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Assurance maladie / Health Insurance

Fronstin P., Sepulveda M.J., Roebuck M.C. (2013). Consumer-directed health plans reduce the long-term use of outpatient physician visits and prescription drugs. *Health Aff. (Millwood.)*, 32 (6) : 1126-1134.

Abstract: Consumer-directed health plans (CDHPs) are designed to make employees more cost- and health-conscious by exposing them more directly to the costs of their care, which should lower demand for care and, in turn, control premium growth. These features have made consumer-directed plans increasingly attractive to employers. We explored effects of consumer-directed health plans on health care and preventive care use, using data from two large employers—one that adopted a CDHP in 2007 and another with no CDHP. Our study had mixed results relative to expectations. After four years under the CDHP, there were 0.26 fewer physician office visits per enrollee per year and 0.85 fewer prescriptions filled, but there were 0.018 more emergency department visits. Also, the likelihood of receiving recommended cancer screenings was lower under the CDHP after one year and, even after recovering somewhat, still lower than baseline at the study's conclusion. If CDHPs succeed in getting people to make more cost-sensitive decisions, plan sponsors will have to design plans to incentivize primary care and prevention and educate members about what the plan covers.

Economie de la santé / Health Economics

Chinitz D (2013). The special interdisciplinary contribution of institutional economics. *Health Economics, Policy and Law*, 8 (3) : 387-396.

Abstract : The Editor's request for papers on interdisciplinary work coincided with the ongoing work of the author on the role of institutional economics in social policy, especially as compared with behavioral economics. The connection is that institutional economics, in its essence, is an interdisciplinary enterprise. The successful applications but also the suboptimal use of institutional economics in social policy analysis provides insights about interdisciplinarity. In particular, it suggests a kind of Gresham's Law of social scientific inquiry: the disciplinary orientation tends not only to obstruct the interdisciplinary, but also to cause the latter to sag back into a disciplinary posture. This tension is perhaps unavoidable, and maybe even healthy, but, following one of the dictums of institutional economics, it is worthwhile to be self-conscious (Williamson, 1975) about this tug of war, and where one is with respect to it at any point of social research and analysis. These themes will be fleshed out in this essay in the following manner. First, some background on institutional economics, in particular the work of Oliver Williamson, who emphasizes the interdisciplinary nature of his work on transactions cost economics, will be provided. This will be followed by a discussion of the 'collapse' of interdisciplinary work back into disciplinary paradigms and the reasons for this. Next, institutional economics will be compared with other purportedly interdisciplinary approaches to health policy analysis: first, interdisciplinary studies of the politics of health regarding macro health policy and also rationing of health care¹; and second, behavioral economics. There follows a discussion of the benefits of strengthening the use of institutional economics in health policy analysis, especially in terms of retaining interdisciplinarity, with special reference to the notion of trust. The conclusion suggests ways forward.

Keegan C., Thomas S., Normand C., Portela C. (2013). Measuring recession severity and its impact on healthcare expenditure. *Int J Health Care Finance Econ*, 13 (2) : 139-155.

Abstract: The financial crisis that manifested itself in late 2007 resulted in a Europe-wide economic crisis by 2009. As the economic climate worsened, Governments and households were put under increased strain and more focus was placed on prioritising expenditures. Across European countries and their heterogeneous health care systems, this paper examines the initial responsiveness of health expenditures to the crisis and whether recession severity can be considered a predictor of health expenditure growth. In measuring severity we move away from solely gross domestic product (GDP) as a metric and construct a recession severity index predicated on a number of key macroeconomic

indicators. We then regress this index on measures of total, public and private health expenditure to identify potential relationships. Analysis suggests that for 2009, the Baltic States, along with Ireland, Italy and Greece, experienced comparatively severe recessions. We find, overall, an initial counter-cyclical response in health spending (both public and private) across countries. However, our analysis finds evidence of a negative relationship between recession severity and changes in certain health expenditures. As a predictor of health expenditure growth in 2009, the derived index is an improvement over GDP change alone.

Gupta I., Joe W. (2013). Refining estimates of catastrophic healthcare expenditure: an application in the Indian context. *Int J Health Care Finance Econ*, 13 (2) : 157-172.

Abstract: Empirics of catastrophic healthcare expenditure, especially in the Indian context, are often based on consumption expenditure data that inadequately informs about the ability to pay. Use of such data can generate a pro-rich bias in the estimation of catastrophic expenditure thereby suggesting greater concentration of such expenditures among richer households. To improve upon the existing approach, this paper suggests a multidimensional approach to comprehend the incidence of catastrophic expenditure. Here, we integrate the information on health expenditure with other social and economic parameters of deprivation. An empirical illustration is provided by using nationally representative survey on morbidity and healthcare in India. The results of the multidimensional approach are consistent with the theoretical underpinnings of the ability-to-pay approach and emphasizes on the severity of the problem in rural areas. The suggested methodology is flexible and allows for context-specific prioritization in selection of parameters of vulnerability while estimating the incidence of catastrophic expenditures.

Zhao F.L., Xie F., Hu H., Li S.C. (2013). Transferability of indirect cost of chronic disease: a systematic review and meta-analysis. *Pharmacoeconomics*, 31 (6) : 501-508.

Abstract: BACKGROUND: Indirect cost is an important component in economic evaluations. The variation in the magnitude of indirect costs across studies and countries is substantial and affects the transferability of results across jurisdictions. OBJECTIVE: This study explored the factors involved in the variation of reported indirect cost and investigated the feasibility of transferring indirect costs across settings. METHODS: A systematic literature review was conducted to identify studies estimating indirect costs for four selected chronic diseases, namely, asthma (AS), diabetes (DI), rheumatoid arthritis (RA) and schizophrenia (SC). A multiple linear regression analysis was run to identify the factors that potentially explain the variation in reported indirect costs. Parametric (fixed- and random-effect models) and non-parametric (bootstrapping method) meta-analyses were applied to local gross domestic product (GDP)/capita-adjusted indirect costs for each disease. Results from the three different analytical methods were compared to ascertain the robustness of estimation. RESULTS: The systematic literature review identified 77 articles that reported indirect costs of AS (n = 18), DI (n = 20), RA (n = 25) and SC (n = 14) for literature synthesis. Substantial inter- and intra-disease variations among the indirect cost studies were observed with respect to geographic distribution, methodology and magnitude of cost estimation. Regression analysis showed that disease categories and local GDP/capita significantly ($p < 0.001$) contributed to the variance of indirect cost. The range of intra-disease variation in indirect costs was substantially reduced after adjusting by and expressing values as local GDP/capita. The GDP-adjusted indirect cost in terms of percentage of local GDP/capita of AS was the lowest and that of SC was the highest. Bootstrapping estimation was relatively conservative, with slightly wider confidence intervals (CIs) than the parametric method, with a mean (95 % CI) of 2.12 % (1.4089-2.9332) for AS, 10.65 % (7.215-14.7438) for DI, 21.98 % (17.4360-27.0631) for RA, and 79.19 % (52.4243-117.833) for SC. CONCLUSION: It would be convenient and feasible to construct a universal reference range of indirect cost for a specific disease based on existing data and present this as a percentage of local GDP to assist local decision making in jurisdictions where indirect cost data are not available.

Nuckols T.K., Escarce J.J., Asch S.M. (2013). The effects of quality of care on costs: a conceptual framework. *Milbank Q*, 91 (2) : 316-353.

Abstract: CONTEXT: The quality of health care and the financial costs affected by receiving care represent two fundamental dimensions for judging health care performance. No existing conceptual framework appears to have described how quality influences costs. METHODS: We developed the Quality-Cost Framework, drawing from the work of Donabedian, the RAND/UCLA Appropriateness

Method, reports by the Institute of Medicine, and other sources. FINDINGS: The Quality-Cost Framework describes how health-related quality of care (aspects of quality that influence health status) affects health care and other costs. Structure influences process, which, in turn, affects proximate and ultimate outcomes. Within structure, subdomains include general structural characteristics, circumstance-specific (e.g., disease-specific) structural characteristics, and quality-improvement systems. Process subdomains include appropriateness of care and medical errors. Proximate outcomes consist of disease progression, disease complications, and care complications. Each of the preceding subdomains influences health care costs. For example, quality improvement systems often create costs associated with monitoring and feedback. Providing appropriate care frequently requires additional physician visits and medications. Care complications may result in costly hospitalizations or procedures. Ultimate outcomes include functional status as well as length and quality of life; the economic value of these outcomes can be measured in terms of health utility or health-status-related costs. We illustrate our framework using examples related to glycemic control for type 2 diabetes mellitus or the appropriateness of care for low back pain. CONCLUSIONS: The Quality-Cost Framework describes the mechanisms by which health-related quality of care affects health care and health status-related costs. Additional work will need to validate the framework by applying it to multiple clinical conditions. Applicability could be assessed by using the framework to classify the measures of quality and cost reported in published studies. Usefulness could be demonstrated by employing the framework to identify design flaws in published cost analyses, such as omitting the costs attributable to a relevant subdomain of quality.

Etat de santé / Health Status

Fransoo R.R. (2013). The Rising Prevalence of Asthma: True Increase, Diagnostic Exchange or Diagnostic Accuracy? *Healthcare Policy*, 8 (4): 27-34.

Abstract : In the midst of frequent reports about "the asthma epidemic"; results from a number of studies by the Manitoba Centre for Health Policy have shown stable or decreasing prevalence of an overall indicator of respiratory diseases which includes asthma. To resolve these apparently contrary findings, we conducted a time trend analysis using administrative data. Results revealed significant potential for diagnostic exchange: asthma prevalence increased, but that of bronchitis decreased.

Géographie de la santé / Geography of Health

Crandall M., Sharp D., Unger E., Straus D., Brasel K., Hsia R., Esposito T. (2013). Trauma Deserts: Distance From a Trauma Center, Transport Times, and Mortality From Gunshot Wounds in Chicago. *Am J Public Health*, 103 (6) : 1103-1109.

Abstract: Objectives. We examined whether urban patients who suffered gunshot wounds (GSWs) farther from a trauma center would have longer transport times and higher mortality. Methods. We used the Illinois State Trauma Registry (1999-2009). Scene address data for Chicago-area GSWs was geocoded to calculate distance to the nearest trauma center and compare prehospital transport times. We used multivariate regression to calculate the effect on mortality of being shot more than 5 miles from a trauma center. Results. Of 11 744 GSW patients during the study period, 4782 were shot more than 5 miles from a trauma center. Mean transport time and unadjusted mortality were higher for these patients ($P < .001$ for both). In a multivariate model, suffering a GSW more than 5 miles from a trauma center was associated with an increased risk of death (odds ratio = 1.23; 95% confidence interval = 1.02, 1.47; $P = .03$). Conclusions. Relative "trauma deserts" with decreased access to immediate care were found in certain areas of Chicago and adversely affected mortality from GSWs. These results may inform decisions about trauma systems planning and funding.

Green M.A. (2013). The equalisation hypothesis and changes in geographical inequalities of age based mortality in England, 2002-2004 to 2008-2010. *Soc Sci Med*, 87 93-98.

Abstract: The equalisation hypothesis argues that during adolescence and early adulthood, inequality in mortality declines and begins to even out. However the evidence for this phenomenon is contested and mainly based on old data. This study proposes to examine how age-specific inequalities in mortality rates have changed over the past decade, during a time of widening health inequalities. To test this, mortality rates were calculated for deprivation quintiles in England, split by individual ages and sex for three time periods (2002-2004, 2005-2007 and 2008-2010). The results showed evidence for equalisation, with a clear decline in the ratio of mortality rates during late adolescence. However this decline was not accounted for by traditional explanations of the hypothesis. Overall, geographical inequalities were shown to be widening for the majority of ages, although there was some narrowing of patterns observed.

Peipins L.A., Graham S., Young R., Lewis B., Flanagan B. (2013). Racial disparities in travel time to radiotherapy facilities in the Atlanta metropolitan area. *Soc Sci Med*, 89 32-38.

Abstract: Low-income women with breast cancer who rely on public transportation may have difficulty in completing recommended radiation therapy due to inadequate access to radiation facilities. Using a geographic information system (GIS) and network analysis we quantified spatial accessibility to radiation treatment facilities in the Atlanta, Georgia metropolitan area. We built a transportation network model that included all bus and rail routes and stops, system transfers and walk and wait times experienced by public transportation system travelers. We also built a private transportation network to model travel times by automobile. We calculated travel times to radiation therapy facilities via public and private transportation from a population-weighted center of each census tract located within the study area. We broadly grouped the tracts by low, medium and high household access to a private vehicle and by race. Facility service areas were created using the network model to map the extent of areal coverage at specified travel times (30, 45 and 60 min) for both public and private modes of transportation. The median public transportation travel time to the nearest radiotherapy facility was 56 min vs. approximately 8 min by private vehicle. We found that majority black census tracts had longer public transportation travel times than white tracts across all categories of vehicle access and that 39% of women in the study area had longer than 1 h of public transportation travel time to the nearest facility. In addition, service area analyses identified locations where the travel time barriers are the greatest. Spatial inaccessibility, especially for women who must use public transportation, is one of the barriers they face in receiving optimal treatment.

Hôpital / Hospitals

Martín E, García J. (2013). Efficiency improvements of public hospitals under a capitation payment scheme. *Health Economics, Policy and Law*, 8 (3) : 335-364.

Abstract: In a context of cost containment and demands for better quality in public health care, payment systems are used as an instrument to promote efficiency improvements in service providers. Andalusia has adopted an original type of risk-adjusted capitation payment mechanism to reimburse public hospitals. This paper presents the main characteristics of the reimbursement mechanism of the Andalusian Health Service highlighting some differences with the mechanisms adopted in other parts of Europe. The paper also explores the evolution of the efficiency and quality of the hospitals after its implementation using the Malmquist index. Results indicate that hospitals have slightly improved their efficiency, particularly urban hospitals, and these improvements are not significantly related to a negative evolution of quality. However, it is not possible to assert to what extent, improvements are the consequence of the new payment system. The organisation of the Servicio Andaluz de Salud and the limited competition between hospitals reduce the effectiveness of the reform;

Press M.J., Scanlon D.P., Ryan A.M., Zhu J., Navathe A.S., Mittler J.N., Volpp K.G. (2013). Limits of readmission rates in measuring hospital quality suggest the need for added metrics. *Health Aff. (Millwood.)*, 32 (6) : 1083-1091.

Abstract: Recent national policies use risk-standardized readmission rates to measure hospital performance on the theory that readmissions reflect dimensions of the quality of patient care that are influenced by hospitals. In this article our objective was to assess readmission rates as a hospital quality measure. First we compared quartile rankings of hospitals based on readmission rates in 2009 and 2011 to see whether hospitals maintained their relative performance or whether shifts occurred that suggested either changes in quality or random variation. Next we examined the relationship between readmission rates and several commonly used hospital quality indicators, including risk-standardized mortality rates, volume, teaching status, and process-measure performance. We found that quartile rankings fluctuated and that readmission rates for lower-performing hospitals in 2009 tended to improve by 2011, while readmission rates for higher-performing hospitals tended to worsen. Regression to the mean (a form of statistical noise) accounted for a portion of the changes in hospital performance. We also found that readmission rates were higher in teaching hospitals and were weakly correlated with the other indicators of hospital quality. Policy makers should consider augmenting the use of readmission rates with other measures of hospital performance during care transitions and should build on current efforts that take a communitywide approach to the readmissions issue.

Colais P., Agabiti N., Fusco D., Pinnarelli L., Sorge C., Perucci C.A., Davoli M. (2013). Inequality in 30-day mortality and the wait for surgery after hip fracture: the impact of the regional health care evaluation program in Lazio (Italy). *Int J Qual. Health Care*, 25 (3) : 239-247.

Abstract: OBJECTIVE: INTERVENTIONS: that address inequalities in health care are a priority for public health research. We evaluated the impact of the Regional Health Care Evaluation Program in the Lazio region, which systematically calculates and publicly releases hospital performance data, on socioeconomic differences in the quality of healthcare for hip fracture. DESIGN: Retrospective cohort study. SETTING: and participants We identified, in the hospital information system, elderly patients hospitalized for hip fracture between 01 January 2006 and 31 December 2007 (period 1) and between 01 January 2009 and 30 November 2010 (period 2). MAIN OUTCOME MEASURES: We used multivariate regression models to test the association between socioeconomic position index (SEP, level I well-off to level III disadvantaged) and outcomes: mortality within 30 days of hospital arrival, median waiting time for surgery and proportion of interventions within 48 h. RESULTS: We studied 11 581 admissions. Lower SEP was associated with a higher risk of 30-day mortality in period 1 (relative risk (RR) = 1.42, P = 0.027), but not in period 2. Disadvantaged people were less likely to undergo intervention within 48 h than well-off persons in period 1 (level II: RR = 0.72, P < 0.001; level III: RR = 0.46, P < 0.001) and period 2 (level II: RR = 0.88, P = 0.037; level III: RR = 0.63, P < 0.001). We observed a higher probability of undergoing intervention within 48 h in period 2 compared with the period 1 for each socioeconomic level. CONCLUSION: This study suggests that a systematic evaluation of health outcome approach, including public disclosure of results, could reduce socioeconomic differences in healthcare through a general improvement in the quality of care.

Rumball-Smith J., Sarfati D., Hider P., Blakely T. (2013). Ethnic disparities in the quality of hospital care in New Zealand, as measured by 30-day rate of unplanned readmission/death. *Int J Qual. Health Care*, 25 (3) : 248-254.

Abstract: OBJECTIVE: To compare the quality of hospital care for New Zealand (NZ) Maori and NZ European adult patients, using the rate of unplanned readmission or death within 30 days of discharge as an indicator of quality. DESIGN: Retrospective cohort study. SETTING: NZ public hospitals. PARTICIPANTS Data from 89 658 patients who were admitted for one of a defined set of surgical procedures at NZ public hospitals 2002-8 were obtained from the NZ Ministry of Health. Outcome The odds of readmission for NZ Maori when compared with NZ European patients were calculated using logistic regression, incorporating variables for age, sex, comorbidity, index procedure, hospital volume and socioeconomic position. RESULTS NZ Maori had 16% higher odds of readmission or death when compared with NZ European patients (OR = 1.16; 95% CI 1.08-1.24) after adjusting for all covariates. Readmission or death was also associated with being female (OR = 1.09; 1.03-1.15), older age (OR = 1.33; 1.19-1.48, for >79 years compared with 18-39 years), higher comorbidity (OR = 2.08; 1.89-2.31, for Charlson score 3+ compared with 0) and higher hospital volume (OR = 0.81; 0.76-0.86, for lowest

volume compared with highest). **CONCLUSIONS:** This study suggests ethnic disparities in the quality of hospital care in NZ using unplanned readmission rate as an indicator of quality. There are well-documented differences in health outcomes between Maori and NZ Europeans, and it is possible that differential treatment within the health system contributes to these health status inequalities.

Wilde E.T. (2013). Do emergency medical system response times matter for health outcomes? *Health Econ*, 22 (7) : 790-806.

Abstract: The introduction of technology aimed at reducing the response times of emergency medical services has been one of the principal innovations in crisis care over the last several decades. These substantial investments have typically been justified by an assumed link between shorter response times and improved health outcomes. However, current medical research does not generally show a relationship between response time and mortality. In this study, we explain the discrepancy between conventional wisdom and mortality; existing medical research fails to account for the endogeneity of incident severity and response times. Analyzing detailed call-level information from the state of Utah's Bureau of Emergency Medical Services, we measure the impact of response time on mortality and hospital utilization using the distance of the incident from the nearest EMS agency headquarters as an instrument for response time. We find that response times significantly affect mortality and the likelihood of being admitted to the hospital, but not procedures or utilization within the hospital.

Cookson G., Jones S., McIntosh B. (2013). Cancelled procedures: inequality, inequity and the national health service reforms. *Health Econ*, 22 (7) : 870-876.

Abstract: Using data for every elective procedure in 2007 in the English National Health Service, we found evidence of socioeconomic inequality in the probability of having a procedure cancelled after admission while controlling for a range of patient and provider characteristics. Whether this disparity is inequitable is inconclusive.

Mueller S.K., Lipsitz S., Hicks L.S. (2013). Impact of hospital teaching intensity on quality of care and patient outcomes. *Med Care*, 51 (7) : 567-574.

Abstract: **BACKGROUND:** : Proposed changes to financing of teaching hospitals and new quality-based performance incentives may differentially impact the financial health of teaching and safety-net institutions. Few data have examined the potential impact of these financial changes on teaching institutions. **OBJECTIVES:** : To determine the association of hospital teaching intensity with processes and outcomes of care for the most common inpatient diagnoses in the United States. **RESEARCH DESIGN:** Cross-sectional analysis of the 2008 Hospital Quality Alliance and 2007 American Hospital Association databases, adjusted for hospital characteristics. **SUBJECTS:** : A total of 2418 hospitals distributed across the country with available data on teaching intensity (resident-to-bed ratio), quality-of-care process measures, and risk-adjusted readmission and mortality rates for acute myocardial infarction (AMI), congestive heart failure (CHF), and pneumonia. **MEASURES:** Hospital-level quality-of-care process indicators and 30-day risk-adjusted readmission and mortality rates for AMI, CHF, and pneumonia. **RESULTS:** : Multivariable analysis demonstrates that all hospitals perform uniformly well on quality-of-care process measures for AMI, CHF, and pneumonia. However, when compared with nonteaching hospitals, increasing hospital teaching intensity is significantly associated with improved risk-adjusted mortality for AMI and CHF, but higher risk-adjusted readmission rates for all 3 conditions. Among high teaching intensity hospitals, those with larger Medicaid populations (safety-net institutions) had particularly high readmission rates for AMI and CHF. **CONCLUSIONS:** In this nationally representative evaluation, we found significant variation in performance on risk-adjusted mortality and readmission rates, and differences in readmission rates based on safety-net status. Our findings suggest that high teaching intensity and safety-net institutions may be disproportionately affected by upcoming changes in hospital payment models.

Merkow R.P., Bentrem D.J., Chung J.W., Paruch J.L., Ko C.Y., Bilimoria K.Y. (2013). Differences in Patients, Surgical Complexity, and Outcomes After Cancer Surgery at National Cancer Institute-designated Cancer Centers Compared to Other Hospitals. *Med Care*, 51 (7) : 606-613.

Abstract: **BACKGROUND:** : Interest in comparing hospital surgical quality continues to increase, particularly with respect to examining certain hospital designations such as National Cancer Institute-designated Cancer Centers (NCI-CC). Our objectives were to compare patients, surgical complexity,

and risk-adjusted 30-day outcomes following major cancer surgery at NCI-CC versus non-NCI centers. **METHODS::** From the American College of Surgeons National Surgical Quality Improvement Program, patients were identified who underwent colorectal, pancreatic, or esophagogastric resection for cancer (2007-2011). Regression methods were used to evaluate characteristics associated with undergoing treatment at NCI-CCs and surgical-complexity-adjusted 30-day morbidity, mortality, and prolonged length-of-stay at NCI-CC versus non-NCI centers. **RESULTS::** NCI-CCs performed 20.2% of colorectal (10,555/52,265), 53.5% of pancreatic (6335/11,838), and 49.8% of esophagogastric (1596/3208) operations for cancer. NCI-CCs were more likely to treat patients who were younger, white, and with fewer comorbidities, but were more likely to perform more complex procedures including synchronous liver resection (eg, colorectal), adjacent organ resections (rectal cancer), and vascular reconstructions (eg, pancreas) (all $P < 0.05$). NCI-CCs had a lower mortality rate for colorectal surgery only (1.2% vs. 1.9%) and increased rates of superficial surgical site infection (SSI) for colorectal (9.8% vs. 7.1%) and pancreatic (10.7% vs. 8.8%) surgery. No differences existed for the remaining complications by NCI-CC designation status. NCI-CCs were distributed throughout hospital quality rankings for all procedures and complications assessed. **CONCLUSIONS::** NCI-CCs treated younger, healthier patients, but performed more complex procedures. Patients treated at NCI-CCs had a lower risk of mortality for colorectal resection, but morbidity was similar to non-NCI centers. Comparison of cancer surgery hospital quality is feasible and should adjust for differences in patient demographics, comorbidities, and surgical complexity.

Inégalités de santé / Health Inequalities

Ahmed N.U., Pelletier V., Winter K., Albatineh A.N. (2013). Factors explaining racial/ethnic disparities in rates of physician recommendation for colorectal cancer screening. *Am J Public Health*, 103 (7) : e91-e99.

Abstract: Objectives. Physician recommendation plays a crucial role in receiving endoscopic screening for colorectal cancer (CRC). This study explored factors associated with racial/ethnic differences in rates of screening recommendation. Methods. Data on 5900 adults eligible for endoscopic screening were obtained from the National Health Interview Survey. Odds ratios of receiving an endoscopy recommendation were calculated for selected variables. Planned, sequenced logistic regressions were conducted to examine the extent to which socioeconomic and health care variables account for racial/ethnic disparities in recommendation rates. Results. Differential rates were observed for CRC screening and screening recommendations among racial/ethnic groups. Compared with Whites, Hispanics were 34% less likely ($P < .01$) and Blacks were 26% less likely ($P < .05$) to receive this recommendation. The main predictors that emerged in sequenced analysis were education for Hispanics and Blacks and income for Blacks. After accounting for the effects of usual source of care, insurance coverage, and education, the disparity reduced and became statistically insignificant. Conclusions. Socioeconomic status and access to health care may explain major racial/ethnic disparities in CRC screening recommendation rates.

Hosseinpour A.R., Stewart Williams J.A., Gautam J., Posarac A., Officer A., Verdes E., Kostanjsek N., Chatterji S. (2013). Socioeconomic inequality in disability among adults: a multicountry study using the world health survey. *Am J Public Health*, 103 (7) : 1278-1286.

Abstract: Objectives. We compared national prevalence and wealth-related inequality in disability across a large number of countries from all income groups. Methods. Data on 218 737 respondents participating in the World Health Survey 2002-2004 were analyzed. A composite disability score (0-100) identified respondents who experienced significant disability in physical, mental, and social functioning irrespective of their underlying health condition. Disabled persons had disability composite scores above 40. Wealth was evaluated using an index of economic status in households based on ownership of selected assets. Socioeconomic inequalities were measured using the slope index of inequality and the relative index of inequality. Results. Median age-standardized disability prevalence was higher in the low- and lower middle-income countries. In all the study countries, disability was

more prevalent in the poorest than in the richest wealth quintiles. Pro-rich inequality was statistically significant in 43 of 49 countries, with disability prevalence higher among populations with lower wealth. Median relative inequality was higher in the high- and upper middle-income countries. Conclusions. Integrating equity components into the monitoring of disability trends would help ensure that interventions reach and benefit populations with greatest need.

Médicaments / Pharmaceuticals

Dylst P. (2012). Reference pricing systems in Europe: characteristics and consequences.

Gabi Journals : Generics and Biosimilars Initiative Journal, 1 (3-4) : 127-131.

Abstract: A reference pricing system is a system that establishes a common reimbursement level or reference price for a group of interchangeable medicines, i.e. the reference group. This article provides an overview of the different characteristics of the different reference pricing systems in Europe. Additionally, the impact of reference pricing on price competition, generic medicine use, pharmaceutical expenditure and health outcome will be discussed. Studies relevant for this article were found by means of a literature review. A survey was carried out to document the current status of reference pricing systems in Europe. Survey data were collected from member associations of the European Generic medicines Association in the context of their 2011 survey of European drug retail markets. Many European governments have introduced reference pricing systems. Reference pricing systems reduce medicine prices but not always below the reference price, increase the use of medicines priced at or below the reference price, generate savings in pharmaceutical expenditure that tend to be limited to the short term, and do not seem to adversely affect health outcomes. Conclusion: Reference pricing is a popular policy for governments to contain pharmaceutical expenditures and seems to be effective in the different European countries.

<http://gabi-journal.net/reference-pricing-systems-in-europe-characteristics-and-consequences.html>

Chen J., Vargas-Bustamante A. (2013). Treatment compliance under physician-industry relationship: a framework of health-care coordination in the USA.

Int J Qual. Health Care, 25 (3) : 340-347.

Abstract: OBJECTIVE: Factors associated with treatment compliance have been well studied. However, no study has examined treatment compliance under the context of physician-industry relationship. This study developed a conceptual framework of physician-industry relationship and treatment compliance, and empirically tested patients' treatment compliance and affordability under the physician-industry relationship in the USA. DESIGN: We first proposed a conceptual framework to analyze different scenarios, where the physician-industry relationship could impact patients' treatment compliance and affordability, taking into consideration the role of health insurers. We then employed a nationally representative data set to investigate these relationships. Multivariable logistic regressions were employed to examine the physician-industry relationship and the physicians' perception of patients' treatment compliance. SETTING AND PARTICIPANTS: 2008 Health Tracking Physician Survey. RESULTS: Our results showed that physicians with closer industry relationships were more likely to report rejection of care by insurers [odds ratios (ORs): 1.24-1.85, $P < 0.001$], patients' non-compliance with treatment (OR: 1.34, $P < 0.01$) and patients' inability to pay (OR: 1.42, $P < 0.01$) as the major problems affecting their ability to provide high quality care, when compared with physicians without industry relationships. CONCLUSIONS: Our results shed light on the lack of articulation among industry, physicians and health insurers in the USA. It is important to make sure that different agents in the health-care marketplace, such as physicians, industry, and health insurers, coordinate more efficiently to provide quality and consistent care to patients.

Agrawal S., Brennan N., Budetti P. (2013). The Sunshine Act-effects on physicians.

N Engl J Med, 368 (22) : 2054-2057.

Skipper N. (2013). On the demand for prescription drugs: heterogeneity in price responses.

Health Econ, 22 (7) : 857-869.

Abstract: This paper estimates the price elasticity of demand for prescription drugs using an exogenous shift in consumer co-payment caused by a reform in the Danish subsidy scheme for the general public. Using purchasing records for the entire Danish population, I show that the average price response for the most commonly used drug yields demand elasticities in the range of -0.36 to -0.5. The reform is shown to affect women, the elderly, and immigrants the most. Furthermore, this paper shows significant heterogeneity in the price response over different types of antibiotics, suggesting that the price elasticity of demand varies considerably even across relatively similar drugs.

Visser S.T., Schuiling-Veninga C.C., Bos J.H., de Jong-van den Berg LT, Postma M.J. (2013). The population-based prescription database IADB.nl: its development, usefulness in outcomes research and challenges. *Expert Rev Pharmacoecon Outcomes Res*, 13 (3) : 285-292.

Abstract: Research databases with large numbers of prescriptions in observational settings can provide valuable information in addition to the initial randomized controlled trials. This paper reports on the development of prescription database IADB, formerly known as InterAction Database. IADB contains prescriptions from 54 community pharmacies in The Netherlands and covers a population of 500,000 people. Both the age distribution and the prevalence of drugs used are comparable to a large extent with the Dutch population. The representativeness of the population covered is examined by comparing population composition and drug use with data of the whole Dutch population. Enriching IADB with, among others, clinical parameters by linking to other databases is explored. A strong and unique aspect of IADB is the possibility to track patients over time, even when they receive their medication from different pharmacies. The authors conclude IADB is a useful tool for pharmacoepidemiological and pharmaco-economic outcomes research

Méthodologie – Statistique / Methodology – Statistics

Congdon P. (2006). Bayesian Statistical Modelling. Wiley Series in Probability and Statistics. Chichester : John Wiley

Abstract: Bayesian methods combine the evidence from the data at hand with previous quantitative knowledge to analyse practical problems in a wide range of areas. The calculations were previously complex, but it is now possible to routinely apply Bayesian methods due to advances in computing technology and the use of new sampling methods for estimating parameters. Such developments together with the availability of freeware such as WINBUGS and R have facilitated a rapid growth in the use of Bayesian methods, allowing their application in many scientific disciplines, including applied statistics, public health research, medical science, the social sciences and economics. Following the success of the first edition, this reworked and updated book provides an accessible approach to Bayesian computing and analysis, with an emphasis on the principles of prior selection, identification and the interpretation of real data sets. The second edition : provides an integrated presentation of theory, examples, applications and computer algorithms ; discusses the role of Markov Chain Monte Carlo methods in computing and estimation ; Includes a wide range of interdisciplinary applications, and a large selection of worked examples from the health and social sciences ; features a comprehensive range of methodologies and modelling techniques, and examines model fitting in practice using Bayesian principles ; provides exercises designed to help reinforce the reader's knowledge and a supplementary website containing data sets and relevant programs (4e de couverture).

Gort M., Broekhuis M., Regts G. (2013). How teams use indicators for quality improvement - a multiple-case study on the use of multiple indicators in multidisciplinary breast cancer teams. *Social Science & Medicine*, (Ahead of pub) :

Abstract: A crucial issue in healthcare is how multidisciplinary teams can use indicators for quality improvement. Such teams have increasingly become the core component in both care delivery and in many quality improvement methods. This study aims to investigate the relationships between (1) team factors and the way multidisciplinary teams use indicators for quality improvement, and (2) both team and process factors and the intended results. An in-depth, multiple-case study was conducted in the Netherlands in 2008 involving four breast cancer teams using six structure, process and outcome indicators. The results indicated that the process of using indicators involves several stages and activities. Two teams applied a more intensive, active and interactive approach as they passed through these stages. These teams were perceived to have achieved good results through indicator use compared to the other two teams who applied a simple control approach. All teams experienced some difficulty in integrating the new formal control structure, i.e. measuring and managing performance, in their operational task, and in using their new managerial task to decide as a team what and how to improve. Our findings indicate the presence of a network of relationships between team factors, the controllability and actionability of indicators, the indicator-use process, and the intended results.

Gerring J., Thacker S.C., Enikolopov R., Arevalo J., Maguire M. (2013). Assessing Health System Performance: A Model-Based Approach. *Social Science & Medicine*, (Ahead of pub) :

Abstract: It is difficult to assess countries' relative success in addressing issues of public health because countries are subject to very different background conditions. To address this problem we offer a model-based approach for assessing health system performance. Specifically, an index of public health is regressed against a vector of variables intended to capture economic, educational, cultural, geographic, and epidemiological endowments. The residual from this model is regarded as a plausible measure of public health performance at the national level. We argue that a model-based approach to performance is informative for policymakers and academics as it focuses attention on those aspects of a country's health profile that are not constrained by structural factors. This sharpens comparisons across countries and through time, and also allows one to evaluate the degree to which health systems have lived up to their potential.

Rowe A.K. (2013). The effect of performance indicator category on estimates of intervention effectiveness. *Int J Qual. Health Care*, 25 (3) : 331-339.

Abstract: BACKGROUND : A challenge for systematic reviews on improving health worker performance is that included studies often use different performance indicators, and the validity of comparing interventions with different indicators is unclear. One potential solution is to adjust comparisons by indicator category, with categories based on steps of the case-management process that can be easily recognized (assessment of symptoms, treatment etc.) and that might require different levels of effort to bring about improvements. However, this approach would only be useful if intervention effect sizes varied by indicator category. To explore this approach, studies were analyzed that evaluated the Integrated Management of Childhood Illness (IMCI) strategy. METHODS: Performance indicators were grouped into four categories: patient assessment, diagnosis, treatment and counseling. An effect size of IMCI was calculated for each indicator. Linear regression modeling was used to test for differences among the mean effect sizes of the indicator categories. RESULTS: Six studies were included, with data from 3136 ill child consultations. Mean effect sizes for 63 assessment indicators, 12 diagnosis indicators, 31 treatment indicators and 34 counseling indicators were 50.9 percentage-points (%-points), 44.7, 36.5 and 46.6%-points, respectively. After adjusting for baseline indicator value, compared with the assessment mean effect size, the diagnosis mean was 7.3%-points lower (P = 0.23), the treatment mean was 15.2%-points lower (P = 0.0004) and the counseling mean was 12.9%-points lower (P = 0.0027). CONCLUSION: Adjusting the results of systematic reviews for indicator category and baseline indicator value might be useful for improving the validity of intervention comparisons.

Politique de santé / Health Policy

(2013). Service public et santé : Actes du colloque : Paris : Editions de Santé ; Les Presses de SciencesPo

Abstract: Le concept de service public qui a, pendant longtemps, constitué le socle du développement des interventions de la puissance publique, paraît aujourd'hui malmené par les transformations de l'action publique, les tensions macroéconomiques et les exigences du droit européen. Sur le champ de la santé, le service public n'a trouvé ses marques que tardivement. Au-delà des missions traditionnelles de police sanitaire, les services publics de prévention n'ont été développés qu'avec parcimonie et le service public hospitalier ne s'est constitué qu'à partir de 1958, avant d'être consacré par la loi Boulin de 1970. Quant à l'assurance maladie, elle s'est inscrite, dès son origine, dans le contexte singulier de la démocratie sociale. Les évolutions législatives et économiques de la dernière décennie ont remis en cause la conception et l'organisation des services publics de santé. Les contributions réunies dans cet ouvrage, à l'occasion du colloque organisé par la chaire Santé de Sciences Po et l'Institut Droit et santé de l'Université Paris Descartes en juin 2012, permettent de s'interroger sur la pertinence et la portée, en 2012, des principes du service public en matière de santé et d'analyser les mutations de la gestion des services publics de soins. Elles invitent ensuite à examiner les conséquences de la tourmente dans laquelle se trouvent actuellement les services publics de santé et à approfondir la réflexion sur leur avenir (4e de couverture) ;

Dab W., Salomon D. (2013). Agir face aux risques sanitaires : Paris : Presses Universitaires de France

Abstract: Une multitude de crises sanitaires a ébranlé la confiance des citoyens dans les institutions. Comprendre les erreurs commises pour améliorer le dispositif de sécurité sanitaire est le principal objectif de ce livre. Moins les réponses apportées aux inquiétudes sont pertinentes et plus la méfiance grandit plus celle-ci croît et plus l'inquiétude se manifeste. Or, risques, incertitudes et confiances sont indissolublement liés. Les crises de sécurité sanitaire révèlent un État fabriquant de la défiance et inadapté à gouverner la complexité et l'incertitude. Cet ouvrage se fonde sur l'analyse de quinze cas. Il souligne l'inadaptation de l'État ainsi que les limites de l'expertise scientifique des risques sanitaires. Soulignant l'émergence d'expériences innovantes, il propose un pacte de confiance sanitaire fondé sur une approche pluraliste de l'évaluation des risques, un soutien aux initiatives citoyennes, des décisions motivées et une responsabilité tournée vers une logique de résultat (4e de couverture).

Shaw C.D., Braithwaite J., Moldovan M., Nicklin W., Grgic I., Fortune T., Whittaker S. (2013). Profiling health-care accreditation organizations: an international survey. *Int J Qual. Health Care*, 25 (3) : 222-231.

Abstract: OBJECTIVE: To describe global patterns among health-care accreditation organizations (AOs) and to identify determinants of sustainability and opportunities for improvement. DESIGN: Web-based questionnaire survey. PARTICIPANTS: Organizations offering accreditation services nationally or internationally to health-care provider institutions or networks at primary, secondary or tertiary level in 2010. MAIN OUTCOME MEASURE: s) External relationships, scope and activity public information. RESULTS: Forty-four AOs submitted data, compared with 33 in a survey 10 years earlier. Of the 30 AOs that reported survey activity in 2000 and 2010, 16 are still active and stable or growing. New and old programmes are increasingly linked to public funding and regulation. CONCLUSIONS: While the number of health-care AOs continues to grow, many fail to thrive. Successful organizations tend to complement mechanisms of regulation, health-care funding or governmental commitment to quality and health-care improvement that offer a supportive environment. Principal challenges include unstable business (e.g. limited market, low uptake) and unstable politics. Many organizations make only limited information available to patients and the public about standards, procedures or results.

Nadeem E., Olin S.S., Hill L.C., Hoagwood K.E., Horwitz S.M. (2013). Understanding the components of quality improvement collaboratives: a systematic literature review. *Milbank Q*, 91 (2) : 354-394.

Abstract: CONTEXT: In response to national efforts to improve quality of care, policymakers and health care leaders have increasingly turned to quality improvement collaboratives (QICs) as an efficient approach to improving provider practices and patient outcomes through the dissemination of evidence-based practices. This article presents findings from a systematic review of the literature on QICs, focusing on the identification of common components of QICs in health care and exploring, when possible, relations between QIC components and outcomes at the patient or provider level.

METHODS: A systematic search of five major health care databases generated 294 unique articles, twenty-four of which met our criteria for inclusion in our final analysis. These articles pertained to either randomized controlled trials or quasi-experimental studies with comparison groups, and they reported the findings from twenty different studies of QICs in health care. We coded the articles to identify the components reported for each collaborative. **FINDINGS:** We found fourteen crosscutting components as common ingredients in health care QICs (e.g., in-person learning sessions, phone meetings, data reporting, leadership involvement, and training in QI methods). The collaboratives reported included, on average, six to seven of these components. The most common were in-person learning sessions, plan-do-study-act (PDSA) cycles, multidisciplinary QI teams, and data collection for QI. The outcomes data from these studies indicate the greatest impact of QICs at the provider level; patient-level findings were less robust. **CONCLUSIONS:** Reporting on specific components of the collaborative was imprecise across articles, rendering it impossible to identify active QIC ingredients linked to improved care. Although QICs appear to have some promise in improving the process of care, there is great need for further controlled research examining the core components of these collaboratives related to patient- and provider-level outcomes.

Dolan P., Kavetsos G., Tsuchiya A. (2013). Sick but satisfied: The impact of life and health satisfaction on choice between health scenarios. *J Health Econ*, 32 (4) : 708-714.

Abstract: Preference elicitation methods require respondents to predict the impact a change in health might have on their future selves. The focus on the change in health is at the possible expense of other experiences of life once in that health state. We analyse personal preferences to a pairwise choice task involving trade-offs between quality and length of life, where satisfaction levels with life or health are introduced in the description of the health states. We find that a health scenario including low levels of satisfaction increases the likelihood of preferring to die sooner in full health, whereas scenarios including high levels of satisfaction increase the likelihood of preferring to live for longer in poor health. The differences highlight the sensitivity of preferences to what is described in health states and therefore show the importance of on-going discussions about precisely what respondents should be asked to consider in preference elicitation studies.

Prévision – Evaluation / Prevision - Evaluation

Penta M., Arnould C., Decruynaere C. (2005). Développer et interpréter une échelle de mesure : applications du modèle de Rasch. Pratiques psychologiques : évaluation et diagnostic. Bruxelles : Mardaga

Abstract: Les questionnaires d'évaluation sont les instruments les plus utilisés aujourd'hui dans le domaine de la médecine et des sciences humaines pour évaluer des variables telles que l'incapacité physique, l'altruisme ou la douleur. Pourtant les praticiens connaissent souvent mal ces instruments. Que mesurent-ils vraiment ? Comment les résultats doivent-ils être interprétés ? Le présent ouvrage s'efforce de répondre à ces questions- . Il ne s'agit pas d'un simple mode d'emploi des questionnaires d'évaluation. Son objectif principal est de fournir à tous, chercheurs et praticiens, les bases méthodologiques nécessaires pour développer un tel instrument et pour en interpréter les résultats. Après avoir exposé les fondements d'une mesure objective formulés par le modèle de Rasch, les auteurs adressent une série de questions fréquemment posées dans leur contexte d'application. Quels sont les critères d'une mesure objective ? Les résultats peuvent-ils être interprétés de manière quantitative ? Comment valider un tel instrument de mesure ? Peut-on comparer les réponses observées chez différents groupes de sujets ? Six chapitres, agrémentés de nombreux exemples pratiques et d'exercices résolus, exposent les bases méthodologiques de l'évaluation quantitative à l'aide du modèle de Rasch. Le septième chapitre décrit, pas à pas, les étapes du développement et de la validation d'une échelle de mesure de l'habileté manuelle.

Albert V., Coutu M.F., Durand M.J. (2013). [Adaptation of a questionnaire measuring representations related to work disability]. *Encephale*, 39 (3) : 174-182.

Abstract: BACKGROUND: Health, illness and treatment representations have been described as key factors for return to work. The Revised Illness Perception Questionnaire (IPQ-R) is a quantitative tool available to assess these factors. However, an adaptation is necessary before its use with workers on prolonged work disability presenting musculoskeletal disorders (MSD). METHODS: Two distinct phases were carried out, firstly, by adapting the IPQ-R for a population of workers in prolonged work disability related to an MSD and, secondly, by conducting a pre-test on the adapted questionnaire to assess item clarity. PHASE 1: The Technique for Research of Information by the Animation of a Group of Experts (TRIAGE) was selected to proceed with the adaptation. TRIAGE is an inductive and structured method aiming at the attainment of group consensus. Consensus was obtained in two steps: for the individual production, each expert had to judge the pertinence of the questioned elements and suggested new elements if needed; for the group production, all suggestions submitted were sorted according to TRIAGE systematic procedure, in order to retain the most pertinent ones by group consensus. Analysis was done simultaneously to data collection, by the attainment of group consensus. The group of experts consisted of six clinicians and two researchers. For the clinicians, selection criteria consisted of: being an occupational therapist or a psychologist and working for at least 2 years in a vocational rehabilitation setting for workers in prolonged work disability; for the researchers, being affiliated to a university and to have pursued a least one research project regarding prolonged work disability following MSD and development/validation of assessment tools. As a result of the adaptation process eight items were excluded because they were not considered pertinent by the experts. The label "illness" was changed for "current health condition" and 26 new items have been added to the questionnaire to better account for the work disability. The adapted questionnaire appears to present good content validity. PHASE 2: The assessment tool was then pre-tested using a widely known method for trans-cultural adaptation of questionnaires. This method adds a 7-point scale following each item in order to assess item clarity. When the questionnaire is filled, questions are asked to the respondent about items with low rating (4 or less on 7) in order to identify potential ambiguities. Inclusion criteria for the respondents consisted of: being between 18 and 64 of age, having more than 3 months of absence from work related to an MSD and being admitted in a rehabilitation program. Workers absent from work for more than a year, unable to understand and/or read French, suffering from an MSD related to a specific pathology, or presenting major psychiatric problems as indicated in their medical record were excluded. Nine workers were recruited using convenience sampling. Average clarity rating was above 4 for each item, suggesting that the adapted questionnaire was clear. Characteristics of participants seem to be representative of the target

population. **CONCLUSION:** A questionnaire was adapted in order to better assess the representations of workers in a situation of work disability following an MSD. The rigorous process used in this study ensures the quality of the adaptation, but a validation study must be conducted before the implementation of the questionnaire in clinic and research.

Psychiatrie / Psychiatry

Ngui A.N., Apparicio P., Fleury M.J, et al. (2013). Spatio-temporal clustering of the incidence of Schizophrenia in Quebec, Canada from 2004 to 2007. *Spatial and Spatio-temporal Epidemiology*, (Ahead of pub) :

Abstract: Exploring spatio-temporal patterns of disease incidence can help to identify areas of significantly elevated or decreased risk, providing potential etiologic clues. In this study, we present a spatio-temporal analysis of the incidence of Schizophrenia in Quebec from 2004 to 2007 using administrative databases from the Régie de l'Assurance Maladie du Quebec and the hospital discharge database. We conducted purely spatial analyses for each age group adjusted by sex for the whole period using SatScan (version 9.1.1). Findings from the study indicated variations in the spatial clustering of schizophrenia according to sex and age. In term of incidence rate, there are high differences between urban and rural-remote areas, as well as between the two main metropolitan areas of the province of Quebec (Island of Montreal and Quebec-City).

Boyer L., Baumstarck K., Boucekine M., Blanc J., Lancon C., Auquier P. (2013). Measuring quality of life in patients with schizophrenia:an overview. *Expert Rev Pharmacoecon Outcomes Res*, 13 (3) : 343-349.

Abstract: Quality of life (QoL) is of great importance to patients with schizophrenia and their families. Although the use of QoL measures may contribute to better adherence to therapeutic interventions, more satisfaction with care, improved health outcomes and reduction of health costs, QoL assessment remains underutilized in clinical practice. In this review, the authors propose a reflection on the limitations and lack of impact of QoL measures in clinical care. Our argument is based on three challenges regarding conceptual aspects and metrics, use and limits and the usefulness of measuring QoL. For each challenge, the authors have suggested pragmatic proposals and new research directions to promote the use of QoL measures in the future. These avenues of research involve a shared responsibility between QoL researchers, the medical community and decision makers. Close collaboration between all parties is necessary to promote the use of QoL measures in schizophrenia.

Llorca P.M., Camus V., Courtet P., Gourion D., Lukasiewicz M., Coulomb S. (2013). [Current status and management of patients with bipolar disorder in France: The MONTRA survey]. *Encephale*, 39 (3) : 212-223.

Abstract: **OBJECTIVES:** The objectives were to assess the characteristics of patients with bipolar disorder (BD) and to evaluate the prescribing practices. **METHODS:** MONTRA is a quantitative survey conducted between December 2010 and February 2011. Data were extracted by the psychiatrists from the medical files of BD patients seen on four consecutive days of consulting. **RESULTS:** Four hundred and thirty-nine psychiatrists included 2529 patients (inpatients, n=319; outpatients from mental clinics, n=1090; outpatients consulting in private practice, n=1020). In the total patient population (mean age: 47 years; women, 58%), BD was distributed as follows: BD type I, 56%; BD type II, 40%; other types of BD, 4%; rapid cyclers, 10%. The prevalence of psychiatric comorbidities was high (anxiety disorders, 48%; abuse and dependence on toxic substances, 17 and 10% respectively), 36% of the patients had a history of suicide attempt and the risk of suicide, when assessed, was 6%. In about half the patients (48%), the polarity of the initial bipolar episode was of the depressive type (versus 39% for the manic/hypomanic type). Outpatients were globally independent and did not require assistance in the management of their disease or its treatment whereas the social and professional lives of inpatients were negatively affected by their condition. Based on the psychiatrist's declarations, 39 to 50% of the outpatients were symptom-free, 36 to 40% were in the intercurrent phase with residual symptoms, 11 to 17% presented either a manic or depressive acute BP episode, and 3 to 4% were in

a mixed state; among inpatients, 52% presented an acute episode either manic or depressive, 38% were in the intercurrent phase and 9% were in a mixed state. In the symptomatic patients from the total population (61%), the most prevalent symptoms were depressive and corresponded to acute symptoms (patients with a depressive episode, 14%) or residual symptoms (patients in the intercurrent phase, 27%). The predominant depressive polarity was observed in both hospitalized and outpatients. The pharmacological treatment of BD included polytherapy in 73% of the patients. In the manic episodes (n=126), the patients were treated with a Mood Stabilizer (MS, 56%) or an atypical antipsychotic (AAP, 52%) in association. In the depressive episodes (n=342), the patients received an antidepressant drug associated with a MS or an AAP (70%). In symptom-free or symptomatic intercurrent periods (n=1943), the patients were treated with a MS (49-58%) or an AAP (37-49%), in association. CONCLUSION: BD patients evaluated in our survey were in majority diagnosed with BD type I, associated with considerable comorbidity. In the symptomatic patients, the most prevalent symptoms, either acute or residual, were of the depressive type. In the majority of the patients, whatever the clinical status, polytherapy was prescribed for the BD.

Soins de santé primaires / Primary Health Care

Rougeron C. (2013). Pour une éthique renouvelée de la santé publique : l'accès aux soins en médecine générale : Paris : L'Harmattan

Abstract: De nombreux points ont fait régresser la France de la première à la huitième place du classement de l'Organisation Mondiale de la Santé, notamment l'accès aux soins. La médecine de proximité, malmenée, déconsidérée, est laminée. Les patients recourent aux urgences, le plus coûteux qui soit pour notre société. Cet ouvrage édicte quelques propositions salvatrices, viables au plan technique et financier.

Thanh N.X. (2013). Wait Time from Primary to Specialty Care: A Trend Analysis from Edmonton, Canada. *Healthcare Policy*, 8 (4) : 35-44.

Abstract: Medical wait time is a top health policy issue in Canada. Reliable data on the referral wait time from primary to specialty care are limited. Existing data on referral wait times are generally self-reported by specialists. In 2008, the Edmonton North Primary Care Network (PCN) developed a Centralized Referral Program, including a specialist database that contains information on specialists' referral requirements, forms and protocols, and has the capability of tracking referrals that the PCN makes on behalf of its family physicians to specialty care. We performed a trend analysis of the referral wait time (defined as the time from referral by a family physician to an appointment date with a specialist) from 2009 to 2011 using the program database (n=33,281 referrals). The study provided a unique and comprehensive picture of wait times for 22 specialties. We identified a decrease in the overall wait time year over year, and improvement in the number of referrals that are accepted the first time. Additionally, specific opportunities for further improvement in referral wait time were noted.

Renzaho A.M., Romios P., Crock C., Sonderlund A.L. (2013). The effectiveness of cultural competence programs in ethnic minority patient-centered health care--a systematic review of the literature. *Int J Qual. Health Care*, 25 (3) : 261-269.

Abstract: PURPOSE: To examine the effectiveness of patient-centered care (PCC) models, which incorporate a cultural competence (CC) perspective, in improving health outcomes among culturally and linguistically diverse patients. DATA SOURCES: The search included seven EBSCO-host databases: Academic Search Complete, Academic Search Premier, CINAHL with Full Text, Global Health, MEDLINE with Full Text, PsycINFO PsycARTICLES, PsycEXTRA, Psychology and Behavioural Sciences Collection and Pubmed, Web of Knowledge and Google Scholar. STUDY SELECTION: The review was undertaken following the preferred reporting items for systematic reviews and meta-analyses, and the critical appraisals skill program guidelines, covering the period from January 2000 to July 2011. Data extraction Data were extracted from the studies using a piloted form, including fields for study research design, population under study, setting, sample size, study results and limitations. RESULTS OF DATA SYNTHESIS: The initial search identified 1450 potentially

relevant studies. Only 13 met the inclusion criteria. Of these, 11 were quantitative studies and 2 were qualitative. The conclusions drawn from the retained studies indicated that CC PCC programs increased practitioners' knowledge, awareness and cultural sensitivity. No significant findings were identified in terms of improved patient health outcomes. CONCLUSION: PCC models that incorporate a CC component are increased practitioners' knowledge about and awareness of dealing with culturally diverse patients. However, there is a considerable lack of research looking into whether this increase in practitioner knowledge translates into better practice, and in turn improved patient-related outcomes. More research examining this specific relationship is, thus, needed.

Aller M.B., Vargas I., Waibel S., Coderch J., Sanchez-Perez I., Colomes L., Llopart J.R., Ferran M., Vazquez M.L. (2013). A comprehensive analysis of patients' perceptions of continuity of care and their associated factors. *Int J Qual. Health Care*, 25 (3) : 291-299.

Abstract: OBJECTIVE: To determine the patients' perceived degree of continuity of care between primary and secondary care and to identify contextual and individual factors that influence patients' perceptions of continuity of care. DESIGN: Cross-sectional study by means of a survey of patients attended to in primary and secondary care. SETTING: Three health-care areas of the Catalanian public health-care system. PARTICIPANTS: > A random sample of 1500 patients. MAIN OUTCOME MEASURES: Relational, informational and managerial continuity of care measured by means of Likert scales, using the CCAENA questionnaire. RESULTS: Overall, 93.8 and 83.8% of patients perceived an ongoing relationship with primary and secondary care physicians, respectively (relational continuity), 71.2% perceived high levels of information transfer (informational continuity) and 90.7% perceived high levels of consistency of care (managerial continuity). Patients from health-care areas where primary and secondary care were managed by a single organization and the elderly tended to perceive higher levels of all three types of continuity. Foreign-born patients were less likely to perceive relational continuity with primary care physicians; those with higher educational levels were less likely to perceive high levels of informational continuity and patients with worse health status were less likely to report high levels of managerial and relational continuity with secondary care physicians. CONCLUSIONS: Study results suggest high levels of perceived continuity of care, especially for relational and managerial continuity. The adopted comprehensive approach proves to be useful to properly understand the phenomenon because perceptions and associated factors vary according to the type of continuity.

Davidson P.M., Inglis S.C., Newton P.J. (2013). Self-care in patients with chronic heart failure. *Expert Rev Pharmacoecon Outcomes Res*, 13 (3) : 351-359.

Abstract: Globally, chronic heart failure is a common, complex syndrome characterized by high levels of healthcare utilization, reduced quality of life and premature mortality. Self-care is a complex decision-making process involving symptom recognition, action and evaluation. The purpose of this article is to define self-care, discuss barriers and facilitators in promoting adherence and summarize the methods available for assessing the individual's capacity to be an active partner in care. The appraisal to undertake self-care will require not only assessment of the individuals' clinical, psychological, social and cultural circumstances, but also the capacity of healthcare providers and healthcare systems to accommodate patients as partners in care.

Brunt C.S., Jensen G.A. (2013). Pricing distortions in Medicare's physician fee schedule and patient satisfaction with care quality and access. *Health Econ*,

Abstract: Medicare adjusts its payments to physicians for geographic differences in the cost of operating a medical practice, but the method it uses is imprecise. We measure the inaccuracy in its geographic adjustment factors and categorize beneficiaries by whether they live where Medicare's formula is favorable or unfavorable to physicians. Then, using the 2001-2003 Medicare Current Beneficiary Survey, we examine whether differences in physician payment generosity, that is, whether favorable or unfavorable, influence the satisfaction ratings Medicare seniors assign to their quality of care and access to services. We find strong evidence that they do. Many beneficiaries live in payment-unfavorable areas and receive a less satisfying quality of care and less satisfying access to services than beneficiaries who live where payments are favorable to physicians

Glennard A.H. (2013). Is patient satisfaction in primary care dependent on structural and organizational characteristics among providers? Findings based on data from the

national patient survey in Sweden. *Health Econ Policy Law*, 8 (3) : 317-333.

Abstract: In parallel to market-like reforms in Swedish primary care, the gathering and compilation of comparative information about providers, for example through survey tools, has been improved. Such information is increasingly being used to guide individuals' choice of provider and payers' assessments of provider performance, often without critically reflecting about underlying factors affecting the results. The purpose of this study was to analyze variation in patient satisfaction, with respect to organizational and structural factors, including the mix of registered individuals, among primary care providers, based on information from a national patient survey in primary care and register data in three Swedish county councils. Systematic variation in patient satisfaction was found with respect to both organizational and structural factors, including characteristics of registered individuals. Smaller practices and practices where a high proportion of all visits were with a doctor were associated with higher patient satisfaction. Also practices where registered individuals had a low level of social deprivation and a high overall illness on average were associated with higher patient satisfaction. Factors that are of relevance for how well providers perform according to patient surveys are more or less possible to control for providers. This adds to the complexity for the use of such information by individuals and payers to assess provider performance.

Systèmes de santé / Health Systems

Denier Y., Gastmans C. (2013). Realizing Good Care within a Context of Cross-Cultural Diversity: An Ethical Guideline for Healthcare Organizations in Flanders, Belgium.

Social Science & Medicine, (Ahead of pub) :

Abstract: Abstract In our globalizing world, health care professionals and organizations increasingly experience cross-cultural challenges in care relationships, which give rise to ethical questions regarding the right thing to do in such situations. For the time being, the international literature lacks examples of elaborated ethical guidelines for cross-cultural healthcare on the organizational level. As such, the ethical responsibility of healthcare organizations in realizing cross-cultural care remains underexposed. This paper aims to fill this gap by offering a case-study that illustrates the bioethical practice on a large-scale organizational level by presenting the ethical guideline developed in the period 2007-2011 by the Ethics Committee of Zorgnet Vlaanderen, a Christian-inspired umbrella organization for over 500 social profit healthcare organizations in Flanders, Belgium. The guideline offers an ethical framework within which fundamental ethical values are being analyzed within the context of cross-cultural care. The case study concludes with implications for healthcare practice on four different levels: (1) the level of the healthcare organization, (2) staff, (3) care receivers, and (4) the level of care supply. The study combines content-based ethics with process-based benchmarks.

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White J. (2013). The 2010 U.S. health care reform: approaching and avoiding how other countries finance health care. *Health Econ Policy Law*, 8 (3) : 289-315.

Abstract: This article describes and analyzes the U.S. health care legislation of 2010 by asking how far it was designed to move the U.S. system in the direction of practices in all other rich democracies. The enacted U.S. reform could be described, extremely roughly, as Japanese pooling with Swiss and American problems at American prices. Its policies are distinctive, yet nevertheless somewhat similar to examples in other rich democracies, on two important dimensions: how risks are pooled and the amount of funds redistributed to subsidize care for people with lower incomes. Policies about compelling people to contribute to a finance system would be further from international norms, as would the degree to which coverage is set by clear and common substantive standards - that is, standardization of benefits. The reform would do least, however, to move the United States toward international practices for controlling spending. This in turn is a major reason why the results would include less standard benefits and incomplete coverage. In short, the United States would remain an outlier on coverage less because of a failure to make an effort to redistribute - a lack of solidarity - than due to a failure to control costs.

Travail et santé / Occupational Health

Pudrovská T., Carr D., McFarland M., Collins C. (2013). Higher-status occupations and breast cancer: A life-course stress approach. *Soc Sci Med*, 89 53-61.

Abstract: Using the 1957-2011 data from 3682 White non-Hispanic women (297 incident breast cancer cases) in the Wisconsin Longitudinal Study, United States, we explore the effect of occupation in 1975 (at age 36) on breast cancer incidence up to age 72. Our study is motivated by the paradoxical association between higher-status occupations and elevated breast cancer risk, which presents a challenge to the consistent health advantage of higher social class. We found that women in professional occupations had 72-122% and women in managerial occupations had 57-89% higher risk of a breast cancer diagnosis than housewives and women in lower-status occupations. We explored an estrogen-related pathway (reproductive history, health behaviors, and life-course estrogen cycle) as well as a social stress pathway (occupational experiences) as potential explanations for the effect of higher-status occupations. The elevated risk of breast cancer among professional women was partly explained by estrogen-related variables but remained large and statistically significant. The association between managerial occupations and breast cancer incidence was fully explained by job authority defined as control over others' work. Exercising job authority was related to higher breast cancer risk (HR = 1.57, 95% CI: 1.12, 2.18), especially with longer duration of holding the professional/managerial job. We suggest that the assertion of job authority by women in the 1970s involved stressful interpersonal experiences that may have promoted breast cancer development via prolonged dysregulation of the glucocorticoid system and exposure of the breast tissue to adverse effects of chronically elevated cortisol. Our study emphasizes complex biosocial pathways through which women's gendered occupational experiences become embodied and drive forward physiological repercussions.

Vieillesse / Ageing

Wittenberg E., Prosser L.A. (2013). Disutility of illness for caregivers and families: a systematic review of the literature. *Pharmacoeconomics*, 31 (6) : 489-500.

Abstract: BACKGROUND: Caring for an ill or disabled family member imposes a well-documented burden on the caregiver. The benefits of a health intervention may be underestimated if "spillover" effects on family members are not captured, resulting in inaccurate conclusions of economic evaluations. OBJECTIVE: To provide an estimate of, and to summarize measurement approaches for, the spillover disutility of illness on family members, relatives, and caregivers, through a systematic review of the literature. METHODS: The medical (PubMed), psychology (PsycINFO), and economics (EconLit) literatures were searched from inception through February 2012 for published studies measuring spillover disutility of illness on family members and caregivers. Inclusion criteria were (1) studies using preference-based measures of health-related quality of life, and (2) studies reporting spillover disutility, or (3) studies reporting data from which a spillover disutility could be inferred. RESULTS: Fifteen studies were included in this review: seven reported estimates of spillover disutility and eight reported data from which disutility could be inferred. Three studies found no disutility associated with spillover, whereas 12 found measurable effects as large as -0.718 (and two found evidence of positive spillover in subsets of their samples). Generic (indirect) utility instruments were primarily used to measure spillover, including the EQ-5D, QWB, and HUI (n = 13), though two studies used modified versions of the time trade-off technique. Illnesses studied included childhood disorders (e.g., spina bifida, congenital malformations), diseases of the elderly (e.g., Alzheimer's disease and dementia), physically disabling conditions (e.g., arthritis, multiple sclerosis), and medical conditions such as cancer and stroke. The persons affected by spillover included parents, grandparents, spouses/partners, other family caregivers, and household members. CONCLUSIONS: There is a

limited literature on the spillover disutility of illness on family members and caregivers, providing some specific estimates of a generally small, negative effect for particular conditions and individuals. Measurement methods vary across studies and a consensus approach has not yet been reached. Evidence suggests that the inclusion of spillover effects in economic evaluations would increase the relative effectiveness of interventions that address conditions with spillover compared to those without, though such differential benefits may be limited to such specific circumstances.

Heaven B., Brown L.J., White M., Errington L., Mathers J.C., Moffatt S. (2013). Supporting Well-Being in Retirement through Meaningful Social Roles: Systematic Review of Intervention Studies. *Milbank Q*, 91 (2) : 222-287.

Abstract: CONTEXT: The marked demographic change toward greater proportions of older people in developed nations poses significant challenges for health and social care. Several studies have demonstrated an association between social roles in later life and positive health and well-being outcomes. After retiring from work, people may lose roles that provide purpose and social contacts. The outcomes of interventions to promote social roles in retirement have not been systematically reviewed. METHODS: We examined three research questions: (1) What kinds of intervention have been developed to promote social roles in retirement? (2) How much have they improved perceived roles? (3) Have these roles improved health or well-being? We included those studies that evaluated the provision of social roles; used a control or comparison group; targeted healthy retirement-transition adults who were living in the community; provided an abstract written in English; took place in a highly developed nation; and reported social role, health, or well-being outcomes. We searched eight electronic databases and combined the results with hand searches. FINDINGS: Through our searches, we identified 9,062 unique publications and eleven evaluative studies of acceptable quality, which reported seven interventions that met our inclusion criteria. These interventions varied in year of inception and scope, but only two were based outside North America. The studies rarely reported the quality or meaning of roles. Only three studies used random allocation, thus limiting inferences of causality from these studies. Interventions providing explicit roles and using supportive group structures were somewhat effective in improving one or more of the following: life satisfaction, social support and activity, physical health and activity, functional health, and cognition. CONCLUSIONS: Social role interventions may improve health and well-being for people in retirement transition. Future research should improve the quality of intervention and assessment and look at which interventions are most effective and acceptable in facilitating social roles for diverse older populations.

Howlett S.E., Rockwood K. (2013). New horizons in frailty: ageing and the deficit-scaling problem. *Age Ageing*, 42 (4) : 416-423.

Abstract: All the current frailty measures count deficits. They differ chiefly in which items, and how many, they consider. These differences are related: if a measure considers only a few items, to define broad risks those items need to integrate across several systems (e.g. mobility or function). If many items are included, the cumulative effect of small deficits can be considered. Even so, it is not clear just how small deficits can be. To better understand how the scale of deficit accumulation might impact frailty measurement, we consider how age-related, subcellular deficits might become macroscopically visible and so give rise to frailty. Cellular deficits occur when subcellular damage has neither been repaired nor cleared. With greater cellular deficit accumulation, detection becomes more likely. Deficit detection can be done by either subclinical (e.g. laboratory, imaging, electrodiagnostic) or clinical methods. Not all clinically evident deficits need cross a disease threshold. The extent to which cellular deficit accumulation compromises organ function can reflect not just what is happening in that organ system, but deficit accumulation in other organ systems too. In general, frailty arises in relation to the number of organ systems in which deficits accumulate. This understanding of how subcellular deficits might scale has implications for understanding frailty as a vulnerability state. Considering the cumulative effects of many small deficits appears to allow important aspects of the behaviour of systems close to failure to be observed. It also suggests the potential to detect frailty with less reliance on clinical observation than current methods employ.

Tiainen K., Luukkaala T., Hervonen A., Jylha M. (2013). Predictors of mortality in men and women aged 90 and older: a nine-year follow-up study in the Vitality 90+ study. *Age Ageing*, 42 (4) : 468-475.

Abstract: BACKGROUND: information about the predictors of mortality among the oldest-old is limited.

Also possible gender differences are poorly known. OBJECTIVE: to examine the predictors of mortality among individuals aged 90 and older, focusing on differences between men and women. We also analysed gender differences in survival at different levels of mobility and activities in daily living (ADL). DESIGN: this 9-year follow-up study is part of the Vitality 90+ study, a population-based study of people aged 90 and older. SUBJECTS: all inhabitants aged 90 and older in the area of Tampere, Finland were contacted, irrespective of health or dwelling place. The study population consisted of 171 men and 717 women. METHODS: data were collected with a mailed questionnaire asking questions concerning ADL and mobility, self-rated health, chronic conditions and socio-economic factors. The participation rate was 79%. Cox regression enter models were used for the analysis. RESULTS: older age, male gender, disability in ADL and mobility, poor self-rated health and institutionalisation increased the risk of mortality in the total study group. In age-adjusted Cox regression models, ADL and mobility were stronger predictors in men than in women (gender interactions, $P < 0.001$). Among those who were partly but not totally dependent in ADL or mobility women survived longer than men. CONCLUSION: the same health indicators that are important at younger old age also predict mortality in the oldest-old. Disability increases the likelihood of death more in men than women. At a very old age, women survive longer with moderate disability than do men;