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Assaf, S., et al. (2017). "Analyzing disparity trends for health care insurance coverage among non-elderly adults in the US: evidence from the Behavioral Risk Factor Surveillance System, 1993-2009." *Eur J Health Econ* 18(3): 387-398.

OBJECTIVE: To explore the changing disparities in access to health care insurance in the United States using time-varying coefficient models. DATA: Secondary data from the Behavioral Risk Factor Surveillance System (BRFSS) from 1993 to 2009 was used. STUDY DESIGN: A time-varying coefficient model was constructed using a binary outcome of no enrollment in health insurance plan versus enrolled. The independent variables included age, sex, education, income, work status, race, and number of health conditions. Smooth functions of odds ratios and time were used to produce odds ratio plots. RESULTS: Significant time-varying coefficients were found for all the independent variables with the odds ratio plots showing changing trends except for a constant line for the categories of male, student, and having three health conditions. Some categories showed decreasing disparities, such as the income categories. However, some categories had increasing disparities in health insurance enrollment such as the education and race categories. CONCLUSIONS: As the Affordable Care Act is being gradually implemented, studies are needed to provide baseline information about disparities in access to health insurance, in order to gauge any changes in health insurance access. The use of time-varying coefficient models with BRFSS data can be useful in accomplishing this task.

Blomgren, J. (2017). "Transition to Retirement and Use of Private Health Care: Evidence From a Universal Public Health Care System." *International Journal of Health Services* 47(2): 312-332.

Associations between retirement and changes in health care use have not been shown in a longitudinal setting. In the Finnish universal health care system, transition into retirement from employment entails loss of access to occupational health care that provides easily accessible primary health care services, which may cause changes in utilization of other health care sectors. The aim of this study was to find out whether transition into old-age retirement is associated with change in utilization of private health care. The panel data consist of a 30% random sample of the Finnish population aged 62–75 in 2006–2011. Register data on National Health Insurance compensation were linked to socio-demographic covariates. Fixed-effects logistic and Poisson regression models were used. Adjusted for changes in covariates, retirement from employment was associated especially with private general practitioner visits but also with specialist visits among both women and men. Interaction analyses showed that retirement was associated with an increase in private care use only among those with higher-than-median income. The results may indicate preferences for quick access to care, mistrust toward the universal system, and problems of the public system in delivering needed services.

Pierre, A. et Jusot, F. (2017) "The likely effects of employer-mandated complementary health insurance on health coverage in France." *Health Policy* 121(3): 321-328.

The rate of people without CHI would be 3.7% after the law implementation (5% before). It could be halved if employees' dependents will also benefit from this coverage. The most vulnerable populations are expected to remain more often without CHI. Non coverage will decrease among the less risk averse and the more present oriented.

Van de Ven, W. P., et al. (2017). "How can the regulator show evidence of (no) risk selection in health insurance markets? Conceptual framework and empirical evidence." *Eur J Health Econ* 18(2): 167-180.

If consumers have a choice of health plan, risk selection is often a serious problem (e.g., as in Germany, Israel, the Netherlands, the United States of America, and Switzerland). Risk selection may threaten the quality of care for chronically ill people, and may reduce the affordability and efficiency of healthcare. Therefore, an important question is: how can the regulator show evidence of (no) risk

selection? Although this seems easy, showing such evidence is not straightforward. The novelty of this paper is two-fold. First, we provide a conceptual framework for showing evidence of risk selection in competitive health insurance markets. It is not easy to disentangle risk selection and the insurers' efficiency. We suggest two methods to measure risk selection that are not biased by the insurers' efficiency. Because these measures underestimate the true risk selection, we also provide a list of signals of selection that can be measured and that, in particular in combination, can show evidence of risk selection. It is impossible to show the absence of risk selection. Second, we empirically measure risk selection among the switchers, taking into account the insurers' efficiency. Based on 2-year administrative data on healthcare expenses and risk characteristics of nearly all individuals with basic health insurance in the Netherlands (N > 16 million) we find significant risk selection for most health insurers. This is the first publication of hard empirical evidence of risk selection in the Dutch health insurance market.

Van Winssen, K. P., et al. (2017). "A voluntary deductible in health insurance: the more years you opt for it, the lower your premium?" *Eur J Health Econ* 18(2): 209-226.

Adverse selection regarding a voluntary deductible (VD) in health insurance implies that insured only opt for a VD if they expect no (or few) healthcare expenses. This paper investigates two potential strategies to reduce adverse selection: (1) differentiating the premium to the duration of the contract for which the VD holds (ex-ante approach) and (2) differentiating the premium to the number of years for which insured have opted for a VD (ex-post approach). It can be hypothesized that premiums will decrease with the duration of the contract or the number of years for which insured have opted for a VD, providing an incentive to insured to opt for a deductible also in (incidental) years they expect relatively high expenses. To test this hypothesis, we examine which premium patterns would occur under these strategies using data on healthcare expenses and risk characteristics of over 750,000 insured from 6 years. Our results show that, under the assumptions made, only without risk equalization the premiums could decrease with the duration of the contract or the number of years for which insured have opted for a VD. With (sophisticated) risk equalization, decreasing premiums seem unfeasible, both under the ex-ante and ex-post approach. Given these findings, we are sceptical about the feasibility of these strategies to counteract adverse selection.

E-santé – Technologies médicales / E-health – Medical Technologies

(2016). "The use and impact of digital technology on population health and health equity gains." *Journal of Public Health Policy* 37(4): 399-402.

Allaert, F. A., et al. (2016). "Les enjeux de la sécurité des objets connectés et applications de santé." *Journal de Gestion et d'Economie Médicales* 34(5-6): 311-319.

Le marché des objets connectés et des applications de santé (OCS) est en plein essor et devrait représenter plusieurs milliards d'euros de chiffre d'affaires dans les prochaines années. Leur développement aura un impact similaire à ce que nous avons connu avec le développement d'internet au début de ce siècle mais plus encore il devrait bouleverser l'organisation de notre système de santé, changer profondément les modalités de prise en charge des patients et révolutionner la prévention, mais il pourrait aussi remettre en question le secret médical et la protection des données personnelles. Cet article analyse les conséquences sociétales des OCS, la nécessité d'une double évaluation médicale et éthique et l'impérative nécessité de l'établissement d'un référentiel de sécurité auxquels pourront se conformer les industriels dans l'optique d'un contrôle non pas a priori mais a posteriori pour ne pas bloquer l'innovation.

Ashwood, J. S., et al. (2017). "Direct-To-Consumer Telehealth May Increase Access To Care But Does Not Decrease Spending." *Health Affairs* 36(3): 485-491.

<http://content.healthaffairs.org/content/36/3/485.abstract>

The use of direct-to-consumer telehealth, in which a patient has access to a physician via telephone or videoconferencing, is growing rapidly. A key attraction of this type of telehealth for health plans and employers is the potential savings involved in replacing physician office and emergency department visits with less expensive virtual visits. However, increased convenience may tap into unmet demand for health care, and new utilization may increase overall health care spending. We used commercial claims data on over 300,000 patients from three years (2011–13) to explore patterns of utilization and spending for acute respiratory illnesses. We estimated that 12 percent of direct-to-consumer telehealth visits replaced visits to other providers, and 88 percent represented new utilization. Net annual spending on acute respiratory illness increased \$45 per telehealth user. Direct-to-consumer telehealth may increase access by making care more convenient for certain patients, but it may also increase utilization and health care spending.

Peyron, C. et Wallut, L. (2016). "Tarification à l'activité et équilibre financier des prises en charge avec télé-médecine : l'exemple du dispositif TéléAVC en Bourgogne." *Journal de Gestion et d'Economie Médicales* 34(8): 415-429.

Afin de contribuer aux réflexions sur un modèle économique pour la télé-médecine, cette étude exploratoire analyse, du point de vue des établissements, les équilibres financiers des prises en charge au sein du dispositif bourguignon TéléAVC. Ce dispositif permet de fibrinolyser, à distance et avec la télé-assistance d'une UNV, les patients victimes d'un accident vasculaire cérébral ischémique et accueillis dans des centres hospitaliers périphériques, dits hôpitaux requérants dans le dispositif. Nous avons mobilisé des données de micro-costing (observation de 18 prises en charge) et exploité des données issues de 92 dossiers patients pour évaluer les coûts hospitaliers réels des prises en charge. Nous avons également collecté les données nécessaires au calcul des recettes perçues pour ces patients. Nous montrons que le coût de l'acte de fibrinolyse est identique dans l'UNV et dans les centres hospitaliers requérants. Pour un patient télé-fibrinolyse, les centres hospitaliers requérants connaissent une perte financière (d'une valeur médiane de -2234 euros) alors que l'UNV qui prend en charge le patient pour la surveillance post télé-fibrinolyse a un solde financier positif (1624 euros). Dans ce dispositif de télé-médecine, la T2A « favorise » les établissements requis. Du point de vue de la collectivité, la logique de financement de la T2A rend, hors transport et infrastructure, la prise en charge avec télé-médecine plus coûteuse qu'une prise en charge conventionnelle. L'impact de la facturation au séjour et non au parcours est déterminant, la nécessité d'un modèle économique adéquat pour la télé-médecine trouve ici des arguments quantifiés.

Varabyova, Y., et al. (2017) "The determinants of medical technology adoption in different decisional systems: A systematic literature review." *Health Policy* 121(3): 230-242.

We systematically reviewed 65 studies analyzing the determinants of medical technology adoption. We identified 62 determinants in four categories: organizational, individual, environmental, and innovation-related. Different categories were targeted when analyzing medical technologies in different decision-making systems. Policymakers should consider decisional systems when steering the adoption of medical technologies. The review points out the research areas that still need to be addressed.

Economie de la santé / Health Economics

Keehan, S. P., et al. (2017). "National Health Expenditure Projections, 2016-25: Price Increases, Aging Push Sector To 20 Percent Of Economy." *Health Aff (Millwood)* 36(3): 553-563.

Under current law, national health expenditures are projected to grow at an average annual rate of 5.6 percent for 2016-25 and represent 19.9 percent of gross domestic product by 2025. For 2016, national health expenditure growth is anticipated to have slowed 1.1 percentage points to 4.8 percent, as a result of slower Medicaid and prescription drug spending growth. For the rest of the projection period, faster projected growth in medical prices is partly offset by slower projected growth

in the use and intensity of medical goods and services, relative to that observed in 2014-16 associated with the Affordable Care Act coverage expansions. The insured share of the population is projected to increase from 90.9 percent in 2015 to 91.5 percent by 2025.

Mcintyre, D., et al. (2017). "What level of domestic government health expenditure should we aspire to for universal health coverage?" *Health Economics, Policy and Law* 12(2): 125-137.

Abstract : Global discussions on universal health coverage (UHC) have focused attention on the need for increased government funding for health care in many low- and middle-income countries. The objective of this paper is to explore potential targets for government spending on health to progress towards UHC. An explicit target for government expenditure on health care relative to gross domestic product (GDP) is a potentially powerful tool for holding governments to account in progressing to UHC, particularly in the context of UHC's inclusion in the Sustainable Development Goals. It is likely to be more influential than the Abuja target, which requires decreases in budget allocations to other sectors and is opposed by finance ministries for undermining their autonomy in making sectoral budget allocation decisions. International Monetary Fund and World Health Organisation data sets were used to analyse the relationship between government health expenditure and proxy indicators for the UHC goals of financial protection and access to quality health care, and triangulated with available country case studies estimating the resource requirements for a universal health system. Our analyses point towards a target of government spending on health of at least 5% of GDP for progressing towards UHC. This can be supplemented by a per capita target of \$86 to promote universal access to primary care services in low-income countries.

Oliva-Moreno, J., et al. (2017). "The Valuation of Informal Care in Cost-of-Illness Studies: A Systematic Review." *Pharmacoeconomics* 35(3): 331-345.

There is a growing interest in incorporating informal care in cost-of-illness studies as a relevant part of the economic impact of some diseases.

Sarti, S., et al. (2017). "Poverty and private health expenditures in Italian households during the recent crisis." *Health Policy* 121(3): 307-314.

The global financial crisis that began in 2008 had an overall effect on the health behaviours of Italian households. Aggregate private health expenditures have decreased while the citizens have increasingly been asked to share health costs. The reduction of households' health expenditure could have serious consequences for health, especially if it concerns the most vulnerable people. The aim of this paper is to analyse the relation between poverty and household health expenditure, considering regional and social group variations. The data used stem from the "Family Expenditure Survey" collected by the Italian Statistical Institute (ISTAT) from 1997 to 2013. Results of multivariate analysis controlling for potential socio-demographic confounders show that the propensity to spend for poor families is decreased in the last years compared to not poor households. Meanwhile, among the households who spend, the average expenditure in euro seems to have been more stable over time. This is an alarming signal for the health of the most vulnerable households. These conditions could result in a gradual deterioration of health in poor families, which is likely to increase the burden on health systems in future. Hence, at this moment public intervention does not seem able to alleviate this situation.

Sirven, N. et Rapp, T. (2017). "The cost of frailty in France." *Eur J Health Econ* 18(2): 243-253.

The objective of the present work is to explore the incremental costs of frailty associated with ambulatory health care expenditures (HCE) among the French population of community-dwellers aged 65 or more in 2012. We make use of a unique dataset that combines nationally representative health survey with respondents' National Health Insurance data on ambulatory care expenditures. Several econometric specifications of generalized linear models are tested and an exponential model with gamma errors is eventually retained. Because frailty is a distinct health condition, its contribution to

HCE was assessed in comparison with other health covariates (including chronic diseases and functional limitations, time-to-death, and a multidimensional composite health index). Results indicate that whatever health covariates are considered, frailty provides significant additional explanative power to the models. Frailty is an important omitted variable in HCE models. It depicts a progressive condition, which has an incremental effect on ambulatory health expenditures of roughly euro750 additional euros for pre-frail individuals and euro1500 for frail individuals.

Etat de santé / Health Status

Kontis, V., et al. (2017). "Future life expectancy in 35 industrialised countries: projections with a Bayesian model ensemble." *Lancet*, Feb. 22.

BACKGROUND: Projections of future mortality and life expectancy are needed to plan for health and social services and pensions. Our aim was to forecast national age-specific mortality and life expectancy using an approach that takes into account the uncertainty related to the choice of forecasting model. **METHODS:** We developed an ensemble of 21 forecasting models, all of which probabilistically contributed towards the final projections. We applied this approach to project age-specific mortality to 2030 in 35 industrialised countries with high-quality vital statistics data. We used age-specific death rates to calculate life expectancy at birth and at age 65 years, and probability of dying before age 70 years, with life table methods. **FINDINGS:** Life expectancy is projected to increase in all 35 countries with a probability of at least 65% for women and 85% for men. There is a 90% probability that life expectancy at birth among South Korean women in 2030 will be higher than 86.7 years, the same as the highest worldwide life expectancy in 2012, and a 57% probability that it will be higher than 90 years. Projected female life expectancy in South Korea is followed by those in France, Spain, and Japan. There is a greater than 95% probability that life expectancy at birth among men in South Korea, Australia, and Switzerland will surpass 80 years in 2030, and a greater than 27% probability that it will surpass 85 years. Of the countries studied, the USA, Japan, Sweden, Greece, Macedonia, and Serbia have some of the lowest projected life expectancy gains for both men and women. The female life expectancy advantage over men is likely to shrink by 2030 in every country except Mexico, where female life expectancy is predicted to increase more than male life expectancy, and in Chile, France, and Greece where the two sexes will see similar gains. More than half of the projected gains in life expectancy at birth in women will be due to enhanced longevity above age 65 years. **INTERPRETATION:** There is more than a 50% probability that by 2030, national female life expectancy will break the 90 year barrier, a level that was deemed unattainable by some at the turn of the 21st century. Our projections show continued increases in longevity, and the need for careful planning for health and social services and pensions. **FUNDING:** UK Medical Research Council and US Environmental Protection Agency.

Géographie de la santé / Geography of Health

Jourdain, A. et Pham, T. (2017/01-02). "Mobilité spatiale des médecins en Europe, politique de santé et offre de soins." *Santé Publique* 29(1): 81-87.

Trois approches de la mobilité professionnelle sont discutées : libérale, normative et éthique. La dernière semble la plus populaire, elle associe la préservation des intérêts nationaux au code global de l'OMS sur le recrutement international des professionnels de santé.

Lekkas, P., et al. (2017). "Illuminating the lifecourse of place in the longitudinal study of neighbourhoods and health." *Social Science & Medicine* 177: 239-247.

<http://www.sciencedirect.com/science/article/pii/S0277953616305329>

Place and health are inextricably entwined. Whilst insights have been gained into the associations

between places, such as neighbourhoods, and health, the understanding of these relationships remains only partial. One of the reasons for this relates to time and change and the inter-relationships between the dynamic nature of both neighbourhoods and health. This paper argues that the lifecourse of place can be used as a conceptual framework to understand the evolution and ongoing development of neighbourhoods, and their impact on the geographies of health, past, present and future. Moreover, this paper discusses the capacity of a longitudinal form of enquiry – latent transition analysis – that is able to operationalise conceptual models of the lifecourse of place. To date, latent transition analysis has not been applied to the study of neighbourhoods and health. Drawing on research across a range of disciplines including developmental psychology, sociology, geography and epidemiology, this paper also considers praxis-based implications and recommendations for applications of latent transition analysis that aim to advance understanding of how neighbourhoods affect health in and over time.

Handicap / Disability

Makdessi, Y. (coor.). et Outin, J. L. (coor.) (2016/10-12). "Handicap, âge, dépendance : quelles populations ? Dossier." *Revue Française des Affaires Sociales*(4): 388p.

Ce dossier thématique répond à deux objectifs principaux. D'une part, valoriser les travaux de recherche conduits, depuis plusieurs années, dans le champ de la perte d'autonomie, notamment en réponse aux appels communs à la mission recherche de la Direction de la recherche, des études, de l'évaluation et des statistiques (DREES) et à la Caisse nationale de solidarité pour l'autonomie (CNSA). D'autre part, favoriser des contributions sur des expérimentations en cours. Quatre axes étaient proposés aux auteurs : la définition des catégories « handicap », « dépendance » et « perte d'autonomie » ; l'évolution et la mise en œuvre des politiques publiques ; la relation d'aide et, enfin, les innovations, technologiques et sociales dans ce champ. Les douze articles sélectionnés sont ici regroupés en deux catégories qui concernent aussi bien le handicap que le vieillissement : « les fondements des droits et les catégories d'action publique » ; « les interventions en acte ». Plusieurs d'entre eux se sont attachés à exploiter des données originales produites par la DREES. Ces articles sont complétés par un cadrage statistique et par la présentation de trois modèles internationaux (Suisse, Allemagne et Québec) en début de dossier. Ils sont suivis du point de vue du conseil départemental du Pas-de-Calais et de trois contributions détaillant des expériences d'habitat dit « intermédiaire » entre le domicile particulier et l'établissement. Une note de lecture sur la bande dessinée de Roz Chast « Est-ce que l'on pourrait parler d'autre chose ? » clôt cet ensemble.

Hôpital / Hospitals

Gentil, S. (2016). "Entre sécurité des soins et injonctions à la performance économique au bloc opératoire : faut-il choisir ?" *Journal de Gestion et d'Economie Médicales* 34(5-6): 291-309.

Dans un contexte où les établissements de santé sont incités à l'efficacité, tout en devant répondre à des impératifs de sécurité des soins, l'article interroge les complémentarités possibles entre ces deux types de performance. La question de la sécurité des soins est explorée sous l'angle des recherches sur les « Organisations hautement fiables » (HRO), en adoptant une lecture « gestionnaire » de ce courant, à travers l'étude des dispositifs organisationnels, rarement abordés en tant que tels dans les écrits sur les HRO [Lorino, 2005 ; Brabet, 2005]. L'étude empirique de deux blocs opératoires met à l'épreuve des faits, et du contexte de rationalisation économique actuel, les principes décrits par le courant des HRO. Elle révèle que les dispositifs organisationnels développés dans le cadre de la rationalisation économique peuvent aussi répondre à des impératifs de sécurité des soins. La complémentarité entre logiques d'efficacité et de sécurité repose toutefois sur le travail d'adaptation des dispositifs que réalisent les personnels paramédicaux face à l'événement. La survenue d'événements au bloc opératoire requiert un pilotage de ces performances au plus près de l'activité.

Cette proposition appelle à ouvrir la « boîte noire » de l'activité, en déplaçant le regard des directions

du travail de structuration en amont de l'action vers le travail d'organisation effectivement réalisé par les personnels soignants, afin de mieux le prendre en compte et le faciliter.

Green, L. A., et al. (2017). "The Reduction in ED and Hospital Admissions in Medical Home Practices Is Specific to Primary Care-Sensitive Chronic Conditions." *Health Serv Res*, Mar. 02.

OBJECTIVE: To determine whether the Patient-Centered Medical Home (PCMH) transformation reduces hospital and ED utilization, and whether the effect is specific to chronic conditions targeted for management by the PCMH in our setting. DATA SOURCES AND STUDY SETTING: All patients aged 18 years and older in 2,218 primary care practices participating in a statewide PCMH incentive program sponsored by Blue Cross Blue Shield of Michigan (BCBSM) in 2009-2012. STUDY DESIGN: Quantitative observational study, jointly modeling PCMH-targeted versus other hospital admissions and ED visits on PCMH score, patient, and practice characteristics in a hierarchical multivariate model using the generalized gamma distribution. DATA COLLECTION: Claims data and PCMH scores held by BCBSM. PRINCIPAL FINDINGS: Both hospital and ED utilization were reduced proportionately to PCMH score. Hospital utilization was reduced by 13.9 percent for PCMH-targeted conditions versus only 3.8 percent for other conditions ($p = .003$), and ED utilization by 11.2 percent versus 3.7 percent ($p = .010$). Hospital PMPM cost was reduced by 17.2 percent for PCMH-targeted conditions versus only 3.1 percent for other conditions ($p < .001$), and ED PMPM cost by 9.4 percent versus 3.6 percent ($p < .001$). CONCLUSIONS: PCMH transformation reduces hospital and ED use, and the majority of the effect is specific to PCMH-targeted conditions.

Guéri, C. et Garnier, Q. (2016/12). "Déploiement des parcours de santé hospitaliers : retour d'une expérience du CHU Paris Ouest." *Gestions Hospitalières*(561): 621-623.

Ingber, M. J., et al. (2017). "Initiative To Reduce Avoidable Hospitalizations Among Nursing Facility Residents Shows Promising Results." *Health Affairs* 36(3): 441-450.

<http://content.healthaffairs.org/content/36/3/441.abstract>

Nursing facility residents are frequently admitted to the hospital, and these hospital stays are often potentially avoidable. Such hospitalizations are detrimental to patients and costly to Medicare and Medicaid. In 2012 the Centers for Medicare and Medicaid Services launched the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, using evidence-based clinical and educational interventions among long-stay residents in 143 facilities in seven states. In state-specific analyses, we estimated net reductions in 2015 of 2.2–9.3 percentage points in the probability of an all-cause hospitalization and 1.4–7.2 percentage points in the probability of a potentially avoidable hospitalization for participating facility residents, relative to comparison-group members. In that year, average per resident Medicare expenditures were reduced by \$60–\$2,248 for all-cause hospitalizations and by \$98–\$577 for potentially avoidable hospitalizations. The effects for over half of the outcomes in these analyses were significant. Variability in implementation and engagement across the nursing facilities and organizations that customized and implemented the initiative helps explain the variability in the estimated effects. Initiative models that included registered nurses or nurse practitioners who provided consistent clinical care for residents demonstrated higher staff engagement and more positive outcomes, compared to models providing only education or intermittent clinical care. These results provide promising evidence of an effective approach for reducing avoidable hospitalizations among nursing facility residents.

Krabbe-Alkemade, Y. J., et al. (2017). "Competition in the Dutch hospital sector: an analysis of health care volume and cost." *Eur J Health Econ* 18(2): 139-153.

This paper evaluates the impact of market competition on health care volume and cost. At the start of 2005, the financing system of Dutch hospitals started to be gradually changed from a closed-end budgeting system to a non-regulated price competitive prospective reimbursement system. The gradual implementation of price competition is a 'natural experiment' that provides a unique opportunity to analyze the effects of market competition on hospital behavior. We have access to a

unique database, which contains hospital discharge data of diagnosis treatment combinations (DBC) of individual patients, including detailed care activities. Difference-in-difference estimates show that the implementation of market-based competition leads to relatively lower total costs, production volume and number of activities overall. Difference-in-difference estimates on treatment level show that the average costs for outpatient DBCs decreased due to a decrease in the number of activities per DBC. The introduction of market competition led to an increase of average costs of inpatient DBCs. Since both volume and number of activities have not changed significantly, we conclude that the cost increase is likely the result of more expensive activities. A possible explanation for our finding is that hospitals look for possible efficiency improvements in predominantly outpatient care products that are relatively straightforward, using easily analyzable technologies. The effects of competition on average cost and the relative shares of inpatient and outpatient treatments on specialty level are significant but contrary for cardiology and orthopedics, suggesting that specialties react differently to competitive incentives.

Pesko, M. F., et al. (2017). "Home Health Care: Nurse-Physician Communication, Patient Severity, and Hospital Readmission." *Health Serv Res.*, Feb. 19.

OBJECTIVE: To evaluate whether communication failures between home health care nurses and physicians during an episode of home care after hospital discharge are associated with hospital readmission, stratified by patients at high and low risk of readmission. **DATA SOURCE/STUDY SETTING:** We linked Visiting Nurse Services of New York electronic medical records for patients with congestive heart failure in 2008 and 2009 to hospitalization claims data for Medicare fee-for-service beneficiaries. **STUDY DESIGN:** Linear regression models and a propensity score matching approach were used to assess the relationship between communication failure and 30-day readmission, separately for patients with high-risk and low-risk readmission probabilities. **DATA COLLECTION/EXTRACTION METHODS:** Natural language processing was applied to free-text data in electronic medical records to identify failures in communication between home health nurses and physicians. **PRINCIPAL FINDINGS:** Communication failure was associated with a statistically significant 9.7 percentage point increase in the probability of a patient readmission (32.6 percent of the mean) among high-risk patients. **CONCLUSIONS:** Poor communication between home health nurses and physicians is associated with an increased risk of hospital readmission among high-risk patients. Efforts to reduce readmissions among this population should consider focusing attention on this factor.

Pollmanns, J., et al. (2017). "Impact of Disease Prevalence Adjustment on Hospitalization Rates for Chronic Ambulatory Care-Sensitive Conditions in Germany." *Health Serv Res.*, Feb. 19.

OBJECTIVES: To explore effects of disease prevalence adjustment on ambulatory care-sensitive hospitalization (ACSH) rates used for quality comparisons. **DATA SOURCES/STUDY SETTING:** County-level hospital administrative data on adults discharged from German hospitals in 2011 and prevalence estimates based on administrative ambulatory diagnosis data were used. **STUDY DESIGN:** A retrospective cross-sectional study using in- and outpatient secondary data was performed. **DATA COLLECTION:** Hospitalization data for hypertension, diabetes, heart failure, chronic obstructive pulmonary disease, and asthma were obtained from the German Diagnosis Related Groups (DRG) database. Prevalence estimates were obtained from the German Central Research Institute of Ambulatory Health Care. **PRINCIPAL FINDINGS:** Crude hospitalization rates varied substantially across counties (coefficients of variation [CV] 28-37 percent across conditions); this variation was reduced by prevalence adjustment (CV 21-28 percent). Prevalence explained 40-50 percent of the observed variation ($r = 0.65-0.70$) in ACSH rates for all conditions except asthma ($r = 0.07$). Between 30 percent and 38 percent of areas moved into or outside condition-specific control limits with prevalence adjustment. **CONCLUSIONS:** Unadjusted ACSH rates should be used with caution for high-stakes public reporting as differences in prevalence may have a marked impact. Prevalence adjustment should be considered in models analyzing ACSH.

Zabawa, C., et al. "Soins ambulatoires et facteurs associés à la réhospitalisation précoce des sujets âgés (65+) après un infarctus du myocarde : étude observationnelle à partir des données

nationales de l'Échantillon généraliste de bénéficiaires (EGB)." Revue d'Epidémiologie et de Santé Publique 65(1): 90-91.

<http://www.em-consulte.com/article/1106098/alerteM>

Les réhospitalisations précoces (RHP), dans les 30 jours suivant la sortie d'hospitalisation, sont fréquentes chez les sujets âgés, notamment après un infarctus du myocarde (IDM). Elles augmentent la morbi-mortalité et les dépenses de santé. Il a été démontré qu'une meilleure organisation de la sortie d'hospitalisation réduit significativement le risque de RHP. Néanmoins, il n'existe aucune recommandation sur le suivi ambulatoire en sortie d'hospitalisation. L'objectif de l'étude était d'analyser les soins ambulatoires post-hospitaliers et les facteurs associés à la RHP des sujets âgés après un IDM. Cette étude observationnelle rétrospective a été réalisée à partir des données nationales de l'Échantillon généraliste de bénéficiaires (EGB). Tous les patients ≥ 65 ans, hospitalisés pour un IDM entre 2011 et 2013 étaient inclus. Les patients hospitalisés pour un IDM dans l'année précédente, ou décédés pendant l'hospitalisation initiale ou dans les 30 jours suivant la sortie étaient exclus. Le critère de jugement principal était la première réhospitalisation, toutes causes, dans les 30 jours suivant la sortie du court-séjour. Des données sociodémographiques, médicales et de soins ambulatoires étaient recueillies. Les déterminants de la RHP étaient identifiés via des modèles de régression logistique. Parmi les 624 patients éligibles, 137 étaient réhospitalisés dans les 30 jours (22 %). L'âge moyen était de 79,2 ans, avec une prédominance masculine (57 %). Le délai moyen de réhospitalisation était de 11,9 jours. En analyse multivariée, la fibrillation atriale (OR=1,81 [1,12–2,91]), l'insuffisance rénale chronique (OR=1,90 [1,01–3,57]) et la délivrance d'un antiagrégant plaquettaire ou anticoagulant dans les sept jours suivant la sortie (OR=0,57 [0,38–0,83]) étaient significativement associés à la RHP. Cette étude, réalisée sur un échantillon représentatif de la population française, confirme le haut risque de RHP chez les sujets âgés en post-IDM. Des interventions ciblées sur les comorbidités et les traitements paraissent nécessaires pour réduire ces RHP.

Inégalités de santé / Health Inequalities

Casanova, L., et al. (2017). "Evolution des inégalités sociales de suivi du diabète en région Provence-Alpes-Côte-d'Azur entre 2008 et 2011." Revue d'Epidémiologie et de Santé Publique 65(1): 29-40.

Des inégalités sociales existent en France dans le suivi des maladies chroniques telles que le diabète. Depuis 2008, la crise économique est responsable d'un accroissement des inégalités de revenus, mais qu'en est-il des inégalités sociales de santé ? Le but de l'étude était de décrire l'évolution des inégalités sociales dans le suivi du diabète en Provence-Alpes-Côte-D'azur (PACA) entre 2008 et 2011. Méthodes : Étude analytique sur données répétées issues des bases de remboursement de frais médicaux du régime général de l'assurance maladie de la région PACA et des bases socio-démographiques de l'INSEE (échelle communale). Les patients ayant bénéficié de trois remboursements d'antidiabétiques oraux l'année précédente ont été inclus au 1er janvier de chaque année. Quatre années distinctes ont été considérées. L'impact du revenu médian par unité de consommation (RMUC) de la commune de résidence des patients a été décrit pour sept indicateurs de suivi du diabète. Les indicateurs ont été analysés par des modèles logistiques mixtes ajustés qui comprenaient les termes d'interactions entre le temps (en année) et le RMUC de la commune de résidence du patient. Résultats : Selon l'année, de 142 055 à 164 929 patients diabétiques ont été identifiés au sein de 941 communes de la région PACA. Les modèles ont montré qu'habiter dans une commune à RMUC élevé ou moyen est significativement associé au suivi des sept indicateurs. Pour six indicateurs, les termes d'interactions étaient significatifs. L'association entre le RMUC de la commune de résidence et les indicateurs diminuait significativement entre 2008 et 2011 pour l'HbA1c, le LDL-cholestérol, la microalbuminurie, le fond d'œil et la consultation avec un spécialiste du diabète. Conclusion : Des inégalités sociales dans le suivi du diabète persistent entre 2008 et 2011 mais ont tendance à diminuer.

Giuntella, O. (2017). "Why does the health of Mexican immigrants deteriorate? New evidence from

linked birth records." *Journal of Health Economics* 54(1): 1-16.

This study uses a unique dataset linking the birth records of two generations of children born in California and Florida (1970–2009) to analyze the mechanisms behind the generational decline observed in birth outcomes of children of Mexican origin. Calibrating a simple model of intergenerational transmission of birth weight, I show that modest positive selection on health at the time of migration can account for the initial advantage in birth outcomes of second-generation Mexicans. Moreover, accounting for the socioeconomic differences between second-generation Mexicans and white natives and the observed intergenerational correlation in birth weight, the model predicts a greater deterioration than that observed in the data. Using a subset of siblings and holding constant grandmother quasi-fixed effects, I show that the persistence of healthier behaviors among second-generation Mexican mothers can explain more than half of the difference between the model prediction and the observed birth outcomes of third-generation Mexicans.

Tsitsakis, C. A., et al. "Features of public healthcare services provided to migrant patients in the Eastern Macedonia and Thrace Region (Greece)." *Health Policy* 121(3): 329-337.

Need of proper hospital information systems, monitoring the epidemiological characteristics of migrant inpatients. Need of preventive exams for detection of health problems, among incoming migrants. Our research confirmed the "healthy migrant effect".

Xiao, Q., et al. (2017). "A prospective investigation of neighborhood socioeconomic deprivation and self-rated health in a large US cohort." *Health & Place* 44: 70-76.

<http://www.sciencedirect.com/science/article/pii/S1353829217300631>

Background : Neighborhood characteristics play a critical role in health. Self-rated health (SRH) is an important indicator of quality of life and a strong predictor of premature death. Prospective study on neighborhood deprivation and SRH is limited. Methods We examined neighborhood socioeconomic deprivation with reporting fair/poor SRH at follow-up (2004–2006) in 249,265 men and women (age 50–71) who reported SRH as good or better at baseline (1995–1996) in the NIH-AARP Health and Diet Study. Baseline addresses were geocoded and linked to 2000 Census. Census tract level variables were used to generate a socioeconomic deprivation index by principle component analysis. Results Residents of more deprived neighborhoods had a higher risk of developing poor/fair SRH at follow-up, even after adjusting for individual-level factors (Odds ratio (95% confidence interval) Q5 vs Q1: 1.26 (1.20, 1.32), p-trend: 0.0001). The results were largely consistent across subgroups with different demographics, health behaviors, and disease conditions and after excluding participants who moved away from their baseline address. Conclusion Neighborhood disadvantage predicts SRH over 10 years.

Médicament / Pharmaceuticals

Ankri, J., et al. (2016/12). "La politique du médicament : dossier." *Actualité et Dossier en Santé Publique*(97): 16-49.

Les Français sont les premiers consommateurs de médicaments innovants en Europe. Aujourd'hui la politique du médicament est confrontée à deux enjeux majeurs : garantir la sécurité avec une prise en charge médicamenteuse efficace, et permettre un accès équitable à l'innovation. Depuis quelques années, de nombreuses spécialités pharmaceutiques arrivent sur le marché à des prix très élevés, posant le problème du financement de l'innovation tout en assurant la soutenabilité du système de santé.

Balopoulos, T., et al. (2017). "Why do generic drugs fail to achieve an adequate market share in Greece? Empirical findings and policy suggestions." *Health Policy* 121(3): 265-272.

An increase of generic drugs penetration is critical for Greece. Analyzed data identified factors

affecting population beliefs toward generics. Income, prescription/dispensing preferences and drug beliefs are related to generics perceptions. New campaigns and incentives toward doctors/pharmacists should be introduced. Policies targeting respondents' beliefs should be developed to increase generics' share.

Blome, C., et al. (2017). "Four years of early benefit assessment of new drugs in Germany: a qualitative study on methodological requirements for quality of life data." *Eur J Health Econ* 18(2): 181-193.

BACKGROUND: Since 2011, an early benefit assessment (EBA) of new drugs constricts free price setting in Germany. According to the Pharmaceutical Market Restructuring Act (AMNOG), pharmaceutical companies are obliged to demonstrate added benefit of new drugs over comparative treatment. Benefit is usually evaluated by the Institute for Quality and Efficiency in Health Care (IQWiG). The final appraisal is made by the Federal Joint Committee, Germany's highest-ranking decision body in the health sector, triggering drug price negotiations between companies and statutory health insurance funds. One of four evaluation criteria is quality of life (QoL). QoL outcomes have, however, only rarely been pivotal in EBAs. **OBJECTIVE:** This study determined methodological requirements for QoL measurement and data presentation in the EBA. **DESIGN:** In a qualitative content analysis, documents of all EBAs completed by 2014 were searched for the term QoL. Relevant passages of all EBAs of 2011-2013 were independently extracted and reduced to key content by two researchers. Recurring patterns were identified and verified through comparison with EBAs of 2014. **RESULTS:** We identified a range of requirements regarding QoL assessment, analysis, presentation, and interpretation, which go beyond official regulations. Disease-specific questionnaires are preferred and have to be validated according to certain standards and in the respective patient group. Effects must exceed the minimal important difference, which in turn must be validated in compliance with specific requirements. Often, instruments were not accepted as QoL measures, sometimes inconsistently across EBAs. Another frequent reason for non-acceptance of QoL data was that more than 30 % of randomized patients could not be analyzed due to missing data. **CONCLUSIONS:** Non-compliance with methodological requirements for QoL evidence impairs chances for positive benefit evaluation.

Clague, F., et al. (2016). "Comorbidity and polypharmacy in people with dementia: insights from a large, population-based cross-sectional analysis of primary care data." *Age Ageing*, Oct. 13.

BACKGROUND: the care of older people with dementia is often complicated by physical comorbidity and polypharmacy, but the extent and patterns of these have not been well described. This paper reports analysis of these factors within a large, cross-sectional primary care data set. **METHODS:** data were extracted for 291,169 people aged 65 years or older registered with 314 general practices in the UK, of whom 10,258 had an electronically recorded dementia diagnosis. Differences in the number and type of 32 physical conditions and the number of repeat prescriptions in those with and without dementia were examined. Age-gender standardised rates were used to calculate odds ratios (ORs) of physical comorbidity and polypharmacy. **RESULTS:** people with dementia, after controlling for age and sex, had on average more physical conditions than controls (mean number of conditions 2.9 versus 2.4; $P < 0.001$) and were on more repeat medication (mean number of repeats 5.4 versus 4.2; $P < 0.001$). Those with dementia were more likely to have 5 or more physical conditions (age-sex standardised OR [sOR] 1.42, 95% confidence interval (CI) 1.35-1.50; $P < 0.001$) and were also more likely to be on 5 or more (sOR 1.46; 95% CI 1.40-1.52; $P < 0.001$) or 10 or more repeat prescriptions (sOR 2.01; 95% CI 1.90-2.12; $P < 0.001$). **CONCLUSIONS:** people with dementia have a higher burden of comorbid physical disease and polypharmacy than those without dementia, even after accounting for age and sex differences. Such complex needs require an integrated response from general health professionals and multidisciplinary dementia specialists.

Datta, A. et Dave, D. (2017). "Effects of Physician-directed Pharmaceutical Promotion on Prescription Behaviors: Longitudinal Evidence." *Health Econ* 26(4): 450-468.

Spending on prescription drugs (Rx) represents one of the fastest growing components of US

healthcare spending and has coincided with an expansion of pharmaceutical promotional spending. Most (83%) of Rx promotion is directed at physicians in the form of visits by pharmaceutical representatives (known as detailing) and drug samples provided to physicians' offices. Such promotion has come under increased public scrutiny, with critics contending that physician-directed promotion may play a role in raising healthcare costs and may unduly affect physicians' prescribing habits towards more expensive, and possibly less cost-effective, drugs. In this study, we bring longitudinal evidence to bear upon the question of how detailing impacts physicians' prescribing behaviors. Specifically, we examine prescriptions and promotion for a particular drug class based on a nationally representative sample of 150,000 physicians spanning 24 months. The use of longitudinal physician-level data allows us to tackle some of the empirical concerns in the extant literature, virtually all of which have relied on aggregate national data. We estimate fixed-effects specifications that bypass stable unobserved physician-specific heterogeneity and address potential targeting bias. In addition, we also assess differential effects at both the extensive and intensive margins of prescribing behaviors and differential effects across physician-level and market-level characteristics, questions that have not been explored in prior work. The estimates suggest that detailing has a significant and positive effect on the number of new scripts written for the detailed drug, with an elasticity magnitude of 0.06. This effect is substantially smaller than those in the literature based on aggregate information, suggesting that most of the observed relationship between physician-directed promotion and drug sales is driven by selection bias. We find that detailing impacts selective brand-specific demand but does not have any substantial effects on class-level demand. The increase in brand-specific demand appears to crowd out demand for the substitute branded drug although not for the generic alternative. Results also indicate that most of the detailing response may operate at the extensive margin; detailing affects the probability of prescribing the drug more than it affects the number of prescriptions conditional on any prescribing. We draw some implications from these estimates with respect to effects on healthcare costs and public health. Copyright (c) 2016 John Wiley & Sons, Ltd.

Formoso, G., et al. (2017). "Drug information by public health and regulatory institutions: Results of an 8-country survey in Europe." *Health Policy* 121(3): 257-264.

We evaluated drug information from regulatory and other public health institutions in 8 European countries. Focus was on type of contents, availability of comparative evidence and accessibility. Substantial heterogeneity in available drug information is present among the analyzed countries. Coordinated efforts at European level are warranted to assess added value and therapeutic role of drugs. Adequate information tools and plans for local implementation are then needed.

Pichetti, S. et Sermet, C. (2016/12). "Le médicament aujourd'hui». In : La politique du médicament : dossier." *Actualité et Dossier en Santé Publique*(97): 17-22.

Les Français sont les premiers consommateurs de médicaments innovants en Europe, avec une dépense plus importante que celles des autres pays européens. L'évaluation de la sécurité des médicaments, les informations sur leur bon usage ou l'étude de leur efficacité ont pris une place accrue dans la politique du médicament.

Rönnerstrand, B. et Lapuente, V. (2017) "Corruption and use of antibiotics in regions of Europe." *Health Policy* 121(3): 250-256.

Quality of government is associated with consumption of antibiotics in European regions. The association is persistent when controlling for socioeconomic development and health system quality. Dysfunctional public institutions partly accounts for between-region variation in antibiotic consumption. Policy-makers interested in prudent use of antibiotics should pay attention to governance.

Méthodologie – Statistique / Methodology - Statistics

Ali, S., et al. (2017). "Addressing care-seeking as well as insurance-seeking selection biases in estimating the impact of health insurance on out-of-pocket expenditure." *Social Science & Medicine* 177: 127-140.
<http://www.sciencedirect.com/science/article/pii/S0277953616306049>

Health Insurance (HI) programmes in low-income countries aim to reduce the burden of out-of-pocket (OOP) health care expenditure. However, if the decisions to purchase insurance and to seek care when ill are correlated with the expected health care expenditure, the use of naïve regression models may produce biased estimates of the impact of insurance membership on OOP expenditure. Whilst many studies in the literature have accounted for the endogeneity of the insurance decision, the potential selection bias due to the care-seeking decision has not been taken into account. We extend the Heckman selection model to account simultaneously for both care-seeking and insurance-seeking selection biases in the health care expenditure regression model. The proposed model is illustrated in the context of a Vietnamese HI programme using data from a household survey of 1,192 individuals conducted in 1999. Results were compared with those of alternative econometric models making no or partial allowance for selection bias. In this illustrative example, the impact of insurance membership on reducing OOP expenditures was underestimated by 21 percentage points when selection biases were not taken into account. We believe this is an important methodological contribution that will be relevant to future empirical work.

Guthmuller, S. et Wittwer, J. (2017). "The Impact of the Eligibility Threshold of a French Means-Tested Health Insurance Programme on Doctor Visits: A Regression Discontinuity Analysis." *Health Econ.*, Mar 20.

This paper assesses the impact of eligibility for a free means-tested complementary health insurance plan, called Couverture Maladie Universelle Complémentaire (CMUC), on doctor visits. We use information on the selection rule to qualify for the plan to identify the effect of eligibility and adopt a regression discontinuity approach. Our sample consists of low-income individuals enrolled in the Health Insurance Fund and recipients of social benefits from the Family Allowance Fund of an urban area in Northern France. Our findings do not show significant impacts of the CMUC threshold on the number of doctor visits within the full sample. Among the subsample of adults under 30 years old, however, eligible individuals are more likely to see a specialist and have, on average, significantly more specialist visits than non-eligible individuals. This specific impact of the CMUC cut-off point among young adults may be explained by the fact that young adults are less likely to be covered by a complementary health insurance plan when they are not recipients of the CMUC plan. (c) 2017 The Authors. Health Economics Published by John Wiley & Sons, Ltd.

Han, B., et al. (2017). "Evaluating the Impact of Parent-Reported Medical Home Status on Children's Health Care Utilization, Expenditures, and Quality: A Difference-in-Differences Analysis with Causal Inference Methods." *Health Serv Res* 52(2): 786-806.

OBJECTIVE: To evaluate the effects of the parent-reported medical home status on health care utilization, expenditures, and quality for children. **DATA SOURCES:** Medical Expenditure Panel Survey (MEPS) during 2004-2012, including a total of 9,153 children who were followed up for 2 years in the survey. **STUDY DESIGN:** We took a causal difference-in-differences approach using inverse probability weighting and doubly robust estimators to study how changes in medical home status over a 2-year period affected children's health care outcomes. Our analysis adjusted for children's sociodemographic, health, and insurance statuses. We conducted sensitivity analyses using alternative statistical methods, different approaches to outliers and missing data, and accounting for possible common-method biases. **PRINCIPAL FINDINGS:** Compared with children whose parents reported having medical homes in both years 1 and 2, those who had medical homes in year 1 but lost them in year 2 had significantly lower parent-reported ratings of health care quality and higher utilization of emergency care. Compared with children whose parents reported having no medical homes in both

years, those who did not have medical homes in year 1 but gained them in year 2 had significantly higher ratings of health care quality, but no significant differences in health care expenditures and utilization. CONCLUSIONS: Having a medical home may help improve health care quality for children; losing a medical home may lead to higher utilization of emergency care.

Jacob, C., et al. (2017). "Assessing asthma severity based on claims data: a systematic review." *Eur J Health Econ* 18(2): 227-241.

INTRODUCTION: Asthma is one of the most common chronic diseases in Germany. Substantial economic evaluation of asthma cost requires knowledge of asthma severity, which is in general not part of claims data. Algorithms need to be defined to use this data source. AIMS AND OBJECTIVES: The aim of this study was to systematically review the international literature to identify algorithms for the stratification of asthma patients according to disease severity based on available information in claims data. METHODS: A systematic literature review was conducted in September 2015 using the DIMDI SmartSearch, a meta search engine including several databases with a national and international scope, e.g. BIOSIS, MEDLINE, and EMBASE. Claims data based studies that categorize asthma patients according to their disease severity were identified. RESULTS: The systematic research yielded 54 publications assessing asthma severity based on claims data. Thirty-nine studies used a standardized algorithm such as HEDIS, Leidy, the GINA based approach or CACQ. Sixteen publications applied a variety of different criteria for the severity categorisation such as asthma diagnoses, asthma-related drug prescriptions, emergency department visits, and hospitalisations. CONCLUSION: There is no best practice method for the categorisation of asthma severity with claims data. Rather, a combination of algorithms seems to be a pragmatic approach. A transfer to the German context is not entirely possible without considering particular conditions associated with German claims data.

Lagarde, M. et Blaauw, D. (2017). "Physicians' responses to financial and social incentives: A medically framed real effort experiment." *Social Science & Medicine* 179: 147-159.
<http://www.sciencedirect.com/science/article/pii/S0277953617301417>

Because compensation policies have critical implications for the provision of health care, and evidence of their effects is limited and difficult to study in the real world, laboratory experiments may be a valuable methodology to study the behavioural responses of health care providers. With this experiment undertaken in 2013, we add to this new literature by designing a new medically framed real effort task to test the effects of different remuneration schemes in a multi-tasking context. We assess the impact of different incentives on the quantity (productivity) and quality of outputs of 132 participants. We also test whether the existence of benefits to patients influences effort. The results show that salary yields the lowest quantity of output, and fee-for-service the highest. By contrast, we find that the highest quality is achieved when participants are paid by salary, followed by capitation. We also find a lot of heterogeneity in behaviour, with intrinsically motivated individuals hardly sensitive to financial incentives. Finally, we find that when work quality benefits patients directly, subjects improve the quality of their output, while maintaining the same levels of productivity. This paper adds to a nascent literature by providing a new approach to studying remuneration schemes and modelling the medical decision making environment in the lab.

Santin, G. et Bénézet, L. (2017). "Une enquête en deux phases pour non-réponse et ses paradonnées pour corriger les biais de non-réponse dans une enquête de surveillance épidémiologique. A two-phase sampling survey for nonresponse and its paradata to correct nonresponse bias in a health surveillance survey." *Revue d'Epidémiologie et de Santé Publique* 65(1): 72-79.

La diminution des taux de participation dans les enquêtes, y compris dans les enquêtes de surveillance épidémiologique, est potentiellement un vrai problème puisqu'il peut entraîner une augmentation du biais de non-réponse. L'objectif de l'étude est d'estimer la contribution d'une enquête complémentaire auprès d'un sous-échantillon de non-répondants et la contribution additionnelle des paradonnées pour corriger la non-réponse dans une enquête de surveillance épidémiologique des

risques professionnels. Méthodes : En 2010, 10 000 travailleurs ont été tirés au sort et ont reçu un questionnaire postal. Des données sociodémographiques étaient disponibles pour l'ensemble de l'échantillon. Après la collecte des données de questionnaire, une enquête complémentaire auprès d'un sous-échantillon aléatoire de 500 non-répondants a été conduite par questionnaire administré par un enquêteur. Des parodonnées ont été collectées pour l'ensemble du sous-échantillon de l'enquête complémentaire. Les biais de non-réponse à l'enquête initiale et aux enquêtes combinées ont été évalués en utilisant des variables issues de bases médico-administratives, disponibles pour l'ensemble de l'échantillon et non-sujettes à des erreurs de mesure différentielles. Des prévalences corrigées par repondération ont été estimées en utilisant d'abord seulement les répondants de l'enquête initiale puis en combinant les répondants à l'enquête initiale et à l'enquête complémentaire, sous différentes hypothèses sur le processus de non-réponse. Les résultats ont été comparés en estimant des erreurs relatives. Résultats : Les taux de réponse à l'enquête initiale et à l'enquête complémentaire étaient respectivement de 23,6 % et 62,6 %. Pour l'enquête initiale et les enquêtes combinées, les erreurs relatives diminuent après correction de la non-réponse sur les variables sociodémographiques. Pour les enquêtes combinées sans l'utilisation des parodonnées, les erreurs relatives diminuent en comparaison de celles estimées via l'enquête initiale. La contribution des parodonnées est faible. Conclusion : Lorsqu'une enquête descriptive a un faible taux de réponse, une enquête complémentaire courte parmi les non-répondants avec un protocole cherchant à maximiser le taux de réponse, est utile. La contribution des variables sociodémographiques pour corriger la non-réponse est importante, alors que la contribution additionnelle des parodonnées pour corriger les biais de non-réponse est discutable.

Stoeklé, H.-C., et al. (2017). "Vers un consentement éclairé dynamique." *Med Sci (Paris)* 33(2): 188-192.

La « médecine personnalisée » ou « médecine des données » doit permettre d'utiliser des données de masse pour adapter le traitement au patient. Ces données proviennent d'analyses d'échantillons biologiques de patients, combinées à des données cliniques. À un moment où une multitude d'informations est disponible instantanément via internet, la protection des données génétiques, en particulier, pose de nouveaux problèmes en termes de nature, de moyens, de statut et d'utilisation. Des solutions aux problèmes que cela pose sont nécessaires, avec une attitude légale, morale et éthique claire et sans équivoque, pour faciliter le développement de la médecine personnalisée. En amont de ces questions se trouve le modèle du consentement éclairé qui n'a pas évolué avec les progrès technologiques. La médecine est devenue beaucoup plus dynamique et les possibilités d'échange et de partage en temps réel d'informations, de données génétiques ou même d'échantillons biologiques entre patients, cliniciens, chercheurs et partenaires industriels doivent maintenant être prises en considération. Nous décrivons ici les avantages particuliers du consentement dit « dynamique » et « enrichi », donné par voie électronique, dans le cadre du développement de la médecine personnalisée.

Politique de santé / Health Policy

Van de Goor, I., et al. (2017). "Determinants of evidence use in public health policy making: Results from a study across six EU countries." *Health Policy* 121(3): 273-281.

Media attitude towards underpinning policy with evidence influences policy decision makers. Individual skills, attitudes, values of policy makers impact the extent evidence use. A solid research infrastructure is facilitating but not sufficient for evidence use. Factors that impact evidence use in policy making differ by country and policy context. Interventions connecting policy makers and researchers in the policy context seem most promising.

Prévision – Evaluation / Prevision - Evaluation

De Abreu Lourenco, R., et al. (2017). "Valuing Meta-Health Effects for Use in Economic Evaluations to Inform Reimbursement Decisions: A Review of the Evidence." Pharmacoeconomics 35(3): 347-362.

This review explores the evidence from the literature regarding how meta-health effects (effects other than health resulting from the consumption of health care) are valued for use in economic evaluations.

Hussey, P. S., et al. (2016). "Episode-Based Approaches to Measuring Health Care Quality." Med Care Res Rev.

Most currently available quality measures reflect point-in-time provider tasks, providing a limited and fragmented assessment of care. The concept of episodes of care could be used to develop quality measurement approaches that reflect longer periods of care. With input from clinical experts, we constructed episode-of-care frameworks for six illustrative conditions and identified potential gaps and measure development priority areas. Episode-based measures could assess changes in health outcomes ("delta measures"), the amount of time during an episode in which a patient has suboptimal health status ("integral measures"), quality contingent upon events occurring previously ("contingent measures"), and composites of measures throughout the episode. This article identifies a number of challenges that will need to be addressed to advance operationalization of episode-based quality measurement.

Psychiatrie / Psychiatry

Plancke, L. et Amariei, A. (2017). "Les hospitalisations longues en psychiatrie." Revue d'Epidémiologie et de Santé Publique 65(1): 9-16.

Les hospitalisations longues en psychiatrie posent problème de par la désocialisation des patients et les coûts qu'elles induisent.

Méthodes : Les variables individuelles concernant les personnes hospitalisées de 16 ans et plus résidant dans la région française du Nord-Pas-de-Calais ont été extraites d'une base médico-administrative sur les séjours psychiatriques à temps complet en 2011–2013. Nous avons calculé la part des personnes ayant connu un séjour d'une durée au moins égale à 292 jours durant la période de l'étude. Une analyse bivariée a été réalisée, puis des caractéristiques écologiques (sur l'offre de soins, la défavorisation et la taille des communes de résidence) ont été introduites dans un modèle de régression multiniveaux, en vue d'identifier les facteurs associés à la variabilité des taux d'hospitalisation psychiatrique au long cours. Résultats : Au total, 2,6 % des personnes hospitalisées en psychiatrie ont connu au moins un séjour de 292 jours ou plus durant la période d'étude ; les journées en séjours longs représentaient 22,5 % des journées d'hospitalisation à temps complet en psychiatrie. L'analyse bivariée a montré que l'ancienneté dans le dispositif psychiatrique est fortement corrélée au taux d'hospitalisation longue. Dans le modèle multiniveaux, les variables individuelles les plus associées à l'augmentation du risque d'hospitalisation longue sont la dépendance totale (OR = 9,0. IC95 % : 6,7–12,2), un diagnostic principal de trouble de développement psychologique (OR = 9,7. IC95 % : 4,5–20,6), de retard mental (OR = 4,5. IC95 % : 2,5–8,2), de schizophrénie (OR = 3,0. IC95 % : 1,7–5,2), le fait d'avoir eu une hospitalisation contrainte (OR = 1,7. IC95 % : 1,4–2,1) et une mesure d'isolement thérapeutique (OR = 1,8. IC95 % : 1,5–2,1). Les variations de taux d'hospitalisation longue selon le type d'établissement sont très élevées, mais la densité en lits d'hospitalisation ou l'intensité de l'activité ambulatoire des services ne sont pas liés à l'hospitalisation longue. Les habitants d'unités urbaines de petite taille connaissent significativement moins de risque d'hospitalisation longue que ceux des grandes agglomérations. Nous n'avons pas trouvé d'influence de la défavorisation matérielle ou sociale sur les séjours au long cours. Conclusion : L'hospitalisation longue en psychiatrie concerne peu de patients mais représente un cinquième des journées d'hospitalisation à temps complet. Les

nouvelles générations de patients sont beaucoup moins exposées au risque de connaître des séjours longs.

Plancke, L. et Amariei, A. (2017). "[Long-term psychiatric hospitalizations]." *Revue d'Epidémiologie et de Santé Publique* 65(1): 9-16.

BACKGROUND: Long-term hospitalizations in psychiatry raise the question of desocialisation of the patients and the inherent costs. METHODS: Individual indicators were extracted from a medical administrative database containing full-time psychiatric hospitalizations for the period 2011-2013 of people over 16 years old living in the French region of Nord-Pas-de-Calais. We calculated the proportion of people who had experienced a hospitalization with a duration of 292 days or more during the study period. A bivariate analysis was conducted, then ecological data (level of health-care offer, the deprivation index and the size of the municipalities of residence) were included into a multilevel regression model in order to identify the factors significantly related to variability of long-term hospitalization rates. RESULTS: Among hospitalized individuals in psychiatry, 2.6% had had at least one hospitalization of 292 days or more during the observation period; the number of days in long-term hospitalization represented 22.5% of the total of days of full-time hospitalization in psychiatry. The bivariate analysis revealed that seniority in the psychiatric system was strongly correlated with long hospitalization rates. In the multivariate analysis, the individual indicators the most related to an increased risk of long-term hospitalization were: total lack of autonomy (OR=9.0; 95% CI: 6.7-12.2; P<.001); diagnoses of psychological development disorders (OR=9.7; CI95%: 4.5-20.6; P<.001); mental retardation (OR=4.5; CI95%: 2.5-8.2; P<.001); schizophrenia (OR=3.0; CI95%: 1.7-5.2; P<.001); compulsory hospitalization (OR=1.7; CI95%: 1.4-2.1; P<.001); having experienced therapeutic isolation (OR=1.8; CI95%: 1.5-2.1; P<.001). Variations of long-term hospitalization rates depending on the type of establishment were very high, but the density of hospital beds or intensity of ambulatory activity services were not significantly linked to long-term hospitalization. The inhabitants of small urban units had significantly less risk of long-term hospitalization than those of large cities. We found no influence of material and social deprivation in the long-term hospitalizations. CONCLUSION: Long-term hospitalization in psychiatry only concerns a minority of patients but represents the fifth of the total number of days of full-time hospitalization. The recent patients were significantly less exposed to the risk of having a long-term hospitalization.

Soins de santé primaires / Primary Health Care

Afendulis, C. C., et al. (2017). "Early Impact Of CareFirst's Patient-Centered Medical Home With Strong Financial Incentives." *Health Affairs* 36(3): 468-475.

<http://content.healthaffairs.org/content/36/3/468.abstract>

In 2011 CareFirst BlueCross BlueShield, a large mid-Atlantic health insurance plan, implemented a payment and delivery system reform program. The model, called the Total Care and Cost Improvement Program, includes enhanced payments for primary care, significant financial incentives for primary care physicians to control spending, and care coordination tools to support progress toward the goal of higher-quality and lower-cost patient care. We conducted a mixed-methods evaluation of the initiative's first three years. Our quantitative analyses used spending and utilization data for 2010–13 to compare enrollees who received care from participating physician groups to similar enrollees cared for by nonparticipating groups. Savings were small and fully shared with providers, which suggests no significant effect on total spending (including bonuses). Our qualitative analysis suggested that early in the program, many physicians were not fully engaged with the initiative and did not make full use of its tools. These findings imply that this and similar payment reforms may require greater time to realize significant savings than many stakeholders had expected. Patience may be necessary if payer-led reform is going to lead to system transformation.

Ammi, M. et Fortier, G. (2017). "The influence of welfare systems on pay-for-performance programs for general practitioners: A critical review." *Social Science & Medicine* 178: 157-166.

<http://www.sciencedirect.com/science/article/pii/S0277953617301089>

While pay-for-performance (P4P) programs are increasingly common tools used to foster quality and efficiency in primary care, the evidence concerning their effectiveness is at best mixed. In this article, we explore the influence of welfare systems on four P4P-related dimensions: the level of healthcare funders' commitment to P4Ps (by funding and length of program operation), program design (specifically target-based vs. participation-based program), physicians' acceptance of the program and program effects. Using Esping-Andersen's typology, we examine P4P for general practitioners (GPs) in thirteen European and North American countries and find that welfare systems contribute to explain variations in P4P experiences. Overall, liberal systems exhibited the most enthusiastic adoption of P4P, with significant physician acceptance, generous incentives and positive but modest program effects. Social democratic countries showed minimal interest in P4P for GPs, with the exception of Sweden. Although corporatist systems adopted performance pay, these countries experienced mixed results, with strong physician opposition. In response to this opposition, health care funders tended to favour participation-based over target-based P4P. We demonstrate how the interaction of decommodification and social stratification in each welfare regime influences these countries' experiences with P4P for GPs, directly for funders' commitment, program design and physicians' acceptance, and indirectly for program effects, hence providing a framework for analyzing P4P in other contexts or care settings.

Broadway, B., et al. (2017). "Do Financial Incentives Influence GPs' Decisions to Do After-hours Work? A Discrete Choice Labour Supply Model." *Health Econ.*, Feb. 20.

This paper analyses doctors' supply of after-hours care (AHC), and how it is affected by personal and family circumstances as well as the earnings structure. We use detailed survey data from a large sample of Australian General Practitioners (GPs) to estimate a structural, discrete choice model of labour supply and AHC. This allows us to jointly model GPs' decisions on the number of daytime-weekday working hours and the probability of providing AHC. We simulate GPs' labour supply responses to an increase in hourly earnings, both in a daytime-weekday setting and for AHC. GPs increase their daytime-weekday working hours if their hourly earnings in this setting increase, but only to a very small extent. GPs are somewhat more likely to provide AHC if their hourly earnings in that setting increase, but again, the effect is very small and only evident in some subgroups. Moreover, higher earnings in weekday-daytime practice reduce the probability of providing AHC, particularly for men. Increasing GPs' earnings appears to be at best relatively ineffective in encouraging increased provision of AHC and may even prove harmful if incentives are not well targeted. Copyright (c) 2017 John Wiley & Sons, Ltd.

Cross, D. A., et al. (2017). "Outcomes For High-Needs Patients: Practices With A Higher Proportion Of These Patients Have An Edge." *Health Affairs* 36(3): 476-484.

<http://content.healthaffairs.org/content/36/3/476.abstract>

High-value primary care for high-needs patients—those with multiple physical, mental, or behavioral health conditions—is critical to improving health system performance. However, little is known about what types of physician practices perform best for high-needs patients. We examined two scale-related characteristics that could predict how well physician practices delivered care to this population: the proportion of patients in the practice that were high-needs and practice size (number of physicians). Using four years of data on commercially insured, high-needs patients in Michigan primary care practices, we found lower spending and utilization among practices with a higher proportion of high-needs patients (more than 10 percent of the practice's panel) compared to practices with smaller proportions. Small practices (those with one or two physicians) had lower overall spending, but not less utilization, compared to large practices. However, practices with a substantial proportion of high-needs patients, as well as small practices, performed slightly worse on a composite measure of process quality than their associated reference group. Practices that treat a high proportion of high-needs patients might have structural advantages or have developed specialized approaches to serve this population. If so, this raises questions about how best to make use of this knowledge to foster high-value care for high-needs patients.

Deligiannidis, K. E. (2017). "Primary Care Issues in Rural Populations." *Prim Care* 44(1): 11-19.

Rural populations have different demographics and health issues compared to their metropolitan counterparts, including higher mortalities from ischemic heart disease, chronic obstructive pulmonary disease, unintentional injuries, motor vehicle accidents, and suicide. Rural primary care physicians (PCPs) have a unique position in counseling, preventing, and treating common issues that are specific to rural populations, such as motor vehicle accidents, unintentional injuries, pesticide poisoning, occupational respiratory illnesses, and mental illness. They are also in a unique position to address prevention and social determinants of health. Rural PCPs can use multiple strategies to improve access to medical care.

Detollenaere, J., et al. (2017). "Postponing a General Practitioner Visit: Describing Social Differences in Thirty-One European Countries." *Health Serv Res*, Feb 19..

OBJECTIVE: To describe social differences in postponing a general practitioner visit in 31 European countries and to explore whether primary care strength is associated with postponement rates. **DATA SOURCES:** Between October 2011 and December 2013, the multicountry QUALICOPC study collected data on 61,931 patients and 7,183 general practitioners throughout Europe. **STUDY DESIGN:** Access to primary care was measured by asking the patients whether they postponed a general practitioner visit in the past year. Social differences were described according to patients' self-rated household income, education, ethnicity, and gender. **DATA COLLECTION/EXTRACTION METHODS:** Data were analyzed using multivariable and multilevel binomial logistic regression analyses. **PRINCIPAL FINDINGS:** According to the variance-decomposition in the multilevel analysis, most of the variance can be explained by patient characteristics. Postponement of general practitioner care is higher for patients with a low self-rated household income, a low education level, and a migration background. In addition, although the point estimates are consistent with a substantial effect, no statistically significant association between primary care strength and postponement in the 31 countries is determined. **CONCLUSIONS:** Despite the universal and egalitarian goals of health care systems, access to general practitioner care in Europe is still determined by patients' socioeconomic status (self-rated household income and education) and migration background.

François, P., et al. (2017). "Les outils d'évaluation des structures pluriprofessionnelles en soins primaires : revue systématique." *Revue d'Epidémiologie et de Santé Publique* 65(1): 61-69.

Les regroupements pluriprofessionnels en soins primaires se développent dans de nombreux pays dont la France. Ces groupements apparaissent très hétérogènes quant au niveau d'intégration et de coopération interprofessionnelle. L'objectif de cette étude était de réaliser une revue systématique des instruments d'évaluation du développement organisationnel des structures de soins primaires. Méthodes : La littérature scientifique a été recherchée dans la base de données Pubmed, la littérature grise a été recherchée sur Internet. Les données récoltées comportaient des informations sur les instruments d'évaluation : origine, contenu, mode d'utilisation, processus de validation. Résultats : Soixante-cinq documents portant sur 16 instruments d'évaluation ont été retenus. Douze ont été développés en Amérique du Nord et quatre en Europe. Quatre instruments étaient des questionnaires d'évaluation, quatre des grilles d'accréditation et huit étaient des matrices de maturité. Les matrices de maturité étaient structurées en niveaux de développement organisationnel. Leur utilisation comportait une auto-évaluation individuelle par chaque professionnel, suivie par un consensus de groupe en présence d'un facilitateur externe. Les questionnaires d'évaluation et les grilles d'accréditation avaient des structures et des modes d'utilisation variables. Les instruments étaient structurés en 4 à 16 dimensions avec une médiane à 7. Six thématiques communes ont été identifiées : la gestion de la structure et de l'équipe, la démarche qualité, la gestion des données des patients, la coopération interprofessionnelle, l'accessibilité et la continuité des soins, et la formation. Les processus de validation des outils étaient très variables et le plus souvent incomplets. Conclusion : Il existe un ensemble hétérogène d'instruments d'évaluation des structures de soins primaires. Ces instruments diffèrent par leur objectif, leur contenu et leur mode d'utilisation. On retrouve cependant des thématiques communes. Un questionnaire d'évaluation des regroupements pluriprofessionnels des soins primaires en langue française serait utile pour évaluer et suivre dans le

temps le développement organisationnel des centres, maisons et pôles de santé en France.

Francois, P., et al. (2017). "[Systematic revue of the tools for multiprofessional primary care teams assessment]." *Revue d'Epidémiologie et de Santé Publique* 65(1): 61-69.

BACKGROUND: Multiprofessional teams in primary care are developing in many countries including France. These groups appear very heterogeneous regarding the level of integration and interprofessional cooperation. A systematic review of the literature was performed to screen the instruments which assess the organizational development of primary care groups. **METHODS:** Scientific literature was searched in the Pubmed database, gray literature was searched for on the Internet. The documents were selected by two independent investigators. The collected data included information on assessment instruments: origin, content, method of use, and validation process. **RESULTS:** Sixty-five documents involving 16 assessment instruments were selected for the study. Twelve instruments have been developed in North America and 4 in Europe. Four instruments were evaluation questionnaires, 4 accreditation tools and 8 were maturity matrices. The maturity matrices were structured by levels of organizational development. Their use were effected by an individual self-assessment of each professional and then by consensus of the group in the presence of an external facilitator. The questionnaire and accreditation tools have organizations and use patterns variable. The number of questions ranged from 25 to 200 with a median of 80. The instruments were organized into 4 to 16 dimensions with a median of 7. Six common themes were identified: practice and staff management, quality development, data patient management, interprofessional cooperation, accessibility and continuity of care, and formation. The validation process of tools were variable and often incomplete. **CONCLUSION:** The set of assessment tools for primary care group is heterogeneous in purpose, content and mode of use. However, common themes were found for all tools. An evaluation questionnaire, in French, would be useful to monitor over time and evaluate the organizational development of centers and health houses in France.

Gale, N., et al. (2017). "Street-level diplomacy? Communicative and adaptive work at the front line of implementing public health policies in primary care." *Social Science & Medicine* 177: 9-18.
<http://www.sciencedirect.com/science/article/pii/S0277953617300539>

Public services are increasingly operating through network governance, requiring those at all levels of the system to build collaborations and adapt their practice. Agent-focused implementation theories, such as 'street-level bureaucracy', tend to focus on decision-making and the potential of actors to subvert national policy at a local level. While it is acknowledged that network leaders need to be adaptable and to build trust, much less consideration has been given to the requirement for skills of 'diplomacy' needed by those at the front line of delivering public services. In this article, drawing on theoretical insights from international relations about the principles of 'multi-track diplomacy', we propose the concept of street level diplomacy, offer illustrative empirical evidence to support it in the context of the implementation of public health (preventative) policies within primary care (a traditionally responsive and curative service) in the English NHS and discuss the contribution and potential limitations of the new concept. The article draws on qualitative data from interviews conducted with those implementing case finding programmes for cardiovascular disease in the West Midlands. The importance of communication and adaptation in the everyday work of professionals, health workers and service managers emerged from the data. Using abductive reasoning, the theory of multi-track diplomacy was used to aid interpretation of the 'street-level' work that was being accomplished.

Menvielle, L., et al. (2016). "Effets de la fréquence d'utilisation des communautés virtuelles de patients sur la relation patients-médecins." *Journal de Gestion et d'Economie Médicales* 34(8): 431-452.

Le monde de la santé connaît depuis peu des changements manifestes en ce qui concerne la prise de pouvoir des patients sur leurs maladies ou celles de leurs proches. Internet a été un véritable catalyseur et a permis d'ouvrir de nombreux espaces virtuels (sites Web, blogues, réseaux sociaux médicaux...) grâce auxquels les individus commentent et échangent quant à leurs pathologies. Les

communautés virtuelles de patients (CVP) s'inscrivent dans cette dynamique et ont modifié la place et le rôle du patient, mais aussi la relation qu'il entretient avec son médecin. Le but de cet article est de mesurer l'impact de la fréquence d'utilisation des communautés virtuelles de patients sur les variables suivantes : confiance à l'égard du médecin, qualité perçue de la relation avec le médecin et attitude vis-à-vis du médecin. Basés sur un échantillon de 266 répondants français, les résultats de cette recherche montrent que la fréquence d'utilisation a un effet sur l'attitude et la qualité de la relation des patients avec leur médecin.

Ricci-Cabello, I., et al. (2017). "Identifying Primary Care Pathways from Quality of Care to Outcomes and Satisfaction Using Structural Equation Modeling." *Health Serv Res.*, Feb. 19.

OBJECTIVE: To study the relationships between the different domains of quality of primary health care for the evaluation of health system performance and for informing policy decision making. **DATA SOURCES:** A total of 137 quality indicators collected from 7,607 English practices between 2011 and 2012. **STUDY DESIGN:** Cross-sectional study at the practice level. Indicators were allocated to subdomains of processes of care ("quality assurance," "education and training," "medicine management," "access," "clinical management," and "patient-centered care"), health outcomes ("intermediate outcomes" and "patient-reported health status"), and patient satisfaction. The relationships between the subdomains were hypothesized in a conceptual model and subsequently tested using structural equation modeling. **PRINCIPAL FINDINGS:** The model supported two independent paths. In the first path, "access" was associated with "patient-centered care" (beta = 0.63), which in turn was strongly associated with "patient satisfaction" (beta = 0.88). In the second path, "education and training" was associated with "clinical management" (beta = 0.32), which in turn was associated with "intermediate outcomes" (beta = 0.69). "Patient-reported health status" was weakly associated with "patient-centered care" (beta = -0.05) and "patient satisfaction" (beta = 0.09), and not associated with "clinical management" or "intermediate outcomes." **CONCLUSIONS:** This is the first empirical model to simultaneously provide evidence on the independence of intermediate health care outcomes, patient satisfaction, and health status. The explanatory paths via technical quality clinical management and patient centeredness offer specific opportunities for the development of quality improvement initiatives.

Spinhirny, F. (2017/01). "La sage-femme comme médecin-philosophe de l'hôpital." *Gestions Hospitalières*(562): 18-21.

Systemes de santé / Health Systems

Cookson, G., et al. (2017). "Cancelled Procedures in the English NHS: Evidence from the 2010 Tariff Reform." *Health Econ.* Feb. 16

This paper explores the role of incentives in the English National Health Service. Until financial year 2009/2010, elective procedures that were cancelled after admission received a fixed reimbursement associated with a specific healthcare resource group code. We investigate whether this induced trusts to admit and then cancel, rather than cancel before admission and/or to cancel low fee over high fee work. As the tariff was ended in April 2010, we conduct an interrupted time series analysis to examine if their behaviour was affected after the tariff removal. The results indicate a small, yet statistically significant, decline in the probability of a last minute cancellation in the post-tariff period, especially for certain types of patients and diagnoses. Copyright (c) 2017 John Wiley & Sons, Ltd.

Duell, D., et al. (2017). "Practice variation in the Dutch long-term care and the role of supply-sensitive care: Is access to the Dutch long-term care equitable?" *Health Econ.*, Ahead of print.

Universal access and generous coverage are important goals of the Dutch long-term care (LTC) system. It is a legal requirement that everyone eligible for LTC should be able to receive it. Institutional care (IC) made up for 90% of Dutch LTC spending. To investigate whether access to IC is as equitable as the

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

Krinsky, S., et al. (2017). "Variation in Payment Rates under Medicare's Inpatient Prospective Payment System." *Health Serv Res* 52(2): 676-696.

OBJECTIVE: To measure variation in payment rates under Medicare's Inpatient Prospective Payment System (IPPS) and identify the main payment adjustments that drive variation. **DATA SOURCES/STUDY SETTING:** Medicare cost reports for all Medicare-certified hospitals, 1987-2013, and Dartmouth Atlas geographic files. **STUDY DESIGN:** We measure the Medicare payment rate as a hospital's total acute inpatient Medicare Part A payment, divided by the standard IPPS payment for its geographic area. We assess variation using several measures, both within local markets and nationally. We perform a factor decomposition to identify the share of variation attributable to specific adjustments. We also describe the characteristics of hospitals receiving different payment rates and evaluate changes in the magnitude of the main adjustments over time. **DATA COLLECTION/EXTRACTION METHODS:** Data downloaded from the Centers for Medicare and Medicaid Services, the National Bureau of Economic Research, and the Dartmouth Atlas. **PRINCIPAL FINDINGS:** In 2013, Medicare paid for acute inpatient discharges at a rate 31 percent above the IPPS base. For the top 10 percent of discharges, the mean rate was double the IPPS base. Variations were driven by adjustments for medical education and care to low-income populations. The magnitude of variation has increased over time. **CONCLUSIONS:** Adjustments are a large and growing share of Medicare hospital payments, and they create significant variation in payment rates.

Travail et santé / Occupational Health

Dirlam, J. et Zheng, H. (2017). "Job satisfaction developmental trajectories and health: A life course perspective." *Social Science & Medicine* 178: 95-103.

<http://www.sciencedirect.com/science/article/pii/S0277953617300473>

Understanding the health consequence of job dissatisfaction becomes increasingly important because job insecurity, stress and dissatisfaction have significantly increased in the United States in the last decade. Despite the extensive work in this area, prior studies nonetheless may underestimate the harmful effect of job dissatisfaction due to the cross-sectional nature of their data and sample selection bias. This study applies a life-course approach to more comprehensively examine the relationship between job satisfaction and health. Using data from the NLSY 1979 cohort, we estimate group based job satisfaction trajectories of respondents starting at age 25 and ending at age 39. Four job satisfaction trajectory groups are identified, a consistently high satisfaction group, a downward group, an upward group, and a lowest satisfaction group. We examine the effects of these trajectories on several physical and mental health outcomes of respondents in their early forties. We find membership in the lowest job satisfaction trajectory group to be negatively associated with all five mental health outcomes, supporting the accumulation of risks life course model. Those in the upward job satisfaction trajectory group have similar health outcomes to those in the high job satisfaction trajectory group, supporting the social mobility life course model. Overall, we find the relationship between job satisfaction trajectories and health to be stronger for mental health compared to physical health.

Sjöberg, O. (2017). "Positive welfare state dynamics? Sickness benefits and sickness absence in Europe 1997–2011." *Social Science & Medicine* 177: 158-168.
<http://www.sciencedirect.com/science/article/pii/S0277953617300497>

Sickness absence is associated with great costs for individuals, companies and society at large. Influenced by neo-classical economic theory, policy advice has emphasized the role of sickness benefit programs for reducing sickness absence rates: too generous benefits without proper control will increase the number of recipients and prolong absence spells as well as possibly cause negative dynamic effects in the long term. This study provides an alternative interpretation of the relationship between sickness benefits and sickness absence. By combining an epidemiological approach to sickness absence and a resource-based approach to welfare, we argue that sickness benefits might be viewed as a "collective resource" that, by providing economic support during times of ill-health, might have positive health effects. Statistical analysis of short-term sickness absence using innovative methodological approaches and combined micro- and macro-level data for 21 EU countries over the period of 1992–2011 indicates that the long run effects of relatively generous sickness benefits is rather to reduce sickness absence. This result also has implications for sickness benefit reform: whereas benefit cuts to some extent may reduce absence in the short run, in the longer run such reforms may actually increase sickness absence rates.

Veille / Ageing

Christensen, H. K., et al. (2017). "Frailty characteristics and preventive home visits: an audit on elderly patients in Danish general practice." *Fam Pract* 34(1): 57-62.

AIM: Preventive home visits (PHVs) to frail elderly patients, provided by the GP, have been widely promoted in many health care systems, including the Danish system. This study investigates to what extent PHVs are provided to patients with characteristics of frailty. METHODS: During a four-week period, GPs and their staff in three different parts of Denmark filled in a questionnaire for each patient aged 75 years or older who attended the clinic or received a home visit. The association between 20 different frailty characteristics and the receipt of a PHV was assessed through logistic regression. RESULTS: A total of 73 GPs and 41 staff members sampled information about 3133 patients, of whom 332 patients (10.7%) had received a PHV within one year prior to their audit date. A PHV was closely associated with the patient's number of frailty characteristics. The adjusted odds ratios show that the receipt of a PHV was associated with a low walking distance 2.34 (1.65-3.31), dementia 3.35 (2.26-4.96), depression 2.24 (1.38-3.63) and a need for home care 3.40 (2.45-4.73), and increased with the GP's tendency to provide PHVs. CONCLUSION: Most PHV-receiving elderly patients have several characteristics of frailty, the most significant being impaired mobility, dementia, depression and a need for home care. PHVs are also more often provided to patients listed with a GP who has an overall high tendency to conduct these visits.

Delouette, I. et Nirello, L. (2016). "Le processus de privatisation du secteur des établissements d'hébergement pour personnes âgées dépendantes." *Journal de Gestion et d'Economie Médicales* 34(7): 387-408.

L'objet de cet article est de décortiquer le processus de privatisation du secteur des EHPAD. L'analyse s'appuie sur une série d'entretiens réalisée auprès d'acteurs clés du domaine et sur l'étude d'un corpus de rapports d'institutions publiques et privées. Nous montrons que la privatisation du secteur est encouragée par les pouvoirs publics au travers de plusieurs dispositifs. D'abord, dès 1997, les régulateurs du champ construisent un rapport de concurrence entre les différents types d'établissements du secteur (public, économie sociale, privé lucratif) en abrogeant la relation privilégiée qu'ils entretenaient avec les acteurs traditionnels non lucratifs, et en ouvrant les financements publics aux établissements privés lucratifs. Les autorités de tarification imposent aussi, au travers des instruments de financement, une médicalisation des établissements menant à une standardisation de leurs activités. Ces normes favorisent le développement des groupes lucratifs tout

en affaiblissant les acteurs traditionnels de l'économie sociale et du public, moins armés face aux nouvelles réglementations et ainsi affaiblis financièrement. Nous observons aussi une concentration économique des groupes d'EHPAD résultant d'incitations publiques et de leur mise en concurrence face à un faible nombre de nouvelles places autorisées. La concentration ouvre enfin la voie à une financiarisation progressive des établissements qu'ils soient privés lucratifs ou de l'économie sociale. La privatisation du secteur s'opère donc par le biais de la croissance du privé lucratif face à un tarissement de l'économie sociale et du public, par l'incorporation des normes du privé par les gestionnaires du champ et, par la privatisation des financements des établissements.

Ellen, M. E., et al. "A Knowledge Translation framework on ageing and health." *Health Policy* 121(3): 282-291.

The need to ensure that research into older peoples' health is translated to policy is immediate. A framework to enable evidence-informed policy making in ageing and health is proposed. The framework consists of seven elements that include researcher and stakeholder initiatives. A four-step process for implementation of the framework is proposed.

Verdier, C., et al. (2016). "Analyse empirique des points de blocage dans le processus de soutien à domicile des personnes fragiles." *Journal de Gestion et d'Economie Médicales* 34(5-6): 321-341.

Le soutien à domicile des personnes fragiles est complexe car il suppose d'offrir des services individualisés, facilement adaptables dans le temps et l'espace, multimodaux (soins, services paramédicaux, services non médicaux, soutien financier, soutien psychologique, socialisation) et coût-efficaces au sein d'environnements juridique, social, organisationnel très contraints. Force est de constater que les approches traditionnelles de modélisation (approche par processus, notamment) d'un tel écosystème sont dysfonctionnelles et trop coûteuses, que les méthodes de conception et de représentation sont inopérantes et que le cadre actuel produit des stratégies d'évitement, de contournement ou de mises en œuvre, pas toujours optimales, mais qui néanmoins fonctionnent. Le but de cet article est donc de présenter au regard des deux grilles de lecture, les politiques publiques et le système d'information, une analyse du terrain de la prise en charge à domicile, étayée par des méthodes adaptées et traduite en buts à atteindre pour lever les points de blocage dans le processus de soutien à domicile des personnes fragiles.