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Veille scientifique
en économie de la santé

Novembre 2017

Sommaire en français

Watch on
Health Economics Literature

November 2017

Contents list in English

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Novembre 2017

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Présentation

Cette publication mensuelle, réalisée par les documentalistes de l'Irdes, rassemble de façon thématique les résultats de la veille documentaire sur les systèmes et les politiques de santé ainsi que sur l'économie de la santé : articles, littérature grise, ouvrages, rapports...

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Veille scientifique en économie de la santé

Directeur de la publication	Denis Raynaud
Documentalistes	Marie-Odile Safon Véronique Suhard
Maquette & Mise en pages	Franck-Séverin Clérembault
Mise en ligne web	Aude Sirvain
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Institut de recherche et documentation en économie de la santé
117bis rue Manin - 75019 Paris • Tél. : 01 53 93 43 00 • www.irdes.fr

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Assurance maladie

Growing Insurance Coverage Did Not Reduce Access to Care for the Continuously Insured

ABDUS S. ET HILL S. C.

2017

Health Aff (Millwood) 36(5): 791-798.

Recent expansions in health insurance coverage have raised concerns about health care providers' capacity to supply additional services and how that may have affected access to care for people who were already insured. When we examined data for the period 2008-14 from the Medical Expenditure Panel Survey, we found no consistent evidence that increases in the proportions of adults with insurance at the local-area level affected access to care for adults residing in the same areas who already had, and continued to have, insurance. This lack of an apparent relationship held true across eight measures of access, which included receipt of preventive care. It also held true among two adult subpopulations that may have been at greater risk for compromised access: people residing in health care professional shortage areas and Medicaid beneficiaries.

Did the Affordable Care Act's Dependent Coverage Expansion Affect Race/Ethnic Disparities in Health Insurance Coverage

BRESLAU J., *et al.*

2017/06

Health Serv Res (Ahead of print).

The aim of the study is to test the impact of the dependent coverage expansion (DCE) on insurance disparities across race/ethnic groups. Survey data from the National Survey of Drug Use and Health (NSDUH). Triple-difference (DDD) models were applied to repeated cross-sectional surveys of the U.S. adult population. Data from 6 years (2008-2013) of the NSDUH were combined. Following the DCE, the relative odds of insurance increased 1.5 times (95 percent CI 1.1, 1.9) among whites compared to blacks and 1.4 times (95 percent CI 1.1, 1.8) among whites compared to Hispanics. Health reform efforts, such as the DCE, can have negative effects on race/ethnic disparities, despite positive impacts in the general population.

Reducing Young Adults' Health Care Spending Through the ACA Expansion of Dependent Coverage

CHEN J., *et al.*

2017

Health Serv Res 52(5): 1835-1857.

The aim of this paper is to estimate health care expenditure trends among young adults ages 19-25 before and after the 2010 implementation of the Affordable Care Act (ACA) provision that extended eligibility for dependent private health insurance coverage. Nationally representative Medical Expenditure Panel Survey data from 2008 to 2012 was used. We conducted repeated cross-sectional analyses and employed a difference-in-differences quantile regression model to estimate health care expenditure trends among young adults ages 19-25 (the treatment group) and ages 27-29 (the control group). Our results show that the treatment group had 14 percent lower overall health care expenditures and 21 percent lower out-of-pocket payments compared with the control group in 2011-2012. The overall reduction in health care expenditures among young adults ages 19-25 in years 2011-2012 was more significant at the higher end of the health care expenditure distribution. Differences in the trends of costs of private health insurance and doctor visits are not statistically significant. Increased health insurance enrollment as a consequence of the ACA provision for dependent coverage has successfully reduced spending and catastrophic expenditures, providing financial protections for young adults.

HUD Housing Assistance Associated with Lower Uninsurance Rates and Unmet Medical Need

SIMON A. E., *et al.*

2017

Health Aff (Millwood) 36(6): 1016-1023.

To investigate whether receiving US Department of Housing and Urban Development (HUD) housing assistance is associated with improved access to health care, we analyzed data on nondisabled adults aged 18-64 who responded to the 2004-12 National Health Interview Survey that were linked with administrative data from HUD for the period 2002-14. To account

for potential selection bias, we compared access to care between respondents who were receiving HUD housing assistance at the time of the survey interview (current recipients) and those who received HUD assistance within twenty-four months of completing the survey interview (future recipients). Receiving assistance was associated with lower uninsurance rates: 31.8 percent of current recipients were uninsured, compared to 37.2 percent of future recipients. Rates of unmet need for health care due to cost were similarly lower for current recipients than for future recipients. No effect of receiving assistance was observed on having a usual source of care. These findings provide evidence that supports the effectiveness of housing assistance in improving health care access.

Health Insurance Coverage and Health: What the Recent Evidence Tells Us

SOMMERS B. D., *et al.*

2017

New England Journal of Medicine 377(6): 586-593.

http://www.nejm.org/doi/full/10.1056/NEJMsb1706645

The national debate over the Affordable Care Act (ACA) has involved substantial discussion about what effects — if any — insurance coverage has on health and mortality. The prospect that the law's replacement might lead to millions of Americans losing coverage has brought this empirical question into sharp focus. For instance, politicians have recently argued that the number of people with health insurance is not a useful policy metric and that no one dies from a lack of access to health care. However, assessing the impact of insurance coverage on health is complex: health effects may take a long time to appear, can vary according to insurance benefit design, and are often clouded by confounding factors, since insurance changes usually correlate with other circumstances that also affect health care use and outcomes.

Making Fair Choices on the Path to Universal Health Coverage: Applying Principles to Difficult Cases

VOORHOEVE, A. *et al,*

2017/06

Health Systems & Reform 3(4): 1-12.

http://equity.bvsalud.org/2017/09/03/making-fair-choices-on-the-path-to-universal-health-coverage-applying-principles-to-difficult-cases/

Progress toward universal health coverage (UHC) requires making difficult trade-offs. In this journal, Dr. Margaret Chan, the World Health Organization (WHO) Director-General, has endorsed the principles for making such decisions put forward by the WHO Consultative Group on Equity and UHC. These principles include maximizing population health, priority for the worse off, and shielding people from health-related financial risks. But how should one apply these principles in particular cases, and how should one adjudicate between them when their demands conflict? This article by some members of the Consultative Group and a diverse group of health policy professionals addresses these questions. It considers three stylized versions of actual policy dilemmas. Each of these cases pertains to one of the three key dimensions of progress toward UHC: which services to cover first, which populations to prioritize for coverage, and how to move from out-of-pocket expenditures to prepayment with pooling of funds. Our cases are simplified to highlight common trade-offs. Though we make specific recommendations, our primary aim is to demonstrate both the form and substance of the reasoning involved in striking a fair balance between competing interests on the road to UHC.

Supplementary Insurance as a Switching Cost for Basic Health Insurance: Empirical Results from the Netherlands

WILLEMSE-DUIJMELINCK D., *et al.*

2017/08

Health Policy (Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.08.003

Switching for basic health insurance can be hindered by supplementary insurance. Supplementary insurance is only a switching cost if insurers apply selective underwriting. In the Netherlands, most insurers do not apply selective underwriting for supplementary insurance. Nevertheless, many high-risks perceive supplementary insurance as a switching cost. Providing information to high-risks about their switching opportunities could increase consumer choice.

E-santé – Technologies médicales

Rapid Growth in Mental Health Telemedicine Use Among Rural Medicare Beneficiaries, Wide Variation Across States

MEHROTRA A., *et al.*

2017

Health Aff (Millwood) 36(5): 909-917.

Congress and many state legislatures are considering expanding access to telemedicine. To inform this debate, we analyzed Medicare fee-for-service claims for the period 2004-14 to understand trends in and recent use of telemedicine for mental health care, also known as telemental health. The study population consisted of rural beneficiaries with a diagnosis of any mental illness or serious mental illness. The number of telemental health visits grew on average 45.1 percent annually, and by 2014 there were 5.3 and 11.8 telemental health visits per 100 rural beneficiaries with any mental illness or serious mental illness, respectively. There was notable variation across states: In 2014 nine had more than twenty-five visits per 100 beneficiaries with serious mental illness, while four states and the District of Columbia had none. Compared to other beneficiaries with mental illness, beneficiaries who received a telemental health visit were more likely to be younger than sixty-five, be eligible for Medicare because of disability, and live in a relatively poor community. States with a telemedicine parity law and a pro-telemental health regulatory environment had significantly higher rates of telemental health use than those that did not.

ehealth in Integrated Care Programs for People with Multimorbidity in Europe: Insights from the ICARE4EU Project

MELCHIORRE M. G., *et al.*

2017

Health Policy (Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.08.006

eHealth applications for multimorbidity are not widely implemented In Europe. In most cases Electronic Health Records (EHRs) are adopted. Adequate funding mechanisms, interoperability and technical support seem to be lacking. eHealth could support integrated care for people with multimorbidity. eHealth could help older people with multimorbidity living in the community.

Économie de la santé

The Impact of Health Expenditure on the Number of Chronic Diseases

BECCHETTI L., *et al.*

2017/07

Health Policy (Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.07.008

We investigate effects of health expenditure on health outcomes on individual data in 13 countries. Lagged health expenditure affects negatively changes in the number of chronic diseases. The effect varies according to age, health behavior, gender, income, and education. Findings are confirmed when instrumenting with parliament political composition.

What Determines the Health Care Expenditure of High Income Countries? A Dynamic Estimation

FENG Y., *et al.*

2017

Applied Economics and Finance 4(6): 16p.

https://doi.org/10.11114/aef.v4i6.2586

Constraining the rise in costs continues to be a major focus of health care policy in high income countries. It is important for governments to understand what is driving the rise in health care expenditure and what the impact will be over the coming years. This paper aims to provide an alternative econometric model to ascertain the determinants of health expenditure. Data from the OECD and IMS data bases for 18 OECD coun-

tries between 1988 and 2012 is collected. The analysis is at the year and country level. This study applies three methods: (1) panel data models with country fixed effects; (2) a first difference model; (3) a Vector Error Correction Model to account for the long run and short run effects as well as the endogeneity of the explanatory variables. The empirical results suggest that the use of different econometric specifications has a significant impact on both establishing the determinants of health expenditure and their magnitudes. Based on results from the Vector Error Correction Model, the GDP is considered as the only driver for country level health care expenditure growth. A 1% increase in the GDP is associated with a 1.1% increase in the health care expenditure.

Economic Impact of Lung Cancer Screening in France: A Modeling Study

GENDARME S., *et al.*

2017

Rev Mal Respir 34(7): 717-728.

The National Lung Screening Trial found that, in a selected population with a high risk of lung cancer, an annual low-dose CT-scan decreased lung cancer mortality by 20% and overall mortality by 7% compared to annual chest X-Ray. In France, a work group stated that individual screening should be considered in this setting. However, the economic impact of an organized and generalized (to all eligible individuals) screening in France was never reported. This is a modeling study using French population demographic data and published data from randomized screening trials. According to the considered model, there would be 1,650,588 to 2,283,993 subjects eligible to screening in France. According to the model and participation rate, lung cancer screening would diagnose 3600 to 10,118 stages 1/2 lung cancer each year. There would be 5991 to 16,839 false-positives, of whom 1416 to 3981 would undergo unnecessary surgery. Screening policy would cost 105 to 215 euro million per year. However, increasing the price of a cigarette pack by 0.05 to 0.10 euro would fully cover the screening costs. CONCLUSION: Participation rate is a key point for screening impact. Screening could be easily funded by a small increase in cigarette prices.

Time-Driven Activity-Based Costing in Health Care: A Systematic Review of the Literature

KEEL G., *et al.*

2017

Health Policy 121(7): 755-763.

Health care organizations around the world are investing heavily in value-based health care (VBHC), and time-driven activity-based costing (TDABC) has been suggested as the cost-component of VBHC capable of addressing costing challenges. The aim of this study is to explore why TDABC has been applied in health care, how its application reflects a seven-step method developed specifically for VBHC, and implications for the future use of TDABC. This is a systematic review following the PRISMA statement. Qualitative methods were employed to analyze data through content analyses. TDABC is applicable in health care and can help to efficiently cost processes, and thereby overcome a key challenge associated with current cost-accounting methods The method's ability to inform bundled payment reimbursement systems and to coordinate delivery across the care continuum remains to be demonstrated in the published literature, and the role of TDABC in this cost-accounting landscape is still developing.

Examining Drivers of Health Care Spending: Evidence on Self-Referral Among a Privately Insured Population

MITCHELL J. M., *et al.*

2017

Med Care 55(7): 684-692.

Despite the enactment of laws to restrict the practice of self-referral, exceptions in these prohibitions have enabled these arrangements to persist and proliferate. Most research documenting the effects of self-referral arrangements analyzed claims records from Medicare beneficiaries. Empirical evidence documenting the effects of self-referral on use of services and spending incurred by persons with private insurance is sparse. We analyzed health insurance claims records from a large private insurer in Texas to evaluate the effects of physician self-referral arrangements involving physical therapy on the treatment of patients with frozen shoulder syndrome, elbow tendinopathy or tendinitis, and patellofemoral pain syndrome. We used regression analysis to evaluate the effects of episode self-referral

status on: (1) initiation of physical therapy; (2) physical therapy visits and services for those who had at least 1 visit; and (3) total condition-related insurer allowed amounts per episode. Physician owners of physical therapy services refer significantly higher percentages of patients to physical therapy and many are equivocal cases.

▶ High-Price and Low-Price Physician Practices Do Not Differ Significantly on Care Quality or Efficiency

ROBERTS E. T., *et al.*

2017

Health Aff (Millwood) 36(5): 855-864.

Consolidation of physician practices has intensified concerns that providers with greater market power may be able to charge higher prices without having to deliver better care, compared to providers with less market power. Providers have argued that higher prices cover the costs of delivering higher-quality care. We examined the relationship between physician practice prices for outpatient services and practices' quality and efficiency of care. Using commercial claims data, we classified practices as being high- or low-price. We used national data from the Consumer Assessment of Healthcare Providers and Systems survey and linked claims for Medicare beneficiaries to compare high- and low-price practices in the same geographic area in terms of care quality, utilization, and spending. Compared with low-price practices, high-price practices were much larger and received 36 percent higher prices. Patients of high-price practices reported significantly higher scores on some measures of care coordination and management but did not differ meaningfully in their overall care ratings, other domains of patient experiences (including physician ratings and access to care), receipt of preventive services, acute care use, or total Medicare spending.

État de santé

▶ Global, Regional, and National Incidence, Prevalence, and Years Lived with Disability for 328 Diseases and Injuries for 195 Countries, 1990-2016: A Systematic Analysis for the Global Burden of Disease Study 2016

VOS T., *et al.*

2017

Lancet 390(10100): 1211-1259.

As mortality rates decline, life expectancy increases, and populations age, non-fatal outcomes of diseases and injuries are becoming a larger component of the global burden of disease. The Global Burden of Diseases, Injuries, and Risk Factors Study 2016 (GBD 2016) provides a comprehensive assessment of prevalence, incidence, and years lived with disability (YLDs) for 328 causes in 195 countries and territories from 1990 to 2016. This study estimates prevalence and incidence for 328 diseases and injuries and 2982 sequelae, their non-fatal consequences.

▶ Health Effects of Overweight and Obesity in 195 Countries over 25 Years

AFSHIN A., *et al.*

2017

N Engl J Med 377(1): 13-27.

Although the rising pandemic of obesity has received major attention in many countries, the effects of this attention on trends and the disease burden of obesity remain uncertain. We analyzed data from 68.5 million persons to assess the trends in the prevalence of overweight and obesity among children and adults between 1980 and 2015. Using the Global Burden of Disease study data and methods, we also quantified the burden of disease related to high body-mass index (BMI), according to age, sex, cause, and BMI in 195 countries between 1990 and 2015. The rapid increase in the prevalence and disease burden of elevated BMI highlights the need for continued focus on surveillance of BMI and identification, implementation, and evaluation of evidence-based interventions to address this problem.

Obesity-Related Mortality in France, Italy, and the United States: A Comparison Using Multiple Cause-Of-Death Analysis

BARBIERI M., *et al.*

2017

International Journal of Public Health 62(6): 623-629.
https://doi.org/10.1007/s00038-017-0978-1

We investigate the reporting of obesity on death certificates in three countries (France, Italy, and the United States) with different levels of prevalence, and we examine which causes are frequently associated with obesity.

Changes in Alcohol Consumption in the 50- to 64-Year-Old European Economically Active Population During an Economic Crisis

BOSQUE-PROUS M., *et al.*

2017/05

Eur J Public Health (Ahead of print).

The aim was to compare alcohol drinking patterns in economically active people aged 50-64 years before the last economic crisis (2006) and during the crisis (2013). Cross-sectional study with data from 25 479 economically active people aged 50-64 years resident in 11 European countries who participated in wave 2 or wave 5 of the SHARE project (2006 and 2013). The outcome variables were hazardous drinking, abstention in previous 3 months and the weekly average number of drinks per drinker. The prevalence ratios of hazardous drinking and abstention, comparing the prevalence in 2013 vs. 2006, were estimated with Poisson regression models with robust variance, and the changes in the number of drinks per week with Poisson regression models. The prevalence of hazardous drinking decreased among both men (PR = 0.75; 95%CI = 0.63-0.92) and women (PR = 0.91; 95%CI = 0.72-1.15), although the latter decrease was smaller and not statistically significant. The proportion of abstainers increased among both men (PR = 1.11; 95%CI = 0.99-1.29) and women (PR = 1.18; 95%CI = 1.07-1.30), although the former increase was smaller and not statistically significant. The weekly average number of drinks per drinker decreased in men and women. The decreases in consumption were larger in Italy and Spain. From 2006 to 2013, the amount of alcohol consumed by late working age drinkers decreased in Europe, with more pronounced declines in the countries hardest hit by the economic crisis.

Stroke in Women - from Evidence to Inequalities

CORDONNIER C., *et al.*

2017

Nat Rev Neurol 13(9): 521-532.
http://dx.doi.org/10.1038/nrneurol.2017.95

Stroke is the second largest cause of disability-adjusted life-years lost worldwide. The prevalence of stroke in women is predicted to rise rapidly, owing to the increasing average age of the global female population. Vascular risk factors differ between women and men in terms of prevalence, and evidence increasingly supports the clinical importance of sex differences in stroke. The influence of some risk factors for stroke - including diabetes mellitus and atrial fibrillation - are stronger in women, and hypertensive disorders of pregnancy also affect the risk of stroke decades after pregnancy. However, in an era of evidence-based medicine, women are notably under-represented in clinical trials - despite governmental actions highlighting the need to include both men and women in clinical trials - resulting in a reduced generalizability of study results to women. The aim of this Review is to highlight new insights into specificities of stroke in women, to plan future research priorities, and to influence public health policies to decrease the worldwide burden of stroke in women.

Trends in International Asthma Mortality: Analysis of Data from the WHO Mortality Database from 46 Countries (1993-2012)

EBMEIER S., *et al.*

2017

The Lancet 390(10098): 935-945.
http://dx.doi.org/10.1016/S0140-6736(17)31448-4

International time trends in asthma mortality have been strongly affected by changes in management and in particular drug treatments. However, little is known about how asthma mortality has changed over the past decade. In this study, we assessed these international trends.

Global, Regional, and National Deaths, Prevalence, Disability-Adjusted Life Years, and Years Lived with Disability for Chronic Obstructive Pulmonary Disease and Asthma, 1990-2013 : A Systematic Analysis for the Global Burden of Disease Study 2015

SORIANO J. B., *et al.*

2017

The Lancet Respiratory Medicine 5(9): 691-706.

http://dx.doi.org/10.1016/S2213-2600(17)30293-X

Chronic obstructive pulmonary disease (COPD) and asthma are common diseases with a heterogeneous distribution worldwide. Here, we present methods and disease and risk estimates for COPD and asthma from the Global Burden of Diseases, Injuries, and Risk Factors (GBD) 2015 study. The GBD study provides annual updates on estimates of deaths, prevalence, and disability-adjusted life years (DALYs), a summary measure of fatal and non-fatal disease outcomes, for over 300 diseases and injuries, for 188 countries from 1990 to the most recent year.

Did the Great Recession Affect Mortality Rates in the Metropolitan United States? Effects on Mortality by Age, Gender and Cause of Death

STRUMPF E. C., *et al.*

2017

Soc Sci Med 189: 11-16.

Mortality rates generally decline during economic recessions in high-income countries, however gaps remain in our understanding of the underlying mechanisms. This study estimates the impacts of increases in unemployment rates on both all-cause and cause-specific mortality across U.S. metropolitan regions during the Great Recession. We estimate the effects of economic conditions during the recent and severe recessionary period on mortality, including differences by age and gender subgroups, using fixed effects regression models. We identify a plausibly causal effect by isolating the impacts of within-metropolitan area changes in unemployment rates and controlling for common temporal trends. We aggregated vital statistics, population, and unemployment data at the area-month-year-age-gender-race level, yielding 527,040 observations across 366 metropolitan areas, 2005-2010. Our finding that all-cause mortality decreased during the Great Recession is consistent with previous studies. Some categories of cause-specific mortality, notably cardiovascular disease, also follow this pattern, and are more pronounced for certain gender and age groups. Our study also suggests that the recent recession contributed to the growth in deaths from overdoses of prescription drugs in working-age adults in metropolitan areas. Additional research investigating the mechanisms underlying the health consequences of macroeconomic conditions is warranted.

Gender and the Structure of Self-Rated Health Across the Adult Life Span

ZAJACOVA A., *et al.*

2017

Soc Sci Med 187: 58-66.

Despite the widespread use of self-rated health (SRH) in population health studies, the meaning of this holistic health judgment remains an open question. Gender differences in health, an issue of utmost importance in population research and policy, are often measured with SRH; the comparisons could be biased if men and women differ in how they form their health judgment. The aim of this study is to examine whether men and women differ in how health inputs predict their health rating across the adult life span. We use the 2002-2015 National Health Interview Survey data from US-born respondents aged 25-84. Our findings suggest that the meaning of SRH is similar for women and men. Both groups use a broad range of health-related information in forming their health judgment. This conclusion strengthens the validity of SRH in measuring gender differences in health.

Géographie de la santé

Comparing Multilevel and Multiscale Convolution Models for Small Area Aggregated Health Data

AREGAY M., *et al.*

2017

Spat Spatiotemporal Epidemiol 22: 39-49.

In spatial epidemiology, data are often arrayed hierarchically. The classification of individuals into smaller units, which in turn are grouped into larger units, can induce contextual effects. On the other hand, a scaling effect can occur due to the aggregation of data from smaller units into larger units. In this paper, we propose a shared multilevel model to address the contextual effects. In addition, we consider a shared multiscale model to adjust for both scale and contextual effects simultaneously. We also study convolution and independent multiscale models, which are special cases of shared multilevel and shared multiscale models, respectively. We compare the performance of the models by applying them to real and simulated data sets. We found that the shared multiscale model was the best model across a range of simulated and real scenarios as measured by the deviance information criterion (DIC) and the Watanabe Akaike information criterion (WAIC).

Spatial Accessibility of Primary Care in England: A Cross-Sectional Study Using a Floating Catchment Area Method

BAUER J., *et al.*

2017

Health Serv Res (Ahead of print).

The aim of this study is to analyze the general practitioners (GPs) with regard to the degree of urbanization, social deprivation, general health, and disability. The analysis is founded on small area population data and GP practice data in England. We used a floating catchment area method to measure spatial GP accessibility with regard to the degree of urbanization, social deprivation, general health, and disability. Data were collected from the Office for National Statistics and the general practice census and analyzed using a geographic information system. This study showed substantially differing GP accessibility throughout England. However, socially deprived areas did not have poorer spatial access to GPs.

GP Shortage Is a Mismatch Problem

BEERSTECHER H. J.

2017

BMJ 358.

http://www.bmj.com/content/bmj/358/bmj.j4078.full.pdf

A. Majeed makes many valid points about the shortage of general practitioners in the NHS. But a shortage points to a mismatch between supply and demand. Many actions to increase the supply of services have been taken.

Handicap

Pay Less, Consume More? The Price Elasticity of Home Care for the Disabled Elderly in France

ROQUEBERT Q. ET TENAND M.

2017

Health Econ 26(9): 1162-1174.

Little is known about the price sensitivity of demand for home care of the disabled elderly. We partially fill this knowledge gap by using administrative data on the beneficiaries of the main French home care subsidy program in a department and exploiting interindividual variation in provider prices. We address the potential endogeneity of prices by taking advantage of

the unequal spatial coverage of providers and instrumenting price by the number of municipalities served by a provider. We estimate a price elasticity of around -0.4 that is significantly different from both 0 and -1. This less than proportionate response of consumption to price has implications for the efficiency and redistributive impact of variation in the level of copayments in home care subsidy schemes.

Hôpital

Hospitalisation en unité hospitalière spécialement aménagée : enquête de satisfaction auprès des patients

DE LABROUHE D., *et al.*

2017

Revue d'Épidémiologie et de Santé Publique 65(4): 285-294.

http://www.sciencedirect.com/science/article/pii/S0398762017303073

En France, les unités hospitalières spécialement aménagées (UHSA) permettent d'accueillir en hospitalisation à temps complet (en soins libres ou sans consentement) les détenus souffrant d'une pathologie psychiatrique. Depuis leur création, en 2010, la qualité des prises en charge qui y sont proposées et l'impact sur le parcours de soins psychiatriques des patients hospitalisés n'ont pas été étudiés. En particulier, aucune enquête de satisfaction n'a été menée auprès des patients. L'objectif principal de cette étude était d'évaluer la satisfaction des patients sur leur hospitalisation en UHSA. Il s'agissait d'une étude descriptive, bicentrique (UHSA de Villejuif et UHSA de Seclin), réalisée auprès de 125 patients majeurs à leur sortie d'hospitalisation en UHSA, sur une période de quatre mois (de février à mai 2015). La satisfaction des patients était évaluée à l'aide d'un hétéro-questionnaire comportant 16 items. L'étude montre que les patients sont satisfaits des conditions d'hospitalisation en UHSA. Compte tenu des liens entre satisfaction des patients et observance, ces structures pourraient présenter un intérêt majeur dans le parcours de soins des personnes incarcérées souffrant de troubles psychiatriques. Ces résultats devront cependant être répliqués dans une étude sur un échantillon de patients plus important et au sein de l'ensemble des UHSA.

Efficacité des filières dédiées à l'Accident Vasculaire Cérébral. Moyens de mesure. Expérience en Bourgogne

DELPONT B., *et al.*

2017

Journal de Gestion et d'Économie Médicales 35(1): 18-31.

http://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-1-page-18.htm

L'AVC reste une maladie fréquente et grave malgré des avancées thérapeutiques majeures, expliquant le rôle structurant de sa prise en charge sur le plan hospitalier et inter-hospitalier. Les filières de soins pour AVC décloisonnées permettent au patient de bénéficier d'une prise en charge optimale de son domicile jusqu'à l'Unité Neuro-Vasculaire (UNV). Les recommandations nationales ont préconisé la mise en place de filières pluridisciplinaires. L'objectif de cette revue est de rapporter les évaluations successives en pratique courante de la filière AVC mise en place en Bourgogne depuis 2003, les réponses apportées aux attentes des patients et des tutelles, et leur transposition aux autres régions sanitaires. L'analyse se base sur les données du Registre Dijonnais des AVC, qui recense depuis 1985 les AVC des résidents de la ville de Dijon intramuros de façon prospective, spécifique et exhaustive.

Reductions in Readmission Rates Are Associated with Modest Improvements in Patient-Reported Health Gains Following Hip and Knee Replacement in England

FRIEBEL R., *et al.*

2017

Med Care 55(9): 834-840.

Although many hospital readmission reduction initiatives have been introduced globally, health care sys-

tems ultimately aim to improve patients' health and well-being. We examined whether the hospitals that report greater success in reducing readmissions also see greater improvements in patient-reported outcomes. We examined hospital groups (Trusts) that provided hip replacement or knee replacement surgery in England between April 2010 and February 2013. For each Trust, we calculated risk-adjusted 30-day readmission rates from administrative datasets. We also obtained changes in patient-reported health between presurgical assessment and 6-month follow-up, using general health EuroQuol five dimensions questionnaire (EQ-5D) and EuroQuol visual analogue scales (EQ-VAS) and procedure-specific (Oxford Hip and Knee Scores) measures. Panel models were used to assess whether changes over time in risk-adjusted readmission rates were associated with changes over time in risk-adjusted health gains. Reductions in readmission rates were associated with modest improvements in patients' sense of their health and well-being at the hospital group level. In particular, fears that efforts to reduce readmission rates have had unintended consequences for patients appear to be unfounded.

Effects of Formal Home Care on Hospitalizations and Doctor Visits

GONÇALVES J. ET WEAVER F.

2017

International Journal of Health Economics and Management 17(2): 203-233.

https://doi.org/10.1007/s10754-016-9200-x

This study estimates the effects of formal home care, provided by paid professionals, on hospitalizations and doctor visits. We look at different lengths-of-stay (LOS) and types of doctor visits—general practitioners (GP) and specialists—and investigate heterogeneous effects by age groups and informal care availability. Two-part generalized linear models are estimated, using data from Switzerland. In this federal country, home care policy is decentralized into 26 cantons. Home care is measured at the canton level and its endogeneity is addressed by using an instrumental variable strategy combined with canton and time fixed-effects. We instrument home care use with the introduction of patient cost sharing for home care in some cantons in 2011. Overall, home care significantly increases the likelihoods of having a hospitalization, any doctor visit, or a GP visit. In addition, home care significantly reduces LOS up to 30 days, but has no effect on the number of doctor visits. These results are driven by the effects on persons 65 years and older. The effects are small, suggesting that the potential of formal home care to limit the growth in inpatient care and doctor visits may be limited.

Effects of Acute-Postacute Continuity on Community Discharge and 30-Day Rehospitalization Following Inpatient Rehabilitation

GRAHAM J. E., *et al.*

2017

Health Serv Res 52(5): 1631-1646.

The aim of this study is to examine the effects of facility-level acute-postacute continuity on probability of community discharge and 30-day rehospitalization following inpatient rehabilitation. We used national Medicare enrollment, claims, and assessment data to study 541,097 patients discharged from 1,156 inpatient rehabilitation facilities (IRFs) in 2010-2011. Medicare beneficiaries in hospital-based rehabilitation units were more likely to be referred from a high-contributing hospital compared to those in freestanding facilities. However, the association between higher acute-postacute continuity and desirable outcomes is significantly better in freestanding rehabilitation facilities than in hospital-based units. Improving continuity is a key premise of health care reform. We found that both observed referral patterns and continuity-related benefits differed markedly by facility type. These findings provide a starting point for health systems establishing or strengthening acute-postacute relationships to improve patient outcomes in this new era of shared accountability and public quality reporting programs.

How Did Market Competition Affect Outpatient Utilization Under the Diagnosis-Related Group-Based Payment System

KIM S. J., *et al.*

2017

Int J Qual Health Care 29(3): 399-405.

Although competition is known to affect quality of care, less is known about the effects of competition on outpatient health service utilization under the diagnosis-related group payment system. This study aimed

to evaluate these effects and assess differences before and after hospitalization in South Korea. We used two data set including outpatient data and hospitalization data from National Health Claim data from 2011 to 2014. The outcome variables included the costs associated with outpatient examinations and the number of outpatient visits within 30 days before and after hospitalization. High-competition areas were associated with lower pre-surgery examination costs (rate ratio [RR]: 0.88, 95% confidence interval [CI]: 0.88-0.89) and fewer outpatient visits before hospitalization (RR: 0.98, 95% CI: 0.98-0.99) as well as after hospitalization compared with moderate-competition areas. Our study reveals that outpatient health service utilization is affected by the degree of market competition. Future evaluations of hospital performance should consider external factors such as market structure and hospital location.

Effects of Long-Term High Continuity of Care on Avoidable Hospitalizations of Chronic Obstructive Pulmonary Disease Patients

LIN I. P. ET WU S. C.

2017

Health Policy 121(9): 1001-1007.

The aim of this study is to examine the effects of high continuity of care (COC) maintained for a longer time on the risk of avoidable hospitalization of patients with chronic obstructive pulmonary disease (COPD). A retrospective cohort study design was adopted. We used a claim data regarding health care utilization under a universal health insurance in Taiwan. We selected 2199 subjects who were newly diagnosed with COPD. We considered COPD-related avoidable hospitalizations as outcome variables. The continuity of care index (COCI) was used to evaluate COC as short- and long-term COC. We concluded that maintaining long-term high COC effectively reduces the risk of avoidable hospitalizations. To encourage development of long-term patient-physician relationships could improve health outcomes.

Reducing Hospital Readmissions Through Preferred Networks of Skilled Nursing Facilities

MCHUGH J. P., *et al.*

2017

Health Aff (Millwood) 36(9): 1591-1598.

Establishing preferred provider networks of skilled nursing facilities (SNFs) is one approach hospital administrators are using to reduce excess thirty-day readmissions and avoid Medicare penalties or to reduce beneficiaries' costs as part of value-based payment models. However, hospitals are also required to provide patients at discharge with a list of Medicare-eligible providers and cannot explicitly restrict patient choice. This requirement complicates the development of a SNF network. Furthermore, there is little evidence about the effectiveness of network development in reducing readmission rates. We used a concurrent mixed-methods approach, combining Medicare claims data for the period 2009-13 with qualitative data gathered from interviews during site visits to hospitals in eight US markets in March-October 2015, to examine changes in rehospitalization rates and differences in practices between hospitals that did and did not develop formal SNF networks. Four hospitals had developed formal SNF networks as part of their care management efforts. These hospitals saw a relative reduction from 2009 to 2013 in readmission rates for patients discharged to SNFs that was 4.5 percentage points greater than the reduction for hospitals without formal networks. Interviews revealed that those with networks expanded existing relationships with SNFs, effectively managed patient data, and exercised a looser interpretation of patient choice.

Reducing Readmissions Among Heart Failure Patients Discharged to Home Health Care: Effectiveness of Early and Intensive Nursing Services and Early Physician Follow-Up

MURTAUGH C. M., *et al.*

2017

Health Serv Res 52(4): 1445-1472.

The aim of this paper is to compare the effectiveness of two «treatments»-early, intensive home health nursing and physician follow-up within a week-versus less intense and later postacute care in reducing readmissions among heart failure (HF) patients discharged to

home health care. The data sources are the National Medicare administrative, claims, and patient assessment data. Patients with a full week of potential exposure to the treatments were followed for 30 days to determine exposure status, 30-day all-cause hospital readmission, other health care use, and mortality. An extension of instrumental variables methods for nonlinear statistical models corrects for nonrandom selection of patients into treatment categories. Our instruments are the index hospital's rate of early aftercare for non-HF patients and hospital discharge day of the week. Our results call for closer coordination between home health and medical providers in the clinical management of HF patients immediately after hospital discharge.

Hospital Quality Variation Matters - A Time-Trend and Cross-Section Analysis of Outcomes in German Hospitals from 2006 to 2014

PROSS C., *et al.*

2017

Health Policy 121(8): 842-852.

Awareness of care variation and associated differences in outcome quality is important for patients to recognize and leverage the benefits of hospital choice and for policy makers, providers, and suppliers to adapt initiatives to improve hospital quality of care. We examine panel data on outcome quality in German hospitals between 2006 and 2014 for cholecystectomy, pacemaker implantation, hip replacement, percutaneous coronary intervention (PCI), stroke, and acute myocardial infarction (AMI). We use risk-adjusted and unadjusted outcomes based on 16 indicators. Median outcome and outcome variation trends are examined via box plots, simple linear regressions and quintile differences. Outcome trends differ across treatment areas and indicators. We found positive quality trends for hip replacement surgery, stroke and AMI 30-day mortality, and negative quality trends for 90-day stroke and AMI readmissions and PCI inpatient mortality. Variation of risk-adjusted outcomes ranges by a factor of 3-12 between the 2nd and 5th quintile of hospitals, both at the national and regional level. Our results show that simply measuring and reporting hospital outcomes without clear incentives or regulation - «carrots and sticks» - to improve performance and to centralize care in high performing hospitals has not led to broad quality improvements. More substantial efforts must be undertaken to narrow the outcome spread between high- and low-quality hospitals.

Changes in Hospital Quality Associated with Hospital Value-Based Purchasing

RYAN A. M., *et al.*

2017

New England Journal of Medicine 376(24): 2358-2366.

http://www.nejm.org/doi/full/10.1056/NEJMsa1613412

Starting in fiscal year 2013, the Hospital Value-Based Purchasing (HVBP) program introduced quality performance-based adjustments of up to 1% to Medicare reimbursements for acute care hospitals. We evaluated whether quality improved more in acute care hospitals that were exposed to HVBP than in control hospitals (Critical Access Hospitals, which were not exposed to HVBP). The measures of quality were composite measures of clinical process and patient experience. Improvements in clinical-process and patient-experience measures were not significantly greater among hospitals exposed to HVBP than among control hospitals, with difference-in-differences estimates of 0.079 SD (95% confidence interval [CI], -0.140 to 0.299) for clinical process and -0.092 SD (95% CI, -0.307 to 0.122) for patient experience. HVBP was not associated with significant reductions in mortality among patients who were admitted for acute myocardial infarction (difference-in-differences estimate, -0.282 percentage points [95% CI, -1.715 to 1.152]) or heart failure (-0.212 percentage points [95% CI, -0.532 to 0.108]), but it was associated with a significant reduction in mortality among patients who were admitted for pneumonia (-0.431 percentage points [95% CI, -0.714 to -0.148]). In our study, HVBP was not associated with improvements in measures of clinical process or patient experience and was not associated with significant reductions in two of three mortality measures.

Analyse de la pertinence des séjours hospitaliers : un exemple de recherche d'optimisation

TROSINI-DÉSERT V., *et al.*

2017/05

Gestions hospitalières 566: 318-321.

L'analyse de la pertinence des journées d'hospitalisation et des raisons de non-pertinence s'inscrit dans le cadre des démarches d'évaluation de la qualité des soins. La nécessité de cette évaluation est devenue incontournable et suscite un vif intérêt car les journées d'inadéquation hospitalières sont source de sous-qualité des soins, d'inefficience du système de santé et de coûts non maîtrisés. Cet article rapporte une étude de pertinence des journées d'hospitalisation menée au sein du groupe hospitalier Paris Saint-Joseph, dans deux services : rhumatologie et cardiologie.

The Ageing Society and Emergency Hospital Admissions

WITTENBERG R., *et al.*

2017

Health Policy 121(8): 923-928.

There is strong policy interest, in England as elsewhere, in slowing the growth in emergency hospital admissions, which for older people increased by 3.3% annually between 2001/2 and 2012/3. Resource constrains have increased the importance of understanding rising emergency admissions, which in policy discourse is often explained by population aging. This study examines how far the rise in emergency admissions of people over 65 was due to population ageing, how far to the changing likelihood of entering hospital at each age, and how far to other factors which might be more amenable to policy measures. It shows that: admission rates rose with age from age 40 upward but each successive birth cohort experienced lower emergency admission rates after standardising for age and other effects. This downward cohort effect largely offset the consequences of an older and larger population aged over 65. Other factors which could explain increasing admissions, such as new technologies or rising expectations, appear more important than the changing size and age structure of the population as drivers of rising emergency admissions in old age. These findings suggest that stemming the rate of increase in emergency admissions of older people may be feasible, if challenging, despite population ageing.

Inégalités de santé

Most Americans Have Good Health, Little Unmet Need, and Few Health Care Expenses

BERK M. L. ET FANG Z.

2017

Health Aff (Millwood) 36(4): 742-746.

The distribution of health care expenditures remains highly concentrated, but most Americans use few health care resources and have low out-of-pocket spending. More than 93 percent of «low spenders» (those in the bottom half of the population) believe they have received all needed care in a timely manner. The low spending by the majority of the population has remained almost unchanged during the thirty-seven-year period examined.

Reforming Refugee Healthcare in Canada: Exploring the Use of Policy Tools

HOLTZER E. ET A L.

2017

Healthcare Policy 12(4): 46-55.

Refugee healthcare in Canada has been a controversial and heavily debated topic over the past several years. In this paper, we present a policy analysis of the 2012 Canadian federal government decision to change the criteria and funding of the Interim Federal Health Program (IFHP). The IFHP provides federally funded healthcare coverage for refugees until they gain access to provincially funded health insurance. The paper offers a policy perspective on the changes to refugee health coverage over time. We draw on the policy concepts of agenda setting, framing, venues and causal stories to explore this topic. We suggest that these concepts represent a set of tools for both

researchers and laypersons to critically appraise any issue on the policy agenda, and understand how certain topics become policy issues and why they are, in particular ways.

Contrepoint - L'accès aux soins des migrants

GRELLEY P.

2016

Informations sociales 194(3): 95-95.

http://www.cairn.info/revue-informations-sociales-2016-3-page-95.htm

Les migrations constituent un enjeu essentiel pour la protection sociale, quelle que soit l'échelle spatiale concernée. Au sein de l'Union européenne (UE), un espace en partie fédéral, tout citoyen d'un État membre peut bénéficier de la protection sociale dans le pays où il travaille. Ces droits sociaux constituent l'un des piliers de l'intégration du continent. Ils ont facilité la libre circulation des personnes, au point que les pays de l'UE les plus touchés par la crise débutée en 2008 sont devenus ou redevenus des terres d'émigration. Ce numéro examine, dans un premier temps, la manière dont les travailleurs migrants ont été traités par la protection sociale, aux différentes étapes historiques de sa construction en France et en Europe, et analyse en particulier les liens entre statut des migrants, droit social et droits fondamentaux (première partie). Compte tenu des difficultés financières qui pèsent sur les États européens, les migrations sont souvent mises en avant comme une contrainte pour la protection sociale, bien que ce constat soit discuté par l'analyse économique (deuxième partie). L'analyse des règles et les conditions d'accès des migrants aux prestations et aux services sociaux se révèlent donc essentielle pour comprendre les enjeux de leur intégration, en France comme au sein de l'UE (troisième partie).

Out of Sight but Not Out of Mind: Home Countries' Macroeconomic Volatilities and Immigrants' Mental Health

NGUYEN H. T. ET CONNELLY L. B.

2017

Health Econ (Ahead of print).

We provide the first empirical evidence that better economic performances by immigrants' countries of origin, as measured by lower consumer price index (CPI) or higher gross domestic product, improve immigrants' mental health. We use an econometrically-robust approach that exploits exogenous changes in macroeconomic conditions across immigrants' home countries over time and controls for immigrants' observable and unobservable characteristics. The CPI effect is statistically significant and sizeable. Furthermore, the CPI effect diminishes as the time since emigrating increases. By contrast, home countries' unemployment rates and exchange rate fluctuations have no impact on immigrants' mental health.

Educational Inequalities in Self-Rated Health Across US States and European Countries

PRÄG P. ET SUBRAMANIAN S. V.

2017

International Journal of Public Health 62(6): 709-716.

https://doi.org/10.1007/s00038-017-0981-6

The US shows a distinct health disadvantage when compared to other high-income nations. A potential lever to reduce this disadvantage is to improve the health situation of lower socioeconomic groups. Our objective is to explore how the considerable within-US variation in health inequalities compares to the health inequalities across other Western countries.

Santé et recours aux soins des jeunes en insertion âgés de 18 à 25 ans suivis en mission locale

ROBERT S., *et al.*

2017

Revue d'Épidémiologie et de Santé Publique 65(4): 265-276.

http://www.sciencedirect.com/science/article/pii/S0398762017303000

En France, les missions locales accueillent les jeunes en insertion âgés de 16 à 25 ans. Elles reçoivent ainsi 10 à 15 % des jeunes de cette tranche d'âge de leur territoire, soit plus de 1,5 millions de jeunes par an. Aucun travail n'a encore étudié leur état de santé à un niveau national. Notre objectif était de décrire cet état de santé et leur recours aux soins et de les comparer à ceux des jeunes en population générale. Les

données de l'étude multicentrique Presaje, conduite en 2011 sur un échantillon aléatoire de 1453 jeunes âgés de 18 à 25 ans fréquentant cinq missions locales (Clichy-sous-Bois, Poitiers, Reims, Sénart, Toulouse), ont été analysées et comparées aux données des 2899 jeunes du même âge du Baromètre Santé 2010 et des 204 jeunes de la cohorte francilienne SIRS 2010. De profils sociaux divers, ces jeunes connaissaient globalement des conditions de vie plus difficiles que les jeunes du même âge de la population générale. Ils accumulaient des facteurs de vulnérabilité vis-à-vis de la santé : couverture sociale insuffisante, faible niveau de formation, accumulation d'événements de vie difficiles dans l'enfance et isolement social.

Health Inequities in the Age of Austerity: The Need for Social Protection Policies

RUCKERT A. ET LABONTE R.

2017

Soc Sci Med 187: 306-311.

This commentary assesses the impacts of the global austerity drive on health inequities in the aftermath of the global financial crisis of 2008. In doing so, it first locates the origins of austerity within the 40 year history of neoliberal economic orthodoxy. It then describes the global diffusion of austerity since 2008, and its key policy tenets. It next describes the already visible impacts of austerity-driven welfare reform on trends in health equity, and documents how austerity has exacerbated health inequities in countries with weak social protection policies. We finally identify the components of an alternative policy response to the financial crisis than that of austerity, with specific reference to the need for shifts in national and global taxation policies and public social protection policies and spending. We conclude with a call for a reorientation of public policy towards making human health an overarching global policy goal, and how this aligns with the multilaterally agreed upon Sustainable Development Goals.

Austerity and Its Implications for Immigrant Health in France

SARGENT C. ET KOTOBI L.

2017

Soc Sci Med 187: 259-267.

The ongoing economic crisis in France increasingly has affected immigrant rights, including access to health care. Consistent with a 2014 League Against Cancer survey, we identify the ways in which sickness produces a «double penalty» for immigrants with serious illness. Immigrants with chronic illnesses such as cancer, diabetes, and other debilitating conditions divert vital funds from daily needs to deal with sickness and loss of work while at the same time national austerity measures shred the state's traditional safety net of social services and support. We examine how immigrants strategize to manage financial exigencies, therapeutic itineraries and social relations in the face of these converging pressures. We base our findings on two studies related by this theme: an investigation of health inequalities in the Medoc region, in which 88 women, 44 of North African and Eastern European origin, were interviewed over a three-year period (2010-2013); and a three-year study (2014-2017) of West African immigrant women with breast cancer seeking treatment in the greater Paris region, 70 members of immigrant associations, and clinical personnel in three hospitals.

Was Mackenbach Right? Towards a Practical Political Science of Redistribution and Health Inequalities

SCHRECKER T.

2017

Health Place 46: 293-299.

In 2010, Mackenbach reflected on England's lack of success in reducing health inequalities between 1997 and 2010, asserting that «it is difficult to imagine a longer window of opportunity for tackling health inequalities»; asking «[i]f this did not work, what will?»; and concluding that reducing health inequalities was not politically feasible at least in that jurisdiction. Exploring the empirics of that observation offers a window into the politics of reducing health inequalities. For purposes of future comparative research, I outline three (not mutually exclusive) perspectives on political feasibility, identify their implications for a political science of health inequalities, and explore what they mean for advocacy in support of reducing those inequalities.

Médicaments

The French Medecine Pricing Committee and the Medicine Economic Policy: Rules and Competences

GIORGI D.

2017

Ann Pharm Fr 75(5): 359-372.

The French medicine pricing committee (CEPS), a governmental and inter-institutional body exercises essential competences for the regulation of the economy of the reimbursable drugs in France. It provides a good example of administered price regulation. It also supervises the proper use of products (control of promotion, conventional control of sales volumes). Finally, it regulates the annual envelope of drug expenditures by means of discounts paid by pharmaceutical companies. The article presents the legal criteria and the doctrine of price setting used in France. It details the types of market access contracts concluded by the CEPS. It specifies the conditions governing the annual envelope of expenditures on reimbursable medicines.

The French Medecine Pricing Committee

GIORGI D.

2017

Ann Pharm Fr 75(5): 373-384.

The French medicine pricing committee (CEPS) has to reconcile several major constraints, including optimal patient access to medicines and a good control of expenditures on reimbursable medicines. From 2013 to 2015, drug price decreases and discounts obtained by CEPS contributed more than euro 5 billion to the balance of the health insurance accounts. As for price setting, there is a significant drop in the prices of medicines in France once they are registered for reimbursement. France is affected by a limited, but costly, flow of innovative medicines, whose prices are higher than those of previous generations, a reflection of an international gradient to which France is obviously subject, despite prices that remain at the low end of the range in Western Europe. The provision of innovative medicines for all patients who need them has been ensured in France over the last fifteen years at a controlled cost. But with the arrival of new expensive products, a resolute policy of control of expenditures must take over from the fall in prices, and original financing channels will have to be explored.

Determinants of Potentially Inappropriate Medication Use Among Community-Dwelling Older Adults

MILLER G. E., *et al.*

2017

Health Serv Res 52(4): 1534-1549.

The aim of this study is to examine the determinants of potentially inappropriate medication (PIM) use U.S. nationally representative data on (n = 16,588) noninstitutionalized older adults (age >= 65) with drug use from the 2006-2010 Medical Expenditure Panel Survey. We operationalized the 2012 Beers Criteria to identify PIM use during the year, and we examined associations with individual-level characteristics hypothesized to be quality enabling or related to need complexity. Almost one-third (30.9 percent) of older adults used a PIM. Multivariate results suggest that poor health status and high-PIM-risk conditions were associated with increased PIM use, while increasing age and educational attainment were associated with lower PIM use. Contrary to expectations, lack of a usual care source of care or supplemental insurance was associated with lower PIM use. Medication intensity appears to be in the pathway between both quality-enabling and need-complexity characteristics and PIM use. Our results suggest that physicians attempt to avoid PIM use in the oldest old but have inadequate focus on the high-PIM-risk conditions. Educational programs targeted to physician practice regarding high-PIM-risk conditions and patient literacy regarding medication use are potential responses.

Ethical Acceptability of Offering Financial Incentives for Taking Antipsychotic Depot Medication: Patients' and Clinicians' Perspectives After a 12-Month Randomized Controlled Trial

NOORDRAVEN E. L., *et al.*

2017

BMC Psychiatry 17(1): 313.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5576283/pdf/12888_2017_Article_1485.pdf

A randomized controlled trial 'Money for Medication'(M4M) was conducted in which patients were offered financial incentives for taking antipsychotic depot medication. This study assessed the attitudes and ethical considerations of patients and clinicians who participated in this trial.

Time for a Change in How New Antibiotics Are Reimbursed: Development of an Insurance Framework for Funding New Antibiotics Based on a Policy of Risk Mitigation

TOWSE A., *et al.*

2017

Health Policy (Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.07.011

We propose a policy change to an insurance model for reimbursing new antibiotics. Current incentives are insufficient to rekindle investment in antibiotic development. Our analysis explores two models that aim to address these shortcomings. A premium price model has uncertain impact and risks putting commercial return and appropriate stewardship in opposition. An insurance model can achieve investment, reduce uncertainty for health systems, and achieve stewardship.

Méthodologie – Statistique

The Impact of Economic Conditions on the Disablement Process: A Markov Transition Approach Using SHARE Data

ARRIGHI Y., *et al.*

2017

Health Policy 121(7): 778-785.

A growing number of studies underline the relationship between socioeconomic status and health at older ages. Following that literature, we explore the impact of economic conditions on changes in functional health overtime. Frailty, a state of physiological instability, has been identified in the public health literature as a candidate for disability prevention but received little attention from health economists. Using SHARE panel data, respondents aged 50 and over from ten European countries were categorised as robust, frail and dependent. The determinants of health states' changes between two interviews were analysed using multinomial Probit models accounting for potential sample attrition. A particular focus was made on initial socioeconomic status, proxied by three alternative measures. Across Europe, poorer and less educated elders were substantially more likely to experience health degradations and also less likely to experience health improvements. The economic gradient for the recovery from frailty was steeper than that of frailty onset, but remained lower than that of dependency onset. The existing social programs in favour of deprived and dependent elders could be widened to those diagnosed as frail to reduce the onset of dependency and economic inequalities in health at older ages.

Algorithms for the Identification of Hospital Stays Due to Osteoporotic Femoral Neck Fractures in European Medical Administrative Databases Using ICD-10 Codes: A Non-Systematic Review of the Literature

CAILLET P., *et al.*

2017

Rev Epidemiol Santé Publique 65 (Suppl 4): S198-S208.

Osteoporotic hip fractures (OHF) are associated with significant morbidity and mortality. The French medico-administrative database (SNIIRAM) offers an interesting opportunity to improve the management of OHF. However, the validity of studies conducted with this database relies heavily on the quality of the algo-

rithm used to detect OHF. The aim of the REDSIAM network is to facilitate the use of the SNIIRAM database. The main objective of this study was to present and discuss several OHF-detection algorithms that could be used with this database.

The Relationship Between Health Services Standardized Costs and Mortality Is Non-Linear: Results from a Large HMO Population

COHEN-MANSFIELD J., *et al.*

2017

Health Policy(Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.07.004

Low Health Services Standardized Costs (HSSC) poses greater mortality risk than medium HSSC. Despite a universal health system, vulnerable status predicted mortality. The low HSSC group may be at risk of underutilizing services.

The REDSIAM Network

GOLDBERG M., *et al.*

2017

Rev Epidemiol Santé Publique 65 (Suppl 4): S144-S148.

The French national health database (SNIIRAM) proved to be very useful for epidemiology, health economics, evaluation, surveillance or public health. However, it is a complex database requiring important resources and expertise for being used. The REDSIAM network has been set up for promoting the collaboration of teams working on the Sniiram. The main aim of REDSIAM is to develop and validate methods for analyzing the Sniiram database for research, surveillance, evaluation and public health purposes by sharing the knowledge and experience of specialized teams in the fields of diseases identification from the Sniiram data. The work conducted within the network is devoted to the development and the validation of algorithms using Sniiram data for identifying specific diseases. The REDSIAM governance includes the Steering Committee composed of the main organizations in charge of producing and using the Sniiram data, the Bureau and the Technical Committee. The network is organized in thematic working groups focused on specific pathological domains, and a charter defines the rules for participation in the network, the functioning of the thematic working groups, the rules for publishing and making available algorithms. The articles in this special issue of the journal present the first results of some of the thematic working groups.

Regression-Based Approaches to Patient-Centered Cost-Effectiveness Analysis

GOTO D., *et al.*

2017

PharmacoEconomics 35(7): 685-695.

https://doi.org/10.1007/s40273-017-0505-5

Achieving comprehensive patient centricity in cost-effectiveness analyses (CEAs) requires a statistical approach that accounts for patients' preferences and clinical and demographic characteristics. Increased availability and accessibility of patient-level health-related utility data from clinical trials or observational database provide enhanced opportunities to conduct more patient-centered CEA. Regression-based approaches that incorporate patient-level data hold great promise for enhancing CEAs to be more patient centered; this paper provides guidance regarding two CEA approaches that apply regression-based approaches utilizing patient-level health-related utility and costs data. The first approach utilizes patient-reported preferences to determine patient-specific utility. This approach evaluates how individuals' unique clinical and demographic factors affect their utility and cost levels over the course of treatment. The underlying motivation of this approach is to produce CEA estimates that reflect patient-level utilities and costs while adjusting for socio-demographic and clinical factors to aid patient-centered coverage and treatment decision-making. In the second approach, patient utilities are estimated based on the clinically defined health states through which a patient may transition throughout the course of treatment. While this approach is grounded on the widely used Markov transition model, we refine the model to facilitate an enhancement in conducting regression-based analysis to achieve transparent understanding of differences in utilities and costs across diverse patient populations. We discuss the unique statistical challenges of each approach and describe how these analytical strategies are related to non-regression-based models in health services research.

Systematic Review Adherence to Methodological or Reporting Quality

PUSSEGODA K., *et al.*

2017

Systematic Reviews 6(1): 131.

https://doi.org/10.1186/s13643-017-0527-2

Guidelines for assessing methodological and reporting quality of systematic reviews (SRs) were developed to contribute to implementing evidence-based health care and the reduction of research waste. As SRs assessing a cohort of SRs is becoming more prevalent in the literature and with the increased uptake of SR evidence for decision-making, methodological quality and standard of reporting of SRs is of interest. The objective of this study is to evaluate SR adherence to the Quality of Reporting of Meta-analyses (QUOROM) and PRISMA reporting guidelines and the A Measurement Tool to Assess Systematic Reviews (AMSTAR) and Overview Quality Assessment Questionnaire (OQAQ) quality assessment tools as evaluated in methodological overviews.

Study of Algorithms to Identify Schizophrenia in the SNIIRAM Database Conducted by the REDSIAM Network

QUANTIN C., *et al.*

2017

Rev Epidemiol Sante Publique 65 (Suppl 4): S226-S235.

The aim of the REDSIAM network is to foster communication between users of French medico-administrative databases and to validate and promote analysis methods suitable for the data. Within this network, the working group «Mental and behavioral disorders» took an interest in algorithms to identify adult schizophrenia in the SNIIRAM database and inventoried identification criteria for patients with schizophrenia in these databases. The methodology was based on interviews with nine experts in schizophrenia concerning the procedures they use to identify patients with schizophrenia disorders in databases. The interviews were based on a questionnaire and conducted by telephone. Patients with schizophrenia can be relatively accurately identified using SNIIRAM data. Different combinations of the selected criteria must be used depending on the objectives and they must be related to an appropriate length of time.

Value of a national administrative database to guide public decisions: From the système national d'information interregimes de l'Assurance Maladie (SNIIRAM) to the système national des données de santé (SNDS) in France

TUPPIN P., *et al.*

2017

Rev Epidemiol Santé Publique 65 (Suppl 4): S149-S167.

In 1999, French legislators asked health insurance funds to develop a "système national d'information interregimes de l'Assurance Maladie (SNIIRAM)" [national health insurance information system] in order to more precisely determine and evaluate health care utilization and health care expenditure of beneficiaries. These data, based on almost 66 million inhabitants in 2015, have already been the subject of numerous international publications on various topics : prevalence and incidence of diseases, patient care pathways, health status and health care utilization of specific populations, real-life use of drugs, assessment of adverse effects of drugs or other health care procedures, monitoring of national health insurance expenditure. SNIIRAM comprises individual information on the sociodemographic and medical characteristics of beneficiaries and all hospital care and office medicine reimbursements, coded according to various systems. SNIIRAM has continued to grow and extend to become, in 2016, the cornerstone of the future système national des données de santé (SNDS) [National health data system], which will gradually integrate new information (causes of death, social and medical data and complementary health insurance). In parallel, the modalities of data access and protection systems have also evolved. This article describes the SNIIRAM data warehouse and its transformation into SNDS, the data collected, the tools developed in order to facilitate data analysis, the limitations encountered, and changing access permissions.

Politique de santé

Overuse of Health Care Services in the Management of Cancer: A Systematic Review

BAXI S. S., *et al.*

2017

Med Care 55(7): 723-733.

Overuse, the provision of health services for which harms outweigh the benefits, results in suboptimal patient care and may contribute to the rising costs of cancer care. We performed a systematic review of the evidence on overuse in oncology. We searched Medline, EMBASE, the Cochrane Library, Web of Science, SCOPUS databases, and 2 grey literature sources, for articles published between December 1, 2011 and March 10, 2017. We included publications from December 2011 to evaluate the literature since the inception of the ABIM Foundation's Choosing Wisely initiative in 2012. We included original research articles quantifying overuse of any medical service in patients with a cancer diagnosis when utilizing an acceptable standard to define care appropriateness, excluding studies of cancer screening. Methodology used PRISMA guidelines. We identified 59 articles measuring overuse of 154 services related to imaging, procedures, and therapeutics in cancer management. Despite recent attention to overuse in cancer, evidence identifying areas of overuse remains limited. Broader investigation, including assessment of active cancer treatment, is critical for identifying improvement targets to optimize value in cancer care.

Improving Population Health Management Strategies: Identifying Patients Who Are More Likely to Be Users of Avoidable Costly Care and Those More Likely to Develop a New Chronic Disease

HIBBARD J. H., *et al.*

2017

Health Serv Res 52(4): 1297-1309.

The aim of this study is to explore using the Patient Activation Measure (PAM) for identifying patients more likely to have ambulatory care-sensitive (ACS) utilization and future increases in chronic disease. Secondary data are extracted from the electronic health record of a large accountable care organization. This is a retrospective cohort design. The key predictor variable, PAM score, is measured in 2011, and is used to predict outcomes in 2012-2014. Outcomes include ACS utilization and the likelihood of a new chronic disease. Our sample of 98,142 adult patients was drawn from primary care clinic users. To be included, patients had to have a PAM score in 2011 and at least one clinic visit in each of the three subsequent years. PAM level is a significant predictor of ACS utilization. Less activated patients had significantly higher odds of ACS utilization compared to those with high PAM scores. Similarly, patients with low PAM scores were more likely to have a new chronic disease diagnosis over each of the years of observation. We conclude that assessing patient activation may help to identify patients who could benefit from greater support. Such an approach may help ACOs reach population health management goals.

How Have Systematic Priority Setting Approaches Influenced Policy Making? A Synthesis of the Current Literature

KAPIRIRI L. ET RAZAVI D.

2017

Health Policy (Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.07.003

Systematic approaches to healthcare priority setting can improve policy making. There is need to assess if the common approaches have impacted policy making. While some have been used, their complexity and resource requirements hamper their institutionalization.

Approaches to Appropriate Care Delivery from a Policy Perspective: A Case Study of Australia, England and Switzerland

ROBERTSON-PREIDLER J., *et al.*

2017

Health Policy 121(7): 770-777.

Appropriateness is a conceptual way for health systems to balance Triple Aim priorities for improving population health, containing per capita cost, and improving the patient experience of care. Comparing system approaches to appropriate care delivery can

help health systems establish priorities and facilitate appropriate care practices. We conceptualized system appropriateness by identifying policies that aim to achieve the Triple Aim and their consequent trade-offs for financing, clinical practice, and the individual patient. We used secondary data sources to compare the appropriate care approaches of Australia, England, and Switzerland according to financial, clinical, and individual appropriateness policies. Integrating the Triple Aim into health system design and policy can facilitate appropriate care delivery at the system, clinical, and individual levels. Approaches will vary and require countries to negotiate and justify priorities and trade-offs within the context of the health system.

Health Policy in Times of Austerity: A Conceptual Framework for Evaluating Effects of Policy on Efficiency and Equity Illustrated with Examples from Europe Since 2008

WENZL M., *et al.*

2017

Health Policy (Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.07.005

We propose a framework to evaluate health policy changes against health system goals. The framework provides a categorisation of policies into distinct health system domains. Policies are evaluated in terms of their effect on efficiency and equity. Policy changes implemented in European countries since 2008 illustrate the framework. Policies mainly aimed to contain cost and likely had mixed effects on efficiency and equity.

Prévention

Alcohol Screening and Brief Interventions for Adults and Young People in Health and Community-Based Settings: A Qualitative Systematic Literature Review

DERGES J., *et al.*

2017

BMC Public Health 17(1): 562.

Systematic reviews of alcohol screening and brief interventions (ASBI) highlight the challenges of implementation in healthcare and community-based settings. Fewer reviews have explored this through examination of qualitative literature and fewer still focus on interventions with younger people. This review aims to examine qualitative literature on the facilitators and barriers to implementation of ASBI both for adults and young people in healthcare and community-based settings. Searches using electronic data bases (Medline on Ovid SP, PsychInfo, CINAHL, Web of Science, and EMBASE), Google Scholar and citation searching were conducted, before analysis. There remain significant barriers to implementation of ASBI among health and community-based professionals. Improving the way health service institutions respond to and co-ordinate alcohol services, including who is most appropriate to address alcohol use, would assist in better implementation of ASBI. Finally, a dearth of qualitative studies looking at alcohol intervention and implementation among young people was noted and suggests a need for further qualitative research.

Inequalities in Cervical Cancer Screening Utilisation and Results: A Comparison Between Italian Natives and Immigrants from Disadvantaged Countries

GALLO F., *et al.*

2017

Health Policy (Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.08.005

Cervical screening underutilisation is well documented among immigrants from poor countries. Participation rate to cervical screening was lower for immigrants than for Italians. Increasing age, illiteracy, being single, negatively influenced immigrants' participation. Severe lesions nearly double among immigrants in first screens compared to Italians. Policy makers should support screening providers in establishing coalitions with immigrants' organisations.

Including Values in Evidence-Based Policy Making for Breast Screening: An Empirically Grounded Tool to Assist Expert Decision Makers

PARKER L.

2017

Health Policy 121(7): 793-799.

Values are an important part of evidence-based decision making for health policy: they guide the type of evidence that is collected, how it is interpreted, and how important the conclusions are considered to be. Experts in breast screening (including clinicians, researchers, consumer advocates and senior administrators) hold differing values in relation to what is important in breast screening policy and practice, and committees may find it difficult to incorporate the complexity and variety of values into policy decisions. The decision making tool provided here is intended to assist with this process. The tool is modified from more general frameworks that are intended to assist with ethical decision making in public health, and informed by data drawn from previous empirical studies on values amongst Australian breast screening experts. It provides a structured format for breast screening committees to consider and discuss the values of themselves and others, suggests relevant topics for further inquiry and highlights areas of need for future research into the values of the public. It enables committees to publicly explain and justify their decisions with reference to values, improving transparency and accountability. It is intended to act alongside practices that seek to accommodate the values of individual women in the informed decision making process for personal decision making about participation in breast screening.

Prévision – Évaluation

How Important Is Severity for the Evaluation of Health Services: New Evidence Using the Relative Social Willingness to Pay Instrument

RICHARDSON J., *et al.*

2017

Eur J Health Econ 18(6): 671-683.

The 'severity hypothesis' is that a health service which increases a patient's utility by a fixed amount will be valued more highly when the initial health state is more severe. Supporting studies have employed a limited range of analytical techniques and the objective of the present paper is to test the hypothesis using a new methodology, the Relative Social Willingness to Pay. Three subsidiary hypotheses are: (1) that the importance of the 'severity effect' varies with the type of medical problem; (2) that the relationship between value and utility varies with the severity of the initial health state; and (3) that there is a threshold beyond which severity effects are insignificant. For each of seven different health problems respondents to a web-based survey were asked to allocate a budget to five services which would, cumulatively, move a person from near death to full health. The time trade-off utilities of health states before and after the service were estimated. The social valuation of the service measured by the budget allocation was regressed upon the corresponding increase in utility and severity as measured by the pre-service health state utility. Results confirm the severity hypothesis and support the subsidiary hypotheses. However, the effects identified are quantitatively significant only for the most severe health states. This implies a relatively limited redistribution of resources from those with less severe to those with more severe health problems.

Psychiatrie

Towards a Community-Based Dementia Care Strategy: How Do We Get There from Here

MORTON C., *et al.*

2016

HealthcarePapers 16(2): 8-32.

As recent policy reports in Ontario and elsewhere have emphasized, most older persons would prefer to age at home. This desire does not diminish for the growing numbers of persons living with dementia (PLWD). Nevertheless, many PLWD end up in residential long-term care (LTC) or in hospital beds. In this lead paper, we begin by exploring the «state of the art» in community-based care for PLWD, highlighting the importance of early and ongoing intervention. We then offer a brief history of dementia care policy in Ontario as an illustrative case study of the challenges faced by policy makers in all jurisdictions as they aim to re-direct healthcare systems focused on «after-the-fact» curative care towards «before-the-fact» prevention and maintenance in the community. Drawing on results from a «balance of care» study, which we conducted in South West Ontario, we examine how, in the absence of viable community-based care options, PLWD can quickly «default» to institutional care. In the final section, we draw from national and international experience to identify the following three key strategic pillars to guide action towards a community-based dementia care strategy.

Entre tutelle et assistance : le débat sur la réforme de la loi de 1838 sur les aliénés des années 1870 aux années 1910

HENCKES N.

2017

Sciences sociales et santé 35(2): 108.

http://www.cairn.info/revue-sciences-sociales-et-sante-2017-2-page-81.htm

Cet article propose un nouvel éclairage sur le débat concernant la réforme de l'assistance aux aliénés entre 1870 et 1914. Il montre que ce dernier a été dominé successivement par deux problématisations portées par deux configurations d'acteurs différentes. Jusqu'à la fin des années 1880, c'est avant tout sous l'angle du statut civil des aliénés et des protections notamment tutélaires à leur apporter que parlementaires, juristes, aliénistes et administrateurs abordent ce débat. À partir des années 1890, une nouvelle problématisation s'ajoute à la première lorsque l'intérêt des réformateurs se déplace vers la question de l'accès de ces mêmes personnes aux institutions susceptibles d'apporter un soulagement à leurs vulnérabilités, qu'ils proposent de faciliter par la création de services d'hospitalisation « ouverts », soit en dehors du système de contraintes et de protections qui caractérise l'internement à l'asile. Le moteur de cette évolution est à la fois l'essor du champ de l'assistance publique et, à l'intérieur de la médecine mentale, celui d'un segment de médecins réformateurs issus du groupe nouvellement formé des médecins des asiles psychiatriques de la Seine. L'article propose finalement une explication supplémentaire à l'échec du débat au Parlement à la veille de la Première Guerre mondiale. Si celui-ci s'explique par la complexité des questions et la diversité des intérêts en jeu, l'impossibilité pour les réformateurs de trancher entre ces deux problématisations s'impose comme un point de blocage majeur.

Évolution des comportements et indicateurs de santé mentale entre 2006 et 2010 dans la population au travail en France

MALARD L., *et al.*

2017

Revue d'Épidémiologie et de Santé Publique 65(4): 309-320.

http://www.sciencedirect.com/science/article/pii/S0398762017304030

Les répercussions de la crise économique de 2008 sur la santé mentale de la population sont encore mal connues, en particulier dans la population au travail. L'objectif de cette étude était d'évaluer l'évolution de la prévalence de comportements et d'indicateurs de santé mentale dans la population au travail en France entre 2006 et 2010, et d'étudier les évolutions différentielles selon l'âge, l'origine, la profession, le secteur d'activité, le secteur public/privé, le statut indépendant/salarié et le type de contrat. L'enquête Santé et itinéraire professionnel (SIP) est une enquête prospective représentative de la population générale française, et parmi les individus interrogés, 5 600 étaient

en emploi en 2006 et en 2010. Les comportements et les indicateurs de santé mentale étudiés étaient la consommation d'alcool à risque, le tabagisme, les problèmes du sommeil (troubles du sommeil et/ou durée de sommeil insuffisante), la prise de psychotropes (antidépresseurs, anxiolytiques et/ou hypnotiques), et la mauvaise santé perçue. Dans la population au travail en France, des augmentations de la prévalence de la consommation d'alcool à risque chez les femmes, des problèmes de sommeil chez les hommes, et de tabagisme, de la durée de sommeil insuffisante et de la mauvaise santé perçue pour les deux genres ont été observées entre 2006 et 2010. Quelques évolutions différentielles ont été mises en évidence, en particulier au détriment des plus jeunes et des personnes en contrat permanent. En conclusion, les politiques de prévention devraient considérer que les prévalences des comportements et des indicateurs de mauvaise santé mentale peuvent avoir augmenté en période de crise économique, en particulier pour certains sous-groupes de la population au travail tels que les plus jeunes et les personnes en contrat permanent. Ces évolutions pourraient laisser présager une augmentation future des pathologies mentales.

▶ Strengthening Mental Health Systems to Respond to Economic Crises

MCDAVID D.

2017

Die Psychiatrie - Grundlagen und Perspektiven 14(2): 61-66.

Mental health systems appear to be among the first casualties of an economic downturn. Growing global political and economic uncertainty in Europe and elsewhere may mean that the next major economic crisis is not far off. This paper considers what mental health systems might do in future to more rapidly respond to the impacts of economic shocks, and reduce the risk and/or mitigate the impacts of poor mental health and deliberate self-harm. It concentrates on two areas of risk to mental health in times of economic shock, namely increasing job insecurity and changing employment conditions, as well as the impacts of unmanageable debt. Addressing the psychological impacts of less job-security and of surviving a downsizing in the workplace may be just as important to mental health as unemployment in an economic crisis. There is also evidence that unmanageable debt is associated with poor mental health and risk of suicide and self-harm. Mental health systems need to develop plans for a rapid response to economic shocks, with a strong focus on a public health approach to mental health. Engaging and collaborating with a wide range of stakeholders, as well as secure budgets, will be imperative to effective.

▶ Without Empowered Patients, Caregivers and Providers, A Community-Based Dementia Care Strategy Will Remain Just That

SAMIR K. S.

2016

HealthcarePapers 16(2): 64-70.

In trying to cope with the needs of the growing number of people living with dementia (PLWD), jurisdictions around the world have been implementing a variety of strategies, policies and programs to enable better access to the supports they and those who care for them require. Despite considerable efforts that have been undertaken, PLWD and their caregivers still face considerable challenges in pursuing care pathways and community-based supports that can help them avoid premature institutionalization. Morton-Chang et al. (2016) have comprehensively reviewed jurisdictional approaches towards the development of dementia strategies, policies and programs; there is a growing understanding and consensus around the things we need to do as societies to better meet the needs of PLWD and their caregivers; however, progress to date could be best characterized as top-down, patchy and fragmented. This paper builds on Morton-Chang, et al (2016) assertion that the development of a comprehensive person and caregiver-centred community-based dementia strategy in Ontario and other parts of Canada is likely achievable, particularly if implemented using a ground-up approach that is well-aligned with other government-related initiatives.

Soins de santé primaires

High Levels of Capitation Payments Needed to Shift Primary Care Toward Proactive Team and Nonvisit Care

BASU S., *et al.*

2017

Health Aff (Millwood) 36(9): 1599-1605.

Capitated payments in the form of fixed monthly payments to cover all of the costs associated with delivering primary care could encourage primary care practices to transform the way they deliver care. Using a microsimulation model incorporating data from 969 US practices, we sought to understand whether shifting to team- and non-visit-based care is financially sustainable for practices under traditional fee-for-service, capitated payment, or a mix of the two. Practice revenues and costs were computed for fee-for-service payments and a range of capitated payments, before and after the substitution of team- and non-visit-based services for low-complexity in-person physician visits. The substitution produced financial losses for simulated practices under fee-for-service payment of $42,398 per full-time-equivalent physician per year; however, substitution produced financial gains under capitated payment in 95 percent of cases, if more than 63 percent of annual payments were capitated. Shifting to capitated payment might create an incentive for practices to increase their delivery of team- and non-visit-based primary care, if capitated payment levels were sufficiently high.

Choosing and Booking-And Attending? Impact of an Electronic Booking System on Outpatient Referrals and Non-Attendances

DUSHEIKO M. ET GRAVELLE H.

2017

Health Econ (Ahead of print).

Patient non-attendance can lead to worse health outcomes and longer waiting times. In the English National Health Service, around 7% of patients who are referred by their general practice for a hospital outpatient appointment fail to attend. An electronic booking system (Choose and Book-C&B) for general practices making hospital outpatient appointments was introduced in England in 2005 and by 2009 accounted for 50% of appointments. It was intended, inter alia, to reduce the rate of non-attendance. Using a 2004-2009 panel with 7,900 English general practices, allowing for the relaxation of constraints on patient of hospital, and for the potential endogeneity of use of C&B, we estimate that the introduction of C&B reduced non-attendance by referred patients in 2009 by 72,160 (8.7%).

Can Pay-For-Performance to Primary Care Providers Stimulate Appropriate Use of Antibiotics

ELLEGARD L. M., *et al.*

2017

Health Econ (Ahead of print).

Antibiotic resistance is a major threat to public health worldwide. As the healthcare sector's use of antibiotics is an important contributor to the development of resistance, it is crucial that physicians only prescribe antibiotics when needed and that they choose narrow-spectrum antibiotics, which act on fewer bacteria types, when possible. Inappropriate use of antibiotics is nonetheless widespread, not least for respiratory tract infections (RTI), a common reason for antibiotics prescriptions. We examine if pay-for-performance (P4P) presents a way to influence primary care physicians' choice of antibiotics. During 2006-2013, 8 Swedish healthcare authorities adopted P4P to make physicians select narrow-spectrum antibiotics more often in the treatment of children with RTI. Exploiting register data on all purchases of RTI antibiotics in a difference-in-differences analysis, we find that P4P significantly increased the share of narrow-spectrum antibiotics. There are no signs that physicians gamed the system by issuing more prescriptions overall.

The Collaboration of General Practitioners and Nurses in Primary Care: A Comparative Analysis of Concepts and Practices in Slovenia and Spain

HÄMEL K. ET VÖSSING C.

2017

Primary Health Care Research & Development 18(5): 492-506.

https://www.cambridge.org/core/services/aop-cambridge-core/content/view/0D74562852566B753EEAF0E6E668DD00/S1463423617000354a.pdf/collaboration_of_general_practitioners_and_nurses_in_primary_care_a_comparative_analysis_of_concepts_and_practices_in_slovenia_and_spain.pdf

The aim of this study is a comparative analysis of concepts and practices of GP-nurse collaborations in primary health centres in Slovenia and Spain. Cross-professional collaboration is considered a key element for providing high-quality comprehensive care by combining the expertise of various professions. In many countries, nurses are also being given new and more extensive responsibilities. Implemented concepts of collaborative care need to be analysed within the context of care concepts, organisational structures, and effective collaboration. Background review of primary care concepts (literature analysis, expert interviews), and evaluation of collaboration in 'best practice' health centres in certain regions of Slovenia and Spain. Qualitative content analysis of expert interviews, presentations, observations, and group discussions with professionals and health centre managers. We conclude that clearly defined structures, shared visions of care and team development are important for implementing and maintaining a good collaboration. Central prerequisites are advanced nursing education and greater acceptance of advanced nursing practice.

Strengthening Primary Health Care Nursing in Europe: The Importance of a Positive Practice Environment

KENDALL S. ET BRYAR R.

2017

Nursing & Society 22(1): In press.

https://kar.kent.ac.uk/61279/

Nurses, form one of the most important groups of human resources for health in Europe – also and especially in primary health care. In this paper it is argued that to support and develop the practice of nurses in primary care, the World Health Organization initiative of Positive Practice Environments should be examined, implemented and the outcomes of such an innovation subjected to rigorous research. Having reflected on the central place of primary health care in all health systems, the evidence concerning the position of nursing in primary health care is considered and innovative models of community based nursing examined. A tool, the 'roadmap', which may be used to examine the current position of nurses in primary health care is outlined and the context within which the 'roadmap' sits, Positive Practice Environments, is then considered in detail. The paper concludes with recommendations for changes in the organisation of primary health care nursing, drawing on the available evidence, and urging the need for implementation and research into Positive Practice Environments to strengthen primary health care and the value of primary health care nursing to be fully realised. The tool could be also helpful to develop primary health care nursing in Germany where, traditionally, primary health care has been fragmented and based on a single disease model.

Financial Incentives and Physician Practice Participation in Medicare's Value-Based Reforms

MARKOVITZ A. A., *et al.*

2017

Health Serv Res (Ahead of print).

The aim of this study is to evaluate whether greater experience and success with performance incentives among physician practices are related to increased participation in Medicare's voluntary value-based payment reforms. Publicly available data from Medicare's Physician Compare (n = 1,278; January 2012 to November 2013) and nationally representative physician practice data from the National Survey of Physician Organizations 3 (NSPO3; n = 907,538; 2013). We linked physician participation data from Medicare's Physician Compare to the NSPO3 survey. Physicians organizations' prior experience and success with performance incentives were related to participation in Medicare ACO arrangements and participation in the meaningful use criteria but not to participation in Physician Compare. We conclude that Medicare must complement financial incentives with additional efforts to address the needs of practices with less experience with such incentives to promote value-based payment on a broader scale.

Patient-Perceived Responsiveness of Primary Care Systems Across Europe and the Relationship with the Health Expenditure and Remuneration Systems of Primary Care Doctors

MURANTE A. M., *et al.*

2017

Soc Sci Med 186: 139-147.

Health systems are expected to be responsive, that is to provide services that are user-oriented and respectful of people. Several surveys have tried to measure all or some of the dimensions of the responsiveness (e.g. autonomy, choice, clarity of communication, confidentiality, dignity, prompt attention, quality of basic amenities, and access to family and community support), however there is little evidence regarding the level of responsiveness of primary care (PC) systems. This work analyses the capacity of primary care systems to be responsive. Data collected from 32 PC systems were used to investigate whether a relationship exists between the responsiveness of PC systems and the PC doctor remuneration systems and domestic health expenditure. We conclude that quality, as measured from the patient's perspective, does not necessarily overlap with PC performance based on structure and process indicators. The results could also stimulate a new debate on the role of economic resources and PC workforce payment mechanisms in the achievement of quality goals, in this case related to the capacity of PC systems to be responsive.

Exploring Context and the Factors Shaping Team-Based Primary Healthcare Policies in Three Canadian Provinces: A Comparative Analysis

MISFELDT R., *et al.*

2017

Healthcare Policy 13(1): 74-93.

This paper discusses findings from a high-level scan of the contextual factors and actors that influenced policies on team-based primary healthcare in three Canadian provinces: British Columbia, Alberta and Saskatchewan. The team searched diverse sources (e.g., news reports, press releases, discussion papers) for contextual information relevant to primary healthcare teams. We also conducted qualitative interviews with key health system informants from the three provinces. Data from documents and interviews were analyzed qualitatively using thematic analysis. We observed physician-centric policy processes with some recent moves to rebalance power and be inclusive of other actors and perspectives. The context review also highlighted the significant influence of changes in political leadership and prioritization in driving policies on team-based care. While this existed in different degrees in the three provinces, the push and pull of political and professional power dynamics shaped Canadian provincial policies governing team-based care. If we are to move team-based primary healthcare forward in Canada, the provinces need to review the external factors and the complex set of relationships and trade-offs that underscore the policy process.

Contrasting Approaches to Primary Care Performance Governance in Denmark and New Zealand

TENBENSEL T. ET BURAU V.

2017

Health Policy 121(8): 853-861.

In high-income countries, the arena of primary health care is becoming increasingly subject to 'performance governance' - the harnessing of performance information to the broader task of governance. Primary care presents many governance challenges because it is predominantly provided by sole practitioners or small organisations. In this article, we compare Denmark and New Zealand, two small countries with tax-funded health systems which have adopted quite different instruments for performance governance in primary care. We conclude that New Zealand's approach has relied heavily on 'extrinsic' incentives, whereas Denmark exhibits the opposite problem of overreliance on intrinsic motivation to improve quality, without 'extrinsic' instruments to address other important goals such as population health and equity. Our comparative framework has the potential to be applied across a wider range of countries.

Do Patient-Centered Medical Homes Improve Health Behaviors, Outcomes, and Experiences of Low-Income Patients? A Systematic Review and Meta-Analysis

VAN DEN BERK-CLARK, C., *et al.*

2017

Health Serv Res (Ahead of print).

The aim of this study is to examine: (1) what elements of patient-centered medical homes (PCMHs) are typically provided to low-income populations, (2) whether PCMHs improve health behaviors, experiences, and outcomes for low-income groups. Existing literature on PCMH utilization among health care organizations serving low-income populations. We obtained papers through existing systematic and literature reviews and via PubMed, Web of Science, and the TRIP databases, which examined PCMHs serving low-income populations. Evidence shows that the PCMH model can increase health outcomes among low-income populations. However, limitations to quality include no assessment for confounding variables. Implications are discussed.

Focused Multidisciplinary Team (MDT) Based Board Rounds Can Significantly Reduce Length of Stays (LOS) and Increase Ward Productivity

WARD K. ET FAROOQ H.

2017/07

Age & Ageing 46(Suppl. 2): ii1–ii6.

Ward 26, Blackpool Victoria Hospital, is a female Care of the Older Person (CoOP) ward. Data collected on current length of stay suggested that there was a problem with performance on the ward. To address the perceived problem it was agreed that the ward team would look at how they could improve the internal processes and improve care for the patients. Four teams of consultants had patients on the ward (as well as patients on a second ward), leading to multiple, overlapping ward rounds. There was a brief board round each day involving the nurses, therapists and discharge team. The board round function was primarily to agree when referrals should be done, rather than goal setting.

Systèmes de santé

Improving Care Transitions Management: Examining the Role of Accountable Care Organization Participation and Expanded Electronic Health Record Functionality

HUBER T. P., *et al.*

2017

Health Serv Res 52(4): 1494-1510.

The aim of this study is to examine the extent to which physician organization participation in an accountable care organization (ACO) and electronic health record (EHR) functionality are associated with greater adoption of care transition management (CTM) processes. We used data from the third National Study of Physician Organization survey (NSPO3) to assess medical practice characteristics, including CTM processes, ACO participation, EHR functionality, practice type, organization size, ownership, public reporting, and pay-for-performance participation. We conclude that the growth of ACOs and similar provider risk-bearing arrangements across the country may improve the management of care transitions by physician organizations.

Decentralization of Health Care Systems and Health Outcomes: Evidence from a Natural Experiment

JIMENEZ-RUBIO D. A-GOMEZ P.

2017

Soc Sci Med 188: 69-81.

While many countries worldwide are shifting responsibilities for their health systems to local levels of government, there is to date insufficient evidence about the potential impact of these policy reforms. We estimate the impact of decentralization of the health services on infant and neonatal mortality using a natural experiment: the devolution of health care decision making powers to Spanish regions. The devolution was implemented gradually and asymmetrically over a twenty-year period (1981-2002). The order in

which the regions were decentralized was driven by political factors and hence can be considered exogenous to health outcomes. In addition, we exploit the dynamic effect of decentralization of health services and allow for heterogeneous effects by the two main types of decentralization implemented across regions: full decentralization (political and fiscal powers) versus political decentralization only. Our difference in differences results based on a panel dataset for the 50 Spanish provinces over the period 1980 to 2010 show that the lasting benefit of decentralization accrues only to regions which enjoy almost full fiscal and political powers and which are also among the richest regions.

The SELFIE Framework for Integrated Care for Multi-Morbidity: Development and Description

LEIJTEN F. R. M., *et al.*

2017

Health Policy(Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.06.002

A framework for integrated care for multi-morbidity is presented. A holistic understanding of the individual is at the core of the framework. Concepts are structured according to the six WHO key components of health systems. The framework can be used by different stakeholders in different contexts. The framework can guide the description and evaluation of integrated care for multi-morbidity.

Health System Responsiveness and Chronic Disease Care - What Is the Role of Disease Management Programs? An Analysis Based on Cross-Sectional Survey and Administrative Claims Data

ROTTGER J., *et al.*

2017

Soc Sci Med 185: 54-62.

Health system responsiveness is an important aspect of health systems performance. The concept of responsiveness relates to the interpersonal and contextual aspects of health care. While disease management programs (DMPs) aim to improve the quality of health care (e.g. by improving the coordination of care), it has not been analyzed yet whether these programs improve the perceived health system responsiveness. Our study aims to close this gap by analyzing the differences in the perceived health system responsiveness between DMP-participants and non-participants. We used linked survey- and administrative claims data from 7037 patients with coronary heart disease in Germany. Of those, 5082 were enrolled and 1955 were not enrolled in the DMP. Responsiveness was assessed with an adapted version of the WHO responsiveness questionnaire in a postal survey in 2013. The results of our study indicate an overall high responsiveness for CHD-care, as well for DMP-participants as for non-participants. Yet, the results also clearly indicate that there is still a need to improve the coordination of care.

Patient-Centred Care in Canada: Key Components and the Path Forward

MONTAGUE T., *et al.*

2017

Healthcare Quarterly 20(1): 50-56.

Canadians' health and its care continue to evolve. Chronic diseases affect more than 50% of our aging population, but the majority of public and professional stakeholders retain a sense of care quality. An emergent issue, however, is generating an increasingly wide debate. It is the concept of patient-centred care, including its definition of key components, and efficacy. To advance the evidence base, the 2013-2014 and 2016 Health Care in Canada (HCIC) surveys measured pan-stakeholder levels of support and implementation priorities for frequently proposed components of patient centricity in healthcare. The public's highest rated component was timely access to care, followed by perceived respect and caring in its delivery, with decisions made in partnership among patients and professional providers, and within a basic belief that care should be based on patients' needs versus their ability to pay. Health professionals' levels of support for key components largely overlapped the public's levels of support for key components, with an additional accent on care influenced by an evidence base and expert opinion. In terms of priority to actually implement enhanced patient-centred care options, timely access was universally dominant among all stakeholders.

An Exploration of Person-Centred Concepts in Human Services: A Thematic Analysis of the Literature

WATERS R. A. ET BUCHANAN A.

2017

Health Policy (Ahead of print).

Being 'person-centred' in the delivery of health and human services has become synonymous with quality care, and it is a core feature of policy reform in Australia and other Western countries. This research aimed to identify the uses, definitions and characteristics of the term 'person-centred' in the ageing, mental health and disability literature. A thematic analysis identified seven common core themes of person-centredness: honouring the person, being in relationship, facilitating participation and engagement, social inclusion/citizenship, experiencing compassionate love, being strengths/capacity focussed, and organisational characteristics. These suggest a set of higher-order experiences for people that are translated differently in different human services. There is no common definition of what it means to be person-centred, despite being a core feature of contemporary health and human service policy, and this suggests that its inclusion facilitates further misunderstanding and misinterpretation. A common understanding and policy conceptualisation of person-centredness is likely to support quality outcomes in service delivery especially where organisations work across human service groups. Further research into the application and service expressions of being 'person-centred' in context is necessary.

Networks in ACA Marketplaces Are Narrower for Mental Health Care Than for Primary Care

ZHU J. M., *et al.*

2017

Health Aff (Millwood) 36(9): 1624-1631.

There is increasing concern about the extent to which narrow-network plans, generally defined as those including fewer than 25 percent of providers in a given health insurance market, affect consumers' choice of and access to specialty providers-particularly in mental health care. Using data for 2016 from 531 unique provider networks in the Affordable Care Act Marketplaces, we evaluated how network size and the percentage of providers who participate in any network differ between mental health care providers and a control group of primary care providers. Compared to primary care networks, participation in mental health networks was low, with only 42.7 percent of psychiatrists and 19.3 percent of nonphysician mental health care providers participating in any network. On average, plan networks included 24.3 percent of all primary care providers and 11.3 percent of all mental health care providers practicing in a given state-level market. These findings raise important questions about provider-side barriers to meeting the goal of mental health parity regulations: that insurers cover mental health services on a par with general medical and surgical services. Concerted efforts to increase network participation by mental health care providers, along with greater regulatory attention to network size and composition, could improve consumer choice and complement efforts to achieve mental health parity.

Travail et santé

Long-Term Health Consequences of Recessions During Working Years

ANTONOVA L., *et al.*

2017

Soc Sci Med 187: 134-143.

Economic crises may have severe consequences for population health. We investigate the long-term effects of macroeconomic crises experienced during prime working age (20-50) on health outcomes later in life using SHARE data (Survey of Health Aging and Retirement in Europe) from eleven European countries. Analyses are based on the first two waves of SHARE data collected in 2004 and 2006 (N = 22,886) and retrospective life history data from SHARELIFE collected in 2008 (N = 13,732). Experiencing a severe crisis in which GDP dropped by at least 1% significantly reduces health later in life. Specifically, respondents hit by such a shock rate their subjective health as worse, are more likely to suffer from chronic diseases and mobility limitations, and have lower grip strength. The effects are twice as large among low-educated respondents. A

deeper analysis of critical periods in life reveals that respondents' health is more affected by crises experienced later in the career (between age 41 and 50). The labor market patterns show that these people drop out of the labor force. While men retire early, women are more likely to become home makers. In line with the literature on the negative consequences of retirement on health, this suggests that early retirement in times of economic crises might be detrimental to health.

The Effectiveness of Medical and Vocational Interventions for Reducing Sick Leave of Self-Employed Workers

BAERT S., *et al.*

2017

Health Econ (Ahead of print).

We investigate whether interventions by (a) medical doctors and (b) occupational specialists are effective in reducing sick leave durations among self-employed workers. Therefore, we exploit unique administrative data comprising all sick leave claims by self-employed workers insured with a major Dutch private insurer between January 2009 and March 2014. We estimate a multivariate duration model dealing with nonrandom selection into the two intervention types by controlling for observable and unobservable claimant characteristics. We find adverse treatment effects for both interventions, irrespective of whether they are started early or (middle) late in the sickness spell.

Employment Insecurity and Employees' Health in Denmark

COTTINI E. ET GHINETTI P.

2017

Health Econ. (Ahead of print).

We use register data for Denmark (IDA) merged with the Danish Work Environment Cohort Survey (1995, 2000, and 2005) to estimate the effect of perceived employment insecurity on perceived health for a sample of Danish employees. We consider two health measures from the SF-36 Health Survey Instrument: a vitality scale for general well-being and a mental health scale. We first analyse a summary measure of employment insecurity. Instrumental variables-fixed effects estimates that use firm workforce changes as a source of exogenous variation show that 1 additional dimension of insecurity causes a shift from the median to the 25th percentile in the mental health scale and to the 30th in that of energy/vitality. It also increases by about 6 percentage points the probability to develop severe mental health problems. Looking at single insecurity dimensions by naive fixed effects, uncertainty associated with the current job is important for mental health. Employability has a sizeable relationship with health and is the only insecurity dimension that matters for the energy and vitality scale. Danish employees who fear involuntary firm internal mobility experience worse mental health.

Vieillissement

Does Increased Medication Use Among Seniors Increase Risk of Hospitalization and Emergency Department Visits

ALLIN S., *et al.*

2017

Health Serv Res 52(4): 1550-1569.

The aim of this study is to examine the extent of the health risks of consuming multiple medications among the older population. The sources are the secondary data from the period 2004-2006. The study setting was the province of Ontario, Canada, and the sample consisted of individuals aged 65 years or older who responded to a national health survey. We estimated a system of equations for inpatient and emergency department (ED) services to test the marginal effect of medication use on hospital services. We controlled for endogeneity in medication use with a two-stage residual inclusion approach appropriate for nonlinear models. We conclude that multiple medications appear to increase the risk of hospitalization among seniors covered by a universal prescription drug plan. These results raise questions about the appropriateness of medication use and the need for increased oversight of current prescribing practices.

The Impact of the 2008 Recession on the Health of Older Workers: Data from 13 European Countries

AXELRAD H. ET SABBATH E. L.

2017

European Journal of Public Health 27(4): 647-652.

Fluctuations in the national economy shape labour market opportunities and outcomes, which in turn influence the health conditions of older workers. This study examined whether overall economic shifts during the 2008 recession was associated with four health indicators among older workers. Data came from 4917 respondents (16 090 contacts) aged 50–70 in 13 European countries (Austria, Belgium, Czech Republic, Denmark, France, Germany, Israel, Italy, Netherlands, Poland, Spain, Sweden, Switzerland) participating in the Survey of Health, Ageing and Retirement in Europe. Health and employment assessments from 2004–13 were linked to annual data on fluctuations in Gross Domestic Product (GDP) per capita, life expectancy and unemployment rates for each country. Overall economic shifts during recessions affect certain health outcomes of older workers, and better health conditions together with being employed or retired may limit the negative health consequences of a recession.

Le RAI-Home Care : utilisation, potentiels et limites dans les soins à domicile

BUSNEL C., *et al.*

2017

Gérontologie et société 39153(2): 182.

http://www.cairn.info/revue-gerontologie-et-societe-2017-2-page-167.htm

Le vieillissement démographique observé dans les pays industrialisés amène les acteurs de la santé à revoir et adapter les modèles de soins en agissant en amont des situations de dépendance des personnes âgées. Cet article discute des potentiels et des limites du « Resident Assessment Instrument – Home Care » (RAI-HC), un instrument utilisé en routine clinique par les infirmières des soins à domicile. Le RAI-HC permet d'évaluer l'état de santé global des bénéficiaires et d'établir des objectifs individualisés de prise en charge. La qualité et la nature des informations ainsi collectées sont suffisamment riches pour permettre le développement d'indicateurs et de scores reflétant des concepts utilisés dans le domaine de la gérontologie (fragilité, comorbidités, complexité). Néanmoins, pour répondre pleinement aux enjeux de prévention de la dépendance, l'utilisation du RAI-HC nécessite d'être complétée par le recours à des instruments cliniques spécifiques aux domaines de santé évalués et accompagnée de formations adaptées. Ce point est illustré par deux situations domiciliaires : le repérage de la dénutrition et celui des troubles cognitifs.

Gaining Weight Through Retirement? Results from the SHARE Survey

GODARD M.

2016

Journal of Health Economics 45(Supplement C): 27-46.

http://www.sciencedirect.com/science/article/pii/S0167629615001228

This paper estimates the causal impact of retirement on the Body Mass Index (BMI) of adults aged 50–69 years old, on the probability of being either overweight or obese and on the probability of being obese. Based on the 2004, 2006 and 2010–2011 waves of the Survey of Health, Ageing and Retirement in Europe (SHARE), our identification strategy exploits variation in European Early Retirement Ages (ERAs) and stepwise increases in ERAs in Austria and Italy between 2004 and 2011 to examine an exogenous shock to retirement behavior. Our results show that retirement induced by discontinuous incentives in early retirement schemes causes a 12-percentage point increase in the probability of being obese among men within a two- to four-year period. We find that the impact of retirement is highly non-linear and mostly affects the right-hand side of the male BMI distribution. Additional results show that this pattern is driven by men retiring from strenuous jobs and by those who were already at risk of obesity. In contrast, no significant results are found among women.

Predicting Discharge to Institutional Long-Term Care Following Acute Hospitalisation: A Systematic Review and Meta-Analysis

HARRISON J. K., *et al.*

2017

Age Ageing 46(4) : 547-558.

Moving into long-term institutional care is a significant life event for any individual. Predictors of institutional care admission from community-dwellers and people with dementia have been described, but those from the acute hospital setting have not been systematically reviewed. Our aim was to establish predictive factors for discharge to institutional care following acute hospitalisation. We searched MEDLINE; EMBASE and CINAHL Plus in September 2015. We included observational studies of patients admitted directly to long-term institutional care following acute hospitalisation where factors associated with institutionalisation were reported. We conclude that discharge to long-term institutional care following acute hospitalisation is common, but current data do not allow prediction of who will make this transition. Potentially important predictors evaluated in community cohorts have not been examined in hospitalised cohorts. Understanding these predictors could help identify individuals at risk early in their admission, and support them in this transition or potentially intervene to reduce their risk.

Frailty Status at Admission to Hospital Predicts Multiple Adverse Outcomes

HUBBARD R. E., *et al.*

2017

Age Ageing 46(5): 801-806.

Frailty is proposed as a summative measure of health status and marker of individual vulnerability. We aimed to investigate the discriminative capacity of a frailty index (FI) derived from interRAI Comprehensive Geriatric Assessment for Acute Care (AC) in relation to multiple adverse inpatient outcomes. In this prospective cohort study, an FI was derived for 1,418 patients ≤70 years across 11 hospitals in Australia. The interRAI-AC was administered at admission and discharge by trained nurses, who also screened patients daily for geriatric syndromes. We conclude the interRAI-AC can be used to derive a single score that predicts multiple adverse outcomes in older inpatients. A score of ≤ 0.40 can well discriminate patients who are unlikely to die or experience a geriatric syndrome. Whether the FI-AC can result in management decisions that improve outcomes requires further study.

Screening for Frailty in Primary Care: Accuracy of Gait Speed and Hand-Grip Strength

LEE L., *et al.*

2017

Canadian Family Physician 63(1): e51-e57.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5257239/

The aim of this study is to examine the accuracy of individual Fried frailty phenotype measures in identifying the Fried frailty phenotype in primary care. The retrospective chart review is a community-based primary care practice in Kitchener, Ont. Using modified Fried frailty phenotype measures, frailty criteria included gait speed, hand-grip strength as measured by a dynamometer, and self-reported exhaustion, low physical activity, and unintended weight loss. Sensitivity, specificity, accuracy, and precision were calculated for single-trait and dual-trait markers. We conclude that there is a need for frailty measures that are psychometrically sound and feasible to administer in primary care. While use of gait speed or grip strength alone was found to be sensitive and specific as a proxy for the Fried frailty phenotype, use of both measures together was found to be accurate, precise, specific, and more sensitive than other possible combinations. Assessing both measures is feasible within primary care.

Let's Put the Pieces Together: Frailty, Social Vulnerability, The Continuum of Care, Prevention and Research Are Key Considerations for a Dementia Care Strategy

MELISSA K. A.

2016

HealthcarePapers 16(2): 34-39.

Improving dementia care in Canada is a challenge to which we must rise. Dementia care strategies with a strong community focus are a key means of doing so. This paper outlines and expands upon the following five core areas that will contribute to the success of dementia care strategies: 1) the relationship between frailty and dementia is critical to understanding and

addressing dementia risk and management; 2) social circumstances are important to formally consider, both as risk factors for adverse outcomes and as practical factors that contribute to care and support planning; 3) a dementia care strategy must span the continuum of care, which has important ramifications for our systems of primary, acute and long-term care; 4) prevention and public education are essential components of dementia care strategies; 5) research and evaluation are critically important to any dementia care strategy, and must be seen as core components as we strive to learn what works in dementia care. Given that a coordinated effort is needed, Canada needs to join other countries that have recognized dementia as a momentous challenge to national and global health. The time for a comprehensive national dementia care strategy is now.

Inequity in Healthcare Use Among Older People After 2008: The Case of Southern European Countries

TAVARES L. P. ET ZANTOMIO F.

2017

Health Policy 121 (10) : 1063-1071

Despite the sizeable cuts in public healthcare spending, which were part of the austerity measures recently undertaken in Southern European countries, little attention has been devoted to monitoring its distributional consequences in terms of healthcare use. This study aims at measuring socioeconomic inequities in primary and secondary healthcare use experienced some time after the crisis onset in Italy, Spain and Portugal. The analysis, based on data drawn from the Survey of Health, Ageing and Retirement in Europe (SHARE), focuses on older people, who generally face significantly higher healthcare needs, and whose health appeared to have worsened in the aftermath of the crisis. The Horizontal Inequity indexes reveal remarkable socioeconomic inequities in older people's access to secondary healthcare in all three countries. In Portugal, the one country facing most severe healthcare budget cuts and where user charges apply also to GP visits, even access to primary care exhibits a significant pro-rich concentration. If reducing inequities in older people's access to healthcare remains a policy objective, austerity measures maybe pulling the Olive belt countries further away from achieving it.

Prognostic Indices for Older Adults During the Year Following Hospitalization in an Acute Medical Ward: An Update

THOMAZEAU J., *et al.*

2017

Presse Med 46(4): 360-373.

As population grow older, chronic diseases are more prevalent. It leads to an increase of hospitalization for acute decompensation, sometimes iterative. Management of these patients is not always clear, and care provided is not always proportional to life expectancy. Making decisions in acute situations is not easy. This review aims to list and describe mortality scores within a year following hospitalization of patients of 65 years or older. Following keywords were searched in title and abstract of articles via an advanced search in PudMed, and by searching Mesh terms: «aged», «aged, 80 and over», «mortality», «prognosis», «hospitalized», «models, statistical», «acute geriatric ward», «frailty», «outcome». Studies published in English between 1985 and 2015 were selected. Last article was published in June 2015. Articles that described prognostic factors of mortality without a scoring system were excluded. Articles that focus either on patients in the Emergency Department and in Intensive Care Unit, or living in institution were excluded. Twenty-two scores are described in 17 articles. These scores use items that refer to functional status, comorbidities, cognitive status and frailty. Scores of mortality 3 or 6 months after hospitalization are not discriminative. Few of the 1-year mortality prognostic score are discriminative with AUC≥ 0.7. This review is not systematic. Practical use of these scores might help management of these patients, in order to initiate appropriate reflexion and palliative care if necessary.

Integrated Care for Older Populations and Its Implementation Facilitators and Barriers: A Rapid Scoping Review

THREAPLETON D. E., *et al.*

2017

Int J Qual Health Care 29(3): 327-334.

Inform health system improvements by summarizing components of integrated care in older populations. Identify key implementation barriers and facilitators. A scoping review was undertaken for evidence from MEDLINE, the Cochrane Library, organizational websites and internet searches. Eligible publications

included reviews, reports, individual studies and policy documents published from 2005 to February 2017. Study selection: Initial eligible documents were reviews or reports concerning integrated care approaches in older/frail populations. Other documents were later sourced to identify and contextualize implementation issues. The thematic synthesis using 30 publications identified 8 important components for integrated care in elderly and frail populations. We conclude that improving integration in care requires many components. However, local barriers and facilitators need to be considered. Changes are expected to occur slowly and are more likely to be successful where elements of integrated care are well incorporated into local settings.

▶ Measuring Active and Healthy Ageing in Europe

ZAIDI A., *et al.*

2017

Journal of European Social Policy 27(2): 138-157.

http://journals.sagepub.com/doi/abs/10.1177/0958928716676550

The active and healthy ageing measure reported here is calculated for the 28 European Union countries, with a specific focus on the current generation of older people and by using the latest data from multiple surveys. It covers diverse aspects of active and healthy ageing, by measuring older people's contribution with respect to not just employment but also their unpaid familial, social and cultural contributions and their independent, healthy and secure living. The article presents the first-of-its-kind quantitative measure of active and healthy ageing in the literature on active and healthy ageing which hitherto has focused largely on concepts, definitions and public policy strategies.

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November 2017

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117bis rue Manin - 75019 Paris • Tél. : 01 53 93 43 00 • www.irdes.fr

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Growing Insurance Coverage Did Not Reduce Access to Care for the Continuously Insured

ABDUS S. ET HILL S. C.

2017

Health Aff (Millwood) 36(5): 791-798.

Recent expansions in health insurance coverage have raised concerns about health care providers' capacity to supply additional services and how that may have affected access to care for people who were already insured. When we examined data for the period 2008-14 from the Medical Expenditure Panel Survey, we found no consistent evidence that increases in the proportions of adults with insurance at the local-area level affected access to care for adults residing in the same areas who already had, and continued to have, insurance. This lack of an apparent relationship held true across eight measures of access, which included receipt of preventive care. It also held true among two adult subpopulations that may have been at greater risk for compromised access: people residing in health care professional shortage areas and Medicaid beneficiaries.

Did the Affordable Care Act's Dependent Coverage Expansion Affect Race/Ethnic Disparities in Health Insurance Coverage

BRESLAU J., *et al.*

2017/06

Health Serv Res (Ahead of print).

The aim of the study is to test the impact of the dependent coverage expansion (DCE) on insurance disparities across race/ethnic groups. Survey data from the National Survey of Drug Use and Health (NSDUH). Triple-difference (DDD) models were applied to repeated cross-sectional surveys of the U.S. adult population. Data from 6 years (2008-2013) of the NSDUH were combined. Following the DCE, the relative odds of insurance increased 1.5 times (95 percent CI 1.1, 1.9) among whites compared to blacks and 1.4 times (95 percent CI 1.1, 1.8) among whites compared to Hispanics. Health reform efforts, such as the DCE, can have negative effects on race/ethnic disparities, despite positive impacts in the general population.

Reducing Young Adults' Health Care Spending Through the ACA Expansion of Dependent Coverage

CHEN J., *et al.*

2017

Health Serv Res 52(5): 1835-1857.

The aim of this paper is to estimate health care expenditure trends among young adults ages 19-25 before and after the 2010 implementation of the Affordable Care Act (ACA) provision that extended eligibility for dependent private health insurance coverage. Nationally representative Medical Expenditure Panel Survey data from 2008 to 2012 was used. We conducted repeated cross-sectional analyses and employed a difference-in-differences quantile regression model to estimate health care expenditure trends among young adults ages 19-25 (the treatment group) and ages 27-29 (the control group). Our results show that the treatment group had 14 percent lower overall health care expenditures and 21 percent lower out-of-pocket payments compared with the control group in 2011-2012. The overall reduction in health care expenditures among young adults ages 19-25 in years 2011-2012 was more significant at the higher end of the health care expenditure distribution. Differences in the trends of costs of private health insurance and doctor visits are not statistically significant. Increased health insurance enrollment as a consequence of the ACA provision for dependent coverage has successfully reduced spending and catastrophic expenditures, providing financial protections for young adults.

HUD Housing Assistance Associated with Lower Uninsurance Rates and Unmet Medical Need

SIMON A. E., *et al.*

2017

Health Aff (Millwood) 36(6): 1016-1023.

To investigate whether receiving US Department of Housing and Urban Development (HUD) housing assistance is associated with improved access to health care, we analyzed data on nondisabled adults aged 18-64 who responded to the 2004-12 National Health Interview Survey that were linked with administrative data from HUD for the period 2002-14. To account

for potential selection bias, we compared access to care between respondents who were receiving HUD housing assistance at the time of the survey interview (current recipients) and those who received HUD assistance within twenty-four months of completing the survey interview (future recipients). Receiving assistance was associated with lower uninsurance rates: 31.8 percent of current recipients were uninsured, compared to 37.2 percent of future recipients. Rates of unmet need for health care due to cost were similarly lower for current recipients than for future recipients. No effect of receiving assistance was observed on having a usual source of care. These findings provide evidence that supports the effectiveness of housing assistance in improving health care access.

Health Insurance Coverage and Health: What the Recent Evidence Tells Us

SOMMERS B. D., *et al.*

2017

New England Journal of Medicine 377(6): 586-593.

http://www.nejm.org/doi/full/10.1056/NEJMsb1706645

The national debate over the Affordable Care Act (ACA) has involved substantial discussion about what effects — if any — insurance coverage has on health and mortality. The prospect that the law's replacement might lead to millions of Americans losing coverage has brought this empirical question into sharp focus. For instance, politicians have recently argued that the number of people with health insurance is not a useful policy metric and that no one dies from a lack of access to health care. However, assessing the impact of insurance coverage on health is complex: health effects may take a long time to appear, can vary according to insurance benefit design, and are often clouded by confounding factors, since insurance changes usually correlate with other circumstances that also affect health care use and outcomes.

Making Fair Choices on the Path to Universal Health Coverage: Applying Principles to Difficult Cases

VOORHOEVE, A. *et al,*

2017/06

Health Systems & Reform 3(4): 1-12.

http://equity.bvsalud.org/2017/09/03/making-fair-choices-on-the-path-to-universal-health-coverage-applying-principles-to-difficult-cases/

Progress toward universal health coverage (UHC) requires making difficult trade-offs. In this journal, Dr. Margaret Chan, the World Health Organization (WHO) Director-General, has endorsed the principles for making such decisions put forward by the WHO Consultative Group on Equity and UHC. These principles include maximizing population health, priority for the worse off, and shielding people from health-related financial risks. But how should one apply these principles in particular cases, and how should one adjudicate between them when their demands conflict? This article by some members of the Consultative Group and a diverse group of health policy professionals addresses these questions. It considers three stylized versions of actual policy dilemmas. Each of these cases pertains to one of the three key dimensions of progress toward UHC: which services to cover first, which populations to prioritize for coverage, and how to move from out-of-pocket expenditures to prepayment with pooling of funds. Our cases are simplified to highlight common trade-offs. Though we make specific recommendations, our primary aim is to demonstrate both the form and substance of the reasoning involved in striking a fair balance between competing interests on the road to UHC.

Supplementary Insurance as a Switching Cost for Basic Health Insurance: Empirical Results from the Netherlands

WILLEMSE-DUIJMELINCK D., *et al.*

2017/08

Health Policy (Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.08.003

Switching for basic health insurance can be hindered by supplementary insurance. Supplementary insurance is only a switching cost if insurers apply selective underwriting. In the Netherlands, most insurers do not apply selective underwriting for supplementary insurance. Nevertheless, many high-risks perceive supplementary insurance as a switching cost. Providing information to high-risks about their switching opportunities could increase consumer choice.

E-health – Medical Technologies

Rapid Growth in Mental Health Telemedicine Use Among Rural Medicare Beneficiaries, Wide Variation Across States

MEHROTRA A., *et al.*

2017

Health Aff (Millwood) 36(5): 909-917.

Congress and many state legislatures are considering expanding access to telemedicine. To inform this debate, we analyzed Medicare fee-for-service claims for the period 2004-14 to understand trends in and recent use of telemedicine for mental health care, also known as telemental health. The study population consisted of rural beneficiaries with a diagnosis of any mental illness or serious mental illness. The number of telemental health visits grew on average 45.1 percent annually, and by 2014 there were 5.3 and 11.8 telemental health visits per 100 rural beneficiaries with any mental illness or serious mental illness, respectively. There was notable variation across states: In 2014 nine had more than twenty-five visits per 100 beneficiaries with serious mental illness, while four states and the District of Columbia had none. Compared to other beneficiaries with mental illness, beneficiaries who received a telemental health visit were more likely to be younger than sixty-five, be eligible for Medicare because of disability, and live in a relatively poor community. States with a telemedicine parity law and a pro-telemental health regulatory environment had significantly higher rates of telemental health use than those that did not.

ehealth in Integrated Care Programs for People with Multimorbidity in Europe: Insights from the ICARE4EU Project

MELCHIORRE M. G., *et al.*

2017

Health Policy (Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.08.006

eHealth applications for multimorbidity are not widely implemented In Europe. In most cases Electronic Health Records (EHRs) are adopted. Adequate funding mechanisms, interoperability and technical support seem to be lacking. eHealth could support integrated care for people with multimorbidity. eHealth could help older people with multimorbidity living in the community.

Health Economics

The Impact of Health Expenditure on the Number of Chronic Diseases

BECCHETTI L., *et al.*

2017/07

Health Policy (Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.07.008

We investigate effects of health expenditure on health outcomes on individual data in 13 countries. Lagged health expenditure affects negatively changes in the number of chronic diseases. The effect varies according to age, health behavior, gender, income, and education. Findings are confirmed when instrumenting with parliament political composition.

What Determines the Health Care Expenditure of High Income Countries? A Dynamic Estimation

FENG Y., *et al.*

2017

Applied Economics and Finance 4(6): 16p.

https://doi.org/10.11114/aef.v4i6.2586

Constraining the rise in costs continues to be a major focus of health care policy in high income countries. It is important for governments to understand what is driving the rise in health care expenditure and what the impact will be over the coming years. This paper aims to provide an alternative econometric model to ascertain the determinants of health expenditure. Data from the OECD and IMS data bases for 18 OECD coun-

tries between 1988 and 2012 is collected. The analysis is at the year and country level. This study applies three methods: (1) panel data models with country fixed effects; (2) a first difference model; (3) a Vector Error Correction Model to account for the long run and short run effects as well as the endogeneity of the explanatory variables. The empirical results suggest that the use of different econometric specifications has a significant impact on both establishing the determinants of health expenditure and their magnitudes. Based on results from the Vector Error Correction Model, the GDP is considered as the only driver for country level health care expenditure growth. A 1% increase in the GDP is associated with a 1.1% increase in the health care expenditure.

Economic Impact of Lung Cancer Screening in France: A Modeling Study

GENDARME S., *et al.*

2017

Rev Mal Respir 34(7): 717-728.

The National Lung Screening Trial found that, in a selected population with a high risk of lung cancer, an annual low-dose CT-scan decreased lung cancer mortality by 20% and overall mortality by 7% compared to annual chest X-Ray. In France, a work group stated that individual screening should be considered in this setting. However, the economic impact of an organized and generalized (to all eligible individuals) screening in France was never reported. This is a modeling study using French population demographic data and published data from randomized screening trials. According to the considered model, there would be 1,650,588 to 2,283,993 subjects eligible to screening in France. According to the model and participation rate, lung cancer screening would diagnose 3600 to 10,118 stages 1/2 lung cancer each year. There would be 5991 to 16,839 false-positives, of whom 1416 to 3981 would undergo unnecessary surgery. Screening policy would cost 105 to 215 euro million per year. However, increasing the price of a cigarette pack by 0.05 to 0.10 euro would fully cover the screening costs. CONCLUSION: Participation rate is a key point for screening impact. Screening could be easily funded by a small increase in cigarette prices.

Time-Driven Activity-Based Costing in Health Care: A Systematic Review of the Literature

KEEL G., *et al.*

2017

Health Policy 121(7): 755-763.

Health care organizations around the world are investing heavily in value-based health care (VBHC), and time-driven activity-based costing (TDABC) has been suggested as the cost-component of VBHC capable of addressing costing challenges. The aim of this study is to explore why TDABC has been applied in health care, how its application reflects a seven-step method developed specifically for VBHC, and implications for the future use of TDABC. This is a systematic review following the PRISMA statement. Qualitative methods were employed to analyze data through content analyses. TDABC is applicable in health care and can help to efficiently cost processes, and thereby overcome a key challenge associated with current cost-accounting methods The method's ability to inform bundled payment reimbursement systems and to coordinate delivery across the care continuum remains to be demonstrated in the published literature, and the role of TDABC in this cost-accounting landscape is still developing.

Examining Drivers of Health Care Spending: Evidence on Self-Referral Among a Privately Insured Population

MITCHELL J. M., *et al.*

2017

Med Care 55(7): 684-692.

Despite the enactment of laws to restrict the practice of self-referral, exceptions in these prohibitions have enabled these arrangements to persist and proliferate. Most research documenting the effects of self-referral arrangements analyzed claims records from Medicare beneficiaries. Empirical evidence documenting the effects of self-referral on use of services and spending incurred by persons with private insurance is sparse. We analyzed health insurance claims records from a large private insurer in Texas to evaluate the effects of physician self-referral arrangements involving physical therapy on the treatment of patients with frozen shoulder syndrome, elbow tendinopathy or tendinitis, and patellofemoral pain syndrome. We used regression analysis to evaluate the effects of episode self-referral

status on: (1) initiation of physical therapy; (2) physical therapy visits and services for those who had at least 1 visit; and (3) total condition-related insurer allowed amounts per episode. Physician owners of physical therapy services refer significantly higher percentages of patients to physical therapy and many are equivocal cases.

▶ High-Price and Low-Price Physician Practices Do Not Differ Significantly on Care Quality or Efficiency

ROBERTS E. T., *et al.*

2017

Health Aff (Millwood) 36(5): 855-864.

Consolidation of physician practices has intensified concerns that providers with greater market power may be able to charge higher prices without having to deliver better care, compared to providers with less market power. Providers have argued that higher prices cover the costs of delivering higher-quality care. We examined the relationship between physician practice prices for outpatient services and practices' quality and efficiency of care. Using commercial claims data, we classified practices as being high- or low-price. We used national data from the Consumer Assessment of Healthcare Providers and Systems survey and linked claims for Medicare beneficiaries to compare high- and low-price practices in the same geographic area in terms of care quality, utilization, and spending. Compared with low-price practices, high-price practices were much larger and received 36 percent higher prices. Patients of high-price practices reported significantly higher scores on some measures of care coordination and management but did not differ meaningfully in their overall care ratings, other domains of patient experiences (including physician ratings and access to care), receipt of preventive services, acute care use, or total Medicare spending.

Health Status

▶ Global, Regional, and National Incidence, Prevalence, and Years Lived with Disability for 328 Diseases and Injuries for 195 Countries, 1990-2016: A Systematic Analysis for the Global Burden of Disease Study 2016

VOS T., *et al.*

2017

Lancet 390(10100): 1211-1259.

As mortality rates decline, life expectancy increases, and populations age, non-fatal outcomes of diseases and injuries are becoming a larger component of the global burden of disease. The Global Burden of Diseases, Injuries, and Risk Factors Study 2016 (GBD 2016) provides a comprehensive assessment of prevalence, incidence, and years lived with disability (YLDs) for 328 causes in 195 countries and territories from 1990 to 2016. This study estimates prevalence and incidence for 328 diseases and injuries and 2982 sequelae, their non-fatal consequences.

▶ Health Effects of Overweight and Obesity in 195 Countries over 25 Years

AFSHIN A., *et al.*

2017

N Engl J Med 377(1): 13-27.

Although the rising pandemic of obesity has received major attention in many countries, the effects of this attention on trends and the disease burden of obesity remain uncertain. We analyzed data from 68.5 million persons to assess the trends in the prevalence of overweight and obesity among children and adults between 1980 and 2015. Using the Global Burden of Disease study data and methods, we also quantified the burden of disease related to high body-mass index (BMI), according to age, sex, cause, and BMI in 195 countries between 1990 and 2015. The rapid increase in the prevalence and disease burden of elevated BMI highlights the need for continued focus on surveillance of BMI and identification, implementation, and evaluation of evidence-based interventions to address this problem.

Obesity-Related Mortality in France, Italy, and the United States: A Comparison Using Multiple Cause-Of-Death Analysis

BARBIERI M., *et al.*

2017

International Journal of Public Health 62(6): 623-629.
https://doi.org/10.1007/s00038-017-0978-1

We investigate the reporting of obesity on death certificates in three countries (France, Italy, and the United States) with different levels of prevalence, and we examine which causes are frequently associated with obesity.

Changes in Alcohol Consumption in the 50- to 64-Year-Old European Economically Active Population During an Economic Crisis

BOSQUE-PROUS M., *et al.*

2017/05

Eur J Public Health (Ahead of print).

The aim was to compare alcohol drinking patterns in economically active people aged 50-64 years before the last economic crisis (2006) and during the crisis (2013). Cross-sectional study with data from 25 479 economically active people aged 50-64 years resident in 11 European countries who participated in wave 2 or wave 5 of the SHARE project (2006 and 2013). The outcome variables were hazardous drinking, abstention in previous 3 months and the weekly average number of drinks per drinker. The prevalence ratios of hazardous drinking and abstention, comparing the prevalence in 2013 vs. 2006, were estimated with Poisson regression models with robust variance, and the changes in the number of drinks per week with Poisson regression models. The prevalence of hazardous drinking decreased among both men (PR = 0.75; 95%CI = 0.63-0.92) and women (PR = 0.91; 95%CI = 0.72-1.15), although the latter decrease was smaller and not statistically significant. The proportion of abstainers increased among both men (PR = 1.11; 95%CI = 0.99-1.29) and women (PR = 1.18; 95%CI = 1.07-1.30), although the former increase was smaller and not statistically significant. The weekly average number of drinks per drinker decreased in men and women. The decreases in consumption were larger in Italy and Spain. From 2006 to 2013, the amount of alcohol consumed by late working age drinkers decreased in Europe, with more pronounced declines in the countries hardest hit by the economic crisis.

Stroke in Women - from Evidence to Inequalities

CORDONNIER C., *et al.*

2017

Nat Rev Neurol 13(9): 521-532.
http://dx.doi.org/10.1038/nrneurol.2017.95

Stroke is the second largest cause of disability-adjusted life-years lost worldwide. The prevalence of stroke in women is predicted to rise rapidly, owing to the increasing average age of the global female population. Vascular risk factors differ between women and men in terms of prevalence, and evidence increasingly supports the clinical importance of sex differences in stroke. The influence of some risk factors for stroke - including diabetes mellitus and atrial fibrillation - are stronger in women, and hypertensive disorders of pregnancy also affect the risk of stroke decades after pregnancy. However, in an era of evidence-based medicine, women are notably under-represented in clinical trials - despite governmental actions highlighting the need to include both men and women in clinical trials - resulting in a reduced generalizability of study results to women. The aim of this Review is to highlight new insights into specificities of stroke in women, to plan future research priorities, and to influence public health policies to decrease the worldwide burden of stroke in women.

Trends in International Asthma Mortality: Analysis of Data from the WHO Mortality Database from 46 Countries (1993-2012)

EBMEIER S., *et al.*

2017

The Lancet 390(10098): 935-945.
http://dx.doi.org/10.1016/S0140-6736(17)31448-4

International time trends in asthma mortality have been strongly affected by changes in management and in particular drug treatments. However, little is known about how asthma mortality has changed over the past decade. In this study, we assessed these international trends.

Global, Regional, and National Deaths, Prevalence, Disability-Adjusted Life Years, and Years Lived with Disability for Chronic Obstructive Pulmonary Disease and Asthma, 1990-2013 : A Systematic Analysis for the Global Burden of Disease Study 2015

SORIANO J. B., *et al.*

2017

The Lancet Respiratory Medicine 5(9): 691-706.
http://dx.doi.org/10.1016/S2213-2600(17)30293-X

Chronic obstructive pulmonary disease (COPD) and asthma are common diseases with a heterogeneous distribution worldwide. Here, we present methods and disease and risk estimates for COPD and asthma from the Global Burden of Diseases, Injuries, and Risk Factors (GBD) 2015 study. The GBD study provides annual updates on estimates of deaths, prevalence, and disability-adjusted life years (DALYs), a summary measure of fatal and non-fatal disease outcomes, for over 300 diseases and injuries, for 188 countries from 1990 to the most recent year.

Did the Great Recession Affect Mortality Rates in the Metropolitan United States? Effects on Mortality by Age, Gender and Cause of Death

STRUMPF E. C., *et al.*

2017

Soc Sci Med 189: 11-16.

Mortality rates generally decline during economic recessions in high-income countries, however gaps remain in our understanding of the underlying mechanisms. This study estimates the impacts of increases in unemployment rates on both all-cause and cause-specific mortality across U.S. metropolitan regions during the Great Recession. We estimate the effects of economic conditions during the recent and severe recessionary period on mortality, including differences by age and gender subgroups, using fixed effects regression models. We identify a plausibly causal effect by isolating the impacts of within-metropolitan area changes in unemployment rates and controlling for common temporal trends. We aggregated vital statistics, population, and unemployment data at the area-month-year-age-gender-race level, yielding 527,040 observations across 366 metropolitan areas, 2005-2010. Our finding that all-cause mortality decreased during the Great Recession is consistent with previous studies. Some categories of cause-specific mortality, notably cardiovascular disease, also follow this pattern, and are more pronounced for certain gender and age groups. Our study also suggests that the recent recession contributed to the growth in deaths from overdoses of prescription drugs in working-age adults in metropolitan areas. Additional research investigating the mechanisms underlying the health consequences of macroeconomic conditions is warranted.

Gender and the Structure of Self-Rated Health Across the Adult Life Span

ZAJACOVA A., *et al.*

2017

Soc Sci Med 187: 58-66.

Despite the widespread use of self-rated health (SRH) in population health studies, the meaning of this holistic health judgment remains an open question. Gender differences in health, an issue of utmost importance in population research and policy, are often measured with SRH; the comparisons could be biased if men and women differ in how they form their health judgment. The aim of this study is to examine whether men and women differ in how health inputs predict their health rating across the adult life span. We use the 2002-2015 National Health Interview Survey data from US-born respondents aged 25-84. Our findings suggest that the meaning of SRH is similar for women and men. Both groups use a broad range of health-related information in forming their health judgment. This conclusion strengthens the validity of SRH in measuring gender differences in health.

Geography of Health

Comparing Multilevel and Multiscale Convolution Models for Small Area Aggregated Health Data

AREGAY M., *et al.*

2017

Spat Spatiotemporal Epidemiol 22: 39-49.

In spatial epidemiology, data are often arrayed hierarchically. The classification of individuals into smaller units, which in turn are grouped into larger units, can induce contextual effects. On the other hand, a scaling effect can occur due to the aggregation of data from smaller units into larger units. In this paper, we propose a shared multilevel model to address the contextual effects. In addition, we consider a shared multiscale model to adjust for both scale and contextual effects simultaneously. We also study convolution and independent multiscale models, which are special cases of shared multilevel and shared multiscale models, respectively. We compare the performance of the models by applying them to real and simulated data sets. We found that the shared multiscale model was the best model across a range of simulated and real scenarios as measured by the deviance information criterion (DIC) and the Watanabe Akaike information criterion (WAIC).

Spatial Accessibility of Primary Care in England: A Cross-Sectional Study Using a Floating Catchment Area Method

BAUER J., *et al.*

2017

Health Serv Res (Ahead of print).

The aim of this study is to analyze the general practitioners (GPs) with regard to the degree of urbanization, social deprivation, general health, and disability. The analysis is founded on small area population data and GP practice data in England. We used a floating catchment area method to measure spatial GP accessibility with regard to the degree of urbanization, social deprivation, general health, and disability. Data were collected from the Office for National Statistics and the general practice census and analyzed using a geographic information system. This study showed substantially differing GP accessibility throughout England. However, socially deprived areas did not have poorer spatial access to GPs.

GP Shortage Is a Mismatch Problem

BEERSTECHER H. J.

2017

BMJ 358.

http://www.bmj.com/content/bmj/358/bmj.j4078.full.pdf

A. Majeed makes many valid points about the shortage of general practitioners in the NHS. But a shortage points to a mismatch between supply and demand. Many actions to increase the supply of services have been taken.

Disability

Pay Less, Consume More? The Price Elasticity of Home Care for the Disabled Elderly in France

ROQUEBERT Q. ET TENAND M.

2017

Health Econ 26(9): 1162-1174.

Little is known about the price sensitivity of demand for home care of the disabled elderly. We partially fill this knowledge gap by using administrative data on the beneficiaries of the main French home care subsidy program in a department and exploiting interindividual variation in provider prices. We address the potential endogeneity of prices by taking advantage of the unequal spatial coverage of providers and instrumenting price by the number of municipalities served by a provider. We estimate a price elasticity of around -0.4 that is significantly different from both 0 and -1. This less than proportionate response of consumption to price has implications for the efficiency and redis-

tributive impact of variation in the level of copayments in home care subsidy schemes.

Hospitals

Hospitalisation en unité hospitalière spécialement aménagée : enquête de satisfaction auprès des patients

DE LABROUHE D., *et al.*

2017

Revue d'Épidémiologie et de Santé Publique 65(4): 285-294.

http://www.sciencedirect.com/science/article/pii/S0398762017303073

En France, les unités hospitalières spécialement aménagées (UHSA) permettent d'accueillir en hospitalisation à temps complet (en soins libres ou sans consentement) les détenus souffrant d'une pathologie psychiatrique. Depuis leur création, en 2010, la qualité des prises en charge qui y sont proposées et l'impact sur le parcours de soins psychiatriques des patients hospitalisés n'ont pas été étudiés. En particulier, aucune enquête de satisfaction n'a été menée auprès des patients. L'objectif principal de cette étude était d'évaluer la satisfaction des patients sur leur hospitalisation en UHSA. Il s'agissait d'une étude descriptive, bicentrique (UHSA de Villejuif et UHSA de Seclin), réalisée auprès de 125 patients majeurs à leur sortie d'hospitalisation en UHSA, sur une période de quatre mois (de février à mai 2015). La satisfaction des patients était évaluée à l'aide d'un hétéro-questionnaire comportant 16 items. L'étude montre que les patients sont satisfaits des conditions d'hospitalisation en UHSA. Compte tenu des liens entre satisfaction des patients et observance, ces structures pourraient présenter un intérêt majeur dans le parcours de soins des personnes incarcérées souffrant de troubles psychiatriques. Ces résultats devront cependant être répliqués dans une étude sur un échantillon de patients plus important et au sein de l'ensemble des UHSA.

Efficacité des filières dédiées à l'Accident Vasculaire Cérébral. Moyens de mesure. Expérience en Bourgogne

DELPONT B., *et al.*

2017

Journal de Gestion et d'Économie Médicales 35(1): 18-31.

http://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-1-page-18.htm

L'AVC reste une maladie fréquente et grave malgré des avancées thérapeutiques majeures, expliquant le rôle structurant de sa prise en charge sur le plan hospitalier et inter-hospitalier. Les filières de soins pour AVC décloisonnées permettent au patient de bénéficier d'une prise en charge optimale de son domicile jusqu'à l'Unité Neuro-Vasculaire (UNV). Les recommandations nationales ont préconisé la mise en place de filières pluridisciplinaires. L'objectif de cette revue est de rapporter les évaluations successives en pratique courante de la filière AVC mise en place en Bourgogne depuis 2003, les réponses apportées aux attentes des patients et des tutelles, et leur transposition aux autres régions sanitaires. L'analyse se base sur les données du Registre Dijonnais des AVC, qui recense depuis 1985 les AVC des résidents de la ville de Dijon intramuros de façon prospective, spécifique et exhaustive.

Reductions in Readmission Rates Are Associated with Modest Improvements in Patient-Reported Health Gains Following Hip and Knee Replacement in England

FRIEBEL R., *et al.*

2017

Med Care 55(9): 834-840.

Although many hospital readmission reduction initiatives have been introduced globally, health care systems ultimately aim to improve patients' health and well-being. We examined whether the hospitals that

report greater success in reducing readmissions also see greater improvements in patient-reported outcomes. We examined hospital groups (Trusts) that provided hip replacement or knee replacement surgery in England between April 2010 and February 2013. For each Trust, we calculated risk-adjusted 30-day readmission rates from administrative datasets. We also obtained changes in patient-reported health between presurgical assessment and 6-month follow-up, using general health EuroQuol five dimensions questionaire (EQ-5D) and EuroQuol visual analogue scales (EQ-VAS) and procedure-specific (Oxford Hip and Knee Scores) measures. Panel models were used to assess whether changes over time in risk-adjusted readmission rates were associated with changes over time in risk-adjusted health gains. Reductions in readmission rates were associated with modest improvements in patients' sense of their health and well-being at the hospital group level. In particular, fears that efforts to reduce readmission rates have had unintended consequences for patients appear to be unfounded.

Effects of Formal Home Care on Hospitalizations and Doctor Visits

GONÇALVES J. ET WEAVER F.

2017

International Journal of Health Economics and Management 17(2): 203-233.
https://doi.org/10.1007/s10754-016-9200-x

This study estimates the effects of formal home care, provided by paid professionals, on hospitalizations and doctor visits. We look at different lengths-of-stay (LOS) and types of doctor visits—general practitioners (GP) and specialists—and investigate heterogeneous effects by age groups and informal care availability. Two-part generalized linear models are estimated, using data from Switzerland. In this federal country, home care policy is decentralized into 26 cantons. Home care is measured at the canton level and its endogeneity is addressed by using an instrumental variable strategy combined with canton and time fixed-effects. We instrument home care use with the introduction of patient cost sharing for home care in some cantons in 2011. Overall, home care significantly increases the likelihoods of having a hospitalization, any doctor visit, or a GP visit. In addition, home care significantly reduces LOS up to 30 days, but has no effect on the number of doctor visits. These results are driven by the effects on persons 65 years and older. The effects are small, suggesting that the potential of formal home care to limit the growth in inpatient care and doctor visits may be limited.

Effects of Acute-Postacute Continuity on Community Discharge and 30-Day Rehospitalization Following Inpatient Rehabilitation

GRAHAM J. E., *et al.*

2017

Health Serv Res 52(5): 1631-1646.

The aim of this study is to examine the effects of facility-level acute-postacute continuity on probability of community discharge and 30-day rehospitalization following inpatient rehabilitation. We used national Medicare enrollment, claims, and assessment data to study 541,097 patients discharged from 1,156 inpatient rehabilitation facilities (IRFs) in 2010-2011. Medicare beneficiaries in hospital-based rehabilitation units were more likely to be referred from a high-contributing hospital compared to those in freestanding facilities. However, the association between higher acute-postacute continuity and desirable outcomes is significantly better in freestanding rehabilitation facilities than in hospital-based units. Improving continuity is a key premise of health care reform. We found that both observed referral patterns and continuity-related benefits differed markedly by facility type. These findings provide a starting point for health systems establishing or strengthening acute-postacute relationships to improve patient outcomes in this new era of shared accountability and public quality reporting programs.

How Did Market Competition Affect Outpatient Utilization Under the Diagnosis-Related Group-Based Payment System

KIM S. J., *et al.*

2017

Int J Qual Health Care 29(3): 399-405.

Although competition is known to affect quality of care, less is known about the effects of competition on outpatient health service utilization under the diagnosis-related group payment system. This study aimed to evaluate these effects and assess differences before and after hospitalization in South Korea. We used two

data set including outpatient data and hospitalization data from National Health Claim data from 2011 to 2014. The outcome variables included the costs associated with outpatient examinations and the number of outpatient visits within 30 days before and after hospitalization. High-competition areas were associated with lower pre-surgery examination costs (rate ratio [RR]: 0.88, 95% confidence interval [CI]: 0.88-0.89) and fewer outpatient visits before hospitalization (RR: 0.98, 95% CI: 0.98-0.99) as well as after hospitalization compared with moderate-competition areas. Our study reveals that outpatient health service utilization is affected by the degree of market competition. Future evaluations of hospital performance should consider external factors such as market structure and hospital location.

Effects of Long-Term High Continuity of Care on Avoidable Hospitalizations of Chronic Obstructive Pulmonary Disease Patients

LIN I. P. ET WU S. C.

2017

Health Policy 121(9): 1001-1007.

The aim of this study is to examine the effects of high continuity of care (COC) maintained for a longer time on the risk of avoidable hospitalization of patients with chronic obstructive pulmonary disease (COPD). A retrospective cohort study design was adopted. We used a claim data regarding health care utilization under a universal health insurance in Taiwan. We selected 2199 subjects who were newly diagnosed with COPD. We considered COPD-related avoidable hospitalizations as outcome variables. The continuity of care index (COCI) was used to evaluate COC as short- and long-term COC. We concluded that maintaining long-term high COC effectively reduces the risk of avoidable hospitalizations. To encourage development of long-term patient-physician relationships could improve health outcomes.

Reducing Hospital Readmissions Through Preferred Networks of Skilled Nursing Facilities

MCHUGH J. P., *et al.*

2017

Health Aff (Millwood) 36(9): 1591-1598.

Establishing preferred provider networks of skilled nursing facilities (SNFs) is one approach hospital administrators are using to reduce excess thirty-day readmissions and avoid Medicare penalties or to reduce beneficiaries' costs as part of value-based payment models. However, hospitals are also required to provide patients at discharge with a list of Medicare-eligible providers and cannot explicitly restrict patient choice. This requirement complicates the development of a SNF network. Furthermore, there is little evidence about the effectiveness of network development in reducing readmission rates. We used a concurrent mixed-methods approach, combining Medicare claims data for the period 2009-13 with qualitative data gathered from interviews during site visits to hospitals in eight US markets in March-October 2015, to examine changes in rehospitalization rates and differences in practices between hospitals that did and did not develop formal SNF networks. Four hospitals had developed formal SNF networks as part of their care management efforts. These hospitals saw a relative reduction from 2009 to 2013 in readmission rates for patients discharged to SNFs that was 4.5 percentage points greater than the reduction for hospitals without formal networks. Interviews revealed that those with networks expanded existing relationships with SNFs, effectively managed patient data, and exercised a looser interpretation of patient choice.

Reducing Readmissions Among Heart Failure Patients Discharged to Home Health Care: Effectiveness of Early and Intensive Nursing Services and Early Physician Follow-Up

MURTAUGH C. M., *et al.*

2017

Health Serv Res 52(4): 1445-1472.

The aim of this paper is to compare the effectiveness of two «treatments»-early, intensive home health nursing and physician follow-up within a week-versus less intense and later postacute care in reducing readmissions among heart failure (HF) patients discharged to home health care. The data sources are the National Medicare administrative, claims, and patient assessment data. Patients with a full week of potential exposure to the treatments were followed for 30 days to determine exposure status, 30-day all-cause hospital

readmission, other health care use, and mortality. An extension of instrumental variables methods for nonlinear statistical models corrects for nonrandom selection of patients into treatment categories. Our instruments are the index hospital's rate of early aftercare for non-HF patients and hospital discharge day of the week. Our results call for closer coordination between home health and medical providers in the clinical management of HF patients immediately after hospital discharge.

Hospital Quality Variation Matters - A Time-Trend and Cross-Section Analysis of Outcomes in German Hospitals from 2006 to 2014

PROSS C., *et al.*

2017

Health Policy 121(8): 842-852.

Awareness of care variation and associated differences in outcome quality is important for patients to recognize and leverage the benefits of hospital choice and for policy makers, providers, and suppliers to adapt initiatives to improve hospital quality of care. We examine panel data on outcome quality in German hospitals between 2006 and 2014 for cholecystectomy, pacemaker implantation, hip replacement, percutaneous coronary intervention (PCI), stroke, and acute myocardial infarction (AMI). We use risk-adjusted and unadjusted outcomes based on 16 indicators. Median outcome and outcome variation trends are examined via box plots, simple linear regressions and quintile differences. Outcome trends differ across treatment areas and indicators. We found positive quality trends for hip replacement surgery, stroke and AMI 30-day mortality, and negative quality trends for 90-day stroke and AMI readmissions and PCI inpatient mortality. Variation of risk-adjusted outcomes ranges by a factor of 3-12 between the 2nd and 5th quintile of hospitals, both at the national and regional level. Our results show that simply measuring and reporting hospital outcomes without clear incentives or regulation - «carrots and sticks» - to improve performance and to centralize care in high performing hospitals has not led to broad quality improvements. More substantial efforts must be undertaken to narrow the outcome spread between high- and low-quality hospitals.

Changes in Hospital Quality Associated with Hospital Value-Based Purchasing

RYAN A. M., *et al.*

2017

New England Journal of Medicine 376(24): 2358-2366.

http://www.nejm.org/doi/full/10.1056/NEJMsa1613412

Starting in fiscal year 2013, the Hospital Value-Based Purchasing (HVBP) program introduced quality performance-based adjustments of up to 1% to Medicare reimbursements for acute care hospitals. We evaluated whether quality improved more in acute care hospitals that were exposed to HVBP than in control hospitals (Critical Access Hospitals, which were not exposed to HVBP). The measures of quality were composite measures of clinical process and patient experience. Improvements in clinical-process and patient-experience measures were not significantly greater among hospitals exposed to HVBP than among control hospitals, with difference-in-differences estimates of 0.079 SD (95% confidence interval [CI], -0.140 to 0.299) for clinical process and -0.092 SD (95% CI, -0.307 to 0.122) for patient experience. HVBP was not associated with significant reductions in mortality among patients who were admitted for acute myocardial infarction (difference-in-differences estimate, -0.282 percentage points [95% CI, -1.715 to 1.152]) or heart failure (-0.212 percentage points [95% CI, -0.532 to 0.108]), but it was associated with a significant reduction in mortality among patients who were admitted for pneumonia (-0.431 percentage points [95% CI, -0.714 to -0.148]). In our study, HVBP was not associated with improvements in measures of clinical process or patient experience and was not associated with significant reductions in two of three mortality measures.

Analyse de la pertinence des séjours hospitaliers : un exemple de recherche d'optimisation

TROSINI-DÉSERT V., *et al.*

2017/05

Gestions hospitalières 566: 318-321.

L'analyse de la pertinence des journées d'hospitalisation et des raisons de non-pertinence s'inscrit dans le cadre des démarches d'évaluation de la qualité des soins. La nécessité de cette évaluation est devenue incontournable et suscite un vif intérêt car les journées d'inadéquation hospitalières sont source de sous-qualité des soins, d'inefficience du système de santé et de coûts non maîtrisés. Cet article rapporte une étude de pertinence des journées d'hospitalisation menée au sein du groupe hospitalier Paris Saint-Joseph, dans deux services : rhumatologie et cardiologie.

The Ageing Society and Emergency Hospital Admissions

WITTENBERG R., *et al.*

2017

Health Policy 121(8): 923-928.

There is strong policy interest, in England as elsewhere, in slowing the growth in emergency hospital admissions, which for older people increased by 3.3% annually between 2001/2 and 2012/3. Resource constrains have increased the importance of understanding rising emergency admissions, which in policy discourse is often explained by population aging. This study examines how far the rise in emergency admissions of people over 65 was due to population ageing, how far to the changing likelihood of entering hospital at each age, and how far to other factors which might be more amenable to policy measures. It shows that: admission rates rose with age from age 40 upward but each successive birth cohort experienced lower emergency admission rates after standardising for age and other effects. This downward cohort effect largely offset the consequences of an older and larger population aged over 65. Other factors which could explain increasing admissions, such as new technologies or rising expectations, appear more important than the changing size and age structure of the population as drivers of rising emergency admissions in old age. These findings suggest that stemming the rate of increase in emergency admissions of older people may be feasible, if challenging, despite population ageing.

Health Inequalities

Most Americans Have Good Health, Little Unmet Need, and Few Health Care Expenses

BERK M. L. ET FANG Z.

2017

Health Aff (Millwood) 36(4): 742-746.

The distribution of health care expenditures remains highly concentrated, but most Americans use few health care resources and have low out-of-pocket spending. More than 93 percent of «low spenders» (those in the bottom half of the population) believe they have received all needed care in a timely manner. The low spending by the majority of the population has remained almost unchanged during the thirty-seven-year period examined.

Reforming Refugee Healthcare in Canada: Exploring the Use of Policy Tools

HOLTZER E. ET A L.

2017

Healthcare Policy 12(4): 46-55.

Refugee healthcare in Canada has been a controversial and heavily debated topic over the past several years. In this paper, we present a policy analysis of the 2012 Canadian federal government decision to change the criteria and funding of the Interim Federal Health Program (IFHP). The IFHP provides federally funded healthcare coverage for refugees until they gain access to provincially funded health insurance. The paper offers a policy perspective on the changes to refugee health coverage over time. We draw on the policy concepts of agenda setting, framing, venues and causal stories to explore this topic. We suggest that these concepts represent a set of tools for both

researchers and laypersons to critically appraise any issue on the policy agenda, and understand how certain topics become policy issues and why they are, in particular ways.

Contrepoint - L'accès aux soins des migrants

GRELLEY P.

2016

Informations sociales 194(3): 95-95.

http://www.cairn.info/revue-informations-sociales-2016-3-page-95.htm

Les migrations constituent un enjeu essentiel pour la protection sociale, quelle que soit l'échelle spatiale concernée. Au sein de l'Union européenne (UE), un espace en partie fédéral, tout citoyen d'un État membre peut bénéficier de la protection sociale dans le pays où il travaille. Ces droits sociaux constituent l'un des piliers de l'intégration du continent. Ils ont facilité la libre circulation des personnes, au point que les pays de l'UE les plus touchés par la crise débutée en 2008 sont devenus ou redevenus des terres d'émigration. Ce numéro examine, dans un premier temps, la manière dont les travailleurs migrants ont été traités par la protection sociale, aux différentes étapes historiques de sa construction en France et en Europe, et analyse en particulier les liens entre statut des migrants, droit social et droits fondamentaux (première partie). Compte tenu des difficultés financières qui pèsent sur les États européens, les migrations sont souvent mises en avant comme une contrainte pour la protection sociale, bien que ce constat soit discuté par l'analyse économique (deuxième partie). L'analyse des règles et les conditions d'accès des migrants aux prestations et aux services sociaux se révèlent donc essentielle pour comprendre les enjeux de leur intégration, en France comme au sein de l'UE (troisième partie).

Out of Sight but Not Out of Mind: Home Countries' Macroeconomic Volatilities and Immigrants' Mental Health

NGUYEN H. T. ET CONNELLY L. B.

2017

Health Econ (Ahead of print).

We provide the first empirical evidence that better economic performances by immigrants' countries of origin, as measured by lower consumer price index (CPI) or higher gross domestic product, improve immigrants' mental health. We use an econometrically-robust approach that exploits exogenous changes in macroeconomic conditions across immigrants' home countries over time and controls for immigrants' observable and unobservable characteristics. The CPI effect is statistically significant and sizeable. Furthermore, the CPI effect diminishes as the time since emigrating increases. By contrast, home countries' unemployment rates and exchange rate fluctuations have no impact on immigrants' mental health.

Educational Inequalities in Self-Rated Health Across US States and European Countries

PRÄG P. ET SUBRAMANIAN S. V.

2017

International Journal of Public Health 62(6): 709-716.

https://doi.org/10.1007/s00038-017-0981-6

The US shows a distinct health disadvantage when compared to other high-income nations. A potential lever to reduce this disadvantage is to improve the health situation of lower socioeconomic groups. Our objective is to explore how the considerable within-US variation in health inequalities compares to the health inequalities across other Western countries.

Santé et recours aux soins des jeunes en insertion âgés de 18 à 25 ans suivis en mission locale

ROBERT S., *et al.*

2017

Revue d'Épidémiologie et de Santé Publique 65(4): 265-276.

http://www.sciencedirect.com/science/article/pii/S0398762017303000

En France, les missions locales accueillent les jeunes en insertion âgés de 16 à 25 ans. Elles reçoivent ainsi 10 à 15 % des jeunes de cette tranche d'âge de leur territoire, soit plus de 1,5 millions de jeunes par an. Aucun travail n'a encore étudié leur état de santé à un niveau national. Notre objectif était de décrire cet état de santé et leur recours aux soins et de les comparer à ceux des jeunes en population générale. Les

données de l'étude multicentrique Presaje, conduite en 2011 sur un échantillon aléatoire de 1453 jeunes âgés de 18 à 25 ans fréquentant cinq missions locales (Clichy-sous-Bois, Poitiers, Reims, Sénart, Toulouse), ont été analysées et comparées aux données des 2899 jeunes du même âge du Baromètre Santé 2010 et des 204 jeunes de la cohorte francilienne SIRS 2010. De profils sociaux divers, ces jeunes connaissaient globalement des conditions de vie plus difficiles que les jeunes du même âge de la population générale. Ils accumulaient des facteurs de vulnérabilité vis-à-vis de la santé : couverture sociale insuffisante, faible niveau de formation, accumulation d'événements de vie difficiles dans l'enfance et isolement social.

Health Inequities in the Age of Austerity: The Need for Social Protection Policies

RUCKERT A. ET LABONTE R.

2017

Soc Sci Med 187: 306-311.

This commentary assesses the impacts of the global austerity drive on health inequities in the aftermath of the global financial crisis of 2008. In doing so, it first locates the origins of austerity within the 40 year history of neoliberal economic orthodoxy. It then describes the global diffusion of austerity since 2008, and its key policy tenets. It next describes the already visible impacts of austerity-driven welfare reform on trends in health equity, and documents how austerity has exacerbated health inequities in countries with weak social protection policies. We finally identify the components of an alternative policy response to the financial crisis than that of austerity, with specific reference to the need for shifts in national and global taxation policies and public social protection policies and spending. We conclude with a call for a reorientation of public policy towards making human health an overarching global policy goal, and how this aligns with the multilaterally agreed upon Sustainable Development Goals.

Austerity and Its Implications for Immigrant Health in France

SARGENT C. ET KOTOBI L.

2017

Soc Sci Med 187: 259-267.

The ongoing economic crisis in France increasingly has affected immigrant rights, including access to health care. Consistent with a 2014 League Against Cancer survey, we identify the ways in which sickness produces a «double penalty» for immigrants with serious illness. Immigrants with chronic illnesses such as cancer, diabetes, and other debilitating conditions divert vital funds from daily needs to deal with sickness and loss of work while at the same time national austerity measures shred the state's traditional safety net of social services and support. We examine how immigrants strategize to manage financial exigencies, therapeutic itineraries and social relations in the face of these converging pressures. We base our findings on two studies related by this theme: an investigation of health inequalities in the Medoc region, in which 88 women, 44 of North African and Eastern European origin, were interviewed over a three-year period (2010-2013); and a three-year study (2014-2017) of West African immigrant women with breast cancer seeking treatment in the greater Paris region, 70 members of immigrant associations, and clinical personnel in three hospitals.

Was Mackenbach Right? Towards a Practical Political Science of Redistribution and Health Inequalities

SCHRECKER T.

2017

Health Place 46: 293-299.

In 2010, Mackenbach reflected on England's lack of success in reducing health inequalities between 1997 and 2010, asserting that «it is difficult to imagine a longer window of opportunity for tackling health inequalities»; asking «[i]f this did not work, what will?»; and concluding that reducing health inequalities was not politically feasible at least in that jurisdiction. Exploring the empirics of that observation offers a window into the politics of reducing health inequalities. For purposes of future comparative research, I outline three (not mutually exclusive) perspectives on political feasibility, identify their implications for a political science of health inequalities, and explore what they mean for advocacy in support of reducing those inequalities.

Pharmaceuticals

The French Medecine Pricing Committee and the Medicine Economic Policy: Rules and Competences

GIORGI D.

2017

Ann Pharm Fr 75(5): 359-372.

The French medicine pricing committee (CEPS), a governmental and inter-institutional body exercises essential competences for the regulation of the economy of the reimbursable drugs in France. It provides a good example of administered price regulation. It also supervises the proper use of products (control of promotion, conventional control of sales volumes). Finally, it regulates the annual envelope of drug expenditures by means of discounts paid by pharmaceutical companies. The article presents the legal criteria and the doctrine of price setting used in France. It details the types of market access contracts concluded by the CEPS. It specifies the conditions governing the annual envelope of expenditures on reimbursable medicines.

The French Medecine Pricing Committee

GIORGI D.

2017

Ann Pharm Fr 75(5): 373-384.

The French medicine pricing committee (CEPS) has to reconcile several major constraints, including optimal patient access to medicines and a good control of expenditures on reimbursable medicines. From 2013 to 2015, drug price decreases and discounts obtained by CEPS contributed more than euro 5 billion to the balance of the health insurance accounts. As for price setting, there is a significant drop in the prices of medicines in France once they are registered for reimbursement. France is affected by a limited, but costly, flow of innovative medicines, whose prices are higher than those of previous generations, a reflection of an international gradient to which France is obviously subject, despite prices that remain at the low end of the range in Western Europe. The provision of innovative medicines for all patients who need them has been ensured in France over the last fifteen years at a controlled cost. But with the arrival of new expensive products, a resolute policy of control of expenditures must take over from the fall in prices, and original financing channels will have to be explored.

Determinants of Potentially Inappropriate Medication Use Among Community-Dwelling Older Adults

MILLER G. E., *et al.*

2017

Health Serv Res 52(4): 1534-1549.

The aim of this study is to examine the determinants of potentially inappropriate medication (PIM) use U.S. nationally representative data on (n = 16,588) noninstitutionalized older adults (age >= 65) with drug use from the 2006-2010 Medical Expenditure Panel Survey. We operationalized the 2012 Beers Criteria to identify PIM use during the year, and we examined associations with individual-level characteristics hypothesized to be quality enabling or related to need complexity. Almost one-third (30.9 percent) of older adults used a PIM. Multivariate results suggest that poor health status and high-PIM-risk conditions were associated with increased PIM use, while increasing age and educational attainment were associated with lower PIM use. Contrary to expectations, lack of a usual care source of care or supplemental insurance was associated with lower PIM use. Medication intensity appears to be in the pathway between both quality-enabling and need-complexity characteristics and PIM use. Our results suggest that physicians attempt to avoid PIM use in the oldest old but have inadequate focus on the high-PIM-risk conditions. Educational programs targeted to physician practice regarding high-PIM-risk conditions and patient literacy regarding medication use are potential responses.

Ethical Acceptability of Offering Financial Incentives for Taking Antipsychotic Depot Medication: Patients' and Clinicians' Perspectives After a 12-Month Randomized Controlled Trial

NOORDRAVEN E. L., *et al.*

2017

BMC Psychiatry 17(1): 313.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5576283/pdf/12888_2017_Article_1485.pdf

A randomized controlled trial 'Money for Medication'(M4M) was conducted in which patients were offered financial incentives for taking antipsychotic depot medication. This study assessed the attitudes and ethical considerations of patients and clinicians who participated in this trial.

Time for a Change in How New Antibiotics Are Reimbursed: Development of an Insurance Framework for Funding New Antibiotics Based on a Policy of Risk Mitigation

TOWSE A., *et al.*

2017

Health Policy (Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.07.011

We propose a policy change to an insurance model for reimbursing new antibiotics. Current incentives are insufficient to rekindle investment in antibiotic development. Our analysis explores two models that aim to address these shortcomings. A premium price model has uncertain impact and risks putting commercial return and appropriate stewardship in opposition. An insurance model can achieve investment, reduce uncertainty for health systems, and achieve stewardship.

Methodology - Statistics

The Impact of Economic Conditions on the Disablement Process: A Markov Transition Approach Using SHARE Data

ARRIGHI Y., *et al.*

2017

Health Policy 121(7): 778-785.

A growing number of studies underline the relationship between socioeconomic status and health at older ages. Following that literature, we explore the impact of economic conditions on changes in functional health overtime. Frailty, a state of physiological instability, has been identified in the public health literature as a candidate for disability prevention but received little attention from health economists. Using SHARE panel data, respondents aged 50 and over from ten European countries were categorised as robust, frail and dependent. The determinants of health states' changes between two interviews were analysed using multinomial Probit models accounting for potential sample attrition. A particular focus was made on initial socioeconomic status, proxied by three alternative measures. Across Europe, poorer and less educated elders were substantially more likely to experience health degradations and also less likely to experience health improvements. The economic gradient for the recovery from frailty was steeper than that of frailty onset, but remained lower than that of dependency onset. The existing social programs in favour of deprived and dependent elders could be widened to those diagnosed as frail to reduce the onset of dependency and economic inequalities in health at older ages.

Algorithms for the Identification of Hospital Stays Due to Osteoporotic Femoral Neck Fractures in European Medical Administrative Databases Using ICD-10 Codes: A Non-Systematic Review of the Literature

CAILLET P., *et al.*

2017

Rev Epidemiol Santé Publique 65 (Suppl 4): S198-S208.

Osteoporotic hip fractures (OHF) are associated with significant morbidity and mortality. The French medico-administrative database (SNIIRAM) offers an interesting opportunity to improve the management of OHF. However, the validity of studies conducted with this database relies heavily on the quality of the algo-

rithm used to detect OHF. The aim of the REDSIAM network is to facilitate the use of the SNIIRAM database. The main objective of this study was to present and discuss several OHF-detection algorithms that could be used with this database.

The Relationship Between Health Services Standardized Costs and Mortality Is Non-Linear: Results from a Large HMO Population

COHEN-MANSFIELD J., *et al.*

2017

Health Policy(Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.07.004

Low Health Services Standardized Costs (HSSC) poses greater mortality risk than medium HSSC. Despite a universal health system, vulnerable status predicted mortality. The low HSSC group may be at risk of underutilizing services.

The REDSIAM Network

GOLDBERG M., *et al.*

2017

Rev Epidemiol Santé Publique 65 (Suppl 4): S144-S148.

The French national health database (SNIIRAM) proved to be very useful for epidemiology, health economics, evaluation, surveillance or public health. However, it is a complex database requiring important resources and expertise for being used. The REDSIAM network has been set up for promoting the collaboration of teams working on the Sniiram. The main aim of REDSIAM is to develop and validate methods for analyzing the Sniiram database for research, surveillance, evaluation and public health purposes by sharing the knowledge and experience of specialized teams in the fields of diseases identification from the Sniiram data. The work conducted within the network is devoted to the development and the validation of algorithms using Sniiram data for identifying specific diseases. The REDSIAM governance includes the Steering Committee composed of the main organizations in charge of producing and using the Sniiram data, the Bureau and the Technical Committee. The network is organized in thematic working groups focused on specific pathological domains, and a charter defines the rules for participation in the network, the functioning of the thematic working groups, the rules for publishing and making available algorithms. The articles in this special issue of the journal present the first results of some of the thematic working groups.

Regression-Based Approaches to Patient-Centered Cost-Effectiveness Analysis

GOTO D., *et al.*

2017

PharmacoEconomics 35(7): 685-695.

https://doi.org/10.1007/s40273-017-0505-5

Achieving comprehensive patient centricity in cost-effectiveness analyses (CEAs) requires a statistical approach that accounts for patients' preferences and clinical and demographic characteristics. Increased availability and accessibility of patient-level health-related utility data from clinical trials or observational database provide enhanced opportunities to conduct more patient-centered CEA. Regression-based approaches that incorporate patient-level data hold great promise for enhancing CEAs to be more patient centered; this paper provides guidance regarding two CEA approaches that apply regression-based approaches utilizing patient-level health-related utility and costs data. The first approach utilizes patient-reported preferences to determine patient-specific utility. This approach evaluates how individuals' unique clinical and demographic factors affect their utility and cost levels over the course of treatment. The underlying motivation of this approach is to produce CEA estimates that reflect patient-level utilities and costs while adjusting for socio-demographic and clinical factors to aid patient-centered coverage and treatment decision-making. In the second approach, patient utilities are estimated based on the clinically defined health states through which a patient may transition throughout the course of treatment. While this approach is grounded on the widely used Markov transition model, we refine the model to facilitate an enhancement in conducting regression-based analysis to achieve transparent understanding of differences in utilities and costs across diverse patient populations. We discuss the unique statistical challenges of each approach and describe how these analytical strategies are related to non-regression-based models in health services research.

Systematic Review Adherence to Methodological or Reporting Quality

PUSSEGODA K., *et al.*

2017

Systematic Reviews 6(1): 131.

https://doi.org/10.1186/s13643-017-0527-2

Guidelines for assessing methodological and reporting quality of systematic reviews (SRs) were developed to contribute to implementing evidence-based health care and the reduction of research waste. As SRs assessing a cohort of SRs is becoming more prevalent in the literature and with the increased uptake of SR evidence for decision-making, methodological quality and standard of reporting of SRs is of interest. The objective of this study is to evaluate SR adherence to the Quality of Reporting of Meta-analyses (QUOROM) and PRISMA reporting guidelines and the A Measurement Tool to Assess Systematic Reviews (AMSTAR) and Overview Quality Assessment Questionnaire (OQAQ) quality assessment tools as evaluated in methodological overviews.

Study of Algorithms to Identify Schizophrenia in the SNIIRAM Database Conducted by the REDSIAM Network

QUANTIN C., *et al.*

2017

Rev Epidemiol Sante Publique 65 (Suppl 4): S226-S235.

The aim of the REDSIAM network is to foster communication between users of French medico-administrative databases and to validate and promote analysis methods suitable for the data. Within this network, the working group «Mental and behavioral disorders» took an interest in algorithms to identify adult schizophrenia in the SNIIRAM database and inventoried identification criteria for patients with schizophrenia in these databases. The methodology was based on interviews with nine experts in schizophrenia concerning the procedures they use to identify patients with schizophrenia disorders in databases. The interviews were based on a questionnaire and conducted by telephone. Patients with schizophrenia can be relatively accurately identified using SNIIRAM data. Different combinations of the selected criteria must be used depending on the objectives and they must be related to an appropriate length of time.

Value of a national administrative database to guide public decisions: From the système national d'information interregimes de l'Assurance Maladie (SNIIRAM) to the système national des données de santé (SNDS) in France

TUPPIN P., *et al.*

2017

Rev Epidemiol Santé Publique 65 (Suppl 4): S149-S167.

In 1999, French legislators asked health insurance funds to develop a "système national d'information interregimes de l'Assurance Maladie (SNIIRAM)" [national health insurance information system] in order to more precisely determine and evaluate health care utilization and health care expenditure of beneficiaries. These data, based on almost 66 million inhabitants in 2015, have already been the subject of numerous international publications on various topics : prevalence and incidence of diseases, patient care pathways, health status and health care utilization of specific populations, real-life use of drugs, assessment of adverse effects of drugs or other health care procedures, monitoring of national health insurance expenditure. SNIIRAM comprises individual information on the sociodemographic and medical characteristics of beneficiaries and all hospital care and office medicine reimbursements, coded according to various systems. SNIIRAM has continued to grow and extend to become, in 2016, the cornerstone of the future système national des données de santé (SNDS) [National health data system], which will gradually integrate new information (causes of death, social and medical data and complementary health insurance). In parallel, the modalities of data access and protection systems have also evolved. This article describes the SNIIRAM data warehouse and its transformation into SNDS, the data collected, the tools developed in order to facilitate data analysis, the limitations encountered, and changing access permissions.

Health Policy

Overuse of Health Care Services in the Management of Cancer: A Systematic Review

BAXI S. S., *et al.*

2017

Med Care 55(7): 723-733.

Overuse, the provision of health services for which harms outweigh the benefits, results in suboptimal patient care and may contribute to the rising costs of cancer care. We performed a systematic review of the evidence on overuse in oncology. We searched Medline, EMBASE, the Cochrane Library, Web of Science, SCOPUS databases, and 2 grey literature sources, for articles published between December 1, 2011 and March 10, 2017. We included publications from December 2011 to evaluate the literature since the inception of the ABIM Foundation's Choosing Wisely initiative in 2012. We included original research articles quantifying overuse of any medical service in patients with a cancer diagnosis when utilizing an acceptable standard to define care appropriateness, excluding studies of cancer screening. Methodology used PRISMA guidelines. We identified 59 articles measuring overuse of 154 services related to imaging, procedures, and therapeutics in cancer management. Despite recent attention to overuse in cancer, evidence identifying areas of overuse remains limited. Broader investigation, including assessment of active cancer treatment, is critical for identifying improvement targets to optimize value in cancer care.

Improving Population Health Management Strategies: Identifying Patients Who Are More Likely to Be Users of Avoidable Costly Care and Those More Likely to Develop a New Chronic Disease

HIBBARD J. H., *et al.*

2017

Health Serv Res 52(4): 1297-1309.

The aim of this study is to explore using the Patient Activation Measure (PAM) for identifying patients more likely to have ambulatory care-sensitive (ACS) utilization and future increases in chronic disease. Secondary data are extracted from the electronic health record of a large accountable care organization. This is a retrospective cohort design. The key predictor variable, PAM score, is measured in 2011, and is used to predict outcomes in 2012-2014. Outcomes include ACS utilization and the likelihood of a new chronic disease. Our sample of 98,142 adult patients was drawn from primary care clinic users. To be included, patients had to have a PAM score in 2011 and at least one clinic visit in each of the three subsequent years. PAM level is a significant predictor of ACS utilization. Less activated patients had significantly higher odds of ACS utilization compared to those with high PAM scores. Similarly, patients with low PAM scores were more likely to have a new chronic disease diagnosis over each of the years of observation. We conclude that assessing patient activation may help to identify patients who could benefit from greater support. Such an approach may help ACOs reach population health management goals.

How Have Systematic Priority Setting Approaches Influenced Policy Making? A Synthesis of the Current Literature

KAPIRIRI L. ET RAZAVI D.

2017

Health Policy (Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.07.003

Systematic approaches to healthcare priority setting can improve policy making. There is need to assess if the common approaches have impacted policy making. While some have been used, their complexity and resource requirements hamper their institutionalization.

Approaches to Appropriate Care Delivery from a Policy Perspective: A Case Study of Australia, England and Switzerland

ROBERTSON-PREIDLER J., *et al.*

2017

Health Policy 121(7): 770-777.

Appropriateness is a conceptual way for health systems to balance Triple Aim priorities for improving population health, containing per capita cost, and improving the patient experience of care. Comparing system approaches to appropriate care delivery can

help health systems establish priorities and facilitate appropriate care practices. We conceptualized system appropriateness by identifying policies that aim to achieve the Triple Aim and their consequent trade-offs for financing, clinical practice, and the individual patient. We used secondary data sources to compare the appropriate care approaches of Australia, England, and Switzerland according to financial, clinical, and individual appropriateness policies. Integrating the Triple Aim into health system design and policy can facilitate appropriate care delivery at the system, clinical, and individual levels. Approaches will vary and require countries to negotiate and justify priorities and trade-offs within the context of the health system.

Health Policy in Times of Austerity: A Conceptual Framework for Evaluating Effects of Policy on Efficiency and Equity Illustrated with Examples from Europe Since 2008

WENZL M., *et al.*

2017

Health Policy (Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.07.005

We propose a framework to evaluate health policy changes against health system goals. The framework provides a categorisation of policies into distinct health system domains. Policies are evaluated in terms of their effect on efficiency and equity. Policy changes implemented in European countries since 2008 illustrate the framework. Policies mainly aimed to contain cost and likely had mixed effects on efficiency and equity.

Prevention

Alcohol Screening and Brief Interventions for Adults and Young People in Health and Community-Based Settings: A Qualitative Systematic Literature Review

DERGES J., *et al.*

2017

BMC Public Health 17(1): 562.

Systematic reviews of alcohol screening and brief interventions (ASBI) highlight the challenges of implementation in healthcare and community-based settings. Fewer reviews have explored this through examination of qualitative literature and fewer still focus on interventions with younger people. This review aims to examine qualitative literature on the facilitators and barriers to implementation of ASBI both for adults and young people in healthcare and community-based settings. Searches using electronic data bases (Medline on Ovid SP, PsychInfo, CINAHL, Web of Science, and EMBASE), Google Scholar and citation searching were conducted, before analysis. There remain significant barriers to implementation of ASBI among health and community-based professionals. Improving the way health service institutions respond to and co-ordinate alcohol services, including who is most appropriate to address alcohol use, would assist in better implementation of ASBI. Finally, a dearth of qualitative studies looking at alcohol intervention and implementation among young people was noted and suggests a need for further qualitative research.

Inequalities in Cervical Cancer Screening Utilisation and Results: A Comparison Between Italian Natives and Immigrants from Disadvantaged Countries

GALLO F., *et al.*

2017

Health Policy (Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.08.005

Cervical screening underutilisation is well documented among immigrants from poor countries. Participation rate to cervical screening was lower for immigrants than for Italians. Increasing age, illiteracy, being single, negatively influenced immigrants' participation. Severe lesions nearly double among immigrants in first screens compared to Italians. Policy makers should support screening providers in establishing coalitions with immigrants' organisations.

Including Values in Evidence-Based Policy Making for Breast Screening: An Empirically Grounded Tool to Assist Expert Decision Makers

PARKER L.

2017

Health Policy 121(7): 793-799.

Values are an important part of evidence-based decision making for health policy: they guide the type of evidence that is collected, how it is interpreted, and how important the conclusions are considered to be. Experts in breast screening (including clinicians, researchers, consumer advocates and senior administrators) hold differing values in relation to what is important in breast screening policy and practice, and committees may find it difficult to incorporate the complexity and variety of values into policy decisions. The decision making tool provided here is intended to assist with this process. The tool is modified from more general frameworks that are intended to assist with ethical decision making in public health, and informed by data drawn from previous empirical studies on values amongst Australian breast screening experts. It provides a structured format for breast screening committees to consider and discuss the values of themselves and others, suggests relevant topics for further inquiry and highlights areas of need for future research into the values of the public. It enables committees to publicly explain and justify their decisions with reference to values, improving transparency and accountability. It is intended to act alongside practices that seek to accommodate the values of individual women in the informed decision making process for personal decision making about participation in breast screening.

Prevision - Evaluation

How Important Is Severity for the Evaluation of Health Services: New Evidence Using the Relative Social Willingness to Pay Instrument

RICHARDSON J., *et al.*

2017

Eur J Health Econ 18(6): 671-683.

The 'severity hypothesis' is that a health service which increases a patient's utility by a fixed amount will be valued more highly when the initial health state is more severe. Supporting studies have employed a limited range of analytical techniques and the objective of the present paper is to test the hypothesis using a new methodology, the Relative Social Willingness to Pay. Three subsidiary hypotheses are: (1) that the importance of the 'severity effect' varies with the type of medical problem; (2) that the relationship between value and utility varies with the severity of the initial health state; and (3) that there is a threshold beyond which severity effects are insignificant. For each of seven different health problems respondents to a web-based survey were asked to allocate a budget to five services which would, cumulatively, move a person from near death to full health. The time trade-off utilities of health states before and after the service were estimated. The social valuation of the service measured by the budget allocation was regressed upon the corresponding increase in utility and severity as measured by the pre-service health state utility. Results confirm the severity hypothesis and support the subsidiary hypotheses. However, the effects identified are quantitatively significant only for the most severe health states. This implies a relatively limited redistribution of resources from those with less severe to those with more severe health problems.

Psychiatry

Towards a Community-Based Dementia Care Strategy: How Do We Get There from Here

MORTON C., *et al.*

2016

HealthcarePapers 16(2): 8-32.

As recent policy reports in Ontario and elsewhere have emphasized, most older persons would prefer to age at home. This desire does not diminish for the growing numbers of persons living with dementia (PLWD). Nevertheless, many PLWD end up in residential long-term care (LTC) or in hospital beds. In this lead paper, we begin by exploring the «state of the art» in community-based care for PLWD, highlighting the importance of early and ongoing intervention. We then offer a brief history of dementia care policy in Ontario as an illustrative case study of the challenges faced by policy makers in all jurisdictions as they aim to re-direct healthcare systems focused on «after-the-fact» curative care towards «before-the-fact» prevention and maintenance in the community. Drawing on results from a «balance of care» study, which we conducted in South West Ontario, we examine how, in the absence of viable community-based care options, PLWD can quickly «default» to institutional care. In the final section, we draw from national and international experience to identify the following three key strategic pillars to guide action towards a community-based dementia care strategy.

Entre tutelle et assistance : le débat sur la réforme de la loi de 1838 sur les aliénés des années 1870 aux années 1910

HENCKES N.

2017

Sciences sociales et santé 35(2): 108.

http://www.cairn.info/revue-sciences-sociales-et-sante-2017-2-page-81.htm

Cet article propose un nouvel éclairage sur le débat concernant la réforme de l'assistance aux aliénés entre 1870 et 1914. Il montre que ce dernier a été dominé successivement par deux problématisations portées par deux configurations d'acteurs différentes. Jusqu'à la fin des années 1880, c'est avant tout sous l'angle du statut civil des aliénés et des protections notamment tutélaires à leur apporter que parlementaires, juristes, aliénistes et administrateurs abordent ce débat. À partir des années 1890, une nouvelle problématisation s'ajoute à la première lorsque l'intérêt des réformateurs se déplace vers la question de l'accès de ces mêmes personnes aux institutions susceptibles d'apporter un soulagement à leurs vulnérabilités, qu'ils proposent de faciliter par la création de services d'hospitalisation « ouverts », soit en dehors du système de contraintes et de protections qui caractérise l'internement à l'asile. Le moteur de cette évolution est à la fois l'essor du champ de l'assistance publique et, à l'intérieur de la médecine mentale, celui d'un segment de médecins réformateurs issus du groupe nouvellement formé des médecins des asiles psychiatriques de la Seine. L'article propose finalement une explication supplémentaire à l'échec du débat au Parlement à la veille de la Première Guerre mondiale. Si celui-ci s'explique par la complexité des questions et la diversité des intérêts en jeu, l'impossibilité pour les réformateurs de trancher entre ces deux problématisations s'impose comme un point de blocage majeur.

Évolution des comportements et indicateurs de santé mentale entre 2006 et 2010 dans la population au travail en France

MALARD L., *et al.*

2017

Revue d'Épidémiologie et de Santé Publique 65(4): 309-320.

http://www.sciencedirect.com/science/article/pii/S0398762017304030

Les répercussions de la crise économique de 2008 sur la santé mentale de la population sont encore mal connues, en particulier dans la population au travail. L'objectif de cette étude était d'évaluer l'évolution de la prévalence de comportements et d'indicateurs de santé mentale dans la population au travail en France entre 2006 et 2010, et d'étudier les évolutions différentielles selon l'âge, l'origine, la profession, le secteur d'activité, le secteur public/privé, le statut indépendant/salarié et le type de contrat. L'enquête Santé et itinéraire professionnel (SIP) est une enquête prospective représentative de la population générale française, et parmi les individus interrogés, 5 600 étaient en emploi en 2006 et en 2010. Les comportements et les indicateurs de santé mentale étudiés étaient la consommation d'alcool à risque, le tabagisme, les problèmes du sommeil (troubles du sommeil et/ou durée de sommeil insuffisante), la prise de psychotropes (antidépresseurs, anxiolytiques et/ou hypnotiques), et

la mauvaise santé perçue. Dans la population au travail en France, des augmentations de la prévalence de la consommation d'alcool à risque chez les femmes, des problèmes de sommeil chez les hommes, et de tabagisme, de la durée de sommeil insuffisante et de la mauvaise santé perçue pour les deux genres ont été observées entre 2006 et 2010. Quelques évolutions différentielles ont été mises en évidence, en particulier au détriment des plus jeunes et des personnes en contrat permanent. En conclusion, les politiques de prévention devraient considérer que les prévalences des comportements et des indicateurs de mauvaise santé mentale peuvent avoir augmenté en période de crise économique, en particulier pour certains sous-groupes de la population au travail tels que les plus jeunes et les personnes en contrat permanent. Ces évolutions pourraient laisser présager une augmentation future des pathologies mentales.

▶ Strengthening Mental Health Systems to Respond to Economic Crises

MCDAVID D.

2017

Die Psychiatrie - Grundlagen und Perspektiven 14(2): 61-66.

Mental health systems appear to be among the first casualties of an economic downturn. Growing global political and economic uncertainty in Europe and elsewhere may mean that the next major economic crisis is not far off. This paper considers what mental health systems might do in future to more rapidly respond to the impacts of economic shocks, and reduce the risk and/or mitigate the impacts of poor mental health and deliberate self-harm. It concentrates on two areas of risk to mental health in times of economic shock, namely increasing job insecurity and changing employment conditions, as well as the impacts of unmanageable debt. Addressing the psychological impacts of less job-security and of surviving a downsizing in the workplace may be just as important to mental health as unemployment in an economic crisis. There is also evidence that unmanageable debt is associated with poor mental health and risk of suicide and self-harm. Mental health systems need to develop plans for a rapid response to economic shocks, with a strong focus on a public health approach to mental health. Engaging and collaborating with a wide range of stakeholders, as well as secure budgets, will be imperative to effective.

▶ Without Empowered Patients, Caregivers and Providers, A Community-Based Dementia Care Strategy Will Remain Just That

SAMIR K. S.

2016

HealthcarePapers 16(2): 64-70.

In trying to cope with the needs of the growing number of people living with dementia (PLWD), jurisdictions around the world have been implementing a variety of strategies, policies and programs to enable better access to the supports they and those who care for them require. Despite considerable efforts that have been undertaken, PLWD and their caregivers still face considerable challenges in pursuing care pathways and community-based supports that can help them avoid premature institutionalization. Morton-Chang et al. (2016) have comprehensively reviewed jurisdictional approaches towards the development of dementia strategies, policies and programs; there is a growing understanding and consensus around the things we need to do as societies to better meet the needs of PLWD and their caregivers; however, progress to date could be best characterized as top-down, patchy and fragmented. This paper builds on Morton-Chang, et al (2016) assertion that the development of a comprehensive person and caregiver-centred community-based dementia strategy in Ontario and other parts of Canada is likely achievable, particularly if implemented using a ground-up approach that is well-aligned with other government-related initiatives.

Primary Health Care

High Levels of Capitation Payments Needed to Shift Primary Care Toward Proactive Team and Nonvisit Care

BASU S., *et al.*

2017

Health Aff (Millwood) 36(9): 1599-1605.

Capitated payments in the form of fixed monthly payments to cover all of the costs associated with delivering primary care could encourage primary care practices to transform the way they deliver care. Using a microsimulation model incorporating data from 969 US practices, we sought to understand whether shifting to team- and non-visit-based care is financially sustainable for practices under traditional fee-for-service, capitated payment, or a mix of the two. Practice revenues and costs were computed for fee-for-service payments and a range of capitated payments, before and after the substitution of team- and non-visit-based services for low-complexity in-person physician visits. The substitution produced financial losses for simulated practices under fee-for-service payment of $42,398 per full-time-equivalent physician per year; however, substitution produced financial gains under capitated payment in 95 percent of cases, if more than 63 percent of annual payments were capitated. Shifting to capitated payment might create an incentive for practices to increase their delivery of team- and non-visit-based primary care, if capitated payment levels were sufficiently high.

Choosing and Booking-And Attending? Impact of an Electronic Booking System on Outpatient Referrals and Non-Attendances

DUSHEIKO M. ET GRAVELLE H.

2017

Health Econ (Ahead of print).

Patient non-attendance can lead to worse health outcomes and longer waiting times. In the English National Health Service, around 7% of patients who are referred by their general practice for a hospital outpatient appointment fail to attend. An electronic booking system (Choose and Book-C&B) for general practices making hospital outpatient appointments was introduced in England in 2005 and by 2009 accounted for 50% of appointments. It was intended, inter alia, to reduce the rate of non-attendance. Using a 2004-2009 panel with 7,900 English general practices, allowing for the relaxation of constraints on patient of hospital, and for the potential endogeneity of use of C&B, we estimate that the introduction of C&B reduced non-attendance by referred patients in 2009 by 72,160 (8.7%).

Can Pay-For-Performance to Primary Care Providers Stimulate Appropriate Use of Antibiotics

ELLEGARD L. M., *et al.*

2017

Health Econ (Ahead of print).

Antibiotic resistance is a major threat to public health worldwide. As the healthcare sector's use of antibiotics is an important contributor to the development of resistance, it is crucial that physicians only prescribe antibiotics when needed and that they choose narrow-spectrum antibiotics, which act on fewer bacteria types, when possible. Inappropriate use of antibiotics is nonetheless widespread, not least for respiratory tract infections (RTI), a common reason for antibiotics prescriptions. We examine if pay-for-performance (P4P) presents a way to influence primary care physicians' choice of antibiotics. During 2006-2013, 8 Swedish healthcare authorities adopted P4P to make physicians select narrow-spectrum antibiotics more often in the treatment of children with RTI. Exploiting register data on all purchases of RTI antibiotics in a difference-in-differences analysis, we find that P4P significantly increased the share of narrow-spectrum antibiotics. There are no signs that physicians gamed the system by issuing more prescriptions overall.

The Collaboration of General Practitioners and Nurses in Primary Care: A Comparative Analysis of Concepts and Practices in Slovenia and Spain

HÄMEL K. ET VÖSSING C.

2017

Primary Health Care Research & Development 18(5): 492-506.

https://www.cambridge.org/core/services/aop-cambridge-core/content/view/0D74562852566B753EEAF0E6E668DD00/S1463423617000354a.pdf/collaboration_of_general_practitioners_and_nurses_in_primary_care_a_comparative_analysis_of_concepts_and_practices_in_slovenia_and_spain.pdf

The aim of this study is a comparative analysis of concepts and practices of GP-nurse collaborations in primary health centres in Slovenia and Spain. Cross-professional collaboration is considered a key element for providing high-quality comprehensive care by combining the expertise of various professions. In many countries, nurses are also being given new and more extensive responsibilities. Implemented concepts of collaborative care need to be analysed within the context of care concepts, organisational structures, and effective collaboration. Background review of primary care concepts (literature analysis, expert interviews), and evaluation of collaboration in 'best practice' health centres in certain regions of Slovenia and Spain. Qualitative content analysis of expert interviews, presentations, observations, and group discussions with professionals and health centre managers. We conclude that clearly defined structures, shared visions of care and team development are important for implementing and maintaining a good collaboration. Central prerequisites are advanced nursing education and greater acceptance of advanced nursing practice.

Strengthening Primary Health Care Nursing in Europe: The Importance of a Positive Practice Environment

KENDALL S. ET BRYAR R.

2017

Nursing & Society 22(1): In press.

https://kar.kent.ac.uk/61279/

Nurses, form one of the most important groups of human resources for health in Europe – also and especially in primary health care. In this paper it is argued that to support and develop the practice of nurses in primary care, the World Health Organization initiative of Positive Practice Environments should be examined, implemented and the outcomes of such an innovation subjected to rigorous research. Having reflected on the central place of primary health care in all health systems, the evidence concerning the position of nursing in primary health care is considered and innovative models of community based nursing examined. A tool, the 'roadmap', which may be used to examine the current position of nurses in primary health care is outlined and the context within which the 'roadmap' sits, Positive Practice Environments, is then considered in detail. The paper concludes with recommendations for changes in the organisation of primary health care nursing, drawing on the available evidence, and urging the need for implementation and research into Positive Practice Environments to strengthen primary health care and the value of primary health care nursing to be fully realised. The tool could be also helpful to develop primary health care nursing in Germany where, traditionally, primary health care has been fragmented and based on a single disease model.

Financial Incentives and Physician Practice Participation in Medicare's Value-Based Reforms

MARKOVITZ A. A., *et al.*

2017

Health Serv Res (Ahead of print).

The aim of this study is to evaluate whether greater experience and success with performance incentives among physician practices are related to increased participation in Medicare's voluntary value-based payment reforms. Publicly available data from Medicare's Physician Compare (n = 1,278; January 2012 to November 2013) and nationally representative physician practice data from the National Survey of Physician Organizations 3 (NSPO3; n = 907,538; 2013). We linked physician participation data from Medicare's Physician Compare to the NSPO3 survey. Physicians organizations' prior experience and success with performance incentives were related to participation in Medicare ACO arrangements and participation in the meaningful use criteria but not to participation in Physician Compare. We conclude that Medicare must complement financial incentives with additional efforts to address the needs of practices with less experience with such incentives to promote value-based payment on a broader scale.

Patient-Perceived Responsiveness of Primary Care Systems Across Europe and the Relationship with the Health Expenditure and Remuneration Systems of Primary Care Doctors

MURANTE A. M., *et al.*

2017

Soc Sci Med 186: 139-147.

Health systems are expected to be responsive, that is to provide services that are user-oriented and respectful

of people. Several surveys have tried to measure all or some of the dimensions of the responsiveness (e.g. autonomy, choice, clarity of communication, confidentiality, dignity, prompt attention, quality of basic amenities, and access to family and community support), however there is little evidence regarding the level of responsiveness of primary care (PC) systems. This work analyses the capacity of primary care systems to be responsive. Data collected from 32 PC systems were used to investigate whether a relationship exists between the responsiveness of PC systems and the PC doctor remuneration systems and domestic health expenditure. We conclude that quality, as measured from the patient's perspective, does not necessarily overlap with PC performance based on structure and process indicators. The results could also stimulate a new debate on the role of economic resources and PC workforce payment mechanisms in the achievement of quality goals, in this case related to the capacity of PC systems to be responsive.

Exploring Context and the Factors Shaping Team-Based Primary Healthcare Policies in Three Canadian Provinces: A Comparative Analysis

MISFELDT R., *et al.*

2017

Healthcare Policy 13(1): 74-93.

This paper discusses findings from a high-level scan of the contextual factors and actors that influenced policies on team-based primary healthcare in three Canadian provinces: British Columbia, Alberta and Saskatchewan. The team searched diverse sources (e.g., news reports, press releases, discussion papers) for contextual information relevant to primary healthcare teams. We also conducted qualitative interviews with key health system informants from the three provinces. Data from documents and interviews were analyzed qualitatively using thematic analysis. We observed physician-centric policy processes with some recent moves to rebalance power and be inclusive of other actors and perspectives. The context review also highlighted the significant influence of changes in political leadership and prioritization in driving policies on team-based care. While this existed in different degrees in the three provinces, the push and pull of political and professional power dynamics shaped Canadian provincial policies governing team-based care. If we are to move team-based primary healthcare forward in Canada, the provinces need to review the external factors and the complex set of relationships and trade-offs that underscore the policy process.

Contrasting Approaches to Primary Care Performance Governance in Denmark and New Zealand

TENBENSEL T. ET BURAU V.

2017

Health Policy 121(8): 853-861.

In high-income countries, the arena of primary health care is becoming increasingly subject to 'performance governance' - the harnessing of performance information to the broader task of governance. Primary care presents many governance challenges because it is predominantly provided by sole practitioners or small organisations. In this article, we compare Denmark and New Zealand, two small countries with tax-funded health systems which have adopted quite different instruments for performance governance in primary care. We conclude that New Zealand's approach has relied heavily on 'extrinsic' incentives, whereas Denmark exhibits the opposite problem of overreliance on intrinsic motivation to improve quality, without 'extrinsic' instruments to address other important goals such as population health and equity. Our comparative framework has the potential to be applied across a wider range of countries.

Do Patient-Centered Medical Homes Improve Health Behaviors, Outcomes, and Experiences of Low-Income Patients? A Systematic Review and Meta-Analysis

VAN DEN BERK-CLARK, C., *et al.*

2017

Health Serv Res (Ahead of print).

The aim of this study is to examine: (1) what elements of patient-centered medical homes (PCMHs) are typically provided to low-income populations, (2) whether PCMHs improve health behaviors, experiences, and outcomes for low-income groups. Existing literature on PCMH utilization among health care organizations serving low-income populations. We obtained papers through existing systematic and literature reviews and via PubMed, Web of Science, and the TRIP databases, which examined PCMHs serving low-income populations. Evidence shows that the PCMH model can increase health outcomes among low-income populations. However, limitations to quality include no assessment for confounding variables. Implications are discussed.

Focused Multidisciplinary Team (MDT) Based Board Rounds Can Significantly Reduce Length of Stays (LOS) and Increase Ward Productivity

WARD K. ET FAROOQ H.

2017/07

Age & Ageing 46(Suppl. 2): ii1–ii6.

Ward 26, Blackpool Victoria Hospital, is a female Care of the Older Person (CoOP) ward. Data collected on current length of stay suggested that there was a problem with performance on the ward. To address the perceived problem it was agreed that the ward team would look at how they could improve the internal processes and improve care for the patients. Four teams of consultants had patients on the ward (as well as patients on a second ward), leading to multiple, overlapping ward rounds. There was a brief board round each day involving the nurses, therapists and discharge team. The board round function was primarily to agree when referrals should be done, rather than goal setting.

Health Systems

Improving Care Transitions Management: Examining the Role of Accountable Care Organization Participation and Expanded Electronic Health Record Functionality

HUBER T. P., *et al.*

2017

Health Serv Res 52(4): 1494-1510.

The aim of this study is to examine the extent to which physician organization participation in an accountable care organization (ACO) and electronic health record (EHR) functionality are associated with greater adoption of care transition management (CTM) processes. We used data from the third National Study of Physician Organization survey (NSPO3) to assess medical practice characteristics, including CTM processes, ACO participation, EHR functionality, practice type, organization size, ownership, public reporting, and pay-for-performance participation. We conclude that the growth of ACOs and similar provider risk-bearing arrangements across the country may improve the management of care transitions by physician organizations.

Decentralization of Health Care Systems and Health Outcomes: Evidence from a Natural Experiment

JIMENEZ-RUBIO D. A-GOMEZ P.

2017

Soc Sci Med 188: 69-81.

While many countries worldwide are shifting responsibilities for their health systems to local levels of government, there is to date insufficient evidence about the potential impact of these policy reforms. We estimate the impact of decentralization of the health services on infant and neonatal mortality using a natural experiment: the devolution of health care decision making powers to Spanish regions. The devolution was implemented gradually and asymmetrically over a twenty-year period (1981-2002). The order in

which the regions were decentralized was driven by political factors and hence can be considered exogenous to health outcomes. In addition, we exploit the dynamic effect of decentralization of health services and allow for heterogeneous effects by the two main types of decentralization implemented across regions: full decentralization (political and fiscal powers) versus political decentralization only. Our difference in differences results based on a panel dataset for the 50 Spanish provinces over the period 1980 to 2010 show that the lasting benefit of decentralization accrues only to regions which enjoy almost full fiscal and political powers and which are also among the richest regions.

The SELFIE Framework for Integrated Care for Multi-Morbidity: Development and Description

LEIJTEN F. R. M., *et al.*

2017

Health Policy(Ahead of print).

http://dx.doi.org/10.1016/j.healthpol.2017.06.002

A framework for integrated care for multi-morbidity is presented. A holistic understanding of the individual is at the core of the framework. Concepts are structured according to the six WHO key components of health systems. The framework can be used by different stakeholders in different contexts. The framework can guide the description and evaluation of integrated care for multi-morbidity.

Health System Responsiveness and Chronic Disease Care - What Is the Role of Disease Management Programs? An Analysis Based on Cross-Sectional Survey and Administrative Claims Data

ROTTGER J., *et al.*

2017

Soc Sci Med 185: 54-62.

Health system responsiveness is an important aspect of health systems performance. The concept of responsiveness relates to the interpersonal and contextual aspects of health care. While disease management programs (DMPs) aim to improve the quality of health care (e.g. by improving the coordination of care), it has not been analyzed yet whether these programs improve the perceived health system responsiveness. Our study aims to close this gap by analyzing the differences in the perceived health system responsiveness between DMP-participants and non-participants. We used linked survey- and administrative claims data from 7037 patients with coronary heart disease in Germany. Of those, 5082 were enrolled and 1955 were not enrolled in the DMP. Responsiveness was assessed with an adapted version of the WHO responsiveness questionnaire in a postal survey in 2013. The results of our study indicate an overall high responsiveness for CHD-care, as well for DMP-participants as for non-participants. Yet, the results also clearly indicate that there is still a need to improve the coordination of care.

Patient-Centred Care in Canada: Key Components and the Path Forward

MONTAGUE T., *et al.*

2017

Healthcare Quarterly 20(1): 50-56.

Canadians' health and its care continue to evolve. Chronic diseases affect more than 50% of our aging population, but the majority of public and professional stakeholders retain a sense of care quality. An emergent issue, however, is generating an increasingly wide debate. It is the concept of patient-centred care, including its definition of key components, and efficacy. To advance the evidence base, the 2013-2014 and 2016 Health Care in Canada (HCIC) surveys measured pan-stakeholder levels of support and implementation priorities for frequently proposed components of patient centricity in healthcare. The public's highest rated component was timely access to care, followed by perceived respect and caring in its delivery, with decisions made in partnership among patients and professional providers, and within a basic belief that care should be based on patients' needs versus their ability to pay. Health professionals' levels of support for key components largely overlapped the public's levels of support for key components, with an additional accent on care influenced by an evidence base and expert opinion. In terms of priority to actually implement enhanced patient-centred care options, timely access was universally dominant among all stakeholders.

An Exploration of Person-Centred Concepts in Human Services: A Thematic Analysis of the Literature

WATERS R. A. ET BUCHANAN A.

2017

Health Policy (Ahead of print).

Being 'person-centred' in the delivery of health and human services has become synonymous with quality care, and it is a core feature of policy reform in Australia and other Western countries. This research aimed to identify the uses, definitions and characteristics of the term 'person-centred' in the ageing, mental health and disability literature. A thematic analysis identified seven common core themes of person-centredness: honouring the person, being in relationship, facilitating participation and engagement, social inclusion/citizenship, experiencing compassionate love, being strengths/capacity focussed, and organisational characteristics. These suggest a set of higher-order experiences for people that are translated differently in different human services. There is no common definition of what it means to be person-centred, despite being a core feature of contemporary health and human service policy, and this suggests that its inclusion facilitates further misunderstanding and misinterpretation. A common understanding and policy conceptualisation of person-centredness is likely to support quality outcomes in service delivery especially where organisations work across human service groups. Further research into the application and service expressions of being 'person-centred' in context is necessary.

Networks in ACA Marketplaces Are Narrower for Mental Health Care Than for Primary Care

ZHU J. M., *et al.*

2017

Health Aff (Millwood) 36(9): 1624-1631.

There is increasing concern about the extent to which narrow-network plans, generally defined as those including fewer than 25 percent of providers in a given health insurance market, affect consumers' choice of and access to specialty providers-particularly in mental health care. Using data for 2016 from 531 unique provider networks in the Affordable Care Act Marketplaces, we evaluated how network size and the percentage of providers who participate in any network differ between mental health care providers and a control group of primary care providers. Compared to primary care networks, participation in mental health networks was low, with only 42.7 percent of psychiatrists and 19.3 percent of nonphysician mental health care providers participating in any network. On average, plan networks included 24.3 percent of all primary care providers and 11.3 percent of all mental health care providers practicing in a given state-level market. These findings raise important questions about provider-side barriers to meeting the goal of mental health parity regulations: that insurers cover mental health services on a par with general medical and surgical services. Concerted efforts to increase network participation by mental health care providers, along with greater regulatory attention to network size and composition, could improve consumer choice and complement efforts to achieve mental health parity.

Occupational Health

Long-Term Health Consequences of Recessions During Working Years

ANTONOVA L., *et al.*

2017

Soc Sci Med 187: 134-143.

Economic crises may have severe consequences for population health. We investigate the long-term effects of macroeconomic crises experienced during prime working age (20-50) on health outcomes later in life using SHARE data (Survey of Health Aging and Retirement in Europe) from eleven European countries. Analyses are based on the first two waves of SHARE data collected in 2004 and 2006 (N = 22,886) and retrospective life history data from SHARELIFE collected in 2008 (N = 13,732). Experiencing a severe crisis in which GDP dropped by at least 1% significantly reduces health later in life. Specifically, respondents hit by such a shock rate their subjective health as worse, are more likely to suffer from chronic diseases and mobility limitations, and have lower grip strength. The effects are twice as large among low-educated respondents. A

deeper analysis of critical periods in life reveals that respondents' health is more affected by crises experienced later in the career (between age 41 and 50). The labor market patterns show that these people drop out of the labor force. While men retire early, women are more likely to become home makers. In line with the literature on the negative consequences of retirement on health, this suggests that early retirement in times of economic crises might be detrimental to health.

The Effectiveness of Medical and Vocational Interventions for Reducing Sick Leave of Self-Employed Workers

BAERT S., *et al.*

2017

Health Econ (Ahead of print).

We investigate whether interventions by (a) medical doctors and (b) occupational specialists are effective in reducing sick leave durations among self-employed workers. Therefore, we exploit unique administrative data comprising all sick leave claims by self-employed workers insured with a major Dutch private insurer between January 2009 and March 2014. We estimate a multivariate duration model dealing with nonrandom selection into the two intervention types by controlling for observable and unobservable claimant characteristics. We find adverse treatment effects for both interventions, irrespective of whether they are started early or (middle) late in the sickness spell.

Employment Insecurity and Employees' Health in Denmark

COTTINI E. ET GHINETTI P.

2017

Health Econ. (Ahead of print).

We use register data for Denmark (IDA) merged with the Danish Work Environment Cohort Survey (1995, 2000, and 2005) to estimate the effect of perceived employment insecurity on perceived health for a sample of Danish employees. We consider two health measures from the SF-36 Health Survey Instrument: a vitality scale for general well-being and a mental health scale. We first analyse a summary measure of employment insecurity. Instrumental variables-fixed effects estimates that use firm workforce changes as a source of exogenous variation show that 1 additional dimension of insecurity causes a shift from the median to the 25th percentile in the mental health scale and to the 30th in that of energy/vitality. It also increases by about 6 percentage points the probability to develop severe mental health problems. Looking at single insecurity dimensions by naive fixed effects, uncertainty associated with the current job is important for mental health. Employability has a sizeable relationship with health and is the only insecurity dimension that matters for the energy and vitality scale. Danish employees who fear involuntary firm internal mobility experience worse mental health.

Ageing

Does Increased Medication Use Among Seniors Increase Risk of Hospitalization and Emergency Department Visits

ALLIN S., *et al.*

2017

Health Serv Res 52(4): 1550-1569.

The aim of this study is to examine the extent of the health risks of consuming multiple medications among the older population. The sources are the secondary data from the period 2004-2006. The study setting was the province of Ontario, Canada, and the sample consisted of individuals aged 65 years or older who responded to a national health survey. We estimated a system of equations for inpatient and emergency department (ED) services to test the marginal effect of medication use on hospital services. We controlled for endogeneity in medication use with a two-stage residual inclusion approach appropriate for nonlinear models. We conclude that multiple medications appear to increase the risk of hospitalization among seniors covered by a universal prescription drug plan. These results raise questions about the appropriateness of medication use and the need for increased oversight of current prescribing practices.

The Impact of the 2008 Recession on the Health of Older Workers: Data from 13 European Countries

AXELRAD H. ET SABBATH E. L.

2017

European Journal of Public Health 27(4): 647-652.

Fluctuations in the national economy shape labour market opportunities and outcomes, which in turn influence the health conditions of older workers. This study examined whether overall economic shifts during the 2008 recession was associated with four health indicators among older workers. Data came from 4917 respondents (16 090 contacts) aged 50–70 in 13 European countries (Austria, Belgium, Czech Republic, Denmark, France, Germany, Israel, Italy, Netherlands, Poland, Spain, Sweden, Switzerland) participating in the Survey of Health, Ageing and Retirement in Europe. Health and employment assessments from 2004–13 were linked to annual data on fluctuations in Gross Domestic Product (GDP) per capita, life expectancy and unemployment rates for each country. Overall economic shifts during recessions affect certain health outcomes of older workers, and better health conditions together with being employed or retired may limit the negative health consequences of a recession.

Le RAI-Home Care : utilisation, potentiels et limites dans les soins à domicile

BUSNEL C., *et al.*

2017

Gérontologie et société 39153(2): 182.

http://www.cairn.info/revue-gerontologie-et-societe-2017-2-page-167.htm

Le vieillissement démographique observé dans les pays industrialisés amène les acteurs de la santé à revoir et adapter les modèles de soins en agissant en amont des situations de dépendance des personnes âgées. Cet article discute des potentiels et des limites du « Resident Assessment Instrument – Home Care » (RAI-HC), un instrument utilisé en routine clinique par les infirmières des soins à domicile. Le RAI-HC permet d'évaluer l'état de santé global des bénéficiaires et d'établir des objectifs individualisés de prise en charge. La qualité et la nature des informations ainsi collectées sont suffisamment riches pour permettre le développement d'indicateurs et de scores reflétant des concepts utilisés dans le domaine de la gérontologie (fragilité, comorbidités, complexité). Néanmoins, pour répondre pleinement aux enjeux de prévention de la dépendance, l'utilisation du RAI-HC nécessite d'être complétée par le recours à des instruments cliniques spécifiques aux domaines de santé évalués et accompagnée de formations adaptées. Ce point est illustré par deux situations domiciliaires : le repérage de la dénutrition et celui des troubles cognitifs.

Gaining Weight Through Retirement? Results from the SHARE Survey

GODARD M.

2016

Journal of Health Economics 45(Supplement C): 27-46.

http://www.sciencedirect.com/science/article/pii/S0167629615001228

This paper estimates the causal impact of retirement on the Body Mass Index (BMI) of adults aged 50–69 years old, on the probability of being either overweight or obese and on the probability of being obese. Based on the 2004, 2006 and 2010–2011 waves of the Survey of Health, Ageing and Retirement in Europe (SHARE), our identification strategy exploits variation in European Early Retirement Ages (ERAs) and stepwise increases in ERAs in Austria and Italy between 2004 and 2011 to examine an exogenous shock to retirement behavior. Our results show that retirement induced by discontinuous incentives in early retirement schemes causes a 12-percentage point increase in the probability of being obese among men within a two- to four-year period. We find that the impact of retirement is highly non-linear and mostly affects the right-hand side of the male BMI distribution. Additional results show that this pattern is driven by men retiring from strenuous jobs and by those who were already at risk of obesity. In contrast, no significant results are found among women.

Predicting Discharge to Institutional Long-Term Care Following Acute Hospitalisation: A Systematic Review and Meta-Analysis

HARRISON J. K., *et al.*

2017

Age Ageing 46(4) : 547-558.

Moving into long-term institutional care is a significant life event for any individual. Predictors of institutional care admission from community-dwellers and people with dementia have been described, but those from the acute hospital setting have not been systematically reviewed. Our aim was to establish predictive factors for discharge to institutional care following acute hospitalisation. We searched MEDLINE; EMBASE and CINAHL Plus in September 2015. We included observational studies of patients admitted directly to long-term institutional care following acute hospitalisation where factors associated with institutionalisation were reported. We conclude that discharge to long-term institutional care following acute hospitalisation is common, but current data do not allow prediction of who will make this transition. Potentially important predictors evaluated in community cohorts have not been examined in hospitalised cohorts. Understanding these predictors could help identify individuals at risk early in their admission, and support them in this transition or potentially intervene to reduce their risk.

Frailty Status at Admission to Hospital Predicts Multiple Adverse Outcomes

HUBBARD R. E., *et al.*

2017

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Frailty is proposed as a summative measure of health status and marker of individual vulnerability. We aimed to investigate the discriminative capacity of a frailty index (FI) derived from interRAI Comprehensive Geriatric Assessment for Acute Care (AC) in relation to multiple adverse inpatient outcomes. In this prospective cohort study, an FI was derived for 1,418 patients ≤70 years across 11 hospitals in Australia. The interRAI-AC was administered at admission and discharge by trained nurses, who also screened patients daily for geriatric syndromes. We conclude the interRAI-AC can be used to derive a single score that predicts multiple adverse outcomes in older inpatients. A score of ≤ 0.40 can well discriminate patients who are unlikely to die or experience a geriatric syndrome. Whether the FI-AC can result in management decisions that improve outcomes requires further study.

Screening for Frailty in Primary Care: Accuracy of Gait Speed and Hand-Grip Strength

LEE L., *et al.*

2017

Canadian Family Physician 63(1): e51-e57.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5257239/

The aim of this study is to examine the accuracy of individual Fried frailty phenotype measures in identifying the Fried frailty phenotype in primary care. The retrospective chart review is a community-based primary care practice in Kitchener, Ont. Using modified Fried frailty phenotype measures, frailty criteria included gait speed, hand-grip strength as measured by a dynamometer, and self-reported exhaustion, low physical activity, and unintended weight loss. Sensitivity, specificity, accuracy, and precision were calculated for single-trait and dual-trait markers. We conclude that there is a need for frailty measures that are psychometrically sound and feasible to administer in primary care. While use of gait speed or grip strength alone was found to be sensitive and specific as a proxy for the Fried frailty phenotype, use of both measures together was found to be accurate, precise, specific, and more sensitive than other possible combinations. Assessing both measures is feasible within primary care.

Let's Put the Pieces Together: Frailty, Social Vulnerability, The Continuum of Care, Prevention and Research Are Key Considerations for a Dementia Care Strategy

MELISSA K. A.

2016

HealthcarePapers 16(2): 34-39.

Improving dementia care in Canada is a challenge to which we must rise. Dementia care strategies with a strong community focus are a key means of doing so. This paper outlines and expands upon the following five core areas that will contribute to the success of dementia care strategies: 1) the relationship between frailty and dementia is critical to understanding and

addressing dementia risk and management; 2) social circumstances are important to formally consider, both as risk factors for adverse outcomes and as practical factors that contribute to care and support planning; 3) a dementia care strategy must span the continuum of care, which has important ramifications for our systems of primary, acute and long-term care; 4) prevention and public education are essential components of dementia care strategies; 5) research and evaluation are critically important to any dementia care strategy, and must be seen as core components as we strive to learn what works in dementia care. Given that a coordinated effort is needed, Canada needs to join other countries that have recognized dementia as a momentous challenge to national and global health. The time for a comprehensive national dementia care strategy is now.

Inequity in Healthcare Use Among Older People After 2008: The Case of Southern European Countries

TAVARES L. P. ET ZANTOMIO F.

2017

Health Policy 121 (10) : 1063-1071

Despite the sizeable cuts in public healthcare spending, which were part of the austerity measures recently undertaken in Southern European countries, little attention has been devoted to monitoring its distributional consequences in terms of healthcare use. This study aims at measuring socioeconomic inequities in primary and secondary healthcare use experienced some time after the crisis onset in Italy, Spain and Portugal. The analysis, based on data drawn from the Survey of Health, Ageing and Retirement in Europe (SHARE), focuses on older people, who generally face significantly higher healthcare needs, and whose health appeared to have worsened in the aftermath of the crisis. The Horizontal Inequity indexes reveal remarkable socioeconomic inequities in older people's access to secondary healthcare in all three countries. In Portugal, the one country facing most severe healthcare budget cuts and where user charges apply also to GP visits, even access to primary care exhibits a significant pro-rich concentration. If reducing inequities in older people's access to healthcare remains a policy objective, austerity measures maybe pulling the Olive belt countries further away from achieving it.

Prognostic Indices for Older Adults During the Year Following Hospitalization in an Acute Medical Ward: An Update

THOMAZEAU J., *et al.*

2017

Presse Med 46(4): 360-373.

As population grow older, chronic diseases are more prevalent. It leads to an increase of hospitalization for acute decompensation, sometimes iterative. Management of these patients is not always clear, and care provided is not always proportional to life expectancy. Making decisions in acute situations is not easy. This review aims to list and describe mortality scores within a year following hospitalization of patients of 65 years or older. Following keywords were searched in title and abstract of articles via an advanced search in PudMed, and by searching Mesh terms: «aged», «aged, 80 and over», «mortality», «prognosis», «hospitalized», «models, statistical», «acute geriatric ward», «frailty», «outcome». Studies published in English between 1985 and 2015 were selected. Last article was published in June 2015. Articles that described prognostic factors of mortality without a scoring system were excluded. Articles that focus either on patients in the Emergency Department and in Intensive Care Unit, or living in institution were excluded. Twenty-two scores are described in 17 articles. These scores use items that refer to functional status, comorbidities, cognitive status and frailty. Scores of mortality 3 or 6 months after hospitalization are not discriminative. Few of the 1-year mortality prognostic score are discriminative with AUC≥ 0.7. This review is not systematic. Practical use of these scores might help management of these patients, in order to initiate appropriate reflexion and palliative care if necessary.

Integrated Care for Older Populations and Its Implementation Facilitators and Barriers: A Rapid Scoping Review

THREAPLETON D. E., *et al.*

2017

Int J Qual Health Care 29(3): 327-334.

Inform health system improvements by summarizing components of integrated care in older populations. Identify key implementation barriers and facilitators. A scoping review was undertaken for evidence from MEDLINE, the Cochrane Library, organizational websites and internet searches. Eligible publications

included reviews, reports, individual studies and policy documents published from 2005 to February 2017. Study selection: Initial eligible documents were reviews or reports concerning integrated care approaches in older/frail populations. Other documents were later sourced to identify and contextualize implementation issues. The thematic synthesis using 30 publications identified 8 important components for integrated care in elderly and frail populations. We conclude that improving integration in care requires many components. However, local barriers and facilitators need to be considered. Changes are expected to occur slowly and are more likely to be successful where elements of integrated care are well incorporated into local settings.

▶ Measuring Active and Healthy Ageing in Europe

ZAIDI A., *et al.*

2017

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The active and healthy ageing measure reported here is calculated for the 28 European Union countries, with a specific focus on the current generation of older people and by using the latest data from multiple surveys. It covers diverse aspects of active and healthy ageing, by measuring older people's contribution with respect to not just employment but also their unpaid familial, social and cultural contributions and their independent, healthy and secure living. The article presents the first-of-its-kind quantitative measure of active and healthy ageing in the literature on active and healthy ageing which hitherto has focused largely on concepts, definitions and public policy strategies.