DOC VEILLE

Veille bibliographique en économie de la santé / Watch on Health Economics Literature

20 septembre 2013 / September 20, 2013

Réalisée par le centre de documentation de l'Irdes, Doc Veille, publication bi-mensuelle, rassemble de façon thématique les résultats de la veille documentaire en économie de la santé : articles, littérature grise, rapports…

Vous pouvez accéder à la version électronique des articles sur notre portail EJS (à l'exception des revues françaises) :
http://ejournals.ebsco.com/Home.asp **(Accès réservé à l'Irdes)**

Les autres documents sont soit accessibles en ligne, soit consultables à la documentation (voir mention à la fin de la notice). Aucune photocopie ne sera délivrée par courrier.
Un historique des Doc Veille se trouve sur le web de l'Irdes :
http://www.irdes.fr/EspaceDoc/Veille.html)

Produced by the Irdes documentation centre, Doc Veille, a bimonthly publication, presents with a thematic classification the results of the documentary monitoring in health economics: articles, grey literature, reports...

You can access to the electronic version of articles on our EJS portal (except for the French journals): http://ejournals.ebsco.com/Home.asp **(Access limited to Irdes team).**

Other documents are accessible online, either available for consultation at the documentation center (see mention at the end of the notice). Requests for photocopies or scans of documents will not be answered. Doc Veille's archives are located on the Irdes website : http://www.irdes.fr/EspaceDoc/Veille.html
.

Sommaire

Economie de la santé / Health Economics

Spadaro A., Mangiavacchi L., Moral-Arce I., Adiego-Estella M., Blanco-Moreno A. (2013). Evaluating the redistributive impact of public health expenditure using an insurance value approach. *Eur J Health Econ,* 14 (5) : 775-787.
Abstract: This article analyses the redistributive impact of public health expenditure in Spain using an insurance value approach to compute individual and household's value of health services non-cash benefit. We model the intensity of use of different health care services using a count data framework on a nationally representative health care survey and then predict probabilities on the 2006 Spanish EU-SILC sample. This allows us to extend disposable income with the expected monetary value of public health services and to compare it with strictly cash income. Since non-cash income due to public health services is associated with health needs, we use needs-adjusted equivalence scales to perform distributional analysis and poverty/inequality comparisons. The results show that public health expenditure in Spain acts progressively on income distribution, and that health in-kind benefits, once considered as part of disposable income, can be extremely effective in reducing poverty and inequality.

Guerriero C., Cairns J., Roberts I., Rodgers A., Whittaker R., Free C. (2013). The cost-effectiveness of smoking cessation support delivered by mobile phone text messaging: Txt2stop. *Eur J Health Econ,* 14 (5) : 789-797.
Abstract: BACKGROUND: The txt2stop trial has shown that mobile-phone-based smoking cessation support doubles biochemically validated quitting at 6 months. This study examines the cost-effectiveness of smoking cessation support delivered by mobile phone text messaging. METHODS: The lifetime incremental costs and benefits of adding text-based support to current practice are estimated from a UK NHS perspective using a Markov model. The cost-effectiveness was measured in terms of cost per quitter, cost per life year gained and cost per QALY gained. As in previous studies, smokers are assumed to face a higher risk of experiencing the following five diseases: lung cancer, stroke, myocardial infarction, chronic obstructive pulmonary disease, and coronary heart disease (i.e. the main fatal or disabling, but by no means the only, adverse effects of prolonged smoking). The treatment costs and health state values associated with these diseases were identified from the literature. The analysis was based on the age and gender distribution observed in the txt2stop trial. Effectiveness and cost parameters were varied in deterministic sensitivity analyses, and a probabilistic sensitivity analysis was also performed. FINDINGS: The cost of text-based support per 1,000 enrolled smokers is pound16,120, which, given an estimated 58 additional quitters at 6 months, equates to pound278 per quitter. However, when the future NHS costs saved (as a result of reduced smoking) are included, text-based support would be cost saving. It is estimated that 18 LYs are gained per 1,000 smokers (0.3 LYs per quitter) receiving text-based support, and 29 QALYs are gained (0.5 QALYs per quitter). The deterministic sensitivity analysis indicated that changes in individual model parameters did not alter the conclusion that this is a cost-effective intervention. Similarly, the probabilistic sensitivity analysis indicated a >90 % chance that the intervention will be cost saving. INTERPRETATION: This study shows that under a wide variety of conditions, personalised smoking cessation advice and support by mobile phone message is both beneficial for health and cost saving to a health system.

Etat de santé / Health Status

Franc C. (2013). Epidemiology of diabetes: frightening predictions. *Med Sci (Paris),* 29 (8-9) : 711-714.

Modrek S., Cullen M.R. (2013). Health consequences of the 'Great Recession' on the employed: Evidence from an industrial cohort in aluminum manufacturing. *Soc Sci*

Med, 92 105-113.
Abstract: While the negative effects of unemployment have been well studied, the consequences of layoffs and downsizing for those who remain employed are less well understood. This study uses human resources and health claims data from a large multi-site fully insured aluminum company to explore the health consequences of downsizing on the remaining workforce. We exploit the variation in the timing and intensity of layoff to categorize 30 plants as high or low layoff plants. Next, we select a stably employed cohort of workers with history of health insurance going back to 2006 to 1) describe the selection process into layoff and 2) explore the association between the severity of plant level layoffs and the incidence of four chronic conditions in the remaining workforce. We examine four health outcomes: incident hypertension, diabetes, asthma/COPD and depression for a cohort of approximately 13,000 employees. Results suggest that there was an increased risk of developing hypertension for all workers and an increased risk of developing diabetes for salaried workers that remain at the plants with the highest level of layoffs. The hypertension results were robust to a several specification tests. In addition, the study design selected only healthy workers, therefore our estimates are likely to be a lower bound and suggest that adverse health consequences of the 2007-2009 recession may have affected a broader proportion of the population than previously expected.

Géographie de la santé / Geography of Health

Castelli A., Jacobs R., Goddard M., Smith P.C. (2013). Health, policy and geography: Insights from a multi-level modelling approach. *Soc Sci Med,* 92 61-73.

Abstract: Improving the health and wellbeing of citizens ranks highly on the agenda of most governments. Policy action to enhance health and wellbeing can be targeted at a range of geographical levels and in England the focus has tended to shift away from the national level to smaller areas, such as communities and neighbourhoods. Our focus is to identify the potential for targeting policy interventions at the most appropriate geographical levels in order to enhance health and wellbeing. The rationale is that where variations in health and wellbeing indicators are larger, there may be greater potential for policy intervention targeted at that geographical level to have an impact on the outcomes of interest, compared with a strategy of targeting policy at those levels where relative variations are smaller. We use a multi-level regression approach to identify the degree of variation that exists in a set of health indicators at each level, taking account of the geographical hierarchical organisation of public sector organisations. We find that for each indicator, the proportion of total residual variance is greatest at smaller geographical areas. We also explore the variations in health indicators within a hierarchical level, but across the geographical areas for which public sector organisations are responsible. We show that it is feasible to identify a sub-set of organisations for which unexplained variation in health indicators is significantly greater relative to their counterparts. We demonstrate that adopting a geographical perspective to analyse the variation in indicators of health at different levels offers a potentially powerful analytical tool to signal where public sector organisations, faced increasingly with many competing demands, should target their policy efforts. This is relevant not only to the English context but also to other countries where responsibilities for health and wellbeing are being devolved to localities and communities.

Bourke L., Taylor J., Humphreys J.S., Wakerman J. (2013). "Rural health is subjective, everyone sees it differently": Understandings of rural health among Australian stakeholders. *Health & Place,* Ahead of pub:

Abstract: In Australia, a diversity of perspectives of rural health have produced a deficit discourse as well as multidisciplinary perspectives that acknowledge diversity and blend in social, cultural and public health concepts. Interviews with 48 stakeholders challenged categories of rural and remote, and discussed these concepts in different ways, but invariably marginalised Aboriginal voices. Respondents overwhelmingly used a deficit discourse to plead for more resources but also blended diverse knowledge and at times reflected a relational understanding of rurality. However, mainstream perspectives dominated Aboriginal voices and racial exclusion remains a serious challenge for rural/remote health in Australia.

Jonker M.F., Congdon P.D., van Lenthe F.J., Donkers B., Burdorf A., Mackenbach J.P. (2013). Small-area health comparisons using health-adjusted life expectancies: A Bayesian random-effects approach. *Health & Place,* 23 (0) : 70-78.
Abstract: Health-adjusted life expectancy (HALE) is one of the most attractive summary measures of population health. It provides balanced attention to fatal as well as non-fatal health outcomes, is sensitive to the severity of morbidity within the population, and can be readily compared between areas with very different population age structures. HALE, however, cannot be calculated at the small-area level using traditional life table methodology. Hence we propose a Bayesian random-effects modeling approach that recognizes correlations and pools strength between sexes, age-groups, geographical areas, and health outcomes. This approach allows for the calculation of HALE for areas as small as 2000 person years at risk and with relatively modest health state survey sample sizes. The feasibility of the Bayesian approach is illustrated in a real-life example, which also shows how differences in areas' health performances can be adequately quantified. Such information can be invaluable for the appropriate targeting and subsequent evaluation of urban regeneration, neighborhood renewal, and community-based initiatives aimed at improving health and reducing health inequalities.

Henderson S.B., Wan V., Kosatsky T. (2013). Differences in heat-related mortality across four ecological regions with diverse urban, rural, and remote populations in British Columbia, Canada. Health & Place, 23 (0) : 48-53.
Abstract: Temperature's mortality analyses are challenging in rural and remote communities with small populations, but this information is needed for climate change and emergency planning. The geographic health areas of British Columbia, Canada were aggregated into four ecoregions delineated by microclimatic conditions. Time series models were used to estimate the effect of maximum apparent temperature on daily non-traumatic mortality. The population of the coldest ecoregion was most sensitive to hot weather, while the population of the hottest ecoregion was least sensitive. The effects were consistently strongest in decedents aged less than 75 years. A province-wide total of 815 deaths was attributed to hot weather over the 25-year study period, with 735 deaths in the most populous ecoregion. The framework described could be adapted to other climatically variable regions with urban, rural, and remote populations.

Hôpital / Hospitals

Moisdon J.C., Nisand G. (2013). Evaluation de la T2A : ressources des établissements. *Revue Hospitalière de France,* (553) : 64-73.
Abstract: Alors que plus aucune représentation institutionnelle n'assure l'évaluation de la T2A, la Fédération hospitalière de France dressait en juin 2013 un bilan d'étape de cette (r)évolution majeure du financement des établissements de santé. Le groupe d'experts constitué en 2012 a conduit l'analyse technique des résultats, d'où ressortent deux grandes problématiques : ce mode de financement est-il adapté au système de santé français ? La T2A permet-elle à l'hôpital de s'inscrire dans une dynamique à la hauteur de ses enjeux ?

Dias S.S., Andreozzi V., Martins R.O. (2013). Analysis of HIV/AIDS DRG in Portugal: a hierarchical finite mixture model. *Eur J Health Econ,* 14 (5) : 715-723.
Abstract: Inpatient length of stay (LOS) is an important measure of hospital activity, but its empirical distribution is often positively skewed, representing a challenge for statistical analysis. Taking this feature into account, we seek to identify factors that are associated with HIV/AIDS through a hierarchical finite mixture model. A mixture of normal components is applied to adult HIV/AIDS diagnosis-related group data (DRG) from 2008. The model accounts for the demographic and clinical characteristics of the patients, as well the inherent correlation of patients clustered within hospitals. In the present research, a normal mixture distribution was fitted to the logarithm of LOS and it was found that a model with two-components had the best fit, resulting in two subgroups of LOS: a short-stay subgroup and a long-stay subgroup. Associated risk factors for both groups were identified as well as some statistical differences in the hospitals. Our findings provide important information for policy

makers in terms of discharge planning and the efficient management of LOS. The presence of "atypical" hospitals also suggests that hospitals should not be viewed or treated as homogenous bodies.

Inégalités de santé / Health Inequalities

Boisard P.Galtier B. (2013). Difficultés vécues dans l'enfance, conséquences à l'âge adulte. *Revue Française des Affaires Sociales,* (1-2) : 7-10.
Abstract: La *RFAS* a choisi de consacrer un dossier aux conséquences à l'âge adulte des difficultés vécues dans l'enfance bien que nombre d'études se soient d'ores et déjà attachées à explorer ce thème. Elles s'attachaient par exemple à mettre en lumière et à comprendre les mécanismes de la transmission intergénérationnelle de la pauvreté.

Pearson A., Apparicio P., Riva M. (2013). Cumulative disadvantage? Exploring relationships between neighbourhood deprivation trends (1991 to 2006) and mortality in New Zealand. *International Journal of Health Geographics,* 12 (1) : 38.
Abstract: BACKGROUND:Area-level socioeconomic deprivation has been shown to exert an independent effect on both individual and population health outcomes and health-related behaviours. Evidence also suggests that health and economic inequalities in many countries are increasing in some areas but may be on the decline in others. While area-level deprivation at a single point in time is known to influence health, the literature relating to longitudinal deprivation of communities and associated health impacts is sparse. This research makes a methodological contribution to this literature. METHODS: Using a Latent Class Growth Model, we identified 12 deprivation trends (1991-2006) for small areas (n=1621) in New Zealand. We then fitted regression models to assess the effects of trends of relative deprivation on a) all-cause mortality, and b) cardiovascular mortality (2005-2007) by census area unit. For comparison, we also fitted regression models to assess the effect of deprivation deciles (in 2006) on outcomes a) and b). RESULTS: Using trends, we found a positive association between deprivation and mortality, except for two trends for both all-cause and CVD-related mortality. When comparing trends and deciles of deprivation, we observed similar patterns. However, we found that AIC values were slightly lower for the model including deciles, indicating better model fit. CONCLUSION: While we found that current deprivation was a slightly better predictor of mortality, the approach used here offers a potentially useful alternative. Future deprivation research must consider the possible loss of information about health benefits of living in areas where relative deprivation has improved in cross-sectional analyses.

Allanson P., Petrie D. (2013). Understanding the vertical equity judgements underpinning health inequality measures. *Health Economics,* Ahead of pub.
Abstract: The choice of income-related health inequality measures in comparative studies is often determined by custom and analytical concerns, without much explicit consideration of the vertical equity judgements underlying alternative measures. This note employs an inequality map to illustrate how these judgements determine the ranking of populations by health inequality. In particular, it is shown that relative indices of inequality in health attainments and shortfalls embody distinct vertical equity judgments, where each may represent ethically defensible positions in specific contexts. Further research is needed to explore people's preferences over distributions of income and health.

Rettenmaier A.J., Wang Z. (2013). What determines health: a causal analysis using county level data. *Eur J Health Econ,* 14 (5) : 821-834.
Abstract: This article revisits the long-standing issue of the determinants of health outcomes. We make two contributions to the literature. First, we use a large and comprehensive US county level health data set that has only recently become available. This data set includes five measures of health outcomes and 24 health risk factors in the categories of health behaviors, clinical care, social and economic factors, and physical environment. Second, to distinguish causality from correlation, we implement an emerging data-driven method to study the causal factors of health outcomes. Among all included potential health risk factors, we identify adult smoking, obesity, motor vehicle crash death

rate, the percent of children in poverty, and violent crime rate to be major causal factors of premature mortality. Adult smoking, preventable hospital stays, college or higher education, employment, children in poverty, and adequacy of social support determine health-related quality of life. Finally, the Chlamydia rate, community safety, and liquor store density are three important factors causally related to low birth weight. Policy implications of these findings are discussed.

Mezuk B., Chaikiat A.S., Li X., Sundquist J., Kendler K.S., Sundquist K. (2013). Depression, neighborhood deprivation and risk of type 2 diabetes. *Health & Place*, 23 (0) : 63-69.
Abstract: Abstract Neighborhood characteristics have been associated with both depression and diabetes, but to date little attention has been paid to whether the association between depression and diabetes varies across different types of neighborhoods. This prospective study examined the relationship between depression, neighborhood deprivation, and risk of type 2 diabetes among 336,340 adults from a national-representative sample of primary care centers in Sweden (2001-"2007). Multi-level logistic regression models were used to assess associations between depression and risk of type 2 diabetes across affluent and deprived neighborhoods. After accounting for demographic, individual-level socioeconomic, and health characteristics, depression was significantly associated with risk of diabetes (odds ratio (OR): 1.10, 95% confidence interval (CI): 1.06-1.14), as was neighborhood deprivation (OR for high vs. low deprivation: 1.66, 95% CI: 1.22-1.34). The interaction term between depression and neighborhood deprivation was non-significant, indicating that the relationship between depression and diabetes risk is similar across levels of neighborhood socioeconomic deprivation.

Mehta N.K., Lee H., Ylitalo K.R. (2013). Child health in the United States: Recent trends in racial/ethnic disparities. In : Social Determinants of Child Health. *Social Science & Medicine,* 95 (0) : 6-15.
Abstract: In the United States, race and ethnicity are considered key social determinants of health because of their enduring association with social and economic opportunities and resources. An important policy and research concern is whether the U.S. is making progress toward reducing racial/ethnic inequalities in health. While race/ethnic disparities in infant and adult outcomes are well documented, less is known about patterns and trends by race/ethnicity among children. Our objective was to determine the patterns of and progress toward reducing racial/ethnic disparities in child health. Using nationally representative data from 1998 to 2009, we assessed 17 indicators of child health, including overall health status, disability, measures of specific illnesses, and indicators of the social and economic consequences of illnesses. We examined disparities across five race/ethnic groups (non-Hispanic white, non-Hispanic black, Hispanic, non-Hispanic Asian, and non-Hispanic other). We found important racial/ethnic disparities across nearly all of the indicators of health we examined, adjusting for socioeconomic status, nativity, and access to health care. Importantly, we found little evidence that racial/ethnic disparities in child health have changed over time. In fact, for certain illnesses such as asthma, black-white disparities grew significantly larger over time. In general, black children had the highest reported prevalence across the health indicators and Asian children had the lowest reported prevalence. Hispanic children tended to be more similar to whites compared to the other race/ethnic groups, but there was considerable variability in their relative standing.

Médicaments / Pharmaceuticals

Godman B., Bishop I., Finlayson A.E., Campbell S., Kwon H.Y., Bennie M. (2013). Reforms and initiatives in Scotland in recent years to encourage the prescribing of generic drugs, their influence and implications for other countries. *Expert Review of Pharmacoeconomics & Outcomes Research,* 13 (4) : 469-482.
Abstract: Scotland has introduced a number of initiatives to enhance the prescribing of low-cost generic drugs versus originators and patent products in a class where these are seen as similar. The objective of this review is to appraise the influence of the various measures on subsequent utilization patterns and expenditure in high-volume classes to provide guidance. This review is principally a

narrative review of published studies. The authors' found supply-side measures resulted in generic prices as low as 3% of pre-patent loss prices. Multiple demand-side measures resulted in high international non-proprietary name prescribing, and a considerable increase in prescribing efficiency for the proton pump inhibitors, statins, renin-angiotensin inhibitor drugs and selective serotonin reuptake inhibitors. There were no specific activities encouraging the prescription of losartan versus other angiotensin receptor blockers or risperidone versus other atypical antipsychotic drugs following generics and no change in their utilization patterns post generics. The authors can conclude multiple measures are needed to change physician prescribing habits. Authorities cannot rely on any 'spillover' effects to affect future prescribing, even in closely related classes.

Tsoi B., Masucci L., Campbell K., Drummond M., O' Reilly D., Goeree R. (2013). Harmonization of reimbursement and regulatory approval processes: a systematic review of international experiences. In : Expert Review of Pharmacoeconomics & Outcomes Research. *Expert Review of Pharmacoeconomics & Outcomes Research,* 13 (4) : 497-511.
Abstract: A considerable degree of overlap exists between reimbursement and regulatory approval of health technologies, and harmonization of certain aspects is both possible and feasible. Various models to harmonization have been suggested in which a number of practical attempts have been drawn from. Based on a review of the literature, approaches can be categorized into those focused on reducing uncertainty and developing economies of scale in the evidentiary requirements; and/or aligning timeframes and logistical aspects of the review process. These strategies can further be classified based on the expected level of structural and organizational change required to implement them into the existing processes. Passive processes require less modification, whereas active processes are associated with greater restructuring. Attempts so far at harmonization have raised numerous legal and practical issues and these must be considered when introducing a more harmonized framework into the existing regulatory and reimbursement arrangements.

Franken M., Nilsson F., Sandmann F., Boer A., Koopmanschap M. (2013). Unravelling Drug Reimbursement Outcomes: A Comparative Study of the Role of Pharmacoeconomic Evidence in Dutch and Swedish Reimbursement Decision Making. *PharmacoEconomics,* 31 (9) : 781-797.
Abstract: To sustainably manage equitable access to effective drugs, many developed countries have established a national system to determine whether drugs should be reimbursed. Our objectives were (i) to investigate the role of pharmacoeconomic evidence in Dutch and Swedish drug reimbursement decision making; and (ii) to determine the extent to which appraising the importance of full economic evaluations relative to other evidence is a transparent process. Data sources included all Dutch and Swedish drug reimbursement information published in the period January 2005 to July 2011. After categorising all the reimbursement applications and decisions in published data sources, we selected all dossiers-in both countries-that included a full economic evaluation (i.e. cost-effectiveness and/or cost-utility analysis) and then investigated how the evidence was appraised for its societal value.
In The Netherlands, only 35 % of the 118 applications on List 1B (i.e. claiming added therapeutic value) were found to include pharmacoeconomic evidence. In all cases where drugs received a 'no' decision, combined with an evaluation that they were of similar (n = 7) or added (n = 5) therapeutic value, we found that the pharmacoeconomic evidence had been judged insufficiently robust. We also found that in 21 % of the 'yes' decisions, combined with an evaluation of similar (n = 2) or added (n = 2) therapeutic value, the pharmacoeconomic evidence had been judged insufficiently robust. In Sweden, we found that drugs that received a 'no' decision (n = 39) had been judged either not cost effective (74 %) or not supported by sufficiently credible data (26 %). Nearly all drugs that received a 'yes' decision (n = 252) had been judged cost effective (92 %). However, of all these judgements, 53 % were based on a price comparison and 10 % on a cost-minimisation analysis; only 33 % were based on a full economic evaluation. More economic evaluations were available in Sweden than in The Netherlands (97 vs. 31, respectively), mainly due to the numerous exemptions from pharmacoeconomic evidence in The Netherlands (65 %). Dossiers for only 11 drugs included a full economic evaluation in both countries; of these, the reimbursement decisions differed for four drugs. Appraisal elements were reported only descriptively; their actual influence on the final decision remained unclear. In four dossiers, the (high) severity of the treatable disease was explicitly mentioned in both countries; three of these were identical and related to indications in cancer. Both countries publish drug reimbursement information. Therapeutic value appears to be the most decisive criterion; the relative importance of full economic evaluations is more modest than would generally be expected, especially in The Netherlands. Although the assessment process is reasonably transparent, both

countries could make the appraisal process more transparent by more explicitly showing the actual role of each different (societal) criterion in their decision making.

Méthodologie – Statistique / Methodology - Statistics

-

Forder J., Malley J., Towers A.M., Netten A. (2013). Using cost-effectiveness estimates from survey data to guide commissioning: an application to home care. *Health Economics, n/a.*

Abstract: The aim is to describe and trial a pragmatic method to produce estimates of the incremental cost-effectiveness of care services from survey data. The main challenge is in estimating the counterfactual; that is, what the patient's quality of life would be if they did not receive that level of service. A production function method is presented, which seeks to distinguish the variation in care-related quality of life in the data that is due to service use as opposed to other factors. A problem is that relevant need factors also affect the amount of service used and therefore any missing factors could create endogeneity bias. Instrumental variable estimation can mitigate this problem. This method was applied to a survey of older people using home care as a proof of concept. In the analysis, we were able to estimate a quality-of-life production function using survey data with the expected form and robust estimation diagnostics. The practical advantages with this method are clear, but there are limitations. It is computationally complex, and there is a risk of misspecification and biased results, particularly with IV estimation. One strategy would be to use this method to produce preliminary estimates, with a full trial conducted thereafter, if indicated. Copyright Â© 2013 John Wiley & Sons, Ltd
http://dx.doi.org/10.1002/hec.2973

Politique de santé / Health Policy

Antonanzas F. (2013). The impact of the economic downturn on healthcare in Spain: consequences and alternatives. *Expert Review of Pharmacoeconomics & Outcomes Research,* 13 (4) : 433-439.

Abstract: In Spain, the economic downturn has caused big changes in most of the public policies, where healthcare system is the one which is deeply affected too. The objective of the paper is to review some of the recent changes achieved in the system, and to discuss about providing some alternative ideas to the implemented policies. The existing universal coverage previous to the crisis, as acknowledged by the law, has changed last year and the new figure of 'insured person' has been introduced into the system. These persons are now the only ones eligible to receive healthcare under the public coverage. New co-payments have been introduced for drugs, and retired persons must also pay a 10% co-payment (which was 0% before) at the chemist office. Healthcare institutions have also implemented several policies to manage tough budget constraints. Some regions have privatized healthcare management of some hospitals (as Madrid) to control budget and presumably to obtain a higher efficiency. Different initiatives dealing with human resources and external purchases are also presented in this paper to mostly achieve budget control. The majority of the changes have been pure budget cuts and a reorganization of the system and institutions is still needed.

Levaggi R., Menoncin F. (2013). Soft budget constraints in health care: evidence from Italy. *Eur J Health Econ,* 14 (5) : 725-737.

Abstract: The reforms that have reshaped the public health care systems have often been coupled with devolution. However, this process has frequently been accompanied by widespread soft budget constraint policies. In this paper we argue that the soft budget constraint arises from a cooperative game between local authorities that force Central Government to bail them out. Our theoretical model is tested using data for Italian regions for the period 2002-2006 and our hypothesis is verified.

Although the model uses Italy as a benchmark, we believe that the framework we propose could be extended to other federal contexts where resources are distributed unevenly and preferences are asymmetric.

Prévision – Evaluation / Prevision – Evaluation

Getsios D., Marton J.P., Revankar N., Ward A., Willke R., Rublee D., Ishak K.J., Xenakis J. (2013). Smoking Cessation Treatment and Outcomes Patterns Simulation: A New Framework for Evaluating the Potential Health and Economic Impact of Smoking Cessation Interventions. *PharmacoEconomics,* 31 (9) : 767-780.
Abstract: Most existing models of smoking cessation treatments have considered a single quit attempt when modelling long-term outcomes. To develop a model to simulate smokers over their lifetimes accounting for multiple quit attempts and relapses which will allow for prediction of the long-term health and economic impact of smoking cessation strategies. A discrete event simulation (DES) that models individuals' life course of smoking behaviours, attempts to quit, and the cumulative impact on health and economic outcomes was developed. Each individual is assigned one of the available strategies used to support each quit attempt; the outcome of each attempt, time to relapses if abstinence is achieved, and time between quit attempts is tracked. Based on each individual's smoking or abstinence patterns, the risk of developing diseases associated with smoking (chronic obstructive pulmonary disease, lung cancer, myocardial infarction and stroke) is determined and the corresponding costs, changes to mortality, and quality of life assigned. Direct costs are assessed from the perspective of a comprehensive US healthcare payer ($US, 2012 values). Quit attempt strategies that can be evaluated in the current simulation include unassisted quit attempts, brief counselling, behavioural modification therapy, nicotine replacement therapy, bupropion, and varenicline, with the selection of strategies and time between quit attempts based on equations derived from survey data. Equations predicting the success of quit attempts as well as the short-term probability of relapse were derived from five varenicline clinical trials. Concordance between the five trials and predictions from the simulation on abstinence at 12 months was high, indicating that the equations predicting success and relapse in the first year following a quit attempt were reliable. Predictions allowing for only a single quit attempt versus unrestricted attempts demonstrate important differences, with the single quit attempt simulation predicting 19 % more smoking-related diseases and 10 % higher costs associated with smoking-related diseases. Differences are most prominent in predictions of the time that individuals abstain from smoking: 13.2 years on average over a lifetime allowing for multiple quit attempts, versus only 1.2 years with single quit attempts. Differences in abstinence time estimates become substantial only 5 years into the simulation. In the multiple quit attempt simulations, younger individuals survived longer, yet had lower lifetime smoking-related disease and total costs, while the opposite was true for those with high levels of nicotine dependence. By allowing for multiple quit attempts over the course of individuals' lives, the simulation can provide more reliable estimates on the health and economic impact of interventions designed to increase abstinence from smoking. Furthermore, the individual nature of the simulation allows for evaluation of outcomes in populations with different baseline profiles. DES provides a framework for comprehensive and appropriate predictions when applied to smoking cessation over smoker lifetimes.

Psychiatrie / Psychiatry

Boiteux C., Gourevitch R, Gluck N (2013). Originalités du parcours de soins en psychiatrie : de l'idée du parcours de soins à la participation du patient à ce parcours.
Revue Hospitalière de France, (553) : 34-35.
Abstract: Dès l'origine et la mise en place du secteur de la psychiatrie, l'organisation des soins intégrait l'idée du parcours de soins : de l'admission en hospitalisation complète jusqu'à la sortie et

l'adressage vers le centre médico-psychologique, de la prévention à la postcure, entre le lieu de vie du patient et les structures hospitalières. Ce parcours semblait bien huilé. Il doit cependant faire face aux évolutions sociétales et psychiatriques. Plus qu'un parcours de soins, il s'agit parfois pour les patients souffrant de pathologies plus lourdes, d'un parcours de vie accompagné par la psychiatrie.

Breuls de Tiecken L. (2013). Dotation annuelle de financement par secteur : répartition sur la base d'indicateurs géopopulationnels. *Revue Hospitalière de France,* (553) : 38-41.
Abstract: L'objectif de cet article est de proposer un indicateur pour mesurer la demande potentielle de soins en santé mentale : in indicateur agrégé, qui peut constituer la clé de répartition de la dotation globale par secteur.

Soins de santé primaires / Primary Health Care

(2013). Les liens P4P font-ils conflit ? *Revue Prescrire,* 33 (359) : 708-710.
Abstract: Maintenant, les médecins libéraux français sont rémunérés, en partie, à la performance. Mais cette partie est amenée à croître, et en échange de cette rémunération, le montant du paiement à l'acte n'évolue plus. Cet article analyse les critères de performance proposés par l'Assurance maladie dans le cadre de la convention médicale et se demande si la performance est un critère pertinent d'évaluation des médecins et de leur rémunération, car le soignant peut-il accepté d'être récompensé.

Michot P.,Catala O, Supper I, et al. (2013). Coopération entre médecins généralistes et pharmaciens : une revue systématique de la littérature. *Santé publique,* (3) : 331-341.
Abstract: Alors que le développement de coopérations interprofessionnelles entre médecins généralistes et pharmaciens est attendu, l'efficacité des interventions envisageables est peu connue. L'objectif de cette étude était d'évaluer l'efficacité des interventions de coopération entre médecins généralistes et pharmaciens. Une revue systématique de la littérature internationale a été réalisée, à partir des banques de données Medline, Cochrane et Pascal. Les mots-clés et/ou termes de recherche (« family physician(s) » ou « general practitioner(s) ») et « pharmacist(s) » ont été croisés. Étaient retenus les essais cliniques randomisés dont les résultats étaient publiés en français ou en anglais et qui testaient l'efficacité de l'intervention complémentaire du pharmacien par rapport à celle du médecin généraliste. Au total, 22 articles ont été inclus. Seize essais montraient un bénéfice pour les patients lié à l'intervention des pharmaciens dans la gestion d'un problème de santé chronique ou dans la gestion des traitements médicamenteux. Un tel bénéfice était observé en particulier dans la prise en charge de l'hypertension artérielle et de l'hypercholestérolémie, et pour limiter les problèmes de prescription médicamenteuse. Les critères de jugements des essais étaient le plus souvent des critères de procédure ou des critères de résultats intermédiaires, et ne comportaient jamais d'analyses coût-efficacité. La coopération entre les pharmaciens et les médecins généralistes peut contribuer à la qualité des soins de santé primaire, en particulier dans le cadre de la prise en charge des problèmes cardiométaboliques et de prescription.

Greene J. (2013). An examination of pay-for-performance in general practice in Australia. *Health Serv Res,* 48 (4) : 1415-1432.
Abstract: OBJECTIVE: This study examines the impact of Australia's pay-for-performance (P4P) program for general practitioners (GPs). The voluntary program pays GPs A$40 and A$100 in addition to fee-for-service payment for providing patients recommended diabetes and asthma treatment over a year, and A$35 for screening women for cervical cancer who have not been screened in 4 years. DESIGN: Three approaches were used to triangulate the program's impact: (1) analysis of trends in national claims for incentivized services pre- and postprogram implementation; (2) fixed effects panel regression models examining the impact of GPs' P4P program participation on provision of incentivized services; and (3) in-depth interviews to explore GPs' perceptions of their own response to the program. RESULTS: There was a short-term increase in diabetes testing and cervical cancer screens after program implementation. The increase, however, was for all GPs. Neither signing onto the program nor claiming incentive payments was associated with increased diabetes testing or

cervical cancer screening. GPs reported that the incentive did not influence their behavior, largely due to the modest payment and the complexity of tracking patients and claiming payment. IMPLICATIONS: Monitoring and evaluating P4P programs is essential, as programs may not spark the envisioned impact on quality improvement.

Terner (M.), D'Silva (J.), Krylova (O.), et al (2013). Assessing Primary Healthcare Using pan-Canadian Indicators of Health and Health System Performance. *Healthcare Quarterly,* 16 (2) : 9-12.
Abstract: Updated primary healthcare (PHC) indicators are now available for use across Canada. The Canadian Institute for Health Information identified and updated two sets of priority indicators – a *policy* set to meet the needs of policy makers and a *provider* set to meet the needs of providers of PHC at the practice and organization levels. A total of 51 indicator definitions were updated to ensure that they are measurable and operational, align with clinical practice guidelines and available data sources and reflect important dimensions of PHC performance in Canada.

Travail et santé / Occupational Health

Dollard M.F., Neser D.Y. (2013). Worker health is good for the economy: Union density and psychosocial safety climate as determinants of country differences in worker health and productivity in 31 European countries. *Soc Sci Med,* 92 114-123.
Abstract: Work stress is recognized globally as a social determinant of worker health. Therefore we explored whether work stress related factors explained national differences in health and productivity (gross domestic product (GDP)). We proposed a national worker health productivity model whereby macro market power factors (i.e. union density), influence national worker health and GDP via work psychosocial factors and income inequality. We combined five different data sets canvasing 31 wealthy European countries. Aggregated worker self-reported health accounted for 13 per cent of the variance in national life expectancy and in national gross domestic product (GDP). The most important factors explaining worker self-reported health and GDP between nations were two levels of labor protection, macro-level (union density), and organizational-level (psychosocial safety climate, PSC, i.e. the extent of management concern for worker psychological health). The majority of countries with the highest levels of union density and PSC (i.e., workplace protections) were Social Democratic in nature (i.e., Sweden, Finland, Denmark, Norway). Results support a type of society explanation that social and economic factors (e.g., welfare regimes, work related policies) in concert with political power agents at a national level explain in part national differences in workplace protection (PSC) that are important for worker health and productivity. Attention should be given across all countries, to national policies to improve worker health, by bolstering national and local democratic processes and representation to address and implement policies for psychosocial risk factors for work stress, bullying and violence. Results suggest worker health is good for the economy, and should be considered in national health and productivity accounting. Eroding unionism may not be good for worker health or the economy either.