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Assurance maladie / Health Insurance

Fuld J., Farag M., Weinstein J., Gale L.B. (2013). Enrolling and retaining uninsured and underinsured populations in public health insurance through a service integration model in New York City. *Am J Public Health,* 103 (2) : 202-205.
Abstract: Innovative strategies to identify uninsured and underinsured populations are critical to successful enrollment and retention in public health insurance. The New York City Department of Health and Mental Hygiene's Office of Health Insurance Services has partnered with the department's Early Intervention Program to implement a Service Integration Model to enroll special needs children, aged 0 to 3 years, into public health insurance. This model uses data from program databases and staff from children's programs to proactively identify uninsured and underinsured children and facilitate their enrollment into public health insurance. The model overcomes enrollment barriers by using consumer-friendly enrollment materials and one-on-one assistance, and shows the benefits of a comprehensive and collaborative approach to assisting families with enrollment into public health insurance
PM:23237169

Economie de la santé / Health Economics

Williams C., Maruthappu M. (2013). "Healthconomic crises": public health and neoliberal economic crises. *Am J Public Health,* 103 (1) : 7-9.
PM:23153141

Chereches R.M., Ungureanu M.I., Sandu P., Rus I.A. (2013). Defining informal payments in healthcare: A systematic review. *Health Policy,* 110 (2-3) : 105-114.
Abstract: Objectives: To explore the literature for the definitions of informal payments in healthcare and critically analyze the proposed definitions. This will serve in the process of getting to a coherent definition of informal payments, which will further support acknowledging and addressing them globally. Methods: A search strategy was developed to identify papers addressing informal payments on PubMed, ScienceDirect, Econlit, EconPapers and Google Scholar. Results: 2225 papers were identified after a first search. 61 papers were included in the systematic review. Out of all definitions provided, we selected three definitions as being original. All other definitions either cite these definitions or do not provide new insight into the topic of informal payments. Although informal payments have been nominated by various terms over the years, there is a tendency in recent years towards an agreement to use this singular term. Definitions differ in terms of the relation of informal payments with other informal activities, their legality and the motivation behind them. Conclusions: The variety of forms which informal payments may take makes it difficult to define them in a comprehensive manner. However, we identified a definition that could serve as a beginning in this process. More effort is needed to build on it and get to a commonly accepted and shared definition of informal payments
PM:23410757

Daidone S., Street A. (2013). How much should be paid for specialised treatment? *Soc Sci.Med,* 84 110-118.
Abstract: English health policy has moved towards establishing specialist multi-disciplinary teams to care for patients suffering rare or particularly complex conditions. But the healthcare resource groups (HRGs), which form the basis of the prospective payment system for hospitals, do not explicitly account for specialist treatment. There is a risk, then, that hospitals in which specialist teams are based might be financially disadvantaged if patients requiring specialised care are more expensive to treat than others allocated to the same HRG. To assess this we estimate the additional costs

associated with receipt of specialised care. We analyse costs for 12,154,599 patients treated in 163 English hospitals in fiscal year 2008/09 according to the type of specialised care received, if any. We account for the distributional features of patient cost data, and estimate ordinary least squares and generalised linear regression models with random effects to isolate what influence the hospital itself has on costs. We find that, for nineteen types of specialised care, patients do not have higher costs than others allocated to the same HRG. However, costs are higher if a patient has cancer, spinal, neurosciences, cystic fibrosis, children's, rheumatology, colorectal or orthopaedic specialised services. Hospitals might be paid a surcharge for providing these forms of specialised care. We also find substantial variation in the average cost of treatment across the hospital sector, due neither to the provision of specialised care nor to other characteristics of each hospital's patients
PM:23453863

Ellis R.P., Fiebig D.G., Johar M., Jones G., Savage E. (2013). Explaining health care expenditure variation large sample evidence using linked survey and health administrative data. *Health Econ,* [Epub ahead of print]
Abstract: Explaining individual, regional, and provider variation in health care spending is of enormous value to policymakers but is often hampered by the lack of individual level detail in universal public health systems because budgeted spending is often not attributable to specific individuals. Even rarer is self-reported survey information that helps explain this variation in large samples. In this paper, we link a cross-sectional survey of 267 188 Australians age 45 and over to a panel dataset of annual healthcare costs calculated from several years of hospital, medical and pharmaceutical records. We use this data to distinguish between cost variations due to health shocks and those that are intrinsic (fixed) to an individual over three years. We find that high fixed expenditures are positively associated with age, especially older males, poor health, obesity, smoking, cancer, stroke and heart conditions. Being foreign born, speaking a foreign language at home and low income are more strongly associated with higher time-varying expenditures, suggesting greater exposure to adverse health shocks. Copyright (c) 2013 John Wiley & Sons, Ltd
PM:23494838

Piacenza M., Turati G. (2013). Does fiscal discipline towards subnational governments affect citizen's well being? Evidence on health. *Health Econ,* [Epub ahead of print]
Abstract: This paper aims to assess the impact on citizens' well-being of fiscal discipline imposed by the central government on subnational governments. Because healthcare policies involve strategic interactions between different layers of governments in many different countries, we focus on a particular dimension of well-being, namely citizens' health. We model fiscal discipline by considering government expectations of future deficit bailouts from the central government. We then study how these bailout expectations affect the expenditure for healthcare policies carried out by decentralized governments. To investigate this issue, we separate efficient health spending from inefficiencies by estimating an input requirement frontier. This allows us to assess the effects of bailout expectations on both the structural component of health expenditure and its deviations from the 'best practice'. The evidence from the 15 Italian ordinary statute regions (observed from 1993 to 2006) points out that bailout expectations do not significantly influence the position of the frontier, thus not affecting citizens' health. However, they do appear to exert a remarkable impact on excess spending. Copyright (c) 2013 John Wiley & Sons, Ltd
PM:23408583

Géographie de la santé / Geography of Health

Audureau E., Rican S.p., Coste J.I. (2003). From deindustrialization to individual health-related quality of life: multilevel evidence of contextual predictors, mediators and modulators across French regions, 2003. *Health & Place,* (Ahead in press) :
Abstract: Although small area effects on health-related quality of life (HRQoL) have been extensively studied, less is known at the regional level, particularly in France where no multilevel evidence is available. Using data from a large representative cross-sectional survey conducted in 2003 (N=16

732), this study explores individual and regional determinants of the SF-36 Physical Functioning and Mental Health subscales. We considered a causal pathway leading from deindustrialization to HRQoL and assessed the roles of net migratory flows, deprivation, and the social and physical environment. Worse HRQoL results were found in regions most affected by deindustrialization, with evidence for mediating effects of migration, voter abstention rate and individual health-related behaviors. Cross-level interactions and intraregional heterogeneity were also found, confirming the complexity of individual-area relationships and the need for carefully conceptualized multilevel analyses to guide health policies effectively
http://www.sciencedirect.com/science/article/pii/S1353829213000403

Saunders M.R., Chin M.H. (2013). Variation in Dialysis Quality Measures by Facility, Neighborhood, and Region. *Medical Care,* 51 (5) :
Abstract: Background : We examined whether dialysis facility characteristics, neighborhood demographics, and region are associated with Centers for Medicare and Medicaid Services (CMS) dialysis facility quality measures in order to determine the most important targets for intervention. Methods: We linked US census data to the CMS Dialysis Compare File which contains information for facility outcomes for all CMS-certified dialysis facilities in 2007 (n=5616). We then used linear and logistic regression to characterize the association between dialysis facility quality-worse than expected patient survival, and the proportion of individuals in a facility achieving dialysis adequacy (urea reduction rate >65) or target hemoglobin (10<Hgb<12 g/dL)-and dialysis facility characteristics, neighborhood demographics, and region. Results: : Only an increasing proportion of African Americans in the neighborhood is consistently associated with worse dialysis facility outcomes, even after controlling for neighborhood poverty. Facilities with the highest proportion of African Americans in the neighborhood had worse patient survival [odds ratio (OR) 4.6; 95% confidence interval (CI), 2.8-7.6], were less likely to have adequate dialysis (β -1.4; 95% CI, -2.3 to -0.6), and achieve targeted hemoglobin (β -3.1; 95% CI, -4.7 to -1.6) compared to those with the lowest proportion. No other predictor-facility, neighborhood, or region-was consistently associated with dialysis facility quality. Conclusions: The proportion of African Americans in the dialysis facility neighborhood is strongly and consistently associated with lower facility quality. Quality improvement efforts are particularly needed for dialysis facilities in minority communities.

Badland H., Turrell G., Giles-Corti B. (2013). Who does well where? Exploring how self-rated health differs across diverse people and neighborhoods. *Health & Place,* (Ahead in press) :
Abstract This work establishes whether neighborhood disadvantage amplifies the impact of socioeconomic position (SEP) on a graded measure of self-rated health (SRH). SRH data were taken from 10,932 adults recruited across 200 Brisbane neighborhoods. After adjusting for demographics, those who lived in the most disadvantaged neighborhoods were more likely to report poor SRH than those living in the least disadvantaged neighborhoods (OR=2.67). Those with the lowest SEP and lived in the most advantaged neighborhoods had a similar probability of reporting excellent SRH as those with the highest SEP living in the most disadvantaged neighborhoods. This work highlights the importance of examining SEP and neighborhood-level disadvantage simultaneously when planning communities

Yiannakoulias N., Bland W., Svenson L.W. (2013). Estimating the effect of turn penalties and traffic congestion on measuring spatial accessibility to primary health care. *Applied Geography,* 39 (0) : 172-182.
Abstract: Geographic variations in spatial accessibility to public resources, such as health care services, raise important questions about the efficiencies and inequities of the processes that determine where these services are located. Spatial accessibility can be measured many different ways, but many of methods in use today involve some measure of travel cost (in time or distance). In this study we explore a simple methodological question: how much are models of spatial accessibility influenced by the precise metric of travel cost? We address this question by comparing spatial accessibility to primary care physicians for two different methods of calculating travel cost (in time) on a street network: free-flow travel time and congested with turn penalties travel time which augments free-flow travel times with the burden of traffic congestion and traffic intersection controls. We consider the effect of these two metrics of travel cost on a gravity-based measure of spatial accessibility to primary health care services in Edmonton, Alberta, Canada. Our results suggest that while travel times

between locations of demand and locations of primary care providers greatly differ based on how travel cost is calculated, the gravity-based measure of spatial accessibility provides similar information for both travel cost metrics. Using congested with turn penalties travel time can be an onerous addition to the analysis of spatial accessibility, and is more useful for measuring absolute travel time rather than modeling relative spatial accessibility

Aschan-Leygonie C., Baudet-Michel S., Mathian H., Sanders L. (2013). Gaining a better understanding of respiratory health inequalities among cities: an ecological case study on elderly males in the larger French cities. *Int J Health Geogr.,* 12 (1) : 19.
Abstract: Background: In recent years, there have been a growing number of studies on spatial inequalities in health covering a variety of scales, from small areas to metropolitan areas or regions, and for various health outcomes. However, few investigations have compared health status between cities with a view to gaining a better understanding of the relationships between such inequalities and the social, economic and physical characteristics. This paper focuses on disparities in respiratory health among the 55 largest French cities. The aim is to explore the relationships between inter-urban health patterns, city characteristics and regional context, and to determine how far a city's health status relates to the features observed on different geographical scales. Methods: We used health data describing hospitalizations for Chronic Obstructive Pulmonary Disease (COPD) as a proxy for respiratory health, and the total number of hospitalizations (overall) as a proxy for general health. This last indicator was used as a benchmark. A large set of indicators relating to socioeconomic, physical and amenity aspects of the cities (urban units) was also constructed. Data were analyzed using linear correlations and multiple linear regression models. Results: The results suggest that socioeconomic characteristics are major discriminators for inequalities in respiratory health status among urban units. Indeed, once combined to socioeconomic characteristics, only a climate indicator remained significant among the physical indicators. It appeared that the pollution indicators which were significantly correlated with COPD hospitalization rates loosed significance when associated to the socio-economic indicators in a multiple regression. The analysis showed that among the socio-economic indicators, an employment indicator derived at the regional scale, and two indicators reflecting the unequal intra-urban spatial distribution of population according to their education, were the most efficient to describe differences in the respiratory health status of urban units. Conclusion: In order to design effective urban policies, it is essential to gain a better understanding of the differences among cities in their entirety, rather than solely differences across small urban areas or individuals
PM:23575258

Chaix B., Meline J., Duncan S., Merrien C., Karusisi N., Perchoux C., Lewin A., Labadi K., Kestens Y. (2013). GPS tracking in neighborhood and health studies: A step forward for environmental exposure assessment, a step backward for causal inference? *Health Place,* 21 46-51.
Abstract: Recent studies have relied on GPS tracking to assess exposure to environmental characteristics over daily life schedules. Combining GPS and GIS allows for advances in environmental exposure assessment. However, biases related to selective daily mobility preclude assessment of environmental effects, to the extent that these studies may represent a step backward in terms of assessment of causal effects. A solution may be to integrate the Public health / Nutrition approach and the Transportation approach to GPS studies, so as to combine a GPS and accelerometer data collection with an electronic mobility survey. Correcting exposure measures and improving study designs with this approach may permit mitigating biases related to selective daily mobility
PM:23425661

Hôpital / Hospitals

Newhouse R.P., Dennison Himmelfarb C., Morlock L., Frick K.D., Pronovost P., Liang Y. (2013). A Phased Cluster-randomized Trial of Rural Hospitals Testing a Quality Collaborative to Improve Heart Failure Care: Organizational Context Matters. *Medical*

Care, 51 (5) : 396-403.
Abstract: Background: Use of evidence-based practices for heart failure (HF) patients has the potential to improve outcomes and reduce variations in care delivery. Objectives: To evaluate the effect of a rural hospital quality collaborative and organizational context (nurse staffing and practice environment) on 4 HF core measures. Research Design: Phased cluster-randomized trial with delayed intervention control group. The intervention included a HF toolkit, 2 onsite meetings, and a monthly phone call. Subjects : Twenty-three rural eastern US hospitals, registered nurses who care for HF patients (N=591). Measures: Seven quarters of 4 HF core measures, nurse staffing (nursing skill mix, registered nurse hours per patient day, nurse-turnover), and a survey of practice environment. RESULTS: Using regression models with generalized estimating equation autoregressive methods, no statistically significant changes were found during the intervention period on all 4 core measures for either group. Higher nurse-turnover was related to all 4 core measures: lower compliance with discharge instructions [β=-1.042; 95% confidence interval (CI): -1.777, -0.307], smoking cessation (β=-1.148; 95% CI: -2.180, -0.117), left ventricular ejection fraction (β=-0.893; 95% CI: -1.784, -0.002), and prescribing angiotensin converting enzyme inhibitors on discharge (β=-1.044; 95% CI: -1.820, -0.269). Better practice environment was related to higher left ventricular ejection fraction (β=0.217; 95% CI: 0.054, 0.379). Conclusions: Significant improvements in 4 core measures were realized in stable environments (less nurse-turnover). Assuring appropriate nurse staffing and stability is essential to increase organizational preparation for quality initiatives and adoption of best practices in HF care in rural hospitals.

De Belvis A.G., Marino M., Avolio M., Pelone F., Basso D., Dei Tos G.A., Cinquetti S., Ricciardi W. (2013). Wait watchers: the application of a waiting list active management program in ambulatory care. *International Journal for Quality in Health Care,* 25 (2) : 205-212.
Abstract: Objective This study describes and evaluates the application of a waiting list management program in ambulatory care. Design Waiting list active management survey (telephone call and further contact); before and after controlled trial. Setting Local Health Trust in Veneto Region (North-East of Italy) in 2008â€“09.Participants Five hundred and one people on a 554 waiting list for C Class ambulatory care diagnostic and/or clinical investigations (electrocardiography plus cardiology ambulatory consultation, eye ambulatory consultation, carotid vessels Eco-color-Doppler, legs Eco-color-Doppler or colonoscopy, respectively).Intervention Active list management program consisting of a telephonic interview on 21 items to evaluate socioeconomic features, self-perceived health status, social support, referral physician, accessibility and patients' satisfaction. A controlled before-and-after study was performed to evaluate anonymously the overall impact on patients' self-perceived quality of care. Main outcome measures The rate of patients with deteriorating healthcare conditions; rate of dropout; interviewed degree of satisfaction about the initiative; overall impact on citizens' perceived quality of care. Results 95.4% patients evaluated the initiative as useful. After the intervention, patients more likely to have been targeted with the program showed a statistically significant increase in self-reported quality of care. Conclusions Positive impact of the program on some dimensions of ambulatory care quality (health status, satisfaction, willingness to remain in the queue), thus confirming the outstanding value of 'not to leave people alone' and 'not to leave them feeling themselves alone' in healthcare delivery.

Georgescu I., Hartmann F.G. (2013). Sources of financial pressure and up coding behavior in French public hospitals. *Health Policy,* 110 (2-3) : 156-163.
Abstract: Drawing upon role theory and the literature concerning unintended consequences of financial pressure, this study investigates the effects of health care decision pressure from the hospital's administration and from the professional peer group on physician's inclination to engage in up coding. We explore two kinds of up coding, information-related and action-related, and develop hypothesis that connect these kinds of data manipulation to the sources of pressure via the intermediate effect of role conflict. Qualitative data from initial interviews with physicians and subsequent questionnaire evidence from 578 physicians in 14 French hospitals suggest that the source of pressure is a relevant predictor of physicians' inclination to engage in data-manipulation. We further find that this effect is partly explained by the extent to which these pressures create role conflict. Given the concern about up coding in treatment-based reimbursement systems worldwide, our analysis adds to understanding how the design of the hospital's management control system may enhance this undesired type of behavior
PM:23477807

Quentin W., Scheller-Kreinsen D., Blumel M., Geissler A., Busse R. (2013). Hospital payment based on diagnosis-related groups differs in Europe and holds lessons for the United States. *Health Aff.(Millwood.),* 32 (4) : 713-723.
Abstract: England, France, Germany, the Netherlands, and Sweden spend less as a share of gross domestic product on hospital care than the United States while delivering high-quality services. All five European countries have hospital payment systems based on diagnosis-related groups (DRGs) that classify patients of similar clinical characteristics and comparable costs. Inspired by Medicare's inpatient prospective payment system, which originated the use of DRGs, European DRG systems have implemented different design options and are generally more detailed than Medicare's system, to better distinguish among patients with less and more complex conditions. Incentives to treat more cases are often counterbalanced by volume ceilings in European DRG systems. European payments are usually broader in scope than those in the United States, including physician salaries and readmissions. These European systems, discussed in more detail in the article, suggest potential innovations for reforming DRG-based hospital payment in the United States
PM:23569051

Benning T.M., Dellaert B.G. (2013). Paying more for faster care? Individuals' attitude toward price-based priority access in health care. *Soc Sci.Med,* 84 119-128.
Abstract: Increased competition in the health care sector has led hospitals and other health care institutions to experiment with new access allocation policies that move away from traditional expert based allocation of care to price-based priority access (i.e., the option to pay more for faster care). To date, little is known about individuals' attitude toward price-based priority access and the evaluation process underlying this attitude. This paper addresses the role of individuals' evaluations of collective health outcomes as an important driver of their attitude toward (price-based) allocation policies in health care. The authors investigate how individuals evaluate price-based priority access by means of scenario-based survey data collected in a representative sample from the Dutch population (N = 1464). They find that (a) offering individuals the opportunity to pay for faster care negatively affects their evaluations of both the total and distributional collective health outcome achieved, (b) however, when health care supply is not restricted (i.e., when treatment can be offered outside versus within the regular working hours of the hospital) offering price-based priority access affects total collective health outcome evaluations positively instead of negatively, but it does not change distributional collective health outcome evaluations. Furthermore, (c) the type of health care treatment (i.e., life saving liver transplantation treatment vs. life improving cosmetic ear correction treatment - priced at the same level to the individual) moderates the effect of collective health outcome evaluations on individuals' attitude toward allocation policies. For policy makers and hospital managers the results presented in this article are helpful because they provide a better understanding of what drives individuals' preferences for health care allocation policies. In particular, the results show that policies based on the "paying more for faster care" principle are more attractive to the general public when treatment takes place outside the regular working hours of a hospital
PM:23466260

Genet N., Kroneman M., Boerma W.G. (2013). Explaining governmental involvement in home care across Europe: An international comparative study. *Health Policy,* 110 (1) : 84-93.
Abstract: The involvement of governments in the home care sector strongly varies across Europe. This study aims to explain the differences through the conditions for the involvement of informal care and governments in society; wealth and the demographic structure. As this study could combine qualitative data and quantitative data analyses, it could consider larger patterns than previous studies which were often based on ideographic historical accounts. Extensive data were gathered in 30 European countries, between 2008 and 2010. In each country, policy documents were analysed and experts were interviewed. International variation in regulation and governmental funding of personal care and domestic aid are associated with differences in prevailing values on family care, tax burden and wealth in a country. Hence, this study provides evidence for the obstacles - i.e. country differences - for transferring home care policies between countries. However, longitudinal research is needed to establish whether this is indeed the causal relationship we expect
PM:23399041

Kozhimannil K.B., Law M.R., Virnig B.A. (2013). Cesarean delivery rates vary tenfold among US hospitals; reducing variation may address quality and cost issues. *Health Aff.(Millwood.),* 32 (3) : 527-535.
Abstract: Cesarean delivery is the most commonly performed surgical procedure in the United States, and cesarean rates are increasing. Working with 2009 data from 593 US hospitals nationwide, we found that cesarean rates varied tenfold across hospitals, from 7.1 percent to 69.9 percent. Even for women with lower-risk pregnancies, in which more limited variation might be expected, cesarean rates varied fifteen fold, from 2.4 percent to 36.5 percent. Thus, vast differences in practice patterns are likely to be driving the costly overuse of cesarean delivery in many US hospitals. Because Medicaid pays for nearly half of US births, government efforts to decrease variation are warranted. We focus on four promising directions for reducing these variations, including better coordinating maternity care, collecting and measuring more data, tying Medicaid payment to quality improvement, and enhancing patient-centered decision making through public reporting
PM:23459732

Inégalités sociales de santé / Social Health Inequalities

Alexander-Eitzman B., Pollio D.E., North C.S. (2013). The neighborhood context of homelessness. *Am J Public Health,* 103 (4) : 679-685.
Abstract: Objectives. We examined and compared the changing neighborhood characteristics of a group of homeless adults over time. Methods. We collected the addresses of previous housing and sleep locations from a longitudinal study of 400 homeless adults in the St. Louis, Missouri, region and compared census measures of housing and economic opportunities at different points along individual pathways from housing to homelessness and at 1- and 2-year follow-up interviews. Results. Sleep locations of homeless adults were much more concentrated in the urban core at baseline than were their previous housed and follow-up locations. These core areas had higher poverty, unemployment, and rent-to-income ratios and lower median incomes. Conclusions. The spatial concentration of homeless adults in areas with fewer opportunities and more economic and housing distress may present additional barriers to regaining stable housing and employment. A big-picture spatial and time-course viewpoint is critical for both policymakers and future homelessness researchers
PM:23409889

Arroyave I., Cardona D., Burdorf A., Avendano M. (2013). The impact of increasing health insurance coverage on disparities in mortality: health care reform in Colombia, 1998-2007. *Am J Public Health,* 103 (3) : e100-e106.
Abstract: Objectives: We examined the impact of expanding health insurance coverage on socioeconomic disparities in total and cardiovascular disease mortality from 1998 to 2007 in Colombia. Methods: We used Poisson regression to analyze data from mortality registries (633 905 deaths) linked to population census data. We used the relative index of inequality to compare disparities in mortality by education between periods of moderate increase (1998-2002) and accelerated increase (2003-2007) in health insurance coverage. Results: Disparities in mortality by education widened over time. Among men, the relative index of inequality increased from 2.59 (95% confidence interval [CI] = 2.52, 2.67) in 1998-2002 to 3.07 (95% CI = 2.99, 3.15) in 2003-2007, and among women, from 2.86 (95% CI = 2.77, 2.95) to 3.12 (95% CI = 3.03, 3.21), respectively. Disparities increased yearly by 11% in men and 4% in women in 1998-2002, whereas they increased by 1% in men per year and remained stable among women in 2003-2007. Conclusions: Mortality disparities widened significantly less during the period of increased health insurance coverage than the period of no coverage change. Although expanding coverage did not eliminate disparities, it may contribute to curbing future widening of disparities
PM:23327277

Muennig P., Cohen A.K., Palmer A., Zhu W. (2013). The relationship between five different measures of structural social capital, medical examination outcomes, and mortality. *Soc Sci.Med,* 85 18-26.

Abstract: Higher social capital is associated with improved mental and physical health and reduced risk of premature mortality. We explored the relationship between five measures of structural social capital and 1) intermediate health outcomes (elevated C-reactive protein, cholesterol, blood pressure, and serum fibrinogen) and 2) distal outcomes (cardiovascular and all cause mortality). We did so using the National Health and Nutrition Examination Survey III 1988-1994 linked to the National Death Index with mortality follow-up through 2006. We employed ordinary least squares regression for the intermediate outcomes, seemingly unrelated regression (SUR) to consider combined effects, and Cox proportionate hazards models for mortality outcomes. We then performed extensive sensitivity analyses, exploring the contribution of various variables and reverse causality. We find that our measures of social capital did not predict statistically significant changes in the laboratory biomarkers we study. Nevertheless, belonging to organizations or attending church >12 times per year were associated with reduced all cause mortality (hazard ratio [HR] = 0.81, 95% confidence interval [CI] = 0.70-0.93 and HR = 0.72, 95% CI = 0.60-0.86, respectively). In SUR analyses, however, combined laboratory values were significant for all measures of social capital we study with the exception of visits to neighbors. This suggests that some forms of structural social capital improve survival through small changes in multiple measures of biological risk factors rather than moderate or large changes in any one measure
PM:23540361

Baker J., Mitchell R., Pell J. (2013). Cross-sectional study of ethnic differences in the utility of area deprivation measures to target socioeconomically deprived individuals.

Soc Sci.Med, 85 27-31.
Abstract: Area deprivation measures provide a pragmatic tool for targeting public health interventions at socioeconomically deprived individuals. Ethnic minority groups in the UK experience higher levels of socioeconomic deprivation and certain associated diseases than the White population. The aim of this study was to explore ethnic differences in the utility of area deprivation measures as a tool for targeting socioeconomically deprived individuals. We carried out a cross-sectional study using the Health Survey for England 2004. 7208 participants aged 16-64 years from the four largest ethnic groups in England (White, Indian, Pakistani and Black Caribbean) were included. The main outcome measures were percentage agreement, sensitivity and positive predictive value (PPV) of area deprivation, measured using Index of Multiple Deprivation 2004, in relation to individual socioeconomic position (measured by education, occupation, income, housing tenure and car access). We found that levels of both area and individual deprivation were higher in the Pakistani and Black Caribbean groups compared to the White group. Across all measures, agreement was lower in the Pakistani (50.9-63.4%) and Black Caribbean (61.0-70.1%) groups than the White (67.2-82.4%) group. However, sensitivity was higher in the Pakistani (0.56-0.64) and Black Caribbean (0.59-0.66) groups compared to the White group (0.24-0.38) and PPV was at least as high. The results for the Indian group were intermediate. We conclude that, in spite of lower agreement, area deprivation is better at identifying individual deprivation in ethnic minority groups. There was no evidence that area based targeting of public health interventions will disadvantage ethnic minority groups
PM:23540362

Asthana S., Gibson A., Halliday J. (2013). The medicalisation of health inequalities and the English NHS: the role of resource allocation.

Health Econ Policy Law, 8 (2) : 167-183.
Abstract: Tackling health inequalities (HI) has become a key policy objective in England in recent years. Yet, despite the wide-ranging policy response of the 1997-2010 Labour Government, socio-economic variations in health continued to widen. In this paper, we seek to explore why. We propose that a meta-narrative has emerged in which the health problems facing England's most deprived areas, and the solution to those problems, have increasingly come to be linked to levels of National Health Service (NHS) funding. This has been, in part, a response to key shortcomings in previous rounds of resource allocation. The very significant sums of money allocated with respect to 'health inequalities' reflects and reinforces the belief that the NHS can and should play a central role in promoting health equity. This medicalisation of HI focuses attention on the role of individual risk factors that lend themselves to medical management, but effectively sidelines the macroprocesses of social inequality, legitimising the kind of society that neo-liberal government has produced in the United Kingdom - one in which health (like other assets) has become a matter of individual and not collective responsibility
PM:22947257

Erreygers G. (2013). A dual Atkinson measure of socioeconomic inequality of health.
Health Econ, 22 (4) : 466-479.
Abstract: The Atkinson index of income inequality is based on a comparison of the average income with the equivalent income, where the equivalent income is defined as the level of income that, if given to everyone, would generate the same social welfare as the existing distribution of income. This paper explores the possibility of extending this approach to the measurement of socioeconomic inequality of health. It assumes a social evaluation function that depends upon two variables: socioeconomic status as well as health status. With a general form of this function, an Atkinson measure is derived, which gives exactly the same result when applied to the socioeconomic variable and when applied to the health variable. The paper examines the properties of the index and suggests various extensions
PM:22514155

Médicaments / Pharmaceuticals

Stordeur S, Vinck I., Neyt M e.a. (2013). Mise sur le marché européen des dispositifs médicaux innovants à haut risque : l'efficacité clinique et la sécurité sont-elles garanties ? *Revue d'Epidémiologie et de Santé Publique,* 61 (2) : 105-110.
Abstract: Position du problème : Les dispositifs médicaux innovants à haut risque, tel qu'un nouveau type de valve cardiaque ou de prothèse de hanche, arrivent souvent plus rapidement sur le marché européen qu'aux États-Unis. La raison en est que la législation européenne autorise la mise sur le marché de ces dispositifs médicaux avant que leur efficacité clinique soit confirmée par des essais cliniques de grande qualité, contrôlés et randomisés. Méthodes : Nous avons étudié et comparé les procédures d'évaluation clinique des dispositifs médicaux innovants à haut risque en Europe et aux États-Unis. Les questions liées à la sécurité du patient et à la transparence de l'information ont été traitées. La littérature scientifique et les textes réglementaires ont été examinés. Les représentants de l'industrie, des autorités compétentes, des organismes certifiés, des comités d'éthique et des agences d'évaluation des technologies de santé ont été consultés. Résultats : Contrairement aux États-Unis, l'Europe n'exige aucune démonstration de l'efficacité clinique des dispositifs médicaux à haut risque avant leur mise sur le marché. Ainsi, le patient peut avoir accès plus rapidement aux nouvelles technologies, mais est aussi confronté à des risques encore inconnus. À l'heure actuelle, les exigences européennes en termes d'études cliniques sont moindres pour ces technologies qu'elles ne le sont pour les médicaments, et les données des essais cliniques conduits avant la mise sur le marché sont pauvres ou inaccessibles. Une nouvelle Directive européenne est actuellement en préparation. Conclusion : En attendant la nouvelle législation européenne, les risques encourus par les patients devraient être réduits en réservant l'utilisation de ces dispositifs aux médecins ayant une formation et une expérience suffisantes. La nouvelle directive devrait exiger que l'efficacité et la sécurité cliniques soient suffisamment démontrées au préalable, avec des études comparatives de bonne qualité, de préférence des essais contrôlés randomisés, un processus de révision transparent et centralisé.

Smith S.W., Sfekas A. (2013). How Much do Physician-Entrepreneurs Contribute to New Medical Devices? *Medical Care,* 51 (5) : 461-7
Abstract: Objectives: As recent public and private initiatives have sought to increase the transparency of physician-industry financial relationships (including calls for restricting collaboration), it is important to understand the extent of physicians' contributions to new medical devices. We quantify the contribution of information from physician-founded startup companies to 170 premarket approval (PMA) applications filed by 4 large incumbent medical device manufacturers over the period 1978-2007. We ask: Are incumbents more likely to incorporate information from physician-founded firms than nonphysician-founded firms? Methods: We matched the text in 4 incumbent medical device firms' PMAs (Medtronic, Johnson & Johnson, Boston Scientific, and Guidant) to the text in patent applications of 118 startup companies that received investment from these incumbents between 1978 and 2007. We use a text-matching algorithm to quantify the information contribution from physician and nonphysician-founded startups to incumbent firms' PMAs. We analyze correlates of backward citations and degree of overlap between incumbents'PMAs and startups' patents using negative binomial and tobit regressions. Findings: On average, physician-founded companies account for 11%

of the information in PMAs, compared with 4% from nonphysician-founded companies. Regression results show that incumbents are significantly more likely to cite physician-founded companies' patents and to incorporate them into new devices. Conclusions: Physicians are an important source of medical device innovation. The results suggest that restrictions on financial relationships between providers and industry, while potentially improving patients' trust, may result in reduced medical innovation if physicians found fewer startups or if incumbent firms reduce investments in physician-founded startups

Michael R.L. (2013). Money Left on the Table: Generic Drug Prices in Canada.

Healthcare Policy, 8 (3) : 17-25.
Abstract: Background: Generic drugs are a major cost-saving opportunity for patients and drug plans. While almost every province has reduced generic drug prices, we have no information on whether these new prices are internationally competitive. Therefore, I compared Canadian prices to those in two other countries. Methods: I used 2009 data from the IMS Brogan Canadian CompuScript and PharmaStat databases and studied the 100 most frequently dispensed generic products in Ontario, which has Canada's lowest generic prices. I compared these prices to those in public drug programs in the United States and New Zealand that use tendering. Using these alternative prices, I calculated the potential savings in Ontario. Results: Of the top 100 generic products, 82 were listed on an international formulary. In 90% of cases, generic products were less expensive in other countries. If Ontario had obtained the lowest comparator price for these products, the annual public sector and overall drug expenditure savings would have been $129 million and $245 million, respectively. Further, the province could have publicly paid for all these generic drugs; both public and private, and saved $87 million compared to current public sector expenditures. Discussion: Even after recent reforms, generic drug prices in Canada remain high by international standards. I found that if Ontario had obtained commonly used generic drugs at international best prices, the province could have publicly paid for all generic drugs and lowered annual expenditures by nearly a quarter-billion dollars.

Allin S., Law M.R., Laporte A. (2013). How does complementary private prescription drug insurance coverage affect seniors' use of publicly funded medications?

Health Policy, 110 (2-3) : 147-155.
Abstract: Background: Like in many other high-income jurisdictions, the public drug program in Ontario, Canada provides comprehensive coverage of prescription drugs to the 65 years and older population with some cost sharing. The objective of this study was to examine the marginal impact of holding private drug coverage on the use of publicly funded medicines among the senior population in Ontario. Methods: We drew on linked survey and administrative data sources to examine the impact of private drug coverage first on total spending and utilization of medications, and second, on clinically recommended medications for individuals with a diagnosis of diabetes. Results: Approximately 27% of Ontario seniors reported having private prescription drug insurance from a current or prior employer. The population-level analysis of all seniors found that individuals with private insurance coverage, on average, took about a quarter of an additional drug and incurred 16% more in costs to the public program in a year compared to those without additional coverage. The disease-specific analysis of seniors with a diagnosis of diabetes found that private coverage was associated with two-fold higher odds of taking an anti-hypertensive drug, but it had no association with the use of statins or anti-diabetic medications. Discussion: The results of this study provide some evidence that seniors in Ontario are sensitive to the price of drugs. These findings raise equity concerns relating to the cost sharing arrangements in the public system and our policy of allowing private plans to "top-up" the public plan
PM:23522381

Kanavos P., Ferrario A., Vandoros S., Anderson G.F. (2013). Higher US Branded Drug Prices And Spending Compared To Other Countries May Stem Partly From Quick Uptake Of New Drugs.

Health Aff.(Millwood.), 32 (4) : 753-761.
Abstract: The United States spends considerably more per capita on prescription drugs than other countries in the Organization for Economic Cooperation and Development (OECD). Drawing on the Intercontinental Medical Statistics Midas database, we examined the variation in drug prices among selected OECD countries in 2005, 2007, and 2010 to determine which country paid the highest prices for brand-name drugs, what factors led to variation in per capita drug spending, and what factors contributed to the rate of increase in drug spending. We found that depending on how prices were weighted for volume across the countries, brand-name prescription drug prices were 5-198 percent

higher in the United States than in the other countries in all three study years. (A limitation is that many negotiated price discounts obtained in the United States may not be fully reflected in the results of this study.) A contributor to higher US per capita drug spending is faster uptake of new and more expensive prescription drugs in the United States relative to other countries. In contrast, the other OECD countries employed mechanisms such as health technology assessment and restrictions on patients' eligibility for new prescription drugs, and they required strict evidence of the value of new drugs. Similarly, US health care decision makers could consider requiring pharmaceutical manufacturers to provide more evidence about the value of new drugs in relation to the cost and negotiating prices accordingly
PM:23569056

Cohen J., Malins A., Shahpurwala Z. (2013). Compared To US Practice, Evidence-Based Reviews In Europe Appear To Lead To Lower Prices For Some Drugs. *Health Aff.(Millwood.),* 32 (4) : 762-770.

Abstract: In Europe drug reimbursement decisions often weigh how new drugs perform relative to those already on the market and how cost-effective they are relative to certain metrics. In the United States such comparative-effectiveness and cost-effectiveness evidence is rarely considered. Which approach allows patients greater access to drugs? In 2000-11 forty-one oncology drugs were approved for use in the United States and thirty-one were approved in Europe. We compared patients' access to the twenty-nine cancer drugs introduced into the health care systems of the United States and four European countries. Relative to the approach used in the US Medicare program in particular, the European evidence-based approach appears to have led to reduced prices for those drugs deemed worthy of approval and reimbursement. The result is improved affordability for payers and increased access for patients to those drugs that were available. The United States lacks a systematic approach to assessing such evidence in the coverage decision-making process, which may prove inadequate for controlling costs, improving outcomes, and reducing inequities in access to care
PM:23569057

Lopert R., Elshaug A.G. (2013). Australia's 'Fourth Hurdle' Drug Review Comparing Costs And Benefits Holds Lessons For The United States. *Health Aff.(Millwood.),* 32 (4) : 778-787.

Abstract: Two decades ago Australia introduced an assessment of value as a prerequisite for adding new medicines to its national drug formulary. Australia's program-a "fourth hurdle" process after a drug is assessed for safety, efficacy, and quality-stands in stark contrast to the situation in the United States, where comparing the clinical and economic value of a proposed new drug to those of existing ones only rarely plays a role in the drug coverage determination process. This article describes the role that Australia's Pharmaceutical Benefits Advisory Committee, a statutory independent expert committee, plays in determining which new drugs the government will help pay for in the nation's pharmaceutical benefit program. The program does not directly control drug prices or ration prescription drugs-policy options that are widely opposed in the United States. Australia's program supports patients' access to important, innovative medications deemed to be cost-effective. The US system could benefit if policy makers examined Australia's experience and adopted a comparative clinical and value review suited to the US political and economic landscape
PM:23569059

Sorenson C., Drummond M., Burns L.R. (2013). Evolving reimbursement and pricing policies for devices in Europe and the United States should encourage greater value.

Health Aff.(Millwood.), 32 (4) : 788-796.

Abstract: Rising health care costs are an international concern, particularly in the United States, where spending on health care outpaces that of other industrialized countries. Consequently, there is growing desire in the United States and Europe to take a more value-based approach to health care, particularly with respect to the adoption and use of new health technology. This article examines medical device reimbursement and pricing policies in the United States and Europe, with a particular focus on value. Compared to the United States, Europe more formally and consistently considers value to determine which technologies to cover and at what price, especially for complex, costly devices. Both the United States and Europe have introduced policies to provide temporary coverage and reimbursement for promising technologies while additional evidence of value is generated. But additional actions are needed in both the United States and Europe to ensure wise value-based reimbursement and pricing policies for all devices, including the generation of better pre- and

postmarket evidence and the development of new methods to evaluate value and link evidence of value to reimbursement
PM:23569060

Degrassat-Theas A., Paubel P., Parent de Curzon O., Le Pen C., Sinegre M. (2013). Temporary authorization for use: does the French patient access programme for unlicensed medicines impact market access after formal licensing?

Pharmacoeconomics, 31 (4) : 335-343.
Abstract: BACKGROUND: To reach the French market, a new drug requires a marketing authorization (MA) and price and reimbursement agreements. These hurdles could delay access to new and promising drugs. Since 1992, French law authorizes the use of unlicensed drugs on an exceptional and temporary basis through a compassionate-use programme, known as Temporary Authorization for Use (ATU). This programme was implemented to improve early access to drugs under development or authorized abroad. However, it is suspected to be inflationary, bypassing public bodies in charge of health technology assessment (HTA) and of pricing. OBJECTIVE: The aim of this study is to observe the market access after the formal licensing of drugs that went through this compassionate-use programme. METHODS: We included all ATUs that received an MA between 1 January 2005 and 30 June 2010. We first examined market access delays from these drugs using the standard administrative path. We positioned this result in relation to launch delays observed in France (for all outpatient drugs) and in other major European markets. Second, we assessed the bargaining power of a hospital purchaser after those drugs had obtained an MA by calculating the price growth rate after the approval. RESULTS: During the study period, 77 ATUs were formally licensed. The study concluded that, from the patient's perspective, licensing and public bodies' review time was shortened by a combined total of 36 months. The projected 11-month review time of public bodies may be longer than delays usually observed for outpatient drugs. Nonetheless, the study revealed significant benefits for French patient access based on comparable processing to launch time with those of other European countries with tight price control policies. In return, a 12 % premium, on average, is paid to pharmaceutical companies while drugs are under this status (sub-analysis on 56 drugs). CONCLUSIONS: In many instances, the ATU programme responds to a public health need by accelerating the availability of new drugs even though this study suggests an impact of the programme on the market access of these drugs for which the standard administrative path is longer than usual. In addition, pharmaceutical companies seem to market compassionate-use drugs with a presumed benefit/risk ratio at a price that guarantees a margin for future negotiation
PM:23529210

Linley W.G., Hughes D.A. (2013). Decision-makers' preferences for approving new medicines in wales: a discrete-choice experiment with assessment of external validity.

Pharmacoeconomics, 31 (4) : 345-355.
Abstract: Background: Few studies to date have explored the stated preferences of national decision makers for health technology adoption criteria, and none of these have compared stated decision-making behaviours against actual behaviours. Assessment of the external validity of stated preference studies, such as discrete-choice experiments (DCEs), remains an under-researched area. Objectives: The primary aim was to explore the preferences of All Wales Medicines Strategy Group (AWMSG) appraisal committee and appraisal sub-committee (the New Medicines Group) members ('appraisal committees') for specific new medicines adoption criteria. Secondary aims were to explore the external validity of respondents' stated preferences and the impact of question choice options upon preference structures in DCEs. Methods: A DCE was conducted to estimate appraisal committees members' preferences for incremental cost effectiveness, quality-adjusted life-years (QALYs) gained, annual number of patients expected to be treated, the impact of the disease on patients before treatment, and the assessment of uncertainty in the economic evidence submitted for new medicines compared with current UK NHS treatment. Respondents evaluated 28 pairs of hypothetical new medicines, making a primary forced choice between each pair and a more flexible secondary choice, which permitted either, neither or both new medicines to be chosen. The performance of the resultant models was compared against previous AWMSG decisions. Results: Forty-one out of a total of 80 past and present members of AWMSG appraisal committees completed the DCE. The incremental cost effectiveness of new medicines, and the QALY gains they provide, significantly ($p < 0.0001$) influence recommendations. Committee members were willing to accept higher incremental cost-effectiveness ratios and lower QALY gains for medicines that treat disease impacting primarily upon survival rather than quality of life, and where uncertainty in the cost-effectiveness estimates has been thoroughly

explored. The number of patients to be treated by the new medicine did not exert a significant influence upon recommendations. The use of a flexible-choice question format revealed a different preference structure to the forced-choice format, but the performance of the two models was similar. Aggregate decisions of the AWMSG were well predicted by both models, but their sensitivity (64 %, 68 %) and specificity (55 %, 64 %) were limited. Conclusions: A willingness to trade the cost effectiveness and QALY gains against other factors indicates that economic efficiency and QALY maximisation are not the only considerations of committee members when making recommendations on the use of medicines in Wales. On average, appraisal committee members' stated preferences appear consistent with their actual decision-making behaviours, providing support for the external validity of our DCEs. However, as health technology assessment involves complex decision-making processes, and each individual recommendation may be influenced to varying degrees by a multitude of different considerations, the ability of our models to predict individual medicine recommendations is more limited
PM:23516033

Pulcini C., Lions C., Ventelou B., Verger P. (2013). Drug-specific quality indicators assessing outpatient antibiotic use among French general practitioners. *Eur J Public Health,* 23 (2) : 262-264.
Abstract: Quality indicators assessing the use of antibiotics among general practitioners (GPs) would be useful to target antibiotic stewardship interventions. We adapted to an individual GP level a set of 12 drug-specific quality indicators of outpatient antibiotic use in Europe developed by the European surveillance of antimicrobial consumption project. We performed a cross-sectional study analysing reimbursement data on outpatient antibiotic prescriptions in adults in south-eastern France in 2009. Substantial heterogeneity in antibiotic prescribing among French GPs was observed, and opportunity to improve antibiotic prescribing can be identified
PM:22843612

Mauskopf J., Chirila C., Birt J., Boye K.S., Bowman L. (2013). Drug reimbursement recommendations by the National Institute for Health and Clinical Excellence: Have they impacted the National Health Service budget? *Health Policy,* 110 (1) : 49-59.
Abstract: Objective: Determine whether reimbursement restrictions recommended by the National Institute for Health and Clinical Excellence (NICE) have impacted the United Kingdom (UK) National Health Service (NHS) budget. Methods: Data were abstracted from NICE guidance documents and costing statements through March 2011. Estimated maximum and adjusted potential budget impact (PBI) on the NHS was derived using estimates of the UK marketing-approved population and the annual cost for the new drug. Descriptive and logistic analyses were used to estimate the correlation between the degree of restrictions on reimbursement recommended by NICE for each new drug indication and the PBI controlling for clinical effectiveness and cost-effectiveness. Results: PBI was significantly correlated with the degree of reimbursement restrictions. In descriptive analysis, the adjusted PBI for drugs that were recommended without restrictions was pound20.3million (SD=22.2) compared with pound49.8million (SD=90.8) for those recommended with restrictions and pound71.1million (SE=99.9) for those not recommended. In logistic analysis, the odds ratio for less restrictive reimbursement was 0.848 (95% CI, 0.762-0.945) for each pound20million increase in the adjusted PBI. Results were similar using the maximum PBI. Conclusions: After controlling for clinical effectiveness and cost-effectiveness, the degree of reimbursement restriction recommended by NICE remains significantly correlated with the PBI, despite that fact that the NICE decision process does not consider budget impact. This correlation might be due to NICE consideration of effectiveness and cost-effectiveness for subgroups of the approved population
PM:23434292

Cotet A.M., Benjamin D.K. (2013). Medical regulation and health outcomes: the effect of the physician examination requirement. *Health Econ,* 22 (4) : 393-409.
Abstract: This article investigates the effect on health outcomes of the regulation prohibiting physicians from prescribing drugs without a prior physical examination. This requirement could improve health by reducing illegal access to prescription drugs. However, it reduces access to health care by making it more difficult for patients and physicians to use many forms of telemedicine. Thus, this regulation generates a trade-off between access and safety. Using matching techniques, we find that the physician examination requirement leads to an increase of 1% in mortality rates from disease, the equivalent of 8.5 more deaths per 100,000 people, and a decrease of 6.7% in injury mortality, the

equivalent of 2.5 deaths per 100,000 people. The magnitude of these effects is larger in rural areas and in areas with low physician density and is accompanied by an 18% increase in the number of days lost each month to illness
PM:22450959

Méthodologie –Statistique / Methodology Statistics-

Giarelli G (2013). Théorie sociologique et sociologie de la santé et de la médecine dans les revues internationales. *Sciences sociales et Santé,* 31 (1) : 13-35P.

Lagarde M. (2013). Investigating attribute non-attendance and its consequences in choice experiments with latent class models. *Health Econ,* 22 (5) : 554-567.
Abstract: A growing literature, mainly from transport and environment economics, has started to explore whether respondents violate some of the axioms about individuals' preferences in Discrete Choice Experiments (DCEs) and use simple strategies to make their choices. One of these strategies, termed attribute non-attendance (ANA), consists in ignoring one or more attributes. Using data from a DCE administered to healthcare providers in Ghana to evaluate their potential resistance to changes in clinical guidelines, this study illustrates how latent class models can be used in a step-wise approach to account for all possible ANA strategies used by respondents and explore the consequences of such behaviours. Results show that less than 3% of respondents considered all attributes when choosing between the two hypothetical scenarios proposed, with a majority looking at only one or two attributes. Accounting for ANA strategies improved the goodness-of-fit of the model and affected the magnitude of some of the coefficient and willingness-to-pay estimates. However, there was no difference in the predicted probabilities of the model taking into account ANA and the standard approach. Although the latter result is reassuring about the ability of DCEs to produce unbiased policy guidance, it should be confirmed by other studies. Copyright (c) 2012 John Wiley & Sons, Ltd
PM:22517664

Li Donni P., Peragine V., Pignataro G. (2013). Ex ante and ex post measurement of equality of opportunity in health : a normative decomposition. *Health Econ,* [Epub ahead of print]
Abstract: This paper proposes and discusses two different approaches to the definition of inequality in health: the ex-ante and the ex-post approach. It proposes strategies for measuring inequality of opportunity in health based on the path-independent Atkinson equality index. The proposed methodology is illustrated using data from the British Household Panel Survey; the results suggest that in the period 2000-2005, at least one-third of the observed health equalities in the UK were equalities of opportunity. Copyright (c) 2013 John Wiley & Sons, Ltd
PM:23427055

Blangiardo M., Cameletti M., Baio G., Rue H. (2013). Spatial and spatio-temporal models with R-INLA. *Spatial and Spatio-temporal Epidemiology,* 4 (0) : 33-49.
Abstract: During the last three decades, Bayesian methods have developed greatly in the field of epidemiology. Their main challenge focusses around computation, but the advent of Markov Chain Monte Carlo methods (MCMC) and in particular of the WinBUGS software has opened the doors of Bayesian modelling to the wide research community. However model complexity and database dimension still remain a constraint. Recently the use of Gaussian random fields has become increasingly popular in epidemiology as very often epidemiological data are characterised by a spatial and/or temporal structure which needs to be taken into account in the inferential process. The Integrated Nested Laplace Approximation (INLA) approach has been developed as a computationally efficient alternative to MCMC and the availability of an R package (R-INLA) allows researchers to easily apply this method. In this paper we review the INLA approach and present some applications on spatial and spatio-temporal data
http://www.sciencedirect.com/science/article/pii/S1877584512000846

Slaghuis S.S., Strating M.M., Bal R.A., Nieboer A.P. (2013). PA measurement instrument for spread of quality improvement in healthcare. *International Journal for Quality in Health Care,* 25 (2) : 125-131.
Abstract: Objective The aim of this study was to develop and test a measurement instrument for spread of quality improvement in healthcare. The instrument distinguishes: (i) spread of work practices and their results and (ii) spread practices and effectiveness. Relations between spread and sustainability of changed work practices were also explored to assess convergent validity. Design We developed and tested a measurement instrument for spread in a follow-up study. The instrument consisted of 18-items with four subscales. Setting and participants The sample consisted of former improvement teams in a quality improvement program for long-term care (nteams = 73, nrespondents = 127). Data were collected in a questionnaire about 1 year post-pilot site improvement implementation.I nterventions Quality improvements in long-term care practices .Main outcome measures Four variables were construed: (i) actions for spread of work practices, (ii) actions for spread of results, (iii) effectiveness of spread of work practices and (iv) effectiveness of spread of results.Results Psychometric analysis yielded positive results on the item level. The intended four-factor model yielded satisfactory fit. The internal consistency of each scale was fine (Cronbach's α 0.70-0.93). Bivariate correlations revealed that the spread variables were strongly related but distinct, and positively related to the sustainability variables. Conclusions The psychometric properties are in line with methodological standards. Convergent validity was confirmed with sustainability. The measurement instrument offers a good starting point for the analysis of spread
http://intqhc.oxfordjournals.org/content/25/2/125.abstract

Rogowski W. (2013). An economic theory of the fourth hurdle. *Health Econ,* 22 (5) : 600-610.
Abstract: Third party payers' decision processes for financing health technologies ('fourth hurdle' processes) are subject to intensive descriptive empirical investigation. This paper addresses the need for a theoretical foundation of this research and develops a theoretical framework for analysing fourth hurdle processes from an economics perspective. On the basis of a decision-analytic framework and the theory of agents, fourth hurdle processes are described as sets of institutions to maximize the value derived from finite healthcare resources. Benefits are assumed to arise from the value of better information about and better implementation of the most cost-effective choice. Implementation is improved by decreased information asymmetries and better alignment of incentives. This decreases the effects of ex ante and ex post moral hazard on service provision. Potential indicators of high benefit include high costs associated with wrong decisions and large population sizes affected by the decision. The framework may serve as a basis both for further theoretical work, for example, on the appropriate degree of participation as well as further empirical work, for example, on comparative assessments of fourth hurdle processes. It needs to be complemented by frameworks for analysing fourth hurdle institutions developed by other disciplines such as bioethics or law. Copyright (c) 2012 John Wiley & Sons, Ltd
PM:22544431

Parkinson B., Goodall S., Norman R. (2013). Measuring the loss of consumer choice in mandatory health programmes using discrete choice experiments. *Appl.Health Econ Health Policy,* 11 (2) : 139-150.
Abstract: Background: Economic evaluation of mandatory health programmes generally do not consider the utility impact of a loss of consumer choice upon implementation, despite evidence suggesting that consumers do value having the ability to choose. Objectives: The primary aim of this study was to explore whether the utility impact of a loss of consumer choice from implementing mandatory health programmes can be measured using discrete choice experiments (DCEs). METHODS: Three case studies were used to test the methodology: fortification of bread-making flour with folate, mandatory influenza vaccination of children, and the banning of trans-fats. Attributes and levels were developed from a review of the literature. An orthogonal, fractional factorial design was used to select the profiles presented to respondents to allow estimation of main effects. Overall, each DCE consisted of 64 profiles which were allocated to four versions of 16 profiles. Each choice task compared two profiles, one being voluntary and the other being mandatory, plus a 'no policy' option, thus each respondent was presented with eight choice tasks. For each choice task, respondents were asked which health policy they most preferred and least preferred. Data was analysed using a mixed logit model with correlated coefficients (200 Halton draws). The compensating variation required for introducing a programme on a mandatory basis (versus achieving the same health impacts with a

voluntary programme) that holds utility constant was estimated. Results: Responses were provided by 535 participants (a response rate of 83 %). For the influenza vaccination and folate fortification programmes, the results suggested that some level of compensation may be required for introducing the programme on a mandatory basis. Introducing a mandatory influenza vaccination programme required the highest compensation (Australian dollars [A$] 112.75, 95 % CI -60.89 to 286.39) compared with folate fortification (A$18.05, 95 % CI -3.71 to 39.80). No compensation was required for introducing the trans-fats programme (-A$0.22, 95 % CI -6.24 to 5.80) [year 2010 values]. In addition to the type of mandatory health programme, the compensation required was also found to be dependent on a number of other factors. In particular, the study found an association between the compensation required and stronger libertarian preferences. ConclusionS: DCEs can be used to measure the utility impact of a loss of consumer choice. Excluding the utility impact of a loss of consumer choice from an economic evaluation taking a societal perspective may result in a sub-optimal, or incorrect, funding decision
PM:23494935

Prévision – Evaluation / Prevision – Evaluation

Knai C., Nolte E., Brunn M., Elissen A., Conklin A., Pedersen J.P., Brereton L., Erler A., Frolich A., Flamm M., Fullerton B., Jacobsen R., Krohn R., Saz-Parkinson Z., Vrijhoef B., Chevreul K., Durand-Zaleski I., Farsi F., Sarria-Santamera A., Soennichsen A. (2013). Reported barriers to evaluation in chronic care: Experiences in six European countries.

Health Policy, 110 (2-3) : 220-228.
Abstract: Introduction: The growing movement of innovative approaches to chronic disease management in Europe has not been matched by a corresponding effort to evaluate them. This paper discusses challenges to evaluation of chronic disease management as reported by experts in six European countries. Methods: We conducted 42 semi-structured interviews with key informants from Austria, Denmark, France, Germany, The Netherlands and Spain involved in decision-making and implementation of chronic disease management approaches. Interviews were complemented by a survey on approaches to chronic disease management in each country. Finally two project teams (France and the Netherlands) conducted in-depth case studies on various aspects of chronic care evaluation. Results: We identified three common challenges to evaluation of chronic disease management approaches: (1) a lack of evaluation culture and related shortage of capacity; (2) reluctance of payers or providers to engage in evaluation and (3) practical challenges around data and the heterogeneity of IT infrastructure. The ability to evaluate chronic disease management interventions is influenced by contextual and cultural factors. Conclusions: This study contributes to our understanding of some of the most common underlying barriers to chronic care evaluation by highlighting the views and experiences of stakeholders and experts in six European countries. Overcoming the cultural, political and structural barriers to evaluation should be driven by payers and providers, for example by building in incentives such as feedback on performance, aligning financial incentives with programme objectives, collectively participating in designing an appropriate framework for evaluation, and making data use and accessibility consistent with data protection policies
PM:23453595

Norman R., Hall J., Street D., Viney R. (2013). Efficiency and equity: a stated preference approach.

Health Econ, 22 (5) : 568-581.
Abstract: Outcome measurement in the economic evaluation of health care considers outcomes independent of to whom they accrue. This article reports on a discrete choice experiment designed to elicit population preferences regarding the allocation of health gain between hypothetical groups of potential patients. A random-effects probit model is estimated, and a technique for converting these results into equity weights for use in economic evaluation is adopted. On average, the modelling predicts a relatively high social value on health gains accruing to nonsmokers, carers, those with a low income and those with an expected age of death less than 45 years. Respondents tend to favour individuals with similar characteristics to themselves. These results challenge the conventional practice of assuming constant equity weighting. For decision makers, whether a formal equity weighting system represents an improvement on more informal approaches to weighing up equity and

efficiency concerns remains uncertain. Copyright (c) 2012 John Wiley & Sons, Ltd
PM:22529053

Haiech J. (2013). [Too much evaluation kills evaluation]. *Med Sci.(Paris),* 29 (2) : 119-120.
PM:23452590

Bilgel F. (2013). The effectiveness of transplant legislation, procedures and management: Cross-country evidence. *Health Policy,* 110 (2-3) : 229-242.
Abstract: This article investigates the impact of legal determinants of cadaveric and living donor organ transplantation rates using panel data on legislative, procedural and managerial aspects of organ transplantation and procurement, government health expenditures, enrollment rates, religious beliefs, legal systems and civil rights and liberties for 62 countries over a 2-year period. Under living donor organ transplantation, we found that guaranteeing traceability of organs by law or performing psychiatric evaluation to living donors has a sizeable, negative impact on living transplant rates once the remaining determinants of living transplantation have been controlled for. Under cadaveric transplantation, our findings do not suggest an unequivocal and positive association between presumed consent, donor registries and cadaveric transplant rates. However, legally requiring family consent or maintaining written procurement standards for deceased donors has a sizeable, negative impact on cadaveric transplant rates. The latter finding suggests that informing families rather than asking for consent may be an effective strategy to raise procurement rates while respecting patient autonomy. Finally, we confirm that predominantly non-Christian countries have significantly higher living but lower cadaveric transplant rates
PM:23347731

Soins de santé primaires/ Primary Health Care

Kirschner K., Braspenning J., Akkermans R.P., Jacobs J.E.A., Grol R. (2013). Assessment of a pay-for-performance program in primary care designed by target users. *Family Practice,* 30 (2) : 161-171.
Abstract: Background. Evidence for pay-for-performance (P4P) has been searched for in the last decade as financial incentives increased to influence behaviour of health care professionals to improve quality of care. The effectiveness of P4P is inconclusive, though some reviews reported significant effects. Objective. To assess changes in performance after introducing a participatory P4P program. Design. An observational study with a pre- and post-measurement. Setting and subjects. Sixty-five general practices in the south of the Netherlands. Intervention. A P4P program designed by target users containing indicators for chronic care, prevention, practice management and patient experience (general practitioners [GP] functioning and organization of care). Quality indicators were calculated for each practice. A bonus with a maximum of 6890 Euros per 1000 patients was determined by comparing practice performance with a benchmark. Main outcome measures. Quality indicators for clinical care (process and outcome) and patient experience. Results. We included 60 practices. After 1 year, significant improvement was shown for the process indicators for all chronic conditions ranging from +7.9% improvement for cardiovascular risk management to +11.5% for asthma. Five outcome indicators significantly improved as well as patients experiences with GP's functioning and organization of care. No significant improvements were seen for influenza vaccination rate and the cervical cancer screening uptake. The clinical process and outcome indicators, as well as patient experience indicators were affected by baseline measures. Smaller practices showed more improvement. Conclusions. A participatory P4P program might stimulate quality improvement in clinical care and improve patient experiences with GP's functioning and the organization of care

Brilleman S.L., Salisbury C. (2013). Comparing measures of multimorbidity to predict outcomes in primary care: a cross sectional study. *Family Practice,* 30 (2): 172-178.
Abstract: Background. An increasing proportion of people are living with multiple health conditions, or multimorbidity. Measures of multimorbidity are useful in studies of interventions in primary care to take account of confounding due to differences in case-mix. Objectives. Assess the predictive validity of

commonly used measures of multimorbidity in relation to a health outcome (mortality) and a measure of health service utilization (consultation rate).Methods. We included 95372 patients registered on 1 April 2005 at 174 English general practices included in the General Practice Research Database. Using regression models we compared the explanatory power of six measures of multimorbidity: count of chronic diseases from the Quality and Outcomes Framework (QOF); Charlson index; count of prescribed drugs; three measures from the John Hopkins ACG software [Expanded Diagnosis Clusters count (EDCs), Adjusted Clinical Groups (ACGs), Resource Utilisation Bands (RUBs)].Results. A model containing demographics and GP practice alone explained 22% of the uncertainty in consultation rates. The number of prescribed drugs, ACG category, EDC count, RUB category, QOF disease count, or Charlson index increased this to 42%, 37%, 36%, 35%, 30%, and 26%, respectively. Measures of multimorbidity made little difference to the fit of a model predicting 3-year mortality. Nonetheless, Charlson index score was the best performing measure, followed by the number of prescribed drugs.Conclusion. The number of prescribed drugs is the most powerful measure for predicting future consultations and the second most powerful measure for predicting mortality. It may have potential as a simple proxy measure of multimorbidity in primary care

Tyo K.R., Gurewich D., Shepard D.S. (2013). Methodological challenges of measuring primary care delivery to pediatric medicaid beneficiaries who use community health centers. *Am J Public Health,* 103 (2) : 273-275.

Abstract: Efforts to measure quality of care have focused on ambulatory care providers. We examined the performance of community health centers serving children on Medicaid in 3 states. Descriptive analysis showed considerable patient population heterogeneity, and regression analysis demonstrated that variation explained by the assigned provider was small (mean R(2) = 4.3%) compared with the variation explained by patient demographic variables (mean R(2) = 29.9%). The results reinforce the need for caution when one is attributing quality differences to provider performance
PM:23237184

Kringos D.S., Boerma W., Van der Zee J., Groenewegen P. (2013). Europe's Strong Primary Care Systems Are Linked To Better Population Health But Also To Higher Health Spending. *Health Aff.(Millwood.),* 32 (4) : 686-694.

Abstract: Strong primary care systems are often viewed as the bedrock of health care systems that provide high-quality care, but the evidence supporting this view is somewhat limited. We analyzed comparative primary care data collected in 2009-10 as part of a European Union-funded project, the Primary Health Care Activity Monitor for Europe. Our analysis showed that strong primary care was associated with better population health; lower rates of unnecessary hospitalizations; and relatively lower socioeconomic inequality, as measured by an indicator linking education levels to self-rated health. Overall health expenditures were higher in countries with stronger primary care structures, perhaps because maintaining strong primary care structures is costly and promotes developments such as decentralization of services delivery. Comprehensive primary care was also associated with slower growth in health care spending. More research is needed to explore these associations further, even as the evidence grows that strong primary care in Europe is conducive to reaching important health system goals
PM:23569048

Hutchison B., Glazier R. (2013). Ontario's Primary Care Reforms Have Transformed The Local Care Landscape, But A Plan Is Needed For Ongoing Improvement. *Health Aff.(Millwood.),* 32 (4) : 695-703.

Abstract: Primary care in Ontario, Canada, has undergone a series of reforms designed to improve access to care, patient and provider satisfaction, care quality, and health system efficiency and sustainability. We highlight key features of the reforms, which included patient enrollment with a primary care provider; funding for interprofessional primary care organizations; and physician reimbursement based on varying blends of fee-for-service, capitation, and pay-for-performance. With nearly 75 percent of Ontario's population now enrolled in these new models, total payments to primary care physicians increased by 32 percent between 2006 and 2010, and the proportion of Ontario primary care physicians who reported overall satisfaction with the practice of medicine rose from 76 percent in 2009 to 84 percent in 2012. However, primary care in Ontario also faces challenges. There is no meaningful performance measurement system that tracks the impact of these innovations, for example. A better system of risk adjustment is also needed in capitated plans so that groups have the

incentive to take on high-need patients. Ongoing investment in these models is required despite fiscal constraints. We recommend a clearly articulated policy road map to continue the transformation
PM:23569049

Faber M., Voerman G., Erler A., Eriksson T., Baker R., De L.J., Grol R., Burgers J. (2013). Survey of 5 European countries suggests that more elements of patient-centered medical homes could improve primary care. *Health Aff.(Millwood.),* 32 (4) : 797-806.
Abstract: The patient-centered medical home is a US model for comprehensive care. This model features a personal physician or registered nurse who is augmented by a proactive team and information technology. Such a model could prove useful for advanced European systems as they strive to improve primary care, particularly for chronically ill patients. We surveyed 6,428 chronically ill patients and 152 primary care providers in five European countries to assess aspects of the patient-centered medical home. Although most patients reported that they had a personal physician and no problems in contacting the practice after hours, for example, other aspects of the patient-centered medical home, such as provision of written self-management support to patients, were not as widespread. We conclude that despite strong organizational structures, European primary care systems need additional efforts to recognize chronically ill patients as partners in care and can embrace patient-centered medical homes to improve care for European patients
PM:23514777

Gale N., Sultan H. (2013). Telehealth as 'peace of mind': embodiment, emotions and the home as the primary health space for people with chronic obstructive pulmonary disorder. *Health Place,* 21 140-147.
Abstract: A theoretical understanding of why some people with chronic obstructive pulmonary disorder (COPD) experienced 'peace of mind' when a new telehealth service was introduced into a community respiratory service (CRS) is presented in this article. This is based on analysis of in-depth, qualitative, situated interviews with COPD patients who were receiving the service. Telehealth brought peace of mind through two mechanisms: legitimising contact with health professionals and increased patient confidence in the management of their condition. When the home is the primary health space, the introduction of telehealth can modify emotional and bodily experiences to an extent that is significant for people with COPD. The process by which technology can provide 'peace of mind' to people with long term conditions should be taken into account when designing or commissioning a service
PM:23474353

Shmueli A., Nissan-Engelcin E. (2013). Local availability of physicians' services as a tool for implicit risk selection. *Soc Sci.Med,* 84 53-60.
Abstract: Risk adjustment of the allocated health budget to health plans plays a major role in the functioning of competitive social health insurance systems. Whenever the risk adjusted allocation is below the expected marginal cost of care for a given person, incentives for risk selection arise. Since coverage is universal, risk selection must take on implicit forms such as stinting and distorting quality of health services. One of the tools for such selection is to strategically determine the local availability of physicians based on the local population. The Israeli competitive national health insurance scheme includes an age (only)-risk adjustment. We argue that the localities' known characteristics are used by the Israeli managed care organizations (sickness funds) to adjust the availability of and accessibility to community health services. Consequently, we expect strong competition and high availability of services in healthier-than-average (and richer) towns, and weak competition and low availability of services in sicker-than-average (and poorer) towns. The empirical analysis combines data on the reception hours of physicians in five specialties and socio-economic and demographic characteristics (age, mean income, mortality rates etc.) of 60 towns in 2004, and strongly confirms that hypothesis, controlling for several other possible explanations for such findings. Such a situation clearly represents a regulation failure and an inefficient and inequitable geographic allocation of health services
PM:23517704

Porter M.E., Pabo E.A., Lee T.H. (2013). Redesigning primary care: a strategic vision to improve value by organizing around patients' needs. *Health Aff.(Millwood.),* 32 (3) : 516-525.
Abstract: Primary care in the United States currently struggles to attract new physicians and to garner

investments in infrastructure required to meet patients' needs. We believe that the absence of a robust overall strategy for the entire spectrum of primary care is a fundamental cause of these struggles. To address the absence of an overall strategy and vision for primary care, we offer a framework based on value for patients to sustain and improve primary care practice. First, primary care should be organized around subgroups of patients with similar needs. Second, team-based services should be provided to each patient subgroup over its full care cycle. Third, each patient's outcomes and true costs should be measured by subgroup as a routine part of care. Fourth, payment should be modified to bundle reimbursement for each subgroup and reward value improvement. Finally, primary care patient subgroup teams should be integrated with relevant specialty providers. We believe that redesigning primary care using this framework can improve the ability of primary care to play its essential role in the health care system
PM:23459730

Eijkenaar F., Emmert M., Scheppach M., Schoffski O. (2013). Effects of pay for performance in health care: A systematic review of systematic reviews. *Health Policy,* 110 (2-3) : 115-130.
Abstract: Background: A vast amount of literature on effects of pay-for-performance (P4P) in health care has been published. However, the evidence has become fragmented and it has become challenging to grasp the information included in it. Objectives: To provide a comprehensive overview of effects of P4P in a broad sense by synthesizing findings from published systematic reviews. Methods: Systematic literature search in five electronic databases for English, Spanish, and German language literature published between January 2000 and June 2011, supplemented by reference tracking and Internet searches. Two authors independently reviewed all titles, assessed articles' eligibility for inclusion, determined a methodological quality score for each included article, and extracted relevant data. Results: Twenty-two reviews contain evidence on a wide variety of effects. Findings suggest that P4P can potentially be (cost-)effective, but the evidence is not convincing; many studies failed to find an effect and there are still few studies that convincingly disentangled the P4P effect from the effect of other improvement initiatives. Inequalities among socioeconomic groups have been attenuated, but other inequalities have largely persisted. There is some evidence of unintended consequences, including spillover effects on unincentivized care. Several design features appear important in reaching desired effects. Conclusion: Although data is available on a wide variety of effects, strong conclusions cannot be drawn due to a limited number of studies with strong designs. In addition, relevant evidence on particular effects may have been missed because no review has explicitly focused on these effects. More research is necessary on the relative merits of P4P and other types of incentives, as well as on the long-term impact on patient health and costs
PM:23380190

Systèmes de santé / Health Care Systems

Brunn M., Chevreul K. (2013). Prise en charge des patients atteints de maladies chroniques : concepts, évaluations et enseignements internationaux. *Santé Publique,* (1) : 87-94.

Papanicolas I., Cylus J., Smith P.C. (2013). An analysis of survey data from eleven countries finds that 'satisfaction' with health system performance means many things. *Health Aff.(Millwood.),* 32 (4) : 734-742.
Abstract: Measures of personal satisfaction with health systems play an increasingly important role in national and international performance assessments. Using data from the 2010 Commonwealth Fund International Health Policy Survey, we analyzed the determinants of personal perceptions of health system performance in eleven high-income countries. In most countries there was a clear relationship between overall satisfaction with the health system and perceptions of affordability and effectiveness of care, as well as ratings of one's regular doctor. There is some evidence that waiting times for appointments and diagnosis were widely associated with discontent, although respondents' perceptions of these factors explained relatively little of the observed variation in overall satisfaction across countries. We conclude that "satisfaction" appears to represent something different in each

health system, and that policy makers can nevertheless use this type of analysis to determine priorities for improvement in their own country. Our findings also indicate that some of the keys to improving overall satisfaction with a health system may lie outside that system's direct control and are related to differences in expectations across countries and to other factors that influence perceptions, such as national political debates, reporting in the news media, and national cultures
PM:23569053

Mackenbach J.P., McKee M. (2013). A comparative analysis of health policy performance in 43 European countries. *Eur J Public Health,* 23 (2) : 195-201.
Abstract: Background: It is unknown whether European countries differ systematically in their pursuit of health policies, and what the determinants of these differences are. In this article, we assess the extent to which European countries vary in the implementation of health policies in 10 different areas, and we exploit these variations to investigate the role of political, economic and social determinants of health policy. Data and methods: We reviewed policies in the field of tobacco; alcohol; food and nutrition; fertility, pregnancy and childbirth; child health; infectious diseases; hypertension detection and treatment; cancer screening; road safety and air pollution. We developed a set of 27 'process' and 'outcome' indicators, as well as a summary score indicating a country's overall success in implementing effective health policies. In exploratory regression analyses, we related these indicators to six background factors: national income, survival/self-expression values, democracy, government effectiveness, left-party participation in government and ethnic fractionalization. Results: We found striking variations between European countries in process and outcome indicators of health policies. On the whole, Sweden, Norway and Iceland perform best, and Ukraine, Russian Federation and Armenia perform worst. Within Western Europe, some countries, such as Denmark and Belgium, perform significantly worse than their neighbours. Survival/self-expression values and ethnic fractionalization were the main predictors of the health policy performance summary score. National income, survival/self-expression values and government effectiveness were the main predictors of countries' performance in specific areas of health policy. Conclusions: Although many new preventive interventions have been developed, their implementation appears to have varied enormously among European countries. Substantial health gains can be achieved if all countries would follow best practice, but this probably requires the removal of barriers related to both the 'will' and the 'means' to implement health policies
PM:23402806

Olsen J.A., Richardson J. (2013). Preferences for the normative basis of health care priority setting: some evidence from two countries. *Health Econ,* 22 (4) : 480-485.
Abstract: The present paper concerns the criteria people would prefer for prioritising health programmes. It differs from most empirical studies as subjects were not asked about their personal preferences for programmes per se. Rather, they were asked about the principles that should guide the choice of programmes. Four different principles were framed as arguments for alternative programmes. The results from population surveys in Australia and Norway suggest that people are least supportive of the principle that decision makers should follow the stated preferences of the public. Rather, respondents expressed more support for decisions based upon health maximisation, equality and urgency
PM:22359416

Travail et santé / Health at Work

Pagan R. (2013). Time allocation of disabled individuals. *Soc Sci.Med,* 84 80-93.
Abstract: Although some studies have analysed the disability phenomenon and its effect on, for example, labour force participation, wages, job satisfaction, or the use of disability pension, the empirical evidence on how disability steals time (e.g. hours of work) from individuals is very scarce. This article examines how disabled individuals allocate their time to daily activities as compared to their non-disabled counterparts. Using time diary information from the Spanish Time Use Survey (last quarter of 2002 and the first three quarters of 2003), we estimate the determinants of time (minutes per day) spent on four aggregate categories (market work, household production, tertiary activities and

leisure) for a sample of 27,687 non-disabled and 5250 disabled individuals and decompose the observed time differential by using the Oaxaca-Blinder methodology. The results show that disabled individuals devote less time to market work (especially females), and more time to household production (e.g. cooking, cleaning, child care), tertiary activities (e.g. sleeping, personal care, medical treatment) and leisure activities. We also find a significant effect of age on the time spent on daily activities and important differences by gender and disability status. The results are consistent with the hypothesis that disability steals time, and reiterate the fact that more public policies are needed to balance working life and health concerns among disabled individuals
PM:23517707

Vieillissement / Ageing

Béland D., Viriot Durandal J.P. (2013). Aging in France: Population Trends, Policy Issues, and Research Institutions. *The Gerontologist,* 53 (2) : 191-197.

Abstract: Like in other advanced industrial countries, in France, demographic aging has become a widely debated research and policy topic. This article offers a brief overview of major aging-related trends in France. The article describes France' demographics of aging, explores key policy matters, maps the institutional field of French social gerontology research, and, finally, points to several emerging issues about aging. In France, these issues include active and healthy aging, the improvement of knowledge on specific vulnerable segments of the elderly population, and the adaptation of the urban landscape and infrastructure to an aging population. At the broadest level, one of the key points formulated in this article is that in France, aging research is dominated by the state, yet it is scattered and compartmentalized, posing a crucial challenge in an era dominated by European and other international networks and coordination efforts in aging policy and knowledge

Hoogendijk E.O., Van Der Horst H.E., Deeg D.J.H., Frijters D.H., Prins B.A., Jansen A.P., Nijpels G., Van Hout H.P. (2013). The identification of frail older adults in primary care: comparing the accuracy of five simple instruments. *Age and Ageing,* 42 (2) : 262-265.

Abstract: Background: many instruments are available to identify frail older adults who may benefit from geriatric interventions. Most of those instruments are time-consuming and difficult to use in primary care. Objective: to select a valid instrument to identify frail older adults in primary care, five simple instruments were compared. Methods: instruments included clinical judgment of the general practitioner, prescription of multiple medications, the Groningen frailty indicator (GFI), PRISMA-7 and the self-rated health of the older adult. Fried's frailty criteria and a clinical judgment by a multidisciplinary expert panel were used as reference standards. Data were used from the cross-sectional Dutch Identification of Frail Elderly Study consisting of 102 people aged 65 and over from a primary care practice in Amsterdam. In this study, frail older adults were oversampled. We estimated the accuracy of each instrument by calculating the area under the ROC curve. The agreement between the instruments and the reference standards was determined by kappa. Results: frailty prevalence rates in this sample ranged from 11.6 to 36.4%. The accuracy of the instruments ranged from poor (AUC = 0.64) to good (AUC = 0.85).Conclusion: PRISMA-7 was the best of the five instruments with good accuracy. Further research is needed to establish the predictive validity and clinical utility of the simple instruments used in this study

Koike S., Furui Y. (2013). Long-term care-service use and increases in care-need level among home-based elderly people in a Japanese urban area. *Health Policy,* 110 (1) : 94-100.

Abstract: OBJECTIVES: The objective of this study was to examine the effects of home-based long-term care insurance services on an increase in care need levels and discuss its policy implications. METHODS: We analyzed care need certification and long-term care service use data for 3006 non-institutionalized elderly persons in a Tokyo ward effective as of October 2009 and 2010. Individual care need assessment intervals and their corresponding changes in care need level were calculated from data at two data acquisition points of care need assessment. Those who had been certified but

did not use any long-term care insurance service were defined as the control group. The Cox proportionate hazard model was used to determine whether the use of a long-term care insurance service is associated with increased care need level. RESULTS: After adjusting for sex, age, and care need level, the hazard ratio for the probability of increased care need level among service users was calculated as 0.75 (95% confidence interval, 0.64-0.88; p<0.001). CONCLUSIONS: Home-based long-term care service use may prevent an increase in care need level. Administrative data on care need certification and services use could be an effective tool for evaluating the long-term care insurance system
PM:23312787