group discussions with healthcare professionals and other specialties, 172 h of ethnographic observation in 12 UK hospitals and reporting of high-level process data (completion of checklist and relevant frailty assessments). Qualitative analysis followed a thematic and theory-driven approach. Through use of the checklist, hospital teams identified limitations in their existing assessments (e.g. absence of delirium protocols) and practices (e.g. unnecessary catheter use). This contributed to hospitals reporting just 24.0% of sampled patients as having received all clinical assessments across key domains for this population for the duration of the project (1,687/7,021 checklists as fully completed). Staff perceptions and experiences of using the checklist varied significantly, primarily driven by the extent to which the aims of this quality improvement project aligned with local service priorities and pre-existing team communications styles. The Frailsafe checklist highlighted limitations with frailty assessment in acute care and motivated teams to review routine practices. Further work is needed to understand whether and how checklists can be embedded in complex, multidisciplinary care.

Burn out des médecins et autres praticiens hospitaliers

SHADILI G., *et al.*

2018

Information Psychiatrique (L') 94(4).

http://www.jle.com/fr/revues/ipe/e-docs/burn_out_des_medecins_et_autres_praticiens_hospitaliers_311271/article.phtml

Le « burn-out », ou syndrome d'épuisement au travail, est très controversé. Il concerne dans une large mesure les professionnels de santé et notamment les médecins. Il est mésestimé, source de dépression, de suicide, de conduites addictives et d'insatisfaction professionnelle. Le taux de burn-out des médecins français serait compris entre 38 % et 52 % et près d'un quart des médecins (23 %) ne chercheraient pas d'aide s'ils se trouvaient en situation de souffrance psychologique et plus de la moitié (54 %) ne sauraient pas vers qui se tourner. De fait, la France a donc un certain retard dans la prise en charge de ce fléau même si certains proposent qu'il soit reconnu comme maladie professionnelle. Cet article a pour objet d'en définir la clinique et de faire une liste non exhaustive des moyens de préventions et d'accompagnement.

Care Pathways and Healthcare Use of Stroke Survivors Six Months After Admission to an Acute-Care Hospital in France in 2012

TUPPIN P., *et al.*

2016

Rev Neurol (Paris) 172(4-5): 295-306.

Care pathways and healthcare management are not well described for patients hospitalized for stroke. Among the 51 million beneficiaries of the French national health insurance general scheme (77% of the French population), patients hospitalized for a first stroke in 2012 and still alive six months after discharge were included using data from the national health insurance information system (Sniiram). Patient

characteristics were described by discharge destination-home or rehabilitation center (for < 3 months)- and were followed during their first three months back home. A total of 61,055 patients had a first admission to a public or private hospital for stroke (mean age; 72 years, 52% female), 13% died during their stay and 37% were admitted to a stroke management unit. Overall, 40,981 patients were still alive at six months: 33% of them were admitted to a rehabilitation center (mean age: 73 years) and 54% were discharged directly to their home (mean age 67 years). For each group, 45 and 62% had been previously admitted to a stroke unit. Patients discharged to rehabilitation centers had more often comorbidities, 39% were highly physically dependent and 44% were managed in specialized neurology centers. For patients with a cerebral infarction who were directly discharged to their home 76% received at least one antihypertensive drug, 96% an antithrombotic drug and 76% a lipid-lowering drug during the following month. For those with a cerebral hemorrhage, these frequencies were respectively 46, 33 and 28%. For those admitted to a rehabilitation center, more than half had at least one visit with a physiotherapist or a nurse, 15% a speech therapist, 10% a neurologist or a cardiologist and 15% a psychiatrist during the following three months back home (average numbers of visits for those with at least one visit: 23 for physiotherapists and 100 for nurses). Patients who returned directly back home had fewer physiotherapist (30%) or nurse (47%) visits but more medical consultations. The 3-month re-hospitalization rate for patients who were discharged directly to their home was 23% for those who had been admitted to a stroke unit and 25% for the others. In rehabilitation centers, this rate was 10% for patients who stayed < 3 months. These results illustrate the value of administrative databases to study stroke management, care pathways and ambulatory care. These data should be used to improve care pathways, organization, discharge planning and treatments.

Health Inequalities

▶ A "Healthy Immigrant Effect" or a "Sick Immigrant Effect"? Selection and Policies Matter

CONSTANT A. F., *et al.*

2018

Eur J Health Econ 19(1): 103-121.

Previous literature on a variety of countries has documented a "healthy immigrant effect" (HIE). Accordingly, immigrants arriving in the host country are, on average, healthier than comparable natives. However, their health status dissipates with additional years in the country. HIE is explained through the positive self-selection of healthy immigrants as well as the positive selection, screening and discrimination applied by host countries. In this article we study the health trajectories of immigrants within the context of selection and migration policies. Using SHARE data we examine the HIE, comparing Israel and 16 European countries that have fundamentally different migration policies. Israel has virtually unrestricted open gates for Jewish people around the world, who in turn have ideological rather than economic considerations to move. European countries have selective policies with regards to the health, education and wealth of migrants, who also self-select themselves. Our results provide evidence that (1) immigrants who move to Israel have compromised health and are significantly less healthy than comparable natives. Their health disadvantage persists for up to 20 years of living in Israel, after which they become similar to natives; (2) immigrants who move to Europe have significantly better health than comparable natives. Their health advantage remains positive for many years. Even though during some time lapses they are not significantly different from natives, their health status never becomes worse than that of natives. Our results are important for migration policy and relevant for domestic health policy.

▶ International Migrants' Use of Emergency Departments in Europe Compared with Non-Migrants' Use: A Systematic Review

CREDÉ S. H., *et al.*

2018

European Journal of Public Health 28(1): 61-73.

http://dx.doi.org/10.1093/eurpub/ckx057

International migration across Europe is increasing. High rates of net migration may be expected to increase pressure on healthcare services, including emergency services. However, the extent to which immigration creates additional pressure on emergency departments (EDs) is widely debated. This review synthesizes the evidence relating to international migrants' use of EDs in European Economic Area (EEA) countries as compared with that of non-migrants. MEDLINE, EMBASE, CINAHL, The Cochrane Library and The Web of Science were searched for the years 2000–16. Studies reporting on ED service utilization by international immigrants, as compared with non-migrants, were eligible for inclusion. Twenty-two articles (from six host countries) were included. Thirteen of 18 articles reported higher volume of ED service use by immigrants, or some immigrant sub-groups. Migrants were seen to be significantly more likely to present to the ED during unsocial hours and more likely than non-migrants to use the ED for low-acuity presentations. Differences in presenting conditions were seen in 4/7 articles; notably a higher rate of obstetric and gynaecology presentations among migrant women. Conclusions: The principal finding of this review is that migrants utilize the ED more, and differently, to the native populations in EEA countries. The higher use of the ED for low-acuity presentations and the use of the ED during unsocial hours suggest that barriers to primary healthcare may be driving the higher use of these emergency services although further research is needed.

Association Between Cultural Distance and Migrant Self-Rated Health

DETOLLENAERE J., *et al.*

2018

Eur J Health Econ 19(2): 257-266.

We study whether migrant health in Europe is associated with the cultural distance between their host country and country of origin. To this end, we run multilevel regression models on data merging self-rated health and social background of ≥ 3800 migrants from the European Social Survey with an index of cultural distance based on country differences in values, norms and attitudes measured in the World Values Survey. We find that higher levels of cultural distance are associated with worse migrant health. This association is comparable in size with the negative association between health and female (compared with male) gender but less important than the association between health and education level. In addition, this association is less significant among second-generation than first-generation migrants.

Migrant Women Living with HIV in Europe: Are They Facing Inequalities in the Prevention of Mother-To-Child-Transmission of HIV? The European Pregnancy and Paediatric HIV Cohort Collaboration (EPPICC) Study Group in Eurocoord

FAVARATO G., *et al.*

2018

European Journal of Public Health 28(1): 55-60.

In pregnancy early interventions are recommended for prevention of mother-to-child-transmission (PMTCT) of HIV. We examined whether pregnant women who live with HIV in Europe and are migrants encounter barriers in accessing HIV testing and care. Four cohorts within the European Pregnancy and Paediatric HIV Cohort Collaboration provided data for pooled analysis of 11 795 pregnant women who delivered in 2002–12 across ten European countries. We defined a migrant as a woman delivering in a country different from her country of birth and grouped the countries into seven world regions. We compared three suboptimal PMTCT interventions (HIV diagnosis in late pregnancy in women undiagnosed at conception, late anti-retroviral therapy (ART) start in women diagnosed but untreated at conception and detectable viral load (VL) at delivery in women on antenatal ART) in native and migrant women using multivariable logistic regression models. We can conclude that migrant women were more likely to be diagnosed in late pregnancy but once on ART virological response was good. Good access to antenatal care enables the implementation of PMTCT protocols and optimises both maternal and children health outcomes generally.

Gypsy, Roma and Traveller Access to and Engagement with Health Services: A Systematic Review

MCFADDEN A., *et al.*

2018

European Journal of Public Health 28(1): 74-81.

Gypsy, Roma and Traveller people represent the most disadvantaged minority groups in Europe, having the poorest health outcomes. This systematic review addressed the question of how Gypsy, Roma and Traveller people access healthcare and what are the best ways to enhance their engagement with health services. Searches were conducted in 21 electronic databases complemented by a focussed Google search. Studies were included if they had sufficient focus on Gypsy, Roma or Traveller populations; reported data pertinent to healthcare service use or engagement and were published in English from 2000 to 2015. Study findings were analyzed thematically and a narrative synthesis reported. This review provides evidence that Gypsy, Roma and Traveller populations across Europe struggle to exercise their right to healthcare on account of multiple barriers; and related to other determinants of disadvantage such as low literacy levels and experiences of discrimination. Some promising strategies to overcome barriers were reported but the evidence is weak; therefore, rigorous evaluations of interventions to improve access to and engagement with health services for Gypsy, Roma and Traveller people are needed.

Adapting Primary Care for New Migrants: A Formative Assessment

SUCH E., *et al.*

2017

BJGP Open.

http://bjgpopen.org/content/bjgpoa/early/2017/01/10/bjgpopen17X100701.full.pdf

Immigration rates have increased recently in the UK. Migrant patients may have particular needs that are inadequately met by existing primary care provision. In the absence of national guidance, local adaptations are emerging in response to these new demands. This aim of this study is to formatively assess the primary care services offered to new migrants and the ways in which practitioners and practices are adapting to meet need. Online survey and case studies of current practice across primary care were conducted in the UK. Case studies were selected from mainstream and specialist general practice as well as primary care provision in the third sector. Survey results indicated that practitioners focused on working with communities and external agencies and adapting processes of, for example, screening, vaccination, and health checks. Lack of funding was cited most frequently as a barrier to service development (n = 51; 73%). Case studies highlighted the prominence partnership working and of an organisational and practitioner focus on equitable care. Adaptations centred on addressing wider social determinants, trauma, and violence, and additional individual needs; and on delivering culturally-competent care. Despite significant resource constraints, some primary care services are adapting to the needs of new migrants. Many adapted approaches can be characterised as equity-oriented.

Population Health and the Economy: Mortality and the Great Recession in Europe

TAPIA GRANADOS J. A. ET IONIDES E. L.

2017

Health Econ 26(12): e219-e235.

We analyze the evolution of mortality-based health indicators in 27 European countries before and after the start of the Great Recession. We find that in the countries where the crisis has been particularly severe, mortality reductions in 2007-2010 were considerably bigger than in 2004-2007. Panel models adjusted for space-invariant and time-invariant factors show that an increase of 1 percentage point in the national unemployment rate is associated with a reduction of 0.5% ($p < .001$) in the rate of age-adjusted mortality. The pattern of mortality oscillating procyclically is found for total and sex-specific mortality, cause-specific mortality due to major causes of death, and mortality for ages 30-44 and 75 and over, but not for ages 0-14. Suicides appear increasing when the economy decelerates-countercyclically-but the evidence is weak. Results are robust to using different weights in the regression, applying nonlinear methods for detrending, expanding the sample, and using as business cycle indicator gross domestic product per capita or employment-to-population ratios rather than the unemployment rate. We conclude that in the European experience of the past 20 years, recessions, on average, have beneficial short-term effects on mortality of the adult population.

Primary Care for Refugees and Newly Arrived Migrants in Europe: A Qualitative Study on Health Needs, Barriers and Wishes

VAN LOENEN T., *et al.*

2018

European Journal of Public Health 28(1): 82-87.

In order to provide effective primary care for refugees and to develop interventions tailored to them, we must know their needs. Little is known of the health needs and experiences of recently arrived refugees and other migrants throughout their journey through Europe. We aimed to gain insight into their health needs, barriers in access and wishes regarding primary health care. In the spring of 2016, we conducted a qualitative, comparative case study in seven EU countries in a centre of first arrival, two transit centres, two intermediate-stay centres and two longer-stay centres using a Participatory Learning and Action research methodology. A total of 98 refugees and 25 healthcare workers participated in 43 sessions. Transcripts and sessions reports were coded and thematically analyzed by local researchers using the same format at all sites; data were synthesized and further analyzed by two other researchers independently. Results: The main health problems of the participants related to war and to their harsh journey like common infections and psychological distress. They encountered important barriers in accessing healthcare: time pressure, linguistic and cultural differences and lack of continuity of care. They wish for compassionate, culturally sensitive healthcare workers and for more information on procedures and health promotion. Conclusion: Health of refugees on the move in Europe is jeopardized by their bad living circumstances and barriers in access to healthcare. To address their needs, healthcare workers have to be trained in providing integrated, compassionate and cultural competent healthcare.

Pharmaceuticals

Un médecin est-il libre de ne pas prescrire un traitement ?

CARTRON D.

2017

Médecine : de la Médecine Factuelle à nos Pratiques 13(10): 466-.

Désormais, il n'est plus rare qu'un patient, adepte de l'internet, vienne consulter son médecin avec le diagnostic et le traitement retrouvés dans ses recherches. Le médecin reste-t-il néanmoins autonome dans sa prescription ?

Diffusion of Innovations Theory, Principles, and Practice

DEARING J. W. ET COX J. G.

2018

Health Aff (Millwood) 37(2): 183-190.

Aspects of the research and practice paradigm known as the diffusion of innovations are applicable to the complex context of health care, for both explanatory and interventionist purposes. This article answers the question, "What is diffusion?" by identifying the parameters of diffusion processes: what they are, how they operate, and why worthy innovations in health care do not spread more rapidly. We clarify how the diffusion of innovations is related to processes of dissemination and implementation, sustainability, improvement activity, and scale-up, and we suggest the diffusion principles that can be readily used in the design of interventions.

Les facteurs influençant la prescription de benzodiazépines hypnotiques pour insomnie chez la personne âgée

STILLMUNKES A., *et al.*

2017

Médecine : De la Médecine Factuelle à nos Pratiques 13(10): 474-479.

En France, les benzodiazépines hypnotiques sont prescrites à 90,5 % par les médecins généralistes. L'objectif de cette étude était de déterminer les facteurs influençant la prescription de benzodiazépines hypnotiques dans l'insomnie transitoire ou chronique chez la per-

sonne de plus de 65 ans non démente en France. Une étude transversale, descriptive, a été basée sur un scénario clinique. Celui-ci a été envoyé aux médecins généralistes du bassin de santé du Lauragais, en Occitanie (France), entre avril et mai 2015. Cinq facteurs modifiaient significativement la prescription des benzodiazépines hypnotiques : l'âge et le sexe du médecin, la réalisation par le praticien lui-même de la prise en charge non médicamenteuse, l'existence de correspondants pour les troubles du sommeil, l'anticipation du sevrage. Des études complémentaires seraient nécessaires pour mieux expliquer ces différents facteurs.

Methodolody - Statistics

Testing the Impact of Mixed-Mode Designs (Mail and Web) and Multiple Contact Attempts Within Mode (Mail or Web) on Clinician Survey Response

BEEBE T. J., *et al.*

2018

Health Serv Res. Ahead of print.

The aim of this study is to compare response rate and nonresponse bias across two mixed-mode survey designs and two single-mode designs. This experiment was embedded in a clinician survey of knowledge and attitudes regarding HPV vaccination (n = 275). Clinicians were randomly assigned one of two mixed-mode (mail/web or web/mail) or single-mode designs (mail-only/web-only). Differences in response rate and nonresponse bias were assessed. PRINCIPAL Using a multiple-contact protocol increased response, and sending a web survey first provided the more rapid response. Overall, the mixed-mode survey designs generated final response rates approximately 10 percentage points higher than their single-mode counterparts, although only the final response differences between the mail-only and web/mail conditions attained statistical significance (32.1 percent vs. 48 percent, respectively; p = .005). Observed differences did not result in nonresponse bias. Results support mixing modes of survey administration and web-based data collection in a multiple contact survey data collection protocol.

Quelle place pour la data science et les big data au sein de la statistique publique ?

COMBES S. ET GIVORD P.

2017

Revue Française des Affaires Sociales(4): 117-126.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-4-page-117.htm

Le phénomène « big data » fait l'objet de beaucoup d'attention dans un contexte de profusion de données (dont une part croissante est ouverte), de collecte et de traitement facilités par les progrès technologiques et de démocratisation des outils. On utilise classiquement les « 3 V » (volume, variété, vitesse) pour qualifier les big data. Si ces données sont caractérisées en premier lieu par leur volume, elles peuvent être également de nature très variée : numériques, textuelles, photographiques, sonores, vidéos... Enfin, elles peuvent être produites en continu et ainsi générer des flux importants. Avec l'amélioration des infrastructures matérielles et logicielles, notamment s'agissant de la collecte, du stockage et de l'optimisation des calculs, tous ces formats sont devenus exploitables dans des délais raisonnables. Ces nouvelles données peuvent offrir de nouvelles opportunités pour les instituts nationaux de statistiques. Au niveau international (Eurostat et ONU), plusieurs réflexions ont été lancées. Les avantages pressentis de ces sources seraient de réduire les délais de publication de certains indicateurs, d'en augmenter la précision et le degré de finesse de la description qu'ils permettent, et enfin d'enrichir la production statistique, tout en réduisant la charge d'enquête. Mais ces questionnements viennent également alimenter une réflexion plus globale autour du métier de statisticien public : cartographier les données, moderniser les outils, les méthodes statistiques et l'organisation du travail.

Utilisation des réseaux bayésiens comme technique de fouille de données massives – application à des données de recours aux soins

DIMEGLIO C., *et al.*

2017

Revue Française des Affaires Sociales(4): 27-55.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-4-page-27.htm

Les réseaux bayésiens sont utilisés selon deux approches distinctes, reposant sur les mêmes principes d'analyse bayésienne : comme outil de modélisation a priori faisant intervenir les hypothèses du chercheur, ou comme outil de fouille de données, sans hypothèse a priori de la part du chercheur. La première approche a diffusé dans la communauté biomédicale. La seconde provient avant tout de l'intelligence artificielle et n'est à notre connaissance pas utilisée en épidémiologie. Cette application est pourtant prometteuse – notamment dans le cas de données massives – et pourrait permettre la découverte de relations causales insoupçonnées. Cela reste cependant à montrer. Nous avons utilisé les données de 2010 de la cohorte SIRS, reposant sur un échantillon représentatif de la population adulte du Grand Paris. Plusieurs publications en épidémiologie sociale sont fondées sur cette cohorte, dont une étudiant les recours aux soins et les caractéristiques sociales en lien avec ces recours. Nous avons réanalysé les données de cette étude avec différents algorithmes de fouille de données permettant tout d'abord d'identifier automatiquement la structure du réseau bayésien représentant les données (le graphe), et ensuite d'estimer les paramètres du réseau à partir des données. Nous avons comparé les résultats obtenus par fouille de données avec les analyses multivariées classiques et les données de la littérature.. L'analyse multivariée identifie des relations entre variables connues de la littérature. Les analyses par réseau bayésien identifient des relations plus complexes, orientées, entre variables, dont les significations sont simples. La majorité des analyses montre une partition entre variables sociales et variables de recours aux soins. La fouille de données massives par réseau bayésien représente un ensemble de techniques théoriquement bien assises, appliquées avec succès dans différents domaines. Notre exemple de résultats obtenus sur des données connues dans le champ de l'épidémiologie sociale suggère que l'intérêt de ce type d'approche doit être clarifié. En particulier, son utilisation en aveugle paraît, au vu de nos résultats, peu pertinente.

The Impact of the Eligibility Threshold of a French Means-Tested Health Insurance Programme on Doctor Visits: A Regression Discontinuity Analysis

GUTHMULLER S. ET WITTWER J.

2017

Health Econ 26(12): e17-e34.

This paper assesses the impact of eligibility for a free means-tested complementary health insurance plan, called Couverture Maladie Universelle Complémentaire (CMUC), on doctor visits. We use information on the selection rule to qualify for the plan to identify the effect of eligibility and adopt a regression discontinuity approach. Our sample consists of low-income individuals enrolled in the Health Insurance Fund and recipients of social benefits from the Family Allowance Fund of an urban area in Northern France. Our findings do not show significant impacts of the CMUC threshold on the number of doctor visits within the full sample. Among the subsample of adults under 30 years old, however, eligible individuals are more likely to see a specialist and have, on average, significantly more specialist visits than non-eligible individuals. This specific impact of the CMUC cut-off point among young adults may be explained by the fact that young adults are less likely to be covered by a complementary health insurance plan when they are not recipients of the CMUC plan.

Decision Heuristic or Preference? Attribute Non-Attendance in Discrete Choice Problems

HEIDENREICH S., *et al.*

2018

Health Econ 27(1): 157-171.

This paper investigates if respondents' choice to not consider all characteristics of a multiattribute health service may represent preferences. Over the last decade, an increasing number of studies account for attribute non-attendance (ANA) when using discrete choice experiments to elicit individuals' preferences. Most studies assume such behaviour is a heuristic and therefore uninformative. This assumption may result in misleading welfare estimates if ANA reflects preferences. This is the first paper to assess if ANA is a heuristic or genuine preference without relying on respondents' self-stated motivation and the first study to explore this question within a health context. Based on find-

ings from cognitive psychology, we expect that familiar respondents are less likely to use a decision heuristic to simplify choices than unfamiliar respondents. We employ a latent class model of discrete choice experiment data concerned with National Health Service managers' preferences for support services that assist with performance concerns. We present quantitative and qualitative evidence that in our study ANA mostly represents preferences. We also show that wrong assumptions about ANA result in inadequate welfare measures that can result in suboptimal policy advice. Future research should proceed with caution when assuming that ANA is a heuristic.

Quantifying Magnitude of Group-Level Differences in Patient Experiences with Health Care

QUIGLEY D. D., *et al.*

2018

Health Serv Res. Ahead of print.

Review approaches assessing magnitude of differences in patient experience scores between different providers. A systematic literature review was conducted on the period: 2000-2016. Of 812 articles mentioning "CAHPS," "patient experience," "patient satisfaction," "important(ce)," "difference," or "significance," we identified 79 possible articles, yielding 35 for data abstraction. We included 22 articles measuring magnitude of differences in patient experiences. We identified three main ways of estimating magnitude of differences in patient experience scores: (1) by distribution/range of patient experience variable, (2) against external anchor, and (3) comparing a difference in patient experience on one covariate to differences in patient experience on other covariates. We suggest routine estimation of magnitude in patient experience research. More work is needed documenting magnitude of differences between providers to make patient experience data more interpretable and usable.

Identifying Primary Care Pathways from Quality of Care to Outcomes and Satisfaction Using Structural Equation Modeling

RICCI-CABELLO I., *et al.*

2018

Health Serv Res 53(1): 430-449.

The aim of this paper is to study the relationships between the different domains of quality of primary health care for the evaluation of health system performance and for informing policy decision making. A total of 137 quality indicators collected from 7,607 English practices between 2011 and 2012. Indicators were allocated to subdomains of processes of care ("quality assurance," "education and training," "medicine management," "access," "clinical management," and "patient-centered care"), health outcomes ("intermediate outcomes" and "patient-reported health status"), and patient satisfaction. The relationships between the subdomains were hypothesized in a conceptual model and subsequently tested using structural equation modeling. This is the first empirical model to simultaneously provide evidence on the independence of intermediate health care outcomes, patient satisfaction, and health status. The explanatory paths via technical quality clinical management and patient centeredness offer specific opportunities for the development of quality improvement initiatives.

Using Latent Class Analysis to Model Preference Heterogeneity in Health: A Systematic Review

ZHOU M., *et al.*

2018

PharmacoEconomics 36(2): 175-187.

https://doi.org/10.1007/s40273-017-0575-4

Latent class analysis (LCA) has been increasingly used to explore preference heterogeneity, but the literature has not been systematically explored and hence best practices are not understood.

Health Policy

What's Involved with Wanting to Be Involved? Comparing Expectations For Public Engagement in Health Policy Across Research and Care Contexts

BARG C.J. ET MICHAEL P.-M.

2017

Healthcare Policy 13(2): 40-56.

The objectives of this study are to explore public preferences for involvement in health policy decisions, across the contexts of medical research and healthcare. We e-surveyed a sample of Canadians, categorizing respondents by preferences for decision control: (1) more authority; (2) more input; (3) status quo. Two generalized ordered logistic regressions assessed influences on preferences. The participation rate was 94%; 1,102 completed responses met quality criteria. The dominant preference was for more input (average = 52.0%), followed by status quo (average = 24.9%) and more authority (average = 21.1%), though preferences for more control were higher in healthcare (57.2%) than medical research (46.8%). Preferences for greater control were associated with constructs related to reduced trust in healthcare systems. The public expects health policy to account for public views, but not base decisions primarily on these views. More involvement was expected in healthcare than medical research policy. As opportunities for public involvement in health research grow, we anticipate increased desired involvement.

Scale Effects and Expected Savings from Consolidation Policies of Italian Local Healthcare Authorities

DI NOVI C., *et al.*

2018

Applied Health Economics and Health Policy 16(1): 107-122.

Consolidation is often considered by policymakers as a means to reduce service delivery costs and enhance accountability. The aim of this study was to estimate the potential cost savings that may be derived from consolidation of local health authorities (LHAs) with specific reference to the Italian setting. For our empirical analysis, we use data relating to the costs of the LHAs as reported in the 2012 LHAs' Income Statements published within the New Health Information System (NSIS) by the Ministry of Health. With respect to the previous literature on the consolidation of local health departments (LHDs), which is based on ex-post-assessments on what has been the impact of the consolidation of LHDs on health spending, we use an ex-ante-evaluation design and simulate the potential cost savings that may arise from the consolidation of LHAs. Our results show the existence of economies of scale with reference to a particular subset of the production costs of LHAs, i.e. administrative costs together with the purchasing costs of goods (such as drugs and medical devices) as well as non-healthcare-related services. The research findings of our paper provide practical insight into the concerns and challenges of LHA consolidations and may have important implications for NHS organisation and for the containment of public healthcare expenditure.

Exploring the Interrelationship Between Sport, Health and Social Outcomes in the UK: Implications for Health Policy

DOWNWARD P., *et al.*

2018

European Journal of Public Health 28(1): 99-104.

http://dx.doi.org/10.1093/eurpub/ckx063

Policy agencies are now re-visiting early aspirations that sport, as a form of physical activity, can be an instrument to foster general health and also subjective well-being (SWB). Both of these concepts capture physical and mental health states. SWB also encompasses broader psychological and life satisfaction as well as mood and affect. Past and current policies also identify a link between sport, social capital and SWB. Methods: Structural Equation Modelling (SEM) is undertaken on data from the UK's Taking Part survey to investigate the interrelationships between sport, general health, social capital and SWB. Results: The SEM shows a simultaneous relationship between sport and SWB. The effect is mediated through general health. The results also show that there is no relationship between social capital and sport but a clear relationship between SWB and social capital. From a health policy perspective there should be an emphasis on encouraging greater sport participation, despite the difficulties that this poses, because there is a potential 'multiplier' effect

on SWB and on general health through mediation. The multiplier effect occurs because once someone engages in sport and has their general health and SWB enhanced, then even further sport participation becomes likely, and subsequent general health and SWB, which would comprise both physical and mental health benefits. To target traditional non participants the research suggests that physical activity should be promoted for enjoyment, with health benefits subsequently following.

Expérimentations : le nouveau cadre

VAYSETTE P.

2018

Esop : La Revue Des Soins Primaires(7): 10-11.

La loi de financement pour la sécurité sociale 2018 instaure, dans son article 51, un nouveau cadre pour l'autorisation et la mise en œuvre d'expérimentations dérogatoires. Sont visées à la fois les innovations organisationnelles et de soins. En attendant les textes réglementaires, les expérimentations en cours (PAERPA, enfant à risque d'obésité, etc...) peuvent se poursuivre. Trois types d'expérimentations sont par ailleurs envisagés : un intéressement collectif à des groupements d'acteurs, le paiement à l'épisode de soins, la rémunération collective.

Public Policy

Des rapports d'âge organisationnels : le rôle des dispositifs de gestion

BOUSSARD V.

2017

Gérontologie et société 39 (153): 57-74.

https://www.cairn.info/revue-gerontologie-et-societe-2017-2-page-57.htm

Cet article s'intéresse à la construction sociale des rapports d'âge en entreprise, à partir d'une approche par les dispositifs de gestion de ces dernières (organisation et division du travail, gestion des ressources humaines, gestion financière). Ces dispositifs ne sont pas mis en œuvre pour traiter ou réguler la question des âges ou des relations intra- ou intergénérationnelles, mais celle des qualifications, de la production et des résultats financiers. Pourtant, ils ont une influence indirecte sur les rapports d'âge au travail et les modèles professionnels dans lesquels ils s'insèrent. À partir de deux monographies d'entreprise, il montre que l'articulation des dispositifs de gestion particulière à chaque organisation crée des configurations singulières de rapports d'âge. Les deux cas soulignent que les dispositifs de gestion participent à définir professionnellement l'âge, le rendant relatif. Ils attribuent des positions et offrent des parcours différenciés en fonction de l'âge ou de l'époque d'entrée dans l'emploi. En créant des configurations particulières, ils participent à construire des relations d'âge spécifiques et variables en fonction des organisations. Ainsi, les rapports d'âge, loin d'être de purs produits institutionnels doivent aussi être pensés comme le résultat de formes organisationnelles locales et spécifiques, ancrées plus généralement dans les façons d'organiser, d'encadrer et d'évaluer le travail.

Prevention

What factors predict the passage of state-level e-cigarette regulations?

MACLEAN J. C., *et al.*

Health Econ : 27(5) : 897-907

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3642

E-cigarettes are controversial products. They may help addicted smokers to consume nicotine in a less harmful manner or to quit tobacco cigarettes entirely, but these products may also entice youth into smoking. This controversy complicates e-cigarette regulation as any regulation may lead to health improvements for some populations, and health declines for other populations. Using data from 2007 to 2016, we examine factors that are plausibly linked with U.S. state e-cigarette regulations. We find that less conservative states are more likely to regulate e-cigarettes and that states with stronger tobacco lobbies are less likely to regulate e-cigarettes. This information can help policymakers as they determine how best to promote public health through regulation.

Prevision - Evaluation

Using Health Technology Assessment to Assess the Value of New Medicines: Results of a Systematic Review and Expert Consultation Across Eight European Countries

ANGELIS A., *et al.*

2018

Eur J Health Econ 19(1): 123-152.

Although health technology assessment (HTA) systems base their decision making process either on economic evaluations or comparative clinical benefit assessment, a central aim of recent approaches to value measurement, including value based assessment and pricing, points towards the incorporation of supplementary evidence and criteria that capture additional dimensions of value. The aim of this paper are to study the practices, processes and policies of value-assessment for new medicines across eight European countries and the role of HTA beyond economic evaluation and clinical benefit assessment. A systematic (peer review and grey) literature review was conducted using an analytical framework examining: (1) 'Responsibilities and structure of HTA agencies'; (2) 'Evidence and evaluation criteria considered in HTAs'; (3) 'Methods and techniques applied in HTAs'; and (4) 'Outcomes and implementation of HTAs'. Study countries were France, Germany, England, Sweden, Italy, Netherlands, Poland and Spain. All countries assess similar types of evidence; however, the specific criteria/endpoints used, their level of provision and requirement, and the way they are incorporated (e.g. explicitly vs. implicitly) varies across countries, with their relative importance remaining generally unknown. Incorporation of additional 'social value judgements' (beyond clinical benefit assessment) and economic evaluation could help explain heterogeneity in coverage recommendations and decision-making. More comprehensive and systematic assessment procedures characterised by increased transparency, in terms of selection of evaluation criteria, their importance and intensity of use, could lead to more rational evidence-based decision-making, possibly improving efficiency in resource allocation, while also raising public confidence and fairness.

Involving Members of the Public in Health Economics Research: Insights from Selecting Health States for Valuation to Estimate Quality-Adjusted Life-Year (QALY) Weights

GOODWIN E., *et al.*

2018

Applied Health Economics and Health Policy 16(2) : 187-194

Over recent years, public involvement in health research has expanded considerably. However, public involvement in designing and conducting health economics research is seldom reported. Here we describe the development, delivery and assessment of

an approach for involving people in a clearly defined piece of health economics research: selecting health states for valuation in estimating quality-adjusted life-years (QALYs). This involvement formed part of a study to develop a condition-specific preference-based measure of health-related quality of life, the Multiple Sclerosis Impact Scale (MSIS-8D), and the work reported here relates to the identification of plausible, or realistic, health states for valuation. An Expert Panel of three people with multiple sclerosis (MS) was recruited from a local involvement network, and two health economists designed an interactive task that enabled the Panel to identify health states that were implausible, or unlikely to be experienced.

A Scoping Review of Economic Evaluations Alongside Randomised Controlled Trials of Home Monitoring in Chronic Disease Management

KIDHOLM K. ET KRISTENSEN M.

2018

Applied Health Economics and Health Policy 16(2) : 167-176

Many countries have considered telemedicine and home monitoring of patients as a solution to the demographic challenges that health-care systems face. However, reviews of economic evaluations of telemedicine have identified methodological problems in many studies as they do not comply with guidelines. The aim of this study was to examine economic evaluations alongside randomised controlled trials of home monitoring in chronic disease management and hereby to explore the resources included in the programme costs, the types of health-care utilisation that change as a result of home monitoring and discuss the value of economic evaluation alongside randomised controlled trials of home monitoring on the basis of the studies identified. A scoping review of economic evaluations of home monitoring of patients with chronic disease based on randomised controlled trials and including information on the programme costs and the costs of equipment was carried out based on a Medline (PubMed) search. Nine studies met the inclusion criteria. All studies include both costs of equipment and use of staff, but there is large variation in the types of equipment and types of tasks for the staff included in the costs. Equipment costs constituted 16–73% of the total programme costs. In six of the nine studies, home monitoring resulted in a reduction in primary care or emergency contacts. However, in total, home monitoring resulted in increased average costs per patient in six studies and reduced costs in three of the nine studies. The review is limited by the small number of studies found and the restriction to randomised controlled trials, which can be problematic in this area due to lack of blinding of patients and healthcare professionals and the difficulty of implementing organisational changes in hospital departments for the limited period of a trial. Furthermore, our results may be based on assessments of older telemedicine interventions.

Frailty Index as a Predictor of Mortality: A Systematic Review and Meta-Analysis

KOJIMA G., *et al.*

2018

Age Ageing 47(2): 193-200.

Two popular operational definitions of frailty, the frailty phenotype and Frailty index (FI), are based on different theories. Although FI was shown to be superior in predicting mortality to the frailty phenotype, no meta-analysis on mortality risk according to FI has been found in the literature. Methods: an electronic systematic literature search was conducted in August 2016 using four databases (Embase, Medline, CINAHL and PsycINFO) for prospective cohort studies published in 2000 or later, examining the mortality risk according to frailty measured by FI. A meta-analysis was performed to synthesise pooled mortality risk estimates. Results: of 2,617 studies identified by the systematic review, 18 cohorts from 19 studies were included. Thirteen cohorts showed hazard ratios (HRs) per 0.01 increase in FI, six cohorts showed HRs per 0.1 increase in FI and two cohorts each showed odds ratios (ORs) per 0.01 and 0.1 increase in FI, respectively. All meta-analyses suggested that higher FI was significantly associated with higher mortality risk (pooled HR per 0.01 FI increase = 1.039, 95% CI = 1.033-1.044, $P < 0.001$; pooled HR per 0.1 FI increase = 1.282, 95% CI = 1.258-1.307, $P < 0.001$; pooled OR per 0.01 FI increase = 1.054, 95% CI = 1.040-1.068, $P < 0.001$; pooled OR per 0.1 FI increase = 1.706, 95% CI = 1.547-1.881, $P < 0.001$). Meta-regression analysis among 13 cohorts with HR per 0.01 increase in FI showed that the studies with shorter follow-up periods and with lower female proportion were associated with higher mortality risks by FI. Conclusions: this systematic review and meta-analysis was the first to quantitatively demon-

strate that frailty measured by the FI is a significant predictor of mortality.

The Impact of Regression to the Mean on Economic Evaluation in Quasi-Experimental Pre-Post Studies: The Example of Total Knee Replacement Using Data from the Osteoarthritis Initiative

SCHILLING C., *et al.*

2017

Health Econ 26(12): e35-e51.

Many treatments are evaluated using quasi-experimental pre-post studies susceptible to regression to the mean (RTM). Ignoring RTM could bias the economic evaluation. We investigated this issue using the contemporary example of total knee replacement (TKR), a common treatment for end-stage osteoarthritis of the knee. Data (n = 4796) were obtained from the Osteoarthritis Initiative database, a longitudinal observational study of osteoarthritis. TKR patients (n = 184) were matched to non-TKR patients, using propensity score matching on the predicted hazard of TKR and exact matching on osteoarthritis severity and health-related quality of life (HrQoL). The economic evaluation using the matched control group was compared to the standard method of using the pre-surgery score as the control. Matched controls were identified for 56% of the primary TKRs. The matched control HrQoL trajectory showed evidence of RTM accounting for a third of the estimated QALY gains from surgery using the pre-surgery HrQoL as the control. Incorporating RTM into the economic evaluation significantly reduced the estimated cost effectiveness of TKR and increased the uncertainty. A generalized ICER bias correction factor was derived to account for RTM in cost-effectiveness analysis. RTM should be considered in economic evaluations based on quasi-experimental pre-post studies.

Psychiatry

Out of Sight but Not Out of Mind: Home Countries' Macroeconomic Volatilities and Immigrants' Mental Health

NGUYEN H. T. ET CONNELLY L. B.

2018

Health Econ 27(1): 189-208.

We provide the first empirical evidence that better economic performances by immigrants' countries of origin, as measured by lower consumer price index (CPI) or higher gross domestic product, improve immigrants' mental health. We use an econometrically-robust approach that exploits exogenous changes in macroeconomic conditions across immigrants' home countries over time and controls for immigrants' observable and unobservable characteristics. The CPI effect is statistically significant and sizeable. Furthermore, the CPI effect diminishes as the time since emigrating increases. By contrast, home countries' unemployment rates and exchange rate fluctuations have no impact on immigrants' mental health.

Primary Health Care

La planification des médecins en Europe : une revue de la littérature des modèles de projection

BENAHMED N., *et al.*

2018

Revue d'Épidémiologie et de Santé Publique 66(1): 63-73.

http://www.sciencedirect.com/science/article/pii/S0398762017305011

Position du problème : Les soins de santé représentent un secteur à forte intensité en capital humain dans

lequel les ressources humaines constituent la moitié des dépenses totales. Le nombre de professionnels, ainsi que la répartition de leurs compétences, font donc l'objet d'une attention soutenue de la part des décideurs tant au niveau national qu'au niveau international. L'objectif de cet article est d'analyser les différents modèles européens de projection de l'offre médicale et de la demande en médecins. Méthodes Afin de décrire les outils de projection utilisés pour la planification médicale en Europe, une revue de la littérature grise a été menée. Résultats Les méthodes quantitatives d'évaluation de l'offre médicale reposent généralement sur une modélisation de type « stock and flow » et plus rarement sur une dynamique systémique. Les paramètres inclus dépendent largement de la disponibilité et de la qualité de ces données. Les modélisations des besoins en médecins se limitent à la consommation de soins et n'envisagent que rarement les besoins dans leur globalité ou des objectifs de santé. Outre les méthodes quantitatives, l'« Horizon scanning » est une technique permettant d'apprécier l'évolution de l'offre et de la demande dans un futur incertain à l'aide de techniques qualitatives telles que celles des enquêtes semi-structurées, des panels Delphi ou des« focus group ». Enfin, les modèles de projection de l'offre et de la demande doivent être régulièrement mis à jour pour vérifier la réalisation des hypothèses de travail. De plus, une analyse post-hoc est également nécessaire mais trop rarement réalisée. Conclusion : La planification des ressources humaines médicales est très inégalement implantée en Europe. L'implémentation politique des résultats des exercices de projection est cruciale pour une planification efficace. Cependant des données importantes comme celles relatives à la mobilité entre les États membres sont mal connues, compliquant les politiques de régulation de l'offre médicale. Ces politiques se limitent généralement à la régulation de la formation et n'envisagent que trop rarement la délégation et la substitution. Background : Healthcare is a labor-intensive sector in which half of the expenses are dedicated to human resources. Therefore, policy makers, at national and internal levels, attend to the number of practicing professionals and the skill mix. This paper aims to analyze the European forecasting model for supply and demand of physicians. Methods : To describe the forecasting tools used for physician planning in Europe, a grey literature search was done. Results Quantitative methods for forecasting medical supply rely mainly on stock-and-flow simulations and less often on systemic dynamics. Parameters included in forecasting models exhibit wide variability for data availability and quality. The forecasting of physician needs is limited to healthcare consumption and rarely considers overall needs and service targets. Besides quantitative methods, horizon scanning enables an evaluation of the changes in supply and demand in an uncertain future based on qualitative techniques such as semi-structured interviews, Delphi Panels, or focus groups. Finally, supply and demand forecasting models should be regularly updated. Moreover, post-hoc analyze is also needed but too rarely implemented. Conclusion : Medical human resource planning in Europe is inconsistent. Political implementation of the results of forecasting projections is essential to insure efficient planning. However, crucial elements such as mobility data between Member States are poorly understood, impairing medical supply regulation policies. These policies are commonly limited to training regulations, while horizontal and vertical substitution is less frequently taken into consideration.

▶ Do Financial Incentives Influence GPs' Decisions to Do After-Hours Work? A Discrete Choice Labour Supply Model

BROADWAY B., *et al.*

2017

Health Econ 26(12): e52-e66.

This paper analyses doctors' supply of after-hours care (AHC), and how it is affected by personal and family circumstances as well as the earnings structure. We use detailed survey data from a large sample of Australian General Practitioners (GPs) to estimate a structural, discrete choice model of labour supply and AHC. This allows us to jointly model GPs' decisions on the number of daytime-weekday working hours and the probability of providing AHC. We simulate GPs' labour supply responses to an increase in hourly earnings, both in a daytime-weekday setting and for AHC. GPs increase their daytime-weekday working hours if their hourly earnings in this setting increase, but only to a very small extent. GPs are somewhat more likely to provide AHC if their hourly earnings in that setting increase, but again, the effect is very small and only evident in some subgroups. Moreover, higher earnings in weekday-daytime practice reduce the probability of providing AHC, particularly for men. Increasing GPs' earnings appears to be at best relatively ineffective in encouraging increased provision of AHC and may even prove harmful if incentives are not well targeted.

Factors that Distinguish High-Performing Accountable Care Organizations in the Medicare Shared Savings Program

D'AUNNO T., *et al.*

2018

Health Serv Res 53(1): 120-137.

The aim of this study is to identify factors that promote the effective performance of accountable care organizations (ACOs) in the Medicare Shared Savings Program. Data come from a convenience sample of 16 Medicare Shared Savings ACOs that were organized around large physician groups. We use claims data from the Center for Medicaid and Medicare Services and data from 60 interviews at three high-performing and three low-performing ACOs. Explanatory sequential design, using qualitative data to account for patterns observed in quantitative assessment of ACO performance. A total of 16 ACOs were first rank-ordered on measures of cost and quality of care; we then selected three high and three low performers for site visits; interview data were content-analyzed. Results identify several factors that distinguish high- from low-performing ACOs: (1) collaboration with hospitals; (2) effective physician group practice prior to ACO engagement; (3) trusted, long-standing physician leaders focused on improving performance; (4) sophisticated use of information systems; (5) effective feedback to physicians; and (6) embedded care coordinators. Shorter interventions can improve ACO performance-use of embedded care coordinators and local, regional health information systems; timely feedback of performance data. However, longer term interventions are needed to promote physician-hospital collaboration and skills of physician leaders. CMS and other stakeholders need realistic timelines for ACO performance.

Can You Recommend Me a Good GP? Describing Social Differences in Patient Satisfaction Within 31 Countries

DETOLLENAERE J., *et al.*

2017

Int J Qual Health Care 30(1) : 9-15

This study aims to explore social differences in patient satisfaction of their general practitioner (GP) according to patient's gender, education, household income and ethnicity in Europe. By using multilevel logistic modelling the impact of socioeconomic indicators (i.e. gender, education, household income and ethnicity) on patient satisfaction is estimated. In each model the authors controlled for indicators of person-focused care and strength of the primary care system in 31 European countries. Patients who were sitting in the waiting room of the GP were asked to participate. They filled in the questionnaire after the consultation with the GP. Intervention: Describing social differences in patient satisfaction among European primary care patients. Main Outcome Measure(s): Patient satisfaction. This study confirms previous research and reveals high levels of satisfaction with primary care in Europe. On average, 92.1% of the respondents would recommend their GP to their family or relatives. Variance in patient satisfaction is mostly explained at patient level, ~75% of the variance can be assigned to patient characteristics. Likewise, women, low-income groups and first generation migrants are less satisfied with their GP. Lastly, all indicators of person-focused care are positively associated with patient satisfaction, showing that the more person-focused the care, the higher the satisfaction among the patients. Conclusions: Notwithstanding the high satisfaction rates in Europe, patient satisfaction is still determined by patients' socioeconomic status (gender and household income), migration background and the degree of person-centred care. Therefore, policymakers and health professionals should target these population groups in order to improve the satisfaction rates in their country.

Changes in Access to Primary Care in Europe and Its Patterning, 2007–12: A Repeated Cross-Sectional Study

DIMITROVOVÁ K. ET PERELMAN J.

2018

European Journal of Public Health: Ahead of print

The strengthening of primary care (PC) has been encouraged as a strategy to achieve more efficient and equitable health systems. However, the Great Recession may have reduced access to PC. This paper analyses the change in access to PC and its patterning in 28 European countries between 2007 and 2012. Methods : We used data from the 2007 and 2012 waves of the EU-SILC questionnaire (n = 687 170). The dependent variable was the self-reported access to PC ('easy' vs. 'difficult'). We modelled the access to PC as a function of the year and individual socioeconomic and country-level health system variables, using a mixed effects logistic regression, adjusting for sex, age, civil status, country of birth, chronic condition and

self-reported health. Additionally, we interacted the year with socioeconomic and country-level variables. Results: The probability of reporting difficult access to PC services was 4% lower in 2012, in comparison with 2007 (OR = 0.96, P <; 0.01). People with the lowest educational level (OR = 1.63, P < 0.01), high difficulty to make ends meet (OR = 1.94, P < 0.01) and with material deprivation (OR = 1.25, P <t; 0.01) experienced a significantly higher likelihood of difficult access. The better access in 2012 was significantly higher in people living in countries with higher health expenditures, a greater number of generalist medical practitioners, and with stronger gatekeeping. Conclusion : Access to PC improved between 2007 and 2012, and this improvement was greater for people living in countries with a higher investment in health and PC. However, the poor access amongst low-SE status people was stable over the period.

Can Pay-For-Performance to Primary Care Providers Stimulate Appropriate Use of Antibiotics?

ELLEGARD L. M., *et al.*

2018

Health Econ 27(1): e39-e54.

Antibiotic resistance is a major threat to public health worldwide. As the healthcare sector's use of antibiotics is an important contributor to the development of resistance, it is crucial that physicians only prescribe antibiotics when needed and that they choose narrow-spectrum antibiotics, which act on fewer bacteria types, when possible. Inappropriate use of antibiotics is nonetheless widespread, not least for respiratory tract infections (RTI), a common reason for antibiotics prescriptions. We examine if pay-for-performance (P4P) presents a way to influence primary care physicians' choice of antibiotics. During 2006-2013, 8 Swedish healthcare authorities adopted P4P to make physicians select narrow-spectrum antibiotics more often in the treatment of children with RTI. Exploiting register data on all purchases of RTI antibiotics in a difference-in-differences analysis, we find that P4P significantly increased the share of narrow-spectrum antibiotics. There are no signs that physicians gamed the system by issuing more prescriptions overall.

La médecine générale au défi de la démographie sanitaire

GROSS O.

2018

Médecine : De la Médecine Factuelle à nos Pratiques 13(10): 462-465.

L'engagement des patients comme acteurs de santé est un phénomène mondial et protéiforme. Il est fondé sur le principe selon lequel il participe de l'amélioration de la qualité des soins. Le DUMG de Paris 13 a recours à vingt patients qui disposent d'un statut d'enseignants vacataires et ils y enseignent en binôme avec des médecins dans 90 % des enseignements. La médecine générale s'est trouvée être au sein de l'université, un acteur essentiel dans le développement de la responsabilité sociale de l'université et dans la mise en œuvre de nouvelles pratiques inspirées des principes de la démocratie en santé. De même, en ville, elle développe des nouvelles pratiques favorisant la mise en œuvre d'une démocratie en santé, jusque-là pensée pour l'hôpital. La médecine générale s'impose donc, dans le cadre de la formation médicale et en ville, comme le fer de lance d'une nouvelle forme de la démocratie en santé.

Incentives to Patients Versus Incentives to Health Care Providers: The Users' Perspective

JELOVAC I. ET POLOME P.

2017

Health Econ 26(12): e319-e331.

In theory, health care providers may adapt their professional behavior to the financial incentives resulting from their remuneration. Our research question is whether the users of health care services anticipate such behavior from their general practitioner (GP) and, if they do, what consequences such anticipation has on their preferences regarding financial incentives. Our theoretical model explains users' preferences for one or another incentives scheme, disentangling the financial motives (incentives amounts, wealth) from the behavioral ones (perceived GPs' sensitivity to incentives). We empirically test our theoretical predictions using data from a survey that elicits individual preferences for either patient or provider hypothetical incentives in France. The empirical results confirm the theoretical ones: users tend to prefer incentives to patients rather than to GPs when the amount of GP

incentives is high, when the amount of patient incentives is low, when they anticipate that their GP's medical decisions are affected by financial incentives or when their wealth is high. Otherwise, they prefer their GP to face financial incentives.

Do Capitation-Based Reimbursement Systems Underfund Tertiary Healthcare Providers? Evidence from New Zealand

SHIN S., *et al.*

2017

Health Econ 26(12): e81-e102.

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

Occupational Health

Sickness Benefit Rules and Work Absence: An Empirical Study Based on European Data

CHAUPAIN-GUILLOT S. ET GUILLOT O.

2017

Revue d'économie politique 127(6): 1109-1137.

https://www.cairn.info/revue-d-economie-politique-2017-6-page-1109.htm

À partir des données de l'European Working Conditions Survey de 2010, cette étude s'intéresse aux déterminants des absences au travail pour raisons de santé dans les pays européens. L'accent est mis sur l'impact des règles d'indemnisation des arrêts maladie. Cinq paramètres du système d'indemnisation sont pris en compte : l'obligation ou non de fournir un certificat médical dès le premier jour d'absence, la durée minimale d'affiliation au régime d'assurance sociale, l'existence ou non d'un délai de carence, le niveau d'indemnisation et la durée maximale de versement des indemnités maladie. Les comportements d'absence des salariés sont analysés à l'aide de régressions logistiques multiniveaux. Les résultats montrent que les écarts entre pays dans la probabilité d'absence au travail peuvent en partie s'expliquer par les différences de législation en matière d'indemnisation des arrêts maladie. Le fait que le salaire soit intégralement maintenu par l'employeur en cas de maladie est l'élément le plus déterminant. Comme attendu, dans les pays où cette règle s'applique, la propension à s'absenter est significativement plus élevée.

Bounding the Causal Effect of Unemployment on Mental Health: Nonparametric Evidence from Four Countries

CYGAN-REHM K., *et al.*

2017

Health Econ 26(12): 1844-1861.

An important, yet unsettled, question in public health policy is the extent to which unemployment causally impacts mental health. The recent literature yields varying findings, which are likely due to differences in data, methods, samples, and institutional settings. Taking a more general approach, we provide comparable evidence for four countries with different institutional settings-Australia, Germany, the UK, and the United States-using a nonparametric bounds analysis. Relying on fairly weak and partially testable assumptions, our paper shows that unemployment has a significant negative effect on mental health in all countries. Our results rule out effects larger than a quarter of a standard deviation for Germany and half a standard deviation for the Anglo-Saxon countries. The effect is significant for both men and women and materialises already for short periods of unemployment. Public pol-

icy should hence focus on early prevention of mental health problems among the unemployed.

Predictors of Working Beyond Retirement in Older Workers with and Without a Chronic Disease - Results from Data Linkage of Dutch Questionnaire and Registry Data

DE WIND A., *et al.*

2018

BMC Public Health 18(1): 265.

https://doi.org/10.1186/s12889-018-5151-0

An increasing number of retirees continue to work beyond retirement despite being eligible to retire. As the prevalence of chronic disease increases with age, working beyond retirement may go along with having a chronic disease. Working beyond retirement may be different for retirees with and without chronic disease. We aim to investigate whether demographic, socio-economic and work characteristics, health and social factors predict working beyond retirement, in workers with and without a chronic disease.

Good Jobs, Good Pay, Better Health? The Effects of Job Quality on Health Among Older European Workers

HENSEKE G.

2018

Eur J Health Econ 19(1): 59-73.

Using data from the Survey of Health, Ageing and Retirement in Europe, this study presents new evidence on the effects of job quality on the occurrence of severe acute conditions, the level of cardiovascular risk factors, musculoskeletal disorders, mental health, functional disabilities and self-assessed health among workers aged 50+. By combining intrinsic job quality with job insecurity and pay the study maps out multiple potential pathways through which work may affect health and well-being. Levering longitudinal data and external information on early retirement ages allows for accounting of unobserved heterogeneity, selection bias and reverse causality. The empirical findings suggest that inequities in health correlate with inequities in job quality, though a substantial fraction of these associations reflect time-constant unobserved heterogeneity. Still, there is evidence for genuine protective effects of better jobs on musculoskeletal disorders, mental health and general health. The effect could contribute to a substantial number of avoidable disorders among older workers, despite relatively modest effect sizes at the level of individuals. Mental health, in particular, responds to changes in job quality. Selection bias such as the healthy worker effect does not alter the results. But the influence of job quality on health may be transitional among older workers. An in-depth analysis of health dynamics reveals no evidence for persistence.

Long Term Unemployment, Income, Poverty, and Social Public Expenditure, and Their Relationship with Self-Perceived Health in Spain (2007–2011)

LÓPEZ DEL AMO GONZÁLEZ M. P., *et al.*

2018

BMC Public Health 18(1): 133.

https://doi.org/10.1186/s12889-017-5004-2

There is scant research that simultaneously analyzes the joint effects of long-term unemployment, poverty and public expenditure policies on poorer self-perceived health during the financial crisis. The aim of the study is to analyze the joint relationship between long-term unemployment, social deprivation, and regional social public expenditure on one side, and self-perceived health in Spain (2007–2011) on the other.

Les valeurs des générations au travail : les introuvables différences

SABA T.

2017

Gérontologie et société (39) 153: 27-41.

https://www.cairn.info/revue-gerontologie-et-societe-2017-2-page-27.htm

La cohabitation de travailleurs issus de plusieurs générations sur les lieux de travail semble de nos jours soulever certaines difficultés en gestion des ressources humaines. On prétend que les générations ont des valeurs et des attentes au travail difficilement conciliables. La cohabitation se prolonge puisque les générations plus âgées tardent à quitter le marché du travail ou y reviennent pour occuper des emplois de transition. L'incohérence des modes de gestion des entreprises exacerbe les difficultés qui émergent

de cette cohabitation. Malgré la force des convictions, nous constatons que les chercheurs ont été incapables d'identifier des différences significatives de valeurs entre les générations et d'expliquer si les comportements et les attitudes au travail varient d'une génération à l'autre. Cet article s'attarde à mettre en contexte les études sur les différences de valeurs entre les générations et à présenter les cadres théoriques et analytiques appropriés susceptibles d'expliquer ces différences. Sont discutés les résultats des études qui montrent que les différences générationnelles de valeurs au travail sont un mythe qui est loin de pouvoir être empiriquement démontré.

Ageing

Health Services Utilization in Older Adults with Dementia Receiving Care Coordination: The MIND at Home Trial

AMJAD H., *et al.*

2018

Health Serv Res 53(1): 556-579.

The aim of this study is to investigate effects of a novel dementia care coordination program on health services utilization. A total of 303 community-dwelling adults aged ≥70 with a cognitive disorder in Baltimore, Maryland (2008-2011). Single-blind RCT evaluating efficacy of an 18-month care coordination intervention were delivered through community-based nonclinical care coordinators, supported by an interdisciplinary clinical team. Study partners reported acute care/inpatient, outpatient, and home- and community-based service utilization at baseline, 9, and 18 months. From baseline to 18 months, there were no significant group differences in acute care/inpatient or total outpatient services use, although intervention participants had significantly increased outpatient dementia/mental health visits from 9 to 18 months ($p = .04$) relative to controls. Home and community-based support service use significantly increased from baseline to 18 months in the intervention compared to control ($p = .005$). While this dementia care coordination program did not impact acute care/inpatient services utilization, it increased use of dementia-related outpatient medical care and nonmedical supportive community services, a combination that may have helped participants remain at home longer. Future care model modifications that emphasize delirium, falls prevention, and behavior management may be needed to influence inpatient service use.

Le logement et les soins dans le grand âge : briser les silos

DESPRÉS C., *et al.*

2017

Gérontologie et société 39 (152): 107-124.

https://www.cairn.info/revue-gerontologie-et-societe-2017-1-page-107.htm

Au Québec, la population des 80 ans et plus a presque quintuplé entre 1970 et 2010. Si personne ne vieillit de la même façon ni au même rythme, les aînés font inévitablement l'expérience d'un affaiblissement progressif. Un choix difficile qu'ont à prendre les aînés lorsqu'une perte d'autonomie sévère se fait sentir est celui de demeurer dans leur logis ou de déménager. Or, plusieurs dimensions de l'environnement bâti des aînés sont associées à des effets sur leur qualité de vie et leur bien-être. Des actions doivent être entreprises pour assurer que les aînés puissent faire des choix éclairés parmi des options de logis non seulement confortables et sécuritaires, mais jugées désirables. Cela requiert de jeter des ponts entre des univers de recherche et d'intervention diversifiés, soit ceux de la santé, du social et de l'aménagement du cadre bâti. Cette action contribuera à l'intégration de données probantes ainsi qu'à combler les lacunes dans les connaissances, à rapprocher des cultures scientifiques et professionnelles qui n'ont pas l'habitude de travailler ensemble, et à donner une voix aux principaux utilisateurs des connaissances, soit les aînés et leurs proches. Cet article rapporte les résultats d'une collaboration initiée à l'été 2015 entre des chercheurs de trois universités canadiennes du Québec et de l'Alberta et des utilisateurs des connaissances autour de la question de l'habitat et des soins dans le grand âge, dans le but de relever ces nombreux défis.

(Re)construire une approche multidimensionnelle des générations de l'entreprise

JOLIVET A.

2017

Gérontologie et société 39 (153): 45-56.

https://www.cairn.info/revue-gerontologie-et-societe-2017-2-page-45.htm

La loi de 2013 sur le contrat de génération a fait de la génération un nouveau référent des politiques publiques. Pourquoi et comment construire une autre approche des générations en emploi et au travail au sein d'une entreprise ou d'une organisation ? Par ses contours, son contenu mais aussi par les accords ou plans d'action qui ont résulté de l'incitation à négocier, le contrat de génération porte une conception de la notion de génération centrée sur l'âge trop restreinte et peu pertinente. Les travaux de K. Mannheim permettent de proposer une approche locale des générations « de » l'entreprise. Deux exemples couplant démographie du travail et observations du travail sont mobilisés pour montrer les apports d'analyses plus fines des spécificités démographiques locales, des parcours, des collectifs de travail. L'objectif est ainsi de (re)construire une analyse par les générations qui fonde des catégories pertinentes au regard du contexte de l'entreprise, des catégories qui ne sont pas figées par des seuils fixés a priori et qui tiennent compte des situations concrètes de travail et des parcours professionnels des personnes.

Les formes alternatives d'habitat pour les personnes âgées, une comparaison Allemagne-France

LEENHARDT H.

2017

Gérontologie et société 39 (152): 187-206.

https://www.cairn.info/revue-gerontologie-et-societe-2017-1-page-187.htm

Les enjeux de l'adaptation de la société aux évolutions démographiques sont analogues en Allemagne et en France, bien que le vieillissement de la population soit plus accentué en Allemagne. Les deux pays affichent la volonté de permettre aux personnes de vieillir au domicile et de développer des formes alternatives d'habitat pour éviter ou retarder autant que possible une entrée en établissement. Pourtant, ces formes alternatives ne connaissent pas le même essor dans les deux pays. La comparaison Allemagne-France dans ce domaine est-elle possible, que nous enseigne-t-elle ?

Le devenir de l'habitat intergénérationnel : une revisite socio-anthropologique

NÉMOZ S.

2017

Gérontologie et société 39 (152): 207-220.

https://www.cairn.info/revue-gerontologie-et-societe-2017-1-page-207.htm

À la fin du XXe siècle, le « logement intergénérationnel » a été inauguré en Espagne. Au fil des années, la formule a été reprise par d'autres pays européens pour promouvoir l'habitat partagé entre étudiants et retraités. À l'heure où la crise économique perdure en Europe, et ce depuis 2008 suite à l'effondrement de différents systèmes dont celui des prêts hypothécaires accordés aux propriétaires américains, cet article interroge le devenir des cohabitations promues à l'origine par des valeurs de solidarité entre différentes classes d'âge. Dans un premier temps, il s'agit de resituer ce que l'on entend par cohabitation, colocation et logement intergénérationnel. En dehors des formes familiales, les modalités de partage du domicile des personnes âgées avec de plus jeunes, en études supérieures, sont ensuite analysées dans leur diversité et leur évolution par une approche socio-anthropologique. Ce retour sur expériences s'appuie sur la comparaison il y a dix ans des modes d'habiter et de leurs organisations en France et en Espagne (Némoz, 2007), ainsi que sur l'analyse des processus d'institutionnalisation poursuivis depuis lors. Il en ressort une affirmation des enjeux financiers en temps de crise, sans qu'ils ne soient pour autant prometteurs d'une nouvelle économie sociale et solidaire entre les générations. Le paradoxe est dans un troisième temps éclairé au regard d'une approche comparative et réflexive de l'agencement plus large des contraintes et des motivations socio-économiques au cœur de l'innovation résidentielle.

Parcours de soins en phase aiguë de la personne âgée en EHPAD : l'expérience de la région Grand Est

SULTER B. *et al.*, E.

2017/12

Gestions hospitalières(571): 619-628.

Dans un contexte de réorganisation de l'offre de soins qui a impacté tous les établissements hospitaliers, une mission de modernisation de l'offre de soins en Moselle-Est (MISMOE) a été mise en place en janvier 2012 par l'agence régionale de santé pour réfléchir au parcours de la personne âgée. La loi 2015-1776 du 28 décembre 2015 relative à l'adaptation de la société au vieillissement a éclairé la réflexion du groupe de recherche, notamment sur l'aspect « adaptation des politiques publiques », qui s'est ainsi centré sur la personne âgée résidant en Ehpad et a choisi de formaliser une modélisation du parcours de soins en phase aiguë afin qu'il puisse être transposable.

L'entraide générationnelle existe ! Nous l'avons rencontrée

VIALARD F.

2017

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https://www.cairn.info/revue-gerontologie-et-societe-2017-2-page-139.htm

Ce texte présente une expérience concrète d'entraide générationnelle à travers la mobilisation d'un collectif d'agents de la fonction publique, relégués dans un service de la direction régionale du travail où l'atmosphère est pour le moins délétère. L'arrivée de deux collègues plus âgées, au parcours divers, va participer à changer l'équilibre et le collectif va s'organiser pour faire au mieux le travail dévolu, s'appuyant sur les atouts de chacun de ses membres. Il trouvera ainsi la force de se défendre face à des injonctions contradictoires et de protéger les agents de la menace du burn-out.