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Sommaire

Assurance maladie / Health Insurance

Haeder, S. F. and D. L. Weimer (2015). "You Can't Make Me Do It, but I Could Be Persuaded: A Federalism Perspective on the Affordable Care Act." J Health Polit Policy Law **40**(2): 281-323.

The Affordable Care Act (ACA) seeks to change fundamentally the US health care system. The responses of states have been diverse and changing. What explains these diverse and dynamic responses? We examine the decision making of states concerning the creation of Pre-existing Condition Insurance Plan programs and insurance marketplaces and the expansion of Medicaid in historical context. This frames our analysis and its implications for future health reform in broader perspective by identifying a number of characteristics of state-federal grants programs: (1) slow and uneven implementation; (2) wide variation across states; (3) accommodation by the federal government; (4) ideological conflict; (5) state response to incentives; (6) incomplete take-up rates of eligible individuals; and (7) programs as stepping-stones and wedges. Assessing the implementation of the three main components of the ACA, we find that partisanship exerts significant influence, yet less so in the case of Medicaid expansion. Moreover, factors specific to the insurance market also play an important role. Finally, we conclude by applying the themes to the ACA and offer an outlook for its continuing implementation. Specifically, we expect a gradual move toward universal state participation in the ACA, especially with respect to Medicaid expansion.

Economie de la santé / Health Economics

Carpenter, A., et al. (2015). "Affordability of out-of-pocket health care expenses among older Australians." Health Policy **119**(7): 907-914.

Australia has universal health insurance, and provides price concessions on health care and prescription pharmaceuticals through government subsidies. However Australia ranks among the highest OECD nations for out-of-pocket health care spending. With high prevalence of multimorbidity (27% aged 65 and over have 2 or more long-term health conditions) older Australians may face a severe financial burden from out-of-pocket health expenses. We surveyed 4574 members of National Seniors Australia aged 50 years or more on their inability to pay out-of-pocket health-related expenses across categories of medical consultations and tests, medications, dental appointments, allied health appointments (e.g. physiotherapy, podiatry) and transport to medical appointments or tests. Almost 4% of those surveyed were unable to afford out-of-pocket costs in at least one category of health care expenses in the previous 3 months. The odds of being unable to afford out-of-pocket medical costs increased with the number of chronic medical conditions (3 conditions: OR 3.05, 95% CI 1.17-6.30; 4 or more conditions: OR 3.45, 95% CI 1.34-7.28, compared with no chronic medical conditions). Despite Australia's universal health insurance, and safety nets for medical and pharmaceutical contributions, older Australians with multiple chronic conditions are at risk of being unable to afford out-of-pocket health care expenses.

Kivimäki, M., et al. (2015/09). "How can we reduce the global burden of disease?" The Lancet : Ahead of pub.

In The Lancet, the Global Burden of Disease (GBD) collaboration1 reports an update on trends of risk factors and health behaviours in 188 countries from 1990 to 2013, as part of the GBD 2013 study. The report is an extraordinary contribution to evidence-based policy

making and will be extensively cited. In his editorial commenting on the first GBD 2010 report, Richard Horton welcomed the prospect that the GBD project will evolve into a continuous process of reviewing data as they become available.

Etat de santé / Health Status

Kinge, J. M., et al. (2015). "Income related inequalities in avoidable mortality in Norway: A population-based study using data from 1994-2011." Health Policy **119**(7): 889-898.
OBJECTIVE: The aim of this study was to measure income-related inequalities in avoidable, amenable and preventable mortality in Norway over the period 1994-2011. METHODS: We undertook a register-based population study of Norwegian residents aged 18-65 years between 1994 and 2011, using data from the Norwegian Income Register and the Cause of Death Registry. Concentration indices were used to measure income-related inequalities in avoidable, amenable and preventable mortality for each year. We compared the trend in income-related inequality in avoidable mortality with the trend in income inequality, measured by the Gini coefficient for income. RESULTS: Avoidable, amenable and preventable deaths in Norway have declined over time. There were persistent pro-poor socioeconomic inequalities in avoidable, amenable and preventable mortality, and the degree of inequality was larger in preventable mortality than in amenable mortality throughout the period. The income-avoidable mortality association was positively correlated with income inequalities in avoidable mortality over time. There was little or no relationship between variations in the Gini coefficient due to tax reforms and socioeconomic inequalities in avoidable mortality. CONCLUSIONS: Income-related inequalities in avoidable, amenable and preventable mortality have remained relatively constant between 1994 and 2011 in Norway. They were mainly correlated with the relationship between income and avoidable mortality rather than with variations in the Gini coefficient of income inequality.

Ruhm, C. J. (2015). "Recessions, healthy no more?" Journal of Health Economics **42**: 17-28.
Over the 1976–2010 period, total mortality shifted from strongly procyclical to being weakly or unrelated to macroeconomic conditions. The association is likely to be poorly measured when using short (less than 15 year) analysis periods. Deaths from cardiovascular disease and transport accidents continue to be procyclical; however, countercyclical patterns have emerged for fatalities from cancer mortality and external causes. Among the latter, non-transport accidents, particularly accidental poisonings, play an important role.

Géographie de la santé / Geography of Health

Calitri, R., et al. (2015). "Distance from practice moderates the relationship between patient management involving nurse telephone triage consulting and patient satisfaction with care." Health Place **34**: 92-96.
The ESTEEM trial was a randomised-controlled trial of telephone triage consultations in general practice. We conducted exploratory analyses on data from 9154 patients from 42 UK general practices who returned a questionnaire containing self-reported ratings of satisfaction with care following a request for a same-day consultation. Mode of care was identified through case notes review. There were seven main types: a GP face-to-face

consultation, GP or nurse telephone triage consultation with no subsequent same day care, or a GP or nurse telephone triage consultation with a subsequent face-to-face consultation with a GP or a nurse. We investigated the contribution of mode of care to patient satisfaction and distance between the patients home and the practice as a potential moderating factor. There was no overall association between patient satisfaction and distance from practice. However, patients managed by a nurse telephone consultation showed lowest levels of satisfaction, and satisfaction for this group of patients increased the further they lived from the practice. There was no association between any of the other modes of management and distance from practice.

Keddem, S., et al. (2015). "Mapping the urban asthma experience: Using qualitative GIS to understand contextual factors affecting asthma control." Soc Sci Med **140**: 9-17.
Asthma is complex and connected to a number of factors including access to healthcare, crime and violence, and environmental triggers. A mixed method approach was used to examine the experiences of urban people with asthma in controlling their asthma symptoms. The study started with an initial phase of qualitative interviews in West Philadelphia, a primarily poor African American community. Data from qualitative, semi-structured interviews indicated that stress, environmental irritants, and environmental allergens were the most salient triggers of asthma. Based on the interviews, the team identified six neighborhood factors to map including crime, housing vacancy, illegal dumping, tree canopy and parks. These map layers were combined into a final composite map. These combined methodologies contextualized respondents' perceptions in the framework of the actual community and built environment which tells a more complete story about their experience with asthma.

Stone, L. C., et al. (2015). "Place as a predictor of health insurance coverage: A multivariate analysis of counties in the United States." Health Place **34**: 207-214.
This study assessed the importance of county characteristics in explaining county-level variations in health insurance coverage. Using public databases from 2008 to 2012, we studied 3112 counties in the United States. Rates of uninsurance ranged widely from 3% to 53%. Multivariate analysis suggested that poverty, unemployment, Republican voting, and percentages of Hispanic and American Indian/Alaskan Native residents in a county were significant predictors of uninsurance rates. The associations between uninsurance rates and both race/ethnicity and poverty varied significantly between metropolitan and non-metropolitan counties. Collaborative actions by the federal, tribal, state, and county governments are needed to promote coverage and access to care.

Hôpital / Hospitals

Acosta, S. C. (2015). "Potentially Avoidable Hospitalizations In France." Health Aff (Millwood) **34**(8): 1428-1429.

Andrews, R. M. and K. A. Schulman (2015). "Enhancing the Value of Statewide Hospital Discharge Data: Improving Clinical Content and Race-Ethnicity Data." Health Serv Res **50** Suppl 1: 1265-1272.

Baxter, P. E., et al. (2015). "Leaders' experiences and perceptions implementing activity-based funding and pay-for-performance hospital funding models: A systematic review." Health

Policy **119**(8): 1096-1110.
INTRODUCTION: Providing cost-effective, accessible, high quality patient care is a challenge to governments and health care delivery systems across the globe. In response to this challenge, two types of hospital funding models have been widely implemented: (1) activity-based funding (ABF) and (2) pay-for-performance (P4P). Although health care leaders play a critical role in the implementation of these funding models, to date their perspectives have not been systematically examined. PURPOSE: The purpose of this systematic review was to gain a better understanding of the experiences of health care leaders implementing hospital funding reforms within Organisation for Economic Cooperation and Development countries. METHODS: We searched literature from 1982 to 2013 using: Medline, EMBASE, CINAHL, Academic Search Complete, Academic Search Elite, and Business Source Complete. Two independent reviewers screened titles, abstracts and full texts using predefined criteria. We included 2 mixed methods and 12 qualitative studies. Thematic analysis was used in synthesizing results. RESULTS: Five common themes and multiple subthemes emerged. Themes include: pre-requisites for success, perceived benefits, barriers/challenges, unintended consequences, and leader recommendations. CONCLUSIONS: Irrespective of which type of hospital funding reform was implemented, health care leaders described a complex process requiring the following: organizational commitment; adequate infrastructure; human, financial and information technology resources; change champions and a personal commitment to quality care.

Bystrov, V., et al. (2015). "Effects of DRG-based hospital payment in Poland on treatment of patients with stroke." Health Policy **119**(8): 1119-1125.
A prospective payment system based on Diagnosis Related Groups (DRGs) presents strong financial incentives to healthcare providers. These incentives may have intended as well as unintended consequences for the healthcare system. In this paper we use administrative data on stroke admissions to Polish hospitals in order to demonstrate the response of hospitals to the incentives embedded in the design of stroke-related groups in Poland. The design was intended to motivate hospitals for the development of specialized stroke units by paying significantly higher tariffs for treatment of patients in these units. As a result, an extensive network of stroke units has emerged. However, as it is shown in the paper, there is no evidence that outcomes in hospitals with stroke units are significantly different from outcomes in hospitals without stroke units. It is also demonstrated that the reliance on the length of stay as a major grouping variable provides incentives for regrouping patients into more expensive groups by extending their length of stay in stroke units. The results of the study are limited by the incompleteness of the casemix data. There is a need to develop information and audit systems which would further inform a revision of the DRG system aimed to reduce the risk of regrouping and up-coding.

Kahn, C. N., 3rd, et al. (2015). "Assessing Medicare's Hospital Pay-For-Performance Programs And Whether They Are Achieving Their Goals." Health Affairs (Millwood) **345**(8): 1281-1288.
Three separate pay-for-performance programs affect the amount of Medicare payment for inpatient services to about 3,400 US hospitals. These payments are based on hospital performance on specified measures of quality of care. A growing share of Medicare hospital payments (6 percent by 2017) are dependent upon how hospitals perform under the Hospital Readmissions Reduction Program, the Value-Based Purchasing Program, and the Hospital-Acquired Condition Reduction Program. In 2015 four of five hospitals subject to these programs will be penalized under one or more of them, and more than one in three major teaching hospitals will be penalized under all three. Interactions among these programs should be considered going forward, including overlap among measures and

differences in scoring performance.

Mesman, R., et al. (2015). "Why do high-volume hospitals achieve better outcomes? A systematic review about intermediate factors in volume-outcome relationships." Health Policy **119**(8): 1055-1067.

OBJECTIVE: To assess the role of process and structural factors in volume-outcome relationships. DATA SOURCES: Pubmed electronic database, until March 2014. STUDY DESIGN: Systematic review. Based on a conceptual framework, peer-reviewed publications were included that presented evidence about explanatory factors in volume-outcome associations. DATA COLLECTION: Two reviewers extracted information about study design, study population, volume and outcome measures, as well as explanatory factors. Included publications were appraised for methodological quality. PRINCIPAL FINDINGS: After screening 1756 titles, 27 met our inclusion criteria. Three main categories of explanatory factors could be identified: 1. Compliance to evidence based processes of care (n=7). 2. Level of specialization (n=11). 3. Hospital level factors (n=10). In ten studies, process and/or structural characteristics partly explained the established volume-outcome association. The median quality score of the 27 studies was 8 out of a possible 18 points. CONCLUSIONS: The vast majority of volume-outcome studies do not focus on the underlying mechanism by including process and structural characteristics as explanatory factors in their analysis. The methodological quality of studies is also modest, which makes us question the available evidence for current policies to concentrate care on the basis of volume.

Vidal N.,(2015/06-07). "L'accès aux soins hospitaliers : la démarche du CH de Guéret." Gestions hospitalières(547): 339-347.

Smyth, A., et al.(2015/09/16) "Alcohol consumption and cardiovascular disease, cancer, injury, admission to hospital, and mortality: a prospective cohort study." The Lancet.

Alcohol consumption is proposed to be the third most important modifiable risk factor for death and disability. However, alcohol consumption has been associated with both benefits and harms, and previous studies were mostly done in high-income countries. We investigated associations between alcohol consumption and outcomes in a prospective cohort of countries at different economic levels in five continents.

Sogaard, R., et al. (2015). "Incentivising effort in governance of public hospitals: Development of a delegation-based alternative to activity-based remuneration." Health Policy **119**(8): 1076-1085.

This paper is a first examination of the development of an alternative to activity-based remuneration in public hospitals, which is currently being tested at nine hospital departments in a Danish region. The objective is to examine the process of delegating the authority of designing new incentive schemes from the principal (the regional government) to the agents (the hospital departments). We adopt a theoretical framework where, when deciding about delegation, the principal should trade off an initiative effect against the potential cost of loss of control. The initiative effect is evaluated by studying the development process and the resulting incentive schemes for each of the departments. Similarly, the potential cost of loss of control is evaluated by assessing the congruence between focus of the new incentive schemes and the principal's objectives. We observe a high impact of the effort incentive in the form of innovative and ambitious selection of projects by the agents, leading to nine very different solutions across departments. However, we also observe some incongruence between the principal's stated objectives and the revealed private interests of the agents. Although this is a baseline study involving high uncertainty about the future, the findings point at some issues with the delegation approach

that could lead to inefficient outcomes.

Sutherland, J. M. (2015). "Pricing hospital care: Global budgets and marginal pricing strategies." Health Policy **119**(8): 1111-1118.

OBJECTIVE: The Canadian province of British Columbia (BC) is adding financial incentives to increase the volume of surgeries provided by hospitals using a marginal pricing approach. The objective of this study is to calculate marginal costs of surgeries based on assumptions regarding hospitals' availability of labor and equipment. DATA: This study is based on observational clinical, administrative and financial data generated by hospitals. Hospital inpatient and outpatient discharge summaries from the province are linked with detailed activity-based costing information, stratified by assigned case mix categorizations. STUDY DESIGN: To reflect a range of operating constraints governing hospitals' ability to increase their volume of surgeries, a number of scenarios are proposed. Under these scenarios, estimated marginal costs are calculated and compared to prices being offered as incentives to hospitals. PRINCIPAL FINDINGS: Existing data can be used to support alternative strategies for pricing hospital care. Prices for inpatient surgeries do not generate positive margins under a range of operating scenarios. Hip and knee surgeries generate surpluses for hospitals even under the most costly labor conditions and are expected to generate additional volume. CONCLUSIONS: In health systems that wish to fine-tune financial incentives, setting prices that create incentives for additional volume should reflect knowledge of hospitals' underlying cost structures. Possible implications of mispricing include no response to the incentives or uneven increases in supply.

Svederud, I., et al. (2015). "Patient perspectives on centralisation of low volume, highly specialised procedures in Sweden." Health Policy **119**(8): 1068-1075.

This study explores important considerations from a patient perspective in decisions regarding centralisation of specialised health care services. The analysis is performed in the framework of the Swedish National Board of Health and Welfare's ongoing work to evaluate and, if appropriate, centralise low volume, highly specialised, health services defined as National Specialised Medical Care. In addition to a literature review, a survey directed to members of patient associations and semi-structured interviews with patient association representatives and health care decision makers were conducted. The results showed that from a patient perspective, quality of care in terms of treatment outcomes is the most important factor in decisions regarding centralisation of low volume, highly specialised health care. The study also indicates that additional factors such as continuity of treatment and a well-functioning care pathway are highly important for patients. However, some of these factors may be dependent on the implementation process and predicting how they will evolve in case of centralisation will be difficult. Patient engagement and patient association involvement in the centralisation process is likely to be a key component in attaining patient focused care and ensuring patient satisfaction with the centralisation decisions.

Inégalités de santé / Health Inequalities

Arevalo, S. P., et al. (2015). "Beyond cultural factors to understand immigrant mental health: Neighborhood ethnic density and the moderating role of pre-migration and post-migration factors." Soc Sci Med **138**: 91-100.

Pre-migration and post-migration factors may influence the health of immigrants. Using a cross-national framework that considers the effects of the sending and receiving social

contexts, we examined the extent to which pre-migration and post-migration factors, including individual and neighborhood level factors, influence depressive symptoms at a 2-year follow-up time point. Data come from the Boston Puerto Rican Health Study, a population-based prospective cohort of Puerto Ricans between the ages of 45 and 75 y. The association of neighborhood ethnic density with depressive symptomatology at follow-up was significantly modified by sex and level of language acculturation. Men, but not women, experienced protective effects of ethnic density. The interaction of neighborhood ethnic density with language acculturation had a non-linear effect on depressive symptomatology, with lowest depressive symptomatology in the second highest quartile of language acculturation, relative to the lowest and top two quartiles among residents of high ethnic density neighborhoods. Results from this study highlight the complexity, and interplay, of a number of factors that influence the health of immigrants, and emphasize the significance of moving beyond cultural variables to better understand why the health of some immigrant groups deteriorates at faster rates overtime.

Ducros D., N. V., Chehoub D. "Les bases médico-administratives pour mesurer les inégalités sociales de santé." Santé Publique(3): 383-394.

Gulland, A. (2015). "The refugee crisis: what care is needed and how can doctors help?" British Medical Journal **351**.

This was the first thought of many when the photographs of Aylan Kurdi, the Syrian boy who died trying to cross the Mediterranean, were published last week. Social media were awash with pleas from ordinary people for essential items such as soap and blankets to send to refugee centres in Europe. However, both Doctors of the World, which is the only charity providing medical aid in Calais, and Médecins sans Frontières (MSF) are urging doctors who wish to help to donate money.

Lee, S. Y., et al. (2015). "Unmet healthcare needs depending on employment status." Health Policy **119**(7): 899-906.

OBJECTIVES: The purpose of study is to find relevance between unmet healthcare needs and employment status and if factors have relevance to unmet healthcare needs due to "economic burden" and "no time to spare". METHODS: The study conducted a survey of 9163 respondents who said they needed a medical treatment or checkup were asked why the need for care was unmet. RESULTS: 22.9% of the respondents said they did not receive a medical treatment or checkup they needed at least once. The rate of unmet healthcare needs caused by "economic burden" was higher among temporary workers (ORs=2.13), day workers (ORs=1.92). However, the rate of unmet needs due to "no time to spare" was lower for temporary workers (ORs=.58) than for regular workers, studies (ORs=.33), housework (ORs=.26), early retirement (ORs=.19) and disease or injury (ORs=.07). CONCLUSION: Non-regular waged workers were more likely to have an unmet need for healthcare due to "economic burden" than regular waged workers. On the other hand, regular waged workers were less likely to receive necessary healthcare services due to "no time to spare" than non-regular waged workers and economically inactive people.

Smith, K. E. and T. Schrecker (2015). "Theorising health inequalities: Introduction to a double special issue." Soc Theory Health **13**(3-4): 219-226.

Médicaments / Pharmaceuticals

Darmon D., B. M., Quien S., et al. (2015). "Facteurs associés à la prescription médicamenteuse en médecine générale : une étude transversale multicentrique." Santé Publique(3): 353-308.

Parkinson, B., et al. (2015). "Disinvestment and Value-Based Purchasing Strategies for Pharmaceuticals: An International Review." PharmacoEconomics **33**(9): 905-924.
Pharmaceutical expenditure has increased rapidly across many Organisation for Economic Cooperation and Development (OECD) countries over the past three decades. This growth is an increasing concern for governments and other third-party payers seeking to provide equitable and comprehensive healthcare within sustainable budgets. In order to create headroom for increasing utilisation, and to fund new high-cost therapies, there is an active push to 'disinvest' from low-value drugs. The aim of this article is to review how reimbursement policy decision makers have sought to partially or completely disinvest from drugs in a range of OECD countries (UK, France, Canada, Australia and New Zealand) where they are publicly funded or subsidised. We employed a systematic literature search strategy and the incorporation of grey literature known to the authorship team. We canvass key policy instruments from each country to outline key approaches to the identification of candidate drugs for disinvestment assessment (passive approaches vs. more active approaches); methods of disinvestment and value-based purchasing (de-listing, restricting treatment, price or reimbursement rate reductions, encouraging generic prescribing); lessons learnt from the various approaches; the potential role of coverage with evidence development; and the need for careful stakeholder management. Dedicated sections are provided with detailed coverage of policy approaches (with drug examples) from each country. Historically, countries have relied on 'passive disinvestment'; however, due to (1) the availability of new cost-effectiveness evidence, or (2) 'leakage' in drug utilisation, or (3) market failure in terms of price competition, there is an increasing focus towards 'active disinvestment'. Isolating low-value drugs that would create headroom for innovative new products to enter the market is also motivating disinvestment efforts by multiple parties, including industry. Historically, disinvestment has mainly taken the form of price reductions, especially when market failures are perceived to exist, and restricting treatment to subpopulations, particularly when a drug is no longer considered value for money. There is considerable experimentation internationally in mechanisms for

Roebuck, M. C., et al. (2015). "Increased Use Of Prescription Drugs Reduces Medical Costs In Medicaid Populations." Health Aff (Millwood) **34**(9): 1586-1593.
We used data on more than 1.5 million Medicaid enrollees to examine the impact of changes in prescription drug use on medical costs. For three distinct groups of enrollees, we estimated the effects of aggregate prescription drug use-and, more specifically, the use of medications to treat eight chronic noncommunicable diseases-on total nondrug, inpatient, outpatient, and other Medicaid spending. We found that a 1 percent increase in overall prescription drug use was associated with decreases in total nondrug Medicaid costs by 0.108 percent for blind or disabled adults, 0.167 percent for other adults, and 0.041 percent for children. Reductions in combined inpatient and outpatient spending from increased drug utilization in Medicaid were similar to an estimate for Medicare by the Congressional Budget Office. Moving forward, policy makers evaluating proposed changes that alter medication use among the nearly seventy million Medicaid recipients should consider the net effects on program spending to ensure that scarce federal and state health care dollars are allocated efficiently.

Shajarizadeh, A. and A. Hollis (2015). "Price-cap Regulation, Uncertainty and the Price Evolution of New Pharmaceuticals." Health Econ **24**(8): 966-977.
This paper examines the effect of the regulations restricting price increases on the evolution of pharmaceutical prices. A novel theoretical model shows that this policy leads firms to price new drugs with uncertain demand above the expected value initially. Price decreases after drug launch are more likely, the higher the uncertainty. We empirically test the model's predictions using data from the Canadian pharmaceutical market. The level of uncertainty is shown to play a crucial role in drug pricing strategies.

Méthodologie – Statistique / Methodology - Statistics

Elek, P., et al. (2015). "Effects of Geographical Accessibility on the Use of Outpatient Care Services: Quasi-Experimental Evidence from Panel Count Data." Health Econ **24**(9): 1131-1146.
In 2010-2012, new outpatient service locations were established in Hungarian micro-regions, which had lacked such capacities before. We exploit this quasi-experiment to estimate the effect of geographical accessibility on outpatient case numbers using both individual-level and semi-aggregate panel data. We find a 24-27 per cent increase of case numbers as a result of the establishments. Our specialty-by-specialty estimates imply that a 1-min reduction of travel time to the nearest outpatient unit increases case numbers for example by 0.9 per cent in internal care and 3.1 per cent in rheumatology. The size of the new outpatient capacities has a separate effect, raising the possibility of the presence of supplier-induced demand. By combining a fixed-effects logit and a fixed-effects truncated Poisson estimator, we decompose the effects into increases in the probability of ever visiting a doctor on the one hand and an increase of the frequency of visits on the other hand. We find that new visits were dominant in the vast majority of specialties, whereas both margins were important for example in rheumatology. Finally, we demonstrate the usefulness of the fixed-effects truncated Poisson estimator in modelling count data by examining its robustness by simulations. Copyright (c) 2015 John Wiley & Sons, Ltd.

Hagger-Johnson, G., et al. (2015). "Identifying Possible False Matches in Anonymized Hospital Administrative Data without Patient Identifiers." Health Serv Res **50**(4): 1162-1178.
OBJECTIVE: To identify data linkage errors in the form of possible false matches, where two patients appear to share the same unique identification number. DATA SOURCE: Hospital Episode Statistics (HES) in England, United Kingdom. STUDY DESIGN: Data on births and re-admissions for infants (April 1, 2011 to March 31, 2012; age 0-1 year) and adolescents (April 1, 2004 to March 31, 2011; age 10-19 years). DATA COLLECTION/EXTRACTION METHODS: Hospital records pseudo-anonymized using an algorithm designed to link multiple records belonging to the same person. Six implausible clinical scenarios were considered possible false matches: multiple births sharing HESID, re-admission after death, two birth episodes sharing HESID, simultaneous admission at different hospitals, infant episodes coded as deliveries, and adolescent episodes coded as births. PRINCIPAL FINDINGS: Among 507,778 infants, possible false matches were relatively rare (n = 433, 0.1 percent). The most common scenario (simultaneous admission at two hospitals, n = 324) was more likely for infants with missing data, those born preterm, and for Asian infants. Among adolescents, this scenario (n = 320) was more common for males, younger patients, the Mixed ethnic group, and those re-admitted more frequently. CONCLUSIONS: Researchers can identify clinically implausible scenarios and patients affected, at the data cleaning stage, to mitigate the impact of possible linkage errors.

Jones, A. M., et al. (2015). "Healthcare Cost Regressions: Going Beyond the Mean to Estimate the Full Distribution." Health Econ **24**(9): 1192-1212.

Understanding the data generating process behind healthcare costs remains a key empirical issue. Although much research to date has focused on the prediction of the conditional mean cost, this can potentially miss important features of the full distribution such as tail probabilities. We conduct a quasi-Monte Carlo experiment using the English National Health Service inpatient data to compare 14 approaches in modelling the distribution of healthcare costs: nine of which are parametric and have commonly been used to fit healthcare costs, and five others are designed specifically to construct a counterfactual distribution. Our results indicate that no one method is clearly dominant and that there is a trade-off between bias and precision of tail probability forecasts. We find that distributional methods demonstrate significant potential, particularly with larger sample sizes where the variability of predictions is reduced. Parametric distributions such as log-normal, generalised gamma and generalised beta of the second kind are found to estimate tail probabilities with high precision but with varying bias depending upon the cost threshold being considered.

Valentine, N., et al. (2015). "Health systems' responsiveness and reporting behaviour: Multilevel analysis of the influence of individual-level factors in 64 countries." Soc Sci Med **138**: 152-160.

Health systems' responsiveness encompasses attributes of health system encounters valued by people and measured from the user's perspective in eight domains: dignity, autonomy, confidentiality, communication, prompt attention, social support, quality of basic amenities and choice. The literature advocates for adjusting responsiveness measures for reporting behaviour heterogeneity, which refers to differential use of the response scale by survey respondents. Reporting behaviour heterogeneity between individual respondents compromises comparability between countries and population subgroups. It can be studied through analysing responses to pre-defined vignettes - hypothetical scenarios recounting a third person's experience in a health care setting. This paper describes the first comprehensive approach to studying reporting behaviour heterogeneity using vignettes. Individual-level variables affecting reporting behaviour are grouped into three categories: (1) sociodemographic, (2) health-related and (3) health value system. We use cross-sectional data from 150 000 respondents in 64 countries from the World Health Organization's World Health Survey (2002-03). Our approach classifies effect patterns for the scale as a whole, in terms of strength and in relation to the domains. For the final eight variables selected (sex; age; education; marital status; use of inpatient services; perceived health (own); caring for close family or friends with a chronic illness; the importance of responsiveness), the strongest effects were present for education, health, caring for friends or relatives with chronic health conditions, and the importance of responsiveness. Patterns of scale elongation or contraction were more common than uniform scale shifts and were usually constant for a particular factor across domains. The dependency of individual-level reporting behaviour heterogeneity on country is greatest for prompt attention, quality of basic amenities and confidentiality domains.

Politique de santé / Health Policy

Correia, T., et al. (2015). "The impact of the financial crisis on human resources for health policies

in three southern-Europe countries." Health Policy [ahead of print]
The public health sector has been the target of austerity measures since the global financial crisis started in 2008, while health workforce costs have been a source of rapid savings in most European Union countries. This article aims to explore how health workforce policies have evolved in three southern European countries under external constraints imposed by emergency financial programmes agreed with the International Monetary Fund, Central European Bank and European Commission. The selected countries, Greece, Portugal and Cyprus, show similarities with regard to corporatist systems of social protection and comprehensive welfare mechanisms only recently institutionalized. Based on document analysis of the Memoranda of Understanding agreed with the Troika, our results reveal broadly similar policy responses to the crisis but also important differences. In Cyprus, General Practitioners have a key position in reducing public expenditure through gatekeeping and control of users' access, while Portugal and Greece seeks to achieve cost containment by constraining the decision-making powers of professionals. All three countries lack innovation as well as monitoring and assessment of the effects of the financial crisis in relation to the health workforce. Consequently, there is a need for health policy development to use human resources more efficiently in healthcare.

Costa D.L (2015). "Health and the Economy in the United States from 1750 to the Present†." Journal of Economic Literature **53**(3): 503-570.
I discuss the health transition in the United States, bringing new data to bear on health indicators and investigating the changing relationship between health, income, and the environment. I argue that scientific advances played an outsize role and that health improvements were largest among the poor. Health improvements were not a precondition for modern economic growth. The gains to health are largest when the economy has moved from “brawn” to “brains” because this is when the wage returns to education are high, leading the healthy to obtain more education. More education may improve use of health knowledge, producing a virtuous cycle.

Jabot, F. and A. C. Marchand (2014). "[Evaluation of public health plans: a driver of change for regional health policy in France?]." Glob Health Promot **21**(1 Suppl): 64-69.
Between 2007-2010, each French region carried out an evaluation of their public health plan, at the very moment when regional health system governance reform was taking place. The objective of this article is to analyze the influence of this dynamic of evaluation on health policy at the regional and national levels. An in-depth analysis in nine regions showed short-term consequences that were inconsistent among regions, depending on the implementation schedule and the evaluation process that was put into place. On the other hand, the lessons that emerged reinforced local expertise that was useful for the new planning exercise. This regional work has not yet been taken up nationally, but we cannot exclude the possibility that it fueled discussions in the working groups preparing the reform.

Ongaro, E., et al. (2015). "The fiscal crisis in the health sector: Patterns of cutback management across Europe." Health Policy **119**(7): 954-963.
PURPOSE: The article investigates trends in health sector cutback management strategies occurred during the ongoing financial and fiscal crisis across Europe. SETTING: A European-wide survey to top public healthcare managers was conducted in ten different countries to understand their perception about public sector policy reactions to the financial and economic crisis; answers from 760 respondents from the healthcare sector (30.7% response rate) were analyzed. METHOD: A multinomial logistic regression was used to assess the characteristics of respondents, countries' institutional healthcare models and the trend in public health resources availability during the crisis associated to the decision to introduce

unselective cuts, targeted cuts or efficiency savings measures. RESULTS: Differentiated responses to the fiscal crisis that buffeted public finances were reported both across and within countries. Organizational position of respondents is significant in explaining the perceived cutback management approach introduced, where decentralized positions detect a higher use of linear cuts compared to their colleagues working in central level organizations. Compared to Bismark-like systems Beveridge-like ones favour the introduction of targeted cuts. Postponing the implementation of new programmes and containing expenses through instruments like pay freezes are some of the most popular responses adopted, while outright staff layoffs or reduction of frontline services have been more selectively employed. CONCLUSION: To cope with the effects of the fiscal crisis healthcare systems are undergoing important changes, possibly also affecting the scope of universal coverage.

Tapia Granados, J. A. and J. M. Rodriguez (2015). "Health, economic crisis, and austerity: A comparison of Greece, Finland and Iceland." Health Policy **119**(7): 941-953.

Reports have attributed a public health tragedy in Greece to the Great Recession and the subsequent application of austerity programs. It is also claimed that the comparison of Greece with Iceland and Finland-where austerity policies were not applied-reveals the harmful effect of austerity on health and that by protecting spending in health and social budgets, governments can offset the harmful effects of economic crises on health. We use data on life expectancy, mortality rates, incidence of infectious diseases, rates of vaccination, self-reported health and other measures to examine the evolution of population health and health services performance in Greece, Finland and Iceland since 1990-2011 or 2012-the most recent years for which data are available. We find that in the three countries most indicators of population health continued improving after the Great Recession started. In terms of population health and performance of the health care system, in the period after 2007 for which data are available, Greece did as good as Iceland and Finland. The evidence does not support the claim that there is a health crisis in Greece. On the basis of the extant evidence, claims of a public health tragedy in Greece seem overly exaggerated.

Prévision – Evaluation / Prevision - Evaluation

Sebas J. (2015). "L'évaluation de la performance dans le système de soins : que disent les théories ?" Santé Publique(3): 395-403.

Soins de santé primaires / Primary Health Care

Coudin, E., et al. (2015). "GP responses to price regulation: evidence from a French nationwide reform." Health Econ **24**(9): 1118-1130.

This paper uses a French reform to evaluate the impacts of overbilling restrictions on general practitioner (GP) care provision, fees and incomes. Since 1990, this reform has introduced conditions self-employed GPs must fulfil to be permitted to bill freely. We exploit 2005 and 2008 public health insurance administrative data on GP activity and fees. We use fuzzy regression discontinuity techniques to estimate local causal impacts for GPs who established practices in 1990 and who were constrained by the new regulation to charge regulated prices (compliers). We find that those GPs practices to income effects. In the regulated fee regime, GPs face prices lower by 42% and provide 50% more care than they would do in the unregulated fee regime. Male care provision increasing reaction is larger than the female one, which results in a higher male labour income in the regulated fee regime than with unregulated fees, whereas it is the opposite for women. With regulated fees, GPs limit side-salaried activities, use more lump-sum payment schemes and occupy more often gatekeeper positions. Copyright (c) 2015 John Wiley & Sons, Ltd.

Douw, K., et al. (2015). "Centralising acute stroke care and moving care to the community in a Danish health region: Challenges in implementing a stroke care reform." Health Policy **119**(8): 1005-1010.

In May 2012, one of Denmark's five health care regions mandated a reform of stroke care. The purpose of the reform was to save costs, while at the same time improving quality of care. It included (1) centralisation of acute stroke treatment at specialised hospitals, (2) a reduced length of hospital stay, and (3) a shift from inpatient rehabilitation programmes to community-based rehabilitation programmes. Patients would benefit from a more integrated care pathway between hospital and municipality, being supported by early discharge teams at hospitals. A formal policy tool, consisting of a health care agreement between the region and municipalities, was used to implement the changes. The implementation was carried out in a top-down manner by a committee, in which the hospital sector - organised by regions - was better represented than the primary care sector-organised by municipalities. The idea of centralisation of acute care was supported by all stakeholders, but municipalities opposed the hospital-based early discharge teams as they perceived this to be interfering with their core tasks. Municipalities would have liked more influence on the design of the reform. Preliminary data suggest good quality of acute care. Cost savings have been achieved in the region by means of closure of beds and a reduction of hospital length of stay. The realisation of the objective of achieving integrated rehabilitation care between hospitals and municipalities has been less successful. It is likely that greater involvement of municipalities in the design phase and better representation of health care professionals in all phases would have led to more successful implementation of the reform.

Friedberg, M. W., et al. (2015). "Effects of a Medical Home and Shared Savings Intervention on Quality and Utilization of Care." JAMA Intern Med **175**(8): 1362-1368.

IMPORTANCE: Published evaluations of medical home interventions have found limited effects on quality and utilization of care. OBJECTIVE: To measure associations between participation in the Northeastern Pennsylvania Chronic Care Initiative and changes in quality and utilization of care. DESIGN, SETTING, AND PARTICIPANTS: The northeast region of the Pennsylvania Chronic Care Initiative began in October 2009, included 2 commercial health

plans and 27 volunteering small primary care practice sites, and was designed to run for 36 months. Both participating health plans provided medical claims and enrollment data spanning October 1, 2007, to September 30, 2012 (2 years prior to and 3 years after the pilot inception date). We analyzed medical claims for 17363 patients attributed to 27 pilot and 29 comparison practices, using difference-in-difference methods to estimate changes in quality and utilization of care associated with pilot participation. EXPOSURES: The intervention included learning collaboratives, disease registries, practice coaching, payments to support care manager salaries and practice transformation, and shared savings incentives (bonuses of up to 50% of any savings generated, contingent on meeting quality targets). As a condition of participation, pilot practices were required to attain recognition by the National Committee for Quality Assurance as medical homes. MAIN OUTCOMES AND MEASURES: Performance on 6 quality measures for diabetes and preventive care; utilization of hospital, emergency department, and ambulatory care. RESULTS: All pilot practices received recognition as medical homes during the intervention. By intervention year 3, relative to comparison practices, pilot practices had statistically significantly better performance on 4 process measures of diabetes care and breast cancer screening; lower rates of all-cause hospitalization (8.5 vs 10.2 per 1000 patients per month; difference, -1.7 [95% CI, -3.2 to -0.03]), lower rates of all-cause emergency department visits (29.5 vs 34.2 per 1000 patients per month; difference, -4.7 [95% CI, -8.7 to -0.9]), lower rates of ambulatory care-sensitive emergency department visits (16.2 vs 19.4 per 1000 patients per month; difference, -3.2 [95% CI, -5.7 to -0.9]), lower rates of ambulatory visits to specialists (104.9 vs 122.2 per 1000 patients per month; difference, -17.3 [95% CI, -26.6 to -8.0]); and higher rates of ambulatory primary care visits (349.0 vs 271.5 per 1000 patients per month; difference, 77.5 [95% CI, 37.3 to 120.5]). CONCLUSIONS AND RELEVANCE: During a 3-year period, this medical home intervention, which included shared savings for participating practices, was associated with relative improvements in quality, increased primary care utilization, and lower use of emergency department, hospital, and specialty care. With further experimentation and evaluation, such interventions may continue to become more effective.

Han, K. T., et al. (2015). "Effective strategy for improving health care outcomes: Multidisciplinary care in cerebral infarction patients." Health Policy **119**(8): 1039-1045.

Multidisciplinary teams provide effective patient treatment strategies. South Korea expanded its health program recently to include multidisciplinary treatment. This study characterized the relationship between multidisciplinary care and mortality within 30 days after hospitalization in cerebral infarction patients. We used the National Health Insurance claim data (n=63,895) from 120 hospitals during 2010-2013 to analyze readmission within 30 days after hospitalization for cerebral infarction. We performed chi(2) tests, analysis of variance and multilevel modeling to investigate the associations between multidisciplinary care and death within 30 days after hospitalization for stroke. Deaths within 30 days of hospitalization due to cerebral infarction was 3.0% (n=1898/63,895). Multidisciplinary care was associated with lower risk of death within 30 days in inpatients with cerebral infarction (odds ratio: 0.84, 95% confidence interval: 0.72-0.99). Patients treated by a greater number of specialists had lower risk of death within 30 days of hospitalization. Additional analyses showed that such associations varied by the combination of specialists (i.e., neurologist and neurosurgeon). In conclusion, death rates within 30 days of hospitalization for cerebral infarction were lower in hospitals with multidisciplinary care. Our findings certainly suggest that a high number of both neurosurgeon and neurologist is not always an effective alternative in managing stroke inpatients, and emphasize the importance of an optimal combination in the same number of hospital staffing.

Hansen, J., et al. (2015). "Living In A Country With A Strong Primary Care System Is Beneficial To

People With Chronic Conditions." Health Affairs **34**(9): 1531-1537.
In light of the growing pressure that multiple chronic diseases place on health care systems, we investigated whether strong primary care was associated with improved health outcomes for the chronically ill. We did this by combining country- and individual-level data for the twenty-seven countries of the European Union, focusing on people's self-rated health status and whether or not they had severe limitations or untreated conditions. We found that people with chronic conditions were more likely to be in good or very good health in countries that had a stronger primary care structure and better coordination of care. People with more than two chronic conditions benefited most: Their self-rated health was higher if they lived in countries with a stronger primary care structure, better continuity of care, and a more comprehensive package of primary care services. In general, while having access to a strong primary care system mattered for people with chronic conditions, the degree to which it mattered differed across specific subgroups (for example, people with primary care–sensitive conditions) and primary care dimensions. Primary care reforms, therefore, should be person centered, addressing the needs of subgroups of patients while also finding a balance between structure and service delivery.

Humphries, R. (2015). "Integrated health and social care in England--Progress and prospects." Health Policy **119**(7): 856-859.
This paper reviews recent policy initiatives in England to achieve the closer integration of health and social care. This has been a policy goal of successive UK governments for over 40 years but overall progress has been patchy and limited. The coalition government has a new national framework for integrated care and variety of new policy initiatives including the 'pioneer' programme, the introduction of a new pooled budget--the 'Better Care Fund'--and a new programme of personal commissioning. Further change is likely as the NHS begins to develop new models of care delivery. There are significant tensions between these very different policy levers and styles of implementation. It is too early to assess their combined impact. Expectations that integration will achieve substantial financial savings are not supported by evidence. Local effort alone will be insufficient to overcome the fundamental differences in entitlement, funding and delivery between the NHS and the social care system. With a national election set to take place in May 2015, all political parties are committed to the integration of health and social care but clear evidence about the best means to achieve it is likely to remain as elusive as ever.

Bourgeois L. (2015). "Les dimensions cognitives de l'intervention en santé publique : l'accompagnement de deux projets de santé de premier recours en milieu rural." Santé Publique(3): 343-351.
Certaines interventions en santé publique visent à accompagner les transformations de la production de soins de premier recours, passant ainsi d'une organisation individuelle à une organisation collective du soin. Ces interventions peuvent être analysées comme des processus de production de connaissances. Elles aident en effet les acteurs engagés dans l'élaboration d'un projet de santé à objectiver et partager collectivement une situation commune sur l'avenir de l'offre de soins de premier recours. Cette vision commune leur permet d'entrer dans une démarche de projet. Elle donne du sens à leur action. Elles incitent les acteurs du projet à se connaître et se reconnaître comme partenaires de la production de soins de premier recours, initiant ainsi l'émergence d'une équipe de professionnels de santé. Elle permet de valoriser et formaliser des pratiques de coordination existantes ainsi que d'inventer des nouvelles pratiques communes. Ainsi, une connaissance collective est produite avec les acteurs du projet et capitalisée par le tiers intervenant. Cette connaissance permet d'objectiver les expériences individuelles et d'aider ainsi à la réflexivité des acteurs. Au final l'intervention de terrain peut se comprendre comme une dynamique de conversion.

Iacobucci, G. (2015). "Conflicts of interest are bound to increase as GPs co-commission more primary care services, report warns. " British Medical jJournal **351**.
Controls for managing conflicts of interests in clinical commissioning groups (CCGs) in England are variable in their robustness and will be increasingly tested as groups commission more general practice services, the National Audit Office (NAO) has warned.A new report produced for the Department of Health, NHS England, and Monitor found that almost all CCGs in England had put in place legislative requirements set out in the Health and Social Care Act 2012 to help them prevent and manage conflicts of interest.1But, where CCGs reported information about their current processes for managing conflicts, the NAO reported that "the adequacy of those controls had varied." It added that new arrangements enabling CCGs to co-commission primary care services from GPs "are likely to significantly increase the number and scale of conflicts of interest."

Rimmer, A. (2015). "GPs' income fell 3% in a year, UK data show." British Medical Journal **351**.
GPs' average income before tax in 2013-14 was £90 200 (€124 000; $140 000), a 3% decrease on the 2012-13 figure, shows an analysis by the NHS Health and Social Care Information Centre.1 The figures relate to UK GPs on the general medical services (GMS) contract and the primary medical services (PMS) contract and to salaried GPs.The average taxable income of contractor GPs working under a GMS or PMS contract in the United Kingdom was £99 800 in 2013-14.

Rudkjobing, A., et al. (2015). "Evaluation of a policy to strengthen case management and quality of diabetes care in general practice in Denmark." Health Policy **119**(8): 1023-1030.
OBJECTIVES: To evaluate the utilization of a policy for strengthening general practitioner's case management and quality of care of diabetes patients in Denmark incentivized by a novel payment mode. We also want to elucidate any geographical variation or variation on the basis of practice features such as solo- or group practice, size of practice and age of the GP. METHODS: On the basis registers encompassing reimbursement data from GPs and practice specific information about geographical location (region), type of practice (solo- or group-practice), size of practice (number of patients listed) and age of the GP were are able to determine differences in use of the policy in relation to the practice-specific information. RESULTS: At the end of the study period (2007-2012) approximately 30% of practices have enrolled extending services to approximately 10% of the diabetes population. There is regional - as well as organizational differences between GPs who have enrolled and the national averages with enrolees being younger, from larger practices and with more patients listed. CONCLUSIONS: Our study documents an organizationally and regionally varied and limited utilization with the overall incentive structure defined in the policy not strong enough to move the majority of GPs to change their way of delivering and financing care for patients with diabetes within a period of more than 5 years.

Rudoler, D., et al. (2015). "Paying for Primary Care: The Factors Associated with Physician Self-selection into Payment Models." Health Econ **24**(9): 1229-1242.
To determine the factors associated with primary care physician self-selection into different payment models, we used a panel of eight waves of administrative data for all primary care physicians who practiced in Ontario between 2003/2004 and 2010/2011. We used a mixed effects logistic regression model to estimate physicians' choice of three alternative payment models: fee for service, enhanced fee for service, and blended capitation. We found that primary care physicians self-selected into payment models based on existing practice characteristics. Physicians with more complex patient populations were less likely to switch into capitation-based payment models where higher levels of effort were not financially

rewarded. These findings suggested that investigations aimed at assessing the impact of different primary care reimbursement models on outcomes, including costs and access, should first account for potential selection effects. Copyright (c) 2015 John Wiley & Sons, Ltd.

Systèmes de santé / Health Systems

Anne, W. and P. Dipti (2015). "Perspectives on Advancing Bundled Payment in Ontario's Home Care System and Beyond." Healthcare Quarterly **18**(1): 18-25.

Now more than ever, healthcare funders are weighing options to drive better value in care delivery, including using bundled payments to compensate healthcare providers based on expected costs to achieve specific health outcomes for patients. Ontario is currently exploring options for expanding bundled payment beyond acute care to home care, primary care, long-term care and across the continuum of care. This paper reviews the evidence, including the Ontario experience with bundled payment, and identifies opportunities for advancing bundled payment in home care as well as with other sectors. The authors consider the most promising opportunities, offer perspectives on where to start and identify the critical success factors. They conclude that is unlikely that payment reform on its own would be sufficient to drive changes in care delivery across providers. Instead, the evidence from the review points to the need to shift the conversation on bundled payment to a larger strategy for integration of care across providers and to engage providers in designing solutions, particularly for supporting chronic and complex patients who require support from multiple providers across the system.

Ashton, T. (2015). "Measuring health system performance: A new approach to accountability and quality improvement in New Zealand." Health Policy **119**(8): 999-1004.

In February 2014, the New Zealand Ministry of Health released a new framework for measuring the performance of the New Zealand health system. The two key aims are to strengthen accountability to taxpayers and to lift the performance of the system's component parts using a 'whole-of-system' approach to performance measurement. Development of this new framework - called the Integrated Performance and Incentive Framework (IPIF) - was stimulated by a need for a performance management framework which reflects the health system as a whole, which encourages primary and secondary providers to work towards the same end, and which incorporates the needs and priorities of local communities. Measures within the IPIF will be set at two levels: the system level, where measures are set nationally, and the local district level, where measures which contribute towards the system level indicators will be selected by local health alliances. In the first year, the framework applies only at the system level and only to primary health care services. It will continue to be developed over time and will gradually be extended to cover a wide range of health and disability services. The success of the IPIF in improving health sector performance depends crucially on the willingness of health sector personnel to engage closely with the measurement process.

Hawkes, N. (2015/09/13). « Providing care at home will not save money for NHS in next five years, Monitor says. » British Medical Journal

Nigel Hawkes1LondonNew models of care being promoted in the NHS in England are unlikely to break even within five years, even if well designed, the health service regulator Monitor says in a new report.1Its analysis of the financial impact of models that aim to provide care

closer to home showed that, even under the most optimistic assumptions, savings would accrue only if they reduced the need for further investment in acute care trusts. “Schemes can deliver care at lower cost, but it’s pretty marginal,” said Chris Walters, Monitor’s chief economist, at a conference held by the Reform think tank on 9 September.New models of care are the cornerstone of NHS England’s Five Year Forward View and are being developed at vanguard sites across the country.2 The future of the NHS depends on them, NHS England’s chief executive, Simon Stevens, has said.Monitor’s analysis did find that four of the modelled schemes—short …

Mechanic, R. E. (2015/08/26) "Mandatory Medicare Bundled Payment — Is It Ready for Prime Time?" New England Journal of Medicine : Ahead of print **0**(0).

Shmueli, A., et al. (2015). "Managed care in four managed competition OECD health systems." Health Policy **119**(7): 860-873.

Managed care emerged in the American health system in the 1980s as a way to manage suppliers' induced demand and to contain insurers' costs. While in Israel the health insurers have always been managed care organizations, owning health care facilities, employing medical personnel or contracting selectively with independent providers, European insurers have been much more passive, submitting themselves to collective agreements between insurers' and providers' associations, accompanied by extensive government regulation of prices, quantities, and budgets. With the 1990s reforms, and the introduction of risk-adjusted "managed competition", a growing pressure to allow the European insurers to manage their own care - including selective contracting with providers - has emerged, with varying speed of the introduction of policy changes across the individual countries. This paper compares experiences with managed care in Israel, The Netherlands, Germany and Switzerland since the 1990s. After a brief description of the health insurance markets in the four countries, we focus comparatively on the emergence of managed care in the markets for ambulatory care and inpatient market care. We conclude with an evaluation of the current situation and a discussion of selected health policy issues.

Travail et santé / Occupational Health

Breuer, C. (2015). "Unemployment and Suicide Mortality: Evidence from Regional Panel Data in Europe." Health Econ **24**(8): 936-950.

This paper addresses the influence of economic activity on suicide mortality in Europe. To this end, it employs a new panel data set of 275 regions in 29 countries over the period 1999-2010. The results suggest that unemployment does have a significantly positive influence on suicides. In line with economic theory, this influence varies among gender and age groups. Men of working age are particularly sensitive, while old-age suicide mortality (older than 65 years old) hardly responds to unemployment. Moreover, real economic growth negatively affects the suicide rates of working-age men. The results withstand several robustness checks, such as sample variations, and after controlling for serial and spatial autocorrelation.

Kivimäki, M., et al. (205/08/19) "Long working hours and risk of coronary heart disease and stroke: a systematic review and meta-analysis of published and unpublished data for 603 838 individuals." The Lancet.

BackgroundLong working hours might increase the risk of cardiovascular disease, but prospective evidence is scarce, imprecise, and mostly limited to coronary heart disease. We

aimed to assess long working hours as a risk factor for incident coronary heart disease and stroke.