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## Assurance maladie / Health Insurance

**Bock, J. O., et al. (2016). "Willingness to pay for health insurance among the elderly population in Germany." Eur J Health Econ 17(2): 149-158.**

**INTRODUCTION:** All elderly Germans are legally obliged to have health insurance. About 90 % of this population are members of social health insurances (SHI) whose premiums are generally income-related and independent of health status. For most of these members, holding social health insurance is mandatory. As a consequence, genuine information about preferences for health insurance is not available. The aim of this study was therefore to determine and analyze the willingness to pay (WTP) for health insurance among elderly Germans. **METHODS:** Data from a population-based 8-year follow-up of a large cohort study conducted in the Saarland, Germany was used. Participants aged 57-84 years passed a geriatric assessment and responded to a health economic questionnaire. Individuals' WTP was elicited based on a contingent valuation method with a payment card. **RESULTS:** Mean monthly WTP per capita for health insurance amounted to euro260. This corresponded to about 20 % of individual disposable income. Regression analyses showed that WTP increased significantly with higher income, male gender, higher educational level, and privately insured status. In contrast, neither increasing morbidity level nor higher individual health care costs influenced WTP significantly. **DISCUSSION:** The relatively large extent of average WTP for health insurance indicates that the elderly would probably accept higher contributions to SHI rather than policy efforts to reduce contributions. The identified determinants of WTP might indicate that elderly generally approve the principle of solidarity of the SHI with contributions depending on income rather than morbidity.

**Duijmelinck, D. M. and W. P. van de Ven (2016). "Switching rates in health insurance markets decrease with age: empirical evidence and policy implications from the Netherlands." Health Econ Policy Law 11(2): 141-159.**

All consumer groups with specific preferences must feel free to easily switch insurer in order to discipline insurers to be responsive to consumers' heterogeneous preferences. This paper provides insight into the switching behaviour of low-risks (i.e. young or healthy consumers) and high-risks (i.e. elderly or unhealthy consumers) in the Netherlands in the period 2009-2012. We analysed: (1) administrative data with objective health status information (i.e. medically diagnosed diseases and pharmaceutical use) and information on health care expenses of nearly the entire Dutch population (n=15.3 million individuals) and (2) three-year sample data (n=1152 individuals). Our findings indicate that switching rates strongly decrease with age. For example, in 2009, consumers aged 25-44 switched 10 times more than consumers aged 75 or older. Another finding is that switching rates decrease as the predicted health care expenses increase. Although healthy consumers switch twice as much as unhealthy consumers, this difference becomes much smaller after adjusting for age. We conclude that our findings can be explained by higher perceived switching costs by elderly consumers than by young consumers. Consequently, insurers have low incentives to act as quality-conscious purchasers of care for the elderly consumers. Therefore, strategies should be developed to increase the choice of insurer of elderly consumers.

**Joseph, T. D. (2016). "What Health Care Reform Means for Immigrants: Comparing the Affordable Care Act and Massachusetts Health Reforms." J Health Polit Policy Law 41(1): 101-116.**

The 2010 Patient Protection and Affordable Care Act (ACA) was passed to provide more affordable health coverage to Americans beginning in 2014. Modeled after the 2006 Massachusetts health care reform, the ACA includes an individual mandate, Medicaid expansion, and health exchanges through which middle-income individuals can purchase coverage from private insurance companies. However, while the ACA provisions exclude all undocumented and some documented immigrants, Massachusetts uses state and hospital funds to extend coverage to these groups. This article examines the ACA reform using the Massachusetts reform as a comparative case study to outline how citizenship status influences individuals' coverage options under both policies. The article then briefly

discusses other states that provide coverage to ACA-ineligible immigrants and the implications of uneven ACA implementation for immigrants and citizens nationwide.

**Peter, R., et al. (2016). "Health Insurance, Health Savings Accounts and Healthcare Utilization."**

Health Economics **25**(3): 357-371.

<http://dx.doi.org/10.1002/hec.3142>

Assuming symmetric information, we show that a high-deductible health plan (HDHP) combined with a tax-favored health savings account (HSA) induces more savings and less treatment compared with a full coverage plan under reasonable risk preferences. Furthermore, a higher tax subsidy increases savings in any case but decreases medical utilization if and only if treatment expenses are above the deductible. A larger deductible increases savings but does not necessarily decrease healthcare utilization. Whether an HDHP/HSA combination is preferred over a full coverage contract depends on absolute risk aversion. A higher tax advantage increases the attractiveness of an HDHP/HSA combination, whereas the effects of changes in the deductible are ambiguous. The paper shows that a potential regulator needs to carefully set the size of the deductible as only in a certain corridor of the probability of sickness, its effect on aggregate healthcare costs are unambiguously favorable. Copyright © 2015 John Wiley & Sons, Ltd.

**Reich, M. R., et al. (2016). "Moving towards universal health coverage: lessons from 11 country studies." Lancet **387**(10020): 811-816.**

In recent years, many countries have adopted universal health coverage (UHC) as a national aspiration. In response to increasing demand for a systematic assessment of global experiences with UHC, the Government of Japan and the World Bank collaborated on a 2-year multicountry research programme to analyse the processes of moving towards UHC. The programme included 11 countries (Bangladesh, Brazil, Ethiopia, France, Ghana, Indonesia, Japan, Peru, Thailand, Turkey, and Vietnam), representing diverse geographical, economic, and historical contexts. The study identified common challenges and opportunities and useful insights for how to move towards UHC. The study showed that UHC is a complex process, fraught with challenges, many possible pathways, and various pitfalls-- but is also feasible and achievable. Movement towards UHC is a long-term policy engagement that needs both technical knowledge and political know-how. Technical solutions need to be accompanied by pragmatic and innovative strategies that address the national political economy context.

**Vilcu, I. and I. Mathauer (2016). "State budget transfers to Health Insurance Funds for universal health coverage: institutional design patterns and challenges of covering those outside the formal sector in Eastern European high-income countries." International Journal for Equity in Health **15**(1): 1-19.**

<http://dx.doi.org/10.1186/s12939-016-0295-y>

Many countries from the European region, which moved from a government financed and provided health system to social health insurance, would have had the risk of moving away from universal health coverage if they had followed a "traditional" approach. The Eastern European high-income countries studied in this paper managed to avoid this potential pitfall by using state budget revenues to explicitly pay health insurance contributions on behalf of certain (vulnerable) population groups who have difficulties to pay these contributions themselves.

## Economie de la santé / Health Economics

**Jacob, C., et al. (2016). "Healthcare costs and resource utilization of asthma in Germany: a claims data analysis." Eur J Health Econ **17**(2): 195-201.**

INTRODUCTION: Asthma is associated with a substantial economic burden on the German Statutory Health Insurance. AIMS AND OBJECTIVES: To determine costs and resource utilization associated with



asthma and to analyze the impact of disease severity on subgroups based on age and gender. METHODS: A claims database analysis from the statutory health insurance perspective was conducted. Patients with an ICD-10-GM code of asthma were extracted from a 10 % sample of a large German sickness fund. Five controls for each asthma patient matched by age and gender were randomly selected from the same database. Costs and resource utilization were calculated for each individual in the asthma and control group. Incremental asthma-related costs were calculated as the mean cost difference. Based on prescribed asthma medication, patients were classified as intermittent or persistent. In addition, age groups of  $\leq 5$ , 6-18, and  $>18$  years were analyzed separately and gender differences were investigated. RESULTS: Overall, 49,668 individuals were included in the asthma group. On average, total annual costs per patient were euro753 higher ( $p = 0.000$ ) compared to the control group (euro 2,168 vs. euro 1,415). Asthma patients had significantly higher ( $p = 0.000$ ) outpatient (euro 217), inpatient (euro 176), and pharmacy costs (euro 259). Incremental asthma-related total costs were higher for patients with persistent asthma compared to patients with intermittent asthma (euro 1,091 vs. euro 408). Women aged  $>18$  years with persistent asthma had the highest difference in costs compared to their controls (euro 1,207;  $p < 0.0001$ ). Corresponding healthcare resource utilization was significantly higher in the asthma group ( $p = 0.000$ ). CONCLUSIONS: The treatment of asthma is associated with an increased level of healthcare resource utilization and significantly higher healthcare costs. Asthma imposes a substantial economic burden on sickness funds.

**Souliotis, K., et al. (2016). "Informal payments in the Greek health sector amid the financial crisis: old habits die last." *Eur J Health Econ* 17(2): 159-170.**

BACKGROUND: Under-the-table informal payments are commonplace as reimbursements for health care services in Greece. As the country faces a severe financial crisis, the need to investigate the extent of such payments, their incidence and their impact on household income is pressing. METHODS: A survey of 2,741 persons from across the country was conducted between December 2011 and February 2012. The sample was defined via a multistage selection process using a quota for municipality of residence, sex and age. The maximum error margin was 2.41 % with a confidence interval of 95 %. RESULTS: The survey reports under-the-table payments for approximately 32.4 % of public hospital admissions. Private clinics, which display the bulk of out-of-pocket payments, naturally display the lowest under-the-table payments. The highest percentage of under-the-table payments in the private sector appears at visits to private practitioners and dentists (36 %). Informal payments are most frequently made upon request, prior to service provision, to facilitate access to care and to reduce waiting times, and at a much lower percentage, to post-service provision, and out of gratitude. CONCLUSIONS: This survey reveals that, due to severe financial pressure, there is a growing unwillingness of citizens to pay informally and an increasing demand for these payments as a prerequisite for access to services or to redeem services provided. This "hidden" financial burden of at least 27 % impacts negatively on the living conditions of households and is not reported as purchasing ability or cost of living.

## Géographie de la santé / Geography of Health

**Alford-Teaster, J., et al. (2016). "Is the closest facility the one actually used? An assessment of travel time estimation based on mammography facilities." *International Journal of Health Geographics* 15(1): 1-10.**  
<http://dx.doi.org/10.1186/s12942-016-0039-7>

Characterizing geographic access depends on a broad range of methods available to researchers and the healthcare context to which the method is applied. Globally, travel time is one frequently used measure of geographic access with known limitations associated with data availability. Specifically, due to lack of available utilization data, many travel time studies assume that patients use the closest facility. To examine this assumption, an example using mammography screening data, which is

considered a geographically abundant health care service in the United States, is explored. This work makes an important methodological contribution to measuring access—which is a critical component of health care planning and equity almost everywhere.

**Ferguson, W. J., et al. (2016). "Using a geographic information system to enhance patient access to point-of-care diagnostics in a limited-resource setting." *International Journal of Health Geographics* 15(1): 1-12.**

<http://dx.doi.org/10.1186/s12942-016-0037-9>

Rapid and accurate diagnosis drives evidence-based care in health. Point-of-care testing (POCT) aids diagnosis by bringing advanced technologies closer to patients. Health small-world networks are constrained by natural connectivity in the interactions between geography of resources and social forces. Using a geographic information system (GIS) we can understand how populations utilize their health networks, visualize their inefficiencies, and compare alternatives.

**Hosseinpour, A. R., et al. (2016). "Monitoring subnational regional inequalities in health: measurement approaches and challenges." *International Journal for Equity in Health* 15(1): 1-13.**

<http://dx.doi.org/10.1186/s12939-016-0307-y>

Monitoring inequalities based on subnational regions is a useful practice to unmask geographical differences in health, and deploy targeted, equity-oriented interventions. Our objective is to describe, compare and contrast current methods of measuring subnational regional inequality. We apply a selection of summary measures to empirical data from four low- or middle-income countries to highlight the characteristics and overall performance of the different measures.

**Langford, M., et al. (2016). "Multi-modal two-step floating catchment area analysis of primary health care accessibility." *Health & Place* 38: 70-81.**

<http://www.sciencedirect.com/science/article/pii/S1353829216000022>

Two-step floating catchment area (2SFCA) techniques are popular for measuring potential geographical accessibility to health care services. This paper proposes methodological enhancements to increase the sophistication of the 2SFCA methodology by incorporating both public and private transport modes using dedicated network datasets. The proposed model yields separate accessibility scores for each modal group at each demand point to better reflect the differential accessibility levels experienced by each cohort. An empirical study of primary health care facilities in South Wales, UK, is used to illustrate the approach. Outcomes suggest the bus-riding cohort of each census tract experience much lower accessibility levels than those estimated by an undifferentiated (car-only) model. Car drivers' accessibility may also be misrepresented in an undifferentiated model because they potentially profit from the lower demand placed upon service provision points by bus riders. The ability to specify independent catchment sizes for each cohort in the multi-modal model allows aspects of preparedness to travel to be investigated.

## Hôpital / Hospitals

**Buisman, L. R., et al. (2016). "Clinical Practice Variation Needs to be Considered in Cost-Effectiveness Analyses: A Case Study of Patients with a Recent Transient Ischemic Attack or Minor Ischemic Stroke." *Appl Health Econ Health Policy* 14(1): 67-75.**

**BACKGROUND AND OBJECTIVE:** The cost-effectiveness of clinical interventions is often assessed using current care as the comparator, with national guidelines as a proxy. However, this comparison is inadequate when clinical practice differs from guidelines, or when clinical practice differs between hospitals. We examined the degree of variation in the way patients with a recent transient ischemic

attack (TIA) or minor ischemic stroke are assessed and used the results to illustrate the importance of investigating possible clinical practice variation, and the need to perform hospital-level cost-effectiveness analyses (CEAs) when variation exists. METHODS: Semi-structured interviews were conducted with 16 vascular neurologists in hospitals throughout the Netherlands. Questions were asked about the use of initial and confirmatory diagnostic imaging tests to assess carotid stenosis in patients with a recent TIA or minor ischemic stroke, criteria to perform confirmatory tests, and criteria for treatment. We also performed hospital-level CEAs to illustrate the consequences of the observed diagnostic strategies in which the diagnostic test costs, sensitivity and specificity were varied according to the local hospital conditions. RESULTS: 56 % (9/16) of the emergency units and 63 % (10/16) of the outpatient clinics use the initial and confirmatory diagnostic tests to assess carotid stenosis in accordance with the national guidelines. Of the hospitals studied, only one uses the recommended criteria for use of a confirmatory test, 38 % (6/16) follow the guidelines for treatment. The most cost-effective diagnostic test strategy differs between hospitals. CONCLUSIONS: If important practice variation exists, hospital-level CEAs should be performed. These CEAs should include an assessment of the feasibility and costs of switching to a different strategy.

**Jia, H., et al. (2016). "Poststroke Rehabilitation and Restorative Care Utilization: A Comparison Between VA Community Living Centers and VA-contracted Community Nursing Homes."**

*Medical Care* 54(3): 235-242.

[http://journals.lww.com/lww-](http://journals.lww.com/lww-medicalcare/Fulltext/2016/03000/Poststroke_Rehabilitation_and_Restorative_Care.4.aspx)

[medicalcare/Fulltext/2016/03000/Poststroke Rehabilitation and Restorative Care.4.aspx](http://journals.lww.com/lww-medicalcare/Fulltext/2016/03000/Poststroke_Rehabilitation_and_Restorative_Care.4.aspx)

Background: Effective poststroke rehabilitation care can speed patient recovery and minimize patient functional disabilities. Veterans affairs (VA) community living centers (CLCs) and VA-contracted community nursing homes (CNHs) are the 2 major sources of institutional long-term care for Veterans with stroke receiving care under VA auspices. Objectives: This study compares rehabilitation therapy and restorative nursing care among Veterans residing in VA CLCs versus those Veterans in VA-contracted CNHs. Research Design: Retrospective observational. Subjects: All Veterans diagnosed with stroke, newly admitted to the CLCs or CNHs during the study period who completed at least 2 Minimum Data Set assessments postadmission. Measures: The outcomes were numbers of days for rehabilitation therapy and restorative nursing care received by the Veterans during their stays in CLCs or CNHs as documented in the Minimum Data Set databases. Results: For rehabilitation therapy, the CLC Veterans had lower user rates (75.2% vs. 76.4%,  $P=0.078$ ) and fewer observed therapy days (4.9 vs. 6.4,  $P<0.001$ ) than CNH Veterans. However, the CLC Veterans had higher adjusted odds for therapy (odds ratio=1.16,  $P=0.033$ ), although they had fewer average therapy days (coefficient=-1.53±0.11,  $P<0.001$ ). For restorative nursing care, CLC Veterans had higher user rates (33.5% vs. 30.6%,  $P<0.001$ ), more observed average care days (9.4 vs. 5.9,  $P<0.001$ ), higher adjusted odds (odds ratio=2.28,  $P<0.001$ ), and more adjusted days for restorative nursing care (coefficient=5.48±0.37,  $P<0.001$ ). Conclusion: Compared with their counterparts at VA-contracted CNHs, Veterans at VA CLCs had fewer average rehabilitation therapy days (both unadjusted and adjusted), but they were significantly more likely to receive restorative nursing care both before and after risk adjustment.

**Kim, S. J., et al. (2016). "The effect of competition on the relationship between the introduction of the DRG system and quality of care in Korea."**

*The European Journal of Public Health* 26(1): 42-

47.

<http://eurpub.oxfordjournals.org/content/eurpub/26/1/42.full.pdf>

Background: The diagnosis-related group-based prospective payment programme was introduced in Korea in 1997 as a pilot programme to control health spending. In July 2013, the programme was implemented throughout the nation. The aim of our study is to evaluate the relationship between quality of care and market competition following the introduction of the new payment system in Korea. Methods: We conduct an observational analysis using National Health Insurance claim data from 2011 to 2014. We analyse data on readmission within 30 days, length of stay, and number of outpatient visits for 1742 hospitals and 821 912 cases. We use a generalized estimating equation model to evaluate readmission within 30 days and number of outpatient visits and a multi-level regression model to assess length of stay. Results: Total readmission within 30 days is 10 727 (1.3%).

High competition areas present a lower risk of readmission [odds ratio (OR): 0.95, P: 0.0277], a longer length of stay (1%, P < 0.0001), and an increased number of outpatient visits (Relative Risk: 1.11, P: 0.0011) as compared with moderate competition areas. Risk of readmission is higher in low competition areas as compared with moderate competition areas (OR: 1.21, P < 0.0001). Conclusion: The effects of the introduction of the new payment system differed by degree of market competition. Thus, evaluation about the effect of new payment system on hospital performance should be measured in combination with the degree of hospital market structure.

**May, P., et al. (2016). "Using Length of Stay to Control for Unobserved Heterogeneity When Estimating Treatment Effect on Hospital Costs with Observational Data: Issues of Reliability, Robustness, and Usefulness ».** *Health Services Research*: Ahead of print

<http://dx.doi.org/10.1111/1475-6773.12460>

**Objective :** To evaluate the sensitivity of treatment effect estimates when length of stay (LOS) is used to control for unobserved heterogeneity when estimating treatment effect on cost of hospital admission with observational data. **Data Sources/Study Setting** We used data from a prospective cohort study on the impact of palliative care consultation teams (PCCTs) on direct cost of hospital care. Adult patients with an advanced cancer diagnosis admitted to five large medical and cancer centers in the United States between 2007 and 2011 were eligible for this study. **Study Design** Costs were modeled using generalized linear models with a gamma distribution and a log link. We compared variability in estimates of PCCT impact on hospitalization costs when LOS was used as a covariate, as a sample parameter, and as an outcome denominator. We used propensity scores to account for patient characteristics associated with both PCCT use and total direct hospitalization costs. **Data Collection/Extraction Methods** We analyzed data from hospital cost databases, medical records, and questionnaires. Our propensity score weighted sample included 969 patients who were discharged alive. **Principal Findings** In analyses of hospitalization costs, treatment effect estimates are highly sensitive to methods that control for LOS, complicating interpretation. Both the magnitude and significance of results varied widely with the method of controlling for LOS. When we incorporated intervention timing into our analyses, results were robust to LOS-controls. **Conclusions** Treatment effect estimates using LOS-controls are not only suboptimal in terms of reliability (given concerns over endogeneity and bias) and usefulness (given the need to validate the cost-effectiveness of an intervention using overall resource use for a sample defined at baseline) but also in terms of robustness (results depend on the approach taken, and there is little evidence to guide this choice). To derive results that minimize endogeneity concerns and maximize external validity, investigators should match and analyze treatment and comparison arms on baseline factors only. Incorporating intervention timing may deliver results that are more reliable, more robust, and more useful than those derived using LOS-controls.

**Nielsen, T. H. (2016). "The Relationship Between Self-Rated Health and Hospital Records." *Health Econ* 25(4): 497-512.**

This paper investigates whether self-rated health (SRH) covaries with individual hospital records. By linking the Danish Longitudinal Survey on Ageing with individual hospital records covering all hospital admissions from 1995 to 2006, I show that SRH is correlated to historical, current, and future hospital records. I use both measures separately to control for health in a regression of mortality on wealth. Using only historical and current hospitalization controls for health yields the common result that SRH is a stronger predictor of mortality than objective health measures. The addition of future hospitalizations as controls shows that the estimated gradient on wealth is similar to one in which SRH is the control. The results suggest that with a sufficiently long time series of individual records, objective health measures can predict mortality to the same extent as global self-rated measures. Copyright (c) 2015 John Wiley & Sons, Ltd.

**Wallace, E., et al. (2016). "Reducing emergency admissions through community based interventions." *BMJ* 352.**

<http://www.bmj.com/bmj/352/bmj.h6817.full.pdf>

Reducing emergency admissions to hospital, both as a measure of care quality and to contain spiralling healthcare expenditure, is gathering interest internationally. Emergency admissions in the United Kingdom rose by 47% from 1998 to 2013, from 3.6 million to 5.3 million, with only a 10% increase in population over this period.<sup>1</sup> These admissions are expensive; in 2012 they cost the NHS £12.5bn (€16.8bn; \$18.3bn).<sup>1</sup> Emergency admission is used as a performance measure for healthcare systems. One of the quality measures for accountable care organisations under the US Affordable Care Act<sup>2</sup> is to reduce emergency admissions for three chronic medical conditions: chronic obstructive pulmonary disease (COPD), congestive heart failure, and asthma.<sup>3</sup> UK policy makers took a step further and introduced a financial incentive for general practitioners to identify the 2% of their practice population at highest risk of emergency admission and to manage them proactively (case management). We discuss the uncertainties around identification, prevention, and management of patients at high risk of emergency admission and suggest alternative approaches. Limited potential for reducing admissions

Risk prediction models use clinical, demographic, and healthcare use data to identify people at risk of emergency admission.<sup>4</sup> <sup>5</sup> A systematic review identified 27 models to predict future emergency admission in community dwelling adults.<sup>7</sup> The six best performing models showed good discrimination for the outcome of future emergency admission (c statistics 0.79-0.83).<sup>7</sup> We used two models—the Scottish patients at risk of readmissions and admission (SPARRA) model<sup>8</sup> and the UK Nuffield trust model<sup>9</sup>—to estimate their likely effects on emergency admissions. SPARRA (version 3) was developed in a cohort of over 3.5 million Scottish people,<sup>8</sup> and the Nuffield trust model was developed in a cohort of over 1.8 million English ...

## Inégalités de santé / Health Inequalities

**Campos-Matos, I., et al. (2016). "The 'dark side' of social capital: trust and self-rated health in European countries." *The European Journal of Public Health* 26(1): 90-95.**  
<http://eurpub.oxfordjournals.org/content/eurpub/26/1/90.full.pdf>

Background: Generalized interpersonal trust (as an indicator of social capital) has been linked to health status at both the individual and ecological level. We sought to examine how changes in contextual and individual trust are associated with changes in self-rated health in the European Social Surveys 2002–12. Methods: A multilevel analysis using a variance components model was performed on 203 452 individuals nested within 145 country cohorts covering 35 countries. Conditional on sociodemographic covariates, we sought to examine the association between self-rated health and individual trust, country average trust and a cross-level interaction between the two. Results: Although individual trust perceptions were significantly correlated with self-rated health [OR = 0.95, 95% confidence interval (0.94–0.96)], country-level trust was not associated [OR = 1.12, 95% confidence interval (0.95–1.32)]. There was, however, a strong crosslevel interaction between contextual and individual trust (P < 0.001), such that individuals with high interpersonal trust reported better health in contexts in which other individuals expressed high average interpersonal trust. Conversely, low trust individuals reported worse health in high trust contexts. Conclusion: Our findings suggest that contexts with increasing average trust can be harmful for low trust individuals, which might reflect the negative impact that social capital can have in certain groups. These findings suggest that contextual trust has a complex role in explaining health inequalities and individual self-rated health.

**Evans, R. G. (2015). "Migrants, Manpower and Math in the Coming Europe." *Health Policy* 11(2): 13-19.**

"A dead child" said Stalin "is a tragedy. Two million are a statistic." A single photograph of a beach riveted world attention, converting syrian refugees from statistics to tragedy. But the statistics remain. Three Canadian columnists have offered contrasting interpretations. Eric Reguly argues that a static and aging Europe needs more manpower to sustain its economy. Margaret Wenthe, however, observes

the failure of integration of migrants in Sweden. Migrants are drawn by open borders and a generous welfare state, but do not fit an advanced, high-skill economy. Gwynne Dyer notes that current inflows, if evenly distributed, are a tiny proportion of the overall European Union. But economic migrants from Africa are a much larger issue. Their numbers are effectively inexhaustible.

**Forchuk, C., et al. (2016). "Social Determinants of Health: Housing and Income." *Healthc Q* 18 Suppl: 27-31.**

Social determinants of health such as housing and income have a large impact on mental health. Community-based initiatives have worked to address access to housing, prevent homelessness and assist people who are homeless with mental health problems. There have been several large research projects to tease out multiple subgroups such as youth and veterans and other individuals experiencing long-term homelessness. The issue of poverty has been addressed by exploring issues related to employment. The use of social enterprises is a promising practice to address issues around poverty, social inclusion and employment. Similarly, the community has worked to move hospital-based employment programs to the community.

**Guerra, G., et al. (2016). "Measuring health inequities in low and middle income countries for the development of observatories on inequities and social determinants of health."**

*International Journal for Equity in Health* 15(1): 1-10.

<http://dx.doi.org/10.1186/s12939-016-0297-9>

Almost seven years after the publication of the final report of the World Health Organization's Commission on Social Determinants of Health (CSDH), its third recommendation has not been attended to properly. Measuring health inequities (HI) within countries and globally, in order to develop and evaluate evidence-based policies and actions aimed at the social determinants of health (SDH), is still a pending task in most low and middle income countries (LMIC) in the Latin American region. In this paper we discuss methodological and conceptual issues to measure HI in LMIC and suggest a three-stage methodology for the creation of observatories on health inequities (OHI) and social determinants of health, based on the experience of the Brazilian Observatory on Health Inequities (BOHI) that has been successfully operating since 2010 at the Fundação Oswaldo Cruz (FIOCRUZ).

**Lamu, A. N. and J. A. Olsen (2016). "The relative importance of health, income and social relations for subjective well-being: An integrative analysis." *Social Science & Medicine* 152: 176-185.**

<http://www.sciencedirect.com/science/article/pii/S0277953616300478>

There is much evidence that health, income and social relationships are important for our well-being, but little evidence on their relative importance. This study makes an integrative analysis of the relative influence of health related quality of life (HRQoL), household income and social relationships for subjective well-being (SWB), where SWB is measured by the first three of the five items on the satisfaction with life scale (SWLS). In a comprehensive 2012 survey from six countries, seven disease groups and representative healthy samples (N = 7933) reported their health along several measures of HRQoL. A Shapley value decomposition method measures the relative importance of health, income and social relationships, while a quantile regression model tests how the effects of each of the three predictors vary across different points of SWB distributions. Results are compared with the standard regression. The respective marginal contribution of social relationships, health and income to SWB (as a share of goodness-of-fit) is 50.2, 19.3 and 7.3% when EQ-5D-5L is used as a measure of health. These findings are consistent across models based on five alternative measures of HRQoL. The influence of the key determinants varied significantly between low and high levels of the SWB distribution, with health and income having stronger influence among those with relatively lower SWB. Consistent with several studies, income has a significantly positive association with SWB, but with diminishing importance.

**Langlois, E. V., et al. (2016). "Refugees: towards better access to health-care services." *Lancet* 387(10016): 319-321.**

**Permanand, G., et al. (2016). "Europe's migration challenges: mounting an effective health system response." *The European Journal of Public Health* 26(1): 3-4.**  
<http://eurpub.oxfordjournals.org/content/eurpub/26/1/3.full.pdf>

Health systems are at the forefront of the response to the ongoing humanitarian crisis facing refugees and other migrants fleeing to Europe, both as a first point of contact for arrivals and later during their resettlement and beyond. (The term 'migrant' is used here with the understanding that there are numerous groups that fall within this categorization, but which are distinct in terms of their status, e.g. asylum-seeker, refugee, undocumented migrant, economic migrant, family-reunited migrant, etc., where a specific group is mentioned by name, it is in a context where this specificity is required.) Yet even if the scale of migration is new, at least in the post-war period, some European countries have considerable experience of sudden large-scale immigration, whether from Algeria to France in the 1960s, East African Asians coming to the United Kingdom in the 1970s, refugees from former Yugoslavia in the 1990s and, more recently, across the Mediterranean to Italy, Malta and Spain. However, few lessons seem to have been learnt, and European health systems vary greatly in their ability to respond to this new challenge. The situation is complicated further by differences in formal entitlement to health care, even though it is now clear that restricting access costs more money in the long run. The challenges facing undocumented migrants are particularly alarming, as many of those now moving either fall into this category already or will soon do so if their applications for asylum are rejected. Even where migrants are entitled to care they may face many barriers. These include language barriers and inadequate information about their rights and how to claim them. At the ...

**Vandentorren, S., et al. (2016). "Characteristics and health of homeless families: the ENFAMS survey in the Paris region, France 2013." *The European Journal of Public Health* 26(1): 71-76.**  
<http://eurpub.oxfordjournals.org/content/eurpub/26/1/71.full.pdf>

Background: The objectives were to estimate the size of homeless family population in Paris region, to describe their living conditions and health and to analyse the impact of homelessness on children's growth and development, which was never investigated in France. Methods: A cross-sectional survey was conducted on a random sample of homeless sheltered families in 2013. Families were interviewed in 17 languages and a nurse took anthropometric measures, blood samples and collected health data from child health reports. Results: The population size was estimated at 10 280 families. Half were single-parent female families and 94% were born outside France. Most families had experienced housing instability and 94% were living below the poverty line (828 euros/month). Malnutrition was a major problem: the prevalence of food insecurity was high (77% of parents and 69% of children), as well as anaemia (50% of mothers and 38% of children), overweight (38% of mothers and 22% of children) and obesity (32% of mothers and 4% of children). High rates of depressive disorders were found in 30% of homeless mothers and 20% of children had signs of possible mental health disorders. Discussion: These first results highlight the important number of families among the homeless population in Paris region. Families differed from other homeless people regarding social characteristics such as birthplace, single-parent status and residential instability that are likely to influence schooling, social ties, health and access to care. These results demonstrate the need for urgent actions targeting homeless families, in terms of reducing housing instability and providing adequate care, especially for children.

## Médicaments / Pharmaceuticals

**Brooks, E. and R. Geyer (2016). "Can a medical need clause help manage the growing costs of prescription drugs in the EU?" *Health Econ Policy Law* 11(2): 179-192.**

Innovation in the development of new drugs has to balance the needs of health actors and

administrators, the pharmaceutical industry and patients. Differing perspectives on what constitutes an innovation, where research and development should be directed and how new drugs should be evaluated and priced cause ongoing tensions within the regulatory framework. In the current climate, where Europe's health systems face rising demand for health services and increasingly restricted resources, the efficiency of pharmaceutical regulation and drug development is under even greater scrutiny. How can regulation foster innovation and industry growth while also serving the public health needs of society, and what is the EU's role in pursuing this objective? Drawing on a provision which formerly existed in Norwegian pharmaceutical legislation, this article explores the potential of a medical need clause (MNC) in addressing these issues. In restricting market authorisations to those drugs that offer an added therapeutic value, might a MNC foster innovation and spending efficiency in Europe's health systems?

**Datta, A. and D. Dave (2016). "Effects of Physician-directed Pharmaceutical Promotion on Prescription Behaviors: Longitudinal Evidence."** *Health Economics*: Ahead of print.  
<http://dx.doi.org/10.1002/hec.3323>

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 © 2016 John Wiley & Sons, Ltd.

**Hien, H., et al. (2016). "[Point of view of older adults on the potentially inappropriate medications prescribing in primary care facilities in Bobo-Dioulasso, Burkina Faso]."** *Rev Epidemiol Santé Publique* **64**(1): 15-21.

**BACKGROUND:** Little is known about the organization of primary care facilities in sub-Saharan Africa that might lead to potentially inappropriate prescribing. The aim of this study was to analyze the factors that could lead to potentially inappropriate prescribing in primary care facilities in Bobo-Dioulasso (Burkina Faso), taking into consideration the patient's perspective. **METHODS:** A cross-sectional qualitative study was conducted in primary care facilities from November 2013 to February 2014. People aged 60 years or more with at least one chronic disease were included. Individual interviews were conducted. An analysis of the thematic content of the interviews was conducted. **RESULTS:** Our results showed that the patient referral system was insufficient. We also found many different prescribers for older people seeking care and poor communication between prescribers and



patients. This caused some consequences such as the absence of review of drugs consumed before a new prescription, a lack of exchange on medication changes and repeated treatment change during hospitalization. Most of the persons who prescribed potentially inappropriate medications were nurses. CONCLUSION: The poor communication between prescribers and patients is a challenge for the prevention of prescribing potentially inappropriate medications. Teamwork is an important feature of the organizational care system, strengthening it could be a way to improve rational prescription.

**Persson, U. and B. Jonsson (2016). "The End of the International Reference Pricing System?"** *Appl Health Econ Health Policy* **14**(1): 1-8.

All 28 EU member states except Sweden and the UK apply international reference pricing (IRP), international price comparison, external reference pricing or cross-reference pricing. The attractiveness of using prices of other countries as a benchmark for decisions within a national price control is obvious. Alternative models for price and reimbursement decision making such as value-based pricing (VBP), i.e. cost-effectiveness analyses, are more complicated. However, IRP provides incentives for stakeholders to take action not in line with optimal (welfare-maximizing) pricing. IRP is costly for two reasons. First, manufacturers are incentivised to limit or delay access to new innovative treatments in countries with small markets and/or a low income, which can be costly in terms of loss of health. Second, all countries also experience a loss of welfare (health) because IRP reduces the opportunities for differential pricing (Ramsey pricing), i.e. using the fact that the ability and willingness to pay differs between countries. Thus, IRP results in less sales revenue to finance research and development of new innovative drugs. We can now observe that payers and manufacturers are engaged in different types of risk-sharing schemes, price-volume negotiations, payback arrangements, confidential discounts, coverage with evidence developments, etc., all with the purpose of returning to the old model of price discrimination and Ramsey pricing. Shortly, real prices for use in IRP systems will cease to exist and, thus, we expect to soon see the end of IRP, a new system for price discrimination and an increasing demand for VBP.

**Walsh, K. A., et al. (2016). "Improving the appropriateness of prescribing in older patients: a systematic review and meta-analysis of pharmacists' interventions in secondary care."** *Age and Ageing* **45**(2): 201-209.  
<http://ageing.oxfordjournals.org/content/45/2/201.abstract>

Introduction: potentially inappropriate prescribing (PIP) in older hospitalised patients, and in particular those with dementia, is associated with poorer health outcomes. PIP reduction is therefore essential in this population. Methods: a comprehensive electronic literature search was conducted using 12 databases from inception up to and including September 2014. Inclusion criteria were controlled trials (randomised or non-randomised) of interventions involving pharmacists conducted in hospitals, with an objective of the study being PIP reduction in patients 65 years or older or patients with dementia of any age, using any validated PIP tool as an outcome measure. Risk of bias assessments were conducted utilising the Cochrane Collaboration's tool. Results: a total of 1,752 records were found after duplicates were removed. Four trials (n = 1,164 patients; two randomised, two non-randomised) from three countries were included in the quantitative analysis. All studies were at moderate risk of bias. No study focused specifically on dementia patients. Three trials reported statistically significant reductions in the Medication Appropriateness Index score in the intervention group (mean difference from admission to discharge = -7.45, 95% CI: -11.14, -3.76) and other PIP tools such as Beers Criteria. One trial reported reduced drug-related readmissions and another reported increased adverse drug reactions. Conclusion: multi-disciplinary teams involving pharmacists may improve prescribing appropriateness in older inpatients, though the clinical significance of observed reductions is unclear. More research is required into the effectiveness of pharmacists' interventions in reducing PIP in dementia patients. Additionally, easily assessed and clinically relevant measures of PIP need to be developed.

## Méthodologie – Statistique / Methodology - Statistics

**Asaria, M., et al. (2015). "Using Linked Electronic Health Records to Estimate Healthcare Costs: Key Challenges and Opportunities." *PharmacoEconomics* 34(2): 155-160.**  
<http://dx.doi.org/10.1007/s40273-015-0358-8>

This paper discusses key challenges and opportunities that arise when using linked electronic health records (EHR) in health economics and outcomes research (HEOR), with a particular focus on estimating healthcare costs. These challenges and opportunities are framed in the context of a case study modelling the costs of stable coronary artery disease in England. The challenges and opportunities discussed fall broadly into the categories of (1) handling and organising data of this size and sensitivity; (2) extracting clinical endpoints from datasets that have not been designed and collected with such endpoints in mind; and (3) the principles and practice of costing resource use from routinely collected data. We find that there are a number of new challenges and opportunities that arise when working with EHR compared with more traditional sources of data for HEOR. These call for greater clinician involvement and intelligent use of sensitivity analysis.

**Lorgelly, P. K., et al. (2015). "Realising the Value of Linked Data to Health Economic Analyses of Cancer Care: A Case Study of Cancer 2015." *PharmacoEconomics* 34(2): 139-154.**  
<http://dx.doi.org/10.1007/s40273-015-0343-2>

There is a growing appetite for large complex databases that integrate a range of personal, socio-demographic, health, genetic and financial information on individuals. It has been argued that 'Big Data' will provide the necessary catalyst to advance both biomedical research and health economics and outcomes research. However, it is important that we do not succumb to being data rich but information poor. This paper discusses the benefits and challenges of building Big Data, analysing Big Data and making appropriate inferences in order to advance cancer care, using Cancer 2015 (a prospective, longitudinal, genomic cohort study in Victoria, Australia) as a case study. Cancer 2015 has been linked to State and Commonwealth reimbursement databases that have known limitations. This partly reflects the funding arrangements in Australia, a country with both public and private provision, including public funding of private healthcare, and partly the legislative frameworks that govern data linkage. Additionally, linkage is not without time delays and, as such, achieving a contemporaneous database is challenging. Despite these limitations, there is clear value in using linked data and creating Big Data. This paper describes the linked Cancer 2015 dataset, discusses estimation issues given the nature of the data and presents panel regression results that allow us to make possible inferences regarding which patient, disease, genomic and treatment characteristics explain variation in health expenditure.

**Mulhern, B., et al. (2016). "Valuing Health Using Time Trade-Off and Discrete Choice Experiment Methods: Does Dimension Order Impact on Health State Values?" *Value in Health*.**  
<http://www.sciencedirect.com/science/article/pii/S1098301515051256>

Background Health states defined by multi-attribute instruments such as the EuroQol five-dimensional questionnaire with five response levels (EQ-5D-5L) can be valued using time trade-off (TTO) or discrete choice experiment (DCE) methods. A key feature of the tasks is the order in which the health state dimensions are presented. Respondents may use various heuristics to complete the tasks, and therefore the order of the dimensions may impact on the importance assigned to particular states. Objective To assess the impact of different EQ-5D-5L dimension orders on health state values. Methods Preferences for EQ-5D-5L health states were elicited from a broadly representative sample of members of the UK general public. Respondents valued EQ-5D-5L health states using TTO and DCE methods across one of three dimension orderings via face-to-face computer-assisted personal interviews. Differences in mean values and the size of the health dimension coefficients across the arms were compared using difference testing and regression analyses. Results Descriptive analysis suggested some differences between the mean TTO health state values across the different dimension

orderings, but these were not systematic. Regression analysis suggested that the magnitude of the dimension coefficients differs across the different dimension orderings (for both TTO and DCE), but there was no clear pattern. Conclusions : There is some evidence that the order in which the dimensions are presented impacts on the coefficients, which may impact on the health state values provided. The order of dimensions is a key consideration in the design of health state valuation studies.

**Onukwugha, E. (2016). "Big Data and Its Role in Health Economics and Outcomes Research: A Collection of Perspectives on Data Sources, Measurement, and Analysis."**

*PharmacoEconomics* **34**(2): 91-93.

<http://dx.doi.org/10.1007/s40273-015-0378-4>

**Rosenkötter, N., et al. (2016). "Key features of an EU health information system: a concept mapping study."** *The European Journal of Public Health* **26**(1): 65-70.

<http://eurpub.oxfordjournals.org/content/eurpub/26/1/65.full.pdf>

Background: Despite the acknowledged value of an EU health information system (EU–HISys) and the many achievements in this field, the landscape is still heavily fragmented and incomplete. Through a systematic analysis of the opinions and valuations of public health stakeholders, this study aims to conceptualize key features of an EU–HISys. Methods: Public health professionals and policymakers were invited to participate in a concept mapping procedure. First, participants (N = 34) formulated statements that reflected their vision of an EU–HISys. Second, participants (N = 28) rated the relative importance of each statement and grouped conceptually similar ones. Principal Component and cluster analyses were used to condense these results to EU–HISys key features in a concept map. The number of key features and the labelling of the concept map were determined by expert consensus. Results: The concept map contains 10 key features that summarize 93 statements. The map consists of a horizontal axis that represents the relevance of an ‘organizational strategy’, which deals with the ‘efforts’ to design and develop an EU–HISys and the ‘achievements’ gained by a functioning EU–HISys. The vertical axis represents the ‘professional orientation’ of the EU–HISys, ranging from the ‘scientific’ through to the ‘policy’ perspective. The top ranking statement expressed the need to establish a system that is permanent and sustainable. The top ranking key feature focuses on data and information quality. Conclusions: This study provides insights into key features of an EU–HISys. The results can be used to guide future planning and to support the development of a health information system for Europe.

**Zorzela, L., et al. (2016). "PRISMA harms checklist: improving harms reporting in systematic reviews."** *BMJ* **352**.

<http://www.bmj.com/bmj/352/bmj.i157.full.pdf>

Introduction : For any health intervention, accurate knowledge of both benefits and harms is needed. Systematic reviews often compound poor reporting of harms in primary studies by failing to report harms or doing so inadequately. While the PRISMA statement (Preferred Reporting Items for Systematic reviews and Meta-Analyses) helps systematic review authors ensure complete and transparent reporting, it is focused mainly on efficacy. Thus, a PRISMA harms checklist has been developed to improve harms reporting in systematic reviews, promoting a more balanced assessment of benefits and harms. Methods A development strategy, endorsed by the EQUATOR Network and existing reporting guidelines (including the PRISMA statement, PRISMA for abstracts, and PRISMA for protocols), was used. After the development of a draft checklist of items, a modified Delphi process was initiated. The Delphi consisted of three rounds of electronic feedback followed by an in-person meeting. Results The PRISMA harms checklist contains four essential reporting elements to be added to the original PRISMA statement to improve harms reporting in reviews. These are reported in the title (“Specifically mention ‘harms’ or other related terms, or the harm of interest in the review”), synthesis of results (“Specify how zero events were handled, if relevant”), study characteristics (“Define each harm addressed, how it was ascertained (eg, patient report, active search), and over what time period”), and synthesis of results (“Describe any assessment of possible causality”).

Additional guidance regarding existing PRISMA items was developed to demonstrate relevance when

synthesising information about harms. Conclusion The PRISMA harms checklist identifies a minimal set of items to be reported when reviewing adverse events. This guideline extension is intended to improve harms reporting in systematic reviews, whether harms are a primary or secondary outcome.

## Politique de santé / Health Policy

**Gulland, A. (2016). "French parliament passes law to allow sedation at end of life." *BMJ* 352.**

<http://www.bmj.com/bmj/352/bmj.i576.full.pdf>

France's parliament has approved a law that will allow terminally ill patients to be put into deep sedation, stopping short of legalising assisted dying or euthanasia. The law was introduced by two MPs: Alain Claeys, of the ruling Socialist Party, and Jean Leonetti, a cardiologist and member of the Union for a Popular Movement. It was passed by the upper and lower chambers of the National Assembly after a yearlong passage through parliament. Patients will be able to request "deep and continued sedation, altering consciousness until death," but only when ...

**Skinner, D. (2016). "The Politics of Native American Health Care and the Affordable Care Act." *J Health Polit Policy Law* 41(1): 41-71.**

This article examines an important but largely overlooked dimension of the Patient Protection and Affordable Care Act (ACA), namely, its significance for Native American health care. The author maintains that reading the ACA against the politics of Native American health care policy shows that, depending on their regional needs and particular contexts, many Native Americans are well-placed to benefit from recent Obama-era reforms. At the same time, the kinds of options made available by the ACA constitute a departure from the service-based (as opposed to insurance-based) Indian Health Service (IHS). Accordingly, the author argues that ACA reforms-private marketplaces, Medicaid expansion, and accommodations for Native Americans-are best read as potential "supplements" to an underfunded IHS. Whether or not Native Americans opt to explore options under the ACA will depend in the long run on the quality of the IHS in the post-ACA era. Beyond understanding the ACA in relation to IHS funding, the author explores how Native American politics interacts with the key tenets of Obama-era health care reform-especially "affordability"-which is critical for understanding what is required from and appropriate to future Native American health care policy making.

## Prévention / Prevention

**Albright, B. B., et al. (2016). "Preventive Care Quality of Medicare Accountable Care Organizations: Associations of Organizational Characteristics With Performance." *Med Care* 54(3): 326-335.**

**BACKGROUND:** Accountable Care Organizations (ACOs) are a delivery and payment model aiming to coordinate care, control costs, and improve quality. Medicare ACOs are responsible for 8 measures of preventive care quality. **OBJECTIVES:** To create composite measures of preventive care quality and examine associations of ACO characteristics with performance. **DESIGN:** This is a cross-sectional study of Medicare Shared Savings Program and Pioneer participants. We linked quality performance to descriptive data from the National Survey of ACOs. We created composite measures using exploratory factor analysis, and used regression to assess associations with organizational characteristics.

**RESULTS:** Of 252 eligible ACOs, 246 reported on preventive care quality, 177 of which completed the survey (response rate=72%). In their first year, ACOs lagged behind PPO performance on the majority of comparable measures. We identified 2 underlying factors among 8 measures and created

composites for each: disease prevention, driven by vaccines and cancer screenings, and wellness screening, driven by annual health screenings. Participation in the Advanced Payment Model, having fewer specialists, and having more Medicare ACO beneficiaries per primary care provider were associated with significantly better performance on both composites. Better performance on disease prevention was also associated with inclusion of a hospital, greater electronic health record capabilities, a larger primary care workforce, and fewer minority beneficiaries. CONCLUSIONS: ACO preventive care quality performance is related to provider composition and benefitted by upfront investment. Vaccine and cancer screening quality performance is more dependent on organizational structure and characteristics than performance on annual wellness screenings, likely due to greater complexity in eligibility determination and service administration.

## Psychiatrie / Psychiatry

**Yrondi, A., et al. (2016). "[Economic impact of consultation-liaison psychiatry in a French University Hospital Centre]." *Encéphale* 42(1): 112-115.**

BACKGROUND: In times of fiscal restraint for health structures, apart from the clinical input, it seems important to discuss the economic impact of liaison psychiatry. There are only a few studies on the economic added value provided by a liaison psychiatry team. In addition to this, only a few psychiatric pathologies are coded as they should be, hence we make the assumption of an additional development provided by a specialised team. METHODS: Over a short period of 4 months, in three departments of the Toulouse University Hospital Centre, the added value to the general pricing system of liaison psychiatry was studied. The population was represented by all the consecutive requests for consultations from patients over 18 years old, men and women, hospitalised at that time. These three departments frequently request consultations with the psychiatry liaison team. They set a diagnostic, and if this is associated with a higher Homogeneous Group of Patients (HGP), it provides added value. RESULTS: Fifty-two patients benefited from a psychiatric consultation over 4 months. The results highlight a development of euro 8630.43 for the traumatology department, euro 3325.03 for the internal medicine department, and euro 513.61 for the haematology department over the study period. The overall development over this period was euro 12,469.07. CONCLUSION: To our knowledge, this approach is one of the first in France to highlight an economic impact of the intervention of liaison psychiatry in the claiming departments.

## Soins de santé primaires / Primary Health Care

**Dahrouge, S., et al. (2016). "A Comprehensive Assessment of Family Physician Gender and Quality of Care: A Cross-Sectional Analysis in Ontario, Canada." *Med Care* 54(3): 277-286.**

BACKGROUND: Studies evaluating primary care quality across physician gender are limited to primary and secondary prevention. OBJECTIVES: Investigate the relationship between family physician gender and quality of primary care using indicators that cover 5 key dimensions of primary care. RESEARCH DESIGN: Cross-sectional analysis using linked health administrative datasets (April 1, 2008 to March 31, 2010). SUBJECTS: All family physicians working in the 3 main primary care models in the province of Ontario (Canada), providing general care and having a panel size >1200. MEASURES: Indicators of cancer screening (3), chronic disease management (9), continuity (2), comprehensiveness (2), and access (5). RESULTS: A total of 4195 physicians (31% female) were eligible. Adjusting for provider and patient factors, patients of female physicians were more likely to have received recommended cancer screening (odds ratios [95% confidence interval (CI)] (OR) range: 1.24 [1.18-1.30], 1.85 [1.78-1.92]) and diabetes management (OR: 1.04 [1.01-1.08], 1.28 [1.05-1.57]). They had fewer emergency room visits (rate ratio [95% CI] (RR) range: 0.83 [0.79-0.87]) and hospitalizations (RR: 0.89 [0.86-0.93]), and higher

referrals (RR: 1.12 [1.09-1.14]). There was evidence of effect modification by patient gender (female vs. male) for hospitalization (RR: 0.74 [0.70-0.79] vs. 0.96 [0.90-1.02]) and emergency room visits (RR: 0.84 [0.81-0.88] vs. 0.98 [0.94-1.01]). Lower emergency room visits were also more evident in more complex patients of female physicians. There were no significant differences in the continuity or comprehensiveness measures. CONCLUSIONS: The indicators assessed in this study point to a benefit for patients under the care of female physicians. Potential explanations are discussed.

**Garattini, L., et al. (2016). "Access to primary care in Italy: time for a shake-up?" *Eur J Health Econ* 17(2): 113-116.**

**Harris, J. E., et al. (2016). "Allocation of Residency Training Positions in Spain: Contextual Effects on Specialty Preferences." *Health Economics*: Ahead of print.**  
<http://dx.doi.org/10.1002/hec.3318>

In Spain's 'MIR' system, medical school graduates are ranked by their performance on a national exam and then sequentially choose from the available residency training positions. We took advantage of a unique survey of participants in the 2012 annual MIR cycle to analyze preferences under two different choice scenarios: the residency program actually chosen by each participant when it came her turn (the 'real') and the program that she would have chosen if all residency training programs had been available (the 'counterfactual'). Utilizing conditional logit models with random coefficients, we found significant differences in medical graduates' preferences between the two scenarios, particularly with respect to three specialty attributes: work hours/lifestyle, prestige among colleagues, and annual remuneration. In the counterfactual world, these attributes were valued preferentially by those nearer to the top, while in the real world, they were valued preferentially by graduates nearer to the bottom of the national ranking. Medical graduates' specialty preferences, which we conclude, are not intrinsically stable but depend critically on the 'rules of the game'. The MIR assignment system, by restricting choice, effectively creates an externality in which those at the bottom, who have fewer choices, want what those at the top already have. Copyright © 2016 John Wiley & Sons, Ltd.

**Hearld, L. R., et al. (2016). "A Systematic Review of the Literature on the Sustainability of Community Health Collaboratives." *Med Care Res Rev* 73(2): 127-181.**

Recent interest in community health collaboratives has been driven by the potential of these types of organizations to solve complex health problems at the local level by bringing together stakeholders that have traditionally operated independently, and often at cross-purposes. Much of the work that is central to the mission of collaboratives can take years to reach fruition, however, and there are a number of challenges to sustaining their activities. In this article, we systematically reviewed the theoretical and empirical literature on health care collaborative sustainability, focusing on definitions and antecedents of sustainability. Given the diversity and fragmentation of this literature, we used this review as a foundation to develop a synthesized definition, conceptual groups of antecedents, and potential research propositions to help guide future research, planning, and practice of sustainable community health collaboratives.

**Krauth, C., et al. (2016). "Would German physicians opt for pay-for-performance programs? A willingness-to-accept experiment in a large general practitioners' sample." *Health Policy* 120(2): 148-158.**

BACKGROUND: Implementing pay-for-performance (P4P) programs is a non-trivial task. As evaluation studies showed, P4P programs often failed to improve performance quality. A crucial element for the successful implementation of P4P is to gain acceptance with health care providers. OBJECTIVES: The aim of our study was to determine, if (and at what bonus rate) German general practitioners (GPs) would participate in a P4P program. We further examined differences between respondents who would participate in a P4P program (participants) versus respondents who would not participate (non-participants). METHODS: A mail survey was conducted among 2493 general practitioners (GPs) in Lower Saxony (with a response rate of 36.2%). The questionnaire addressed attitudes toward P4P and

included a willingness to accept experiment concerning P4P implementation. RESULTS: The participation rate increased from 28% (at a bonus of 2.5%) to 50% (at a bonus of 20%). Participants showed better performance in target achievement and expected higher gains from P4P than non-participants. Major attitude differences were found in assessing feasibility of P4P, incentivizing performance and unintended consequences. The crucial factor for (not) accepting P4P might be the sense of (un)fairness of P4P. CONCLUSION: To convince GPs to participate in P4P, better evidence for the effectiveness of P4P is required. To address the concerns of GPs, future endeavors should be directed to tailoring P4P programs. Finally, program implementation must be well communicated and thoroughly discussed with health care providers.

**Marron-Delabre, A., et al. (2015). "Relation médecin-patient en situation de précarité économique : point de vue des patients." *Santé Publique* 27(6): 837-840.**

<http://www.cairn.info/revue-sante-publique-2015-6-page-837.htm>

Objectif : En France, les inégalités sociales de santé se creusent. Du point de vue des médecins, la relation médecin-patient en situation de précarité économique semble poser des difficultés spécifiques. Cette étude qualitative auprès de personnes en situation de précarité économique avait pour objectif d'identifier les difficultés et les aspects facilitateurs spécifiques à la relation patient-médecin traitant. Méthodes : Étude qualitative menée sous forme d'entretiens individuels semi-dirigés par un médecin auprès de personnes majeures, ayant déclaré un médecin traitant et en situation de précarité économique, allocataires d'un minima social, et/ou de la couverture médicale universelle-complémentaire, et/ou fréquentant une association offrant repas et vestiaire. Résultats : Au total, 19 personnes ont été interviewées. La dimension humaine est soulignée par les participants ; le respect, le charisme, l'ouverture d'esprit sont des qualités attendues. La qualité de l'accueil et de la communication facilite la relation. Le manque de disponibilité, l'interaction autoritaire, l'intrusion sont des freins à cette relation. Les patients ne semblaient pas avoir de demande relationnelle supplémentaire induite par leur situation de précarité économique. Conclusion : Face à leur médecin, les patients ne se définissaient pas par leur précarité. Le vécu et les attentes des patients vis-à-vis de leur médecin traitant semblent rejoindre ceux de la population générale.

**McClellan, S. R., et al. (2016). "Patient-initiated Electronic Messages and Quality of Care for Patients With Diabetes and Hypertension in a Large Fee-for-Service Medical Group: Results From a Natural Experiment." *Medical Care* 54(3): 287-295.**

[http://journals.lww.com/lww-medicalcare/Fulltext/2016/03000/Patient\\_initiated\\_Electronic\\_Messages\\_and\\_Quality.10.aspx](http://journals.lww.com/lww-medicalcare/Fulltext/2016/03000/Patient_initiated_Electronic_Messages_and_Quality.10.aspx)

Background: Few studies have examined the association between patient-initiated electronic messaging (e-messaging) and clinical outcomes in fee-for-service settings. Objective: To estimate the association between patient-initiated e-messages and quality of care among patients with diabetes and hypertension. Design: Longitudinal observational study from 2009 to 2013. In March 2011, the medical group eliminated a \$60/year patient user fee for e-messaging and established a provider payment of \$3–5 per patient-initiated e-message. Quality of care for patients initiating e-messages was compared before and after March 2011, relative to nonmessaging patients. Propensity score weighting accounted for differences between e-messaging and nonmessaging patients in generalized estimating equations. Setting: Large multispecialty practice in California compensating providers' fee-for-service. Subjects: Patients with diabetes (N=4232) or hypertension (N=15,463) who had activated their online portal but not e-messaged before e-messaging became free. Measures: Quality of care included HEDIS-based process measures for hemoglobin (Hb) A1c, blood pressure, low-density lipoprotein (LDL), nephropathy, and retinopathy tests, and outcome measures for HbA1c, blood pressure, and LDL. E-messaging was measured as counts of patient-initiated e-message threads sent to providers. Patients were categorized into quartiles by e-messaging frequency. Results: The probability of annually completing indicated tests increased by 1%–7% for e-messaging patients, depending on the outcome and e-messaging frequency. E-messaging was associated with small improvements in HbA1c and LDL for some patients with diabetes. Conclusion: Patient-initiated e-messaging may increase the likelihood of completing recommended tests, but may not be sufficient to improve clinical outcomes for most patients with diabetes or hypertension without additional interventions.

**McHugh, M., et al. (2016). "Patient-Centered Medical Home Adoption: Results From Aligning Forces For Quality." *Health Affairs* 35(1): 141-149.**  
<http://content.healthaffairs.org/content/35/1/141.abstract>

To improve health care quality within communities, increasing numbers of multistakeholder alliances—groups of payers, purchasers, providers, and consumers—have been created. We used data from two rounds (conducted in July 2007–March 2009 and January 2012–November 2013) of a large nationally representative survey of small and medium-size physician practices. We examined whether the adoption of patient-centered medical home processes spread more rapidly in fourteen Robert Wood Johnson Foundation Aligning Forces for Quality communities, where multistakeholder health care alliances promoted their use, than in other communities. We found no difference in the overall growth of adoption of the processes between the two types of communities. However, improvement on a care coordination subindex was 7.17 percentage points higher in Aligning Forces for Quality communities than in others. Despite the enthusiasm for quality improvement led by multistakeholder alliances, such alliances may not be a panacea for spreading patient-centered medical home processes across a community.

**Pineault, R., et al. (2016). "Why Is Bigger Not Always Better in Primary Health Care Practices? The Role of Mediating Organizational Factors." *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 53.**  
<http://inq.sagepub.com/content/53/0046958015626842.abstract>

Size of primary health care (PHC) practices is often used as a proxy for various organizational characteristics related to provision of care. The objective of this article is to identify some of these organizational characteristics and to determine the extent to which they mediate the relationship between size of PHC practice and patients' experience of care, preventive services, and unmet needs. In 2010, we conducted population and organization surveys in 2 regions of the province of Quebec. We carried out multilevel linear and logistic regression analyses, adjusting for respondents' individual characteristics. Size of PHC practice was associated with organizational characteristics and resources, patients' experience of care, unmet needs, and preventive services. Overall, the larger the size of a practice, the higher the accessibility, but the lower the continuity. However, these associations faded away when organizational variables were introduced in the analysis model. This result supports the hypothesized mediating effect of organizational characteristics on relationships between practice size and patients' experience of care, preventive services, and unmet needs. Our results indicate that size does not add much information to organizational characteristics. Using size as a proxy for organizational characteristics can even be misleading because its relationships with different outcomes are highly variable.

**Richards, M. R. and D. Polsky (2016). "Influence of provider mix and regulation on primary care services supplied to US patients." *Health Econ Policy Law* 11(2): 193-213.**

Access to medical care and how it differs for various patients remain key policy issues. While existing work has examined clinic structure's influence on productivity, less research has explored the link between provider mix and access for different patient types - which also correspond to different service prices. We exploit experimental data from a large field study spanning 10 US states where trained audit callers were randomly assigned an insurance status and then contacted primary care physician practices seeking new patient appointments. We find clinics with more non-physician clinicians are associated with better access for Medicaid patients and lower prices for office visits; however, these relationships are only found in states granting full practice autonomy to these providers. Substituting more non-physician labor in primary care settings may facilitate greater appointment availability for Medicaid patients, but this likely rests on a favorable policy environment. Relaxing regulations for non-physicians may be an important initiative as US health reforms continue and also relevant to other countries coping with greater demands for medical care and related financial strain.



**Supper, I., et al. (2015). "Interprofessional collaboration in primary health care: a review of facilitators and barriers perceived by involved actors." *Journal of Public Health* 37(4): 716-727.** <http://jpubhealth.oxfordjournals.org/content/37/4/716.abstract>

**Background** The epidemiological transition calls for redefining the roles of the various professionals involved in primary health care towards greater collaboration. We aimed to identify facilitators of, and barriers to, interprofessional collaboration in primary health care as perceived by the actors involved, other than nurses. **Methods** Systematic review using synthetic thematic analysis of qualitative research. Articles were retrieved from Medline, Web of science, Psychinfo and The Cochrane library up to July 2013. Quality and relevance of the studies were assessed according to the Dixon-Woods criteria. The following stakeholders were targeted: general practitioners, pharmacists, mental health workers, midwives, physiotherapists, social workers and receptionists. **Results** Forty-four articles were included. The principal facilitator of interprofessional collaboration in primary care was the different actors' common interest in collaboration, perceiving opportunities to improve quality of care and to develop new professional fields. The main barriers were the challenges of definition and awareness of one another's roles and competences, shared information, confidentiality and responsibility, team building and interprofessional training, long-term funding and joint monitoring. **Conclusions** Interprofessional organization and training based on appropriate models should support collaboration development. The active participation of the patient is required to go beyond professional boundaries and hierarchies. Multidisciplinary research projects are recommended.

**Wong, S. T., et al. (2015). "Incorporating Group Medical Visits into Primary Healthcare: Are There Benefits?" *Healthc Policy* 11(2): 27-42.**

**OBJECTIVE:** Group medical visits (GMVs) have been touted as an innovation to effectively and efficiently provide primary healthcare (PHC) services. The purpose of this paper is to report whether GMVs have tangible benefits for providers and patients. **METHODS:** This descriptive study included in-depth interviews with patients attending and providers facilitating GMVs and direct observation. Five primary care practices in rural towns and four First Nations communities participated. This paper reports on an analysis of interviews and observations. **RESULTS:** Thirty-four providers and 29 patients were interviewed. Patient participants were an average of 62 years old, mostly female and married. The three most common chronic conditions reported by patients were diabetes (n = 9), high blood pressure (n = 8) and arthritis (n = 7). Three themes illustrated how GMVs: (1) can foster access to needed health services; (2) expand opportunities for collaboration and team-based care; and (3) improve patient and provider experiences. A fourth theme captured structural challenges in delivering GMVs. **DISCUSSION:** There are tangible benefits in delivering GMVs in PHC. While whole patient panels can benefit from the integration of GMVs into practice, those who could gain the most are patients with complex medical and social needs. GMVs provide an opportunity to enhance PHC, strengthening the system particularly for patients with chronic conditions.

**Wu, F. M., et al. (2016). "Assessing Differences between Early and Later Adopters of Accountable Care Organizations Using Taxonomic Analysis." *Health Services Research*: Ahead of print.** <http://dx.doi.org/10.1111/1475-6773.12473>

**Objective** To compare early and later adopters of the accountable care organization (ACO) model, using the taxonomy of larger, integrated system; smaller, physician-led; and hybrid ACOs. **Data sources** The National Survey of ACOs, Waves 1 and 2. **Study design** Cluster analysis using the two-step clustering approach, validated using discriminant analysis. Wave 2 data analyzed separately to assess differences from Wave 1 and then data pooled across waves. **Findings** Compared to early ACOs, later adopter ACOs included a greater breadth of provider group types and a greater proportion self-reported as integrated delivery systems. When data from the two time periods were combined, a three-cluster solution similar to the original cluster solution emerged. Of the 251 ACOs, 31.1 percent were larger, integrated system ACOs; 45.0 percent were smaller physician-led ACOs; and 23.9 percent were hybrid ACOs—compared to 40.1 percent, 34.0 percent, and 25.9 percent from Wave 1 clusters, respectively. **Conclusions** While there are some differences between ACOs formed prior to August 2012 and those formed in the following year, the three-cluster taxonomy appears to best describe the

types of ACOs in existence as of July 2013. The updated taxonomy can be used by researchers, policy makers, and health care organizations to support evaluation and continued development of ACOs.

**Zweifel, P. and H. E. Frech, 3rd (2015). "Why 'Optimal' Payment for Healthcare Providers Can Never be Optimal Under Community Rating." Appl Health Econ Health Policy.**

This article extends the existing literature on optimal provider payment by accounting for consumer heterogeneity in preferences for health insurance and healthcare. This heterogeneity breaks down the separation of the relationship between providers and the health insurer and the relationship between consumers and the insurer. Both experimental and market evidence for a high degree of heterogeneity are presented. Given heterogeneity, a uniform policy fails to effectively control moral hazard, while incentives for risk selection created by community rating cannot be neutralized through risk adjustment. Consumer heterogeneity spills over into relationships with providers, such that a uniform contract with providers also cannot be optimal. The decisive condition for ensuring optimality of provider payment is to replace community rating (which violates the principle of marginal cost pricing) with risk rating of contributions combined with subsidization targeted at high risks with low incomes.

## Systemes de santé / Health Systems

**Labonte, A. J., et al. (2016). "The Effects of Organization Design and Patient Perceptions of Care on Switching Behavior and Reliance on a Health Care System Across Time." Med Care Res Rev 73(2): 182-204.**

Sustaining ongoing relationships with patients is a strategic, clinically relevant goal of health care systems. This study develops and tests a conceptual model that aims to account for the influence of organization design, perceptions of quality of patient care, and other patient-level factors on the extent to which patients sustain reliance on a health care system. We use a longitudinal survey design and structural equation modeling to predict increases or decreases in patient reliance on the Department of Veterans Affairs health care system across a 4-year period for Veterans with Parkinson's Disease. Our findings show that specialized and integrated clinical practices have a positive association with the quality of patient care. Health care systems may be able to foster long-term relations with patients and improve service quality by allocating resources to form integrated, specialized, disease-specific centers of care designed for patients with chronic illnesses.

**Lamont, T., et al. (2016). "New approaches to evaluating complex health and care systems." BMJ 352.**

<http://www.bmj.com/bmj/352/bmj.i154.full.pdf>

The NHS has many examples of effective service changes that took too long to implement, from structured patient education in diabetes to enhanced recovery programmes in surgery. Other initiatives have seemed promising but didn't deliver—or made things worse. For example, telephone triage and some types of case management increase demand for services rather than divert pressure from urgent care. Without the right evaluation, it is difficult to know which innovations are worth adopting. The scale of opportunity and real costs of implementing untested innovations and ignoring lessons learnt elsewhere are substantial. In 2015 a large international summit was held in London, convened by the National Institute for Health Research, the Health Foundation, the Medical Research Council (MRC), Universities UK, and AcademyHealth, which led to an authoritative overview of the array of methods available to evaluate healthcare services.<sup>4</sup> Here we summarise a parallel discussion that took place between research funders, practitioners, and leaders to identify the institutional barriers to healthcare evaluation and potential solutions. We argue for closer partnership between service leaders and researchers, based on a shared culture of basic principles and awareness of a range of options for evaluation. Time to evaluate At a time of straitened resources we cannot afford to

make poor choices. As Twain said, "Supposing is good, but finding out is better." This is the right time for researchers to get more engaged in supporting service change. In 2014 the NHS Five Year Forward View set out clearly the case for major system innovations and new ways of working. It suggests that future gains will come as much from changes in process and service delivery ...

**Steffen, M. (2016). "Universalism, Responsiveness, Sustainability — Regulating the French Health Care System." *New England Journal of Medicine* 374(5): 401-405.**  
<http://www.nejm.org/doi/full/10.1056/NEJMp1504547>

**Stordeur, S., et al. (2016). "Reference centres for adults with rare and complex cancers - Policy recommendations to improve the organisation of care in Belgium." *Rev Epidemiol Sante Publique* 64(1): 1-6.**

BACKGROUND: Rare and/or complex cancers call for a very specific expertise and adequate infrastructure. In Belgium, every hospital with a programme in oncology can deliver care for adults with rare and/or complex cancer types, without having demonstrated a specific know-how to adequately manage these patients. Therefore, the Minister of Health ordered a scenario for the organisation of care for adults with rare and/or complex cancers, taking into account the current Belgian situation and relevant foreign experience. METHODS: Combined methods were used in this study: a literature review, the consultation of stakeholders, in depth discussions in 14 multidisciplinary groups leading to concrete proposals for several rare/complex cancers and the consultation of a panel of expert pathologists. RESULTS: The core recommendation is the set-up of shared care networks around reference centres, with multidisciplinary teams of recognised expertise in specific rare/complex cancers. The definition of minimum caseloads for hospitals and medical specialists, the evaluation of the quality of care, a model of diagnostic confirmation and the set-up of a national portal website which provides information on rare and/or complex cancers and reference centres are highly recommended. CONCLUSION: It is no longer practicable, efficient or ethical that every hospital or every practitioner continues to offer care for every rare/complex cancer. Improving the quality of rare/complex cancer care requires to concentrate expertise and sophisticated infrastructure in reference centres. Furthermore, the formation of networks between reference centres and peripheral centres will allow a delivery of care combining expertise and proximity. The next step is the translation of the recommendations into policy decisions. It is very well realised that this will take some courage and that a certain degree of resistance will have to be surmounted, but eventually, the best interest of the patient should prevail.

**Zwarenstein, M. (2015). "Systematically Identified Failure Is the Route to a Successful Health System." *Healthc Pap* 15(2): 8-14.**

Although we have a systematic approach to innovation and evaluation (and scale-up) for treatments, medical technologies and diagnostic tests in healthcare, we have no equivalent for service delivery innovations. Service delivery innovation is common but frequently goes unevaluated, leading to less systematic decisions about which innovations are scaled up and which ones are not. The absence of a formal evaluation system for service delivery innovation means that there is no objective standard for evaluating an innovation's success or failure, and thus no way to decide whether it should be scaled up, adapted and retested, or not scaled up at all. This results in "bad failure" - the scale-up of innovations that are untested, and the failure to scale-up other innovations that might have been effective but no one measured their effectiveness in a systematic way.

## Travail et santé / Occupational Health

**Le Clainche C. (2016). "Analyser les liens entre la santé et le travail : le point de vue d'un économiste." *Sciences Sociales et Santé* 34(1): 65-76.**

**Monneraud L., et al. (2016). "Expérience de maladie chronique et vie professionnelle : les ajustements professionnels des travailleurs atteints de broncho-pneumopathie chronique obstructive." *Sciences Sociales et Santé* 34(1): 39-63.**

## Vieillessement / Ageing

**Comans, T. A., et al. (2016). "The increase in healthcare costs associated with frailty in older people discharged to a post-acute transition care program." *Age and Ageing* 45(2): 317-320.**  
<http://ageing.oxfordjournals.org/content/45/2/317.abstract>

Background: older people are high users of healthcare resources. The frailty index can predict negative health outcomes; however, the amount of extra resources required has not been quantified. Objective: to quantify the impact of frailty on healthcare expenditure and resource utilisation in a patient cohort who entered a community-based post-acute program and compare this to a cohort entering residential care. Methods: the interRAI home care assessment was used to construct a frailty index in three frailty levels. Costs and resource use were collected alongside a prospective observational cohort study of patients. A generalized linear model was constructed to estimate the additional cost of frailty and the cost of alternative residential care for those with high frailty. Results: participants (n = 272) had an average age of 79, frailty levels were low in 20%, intermediate in 50% and high in 30% of the cohort. Having an intermediate or high level of frailty increased the likelihood of re-hospitalisation and was associated with 22 and 43% higher healthcare costs over 6 months compared with low frailty. It was less costly to remain living at home than enter residential care unless >62% of subsequent hospitalisations in 6 months could be prevented. Conclusions: the frailty index can potentially be used as a tool to estimate the increase in healthcare resources required for different levels of frailty. This information may be useful for quantifying the amount to invest in programs to reduce frailty in the community.

**Di Gessa, G., et al. (2016). "The impact of caring for grandchildren on the health of grandparents in Europe: A lifecourse approach." *Social Science & Medicine* 152: 166-175.**  
<http://www.sciencedirect.com/science/article/pii/S0277953616300429>

Grandparents are becoming an increasingly important source of childcare. However, caring for grandchildren may have negative health consequences particularly for grandparents with intensive commitments such as those with primary care responsibilities. To date most studies on this issue are based on cross-sectional data and do not take earlier life circumstances into account. Thus, it is not known whether (or to what extent) the relationship between grandparental childcare and health is due to cumulative advantage or disadvantage throughout the lifecourse or to the impact of grandchild care per se. Employing data from waves 1–3 of the Survey of Health, Ageing and Retirement in Europe we investigated the longitudinal relationship between grandparental childcare (i.e. intensive and non-intensive) and health once cumulative histories of advantage or disadvantage are taken into account. We used latent class analysis to categorise respondents according to childhood socio-economic and health conditions drawing on life history information. Experiences in adulthood (e.g. periods of ill health) were also captured. We created a latent continuous physical health variable based on self- and observer-measured indicators. OLS regression was used to explore the association between physical health at wave 2 and grandparental childcare at baseline, controlling for conditions in childhood and adulthood, and for health and socio-economic characteristics. We found a positive longitudinal association between grandchild care and health even after earlier life health and socio-economic conditions were taken into account. However, this significant association was found only for grandmothers, and not grandfathers. Our results suggesting the health benefits of grandchild care are important given the widespread provision of grandparental childcare in Europe. However, further research on underlying mechanisms and causal pathways between grandchild care and grandparent

health, as well as on gender differences in the pattern of association, is needed.