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**DOC VEILLE** : veille bibliographique en économie de la santé

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## Assurance maladie

**Afendulis C.C., Landrum M.B., Chernew M.E. (2012). The impact of the Affordable Care Act on Medicare Advantage plan availability and enrollment.** Health Serv Res, 47 (6) : 2339-2352.

Abstract: OBJECTIVE: To assess the impact of the Patient Protection and Affordable Care Act's (ACA) changes in Medicare Advantage (MA) payment rates on the availability of and enrollment in MA plans. DATA SOURCES: Secondary data on MA plan offerings, contract offerings, and enrollment by state and county, in 2010-2011. STUDY DESIGN: We estimated regression models of the change in the number of plans, the number of contracts, and enrollment as a function of quartiles of FFS spending and pre-ACA MA payment generosity. Counties in the lowest quartile of spending are treated most generously by the ACA. PRINCIPAL FINDINGS: Relative to counties in the highest quartile of spending, the number of plans in counties in the first, second, and third quartiles rose by 12 percent, 7.6 percent, and 5.4 percent, respectively. Counties with more generous MA payment rates before the ACA lost significantly more plans. We did not find a similar impact on the change in contracts or enrollment. CONCLUSIONS: The ACA-induced MA payment changes reduced the number of plan choices available for Medicare beneficiaries, but they have yet affected enrollment patterns

Aron-Dine A., Einav L., Finkelstein A. (2012). The RAND Health Insurance Experiment, Three **Decades Later** : Cambridge : NBER

Abstract: This paper re-presents and re-examines the analysis from the famous RAND Health Insurance Experiment from the 1970s on the impact of consumer cost sharing in health insurance on medical spending. It begins by summarizing the experiment and its core findings in a manner that would be standard in the current age. It then examines potential threats to the validity of a causal interpretation of the experimental treatment effects stemming from different study participation and differential reporting of outcomes across treatment arms. Finally, it re-considers the famous RAND estimate that the elasticity of medical spending with respect to its out-of-pocket price is -0.2, emphasizing the challenges associated with summarizing the experimental treatment effects from non-linear health insurance contracts using a single price elasticity

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<http://www.nber.org/papers/w18642>

## Economie de la santé

**Cylus J., Mladovsky P., McKee M. (2012). Is there a statistical relationship between economic crises and changes in government health expenditure growth? an analysis of twenty-four European countries.** Health Serv Res, 47 (6) : 2204-2224.

Abstract: OBJECTIVE: To identify whether, by what means, and the extent to which historically, government health care expenditure growth in Europe has changed following economic crises. DATA SOURCES: Organization for Economic Cooperation and Development Health Data 2011. STUDY DESIGN: Cross-country fixed effects multiple regression analysis is used to determine whether statutory health care expenditure growth in the year after economic crises differs from that which would otherwise be predicted by general economic trends. Better understanding of the mechanisms involved is achieved by distinguishing between policy responses which lead to cost-shifting and all others. FINDINGS: In the year after an economic downturn, public health care expenditure grows more slowly than would have been expected given the longer term economic climate. Cost-shifting

and other policy responses are both associated with these slowdowns. However, while changes in tax-derived expenditure are associated with both cost-shifting and other policy responses following a crisis, changes in expenditure derived from social insurance have been associated only with changes in cost-shifting. CONCLUSIONS: Disproportionate cuts to the health sector, as well as reliance on cost-shifting to slow growth in health care expenditure, serve as a warning in terms of potentially negative effects on equity, efficiency, and quality of health services and, potentially, health outcomes following economic crises.

**Jones A.M., Rice N., Bago D.T., Balia S. (2012). Applied health economics. Routledge Advanced Texts in Economics and Finance.** Abington : Routledge Taylor & Francis Group

Abstract: The first edition of Applied Health Economics did an expert job of showing how the availability of large scale data sets and the rapid advancement of advanced econometric techniques can help health economists and health professionals make sense of information better than ever before. This second edition has been revised and updated throughout and includes a new chapter on the description and modelling of individual health care costs, thus broadening the book's readership to those working on risk adjustment and health technology appraisal. The text also fully reflects the very latest advances in the health economics field and the key journal literature. Large-scale survey datasets, in particular complex survey designs such as panel data, provide a rich source of information for health economists. They offer the scope to control for individual heterogeneity and to model the dynamics of individual behaviour. However, the measures of outcome used in health economics are often qualitative or categorical. These create special problems for estimating econometric models. The dramatic growth in computing power over recent years has been accompanied by the development of methods that help to solve these problems. The purpose of this book is to provide a practical guide to the skills required to put these techniques into practice. Practical applications of the methods are illustrated using data on health from the British Health and Lifestyle Survey (HALS), the British Household Panel Survey (BHPS), the European Community Household Panel (ECHP), the US Medical Expenditure Panel Survey (MEPS) and Survey of Health, Ageing and Retirement in Europe (SHARE). There is a strong emphasis on applied work, illustrating the use of relevant computer software with code provided for Stata. Familiarity with the basic syntax and structure of Stata is assumed. The Stata code and extracts from the statistical output are embedded directly in the main text and explained at regular intervals. The book is built around empirical case studies, rather than general theory, and the emphasis is on learning by example. It presents a detailed dissection of methods and results of some recent research papers written by the authors and their colleagues. Relevant methods are presented alongside the Stata code that can be used to implement them and the empirical results are discussed at each stage. This text brings together the theory and application of health economics and econometrics, and will be a valuable reference for applied economists and students of health economics and applied econometrics (4e de couverture)

Cote Irdes : A4412

## Etat de santé

**Kerdraon R., Procaccia C. (2012). Rapport d'information sur la sécurité sociale et la santé des étudiants** : Paris : Sénat.

Abstract: Créé en février 2012, le groupe de travail de la commission des affaires sociales consacré à la sécurité sociale et à la santé des étudiants a organisé dix-sept auditions et quatre déplacements. Régulièrement interpellés par des familles sur les dysfonctionnements du régime étudiant de



sécurité sociale, les sénateurs ont souhaité apporter des réponses concrètes et proposent des mesures d'urgence pour simplifier le système qui souffre d'une complexité abracadabrante. Au-delà, l'avenir du régime doit être considéré sans passion. Il doit au minimum évoluer vers un plus grand partage des tâches de gestion avec le régime général, notamment en ce qui concerne l'informatique, pour diminuer les coûts de gestion. Pour aller plus loin, le groupe de travail présente les avantages et les inconvénients d'une évolution plus radicale : soit conserver le régime délégué, mais ne confier sa gestion qu'à un seul organisme ; soit supprimer le régime délégué, en maintenant l'affiliation de l'étudiant au régime de ses parents, à titre indépendant. Par ailleurs, si les étudiants sont dans leur très grande majorité en bonne santé, les pouvoirs publics doivent rester attentifs à certaines difficultés éventuelles, notamment la fréquence de la fragilité psychologique, le développement des conduites à risques ou addictives et l'accès aux soins en dentaire, optique ou gynécologie. Le groupe de travail formule plusieurs propositions dans ce domaine, notamment en faveur d'un meilleur accompagnement des étudiants au sein de leurs établissements et d'une plus grande coordination des acteurs de la prévention (résumé de l'éditeur)

Cote Irdes : En ligne

<http://www.senat.fr/rap/r12-221/r12-221.html>

## Géographie de la santé

**(2012). Le pacte territoire-santé pour lutter contre les déserts médicaux** : Paris : MSSPS  
Abstract: L'accès de tous les Français sur l'ensemble du territoire à des soins de qualité est une priorité absolue pour le gouvernement. Depuis 5 ans, 2 millions de Français supplémentaires sont touchés par la désertification médicale. Les inégalités entre les territoires ne cessent d'augmenter. Les délais pour accéder à un médecin spécialiste sont de plus en plus longs. Pour faire face à cet enjeu majeur, la Ministre a présenté un « pacte territoire-santé », composé de 12 engagements et d'une méthode volontariste. Les 12 engagements proposés s'articulent autour de 3 objectifs : Changer la formation et faciliter l'installation des jeunes médecins, Transformer les conditions d'exercice des professionnels de santé, Investir dans les territoires isolés

Cote Irdes : En ligne

[http://www.social-sante.gouv.fr/IMG/pdf/12\\_engagements\\_-\\_pacte\\_Territoire-S-ante\\_DP\\_VDef.pdf](http://www.social-sante.gouv.fr/IMG/pdf/12_engagements_-_pacte_Territoire-S-ante_DP_VDef.pdf)

**Brutel C., Levy D. (2012). Le nouveau zonage en bassins de vie de 2012. Trois quarts des bassins de vie sont ruraux.** Insee Première, (1425) : -4p.

Abstract: En 2012, 1 666 bassins de vie structurent le territoire français, dont 1 644 en France métropolitaine et 22 dans les DOM. Chaque bassin de vie est construit autour d'un pôle de services qui dispose au moins de la moitié des équipements de la gamme intermédiaire, comme par exemple les supermarchés, les collèges et les postes de police ou de gendarmerie. La quasi-totalité des 1 666 bassins de vie héberge par ailleurs tous les types d'équipements de proximité comme les commerces de proximité, les écoles ou encore les professionnels de la médecine de premier secours. Selon les critères utilisés par la Commission européenne, les trois quarts des bassins de vie français sont ruraux. Ils concentrent plus des deux tiers des communes françaises, soit 78 % de la superficie du pays, mais seulement 31 % de sa population ; leur densité de population est huit fois moindre. Toutefois, depuis dix ans, la population des espaces ruraux a augmenté 1,5 fois plus vite qu'en milieu urbain

Cote Irdes : P172

<http://www.insee.fr/fr/ffc/ipweb/ip1425/ip1425.pdf>



**Cooper H.L., Wodarski S., Cummings J., Hunter-Jones J., Karnes C., Ross Z., Druss B., Bonney L.E. (2012). Public housing relocations in Atlanta, Georgia, and declines in spatial access to safety net primary care.** *Health Place*, 18 (6) : 1255-1260.

Abstract: This analysis investigates changes in spatial access to safety-net primary care in a sample of US public housing residents relocating via the HOPE VI initiative from public housing complexes to voucher-subsidized rental units; substance misusers were oversampled. We used gravity-based models to measure spatial access to care, and used mixed models to assess pre-/post-relocation changes in access. Half the sample experienced declines in spatial access of  $\geq 79.83\%$ ; declines did not vary by substance misuse status. Results suggest that future public housing relocation initiatives should partner with relocaters, particularly those in poor health, to help them find housing near safety-net clinics

**Acevedo-Garcia D., Almeida J. (2012). Special issue introduction: Place, migration and health.** *Soc Sci.Med*, 75 (12) : 2055-2059.PM:23072818

Vallee J., Chauvin P. (2012). Investigating the effects of medical density on health-seeking behaviours using a multiscale approach to residential and activity spaces. Results from a prospective cohort study in the Paris metropolitan area, France. *International Journal of Health Geographics*, 11 (1) : 54.

Abstract: BACKGROUND:When measuring neighbourhood effects on health, it is both incorrect to treat individuals as if they were static and tied to their residential neighbourhood and to consider neighbourhoods rigid places whose geographical scales can be delineated a priori. We propose here to investigate the effects of residential medical density on health-seeking behaviours, taking into account the mono/polycentric structure of individual activity space (i.e., the space within which people move in the course of their daily activities) and exploring various neighbourhood units based on administrative delineations and regular grids. METHODS:We used data collected in the SIRS cohort study, which was carried out over a 5-year period (2005--2010) among a representative population living in 50 census blocks in the Paris metropolitan area. In the 662 women who lived in the same census blocks during the follow-up period and who had reported a recent cervical screening at baseline, we studied the association between residential medical density and individual activity space and the incidence of delayed cervical screening ( $> 3$  years) in multilevel logistic regression models after adjustment for potential confounders.RESULTS:Among the 662 women studied, there were 94 instances of delayed cervical screening in 2010 (14%). The women who indicated that their activity space was concentrated within their neighbourhood of residence were significantly more at risk for an incident delayed cervical screening. No significant association was found between residential medical density and the incidence of delayed cervical screening. However, we observed a significant interaction between individual activity space and residential practitioner density. Indeed, women living in neighbourhoods with a low medical density had a significantly higher risk of delayed screening, but only if they reported that their daily activities were centred within their neighbourhood of residence. Lastly, a sensitivity analysis exploring various neighbourhood spatial units revealed that the incidence of delayed screening was better modelled when residential medical densities were calculated from a 1400 x 1400 metre grid or from adjacent census blocks.CONCLUSION:This analysis underscores the view that people and neighbourhoods should be considered dynamic, interacting entities. Using unsuitable neighbourhood units or neglecting the structure of individual activity space would result in downplaying the importance of access to local health resources when addressing inequalities in health-seeking behaviours<http://www.ij-healthgeographics.com/content/11/1/54>

## Hôpital

### **Granger B., Pierru F. (2012). L'hôpital en sursis. Idées reçues sur le système hospitalier. Idées reçues.** Paris : le Cavalier Bleu

Abstract: L'hôpital public est en crise... Ce leitmotiv s'accompagne généralement de jugements définitifs tels que : " L'hôpital est mal géré ", " Les hôpitaux manquent de personnel ", " Le secteur privé à l'hôpital est une honte ", " Les hôpitaux de proximité disparaissent ", " Les urgences font de la bobologie ", etc. Touchant le système de santé publique, donc notre santé, ces idées reçues ont un écho d'autant plus fort que nous disposons rarement des connaissances suffisantes pour faire la part entre la polémique politicienne et la réalité. Regard croisé d'un praticien hospitalier et d'un sociologue spécialiste des systèmes de santé, cet ouvrage nous offre une analyse précise et complète, détaillant tant les aspects historiques, économiques que les comparaisons avec les autres pays, sans oublier la dimension humaine de la vie quotidienne de l'hôpital (4è de couv)

Cote Irdes : A4413

### **(2013). Analyse comparative de l'activité hospitalière entre les régions :** Paris : ATIH.

Abstract: A la suite de la publication de l'analyse nationale de l'activité hospitalière 2011, ce rapport présente une étude comparative de l'activité hospitalière 2011 entre les régions. Cette étude est composée de deux tomes. Le premier compare l'activité hospitalière régionale selon différents critères : âge des patients, type d'hospitalisation, catégories d'activité de soins, etc. Il présente également les résultats d'une analyse exploratoire sur les relations entre les données d'activité hospitalières avec les données sur le contexte socio-démographique et sur les caractéristiques de morbidité et de mortalité des régions. Le deuxième tome, intitulé 'Atlas régional', est composé d'une fiche par région qui décrit l'activité hospitalière en distinguant les établissements de santé selon leur secteur de financement. Cette approche souligne les différentes dynamiques d'activité au sein même d'une région. De plus, des informations d'analyse qualitative issues des Agences régionales de santé (ARS) apportent un éclairage complémentaire notamment sur les problématiques de démographie médicale et de restructuration de l'offre de soins (résumé de l'éditeur)

Cote Irdes : En ligne

<http://www.atih.sante.fr/index.php?id=0009500002FF>

### **Tummers L.G., Van de Walle S. (2012). Explaining health care professionals' resistance to implement Diagnosis Related Groups: (No) benefits for society, patients and professionals.** Health Policy, 108 (2-3) : 158-166.

Abstract: BACKGROUND: Effective health system reform requires support from health care professionals. However, many studies show an increasing discontent among health care professionals toward certain government policies. When professionals resist implementing policies, this may have serious consequences for policy effectiveness. OBJECTIVE: To develop and test a model for explaining resistance of health professionals to implement policies, based on three dimensions: societal benefits (such as improving efficiency), patient benefits (such as improving quality for individual patients) and personal benefits for professionals (for example increased income or fewer administrative burdens). METHODS: We conduct a survey among 1317 Dutch psychologists, psychotherapists and psychiatrists in 2010 who had to implement a new policy: Diagnosis Related Groups (DRGs). The dependent variable is professionals' resistance to implement these DRGs. As independent variables we develop scales to measure perceived societal benefits, patient benefits and personal benefits. Socio-demographic variables are also included. RESULTS: The model worked adequately in that the three benefit dimensions, together with control variables, explained 43% of

the variance in resistance to implement DRGs. Results indicate that health professionals were overall quite resistant towards the policy. The main reason was widespread belief that DRGs neither contribute to care quality nor help to control costs (low societal benefits). Resistance can also be explained by fears for one's personal status, income, and administrative burdens. Professionals furthermore doubt whether the policy is beneficial for patients, although this dimension is the least influential, which was unexpected. Perceived effects on patient choice, furthermore, do not contribute to willingness or resistance to work with DRGs. These insights can help in understanding why health care professionals embrace or resist the implementation of particular policies<sup>8</sup>

**Kruse G.B., Polsky D., Stuart E.A., Werner R.M. (2012). The impact of hospital pay-for-performance on hospital and Medicare costs.** Health Serv Res, 47 (6) : 2118-2136.

Abstract: OBJECTIVE: To evaluate the effects of Medicare's hospital pay-for-performance demonstration project on hospital revenues, costs, and margins and on Medicare costs. DATA SOURCES/STUDY SETTING: All health care utilization for Medicare beneficiaries hospitalized for acute myocardial infarction (AMI; ICD-9-CM code 410.x1) in fiscal years 2002-2005 from Medicare claims, containing 420,211 admissions with AMI. STUDY DESIGN: We test for changes in hospital costs and revenues and Medicare payments among 260 hospitals participating in the Medicare hospital pay-for-performance demonstration project and a group of 780 propensity-score-matched comparison hospitals. Effects were estimated using a difference-in-difference model with hospital fixed effects, testing for changes in costs among pay-for-performance hospitals above and beyond changes in comparison hospitals. PRINCIPAL FINDINGS: We found no significant effect of pay-for-performance on hospital financials (revenues, costs, and margins) or Medicare payments (index hospitalization and 1 year after admission) for AMI patients. CONCLUSIONS: Pay-for-performance in the CMS hospital demonstration project had minimal impact on hospital financials and Medicare payments to providers. As P4P extends to all hospitals under the Affordable Care Act, these results provide some estimates of the impact of P4P and emphasize our need for a better understanding of the financial implications of P4P on providers and payers if we want to create sustainable and effective programs to improve health care value

**Grytten J., Monkerud L., Sorensen R. (2012). Adoption of diagnostic technology and variation in caesarean section rates: a test of the practice style hypothesis in Norway.** Health Serv Res, 47 (6) : 2169-2189.

Abstract: OBJECTIVE: To examine whether the introduction of advanced diagnostic technology in maternity care has led to less variation in type of delivery between hospitals in Norway. DATA SOURCES: The Medical Birth Registry of Norway provided detailed medical information for 1.7 million deliveries from 1967 to 2005. Information about diagnostic technology was collected directly from the maternity units. STUDY DESIGN: The data were analyzed using a two-level binary logistic model with Caesarean section as the outcome measure. Level one contained variables that characterized the health status of the mother and child. Hospitals are level two. A heterogeneous variance structure was specified for the hospital level, where the error variance was allowed to vary according to the following types of diagnostic technology: two-dimensional ultrasound, cardiotocography, ST waveform analysis, and fetal blood analyses. PRINCIPAL FINDING: There was a marked variation in Caesarean section rates between hospitals up to 1973. After this the variation diminished markedly. This was due to the introduction of ultrasound and cardiotocography. CONCLUSION: Diagnostic technology reduced clinical uncertainty about the diagnosis of risk factors of the mother and child during delivery, and variation in type of delivery between hospitals was reduced accordingly. The results support the practice style hypothesis

**Madigan E.A., Gordon N.H., Fortinsky R.H., Koroukian S.M., Pina I., Riggs J.S. (2012). Rehospitalization in a national population of home health care patients with heart failure.** Health Serv Res, 47 (6) : 2316-2338.

Abstract: OBJECTIVE: Patients with heart failure (HF) have high rates of rehospitalization. Home

health care (HHC) patients with HF are not well studied in this regard. The objectives of this study were to determine patient, HHC agency, and geographic (i.e., area variation) factors related to 30-day rehospitalization in a national population of HHC patients with HF, and to describe the extent to which rehospitalizations were potentially avoidable. DATA SOURCES: Chronic Condition Warehouse data from the Centers for Medicare & Medicaid Services. STUDY DESIGN: Retrospective cohort design. DATA EXTRACTION: The 2005 national population of HHC patients was matched with hospital and HHC claims, the Provider of Service file, and the Area Resource File. PRINCIPAL FINDINGS: The 30-day rehospitalization rate was 26 percent with 42 percent of patients having cardiac-related diagnoses for the rehospitalization. Factors with the strongest association with rehospitalization were consistent between the multilevel model and Cox proportional hazard models: number of prior hospital stays, higher HHC visit intensity category, and dyspnea severity at HHC admission. Substantial numbers of rehospitalizations were judged to be potentially avoidable. CONCLUSIONS: The persistently high rates of rehospitalization have been difficult to address. There are health care-specific actions and policy implications that are worth examining to improve rehospitalization rates

## Inégalités sociales de santé

### **Legido-Quigley H., McKee M. (2012). Health and social fields in the context of lifestyle migration.**

Health Place, 18 (6) : 1209-1216.

Abstract: Migrants occupy different social fields encompassing both their origin and their destination. Much previous work on interactions within these fields has focused on economic migrants. In this paper we seek to understand the social fields occupied by British pensioners who have moved to Spain and how these interact with their health and their experience of the healthcare system. We explore the links between health, social fields, healthcare, place and social relationships. We use in-depth interviews conducted among those living in a variety of settings. We draw upon Bourdieu's concept of habitus and social fields and differentiate, between ways of being and ways of belonging in the fields. We identified three social fields. The first embraced interviewees' social networks back in the UK where implicit comparisons of healthcare were made. The second embraced their expatriate social networks in Spain which includes their conceptualization of a "healthy life", while the third included the interaction with Spanish institutions, including the healthcare system. This conceptual framework provides new insights for those considering retirement abroad, and those that want to understand how lifestyles and navigating distinct social fields influence health and the healthcare experience

### **Villarroel N., Artazcoz L. (2012). Heterogeneous patterns of health status among immigrants in Spain**

Health Place, 18 (6) : 1282-1291.

Abstract: OBJECTIVES: (1) To analyse differences in the self-perceived health and mental health status between the Spanish population and immigrants from the seven leading countries in terms of number of immigrants; (2) to examine whether differences are accounted for by socio-economic characteristics, and (3) to determine whether the patterns of associations differ by gender. METHODS: Data come from the 2006 Spanish National Health Survey. The sample was composed of all 20-64 year old Spaniards and immigrants from the seven countries with most immigrants in Spain (Argentina, Bolivia, Colombia, Ecuador, Peru, Romania and Morocco) [n=20,731]. RESULTS: In both sexes, people from Bolivia had poorer health outcomes, above all Bolivian males. Conversely, people from Argentina and Colombia had the best health outcomes. For the rest of the countries varied results depending on gender, country and health indicator were found. CONCLUSIONS: Differences in health status between people born in Spain and foreign-born people depend on relationships

between country of birth, characteristics of the migration process, gender, ethnicity and the health outcome analyzed

**Acevedo-Garcia D., Sanchez-Vaznaugh E.V., Viruell-Fuentes E.A., Almeida J. (2012). Integrating social epidemiology into immigrant health research: a cross-national framework.** Soc Sci.Med, 75 (12) : 2060-2068.

Abstract: Scholarship on immigrant health has steadily increased over the past two decades. This line of inquiry is often approached as a "specialty" topic involving a discrete de-contextualized population, rather than a topic that is central for understanding patterns of population health within and between sending and receiving countries. Frequently immigrant health research employs theoretical frameworks (e.g., acculturation) that emphasize cultural explanations, while less commonly utilized is the "social determinants of health" framework, which emphasizes social and structural explanations. Drawing upon literature in the fields of economics, sociology of immigration, and social epidemiology, we present a conceptual framework for understanding immigrant health from a cross-national perspective. We discuss the theoretical foundations of this framework; the methodological challenges for undertaking research on immigration and health using this framework; examples of emerging research in this area; and directions for future research. Progress in immigrant health research and population health improvements can be achieved through an enhanced understanding of population health patterns in sending and receiving societies. Immigrant health research needs to be better integrated into social epidemiology. Concurrently, immigrant health research offers conceptual, empirical, and analytic opportunities to advance social epidemiological research. Together, scholarship in immigrant health and social epidemiology can make significant contributions toward one of their mutual and ultimate goals: to improve knowledge about population health

**Hill T.D., Angel J.L., Balistreri K.S., Herrera A.P. (2012). Immigrant status and cognitive functioning in late-life: an examination of gender variations in the healthy immigrant effect.** Soc Sci.Med, 75 (12) : 2076-2084.

Abstract: Although some research suggests that the healthy immigrant effect extends to cognitive functioning, it is unclear whether this general pattern varies according to gender. We use six waves of data collected from the original cohort of the Hispanic Established Populations for the Epidemiologic Study of the Elderly to estimate a series of linear growth curve models to assess variations in cognitive functioning trajectories by nativity status and age at migration to the U.S.A. among women and men. Our results show, among women and men, no differences in baseline cognitive status (intercepts) between early- (before age 20) and late-life (50 and older) immigrants and U.S.-born individuals of Mexican-origin. We also find, among women and men, that middle-life (between the ages of 20 and 49) immigrants tend to exhibit higher levels of baseline cognitive functioning than the U.S.-born. Our growth curve analyses suggest that the cognitive functioning trajectories (slopes) of women do not vary according to nativity status and age at migration. The cognitive functioning trajectories of early- and late-life immigrant men are also similar to those of U.S.-born men; however, those men who migrated in middle-life tend to exhibit slower rates of cognitive decline. A statistically significant interaction term suggests that the pattern for middle-life migration is more pronounced for men (or attenuated for women). In other words, although women and men who migrated in middle-life exhibit higher levels of baseline cognitive functioning, immigrant men tend to maintain this advantage for a longer period of time. Taken together, these patterns confirm that gender is an important conditioning factor in the association between immigrant status and cognitive functioning

**Viruell-Fuentes E.A., Miranda P.Y., Abdulrahim S. (2012). More than culture: structural racism, intersectionality theory, and immigrant health.** Soc Sci.Med, 75 (12) : 2099-2106.

Abstract: Explanations for immigrant health outcomes often invoke culture through the use of the concept of acculturation. The over reliance on cultural explanations for immigrant health outcomes



has been the topic of growing debate, with the critics' main concern being that such explanations obscure the impact of structural factors on immigrant health disparities. In this paper, we highlight the shortcomings of cultural explanations as currently employed in the health literature, and argue for a shift from individual culture-based frameworks, to perspectives that address how multiple dimensions of inequality intersect to impact health outcomes. Based on our review of the literature, we suggest specific lines of inquiry regarding immigrants' experiences with day-to-day discrimination, as well as on the roles that place and immigration policies play in shaping immigrant health outcomes. The paper concludes with suggestions for integrating intersectionality theory in future research on immigrant health

**Becares L., Nazroo J., Jackson J., Heuvelman H. (2012). Ethnic density effects on health and experienced racism among Caribbean people in the US and England: a cross-national comparison.** Soc Sci.Med, 75 (12) : 2107-2115.

Abstract: Studies indicate an ethnic density effect, whereby an increase in the proportion of racial/ethnic minority people in an area is associated with reduced morbidity among its residents, though evidence is varied. Discrepancies may arise due to differences in the reasons for and periods of migration, and socioeconomic profiles of the racial/ethnic groups and the places where they live. It is important to increase our understanding of how these factors might promote or mitigate ethnic density effects. Cross-national comparative analyses might help in this respect, as they provide greater heterogeneity in historical and contemporary characteristics in the populations of interest, and it is when we consider this heterogeneity in the contexts of peoples' lives that we can more fully understand how social conditions and neighbourhood environments influence the health of migrant and racial/ethnic minority populations. This study analysed two cross-sectional nationally representative surveys, in the US and in England, to explore and contrast the association between two ethnic density measures (black and Caribbean ethnic density) and health and experienced racism among Caribbean people. Results of multilevel logistic regressions show that nominally similar measures of ethnic density perform differently across health outcomes and measures of experienced racism in the two countries. In the US, increased Caribbean ethnic density was associated with improved health and decreased experienced racism, but the opposite was observed in England. On the other hand, increased black ethnic density was associated with improved health and decreased experienced racism of Caribbean English (results not statistically significant), but not of Caribbean Americans. By comparing mutually adjusted Caribbean and black ethnic density effects in the US and England, this study examined the social construction of race and ethnicity as it depends on the racialised and stigmatised meaning attributed to it, and the association that these different racialised identities have on health

**Murayama H., Wakui T., Arami R., Sugawara I., Yoshie S. (2012). Contextual effect of different components of social capital on health in a suburban city of the greater Tokyo area: a multilevel analysis.** Soc Sci.Med, 75 (12) : 2472-2480.

Abstract: Social capital (SC) can be broken down into a number of aspects and dimensions, but few studies have differentiated between the effects of different components of SC on health. This study examined the relationship between contextual SC and health (self-rated health, and co-occurrence of lifestyle risk factors such as smoking, drinking, overweight/underweight and physical inactivity) among the general population in a Japanese suburban area. The specific research question was to explore which components of contextual SC had what effects on health. In 2009, we randomly selected 4123 residents, aged 20 years and over, from 72 districts in the city of Kashiwa, Chiba prefecture (a typical suburban city of Tokyo) to participate in a cross-sectional survey using mailed questionnaires. We used four indicators of SC: cognitive/horizontal (trust in neighbors), cognitive/vertical (institutional trust in the national social security system), structural/horizontal (participation in groups with egalitarian relationships) and structural/vertical (participation in groups with hierarchical relationships). District-level SC was calculated by aggregating the individual responses of each SC indicator within each district. The response rate was 42.1% (1716

questionnaires), 43.7% of the respondents were male, and the mean age was 54.8 +/- 16.4 (ranging from 20 to 97). A multilevel analysis showed that higher district-level institutional mistrust was associated with self-rated poor health, but higher district-level mistrust in neighbors was inversely associated with it, after adjusting for individual-level covariates. There was no contextual effect of any SC components on co-occurrence of risk factors. Our findings showed that institutional trust has a beneficial effect on self-rated health, but trust among neighbors might negatively affect the health of the residents in a Japanese suburban city. These unique findings could suggest the advantage of breaking down SC to examine more specific relationships between SC and health, and the importance of accumulating the evidence in specific cohorts to develop customized health promotion strategies

## Médicaments

### **(2012). Livre blanc de la pharmacie d'officine européenne. Contribution des pharmaciens à l'efficacité des traitements et à la performance des systèmes de santé en Europe** : Bruxelles : GPEU.

Abstract: Ce document présente la vision commune des pharmaciens d'officine européens sur l'avenir de leur métier. Celle-ci est présentée en quatre parties : la mise à disposition de médicaments toujours plus sûrs, le renforcement de l'efficacité des traitements par une prise en charge individualisée des patients, la participation aux actions de santé publique, la contribution à l'efficacité et à la qualité des systèmes

Cote Irdes : En ligne

<http://www.ordre.pharmacien.fr/Communications/Rapports-Publications-ordinal-es/Livre-blanc-de-la-pharmacie-d-officine-europeenne>

### **(2012). La fabrique des DCI. Deuxième partie : comprendre les segments-clés pour donner du sens au nom des médicaments.** Revue Prescrire, 32 (350) : 940-946.

Abstract: Conçue sous l'égide de l'Organisation mondiale de la santé (OMS), la dénomination commune internationale (DCI) permet d'identifier une substance pharmaceutique de la même façon, partout dans le monde. Cet article est la première partie d'une visite guidée de la fabrique des DCI

Cote Irdes : P80

### **Lajoux C. (2012). Médicament : l'état d'urgence. Collection Santé.** Paris : le Cherche Midi

Abstract: Dans une crise sanitaire, il est légitime que la colère et l'inquiétude trouvent des voies d'expression. Mais il faut pouvoir échapper à l'émotion et aux idées reçues pour s'engager dans une analyse objective et documentée d'un secteur industriel pourvoyeur de progrès. Les enjeux, pour le pays et pour les patients, sont trop importants pour être passés sous silence. ». À la tête du Leem, l'organisation professionnelle des industriels du médicament, Christian Lajoux a vécu de l'intérieur la crise du Mediator et son retentissement politique, médiatique et sociétal. Une crise révélatrice d'une défiance galopante entre la société et ses « élites », et de la difficulté d'établir un diagnostic dépassionné sur le rôle de l'industrie du médicament, sur l'efficacité des autorités sanitaires et sur la place de la France dans les sciences du vivant (4ème de couv.)

Cote Irdes : A44415

### **Epstein A.J., Johnson S.J. (2012). Physician response to financial incentives when choosing drugs to treat breast cancer.** Int J Health Care Finance Econ, 12 (4) : 285-302.

Abstract: This paper considers physician agency in choosing drugs to treat metastatic breast cancer, a clinical setting in which patients have few protections from physicians' rent seeking. Physicians have



explicit financial incentives attached to each potential drug treatment, with profit margins ranging more than a hundred fold. SEER-Medicare claims and Medispan pricing data were formed into a panel of 4,503 patients who were diagnosed with metastatic breast cancer and treated with anti-cancer drugs from 1992 to 2002. We analyzed the effects of product attributes, including profit margin, randomized controlled trial citations, FDA label, generic status, and other covariates on therapy choice. Instruments and drug fixed effects were used to control for omitted variables and possible measurement error associated with margin. We find that increasing physician margin by 10% yields between an 11 and 177% increase in the likelihood of drug choice on average across drugs. Physicians were more likely to use drugs with which they had experience, had more citations, and were FDA-approved to treat breast cancer. Oncologists are susceptible to financial incentives when choosing drugs, though other factors play a large role in their choice of drug

## Méthodologie - Statistique

**Garrido M.M., Deb P., Burgess J.F., Jr., Penrod J.D. (2012). Choosing models for health care cost analyses: issues of nonlinearity and endogeneity.** Health Serv Res, 47 (6) : 2377-2397.

Abstract: OBJECTIVE: To compare methods of analyzing endogenous treatment effect models for nonlinear outcomes and illustrate the impact of model specification on estimates of treatment effects such as health care costs. DATA SOURCES: Secondary data on cost and utilization for inpatients hospitalized in five Veterans Affairs acute care facilities in 2005-2006. STUDY DESIGN: We compare results from analyses with full information maximum simulated likelihood (FIMSL); control function (CF) approaches employing different types and functional forms for the residuals, including the special case of two-stage residual inclusion; and two-stage least squares (2SLS). As an example, we examine the effect of an inpatient palliative care (PC) consultation on direct costs of care per day. DATA COLLECTION/EXTRACTION METHODS: We analyzed data for 3,389 inpatients with one or more life-limiting diseases. PRINCIPAL FINDINGS: The distribution of average treatment effects on the treated and local average treatment effects of a PC consultation depended on model specification. CF and FIMSL estimates were more similar to each other than to 2SLS estimates. CF estimates were sensitive to choice and functional form of residual. CONCLUSIONS: When modeling cost or other nonlinear data with endogeneity, one should be aware of the impact of model specification and treatment effect choice on results

**Metfessel B.A., Greene R.A. (2012). A nonparametric statistical method that improves physician cost of care analysis.** Health Serv Res, 47 (6) : 2398-2417.

Abstract: OBJECTIVE: To develop a compositing method that demonstrates improved performance compared with commonly used tests for statistical analysis of physician cost of care data. DATA SOURCE: Commercial preferred provider organization (PPO) claims data for internists from a large metropolitan area. STUDY DESIGN: We created a nonparametric composite performance metric that maintains risk adjustment using the Wilcoxon rank-sum (WRS) test. We compared the resulting algorithm to the parametric observed-to-expected ratio, with and without a statistical test, for stability of physician cost ratings among different outlier trimming methods and across two partially overlapping time periods. PRINCIPAL FINDINGS: The WRS algorithm showed significantly greater within-physician stability among several typical outlier trimming and capping methods. The algorithm also showed significantly greater within-physician stability when the same physicians were analyzed across time periods. CONCLUSIONS: The nonparametric algorithm described is a more robust and more stable methodology for evaluating physician cost of care than commonly used observed-to-

expected ratio techniques. Use of such an algorithm can improve physician cost assessment for important current applications such as public reporting, pay for performance, and tiered benefit design

## Politique de santé

### Prévention

#### **Burns R., Walsh B., O'Neill S., O'Neill C. (2012). An examination of variations in the uptake of prostate cancer screening within and between the countries of the EU-27.**

Health Policy, 108 (2-3) : 268-276.

Abstract: OBJECTIVES: Prostate specific antigen (PSA) testing as a part of a prostate cancer control strategy is the subject of much debate. This paper examines variations in the uptake of PSA testing across Europe and the role of individual and contextual variables in explaining this variation. METHODS: Data were taken from Eurobarometer 66.2 "Health in the European Union" 2006 on self-reported uptake of screening. Data related to men across the EU-27 and Croatia, aged 40 and over (N=6986). A logistic regression analysis examines the role of individual characteristics across and within the countries. RESULTS: A range of individual characteristics were found to be statistically significant predictors of uptake including education, marital status, and smoking status. Socio-economic status (SES) was also a statistically significant predictor of the likelihood of screening. Variation across countries in uptake was evident; importantly a significant role was accorded primary care in explaining variation in uptake. CONCLUSION: Uptake of PSA testing varies considerably within and across European countries. Differences within states relate to the characteristics of individuals offered tests and differences between states, to the system of primary care in operation. Given the significant welfare losses implicit in the evident variations the role of primary care warrants further investigation

### Prévision – Evaluation

#### **Shah K., Tsuchiya A., Risa H.A. (2012). Valuing health at the end of life: A stated preference discrete choice experiment**

Abstract: In 2009, the UK's National Institute for Health and Clinical Excellence (NICE) issued supplementary advice that its Appraisal Committees are to consider when assessing treatments that extend life at the end of life. This includes an option for approving such treatments for use in the NHS if certain criteria are met, even if base case cost-effectiveness estimates exceed the range usually considered acceptable. These criteria are: the treatment is indicated for patients with short life expectancies, normally less than 24 months; sufficient evidence exists to indicate that the treatment can extend life compared to current NHS treatment, usually by at least three months; the treatment is licensed or otherwise indicated for small patient populations. The policy thus places additional weight on the survival benefits for a small numbers of patients with terminal illnesses and short life expectancies. It assumes that this accurately reflects the preferences of the general public. However,

little scientific evidence is available to support that premise. To help fill this void, a discrete choice experiment was conducted in March 2012 with a sample of 3,969 members of the general public in England and Wales. Respondents were presented with a series of priority-setting scenarios. They were asked which of two hypothetical patients they thought should be treated, assuming the health service had enough funds to treat only one of them. For each patient, life expectancy and quality of life, with and without treatment, were describe

Cote Irdes : En ligne

<http://www.ohe.org/publications/article/valuing-health-at-the-end-of-life-1-25.cfm>

## Psychiatrie

**Milon A. (2012). Rapport d'information relatif à la prise en charge psychiatrique des personnes atteintes de troubles mentaux.** Rapport d'information du Sénat ; n°249. Paris : Sénat.

Abstract: Malgré une actualité souvent tragique et une vingtaine de rapports publiés depuis dix ans, la psychiatrie française n'a été abordée par la loi que sous l'angle de la dangerosité des malades, optique restrictive que la commission des affaires sociales avait regrettée. Ce rapport présenté entend préparer l'arrivée des grands textes de santé publique et d'organisation des soins en dressant un bilan de la prise en charge psychiatrique des personnes atteintes de troubles mentaux, sans ignorer la situation de celles souffrant de troubles du comportement ou de troubles envahissant du développement, et en formulant des propositions destinées à améliorer la prise en charge des patients. La commission des affaires sociales a adopté onze propositions pour remédier aux difficultés persistantes de la prise en charge psychiatrique des malades et favoriser la diffusion des meilleures pratiques en associant étroitement les soignants, les malades et les familles

Cote Irdes : En ligne

<http://www.senat.fr/rap/r12-249/r12-2491.pdf>

## Réglementation

**Nagelhout G.E., Willemsen M.C., Gebhardt W.A., van den Putte B., Hitchman S.C., Crone M.R., Fong G.T., van der Heiden S., de V.H. (2012). Does smoke-free legislation and smoking outside bars increase feelings of stigmatization among smokers? Findings from the International Tobacco Control (ITC) Netherlands Survey.** Health Place, 18 (6) : 1436-1440.

Abstract: This study examined whether smokers' perceived level of stigmatization changed after the implementation of smoke-free hospitality industry legislation and whether smokers who smoked outside bars reported more perceived stigmatization. Longitudinal data from the International Tobacco Control (ITC) Netherlands Survey was used, involving a nationally representative sample of 1447 smokers aged 15 years and older. Whether smoke-free legislation increases smokers' perceived stigmatization depends on how smokers feel about smoking outside. The level of perceived stigmatization did not change after the implementation of smoke-free hospitality industry legislation in the Netherlands, possibly because most Dutch smokers do not feel negatively judged when smoking outside

## Soins de santé primaires

**Salinero-Fort M.A., Jimenez-Garcia R., del Otero-Sanz L., de Burgos-Lunar C., Chico-Moraleja R.M., Martin-Madrado C., Gomez-Campelo P. (2012). Self-reported health status in primary health care: the influence of immigration and other associated factors.** PLoS One, 7 (6) : e38462.

**Abstract:** OBJECTIVE: The aims of this study are to compare self-reported health status between Spanish-born and Latin American-born Spanish residents, adjusted by length of residence in the host country; and additionally, to analyse sociodemographic and psychosocial variables associated with a better health status. DESIGN: This is a cross-sectional population based study of Latin American-born (n = 691) and Spanish-born (n = 903) in 15 urban primary health care centres in Madrid (Spain), carried out between 2007 and 2009. The participants provided information, through an interview, about self-reported health status, socioeconomic characteristics, psychosocial factors and migration conditions. Descriptive and multiple logistic regression analyses were conducted. RESULTS: The Spanish-born participants reported a better health status than the Latin America-born participants (79.8% versus 69.3%,  $p < 0.001$ ). Different patterns of self-reported health status were observed depending on the length of residence in the host country. The proportion of immigrants with a better health status is greater in those who have been in Spain for less than five years compared to those who have stayed longer. Better health status is significantly associated with being men, under 34 years old, being Spanish-born, having a monthly incomes of over 1000 euros, and having considerable social support and low stress. CONCLUSIONS: Better self-reported health status is associated with being Spanish-born, men, under 34 years old, having an uppermiddle-socioeconomic status, adequate social support, and low stress. Additionally, length of residence in the host country is seen as a related factor in the self-reported health status of immigrants

**Ognyanova D., Maier C.B., Wismar M., Girasek E., Busse R. (2012). Mobility of health professionals pre and post 2004 and 2007 EU enlargements: Evidence from the EU project PROMeTHEUS.** Health Policy, 108 (2-3) : 122-132.

**Abstract:** BACKGROUND: EU enlargement has facilitated the mobility of EU citizens, including health professionals, from the 2004 and 2007 EU accession states. Fears have been raised about a mass exodus of health professionals and the consequences for the operation of health systems. However, to date a systematic analysis of the EU enlargement's effects on the mobility of health professionals has been lacking. The aim of this article is to shed light on the changes in the scale of movement, trends and directions of flows pre and post 2004 and 2007 EU enlargements. METHODS: The study follows a pan-European secondary data analysis to (i) quantitatively and (ii) qualitatively analyse mobility before and after the EU enlargement. (i) The secondary data analysis covers 34 countries (including all EU Member States). (ii) Data were triangulated with the findings of 17 country case studies to qualitatively assess the effects of enlargement on health workforce mobility. RESULTS: The stock of health professionals from the new (EU-12) into the old EU Member States (EU-15) have increased following EU accession. The stock of medical doctors from the EU-12 in the EU-15 countries has more than doubled between 2003 and 2007. The available data suggest the same trend for dentists. The extremely limited data for nurses show that the stock of nurses has, in contrast, only slightly increased. However, while no reliable data is available evidence suggests that the number of undocumented or self-employed migrant nurses in the home-care sector has significantly increased. Health professionals trained in the EU-12 are becoming increasingly important in providing sufficient health care in some destination countries and regions facing staff shortages. CONCLUSION: A mass exodus of health professionals has not taken place after the 2004 and 2007 EU enlargements. The estimated annual outflows from the EU-12 countries have rarely exceeded 3% of the domestic

workforce. This is partly due to labour market restrictions in the destination countries, but also to improvements in salaries and working conditions in some source countries. The overall mobility of health professionals is hence relatively moderate and in line with the overall movement of citizens within the EU. However, for some countries even losing small numbers of health professionals can have impacts in underserved regions

**Sicsic J., Le V.M., Franc C. (2012). Intrinsic and extrinsic motivations in primary care: An explanatory study among French general practitioners.** *Health Policy*, 108 (2-3) : 140-148.

Abstract: **BACKGROUND:** Like many other OECD nations, France has implemented a pay-for-performance (P4P) model in primary care. However, the benefits have been debated, particularly regarding the possibly undesirable effects of extrinsic motivation (EM) on intrinsic motivation (IM). **OBJECTIVE:** To examine the relationship between French GPs' IM and EM based on an intrinsic motivation composite score (IMCS) developed for this purpose. If a negative relationship is found, P4P schemes could have side effects on GPs' IM that is a key determinant of quality of care. **METHOD:** From data on 423 GPs practicing in a region of France, IM indicators are selected using a multiple correspondence analysis and aggregated from a multilevel model. **RESULTS:** Several doctors' characteristics have significant impacts on IMCS variability, especially group practice and salaried practice. Qualitative EM variables are negatively correlated with the IMCS: GPs who report not being satisfied with their income or feeling "often" constrained by patients' requests in terms of consultations length and office appointments obtain a lower mean IMCS than other GPs. **CONCLUSION:** Our results provide a cautionary message to regulators who should take into account the potential side effects of increasing EM through policies such as P4P

**Gaskin D.J., Dinwiddie G.Y., Chan K.S., McCleary R.R. (2012). Residential segregation and the availability of primary care physicians.** *Health Serv Res*, 47 (6) : 2353-2376.

Abstract: **OBJECTIVE:** To examine the association between residential segregation and geographic access to primary care physicians (PCPs) in metropolitan statistical areas (MSAs). **DATA SOURCES:** We combined zip code level data on primary care physicians from the 2006 American Medical Association master file with demographic, socioeconomic, and segregation measures from the 2000 U.S. Census. Our sample consisted of 15,465 zip codes located completely or partially in an MSA. **METHODS:** We defined PCP shortage areas as those zip codes with no PCP or a population to PCP ratio of >3,500. Using logistic regressions, we estimated the association between a zip code's odds of being a PCP shortage area and its minority composition and degree of segregation in its MSA. **PRINCIPAL FINDINGS:** We found that odds of being a PCP shortage area were 67 percent higher for majority African American zip codes but 27 percent lower for majority Hispanic zip codes. The association varied with the degree of segregation. As the degree of segregation increased, the odds of being a PCP shortage area increased for majority African American zip codes; however, the converse was true for majority Hispanic and Asian zip codes. **CONCLUSIONS:** Efforts to address PCP shortages should target African American communities especially in segregated MSAs

**Hoff T., Weller W., DePuccio M. (2012). The Patient-Centered Medical Home: A Review of Recent Research.** *Medical Care Research and Review*, 69 (6) : 619-644.

Abstract: The patient-centered medical home is an important innovation in health care delivery. There is a need to assess the scope and substance of published research on medical homes. This article reviews published evaluations of medical home care for the period 2007 to 2010. Chief findings from these evaluations as a whole include associations between the provision of medical home care and improved quality, in addition to decreased utilization associated with medical home care in high-cost areas such as emergency department use. However, fewer associations were found across evaluations between medical home care and enhanced patient or family experiences. The early medical home research appears to reflect both the wide variation in how medical homes are being designed and implemented in practice and in how researchers are choosing to evaluate



patient-centered medical home design and implementation. While some aspects of medical home care show promise, continued evolution of medical home evaluative research is needed

**Aizpuru F., Latorre A., Ibáñez B., Garcia K.L., Vergara I., et al. (2012). Variability in the detection and monitoring of chronic patients in primary care according to what is registered in the electronic health record.** Family Practice, 29 (6) : 696-705.

Abstract: Background The electronic health record (EHR) allows a detailed study of the primary care consultations and assessment of variability among physicians regarding the implementation of practices for prevention, detection and monitoring of chronic diseases. Objectives To describe the variability in the detection and surveillance of chronic conditions in primary care. Methods Review of the medical records maintained by 1685 primary care physicians in the Basque Health Service. Estimation of age and sex standardized rates of compliance with evidence-based recommendations and the systematic component of variation (SCV). Results Compliance with screening recommendations varied from 14.2% for chronic obstructive pulmonary disease (COPD) to 37.2% for hypercholesterolaemia of the at-risk populations. Variability between Primary Care Units (PCUs) was low (SCV<sub>95</sub> < 0.10) for high blood pressure, hypercholesterolaemia and diabetes and high (SCV<sub>95</sub> > 0.20) for COPD. Based on the EHR registries, recommendations were followed to in at least 50% of relevant patients according to only 10 of the 44 good care practice (GCP) criteria. For 16 of the GCP criteria, the EHR data indicated compliance to the recommendations in <25% of patients diagnosed. Conclusions EHR data indicate that some of the preventative care practices recommended to detect chronic problems in primary care are unevenly implemented across PCUs. Notably, there is less variation in the case of conditions for which evidence-based clinical practice guidelines have been published. The level of monitoring is inadequate for all the conditions studied; particularly in those in which it is less evident that primary care is the right level of the health service to provide this care

**Cominol E.J., Davies G.P., Krastev Y. (2012). A systematic review of interventions to enhance access to best practice primary health care for chronic disease management, prevention and episodic care.** BMC Health Services Research, 12 (145) : 9, fig.

Abstract: Although primary health care (PHC) is a key component of all health care systems, services are not always readily available, accessible or affordable. This systematic review examines effective strategies to enhance access to best practice processes of PHC in three domains: chronic disease management, prevention and episodic care. The authors searched over 3,000 citations, and under the three domains identified study quality (high, medium, low). The authors describe how this review suggests that multiple, linked strategies targeting different levels of the health care system are most likely to improve access to best practice PHC. The proposed changes in the structure of PHC in Australia may provide opportunities to investigate the factors that influence access to best practice PHC and to develop and implement effective, evidence based strategies to address these

Cote Irdes : c, en ligne

<http://www.biomedcentral.com/content/pdf/1472-6963-12-415.pdf>

**Epstein A.J., Nicholson S., Asch D.A. (2013). The Production of and Market for New Physicians' Skill :** Cambridge : NBER

Abstract: Our understanding of the determinants of physician skill and the extent to which skill is valued in the marketplace is superficial. Using a large, detailed panel of new obstetricians, we find that, even though physicians' maternal complication rates improve steadily with years of practice, initial skill (as measured by performance in a physician's first year of practice) explains most of the variation in physician performance over time. At the same time, we find that the trajectories of new physicians' delivery volume develop in a way partially consistent with Bayesian learning about physician quality. In particular, as physician- s gain experience, their volume becomes increasingly sensitive to the information in their accumulated prior

Cote Irdes : C, en ligne

<http://www.nber.org/papers/w18678>

## Systèmes de santé

### **Toma O. (2012). Hippocrate, au secours ! Comment bâtir un système de santé durable. Les temps changent.** Paris : Pearson France

Abstract: Cet ouvrage dénonce les incohérences du système de santé français. Il dresse un état des lieux des problématiques dans lesquelles se noie ce secteur : méconnaissance du terrain par les décideurs, visions court-termistes des élus politiques, opacité des financements et des tarifs, toute-puissance des firmes pharmaceutiques... Les lourdeurs administratives, le manque de moyens et l'usure du quotidien entravent la créativité des acteurs de terrain et démotivent les plus investis d'entre eux. Il propose ici de réelles pistes de réflexion et d'action pour fonder une nouvelle politique de santé basée sur les principes du développement durable (d'après 4e de couverture)

Cote Irdes : A4414

<http://www.pearson.fr/livre/?GCOI=27440100339040>

### **Witmeur R., Desir D., Hut F. (2010). La réforme Obama du système de santé** : Bruxelles : CRISP.

Abstract: Le système de soins de santé en vigueur aux États-Unis suscite de nombreuses interrogations en Europe. Il est le plus cher et le plus complexe de tous les pays de l'OCDE sans être pour autant l'un des plus performants, ni en termes de santé publique, ni en termes de qualité des soins ou d'accessibilité. L'élection présidentielle américaine du 6 novembre 2012 a attiré l'attention des Européens sur les réformes introduites par Barack Obama lors de son premier mandat, et que souhaitait abroger le Parti républicain représenté par Mitt Romney. La victoire démocrate assure le maintien de la loi du 23 mars 2010, surnommée Obamacare, qui oblige la plupart des Américains à s'assurer avant 2014. Pour atteindre cet objectif, des subventions sont accordées aux citoyens à bas revenus et les compagnies d'assurance ne peuvent plus refuser de couvrir une personne en raison de ses antécédents médicaux. La réforme devrait coûter 940 milliards de dollars sur dix ans. Après avoir présenté le système de soins de santé américain et ses réformes en cours, ce Courrier hebdomadaire analyse les implications politiques, sociales, fiscales, budgétaires et culturelles de la réforme menée par Barack Obama, non seulement pour les États-Unis mais également pour la planète entière. Outre ses effets en politique intérieure, l'Obamacare aura des répercussions internationales en raison du leadership scientifique et technologique des États-Unis dans le domaine médical

Cote Irdes : B7131

### **Ciani O., Tarricone R., Torbica A. (2012). Diffusion and use of health technology assessment in policy making: What lessons for decentralised healthcare systems?**

Health Policy, 108 (2-3) : 194-202.

Abstract: OBJECTIVE: The Italian National Healthcare System (NHS) is one of the most decentralised systems since the devolution reform approved in 2001. HTA is spreading as an important tool for decision-making processes both at central and local levels. The aims of this study were to review the state of the health technology assessment (HTA) programmes in Italy - with a focus on regional and central initiatives - and to discuss consequences of a multi-level structure of HTA agencies in highly regionalised healthcare systems. METHODS: Our method combined documentary review with interviews. We reviewed scientific literature about HTA's activities in decentralised systems, legislative and administrative documents from national as well as regional authorities. Semi-



structured interviews were conducted with 18 key individuals associated with HTA both at the national and regional levels. Data on HTA programmes implemented or under development in nine regions were collected and analysed according to key principles for the improved conduct of health technology assessments for resource allocation decisions. RESULTS: HTA is in the early stage of development in Italy, although with great heterogeneity across regions. The National Agency for Health Services has certainly contributed to HTA diffusion through supporting and training activities. However, the multi-level structure of HTA in Italy has not yet provided full coordination and harmonisation of practices and outcomes across the country, with a consequent exacerbate inequality of access to services and technologies. CONCLUSIONS: There is probably need to rethink the multi-layer organizational framework of HTA in Italy by leveraging on current knowledge and efficient redistribution of activities across regions. We would advise for different jurisdictions playing different roles while achieving similar health outcomes for their patients, rather than jurisdictions aiming at doing exactly the same things resulting in unequal access to healthcare service provision

**Garcia-Goni M., Hernandez-Quevedo C., Nuno-Solinis R., Paolucci F. (2012). Pathways towards chronic care-focused healthcare systems: Evidence from Spain.** Health Policy, 108 (2-3) : 236-245.

Abstract: Increasing healthcare expenditure is a matter of concern in many countries, particularly in relation to the underlying drivers of such escalation that include ageing, medical innovation, and changes in the burden of disease, such as the growing prevalence of chronic diseases. Most healthcare systems in developed countries have been designed to 'cure' acute episodes, rather than to 'manage' chronic conditions, and therefore they are not suitably or efficiently organized to respond to the changing needs and preferences of users. New models of chronic care provision have been developed to respond to the changing burden of disease and there is already considerable practical experience in several different countries showing their advantages but also the difficulties associated with their implementation. In this paper, we focus on the Spanish experience in terms of policy changes and pilot studies focused on testing the feasibility of moving towards chronic care models. In particular, we discuss a framework that identifies and analyses ten key prerequisites to achieving high performing chronic care-based healthcare systems and apply it to the current Spanish National Health System (NHS). We find that the design of the Spanish NHS already meets some of these pre-requisites. However, other features are still in their early stages of development or are being applied only in limited geographical and clinical contexts. We outline the policies that are being implemented and the pathway that the Spanish NHS is taking to address the crucial challenge of the transition towards an optimal health system focused on chronic care. Given the current evidence and trends, we expect that the pathway for developing a chronicity strategy being followed by the Spanish NHS will significantly transform its current healthcare delivery model in the next few years

**Robinson S., Williams I., Dickinson H., Freeman T., Rumbold B. (2012). Priority-setting and rationing in healthcare: evidence from the English experience.** Soc Sci.Med, 75 (12) : 2386-2393.

Abstract: In a context of ever increasing demand, the recent economic downturn has placed further pressure on decision-makers to effectively target healthcare resources. Over recent years there has been a push to develop more explicit evidence-based priority-setting processes, which aim to be transparent and inclusive in their approach and a number of analytical tools and sources of evidence have been developed and utilised at national and local levels. This paper reports findings from a qualitative research study which investigated local priority-setting activity across five English Primary Care Trusts, between March and November 2012. Findings demonstrate the dual aims of local decision-making processes: to improve the overall effectiveness of priority-setting (i.e. reaching 'correct' resource allocation decisions); and to increase the acceptability of priority-setting processes for those involved in both decision-making and implementation. Respondents considered priority-setting processes to be compartmentalised and peripheral to resource planning and allocation. Further progress was required with regard to disinvestment and service redesign with respondents

noting difficulty in implementing decisions. While local priority-setters had begun to develop more explicit processes, public awareness and input remained limited. The leadership behaviours required to navigate the political complexities of working within and across organisations with differing incentives systems and cultures remained similarly underdeveloped

**(2012). Intersectoral governance and Health in All Policies.** Eurohealth, 18 (4) : -40p.

Abstract: This issue's Eurohealth Observer section explores key intersectoral structures used by governments, parliaments and the civil service to promote Health in All Policies. Four case study articles focus on specific intersectoral governance structures – parliamentary committees, inter-departmental units and committees, joint budgeting and industry engagement. Other articles include: Revising the Clinical Trials Directive; Medicines innovation in severe mental illness; Developing reference networks for Europe; Health reforms in Kazakhstan; and Eurohealth Monitor

Cote Irdes : Bulletin étranger

[http://www.euro.who.int/data/assets/pdf\\_file/0008/179729/Eurohealth\\_v18n4-.pdf](http://www.euro.who.int/data/assets/pdf_file/0008/179729/Eurohealth_v18n4-.pdf)

**(2013). U.S. Health in International Perspective: Shorter Lives, Poorer Health. Panel on Understanding Cross-National Health Differences Among High-Income Countries :**

Washington DC : National Academies Press.

Abstract: The United States is among the wealthiest nations in the world, but it is far from the healthiest. Although life expectancy and survival rates in the United States have improved dramatically over the past century, Americans live shorter lives and experience more injuries and illnesses than people in other high-income countries. The U.S. health disadvantage cannot be attributed solely to the adverse health status of racial or ethnic minorities or poor people: even highly advantaged Americans are in worse health than their counterparts in other, "peer" countries. In light of the new and growing evidence about the U.S. health disadvantage, the National Institutes of Health asked the National Research Council (NRC) and the Institute of Medicine (IOM) to convene a panel of experts to study the issue. The Panel on Understanding Cross-National Health Differences Among High-Income Countries examined whether the U.S. health disadvantage exists across the life span, considered potential explanations, and assessed the larger implications of the findings. This report presents detailed evidence on the issue, explores the possible explanations for the shorter and less healthy lives of Americans than those of people in comparable countries, and recommends actions by both government and nongovernment agencies and organizations to address the U.S. health disadvantage (tiré du résumé)

Cote Irdes : En ligne

[http://www.nap.edu/catalog.php?record\\_id=13497](http://www.nap.edu/catalog.php?record_id=13497)

**Schoen C., Guterman S., Zezza M. (2013). Confronting Costs. Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System :** New York :

The Commonwealth Fund.

Abstract: The Commonwealth Fund Commission on a High Performance Health System, to hold increases in national health expenditures to no more than long-term economic growth, recommends a set of synergistic provider payment reforms, consumer incentives, and systemwide reforms to confront costs while improving health system performance. This approach could slow spending by a cumulative \$2 trillion by 2023—if begun now with public and private payers acting in concert. Payment reforms would: provide incentives to innovate and participate in accountable care systems; strengthen primary care and patient-centered teams; and spread reforms across Medicare, Medicaid, and private insurers. With better consumer information and incentives to choose wisely and lower provider administrative costs, incentives would be further aligned to improve population health at more affordable cost. Savings could be substantial for families, businesses, and government at all levels and would more than offset the costs of repealing scheduled Medicare cuts in physician fees

<http://www.commonwealthfund.org/Publications/Fund-Reports/2013/Jan/Confronting-Costs.aspx?page=all>

## Travail et santé

**Bradley C.J., Neumark D., Motika M. (2012). The effects of health shocks on employment and health insurance: the role of employer-provided health insurance.** Int J Health Care Finance Econ, 12 (4) : 253-267.

Abstract: Employment-contingent health insurance (ECHI) has been criticized for tying insurance to continued employment. Our research sheds light on two central issues regarding employment-contingent health insurance: whether such insurance "locks" people who experience a health shock into remaining at work; and whether it puts people at risk for insurance loss upon the onset of illness, because health shocks pose challenges to continued employment. We study how men's dependence on their own employer for health insurance affects labor supply responses and health insurance coverage following a health shock. We use the Health and Retirement Study (HRS) surveys from 1996 through 2008 to observe employment and health insurance status at interviews 2 years apart, and whether a health shock occurred in the intervening period between the interviews. All employed married men with health insurance either through their own employer or their spouse's employer, interviewed in at least two consecutive HRS waves with non-missing data on employment, insurance, health, demographic, and other variables, and under age 64 at the second interview are included in the study sample. We then limited the sample to men who were initially healthy. Our analytical sample consisted of 1,582 men of whom 1,379 had ECHI at the first interview, while 203 were covered by their spouse's employer. Hospitalization affected 209 men with ECHI and 36 men with spouse insurance. A new disease diagnosis was reported by 103 men with ECHI and 22 men with other insurance. There were 171 men with ECHI and 25 men with spouse employer insurance who had a self-reported health decline. Labor supply response differences associated with ECHI-with men with health shocks and ECHI more likely to continue working-appear to be driven by specific types of health shocks associated with future higher health care costs but not with immediate increases in morbidity that limit continued employment. Men with ECHI who have a self-reported health decline are significantly more likely to lose health insurance than men with insurance through a spouse. With the passage of health care reform, the tendency of men with ECHI as opposed to other sources of insurance to remain employed following a health shock may be diminished, along with the likelihood of losing health insurance

**Burstrom B., Nylén L., Barr B., Clayton S., Holland P., Whitehead M. (2012). Delayed and differential effects of the economic crisis in Sweden in the 1990s on health-related exclusion from the labour market: a health equity assessment.** Soc Sci.Med, 75 (12) : 2431-2436.

Abstract: Many OECD countries are currently experiencing economic crisis and introducing counter-measures with unknown effects. To learn from previous experience, we explored whether there were delayed or differential effects of the Swedish recession in the 1990s and the government's response to it for people with limiting longstanding illness or disability (LLSI) from different socioeconomic groups (SEGs), by policy analysis and secondary data analysis of the Swedish Survey of Living Conditions (ULF) from 1978 to 2005. The government policy response involved cutting public expenditure, privatising some services and measures to boost private sector employment. There was a decline in overall employment rates from the early 1990s, particularly among men and women with LLSI and in lower SEGs. Public sector employment declined from 53 to 40 percent among women and from 23 to 14 percent among men. Private sector employment increased modestly for women (from

31 percent to 37 percent), and stayed stable at 59-60 percent among men. Following economic recovery, employment rates continued to decline among men and women with LLSI from manual SEGs, while the employment levels increased among most healthy men and women. There was a concomitant increase in rates of LLSI, sickness absence and rates of disability pension particularly among women in lower SEGs. Conclusion: The policy response to the 1990s economic crisis in Sweden had differential consequences, hitting the employment of women in the public sector, especially women with both LLSI and low socioeconomic status. The observed increase in disability pension rates, particularly among women with LLSI in lower SEGs, may be a delayed effect of the policy response to the economic crisis

## Vieillesse

**Mein G., Seale C., Rice H., Johal S., Ashcroft R.E., Ellison G., Tinker A. (2012). Altruism and participation in longitudinal health research? Insights from the Whitehall II Study.** Soc Sci.Med, 75 (12) : 2345-2352.

Abstract: Research that follows people over a period of time (longitudinal or panel studies) is important in understanding the ageing process and changes over time in the lives of older people. Older people may choose to leave studies due to frailty, or illness and this may diminish the value of the study. However, people also drop out of studies for other reasons and understanding the motivation behind participation or drop out may prevent further loss of valuable longitudinal information and assist the continuation of longitudinal studies. This paper examines qualitative data from interviews and focus groups in 2003/2008 with participants of the Whitehall II Study (based at UCL), and investigates reasons participants give for participating in longitudinal health studies, and recommendations they give for encouraging continued participation as they grow older. A total of 28 participants and 14 staff were interviewed, and 17 participants took part in focus groups. Our findings are discussed in the light of the debate between of altruism and reciprocity. Rather than being wholly motivated by altruism, as research staff had assumed, participants were motivated by the benefits they perceived, particularly the information and care received during the medical examinations and the sense of loyalty and membership associated with being part of the study. Our findings support the view that far from being primarily motivated by altruism, research participation in studies such as this may also involve a degree of implicit and explicit reciprocity. However, participants disliked the obligation to complete the study questionnaires--which may have influenced the expectation of payment or reciprocation, as participation was not wholly pleasing. To try and maintain participation in longitudinal health studies this project recommended gathering information from exit interviews as a way of preventing further withdrawals and closer involvement of participants through a user panel

**Behaghel L., Blau D.M. (2012). Framing Social Security Reform: Behavioral Responses to Changes in the Full Retirement Age.** American Economic Journal: Economic Policy, 4 (4) : 41-67.

**Robben S., van Kempen J., Heinen M., Zuidema S., Olde Rikkert M., Schers H., Melis R. (2012). Preferences for receiving information among frail older adults and their informal caregivers: a qualitative study.** Family Practice, 29 (6) : 742-747.

Abstract: Background Patient involvement in clinical decision making is increasingly advocated. Although older patients may be more reluctant to become involved, most do appreciate being informed. However, knowledge about their experiences with and preferences for receiving information is limited, and even less is known about these topics for frail older people. Objective To

explore the experiences of frail older people and informal caregivers with receiving information from health care professionals as well as their preferences for receiving information. Methods We conducted semi-structured interviews with frail older people (n = 11, 65-90 years) and informal caregivers (n = 11, 55-87 years). Interviews were transcribed verbatim and analysed using a grounded theory approach. Results Frail older people and informal caregivers varied in their information needs and discussed both positive and negative experiences with receiving information. They preferred receiving verbal information from their physician during the consultation; yet would appreciate receiving brief, clearly written information leaflets in addition. They employed several strategies to enhance the information provided, i.e. advocacy, preparing for a consultation and searching their own information. Contextual factors for receiving information, such as having enough time and having a good relationship with professionals involved, were considered of great importance. Conclusions Participants described a wide range of experiences with and preferences for receiving information. However, even if the information provided would meet all their preferences, this would be of limited significance if not provided within the context of an ongoing trusting relationship with a professional, such as a GP or practice nurse, who genuinely cared for them

**Kotsadam A. (2012). The employment costs of caregiving in Norway.** Int J Health Care Finance Econ, 12 (4) : 269-283.

Abstract: Informal eldercare is an important pillar of modern welfare states and the ongoing demographic transition increases the demand for it while social trends reduce the supply. Substantial opportunity costs of informal eldercare in terms of forgone labor opportunities have been identified, yet the effects seem to differ substantially across states and there is a controversy on the effects in the Nordic welfare states. In this study, the effects of informal care on the probability of being employed, the number of hours worked, and wages in Norway are analyzed using data from the Life Course, Generation, and Gender survey. New and previously suggested instrumental variables are used to control for the potential endogeneity existing between informal care and employment-related outcomes. In total, being an informal caregiver in Norway is found to entail substantially less costs in terms of forgone formal employment opportunities than in non-Nordic welfare states

**Lipszyk B., Sail E., Xavier A. (2012). Long-term care: need, use and expenditure in the EU-27** : Bruxelles : Commission européenne

Abstract: Public provision of long-term care (LTC) will pose an increasing challenge to the sustainability of public finances in the EU, due to an ageing population. In this view, the paper aims to provide indications on the timing and potential fiscal impact associated to changes in the demographic structure. The ageing of the population is expected to put pressure on governments to provide long-term care services as (very) old people often develop multi-morbidity conditions, which require not only long-term medical care but assistance with a number of daily tasks. This paper presents the projections of public expenditure on LTC in the long run (2060) under alternative assumptions. All scenarios project a non-negligible increase in public expenditure. All other things being equal, the expected increase in the demand for formal LTC support will vary across EU-27 Member States according to their current patterns of LTC provision: the balance between formal and informal care, the emphasis they put on institutional care, home care or provision of cash benefits, the supply constraints both in the formal and informal care sectors, the current average cost and coverage rate for each type of care and their distribution across age groups. The paper also discusses policy implications of the projection results

Cote Irdes : En ligne

[http://ec.europa.eu/economy\\_finance/publications/economic\\_paper/2012/pdf/ec\\_p469\\_en.pdf](http://ec.europa.eu/economy_finance/publications/economic_paper/2012/pdf/ec_p469_en.pdf)

**Spagnolo G.C., Bergman M.A., Lundberg S. (2012). Privatization and Quality: Evidence from Elderly Care in Sweden** : Stockholm : Stockholm Institute of Transition Economics.

Abstract: Many quality dimensions are hard to contract upon and are at risk of degradation when services are procured rather than produced in-house. However, procurement may foster



performance-improving innovation. We assemble a large data set on elderly care services in Sweden between 1990 and 2009, including survival rates - our measure of non-contractible quality - and subjectively perceived quality of service. We estimate how procurement from private providers affects these measures using a difference-in-difference approach. The results indicate that procurement significantly increases non-contractible quality as measured by survival rate, reduces the cost per resident but does not affect subjectively perceived quality

Cote Irdes : En ligne

<http://swopec.hhs.se/hasite/papers/hasite0019.pdf>

**Rutledge M.S. (2012). Holding Out or Opting Out? Deciding Between Retirement and Disability Applications in Recessions :** Chestnut Hill : Center for Retirement Research at Boston College

Abstract: Workers over age 55 with chronic health conditions must choose between applying for Social Security Disability Insurance (SSDI) benefits or continuing to work until their Social Security retirement benefits become available. Previous research has investigated the influence of macroeconomic conditions on disability application and, separately, on retirement claiming. This project uses data from the Survey of Income and Program Participation Gold Standard File to determine whether there is a relationship between national and state unemployment rates and disability applications, taking into account the current or future receipt of Social Security retirement benefits. First, reduced-form estimates indicate that retirement beneficiaries are more likely to apply for SSDI as unemployment increases – and, conversely, eligible individuals who have not yet claimed benefits are less likely to apply when unemployment rises. But after accounting for unobserved characteristics associated with both the decision to apply for disability insurance and Social Security benefits, individuals are no more likely to apply for disability benefits when unemployment is high. Second, we find that the probability of SSDI application among individuals age 55-61 is unrelated to macroeconomic conditions and unrelated to proximity to one's 62nd birthday. These results suggest that, unlike prime-age adults, the decision among older individuals to apply for disability is based primarily on health, and not financial incentives

Cote Irdes : En ligne

[http://crr.bc.edu/wp-content/uploads/2012/11/wp\\_2012-26.pdf](http://crr.bc.edu/wp-content/uploads/2012/11/wp_2012-26.pdf)

**Richardson D., Patana P. (2012). Integrating service delivery: why, for who, and how?** Paris : OCDE

Abstract: There is a need for a policy shift from separation to integration of services in order to tackle the complex social problems experienced by vulnerable populations. Moreover, the growing share of the elderly population, which is more likely to suffer from chronic diseases and have dual or multiple diagnoses, will also increase health expenditure (Vondeling, 2004). In order to prevent the costs of health care increasing in the future, more integrated care delivery solutions are needed to better meet the complex needs of the elderly. The limited empirical evidence-base for, and the absence of tools for, measurement and comparison of integrated services remain a significant barrier for the evaluation and implementation of these policies. There is a need for policy discussion and comparative analysis on integrated services at an international level to assist stakeholders and policymakers to prepare for future challenges

Cote Irdes : En ligne

[http://www.oecd.org/els/socialpoliciesanddata/Richardson\\_Patana%20INTEGRATING%20SERVICE%20DELIVERY%20WHY%20FOR%20WHO%20AND%20HOW.pdf](http://www.oecd.org/els/socialpoliciesanddata/Richardson_Patana%20INTEGRATING%20SERVICE%20DELIVERY%20WHY%20FOR%20WHO%20AND%20HOW.pdf)