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DOC VEILLE : veille bibliographique en économie de la santé

31 mai 2013

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Assurance maladie

Vayssette P (2013). La question de l'accès aux données de santé anonymisées : entretien avec Christian Babusiaux (IDS). *Réseaux Santé et Territoire*, (43) : 12-15.

Cote Irdes : P204

Lamiraud K. (2013). Switching costs in competitive health insurance markets : Cergy Pontoise : Essec

Abstract: Cet article analyse la présence de coûts de changement (coûts de switching) lorsque les consommateurs ont la possibilité de changer d'assureur pour l'assurance maladie de base. Nous nous intéressons au cas de la Suisse qui a mis en place une forme relativement pure de concurrence en assurance maladie. Nous identifions différents types de coûts de changement : l'excès de choix (en Pôle Documentation de l'Irdes - Marie-Odile Safon et Véronique Suhard

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termes de nombre de compagnies présentes sur le marché), le biais de statu quo, la possession d'un contrat d'assurance supplémentaire pour les assurés déclarant un mauvais état de santé, les stratégies tarifaires des firmes qui utilisent l'assurance supplémentaire comme produit d'appel, la mauvaise régulation des réserves des caisses et les limites liées au mécanisme initial de compensation des risques.

Cote Irdes : En ligne

<http://hal-essec.archives-ouvertes.fr/docs/00/80/84/20/PDF/WP1305.pdf>

Guthmuller S., Jusot F., Wittwer J., Despres C. (2013). Faire valoir ses droits à l'Aide complémentaire santé : les résultats d'une expérimentation sociale. In : Systèmes de santé. *Economie et Statistique*, (455-456) : 53-70.

Abstract: L'Aide complémentaire santé (ACS) ou « chèque santé » a été mise en place en 2005 pour inciter les ménages dont le niveau de vie se situe juste au-dessus du plafond CMU-C à acquérir une couverture complémentaire santé grâce à une subvention. Même si le nombre de bénéficiaires a lentement progressé depuis son introduction, le recours à l'ACS reste faible. Deux hypothèses peuvent expliquer cet état de fait : le défaut d'information sur l'existence du dispositif, son fonctionnement et sur les démarches à entreprendre pour en bénéficier ; un montant d'aide insuffisant, la complémentaire resterait trop chère même après déduction de l'aide. Afin de tester la validité de ces deux hypothèses, une expérimentation sociale contrôlée a été mise en place par l'université Paris-Dauphine à Lille auprès d'un échantillon de 4 209 assurés sociaux potentiellement éligibles à l'ACS. Un montant majoré d'aide ainsi qu'un accès différencié à de l'information sur le dispositif ont été proposés de manière aléatoire à certains assurés.

Cote Irdes : R1921, S18

http://www.insee.fr/fr/themes/document.asp?reg_id=0&id=3963

Dormont B., Geoffard P.Y., Lamiraud K. (2013). Assurance maladie en Suisse : les assurances supplémentaires nuisent-elles à la concurrence sur l'assurance de base ? In : Systèmes de santé. *Economie et Statistique*, (455-456) : 71-87.

Abstract: L'objet de cet article est d'analyser le fonctionnement d'un système de concurrence régulée en assurance maladie. En considérant le cas de la Suisse, on s'intéresse aux interférences potentielles entre le marché des assurances supplémentaires et la concurrence sur le marché de l'assurance de base. L'organisation actuelle de l'assurance maladie en France diffère de celle du système suisse. Mais les assurances complémentaires participent de plus en plus à la couverture des soins dans notre pays. La question de la régulation du marché des assurances complémentaires doit donc être posée. L'analyse du système suisse, qui s'appuie sur un marché régulé d'assurance maladie, peut illustrer certains enjeux du système français (résumé d'auteur).

Cote Irdes : S18

http://www.insee.fr/fr/themes/document.asp?reg_id=98&id=3964

Geoffard P.Y., Lagasnerie G. (2013). Réformer le système de remboursement pour les soins de ville, une analyse par microsimulation. In : Systèmes de santé. *Economie et Statistique*, (455-456) : 89-113.

Abstract: Les évolutions du système de remboursement des dépenses de soins par l'assurance publique ont progressivement diminué la couverture publique du risque maladie. Ce système laisse à la charge des assurés des sommes qui peuvent s'avérer importantes lorsque ceux-ci traversent des épisodes de maladie longs et coûteux, et parfois même lorsqu'ils bénéficient d'exonérations au titre d'une affection de longue durée. L'assurance complémentaire est de fait devenue nécessaire. Cependant, 7 % de la population ne jouit pas d'une telle assurance. Cet article étudie une réforme possible de l'assurance maladie obligatoire qui prend la forme d'un plafond annuel de la participation financière en soins de ville. Un tel plafond serait financé par l'instauration de franchises annuelles. Nous évaluons cette réforme à partir de micro-simulations appliquées aux données de l'enquête santé soins médicaux 2003, appariée avec les données de remboursement de l'assurance maladie publique (SNIIR-AM) (résumé d'auteur).

Cote Irdes : S18

http://www.insee.fr/fr/themes/document.asp?reg_id=0&id=3965

(2013). Europe : renforcer la viabilité des régimes de sécurité sociale. *Perspectives en Politique Sociale*, (29) : -4p.

Abstract: Ce numéro met en lumière les enjeux en perpétuelle évolution auxquels sont confrontés les

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régimes de sécurité sociale européens ; présente les innovations destinées à favoriser l'excellence administrative et à préserver la sécurité sociale en Europe ; explique comment les politiques sociales et du marché du travail peuvent concourir à l'obtention de résultats cohérents ; préconise une association plus efficace des rôles protecteur, proactif et préventif de la sécurité sociale.

Cote Irdes : En ligne

<http://www.issa.int/fre/Ressources/Perspectives-en-politique-sociale>

Economie de la santé

Kohn J.L., Liu J.S. (2013). The dynamics of medical care use in the British household panel survey. *Health Econ*, 22 (6) : 687-710.

Abstract: We explore whether medical care use is persistent over a long panel using 18 waves of the British Household Panel Survey. Of particular interest is high medical care use because a few high users account for a disproportionate amount of use while many individuals use no medical care in a given year. If health is a primary driver of medical care demand, and we control for health, then past medical care use should be uninformative for future use. However, we find that conditional on health, other covariates and unobservable heterogeneity, medical care use remains significantly persistent. "No use" and "high use" are more strongly persistent, and persistence is generally stronger for women, those in poor health, and at older ages. We find that unobservable heterogeneity explains between 10% and 25% of the variation in medical care use. This heterogeneity is significantly correlated with both medical care use and health over our long panel. These findings have implications for the econometric modeling of medical care demand and suggest that policies aimed to reduce aggregate medical care spending by improving health, particularly the health of seniors, may be less effective than projected using static models.

Ginsburg P.B. (2013). Achieving health care cost containment through provider payment reform that engages patients and providers. *Health Aff.(Millwood.)*, 32 (5) : 929-934.

Abstract: The best opportunity to pursue cost containment in the next five to ten years is through reforming provider payment to gradually diminish the role of fee-for-service reimbursement. Public and private payers have launched many promising payment reform pilots aimed at blending fee-for-service with payment approaches based on broader units of care, such as an episode or patients' total needs over a period of time, a crucial first step. But meaningful cost containment from payment reform will not be achieved until Medicare and Medicaid establish stronger incentives for providers to contract in this way, with discouragement of nonparticipation increasing over time. In addition, the models need to evolve to engage beneficiaries, perhaps through incentives for patients to enroll in an accountable care organization and to seek care within that organization's network of providers.

Rauch F. (2013). Les dépenses de santé en France : principaux indicateurs. *Cahiers de Santé Publique et de Protection Sociale (Les)*, (2) : 55-59.

Abstract: Le système de santé est malade des réformes libérales mises en œuvre pour tenter de l'adapter à la gestion de la crise systémique en France, comme en Europe. En France, l'obsession de la réduction de la dette publique et sociale touche les dépenses de santé. Cet article porte, tout d'abord, sur la mesure et la structure des dépenses de santé en France. Il présente ensuite des modèles alternatifs pour promouvoir une réforme de progrès et d'efficacité du système de santé, tournant le dos aux politiques de rigueur actuelle.

Cote Irdes : B7151

Etat de santé

Jusot F., Tubeuf S., Trannoy A. (2013). Les différences d'état de santé en France : inégalités des chances ou reflet des comportements à risques ? In : *Systèmes de santé. Economie et Statistique*, (455-456) : 37-51.

Abstract: Cet article propose d'évaluer la part des inégalités de santé perçue liées aux conditions dans l'enfance, et celle liées aux comportements à risque, en considérant deux positions éthiques possibles relatives à la corrélation entre milieu d'origine et comportements à risque. Dans une première étape, seul l'effet direct sur la santé du milieu d'origine est considéré comme source d'inégalités des chances. Dans une seconde étape, son effet indirect sur les comportements liés à la santé est en outre considéré comme source d'inégalités illégitimes. L'application aux données de l'enquête Santé Protection Sociale 2006 de l'Irdes, dans laquelle a été introduit un module spécifique de questions sur les conditions de vie dans l'enfance, met en évidence la contribution massive du milieu d'origine aux inégalités de santé et ce, quelle que soit la position éthique retenue. Ainsi, les inégalités des chances représentent jusqu'à 46 % des inégalités de santé alors que celles liées aux comportements à risque ne dépassent pas 7 %, les inégalités résiduelles étant liées à l'influence de l'âge et du sexe.

Cote Irdes : R1920, S18

http://www.insee.fr/fr/themes/document.asp?reg_id=0&id=3962

Hosseinpoor A.R., Stewart Williams J.A., Gautam J., Posarac A., Officer A., Verdes E., Kostanjsek N., Chatterji S. (2013). Socioeconomic Inequality in Disability Among Adults: A Multicountry Study Using the World Health Survey. In : *American Journal of Public Health. American Journal of Public Health*, e1-e9.

Abstract: Objectives. We compared national prevalence and wealth-related inequality in disability across a large number of countries from all income groups. Methods. Data on 218?737 respondents participating in the World Health Survey 2002?2004 were analyzed. A composite disability score (0?100) identified respondents who experienced significant disability in physical, mental, and social functioning irrespective of their underlying health condition. Disabled persons had disability composite scores above 40. Wealth was evaluated using an index of economic status in households based on ownership of selected assets. Socioeconomic inequalities were measured using the slope index of inequality and the relative index of inequality. Results. Median age-standardized disability prevalence was higher in the low- and lower middle-income countries. In all the study countries, disability was more prevalent in the poorest than in the richest wealth quintiles. Pro-rich inequality was statistically significant in 43 of 49 countries, with disability prevalence higher among populations with lower wealth. Median relative inequality was higher in the high- and upper middle-income countries. Conclusions. Integrating equity components into the monitoring of disability trends would help ensure that interventions reach and benefit populations with greatest need. (Am J Public Health. Published online ahead of print May 16, 2013: e1?e9. doi:10.2105/AJPH.2012.301115)

Objectives. We compared national prevalence and wealth-related inequality in disability across a large number of countries from all income groups. Methods. Data on 218?737 respondents participating in the World Health Survey 2002?2004 were analyzed. A composite disability score (0?100) identified respondents who experienced significant disability in physical, mental, and social functioning irrespective of their underlying health condition. Disabled persons had disability composite scores above 40. Wealth was evaluated using an index of economic status in households based on ownership of selected assets. Socioeconomic inequalities were measured using the slope index of inequality and the relative index of inequality. Results. Median age-standardized disability prevalence was higher in the low- and lower middle-income countries. In all the study countries, disability was more prevalent in the poorest than in the richest wealth quintiles. Pro-rich inequality was statistically significant in 43 of 49 countries, with disability prevalence higher among populations with lower wealth. Median relative inequality was higher in the high- and upper middle-income countries. Conclusions. Integrating equity components into the monitoring of disability trends would help ensure that interventions reach and benefit populations with greatest need.

Géographie de la santé

Audureau E. (2012). Etude des déterminants géographiques et spatiaux de la qualité de vie liée à la santé en France. Thèse pour le Doctorat en Santé Publique. Spécialité épidémiologie. Paris : Université Paris Descartes.

Abstract: La France est caractérisée par l'existence de fortes disparités socioéconomiques et géographiques de l'état de santé, le plus souvent objectivées par des indicateurs objectifs de morbidité et de mortalité. La distribution territoriale des mesures de santé perçue comme la qualité de vie liée à la santé (QdVLS) reste mal connue en population générale. Une meilleure connaissance de la répartition et des déterminants – en particulier contextuels - de ces indicateurs subjectifs permettrait de mieux comprendre leur signification par rapport aux indicateurs objectifs et d'apprécier l'intérêt spécifique de leur suivi en population générale. Les objectifs de cette recherche étaient d'étudier l'existence de disparités spatiales de QdVLS dans la population française et d'analyser leur évolution dans le temps, d'étudier les déterminants de la QdVLS à la fois individuels et contextuels dans le cadre d'une analyse multiniveau, et d'évaluer les associations écologiques entre QdVLS et mortalité ultérieure à cinq ans d'intervalle. (résumé d'auteur).

<http://tel.archives-ouvertes.fr/tel-00800664/>

Eibich P., Ziebarth N.R. (2013). Analyzing Regional Variation in Health Care Utilization Using (Rich) Household Microdata : Berlin : DIW

Abstract: This paper exploits rich SOEP microdata to analyze state-level variation in health care utilization in Germany. Unlike most studies in the field of the Small Area Variation (SAV) literature, our approach allows us to net out a large array of individual-level and state-level factors that may contribute to the geographic variation in health care utilization. The raw data suggest that state-level hospitalization rates vary from 65 percent to 165 percent of the national mean. Ambulatory doctor visits range from 90 percent to 120 percent of the national mean. Interestingly, in the former GDR states doctor visit rates are significantly below the national mean, while hospitalization rates lie above the national mean. The significant state-level differences vanish once we control for individual-level socio-economic characteristics, the respondents' health status, their health behavior as well as supply-side state-level factors.

http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2258421

Delattre E., Samson A.L. (2013). Stratégies de localisation des médecins généralistes français : mécanismes économiques ou hédonistes ? In : Systèmes de santé. *Economie et Statistique*, (455-456) : 115-142.

Abstract: En France, la densité médicale est élevée mais les médecins généralistes sont très inégalement répartis sur le territoire. Parce qu'elle renvoie à des questions d'équité et d'efficacité, cette mauvaise répartition constitue aujourd'hui un enjeu majeur de la régulation de la démographie médicale. Un échantillon exhaustif de 9 000 médecins généralistes ayant débuté leur carrière libérale entre 1997 et 2002 est mobilisé afin d'analyser les déterminants des choix individuels de localisation des médecins généralistes et, ainsi, de rendre compte des outils qui pourraient être utilisés spécifiquement au niveau régional pour modifier leurs comportements de localisation. Nous modélisons deux décisions : le choix du changement de région entre la date de la soutenance de la thèse et l'installation et le choix de la région d'exercice pour les seuls médecins qui quittent la région où ils ont soutenu leur thèse. Au travers de ces choix individuels, nous étudions en particulier l'attractivité monétaire des régions afin de déterminer dans quelle mesure les comportements des médecins pourraient être influencés par l'instauration de primes à l'installation dans les zones sous-dotées en médecins (résumé d'auteur)

Cote Irdes : S18

http://www.insee.fr/fr/themes/document.asp?reg_id=0&id=3966

Hôpital

Dormont B., Milcent C. (2013). Comment évaluer la productivité et l'efficacité des hôpitaux publics et privés ? Les enjeux de la convergence tarifaire. In : Systèmes de santé. *Economie et Statistique*, (455-456) : 143-173.

Abstract: Cet article a pour but de comprendre les différences de productivité observées en France

entre les hôpitaux publics, les hôpitaux privés à but non lucratif (PSPH) et les cliniques privées. Nous examinons s'il existe une influence de la composition de la patientèle et des séjours sur la productivité des hôpitaux. Si tel est le cas, introduire de la concurrence entre les hôpitaux sur la base de la Tarification à l'Activité ne promeut pas seulement l'efficacité, mais crée aussi de fortes pressions au sein des établissements en faveur d'une réorientation de l'offre de soins. La base de données utilisée est un panel d'hôpitaux proche de l'exhaustivité pour les soins aigus : 1 604 hôpitaux sont observés sur la période 1998-2003. L'analyse couvre les six années précédant l'introduction de la T2A en France afin d'observer la situation qui préexistait avant la mise en place de nouvelles incitations (résumé d'auteur)

Cote Irdes : S18

http://www.insee.fr/fr/themes/document.asp?reg_id=0&id=3967

Studer N. (2013). Quelles évolutions récentes de la productivité hospitalière dans le secteur public ? In : Systèmes de santé. *Economie et Statistique*, (455-456) : 175-202.

Abstract: Après plusieurs décennies de forte croissance des dépenses de santé, leur efficacité fait l'objet d'une attention accrue. La description fine de l'activité de court séjour fournie par le Programme de médicalisation du système d'information (PMSI) permet d'analyser l'évolution de la performance économique des établissements de santé. Ce travail se propose ainsi de définir un indice de productivité globale construit à partir de l'estimation sur la période 2003-2007 d'une fonction de production pour le secteur hospitalier public. L'indicateur d'activité retenu est la somme des séjours ou actes par groupe homogène de malades (GHM), pondérés par les coûts observés dans un échantillon d'hôpitaux en 2002-2003. Il s'agit donc essentiellement d'un indicateur d'activité, à qualité des soins supposée constante. On cherche à rendre compte de cette activité par la composition du personnel, ainsi que d'autres caractéristiques observables des établissements, dont la taille et un indice de plateau technique. L'indice de productivité correspond à la part de l'activité qui n'est pas expliquée par le niveau de ces différents facteurs explicatifs (résumé d'auteur)

Cote Irdes : S18

http://www.insee.fr/fr/themes/document.asp?reg_id=0&id=3967

Murphy M., Martikainen P. (2013). Use of hospital and long-term institutional care services in relation to proximity to death among older people in Finland. *Social Science & Medicine*, 88 (0) : 39-47.

Abstract: Abstract Using nationally-representative register data for older people in Finland in period 1998-2003 we study how the number of days in acute hospital and long term institutional care services varies by age and proximity to death and how these use patterns change as mortality improves. Acute health care use depends more on proximity to death than on age, a finding often interpreted as showing that the need for care services among older people will be substantially less than would be expected based on the likely increase in population numbers. We show that this assumption is too optimistic for three reasons: (1) the increase in population numbers will be concentrated mainly among the "old old" where use of services is substantial; (2) earlier findings of much lower use of acute care services by older than younger people who are close to death are not observed; and (3) any savings in acute care are more than offset by greater use of residential long-term care (LTC). The main consequences of improving mortality are: (1) to postpone rather than to reduce overall demand for health care; (2) to shift the balance of care from acute to long-term care services; and (3) to increase considerably the average age of time spent in care. We further construct a new indicator "a care-free life expectancy" based on number of days in hospital and long-term care to summarise care use patterns for cohorts under a range of plausible mortality assumptions. As mortality improves, lifetime use of acute hospital and long-term care after age 65 and the proportion of life spent in LTC increases for later cohorts, but the proportion spent in acute care decreases slightly.

Karnon J., Caffrey O., Pham C., Grieve R., Ben-Tovim D., Hakendorf P., Crotty M. (2013). Applying risk adjusted cost effectiveness (race) analysis to hospitals: estimating the costs and consequences of variation in clinical practice. *Health Economics*, 22 (6) : 631-642.

Abstract: Cost-effectiveness analysis is well established for pharmaceuticals and medical technologies but not for evaluating variations in clinical practice. This paper describes a novel methodology risk adjusted cost-effectiveness (RAC-E) that facilitates the comparative evaluation of applied clinical practice processes. In this application, risk adjustment is undertaken with a multivariate matching algorithm that balances the baseline characteristics of patients attending different settings (e.g.

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hospitals). Linked, routinely collected data are used to analyse patient-level costs and outcomes over a 2-year period, as well as to extrapolate costs and survival over patient lifetimes. The study reports the relative cost-effectiveness of alternative forms of clinical practice, including a full representation of the statistical uncertainty around the mean estimates. The methodology is illustrated by a case study that evaluates the relative cost-effectiveness of services for patients presenting with acute chest pain across the four main public hospitals in South Australia. The evaluation finds that services provided at two hospitals were dominated, and of the remaining services, the more effective hospital gained life years at a low mean additional cost and had an 80% probability of being the most cost-effective hospital at realistic cost-effectiveness thresholds. Potential determinants of the estimated variation in costs and effects were identified, although more detailed analyses to identify specific areas of variation in clinical practice are required to inform improvements at the less cost-effective institutions. Copyright © 2012 John Wiley & Sons, Ltd <http://dx.doi.org/10.1002/hec.2828>

Johar M., Jones G.S., Savage E. (2013). Emergency admissions and elective surgery waiting times. *Health Econ*, 22 (6) : 749-756.

Abstract: An average patient waits between 2 and 3 months for an elective procedure in Australian public hospitals. Approximately 60% of all admissions occur through an emergency department, and bed competition from emergency admission provides one path by which waiting times for elective procedures may be lengthened. In this article, we investigated the extent to which public hospital waiting times are affected by the volume of emergency admissions and whether there is a differential impact by elective patient payment status. The latter has equity implications if the potential health cost associated with delayed treatment falls on public patients with lower ability to pay. Using annual data from public hospitals in the state of New South Wales, we found that, for a given available bed capacity, a one standard deviation increase in a hospital's emergency admissions lengthens waiting times by 19 days on average. However, paying (private) patients experience no delay overall. In fact, for some procedures, higher levels of emergency admissions are associated with lower private patient waiting times. Copyright (c) 2012 John Wiley & Sons, Ltd PM:22696235

He D., Mellor J.M., Jankowitz E. (2013). Racial and ethnic disparities in the surgical treatment of acute myocardial infarction: the role of hospital and physician effects.

Med Care Res Rev, 70 (3) : 287-309.

Abstract: Many studies document disparities between Blacks and Whites in the treatment of acute myocardial infarction on controlling for patient demographic factors and comorbid conditions. Other studies provide evidence of disparities between Hispanics and Whites in cardiac care. Such disparities may be explained by differences in the hospitals where minority and nonminority patients obtain treatment and by differences in the traits of physicians who treat minority and nonminority patients. We used 1997-2005 Florida hospital inpatient discharge data to estimate models of cardiac catheterization, percutaneous transluminal coronary angioplasty, and coronary artery bypass grafting in Medicare fee-for-service patients 65 years and older. Controlling for hospital fixed effects does not explain Black-White disparities in cardiac treatment but largely explains Hispanic-White disparities. Controlling for physician fixed effects accounts for some extent of the racial disparities in treatment and entirely explains the ethnic disparities in treatment.

Jiang S, Couralet M, Girault A (2013). The rationale for the French experiment with P4P (Ifaq): lessons from abroad. *Journal de Gestion et d'Economie Médicale*, 30 (7-8) : 435-453.

Abstract: A pay-for-performance (P4P) initiative is launched in 2012 for French hospitals. The research group COMPAQ8Hpst has been mandated to develop the methodology of the experiment. Previous P4P programs in other countries have been reviewed, and their strengths and weaknesses have been analysed.

Cote Irdes : P85

(2013). Managing Hospital Volumes: Germany and Experiences from OECD Countries : Paris : OCDE

Abstract: To help inform the Conference on Managing Hospital Volumes, co-organised by the German Federal Ministry of Health and the OECD, to be held on the 11th April 2013 in Berlin, the OECD Secretariat has produced a paper to provide an international perspective on Germany's situation and the current policy debate. The paper begins by comparing the structure of the hospital sector in Germany and its level of volumes with other OECD countries. It then provides a general background on how hospitals are financed in Germany. Finally, it provides some observations on the operation of

the German hospital system from an international perspective, with a view to highlighting potential areas of discussion for policy.

Cote Irdes : En ligne

http://www.oecd.org/els/health-systems/ManagingHospitalVolumes_GermanyandExperiencesfromOECDCountries.pdf

Yin Y., Luras H., Hagen T.P. (2013). The effect of activity-based financing on hospital length of stay for elderly patients suffering from heart diseases in Norway. *Bmc Health Services Research*, 13 (172) : 9, fig.

Abstract: Background: Whether activity-based financing of hospitals creates incentives to treat more patients and to reduce the length of each hospital stay is an empirical question that needs investigation. This paper examines how the level of the activity-based component in the financing system of Norwegian hospitals influences the average length of hospital stays for elderly patients suffering from ischemic heart diseases. During the study period, the activity-based component changed several times due to political decisions at the national level. Methods: The repeated cross-section data were extracted from the Norwegian Patient Register in the period from 2000 to 2007, and included patients with angina pectoris, congestive heart failure, and myocardial infarction. Data were analysed with a log-linear regression model at the individual level. Results: The results show a significant, negative association between the level of activity-based financing and length of hospital stays for elderly patients who were suffering from ischemic heart diseases. The effect is small, but an increase of 10 percentage points in the activity-based component reduced the average length of each hospital stay by 1.28%. Conclusions: In a combined financing system such as the one prevailing in Norway, hospitals appear to respond to economic incentives, but the effect of their responses on inpatient cost is relatively meagre. Our results indicate that hospitals still need to discuss guidelines for reducing hospitalisation costs and for increasing hospital activity in terms of number of patients and efficiency.

Cote Irdes : c, en ligne

Inégalités de santé

Baker J., Mitchell R., Pell J. (2013). Cross-sectional study of ethnic differences in the utility of area deprivation measures to target socioeconomically deprived individuals. *Soc Sci.Med*, 85 27-31.

Abstract: Area deprivation measures provide a pragmatic tool for targeting public health interventions at socioeconomically deprived individuals. Ethnic minority groups in the UK experience higher levels of socioeconomic deprivation and certain associated diseases than the White population. The aim of this study was to explore ethnic differences in the utility of area deprivation measures as a tool for targeting socioeconomically deprived individuals. We carried out a cross-sectional study using the Health Survey for England 2004. 7208 participants aged 16-64 years from the four largest ethnic groups in England (White, Indian, Pakistani and Black Caribbean) were included. The main outcome measures were percentage agreement, sensitivity and positive predictive value (PPV) of area deprivation, measured using Index of Multiple Deprivation 2004, in relation to individual socioeconomic position (measured by education, occupation, income, housing tenure and car access). We found that levels of both area and individual deprivation were higher in the Pakistani and Black Caribbean groups compared to the White group. Across all measures, agreement was lower in the Pakistani (50.9-63.4%) and Black Caribbean (61.0-70.1%) groups than the White (67.2-82.4%) group. However, sensitivity was higher in the Pakistani (0.56-0.64) and Black Caribbean (0.59-0.66) groups compared to the White group (0.24-0.38) and PPV was at least as high. The results for the Indian group were intermediate. We conclude that, in spite of lower agreement, area deprivation is better at identifying individual deprivation in ethnic minority groups. There was no evidence that area based targeting of public health interventions will disadvantage ethnic minority groups.

Echazu L., Nocetti D. (2013). Priority setting in health care: disentangling risk aversion from inequality aversion. *Health Econ*, 22 (6) : 730-740.

Abstract: In this paper, we introduce a tractable social welfare function that is rich enough to

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disentangle attitudes towards risk in health outcomes from attitudes towards health inequalities across individuals. Given this preference specification, we evaluate how the introduction of uncertainty over the severity of illness and over the effectiveness of treatments affects the optimal allocation of healthcare resources. We show that the way in which uncertainty affects the optimal allocation within our proposed specification may differ sharply from that in the standard expected utility framework. Copyright (c) 2012 John Wiley & Sons, LtdPM:22736580

Mir G., Salway S., Kai J., Karlsen S., Bhopal R., Ellison G.T., Sheikh A. (2013). Principles for research on ethnicity and health: the Leeds Consensus Statement. *The European Journal of Public Health*, 23 (3): 504-510.

Abstract: Background: There is substantial evidence that health and health-care experiences vary along ethnic lines and the need to understand and tackle ethnic health inequalities has repeatedly been highlighted. Research into ethnicity and health raises ethical, theoretical and methodological issues and, as the volume of research in this area grows, so too do concerns regarding its scientific rigour and reporting, and its contribution to reducing inequalities. Guidance may be helpful in encouraging researchers to adopt standard practices in the design, conduct and reporting of research. However, past efforts at introducing such guidance have had limited impact on research practice, and the diversity of disciplinary perspectives on the key challenges and solutions may undermine attempts to derive and promote guiding principles. Methods: A consensus building Delphi exercise - "the first of its kind in this area of research practice" - was undertaken with leading academics, practitioners and policymakers from a broad range of disciplinary backgrounds to assess whether consensus on key principles could be achieved. Results: Ten key principles for conducting research on ethnicity and health emerged, covering: the aims of research in this field; how such research should be framed and focused; key design-related considerations; and the direction of future research. Despite some areas of dispute, participants were united by a common concern that the generation and application of research evidence should contribute to better health-care experiences and health outcomes for minority ethnic people. Conclusion: The principles provide a strong foundation to guide future ethnicity-related research and build a broader international consensus.

<http://eurpub.oxfordjournals.org/content/early/2012/05/02/eurpub.cks028.full.pdf>

Gundgaard J., Lauridsen J. (2013). Explaining the Sources of Income-Related Inequality in Health Care Utilization in Denmark : Odense : University of Southern Denmark

Abstract: Objectives with the health care system often include equity considerations. One objective is equal treatment for equal need. In this paper we explain the sources of income-related inequality in utilization of health care services in Funen County, Denmark, by linking survey data to register based data. A decomposition of the concentration index was used to explain the sources of overall income-related inequality in utilization. The decomposition approach suggests that health care is in general equally distributed in Denmark when need based variables are controlled for. However, this overall result is a consequence of a number of off-setting effects from different types of health care and a complicated pattern of various explanatory variables

Cote Irdes : En ligne

<http://static.sdu.dk/mediafiles/7/E/A/%7B7EAAD453-248F-46AF-874E-3CA76B885892%7D20131.pdf>

Lalloue B., Monnez J.M., Padilla C. (2013). A statistical procedure to create a neighborhood socioeconomic index for health inequalities analysis. *International Journal for Equity in Health*, 12 (21) : 11, fig, tabl.

Abstract: Introduction: In order to study social health inequalities, contextual (or ecologic) data may constitute an appropriate alternative to individual socioeconomic characteristics. Indices can be used to summarize the multiple dimensions of the neighborhood socioeconomic status. This work proposes a statistical procedure to create a neighborhood socioeconomic index. Methods: The study setting is composed of three French urban areas. Socioeconomic data at the census block scale come from the 1999 census. Successive principal components analyses are used to select variables and create the index. Both metropolitan area-specific and global indices are tested and compared. Socioeconomic categories are drawn with hierarchical clustering as a reference to determine "optimal" thresholds able to create categories along a one-dimensional index. Results: Among the twenty variables finally selected in the index, 15 are common to the three metropolitan areas. The index explains at least 57% of the variance of these variables in each metropolitan area, with a contribution of more than 80% of the 15 common variables. Conclusion: s: The proposed procedure is statistically justified and robust. It

can be applied to multiple geographical areas or socioeconomic variables and provides meaningful information to public health bodies. We highlight the importance of the classification method. We propose an R package in order to use this procedure

Cote Irdes : En ligne

<http://www.equityhealthj.com/content/pdf/1475-9276-12-21.pdf>

Médicaments

Pulcini C., Lions C., Ventelou B., Verger P. (2013). Drug-specific quality indicators assessing outpatient antibiotic use among French general practitioners. *European Journal of Public Health*, 23 (2) : 262-264.

European Journal of Public Health, 23 (2) : 262-264.

Cote Irdes : c, en ligne

(2013). Les enjeux du médicament. *Regards Croisés Sur la Santé*, (7) : -19p.

Abstract: Dans ce numéro de Regards croisés sur la santé, chaque personne interviewée apporte un éclairage particulier sur la diversité des questions que nous nous posons face à cinq principaux enjeux du médicament qui semblent aujourd'hui prioritaires du point de vue des malades. Ces enjeux reprennent pour la plupart les idées fortes, peut-être parfois aussi les idées reçues, qui traversent l'opinion publique : le nombre excessif de médicaments sur le marché français, la lisibilité de l'information sur le médicament et la visibilité de la pharmacovigilance, les questionnements sur les génériques, l'encadrement des prescriptions « hors autorisation de mise sur le marché » dans le cadre des nouvelles « recommandations temporaires d'utilisation », la politique de fixation des prix des médicaments (résumé d'auteur)

Cote Irdes : B7153

Méthodologie – Statistique

Davern M. (2013). Nonresponse Rates are a Problematic Indicator of Nonresponse Bias in Survey Research. *Health Serv Res*, 48 (3) : 905-912.PM:23656501

(2013). The fade-away effect of initial nonresponse in panel surveys: Empirical results for EU-SILC. Methodologies & Working papers. Luxembourg: Publications Office of the European Union

Abstract: Dans une enquête de panel, les habitudes de participation lors des vagues les plus récentes est différente de celle au début du panel. Grâce aux données de registres administratifs qui fournissent aussi de l'information pour les non-répondants on peut observer un effet d'effacement des différences entre l'échantillon complet, y compris les non-répondants, et le sous-échantillon des répondants, sans les non-répondants. Cet effet peut être expliqué en utilisant un modèle de chaîne de Markov. Dans des conditions de régularité appropriées la distribution de l'espace d'états converge vers la distribution stable de la chaîne, qui est indépendante de sa distribution initiale. Par conséquent, l'effet d'effacement est considéré comme un effet d'oscillation amenant à l'état de distribution stable. Dans ce Working Paper ce phénomène est étudié avec des données EU-SILC finlandaises sur le revenu net des ménages. La rapidité de l'évolution vers l'état de distribution stable est également étudiée pour 25 pays de l'UE.

Cote Irdes : c, En ligne

http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-RA-13-012/EN/KS-RA-13-012-EN.PDF

Halbesleben J.R., Whitman M.V. (2013). Evaluating survey quality in health services research: a decision framework for assessing nonresponse bias. *Health Serv Res*, 48 (3)

: 913-930.

Abstract: OBJECTIVE: To address the issue of nonresponse as problematic and offer appropriate strategies for assessing nonresponse bias. STUDY DESIGN: A review of current strategies used to assess the quality of survey data and the challenges associated with these strategies is provided along with appropriate post-data collection techniques that researchers should consider. PRINCIPAL FINDINGS: Response rates are an incomplete assessment of survey data quality, and quick reactions to response rate should be avoided. Based on a five-question decision making framework, we offer potential ways to assess nonresponse bias, along with a description of the advantages and disadvantages to each. CONCLUSIONS: It is important that the quality of survey data be considered to assess the relative contribution to the literature of a given study. Authors and funding agencies should consider the potential effects of nonresponse bias both before and after survey administration and report the results of assessments of nonresponse bias in addition to response rates.

(2013). QALYs et DALYs : l'utilité en indicateurs. *Revue Prescrire*, (355) : 381-383.

Abstract: Deux indicateurs sont couramment utilisés dans les études dites de coût/utilité : les Qalys (années de vie ajustées par leur qualité) et les Dalys (années de vie ajustées par l'incapacité). Après une présentation des modes de calcul de ces indicateurs, cet article évalue leur portée dans la prise de décision à l'échelle d'une population.

Cote Irdes : P90

Prévention santé

Poirier G. (2013). L'accès aux soins et à la prévention des personnes en situation de handicap mental *Enquête épidémiologique descriptive* : Lille : ORS Nord-Pas de Calais.

Abstract: Cette étude s'attache à décrire et analyser l'accès à la santé des personnes déficientes intellectuelles accueillies ou accompagnées par les associations des Papillons Blancs du Nord, fédérées au sein de l'UDAPEI du Nord. L'accès à la santé pour cette population ne se limite pas seulement à l'accès aux soins courants, mais comprend également les recours effectifs à d'autres volets de la santé tels que la prévention (sexualité, cancer, cardiologie, alimentation, addiction, etc.)

Cote Irdes : En ligne

http://www.orsnpdc.org/etudes/286963_1u12-1.pdf

Prévision - Evaluation

Fleurbaey M., Luchini S., Schokkaert E., Von De Voorde C. (2013). Evaluation des politiques de santé : pour une prise en compte équitable des intérêts des populations.

In : *Systèmes de santé. Economie et Statistique*, (455-456) : 11-36.

Abstract: Cet article propose une amélioration de l'analyse coût-bénéfice qui permet d'éviter de donner la priorité aux préférences des plus riches. Un fondement théorique est donné à la définition de pondérations à appliquer aux consentements à payer des individus, pondérations qui reposent sur une mesure du bien-être individuel et tiennent compte de la santé des personnes et de leurs préférences sur les arbitrages santé-revenu. Estimés pour différents niveaux d'aversion aux inégalités sur un échantillon représentatif des français, les coefficients de pondérations calculés par les auteurs peuvent être utilisés dans des analyses coûts-bénéfices de futures politiques de santé (résumé d'auteur)

Cote Irdes : S18

http://www.insee.fr/fr/themes/document.asp?reg_id=0&id=3962

Psychiatrie

Hansen H.B., Donaldson Z., Link B.G., Bearman P.S., Hopper K., Bates L.M., Cheslack-Postava K., Harper K., Holmes S.M., Lovasi G., Springer K.W., Teitler J.O. (2013). Independent Review Of Social And Population Variation In Mental Health Could Improve Diagnosis In DSM Revisions. *Health Aff. (Millwood.)*, 32 (5) : 984-993.

Abstract: At stake in the May 2013 publication of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), are billions of dollars in insurance payments and government resources, as well as the diagnoses and treatment of millions of patients. We argue that the most recent revision process has missed social determinants of mental health disorders and their diagnosis: environmental factors triggering biological responses that manifest themselves in behavior; differing cultural perceptions about what is normal and what is abnormal behavior; and institutional pressures related to such matters as insurance reimbursements, disability benefits, and pharmaceutical marketing. In addition, the experts charged with revising the DSM lack a systematic way to take population-level variations in diagnoses into account. To address these problems, we propose the creation of an independent research review body that would monitor variations in diagnostic patterns, inform future DSM revisions, identify needed changes in mental health policy and practice, and recommend new avenues of research. Drawing on the best available knowledge, the review body would make possible more precise and equitable psychiatric diagnoses and interventions.

Sciences de l'information

Lungu V. (2013). Knowledge management en entreprise : la gestion des connaissances au service de la performance. Collection L'essentiel pour agir. Le Mans : Cereso

Abstract: Pour les entreprises, le challenge d'aujourd'hui est d'évoluer aussi vite que le monde qui les entoure. Le Knowledge Management associe les deux axes essentiels de toute activité : pérennisation et développement du business. Cet ouvrage décompose le processus du Knowledge Management, en commençant par la réalisation d'une cartographie des méthodes de l'ingénierie des connaissances et du développement d'activité. Dans l'esprit de son premier livre Learning Management System pour l'entreprise, l'auteur aborde la gestion des connaissances au service de l'entreprise en passant de la théorie à la pratique avec la présentation d'une situation d'entreprise. Le Knowledge Management n'est pas un énième outil miracle de gestion RH, mais bien une philosophie, un état d'esprit, qui se traduit par un plan concret pour l'entreprise d'aujourd'hui et de demain (4e de couverture).

Cote Irdes : A4451

Soins de santé primaires

(2013). Maisons et pôles de santé : construire l'avenir. *Réseaux Santé et Territoire*, (43) : 23-25.

Cote Irdes : P204

Vaysette (2013). Le protocole Asalée infirmier-médecin s'étend. *Réseaux Santé et Territoire*, (43) : 26-27.

Cote Irdes : P204

Lutfey K.E., Gerstenberger E., McKinlay J.B. (2013). Physician styles of patient management as a potential source of disparities: cluster analysis from a factorial

experiment. *Health Serv Res*, 48 (3) : 1116-1134.

Abstract: OBJECTIVE: To identify styles of physician decision making (as opposed to singular clinical actions) and to analyze their association with variations in the management of a vignette presentation of coronary heart disease (CHD). DATA SOURCE: Primary data were collected from primary care physicians in North and South Carolina. STUDY DESIGN: In a balanced factorial experimental design, primary care physicians viewed one of 16 (2(4)) video vignette presentations of CHD and provided detailed information about how they would manage the case. DATA COLLECTION METHOD: 256 MD primary care physicians were interviewed face-to-face in North and South Carolina. PRINCIPAL FINDINGS: We identify three clusters depicting unique styles of CHD management that are robust to controls for physician (gender and level of experience) and patient characteristics (age, gender, socioeconomic status, and race) as well as key organizational features of physicians' work settings. Physicians in Cluster 1 "Cardiac" (N = 92) were more likely to focus on cardiac issues compared with their counterparts; physicians in Cluster 2 "Talkers" (N = 93) were more likely to give advice and take additional medical history; whereas physicians in Cluster 3 "Minimalists" (N = 71) were less likely than their counterparts to take action on any of the types of management behavior. CONCLUSIONS: Variations in styles of decision making, which encompass multiple outcome variables and extend beyond individual-level demographic predictors, may add to our understanding of disparities in health quality and outcomes.

Hagiwara N., Penner L.A., Gonzalez R., Eggly S., Dovidio J.F., Gaertner S.L., West T., Albrecht T.L. (2013). Racial attitudes, physician-patient talk time ratio, and adherence in racially discordant medical interactions. *Soc Sci.Med*, 87 123-131.

Abstract: Physician racial bias and patient perceived discrimination have each been found to influence perceptions of and feelings about racially discordant medical interactions. However, to our knowledge, no studies have examined how they may simultaneously influence the dynamics of these interactions. This study examined how (a) non-Black primary care physicians' explicit and implicit racial bias and (b) Black patients' perceived past discrimination affected physician-patient talk time ratio (i.e., the ratio of physician to patient talk time) during medical interactions and the relationship between this ratio and patients' subsequent adherence. We conducted a secondary analysis of self-report and video-recorded data from a prior study of clinical interactions between 112 low-income, Black patients and their 14 non-Black physicians at a primary care clinic in the Midwestern United States between June, 2006 and February, 2008. Overall, physicians talked more than patients; however, both physician bias and patient perceived past discrimination affected physician-patient talk time ratio. Non-Black physicians with higher levels of implicit, but not explicit, racial bias had larger physician-patient talk time ratios than did physicians with lower levels of implicit bias, indicating that physicians with more negative implicit racial attitudes talked more than physicians with less negative racial attitudes. Additionally, Black patients with higher levels of perceived discrimination had smaller physician-patient talk time ratios, indicating that patients with more negative racial attitudes talked more than patients with less negative racial attitudes. Finally, smaller physician-patient talk time ratios were associated with less patient subsequent adherence, indicating that patients who talked more during the racially discordant medical interactions were less likely to adhere subsequently. Theoretical and practical implications of these findings are discussed in the context of factors that affect the dynamics of racially discordant medical interactions.

Weiner S.J., Schwartz A., Sharma G., Binns-Calvey A., Ashley N., Kelly B., Dayal A., Patel S., Weaver F.M., Harris I. (2013). Patient-Centered Decision Making and Health Care Outcomes. An Observational Study. *Annals of Internal Medicine*, 158 (8) : 573-579.

Abstract: Chinese translation Background: Patient-centered decision making (PCDM) is the process of identifying clinically relevant, patient-specific circumstances and behaviors to formulate a contextually appropriate care plan. Objective: To ascertain whether encounters in which PCDM occurs are followed by improved health care outcomes compared with encounters where there is inattention to patient context .Design: Patients surreptitiously audio-recorded encounters with their physicians. Medical records of these encounters were then screened for contextual red flags• such as deteriorating self-management of a chronic condition, that could reflect such underlying contextual factors as competing responsibilities or loss of social support. When a contextual factor was identified, either as a result of physician questioning or because a patient volunteered information, physicians were scored on the basis of whether they adapted the care plan to it. Setting: Internal medicine clinics at 2 Veterans Affairs facilities. Participants: 774 patients audio-recorded encounters with 139 resident physicians. Measurements: Individualized outcome measures were based on the contextual red flag, such as

improved blood pressure control in a patient presenting with hypertension and loss of medication coverage. Outcome coders were blinded to physician performance. Results: Among 548 contextual red flags, 208 contextual factors were confirmed, either when physicians probed or patients volunteered information. Physician attention to contextual factors (both probing for them and addressing them in care plans) varied according to the presenting contextual red flags. Outcome data were available for 157 contextual factors, of which PCDM was found to address 96. Of these, health care outcomes improved in 68 (71%), compared with 28 (46%) of the 61 that were not addressed by PCDM ($P = 0.002$). Limitation: The extent to which the findings can be generalized to other clinical settings is unknown. Conclusion: Attention to patient needs and circumstances when planning care is associated with improved health care outcomes; .

Poirier L.R., Descoteaux S., Levesque J.F. (2013). Synthèse accélérée des connaissances sur les conditions de mise en œuvre des réseaux de services intégrés aux personnes âgées : Québec : INSPQ.

Abstract: Ce document résume les principales observations d'un groupe d'experts sur les conditions de mise en œuvre des Réseaux de services intégrés pour les personnes âgées (RSIPA). Le travail d'analyse repose sur une revue de la littérature scientifique et grise, sur des études de cas décrivant l'expérience de mise en œuvre dans six territoires de centres de santé et de services sociaux (CSSS) et sur un forum délibératif au cours duquel les résultats préliminaires ont été soumis à la discussion auprès d'une vingtaine de participants qui représentent divers types d'acteurs concernés par le sujet au Québec.

Cote Irdes : c, En ligne

http://www.inspq.qc.ca/pdf/publications/1640_SynthAccConnCondMiseOeuvreResServIntPersAgees.pdf

Systemes de santé

Kondilis E., Giannakopoulos S., Gavana M., Ierodiakonou I., Waitzkin H., Benos A. (2013). Economic Crisis, Restrictive Policies, and the Population's Health and Health Care: The Greek Case. *American Journal of Public Health*, 103 (6) : 973-979.

Van E.C., Van Der Horst.S., Besseling P. (2013). The future of health care : La Hague : CPB

Abstract: The Netherlands knows two standard packages of uniform health care insurance for all its citizens: the Health Insurance Act (Zvw) for curative care and the Exceptional Medical Expenses Act (AWBZ) for long-term care. The quality and accessibility of Dutch health care are high, according to international standards, among other things because of the application of advanced but also more expensive medical technology, as well as the increasing numbers of well-informed citizens who know where to go for which type of care. The likely continuation of this trend will also see a continuation of the current debate on the sustainability of the care system. This study offers a framework for thinking on the future health care system. This framework consists of four different worlds along two fundamental dimensions: those of care solidarity and risk solidarity. Care solidarity concerns the health care itself and the consideration between systems with uniformly and publicly organised health care on the one side and those that offer more differentiated and personalised care on the other. The considerations for risk solidarity relate to the desire to insure the risks and the necessity of personal financial contributions to reduce any excessive use of health care. The core issue, here, is that of the large societal value of health insurance combined with the increasing demand for freedom of choice and personal management.

Cote Irdes : En ligne

<http://www.cpb.nl/sites/default/files/publicaties/download/cpb-policy-brief-2013-03-future-health-care.pdf>

Technologies médicales

Willeme P., Dumont M. (2013). Machines that go 'ping': medical technology and health expenditures in OECD countries. Federal Planning Bureau

Abstract: While rising health care expenditures as a percentage of national income is a well-known and widely documented feature across the industrialized world, it has proved difficult to quantify the effects of the underlying cost drivers. The main difficulty is to find suitable proxies to measure medical technological innovation, which is believed to be a major determinant of steadily increasing health spending. This paper's main contribution is the use of data on approved medical devices and drugs to proxy for medical technological progress. The effects of these variables on total real per capita health spending are estimated using a panel model for 18 OECD countries covering the period 1981-2009. The results confirm the substantial cost-increasing effect of medical technology, which may account for at least 50% of the explained historical growth of spending. Excluding the approval variables causes a significant upward bias of the estimated income elasticity of health spending and negatively affects some model specification tests. Despite the overall net positive effect of technology, the effect of two subgroups of approvals on expenditure is significantly negative. These subgroups can be thought of as representing 'incremental medical innovation', while the positive effects are related to radically innovative pharmaceutical products and devices. The results are consistent with those reported in other studies which suggest that some new products, despite their high price when they are introduced, can ultimately save money by reducing spending on other medical interventions.

Cote Irdes : en ligne

http://www.plan.be/admin/uploaded/201302120728090.WP_1302_10422_E.pdf

Travail et santé

Poletti B. (2013). Les arrêts de travail : pour un dispositif plus transparent et plus juste. Rapport d'information ; 986. Paris Assemblée nationale.

Abstract: Même si les dépenses d'Indemnités journalières maladie n'ont jamais évolué aussi sagement qu'en 2012, les députés de la Mission d'évaluation et de contrôle des lois de financement de la Sécurité sociale (MECSS) s'inquiètent de leur évolution à moyen terme. Ils relèvent que le nombre de journées indemnisées au titre de la maladie est passé de 180 millions de journées en 2000 à 204 millions en 2011 et que les dépenses d'indemnités journalières correspondantes ont progressé de 47 % dans le même temps, soit une augmentation moyenne par an de 3,6 %. Elles s'élevaient à 4,3 milliards d'euros en 2000 et ont atteint 6,3 milliards d'euros en 2011. Le rapport présenté mercredi 24 avril par Bérangère Poletti suggère de renforcer les contrôles de l'Assurance maladie. Alors qu'actuellement, 90 % de ces contrôles concernent des arrêts longs, de plus de 45 jours (qui représentent 80 % de la dépense des arrêts maladie), la mission propose de s'attaquer aux arrêts de moins de sept jours (pour cela, il faudra développer la dématérialisation). En outre, elle estime que les médecins gros prescripteurs d'arrêts pourraient être mieux ciblés et les contrôles généralisés dans la Fonction publique. La dématérialisation des procédures de contrôle devra être généralisée dans un délai de deux ans. En contrepartie, les parlementaires suggèrent d'adapter le dispositif à l'évolution du marché du travail qui a vu le développement de l'intérim et du temps partiel, étendant l'indemnisation des arrêts de travail aux salariés qui n'y ont pas accès, soit parce qu'ils n'ont pas assez travaillé, soit parce qu'ils n'ont pas assez cotisé. Le rapport pointe par ailleurs le niveau trop élevé des dépenses liées aux accidents du travail et aux maladies professionnelles. Après une tendance à la baisse observée depuis 1970, les accidents ont été plus nombreux en 2011, par rapport à 2010 (+1,7). Les maladies professionnelles sont aussi en hausse sur ces deux années (+8,6 %). La Mecss préconise donc d'accentuer la prévention des risques professionnels et d'améliorer la sensibilisation aux maladies professionnelles. Elle recommande enfin d'harmoniser les méthodes de calcul des indemnités journalières maladie et AT-MP et ne retenir qu'une seule assiette du salaire de référence, de procéder à la liquidation des IJ itératifs (répétés) d'une même année sur la base de l'indemnisation versée lors du premier arrêt de travail, afin de ne pas faire subir de perte temporaire de revenu aux salariés et de simplifier la tâche des caisses et des entreprises.

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www.irdes.fr/EspaceDoc/Veille.html

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<http://www.assemblee-nationale.fr/14/pdf/rap-info/i0986.pdf>

Jones M.K., Latreille P.L., Sloane P.J., Staneva A.V. (2013). Work-related health risks in Europe: Are older workers more vulnerable? *Social Science & Medicine*, 88 (0) : 18-29.

Abstract: Abstract Recent policy reforms in a number of countries are extending working lives and deferring the statutory retirement age. Yet such changes may have profound implications for the well-being of older workers if such individuals are more likely to suffer work-related health problems. Using international data from the European Working Conditions Survey for 2005, we test whether older workers (aged 55â€“65 years) differ significantly from younger workers across a range of self-reported job-related indicators including health risk perception, mental and physical health, sickness absence, injury and fatigue. We estimate discrete choice (probit) models of the outcomes above for a sample comprising 17,459 individuals in 23 countries, and control for personal, job and work characteristics including exposure to physical, ergonomic and psychosocial risk factors. Our results show that failure to account for both endogeneity and the “healthy worker effect” (sample selection) can lead to misleading inferences. The latter is especially important: only after controlling for selection bias (using a re-weighting approach) do we find older workers are more vulnerable than their younger counterparts in the sense of being significantly more likely to perceive each of the various adverse health outcomes above, with the exception of injury. For the remaining indicators, our estimates suggest the magnitude of this difference is substantial: between 5 and 11 percentage points compared with prime age workers, and 8 and 14 points relative to workers aged 15â€“35, depending on the measure under consideration.

<http://www.sciencedirect.com/science/article/pii/S0277953613001962>

Kostol A.R., Mogstad M. (2013). How Financial Incentives Induce Disability Insurance Recipients to Return to Work : Cambridge : NBER

Abstract: Disability Insurance (DI) programs have long been criticized by economists for apparent work disincentives. Some countries have recently modified their programs such that DI recipients are allowed to keep some of their benefits if they return to work, and other countries are considering similar return-to-work policies. However, there is little empirical evidence of the effectiveness of programs that incentivize the return to work by DI recipients. Using a local randomized experiment that arises from a sharp discontinuity in DI policy in Norway, we provide transparent and credible identification of how financial incentives induce DI recipients to return to work. We find that many DI recipients have considerable capacity to work that can be effectively induced by providing financial work incentives. We further show that providing work incentives to DI recipients may both increase their disposable income and reduce program costs. Our findings also suggest that targeted policies may be the most effective in encouraging DI recipients to return to work.

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<http://papers.nber.org/papers/w19016>

Vieillesse

Lopez Ulloa B.F., Moller V., Sousa-Posa A. (2013). How does subjective well-being evolve with age? A literature review : Stuttgart : University of Hohenheim.

Abstract: This literature review provides an overview of the theoretical and empirical research in several disciplines on the relation between ageing and subjective well-being, i.e., how subjective well-being evolves across the lifespan. Because of the different methodologies, data sets and samples used, comparison among disciplines and studies is difficult. However, extant studies do show either a U-shaped, inverted U-shaped or linear relation between ageing and subjective well-being.

Cote Irdes : En ligne

<https://fzid.uni-hohenheim.de/71978.html>

(2013). Long-term care in Europe : improving policy and practice : Basingstoke : Palgrave Macmillan

Abstract: This book challenges the prevailing discourse centred on the problems of demographic change and long-term care provision for older people by focusing on solutions emerging from progression and improvement in policy and practice. Building on ample research in 13 European countries- , evidence is provided for how the construction of long-term care systems can be taken forward by practitioners, policy-makers and stakeholder organizations. By focusing on prevention and rehabilitation, the support of informal care, the enhancement of quality development as well as by decent governance and financing mechanisms for long-term care, stakeholders may learn from European experiences and solutions on the local, regional and national levels (4e de couverture)
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<http://www.palgrave.com/products/title.aspx?pid=601806>

Jimenez-Martin S., Vilaplana C. (2013). Do Spanish informal caregivers come to the rescue of dependent people with formal care unmet needs? Economics Working Papers; 1366. Barcelone : Universitat Pompeu Fabra

Abstract: This paper analyses the effect of unmet formal care needs on informal caregiving hours in Spain using the two waves of the Informal Support Survey (1994, 2004). Testing for double sample selection from formal care receipt and the emergence of unmet needs provides evidence that the omission of either one of these two variables would cause underestimation of the number of informal caregiving hours. After controlling for these two factors the number of hours of care increases with both the degree of dependency and unmet needs. In the presence of unmet needs, the number of informal caregiving hours increases when some formal care is received. This result refutes the substitution model and supports complementarity or task specificity between both types of care. For the same combination of formal care and unmet needs, informal caregiving hours increased between 1994 and 2004. Finally, in the model for 2004, the selection term associated with the unmet needs equation is larger than that of the formal care equation, suggesting that using the number of formal care recipients as an indicator of the goodness of the long-term care system may be confounding, if we do not complete this information with other quality indicators

Cote Irdes : En ligne

<http://www.econ.upf.edu/en/research/onepaper.php?id=1366>

(2013). Europeans of retirement age: chronic diseases and economic activity :

Luxembourg: Office for Official Publications of the European Communities.

Abstract: The Dutch National Institute for Public Health and the Environment (RIVM) prepared this report in 2012 in response to a call by the European Commission (DG SANCO, Directorate-General Health and Consumers). The purpose of the report is to review the impact of chronic disease on the population of pre- (50+) and post-retirement age in the European Union (EU). This report addresses the following topics: The burden of chronic disease in the older population pre- and post-retirement (chapter 3); The impact of chronic disease on the exit from the labour market (including unemployment, disability and early retirement) (chapter 4); The impact of leaving the labour market on the burden of chronic disease (chapter 4); Interventions to increase the social participation (including work participation) of people with a chronic disease (chapter 5). Chapter 6 provides a list of policy recommendations that follow from our analysis, including an overview of gaps and needs for further action at EU, and Member State level (tiré de l'introduction).

Cote Irdes : En ligne

http://ec.europa.eu/health/major_chronic_diseases/docs/rivm_report_retirement_en.pdf

Jousten A., Lefebvre M. (2013). Retirement Incentives in Belgium: Estimations and Simulations Using SHARE Data : Bonn : IZA

Abstract: The paper studies retirement behavior of wage-earners in Belgium – for the first time using rich survey data to explore retirement incentives as faced by individuals. Specifically, we use SHARE data to estimate a model à la Stock and Wise (1990). Exploring the longitudinal nature of SHARELIFE, we construct measures of financial and non-financial incentive. Our analysis explicitly takes into account the different take-up rates of the various early retirement exit paths across time and ages. The results show that financial incentives play a strong role. Health and education also matter, as does regional variation – though the latter in an unexpected way. A set of policy simulations illustrate the scope and also the limits associated with selective parametric reforms.

Cote Irdes : En ligne

<http://ftp.iza.org/dp7387.pdf>

Kyyra T., Tuomala J. (2013). Does Experience Rating Reduce Disability Inflow? Bonn : IZA

Abstract: This study explores whether the experience rating of employers' disability insurance premiums affects the inflow of older employees to disability benefits in Finland. To identify the causal effect of experience rating, we exploit a pension reform that extended the coverage of the experience-rated premiums. The results show that a new disability benefit claim can cause substantial cost to the former employer through an increased premium. Nonetheless, we find no evidence of the significant effects of experience rating on the disability inflow. The lack of the behavioral effects may be due to the complexity of experience rating calculations and/or limited employer awareness.

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<http://ftp.iza.org/dp7344.pdf>