

**Reproduction sur d'autres sites interdite mais lien vers le document accepté :**

<http://www.irdes.fr/EspaceDoc/Veille.html>

**Any and all reproduction is prohibited but direct link to the document is accepted:**

<http://www.irdes.fr/EspaceAnglais/DocumentationCentre/Veille.html>

## DOC VEILLE

Veille bibliographique en économie de la santé / Watch on Health Economics Literature

23 août 2013 / August 23, 2013

Réalisée par le centre de documentation de l'Irdes, Doc Veille, publication bi-mensuelle, rassemble de façon thématique les résultats de la veille documentaire en économie de la santé : articles, littérature grise, rapports...

Vous pouvez accéder à la version électronique des articles sur notre portail EJS (à l'exception des revues françaises) : <http://ejournals.ebsco.com/Home.asp> (**Accès réservé à l'Irdes**)

Les autres documents sont soit accessibles en ligne, soit consultables à la documentation (voir mention à la fin de la notice). Aucune photocopie ne sera délivrée par courrier.

Un historique des Doc Veille se trouve sur le web de l'Irdes :

<http://www.irdes.fr/EspaceDoc/Veille.html>)

Produced by the Irdes documentation centre, Doc Veille, a bimonthly publication, presents with a thematic classification the results of the documentary monitoring in health economics: articles, grey literature, reports...

You can access to the electronic version of articles on our EJS portal (except for the French journals): <http://ejournals.ebsco.com/Home.asp> (**Access limited to Irdes team**).

Other documents are accessible online, either available for consultation at the documentation center (see mention at the end of the notice). Requests for photocopies or scans of documents will not be answered. Doc Veille's archives are located on the Irdes website : <http://www.irdes.fr/EspaceDoc/Veille.html>

## Sommaire

### **Economie de la santé / Health Economics ..... 6**

- Omachi T.A., Gregorich S.E., Eisner M.D., Penaloza R.A., Tolstykh I.V., Yelin E.H., Iribarren C., Dudley R.A., Blanc P.D. (2013). Risk adjustment for health care financing in chronic disease: what are we missing by failing to account for disease severity? ..... 6
- Richardson J., Iezzi A., Sinha K., Khan M.A., Mckie J. (2013). An instrument for measuring the social willingness to pay for health state improvement ..... 6
- Kriza C., Emmert M., Wahlster P., Niederlander C., Kolominsky-Rabas P. (2013). Cost of illness in colorectal cancer: an international review. .... 6
- Silva M.L., Späth H.M., Perrier L. e.al. (2013). The use of economic evaluations in health decision-making at the macro level: a literature review ..... 7
- Charrier N., Chevreur K., Durand-Zaleski I. (2013). [The cost of schizophrenia: a literature review ..... 7
- Chang S., He Y., Hsieh C.R. (2013). The determinants of health care expenditure toward the end of life: evidence from Taiwan ..... 7
- Perelman J., Roch I., Heymans I., Moureaux C., Lagasse R., Annemans L., Closon M.C. (2013). Medical homes versus individual practice in primary care: impact on health care expenditures..... 8

### **Etat de santé / Health Status ..... 8**

- Fransoo R.R., Martins P.J. (2013). The Rising Prevalence of Asthma: True Increase, Diagnostic Exchange or Diagnostic Accuracy? ..... 8

### **Géographie de la santé / Geography of Health ..... 8**

- Factor R., Awerbuch T., Levins R. (2013). Social and land use composition determinants of health: Variability in health indicators..... 8
- Augurzky B., Kopetsch T., Schmitz H. (2013). What accounts for the regional differences in the utilisation of hospitals in Germany? ..... 8
- Castelli A., Jacobs R., Goddard M., Smith P.C. (2013). Health, policy and geography: Insights from a multi-level modelling approach ..... 9
- Dunn C.E. (2013). Showcasing geographies of health: An introduction to selected research from the 14th International Medical Geography Symposium, Durham, UK..... 9

### **Hôpital / Hospitals ..... 9**

- Mougeot M., Naegelen F. (2013). La théorie normative de la régulation hospitalière..... 9

Garcia-Lacalle J., Martin E. (2013). Efficiency improvements of public hospitals under a capitation payment scheme .....	10
Marques E., Noble S., Blom A.W., Hollingworth W. (2013). Disclosing total waiting times for joint replacement: Evidence from the English NHS linked HES data .....	10
Gutacker N, Bojke C., Daidone D. et al. (2013). Truly inefficient or providing better quality of care? Analysing the relationship between risk-adjusted hospital costs and patients' health outcomes .....	10
Rasch E.K., Gulley S.P., Chan L. (2013). Use of Emergency Departments among Working Age Adults with Disabilities: A Problem of Access and Service Needs .....	10
Spector W.D., Limcangco R., Williams C., Rhodes W., Hurd D. (2013). Potentially Avoidable Hospitalizations for Elderly Long-stay Residents in Nursing Homes.....	10
Kocher K.E., Dimick J.B., Nallamotheu B.K. (2013). Changes in the source of unscheduled hospitalizations in the United States .....	11
<b>Inégalités de santé / Health Inequalities .....</b>	<b>11</b>
Apouey B., Geoffard P.Y. (2013). Family income and child health in the UK. ....	11
Carman K.G. (2013). Inheritances, Intergenerational Transfers, and the Accumulation of Health.....	12
Becares L., Das-Munshi J. (2013). Ethnic density, health care seeking behaviour and expected discrimination from health services among ethnic minority people in England. ....	12
Badland H., Turrell G., Giles-Corti B. (2013). Who does well where? Exploring how self-rated health differs across diverse people and neighborhoods .....	12
<b>Médicaments / Pharmaceuticals.....</b>	<b>12</b>
Skipper N. (2013). On the demand for prescription drugs: heterogeneity in price responses .....	12
Filippini M., Ortiz L.G., Masiero G. (2013). Assessing the impact of national antibiotic campaigns in Europe.....	12
Feldman R., Lobo F. (2013). Competition in prescription drug markets: the roles of trademarks, advertising, and generic names .....	13
Thengilsdottir G., Gardarsdottir H., Almarsdottir A.B., McClure C.B., Heerdink E.R. (2013). The association between lifting an administrative restriction on antidepressant dispensing and treatment patterns in Iceland. ....	13
Hameen-Anttila K., Luhtanen S., Airaksinen M., Pohjanoksa-Mantyla M. (2013). Developing a national medicines information strategy in Finland-A stakeholders' perspective on the strengths, challenges and opportunities in medicines information....	13
<b>Méthodologie – Statistique / Methodology – Statistics.....</b>	<b>14</b>

de Bekker-Grob E.W., Chorus C.G. (2013). Random regret-based discrete-choice modelling: an application to healthcare.....	14
<b>Politique de santé / Health Policy.....</b>	<b>14</b>
Tabuteau D. (2013). 1983-2013 : les évolutions de la politique de santé.....	14
<b>Prévention / Prevention .....</b>	<b>14</b>
Etner J, Tabo A. (2013). Prévention en santé et ambiguïté .....	14
<b>Psychiatrie / Psychiatry .....</b>	<b>15</b>
Liggins J., Kearns R.A., Adams P.J. (2013). Using autoethnography to reclaim the place of healing in mental health care.....	15
Kyanko K.A., Curry L.A., Busch S.H. (2013). Out-of-Network Provider Use More Likely in Mental Health than General Health Care Among Privately Insured .....	15
<b>Soins de santé primaires / Primary Health Care .....</b>	<b>15</b>
Lee J.Milligan J. H.L.e.al. (2013). Enhancing Care for Individuals with Mobility Impairments: Lessons Learned in the Implementation of a Primary Care–Based Mobility Clinic .....	15
Thanh N.X. (2013). Wait Time from Primary to Specialty Care: A Trend Analysis from Edmonton,.....	16
Paustian M.L., Alexander J.A., El Reda D.K., Wise C.G., Green L.A., Fetters M.D. (2013). Partial and Incremental PCMH Practice Transformation: Implications for Quality and Costs.....	16
Paulus D., Van den Heede K., Gerkens S., Desomer A., Mertens R. (2013). Development of a national position paper for chronic care: Example of Belgium. ....	16
Glennard A.H. (2013). Productivity and patient satisfaction in primary care–Conflicting or compatible goals? .....	17
Rischatsch M., Zweifel P. (2013). What do physicians dislike about managed care? Evidence from a choice experiment.....	17
Decker S.L. (2013). Two-thirds of primary care physicians accepted new Medicaid patients in 2011-12: a baseline to measure future acceptance rates .....	17
Kern L.M., Dhopeswarkar R.V., Edwards A., Kaushal R. (2013). Patient experience over time in patient-centered medical homes .....	17
Shi L., Lebrun-Harris L.A., Daly C.A., Sharma R., Sripipatana A., Hayashi A.S., Ngo-Metzger Q. (2013). Reducing disparities in access to primary care and patient satisfaction with care: the role of health centers. ....	18
Scott A., Witt J., Humphreys J., Joyce C., Kalb G., Jeon S.H., McGrail M. (2013). Getting doctors into the bush: General Practitioners' preferences for rural location .....	18
Rathert C, Wyrwich M., Boren S (2013). Patient-Centered Care and Outcomes .....	18

Bekelman D.B., Plomondon M.E., Sullivan M.D., Nelson K., Hattler B., McBryde C., Lehmann K.G., Potfay J., Heidenreich P., Rumsfeld J.S. (2013). Patient-centered disease management (PCDM) for heart failure: study protocol for a randomised controlled trial.....	19
Glennard A.H. (2013). Productivity and patient satisfaction in primary care-Conflicting or compatible goals? .....	19
<b>Systèmes de santé / Health Systems .....</b>	<b>19</b>
White J. (2013). The 2010 U.S. health care reform: approaching and avoiding how other countries finance health care.....	19
Conti M.S. (2013). Effect of medicaid disease management programs on emergency admissions and inpatient costs.....	19
Ozawa S., Sripad P. (2013). How do you measure trust in the health system? A systematic review of the literature. ....	20
<b>Travail et santé / Occupational Health .....</b>	<b>20</b>
Van Hal L., Meershoek A., Nijhuis F., Horstman K. (2013). Disembodied abilities: Sick role and participation in an activating return-to-work practices.....	20
<b>Vieillesse / Ageing .....</b>	<b>21</b>
Vayssette P. (2013). Expérimentation Paerpa : 8 régions retenues.....	21

## Economie de la santé / Health Economics

### **Omachi T.A., Gregorich S.E., Eisner M.D., Penaloza R.A., Tolstykh I.V., Yelin E.H., Iribarren C., Dudley R.A., Blanc P.D. (2013). Risk adjustment for health care financing in chronic disease: what are we missing by failing to account for disease severity?**

*Med Care*, 51 (8) : 740-747.

**Abstract:** BACKGROUND: Adjustment for differing risks among patients is usually incorporated into newer payment approaches, and current risk models rely on age, sex, and diagnosis codes. It is unknown the extent to which controlling additionally for disease severity improves cost prediction. Failure to adjust for within-disease variation may create incentives to avoid sicker patients. We address this issue among patients with chronic obstructive pulmonary disease (COPD). METHODS: Cost and clinical data were collected prospectively from 1202 COPD patients at Kaiser Permanente. Baseline analysis included age, sex, and diagnosis codes (using the Diagnostic Cost Group Relative Risk Score) in a general linear model predicting total medical costs in the following year. We determined whether adding COPD severity measures-forced expiratory volume in 1 second, 6-Minute Walk Test, dyspnea score, body mass index, and BODE Index (composite of the other 4 measures)-improved predictions. Separately, we examined household income as a cost predictor. RESULTS: Mean costs were \$12,334/y. Controlling for Relative Risk Score, each (1/2) SD worsening in COPD severity factor was associated with \$629 to \$1135 in increased annual costs (all  $P < 0.01$ ). The lowest stratum of forced expiratory volume in 1 second ( $< 30\%$  normal) predicted \$4098 (95% confidence interval, \$576-\$8773) additional costs. Household income predicted excess costs when added to the baseline model ( $P = 0.038$ ), but this became nonsignificant when also incorporating the BODE Index. CONCLUSIONS: Disease severity measures explain significant cost variations beyond current risk models, and adding them to such models appears important to fairly compensate organizations that accept responsibility for sicker COPD patients. Appropriately controlling for disease severity also accounts for costs otherwise associated with lower socioeconomic status.

### **Richardson J., Iezzi A., Sinha K., Khan M.A., Mckie J. (2013). An instrument for measuring the social willingness to pay for health state improvement.** *Health Economics*, Ahead of pub.

**Abstract:** This paper describes an instrument for measuring the social value of changes in health status, the Relative Social Willingness to Pay. It is a unique combination of measurement attributes designed to minimise cognitive complexity and provide an additional option for measuring a social value. Similar to the person trade-off (PTO), it adopts a social perspective and asks respondents to evaluate programmes on behalf of society. Unlike the PTO, trade-offs between the options use dollars, not numbers of patients. Respondents are not, however, asked for their personal willingness to pay. Rather, the opportunity cost of funds spent on one service is as an offsetting reduction in funds for a second service. The amount spent on each service therefore indicates relative, not absolute, value. However, the two services combine to produce one Quality adjusted life year which allows the calculation of a Quality adjusted life year-like unit of social value on a 0 € 1 scale. A three-stage survey was used to test the instrument's reliability, validity and sensitivity to the framing of the main question. Results indicate that the Relative Social Willingness to Pay produces values similar to but less than the PTO and time trade-off techniques. Copyright © 2013 John Wiley & Sons, Ltd.

### **Kriza C., Emmert M., Wahlster P., Niederlander C., Kolominsky-Rabas P. (2013). Cost of illness in colorectal cancer: an international review.** *Pharmacoeconomics*, 31 (7) : 577-588.

**Abstract:** OBJECTIVES: Given the current-and increasing-pressure to limit expenditure on health care provision in many countries, a better understanding of the cost burden of colorectal cancer is needed. Cost-of-illness studies and reviews thereof can be a useful tool for analysing and critically evaluating the cost-related development of colorectal cancer, and they highlight important cost drivers. METHODS: A systematic review was conducted from 2002 to 2012 to identify cost-of-illness studies related to colorectal cancer, searching the Medline, PubMed, Science Direct, Cochrane Library and the York CRD databases. RESULTS: Among the 10 studies (from France, the US, Ireland and Taiwan) included in the review, 6 studies reported prevalence-based estimates and 4 studies focussed on incidence-based data. In the studies included in the review, long-term costs for colorectal cancer of up to \$50,175 per patient (2008 values) were estimated. Most of the studies in the review showed that

the initial and terminal phases of colorectal cancer care are the most expensive, with continuing treatment being the least costly phase. One study also highlighted that stage I CRC disease was the least costly and stage III the most costly of all 4 stages, due to the high cost impact of biological agents. CONCLUSIONS: This review has highlighted a trend for rising costs associated with CRC, which is linked to the increasing use of targeted biological therapies. COI studies in colorectal cancer can identify specific components and areas of care that are especially costly, thereby focusing attention on more cost-effective approaches, which is especially relevant to the increased use of biological agents in the field of personalised medicine. COI studies are an important tool for further health economic evaluations of personalised medicine.

**Silva M.L., Späth H.M., Perrier L. e.al. (2013). The use of economic evaluations in health decision-making at the macro level: a literature review.** *Journal d'économie médicale*, 31 (1) : 31-52.

**Charrier N., Chevreul K., Durand-Zaleski I. (2013). [The cost of schizophrenia: a literature review].** *Encéphale*, 39 Suppl 1 S49-S56.

Abstract: INTRODUCTION: Schizophrenia represents a major burden for patients, their families, healthcare systems and societies. The objective of this literature review is to document the economic burden of schizophrenia. METHOD: The literature search was performed using the MEDLINE-PUBMED database and the following keywords: schizophrenia and cost, burden of disease, qaly or price. The grey literature search was performed using several databases (e.g. Banque de Donnees en Sante Publique) and the Google Scholar((R)) web search engine. The studies that met the following criteria were included: published since 1998, written in English or French, studied OECD countries and presented costs data that were given in monetary terms. The costs data identified in the literature were classified into the following five main categories: cost for healthcare system, cost for social and medico-social system (medico-social system is a French specificity), cost for prison and legal systems, cost of informal care given by family, and cost associated with productivity losses. To improve comparability, costs were reported as a percentage of health care expenditures and as a per-ten-thousand of GDP (gross domestic product). RESULTS: Among the 201 articles identified as potentially relevant to the topic, nine were included in the literature review. Schizophrenia health care costs ranged from four (Ireland) to 140000 of GDP (Spain). Hospital care was the main health care cost driver but ranged from 19 (USA) to 92% (Belgium) demonstrating a great variability in treatment patterns. The costs for social and medico-social system ranged from 1.3 (Korea) to 13.80000 of GDP (USA) and the costs of informal caregivers ranged from 1.2 (Australia) to 12.70000 of GDP (Spain). The productivity losses associated with unemployment ranged from 6.2 (Australia) to 21.30000 of GDP (USA). The productivity losses associated with premature mortality ranged from less than 0.01 (Canada) to 3.850000 (Ireland). Among others factors, such as targeted population, the choice of valuation method between "Friction costs" and "Human Capital" could account for the heterogeneity of estimates. DISCUSSION: Median health care costs of schizophrenia represented 1.1% of total national health care expenditures. Productivity losses associated with morbidity constituted the major cost burden of schizophrenia. Valuation method, costs items, target populations and prevalence rates differed widely from study to study. Furthermore, the burden attributable to loss of quality of life was not estimated in the studies. CONCLUSION: Cost-of-illness studies of schizophrenia provide information about its burden on society. The external validity of such studies however is poor and justifies country-specific data collection.

**Chang S., He Y., Hsieh C.R. (2013). The determinants of health care expenditure toward the end of life: evidence from Taiwan.** *Health Economics*, n/a.

Abstract: This paper empirically investigates the relationship between the health care expenditure of end-of-life patients and hospital characteristics in Taiwan where (i) hospitals of different ownership differ in their financial incentives; (ii) patients are free to choose their providers; and (iii) health care services are paid for by a single public payer on a fee-for-services basis with a global budget cap. Utilizing insurance claims for 11 to 863 individuals who died during 2005 - "2007, we trace their hospital expenditures over the last 24 months of their lives. We find that end-of-life patients who are treated by private hospitals in general are associated with higher inpatient expenditures than those treated by public hospitals, while there is no significant difference in days of hospital stay. This finding is consistent with the difference in financial incentives between public and private hospitals in Taiwan. Nevertheless, we also find that the public - "private differences vary across accreditation levels.

**Perelman J., Roch I., Heymans I., Moureaux C., Lagasse R., Annemans L., Closon M.C. (2013). Medical homes versus individual practice in primary care: impact on health care expenditures. *Med Care*, 51 (8) : 682-688.**

Abstract: BACKGROUND: The medical home (MH) model has prompted increasing attention given its potential to improve quality of care while reducing health expenditures. OBJECTIVES: We compare overall and specific health care expenditures in Belgium, from the third-party payer perspective (compulsory social insurance), between patients treated at individual practices (IP) and at MHs. We compare the sociodemographic profile of MH and IP users. RESEARCH DESIGN: This is a retrospective study using public insurance claims data. Generalized linear models estimate the impact on health expenditures of being treated at a MH versus IP, controlling for individual, and area-based sociodemographic characteristics. The choice of primary care setting is modeled using logistic regressions. SUBJECTS: A random sample of 43,678 persons followed during the year 2004. MEASURES: Third-party payer expenditures for primary care, secondary care consultations, pharmaceuticals, laboratory tests, acute and long-term inpatient care. RESULTS: Overall third-party payer expenditures do not differ significantly between MH and IP users (&OV0556;+27). Third-party payer primary care expenditures are higher for MH than for IP users (&OV0556;+129), but this difference is offset by lower expenditures for secondary care consultations (&OV0556;-11), drugs (&OV0556;-40), laboratory tests (&OV0556;-5) and acute and long-term inpatient care (&OV0556;-53). MHs attract younger and more underprivileged populations. CONCLUSIONS: MHs induce a shift in expenditures from secondary care, drugs, and laboratory tests to primary care, while treating a less economically favored population. Combined with positive results regarding quality, MH structures are a promising way to tackle the challenges of primary care.

## Etat de santé / Health Status

**Fransoo R.R., Martins P.J. (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

**Factor R., Awerbuch T., Levins R. (2013). Social and land use composition determinants of health: Variability in health indicators. *Health & Place*, 22 90-97.**

Abstract: Previous studies have shown that a community's socioeconomic status has a significant impact on its residents' health, and that vulnerability in deprived populations expresses itself as variability in health outcomes. The current study adds to this ecological research approach the notion that underlying community vulnerabilities are also related to the physical environment and population growth of a locality. The paper explores the variability in various health indicators in 252 localities in Israel as a function of the localities' socioeconomic status, population growth, and land use composition measures. The results indicate that a locality's socioeconomic status and its land use composition are both strongly associated with various health outcomes and their variability. These findings are of particular interest in light of the fact that the results were obtained from a country with a universal healthcare system.

**Augurzky B., Kopetsch T., Schmitz H. (2013). What accounts for the regional differences in the utilisation of hospitals in Germany? *Eur J Health Econ*, 14 (4) : 615-627.**

Abstract: There are huge regional variations in the utilisation of hospital services in Germany. In 2007 and 2008 the states of Hamburg and Baden-Wurttemberg had on average just under 38 % fewer hospitalisations per capita than Saxony-Anhalt. We use data from the DRG statistics aggregated at the county level in combination with numerous other data sources (e.g. INKAR Database, accounting data from the National Association of Statutory Health Insurance Physicians (KBV), Federal Medical Registry, Germany Hospital Directory, population structure per county) to establish the proportion of the observed regional differences that can be explained at county and state levels. Overall we are able to account for 73 % of the variation at state level in terms of observable factors. By far the most important reason for the regional variation in the utilisation of in-patient services is differences in medical needs. Differences in the supply of medical services and the substitutability of outpatient and inpatient treatment are also relevant, but to a lesser extent.

**Castelli A., Jacobs R., Goddard M., Smith P.C. (2013). Health, policy and geography: Insights from a multi-level modelling approach.** *Social Science & Medicine*, 92 (0) : 61-73.

Abstract: Abstract Improving the health and wellbeing of citizens ranks highly on the agenda of most governments. Policy action to enhance health and wellbeing can be targeted at a range of geographical levels and in England the focus has tended to shift away from the national level to smaller areas, such as communities and neighbourhoods. Our focus is to identify the potential for targeting policy interventions at the most appropriate geographical levels in order to enhance health and wellbeing. The rationale is that where variations in health and wellbeing indicators are larger, there may be greater potential for policy intervention targeted at that geographical level to have an impact on the outcomes of interest, compared with a strategy of targeting policy at those levels where relative variations are smaller. We use a multi-level regression approach to identify the degree of variation that exists in a set of health indicators at each level, taking account of the geographical hierarchical organisation of public sector organisations. We find that for each indicator, the proportion of total residual variance is greatest at smaller geographical areas. We also explore the variations in health indicators within a hierarchical level, but across the geographical areas for which public sector organisations are responsible. We show that it is feasible to identify a sub-set of organisations for which unexplained variation in health indicators is significantly greater relative to their counterparts. We demonstrate that adopting a geographical perspective to analyse the variation in indicators of health at different levels offers a potentially powerful analytical tool to signal where public sector organisations, faced increasingly with many competing demands, should target their policy efforts. This is relevant not only to the English context but also to other countries where responsibilities for health and wellbeing are being devolved to localities and communities.

**Dunn C.E. (2013). Showcasing geographies of health: An introduction to selected research from the 14th International Medical Geography Symposium, Durham, UK, July 2011.** *Social Science & Medicine*, 91 (0) : 102-104.

<http://www.sciencedirect.com/science/article/pii/S0277953613002402>

## Hôpital / Hospitals

**Mougeot M., Naegelen F. (2013). La théorie normative de la régulation hospitalière.**

*Revue d'Economie Politique*, 123 (2) : 179-210.

Abstract: Cet article fait un bilan des travaux théoriques récents sur la régulation des hôpitaux. Aux arbitrages usuels induits par l'asymétrie d'information s'ajoutent des arbitrages spécifiques entre l'accroissement de la qualité des soins et la baisse des coûts ainsi que ceux qui résultent de la possibilité de sélectionner les patients. Lorsque seul l'aléa moral est en cause, la tarification forfaitaire peut permettre d'atteindre la solution de premier rang si la demande augmente avec la qualité alors qu'elle ne le peut que dans le cas d'un hôpital parfaitement altruiste dans l'hypothèse inverse. L'article analyse aussi les implications de l'asymétrie d'information sur l'état de santé et les politiques optimales à mettre en œuvre dans ce cas. Le rôle de l'altruisme dans la définition de ces politiques est mis en évidence, ainsi que les moyens permettant de dissuader de sélectionner les patients.

**Garcia-Lacalle J., Martin E. (2013). Efficiency improvements of public hospitals under a capitation payment scheme.** *Health Economics, Policy and Law*, 8 (03) : 335-364.

**Marques E., Noble S., Blom A.W., Hollingworth W. (2013). Disclosing total waiting times for joint replacement: Evidence from the English NHS linked HES data.** *Health Economics*, n/a.

Abstract: For the last decade, stringent monitoring of waiting time performance targets provided English hospitals with incentives to reduce official waiting times for elective surgery. It is less clear whether the total amount of time patients waited in secondary care, from first referral to outpatient clinic until treatment, has also fallen. We used Hospital Episode Statistics inpatient data for patients undergoing total joint replacement during a period of active monitoring of targets (between 2006/7 and 2008/9) and linked it to outpatient data to reconstruct patients' pathway in the 3 years before surgery and provide alternative measurements of waiting times. Our findings suggest that although official waiting times decreased drastically in our study period, total waiting time in secondary care has not declined. Patients with shorter official waits spent a longer time in a work-up period prior to inclusion in the official waiting list, and socio-economic inequities persisted in waiting times for joint replacement. We found no evidence that target policies achieved efficiency gains during our study period. Copyright © 2013 John Wiley & Sons, Ltd.

**Gutacker N., Bojke C., Daidone D. et al. (2013). Truly inefficient or providing better quality of care? Analysing the relationship between risk-adjusted hospital costs and patients' health outcomes.** *Health Economics*, 22 (8) : 931-947.

Abstract: Observed variation in hospital costs may be attributable to differences in patients' health outcomes. Previous studies have resorted to inherently incomplete outcome measures such as mortality or re-admission rates to assess this claim. This study makes use of a novel dataset of routinely collected patient-reported outcome measures (PROMs) linked to inpatient records to (i) access the degree to which cost variation is associated with variation in patients' health gain and (ii) explore how far judgement about hospital cost performance changes when health outcomes are accounted for. We use multilevel modelling to address the clustering of patients in providers and isolate unexplained cost variation. We find some evidence of a U-shaped relationship between risk-adjusted costs and outcomes for hip replacement surgery. For three other procedures (knee replacement, varicose vein and groin hernia surgery), the estimated relationship is sensitive to the choice of PROM instrument. We do not observe substantial changes in cost performance estimates when outcomes are explicitly accounted for. Copyright © 2012 John Wiley & Sons, Ltd.

**Rasch E.K., Gulley S.P., Chan L. (2013). Use of Emergency Departments among Working Age Adults with Disabilities: A Problem of Access and Service Needs.** *Health Services Research*, 48 (4) : 1334-1358.

Abstract: OBJECTIVE: To examine the relationship between emergency department (ED) use and access to medical care and prescription medications among working age Americans with disabilities. DATA SOURCE: Pooled data from the 2006-2008 Medical Expenditure Panel Survey (MEPS), a U.S. health survey representative of community-dwelling civilians. STUDY DESIGN: We compared the health and service utilization of two groups of people with disabilities to a contrast group without disability. We modeled ED visits on the basis of disability status, measures of health and health conditions, access to care, and sociodemographics. DATA EXTRACTION: These variables were aggregated from the household component, the medical condition, and event files to provide average annual estimates for the period spanning 2006-2008. PRINCIPAL FINDINGS: People with disabilities accounted for almost 40 percent of the annual visits made to U.S. EDs each year. Three key factors affect their ED use: access to regular medical care (including prescription medications), disability status, and the complexity of individuals' health profiles. CONCLUSIONS: Given the volume of health conditions among people with disabilities, the ED will always play a role in their care. However, some ED visits could potentially be avoided if ongoing care were optimized.

**Spector W.D., Limcangco R., Williams C., Rhodes W., Hurd D. (2013). Potentially Avoidable Hospitalizations for Elderly Long-stay Residents in Nursing Homes.** *Med Care*, 51 (8) : 673-681.

Abstract: BACKGROUND: Hospitalizations of long-stay nursing home (NH) residents are common. The high estimates of potentially avoidable hospitalizations in NHs suggest that efforts to reduce avoidable hospitalizations may be effective in lowering health care expenditures as well as improving

the quality of care for NH residents. OBJECTIVE: To determine the relationship between clinical risk factors, facility characteristics and State policy variables, and both avoidable and unavoidable hospitalizations. METHOD: Hospitalization risk is estimated using competing risks proportional hazards regressions. Three hospitalization measures were constructed: (1) ambulatory care-sensitive conditions (ACSCs); (2) additional NH-sensitive avoidable conditions (ANHACs); and (3) nursing home "unavoidable" conditions (NHUCs). In all models, we include clinical risk factors, facility characteristics, and State policy variables that may influence the decision to hospitalize. SUBJECTS: The population of interest is a cohort of long-stay NH residents. Data are from the Nursing Home Stay file, a sample of residents in 10% of certified NHs in the United States (2006-2008). RESULTS: Three fifths of hospitalizations were potentially avoidable and the majority was for infections, injuries, and congestive heart failure. Clinical risk factors include renal disease, diabetes, and a high number of medications among others. Staffing, quality, and reimbursement affect avoidable, but not unavoidable hospitalizations. CONCLUSIONS: A NH-sensitive measure of avoidable hospitalizations identifies both clinical facility and policy risk factors, emphasizing the potential for both reimbursement and clinical strategies to reduce hospitalizations from NHs.

**Kocher K.E., Dimick J.B., Nallamothu B.K. (2013). Changes in the source of unscheduled hospitalizations in the United States. *Med Care*, 51 (8) : 689-698.**

Abstract: BACKGROUND: Hospitalizations represent a significant portion of the annual expenditures for the US health care system. Understanding recent changes in the sources of unscheduled admissions may provide opportunities to improve the quality and cost of inpatient care. OBJECTIVES: To examine sources of unscheduled hospitalization over a 10-year period and implications for inpatient mortality and length of stay (LOS). RESEARCH DESIGN: Observational study using the 2000-2009 Nationwide Inpatient Sample. SUBJECTS: We categorized unscheduled hospitalizations as those related to transfers, direct admissions from outpatient providers, and the emergency department (ED). MEASURES: Hospitalization rates by source and clinical condition with multivariable regression analyses adjusted for patient demographics, comorbid conditions, and hospital factors to evaluate associated mortality and LOS outcomes. RESULTS: Unscheduled hospitalizations arising from direct admissions and the ED changed substantially while those due to transfers remained relatively stable. The ED admitted 64.9% [95% confidence interval (CI), 62.8%-66.9%] of unscheduled hospitalizations in 2000, rising to 81.8% (95% CI, 80.5%-83.1%) by 2009, whereas direct admissions from outpatient providers correspondingly declined. In 2009, despite higher illness severity and chronic disease burden, hospitalization through the ED as compared with direct admissions was associated with an overall lower mortality adjusted odds ratio of 0.85 (95% CI, 0.77-0.93) and shorter adjusted hospital LOS of -0.84 (95% CI, -0.99 to -0.70) days. CONCLUSIONS: Sources of unscheduled hospitalization in the United States have evolved, mostly resulting from care for a variety of clinical conditions now originating in the ED. This trend does not seem to be harming patients or worsening LOS.

## Inégalités de santé / Health Inequalities

**Apouey B., Geoffard P.Y. (2013). Family income and child health in the UK. *Journal of Health Economics*, 32 (4) : 715-727.**

Abstract: Abstract Recent studies examining the relationship between family income and child health in the UK have produced mixed findings. We re-examine the income gradient in child general health and its evolution with child age in this country, using a very large sample of British children. We find that there is no correlation between income and child general health at ages 0-1, that the gradient emerges around age 2 and is constant from age 2 to age 17. In addition, we show that the gradient remains large and significant when we reduce the endogeneity of income. Furthermore, our results indicate that the gradient in general health reflects a greater prevalence of chronic conditions among low-income children and a greater severity of these conditions. Taken together, these findings suggest that income does matter for child health in the UK and may play a role in the intergenerational transmission of socioeconomic status.

**Carman K.G. (2013). Inheritances, Intergenerational Transfers, and the Accumulation of Health.** *American Economic Review*, 103 (3) : 451-455.

Abstract: This paper considers the mechanisms behind a positive correlation between inheritances and health. First, there may merely be a correlation: those from families with enough wealth to provide an inheritance tend to have better health. Second, financial resources could be used to purchase inputs to health. Third, bequests may signal a stronger interest in one's child. This reminder to the child could improve their emotional well-being. On average, the positive correlation suggests merely correlation. However, among subsets of the population, particularly men and those expecting to receive an inheritance, there is a causal relationship likely driven by the third mechanism.

**Becares L., Das-Munshi J. (2013). Ethnic density, health care seeking behaviour and expected discrimination from health services among ethnic minority people in England.** *Health Place*, 22 48-55.

Abstract: The health of ethnic minority people is reported to be poorer in areas of lower ethnic density. Based on this literature, higher rates of health seeking behaviours would be expected among ethnic minorities resident in neighbourhoods of lower ethnic density. Should health seeking not increase in areas of lower ethnic density, a possible explanation might be that ethnic minority people resident in these neighbourhoods are not accessing services for fear of racial discrimination. The present study examined this hypothesis using two nationally-representative surveys from England. Health seeking behaviour did not vary by ethnic density. Lower ethnic density was associated with increased reports of expected discrimination from services, but also with increased satisfaction with services.

**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*, 22 82-89.

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;

## Médicaments / Pharmaceuticals

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

**Filippini M., Ortiz L.G., Masiero G. (2013). Assessing the impact of national antibiotic campaigns in Europe.** *Eur J Health Econ*, 14 (4) : 587-599.

Abstract: Because of evidence of causal association between antibiotic use and bacterial resistance, the implementation of national policies has emerged as an interesting tool for controlling and reversing bacterial resistance. The aim of this study was to assess the impact of public policies on antibiotic use in Europe using a differences-in-differences approach. Comparable data on systemic antibiotics

administered in 21 European countries are available for a 11-year period between 1997 and 2007. Data on national campaigns are drawn from the public health literature. We estimate an econometric model of antibiotic consumption with country fixed effects and control for the main socioeconomic and epidemiological factors. Lagged values and the instrumental variables approach are applied to address endogeneity aspects of the prevalence of infections and the adoption of national campaigns. We find evidence that public campaigns significantly reduce the use of antimicrobials in the community by 1.3-5.6 defined daily doses per 1,000 inhabitants yearly. This represents an impact of roughly 6.5-28.3 % on the mean level of antibiotic use in Europe between 1997 and 2007. The effect is robust across different measurement methods. Further research is needed to investigate the effectiveness of policy interventions targeting different social groups such as general practitioners or patients.

**Feldman R., Lobo F. (2013). Competition in prescription drug markets: the roles of trademarks, advertising, and generic names.** *Eur J Health Econ*, 14 (4) : 667-675.

Abstract: We take on two subjects of controversy among economists—advertising and trademarks—in the context of the market for generic drugs. We outline a model in which trademarks for drug names reduce search costs but increase product differentiation. In this particular framework, trademarks may not benefit consumers. In contrast, the generic names of drugs or "International Nonproprietary Names" (INN) have unquestionable benefits in both economic theory and empirical studies. We offer a second model where advertising of a brand-name drug creates recognition for the generic name. The monopoly patent-holder advertises less than in the absence of a competitive spillover.

**Thengilsdottir G., Gardarsdottir H., Almarsdottir A.B., McClure C.B., Heerdink E.R. (2013). The association between lifting an administrative restriction on antidepressant dispensing and treatment patterns in Iceland.** *Health Policy*, 111 (2) : 193-199.

Abstract: PURPOSE: On March 1st 2009, restrictions on the dispensing of selective serotonin reuptake inhibitors (SSRI) in Iceland were lifted. Incident rates and changes in early discontinuation and switching before and after the change were investigated. METHODS: New users of antidepressants between March 1st 2006 and March 1st 2010 were selected from the Icelandic Prescriptions Database. The study population was split into one intervention cohort (2009) and three comparison cohorts (2006, 2007, and 2008). Incidence rate ratios (IRR) and odds ratios (OR) were used to compare incidence rates and early discontinuation. RESULTS: The overall incidence rates of antidepressant use decreased from 33.10 to 28.71 per 1000 persons per year (IRR 0.87; 95% confidence interval (CI), 0.78-0.97) from the 2006 to the 2009 cohort. The incidence rate for SSRIs did not change over the period. Early discontinuation for SSRIs increased from 30.2% in 2006 to 34.1% in 2009 (OR 1.19; 95% CI 1.06-1.33). CONCLUSIONS: The change in reimbursement does not seem to have affected incidence rates but it may be related to increased early discontinuation, which can lead to increased drug wastage. It might be more clinically rational to initiate patients on smaller supply, allowing for more frequent check-up visits.

**Hameen-Anttila K., Luhtanen S., Airaksinen M., Pohjanoksa-Mantyla M. (2013). Developing a national medicines information strategy in Finland-A stakeholders' perspective on the strengths, challenges and opportunities in medicines information.** *Health Policy*, 111 (2) : 200-205.

Abstract: PURPOSE AND SETTING: The Finnish Medicines Agency was mandated to develop a national medicines information strategy. The objectives of this study were to assess stakeholders' views on strengths, challenges and opportunities in medicines information for the basis of the strategy. METHODS: Interviews among stakeholder representatives (n=28) from patient organizations, universities, pharmacies, and professional associations in medicine, pharmacy and nursing were conducted in 2011. Interview memos were thematically content-analysed. The draft strategy was finalized through two public hearings and a public consultation. RESULTS: Stakeholders highlighted the need to increase cooperation and coordination in medicines information. The existence of numerous quality- and evidence-based medicines information sources was identified as a strength; although the stakeholders were concerned about the fragmented and unequal access to them. The strengthening of the role of health care professionals in communicating about medicines was seen as an opportunity, but its realization requires improvements in basic and continuing education. Furthermore, the stakeholders emphasized the importance of uniform medicines information regardless of source. CONCLUSIONS: Stakeholders identified multiple strengths, challenges and opportunities in medicines information that were fundamental to developing the national medicines

information strategy. An inventory of stakeholder perspectives can be recommended as a tool to support decision-making in pharmaceutical policy.

## Méthodologie – Statistique / Methodology – Statistics

**de Bekker-Grob E.W., Chorus C.G. (2013). Random regret-based discrete-choice modelling: an application to healthcare.** *Pharmacoeconomics*, 31 (7) : 623-634.

**Abstract:** BACKGROUND: A new modelling approach for analysing data from discrete-choice experiments (DCEs) has been recently developed in transport economics based on the notion of regret minimization-driven choice behaviour. This so-called Random Regret Minimization (RRM) approach forms an alternative to the dominant Random Utility Maximization (RUM) approach. The RRM approach is able to model semi-compensatory choice behaviour and compromise effects, while being as parsimonious and formally tractable as the RUM approach. OBJECTIVES: Our objectives were to introduce the RRM modelling approach to healthcare-related decisions, and to investigate its usefulness in this domain. METHODS: Using data from DCEs aimed at determining valuations of attributes of osteoporosis drug treatments and human papillomavirus (HPV) vaccinations, we empirically compared RRM models, RUM models and Hybrid RUM-RRM models in terms of goodness of fit, parameter ratios and predicted choice probabilities. RESULTS: In terms of model fit, the RRM model did not outperform the RUM model significantly in the case of the osteoporosis DCE data ( $p = 0.21$ ), whereas in the case of the HPV DCE data, the Hybrid RUM-RRM model outperformed the RUM model ( $p < 0.05$ ). Differences in predicted choice probabilities between RUM models and (Hybrid RUM-) RRM models were small. Derived parameter ratios did not differ significantly between model types, but trade-offs between attributes implied by the two models can vary substantially. CONCLUSION: Differences in model fit between RUM, RRM and Hybrid RUM-RRM were found to be small. Although our study did not show significant differences in parameter ratios, the RRM and Hybrid RUM-RRM models did feature considerable differences in terms of the trade-offs implied by these ratios. In combination, our results suggest that RRM and Hybrid RUM-RRM modelling approach hold the potential of offering new and policy-relevant insights for health researchers and policy makers.

## Politique de santé / Health Policy

**Tabuteau D. (2013). 1983-2013 : les évolutions de la politique de santé.** *Journal d'économie médicale*, 31 (1) : 53-68.

## Prévention / Prevention

**Etner J, Tabo A. (2013). Prévention en santé et ambiguïté.** *Revue économique*, 64 (4) : 665-683.

**Abstract:** Dans cet article, nous étudions les comportements individuels de prévention face à une incertitude sur l'état de santé. Nous analysons les choix individuels de prévention primaire et de prévention secondaire lorsque la probabilité d'apparition de la maladie n'est pas parfaitement connue. Afin de distinguer l'aversion pour le risque et l'aversion à l'ambiguïté, nous utilisons le modèle de représentation des préférences proposé par Klibanoff, Marinacci et Mukerji [2005]. Nous montrons que l'aversion à l'ambiguïté incite les individus à faire plus de prévention primaire et secondaire sous l'hypothèse d'une utilité marginale de la richesse croissante avec l'état de santé.

## Psychiatrie / Psychiatry

### **Liggins J., Kearns R.A., Adams P.J. (2013). Using autoethnography to reclaim the place of healing in mental health care.** *Social Science & Medicine*, 91 (0) : 105-109.

Abstract: Geographies of mental health in the era of deinstitutionalisation have examined a range of places, policy processes and people's experiences associated with community care. However, such assessments have tended, given their community focus, to necessarily be silent on the character of inpatient spaces of care. There is silence too on the potential of such spaces to assist in the healing journey. While there have been a few investigations of hospital design, there has been little consideration of users' experiences of hospital spaces as critical sites and spaces of transition on the illness journey. In this paper, we critically reflect on a project that seeks, two decades after the closure of the last major institution in New Zealand, to investigate the acute care environment with an emphasis on its capacity for healing. The vehicle facilitating this investigation is a novel approach to understanding the inpatient journey: autoethnography. This methodology allows the first author (JL) to critically reflect on her multiple roles as compassionate observer, service-user and mental health professional, and developing transdisciplinary insights that, in conversation with the other authors' geographical (RK) and psychological (PA) vantage points, assist in the reconsideration of the place of the inpatient unit as a place of healing. The paper reveals how voice, experience and theory become mutually entwined concerns in an investigation which potentially stretches the therapeutic landscape idea through critical attention to the redemptive qualities of place by means of attentiveness to both the world within and the world without.

### **Kyanko K.A., Curry L.A., Busch S.H. (2013). Out-of-Network Provider Use More Likely in Mental Health than General Health Care Among Privately Insured.** *Med Care*, 51 (8) : 699-705.

Abstract: OBJECTIVE: Previous research has shown relatively high use of out-of-network mental health providers, although direct comparisons with rates among general health providers are not available. We aimed to (1) estimate the proportion of privately insured adults using an out-of-network mental health provider in the past 12 months; (2) compare rates of out-of-network mental health provider use with out-of-network general medical use; (3) determine reasons for out-of-network mental health care use. METHODS: A nationally representative sample of privately insured US adults was surveyed using the internet in February 2011. Screener questions identified if the participant had used either a general medical physician or a mental health professional within the past 12 months. Respondents using either type of out-of-network provider completed a 10-minute survey on details of their out-of-network care experiences. RESULTS: Eighteen percent of individuals who used a mental health provider reported at least 1 contact with an out-of-network mental health provider, compared to 6.8% who used a general health provider ( $P < 0.01$ ). The most common reasons for choosing an out-of-network mental health provider were the physician was recommended (26.1%), continuity with a previously known provider (23.7%), and the perceived skill of the provider (19.3%). CONCLUSIONS: Out-of-network provider use is more likely in mental health care than general health care. Most respondents chose an out-of-network mental health provider based on perceived provider quality or continuing care with a previously known provider rather than issues related to the availability of an in-network provider, convenient location, or appointment wait time.

## Soins de santé primaires / Primary Health Care

### **Lee J.Milligan J. H.L.e.al. (2013). Enhancing Care for Individuals with Mobility Impairments: Lessons Learned in the Implementation of a Primary Care-Based Mobility Clinic.** *Healthcare Quarterly*, 16 (2) : 49-54.

Abstract: Persons with mobility impairments experience significant barriers to primary healthcare. This study examines key lessons learned, as derived from interviews with referral sources and Centre for Family Medicine Mobility Clinic team members, in the development and implementation of a primary care and dash;based mobility clinic aimed at reducing these barriers, and it reflects on the implications

Pôle documentation de l'Irdes / Irdes Documentation centre - Safon M.-O., Suhard V.

Page 15 sur 21

[www.irdes.fr/EspaceDoc](http://www.irdes.fr/EspaceDoc)

[www.irdes.fr/EspaceDoc/Veille.html](http://www.irdes.fr/EspaceDoc/Veille.html)

[www.irdes.fr/EspaceAnglais/DocumentationCentre/Veille.html](http://www.irdes.fr/EspaceAnglais/DocumentationCentre/Veille.html)

of this model of care on the system of care. Results highlight the importance of accessibility, specialized equipment, promotional activities and management support as well as challenges reflected by system barriers to care. The results of this study have implications for the application of this model of care in other settings.

**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.

**Paustian M.L., Alexander J.A., El Reda D.K., Wise C.G., Green L.A., Fetters M.D. (2013). Partial and Incremental PCMH Practice Transformation: Implications for Quality and Costs. *Health Services Research*, Ahead of pub.**

Abstract: Objective To examine the associations between partial and incremental implementation of the Patient Centered Medical Home (PCMH) model and measures of cost and quality of care. Data Source We combined validated, self-reported PCMH capabilities data with administrative claims data for a diverse statewide population of 2,432 primary care practices in Michigan. These data were supplemented with contextual data from the Area Resource File. Study Design We measured medical home capabilities in place as of June 2009 and change in medical home capabilities implemented between July 2009 and June 2010. Generalized estimating equations were used to estimate the mean effect of these PCMH measures on total medical costs and quality of care delivered in physician practices between July 2009 and June 2010, while controlling for potential practice, patient cohort, physician organization, and practice environment confounders. Principal Findings Based on the observed relationships for partial implementation, full implementation of the PCMH model is associated with a 3.5 percent higher quality composite score, a 5.1 percent higher preventive composite score, and \$26.37 lower per member per month medical costs for adults. Full PCMH implementation is also associated with a 12.2 percent higher preventive composite score, but no reductions in costs for pediatric populations. Incremental improvements in PCMH model implementation yielded similar positive effects on quality of care for both adult and pediatric populations but were not associated with cost savings for either population. Conclusions Estimated effects of the PCMH model on quality and cost of care appear to improve with the degree of PCMH implementation achieved and with incremental improvements in implementation.

**Paulus D., Van den Heede K., Gerkens S., Desomer A., Mertens R. (2013). Development of a national position paper for chronic care: Example of Belgium. *Health Policy*, 111 (2) : 105-109.**

Abstract: The management of chronic diseases is a prime challenge of most 21st century health care systems. Many Western countries have invested heavily in care plans oriented towards specific conditions and diseases, such as dementia and cancer. The major downside of this narrowly focused approach is that treatment of multimorbidity is ignored. This paper describes the development and main stance of a national position that proposes streamlined reforms of the Belgian health care system to improve care for patients with multiple chronic diseases. We used a combination of methods to develop this stance: literature review and stakeholders' consultation. The latter identified areas for improvement: efficiency of the health care system, coordination of care, investments in human care resources, informal caregivers' support, better accessibility, and changes in the financial payment system. The position paper list 20 recommendations that are translated into about 50 action points to reform the health care system. Chronic care tailored to the patient's needs, including implementation of multidisciplinary teamwork, new functions, task delegation in primary care, and empowerment of the patient and informal caregivers are some major areas discussed. In addition, improved support,

revised payment mechanisms, and setting up a quality system, along with the tailoring of patient care, can all facilitate delivery of high quality care in patients with chronic comorbidities.

**Glennard A.H. (2013). Productivity and patient satisfaction in primary care-Conflicting or compatible goals?** *Health Policy*, 111 (2) : 157-165.

Abstract: Following recent reforms in Swedish primary care, providers are accountable to both citizens and county councils, in their role as payers. Productivity and quality measurement is fundamental for ensuring health care providers accountability to payers and that resources are spent as intended. The purpose was to study productivity and patient satisfaction in Swedish primary care. One measure of productivity capturing volume of visits and one measure capturing individual's judgment about the quality of services in relation to allocated resources was estimated. The potential conflict between the two measures and variation with respect to different factors was analyzed. There was a great variation in both measures of productivity. No conflict between the two measures of productivity was found. Thus, most providers could increase their volume of services without adverse effects for the quality and vice versa. Providers are however faced with different conditions. Traditional productivity measures are not enough to assess whether allocated resources are used according to set priorities and generates value for money. Information about the length and content of visits and the distribution of services produced is also needed, in particular to assess if resources allocated based on expected great needs among certain groups actually benefits those individuals. Effects of services produced are also needed. This is particularly important to assess if resources allocated based on expected great needs among certain groups actually benefits those individuals.

**Rischatsch M., Zweifel P. (2013). What do physicians dislike about managed care? Evidence from a choice experiment.** *Eur J Health Econ*, 14 (4) : 601-613.

Abstract: Managed care (MC) imposes restrictions on physician behavior, but also holds promises, especially in terms of cost savings and improvements in treatment quality. This contribution reports on private-practice physicians' willingness to accept (WTA, compensation asked, respectively) for several MC features. In 2011, 1,088 Swiss ambulatory care physicians participated in a discrete choice experiment, which permits putting WTA values on MC attributes. With the exception of shared decision making and up to six quality circle meetings per year, all attributes are associated with non-zero WTA values. Thus, health insurers must be able to achieve substantial savings in order to create sufficient incentives for Swiss physicians to participate voluntarily in MC plans.

**Decker S.L. (2013). Two-thirds of primary care physicians accepted new Medicaid patients in 2011-12: a baseline to measure future acceptance rates.** *Health Aff.(Millwood.)*, 32 (7) : 1183-1187.

Abstract: As part of the Affordable Care Act, primary care physicians providing services to patients insured through Medicaid in some states will receive higher payments in 2013 and 2014 than in the past. Payments for some services will increase to match Medicare rates. This change may lead to wider acceptance of new Medicaid patients among primary care providers. Using data from the 2011-12 National Ambulatory Medical Care Survey Electronic Medical Records Supplement, I summarize baseline rates of acceptance of new Medicaid patients among office-based physicians by specialty and practice type. I also report state-level acceptance rates for both primary care and other physicians. About 33 percent of primary care physicians (those in general and family medicine, internal medicine, or pediatrics) did not accept new Medicaid patients in 2011-12, ranging from a low of 8.9 percent in Minnesota to a high of 54.0 percent in New Jersey. Primary care physicians in New Jersey, California, Alabama, and Missouri were less likely than the national average to accept new Medicaid patients in 2011-12. The data presented here provide a baseline for comparison of new Medicaid acceptance rates in 2013-14.

**Kern L.M., Dhopeswarkar R.V., Edwards A., Kaushal R. (2013). Patient experience over time in patient-centered medical homes.** *Am J Manag Care*, 19 (5) : 403-410.

Abstract: Objectives: Although the Patient-Centered Medical Home (PCMH) model is being implemented across the country to transform primary care, it is not yet clear whether this model actually improves patients' experiences with healthcare. Our objective was to measure patients' experiences over time in practices that transformed into PCMHs. Study Design: We conducted a prospective study, using 2 serial cross-sectional samples, in a multipayer community. Methods: We surveyed 715 patients: 346 at baseline, when practices had just completed transformation, and 369 at follow-up, which was a median of 15 months later. These patients received care from 120 primary care

providers at 10 ambulatory practices (20 sites) that achieved Level III PCMH, as defined by the National Committee for Quality Assurance. We measured patient experience, as defined by the 7 domains of the Clinician and Group-Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) Adult Primary Care Questionnaire. Results: Patients' self-reported experience with access to care improved significantly over time, with 61% of respondents giving access to care the highest rating at baseline versus 69% at follow-up ( $P = .02$ ). There were no significant changes over time for the other domains. Conclusions: The PCMH was associated with improvements in patients' experience with access to care but not other domains of care. This study, which took place in a multi-payer community, is one of the first to find a positive effect of the PCMH on patient experience.

**Shi L., Lebrun-Harris L.A., Daly C.A., Sharma R., Sripipatana A., Hayashi A.S., Ngo-Metzger Q. (2013). Reducing disparities in access to primary care and patient satisfaction with care: the role of health centers. *J Health Care Poor Underserved*, 24 (1) : 56-66.**

Abstract: This paper examined disparities in access to and satisfaction with primary care among patients of different racial/ethnic groups and insurance coverage, in health centers and the nation overall. Data came from the 2009 Health Center Patient Survey and 2009 Medical Expenditure Panel Survey. Study outcomes included usual source of care, type of usual source of care, satisfaction with provider office hours, and satisfaction with overall care. Health center patients were more racially and ethnically diverse than national patients, and health center patients were more likely than national patients to be uninsured or publicly insured. No significant health care disparities in access to care existed among patients from different racial/ethnic and insurance groups among health centers, unlike low-income patients nationwide or the U.S. population in general. Additional focus on the uninsured, in health centers and other health care settings nationwide, is needed to enhance satisfaction with care among these patients.

**Scott A., Witt J., Humphreys J., Joyce C., Kalb G., Jeon S.H., McGrail M. (2013). Getting doctors into the bush: General Practitioners' preferences for rural location. *Social Science & Medicine*, (Ahead of pub) :**

Abstract: Abstract A key policy issue in many countries is the maldistribution of doctors across geographic areas, which has important effects on equity of access and health care costs. Many government programs and incentive schemes have been established to encourage doctors to practice in rural areas. However, there is little robust evidence of the effectiveness of such incentive schemes. The aim of this study is to examine the preferences of general practitioners (GPs) for rural location using a discrete choice experiment. This is used to estimate the probabilities of moving to a rural area, and the size of financial incentives GPs would require to move there. GPs were asked to choose between two job options or to stay at their current job as part of the Medicine in Australia: Balancing Employment and Life (MABEL) longitudinal survey of doctors. 3,727 GPs completed the experiment. Sixty five per cent of GPs chose to stay where they were in all choices presented to them. Moving to an inland town with less than 5,000 population and reasonable levels of other job characteristics would require incentives equivalent to 64% of current average annual personal earnings (\$116,000). Moving to a town with a population between 5,000 and 20,000 people would require incentives of at least 37% of current annual earnings, around \$68,000. The size of incentives depends not only on the area but also on the characteristics of the job. The least attractive rural job package would require incentives of at least 130% of annual earnings, around \$237,000. It is important to begin to tailor incentive packages to the characteristics of jobs and of rural areas.

**Rathert C, Wyrwich M., Boren S (2013). Patient-Centered Care and Outcomes. *Medical Care Research and Review*, 70 (4) : 351-379.**

Abstract: Patient-centered care (PCC) has been studied for several decades. Yet a clear definition of PCC is lacking, as is an understanding of how specific PCC processes relate to patient outcomes. We conducted a systematic review of the PCC literature to examine the evidence for PCC and outcomes. Three databases were searched for all years through September 2012. We retained 40 articles for the analysis. Results found mixed relationships between PCC and clinical outcomes, that is, some studies found significant relationships between specific elements of PCC and outcomes but others found no relationship. There was stronger evidence for positive influences of PCC on satisfaction and self-management. Future research should examine specific dimensions of PCC and how they relate to technical care quality, particularly some dimensions that have not been studied extensively. Future research also should identify moderating and mediating variables in the PCC-outcomes relationship.

**Bekelman D.B., Plomondon M.E., Sullivan M.D., Nelson K., Hattler B., McBryde C., Lehmann K.G., Pottfay J., Heidenreich P., Rumsfeld J.S. (2013). Patient-centered disease management (PCDM) for heart failure: study protocol for a randomised controlled trial. *BMC Cardiovasc.Disord.*, 13 (1) : 49.**

Abstract: BACKGROUND: Chronic heart failure (HF) disease management programs have reported inconsistent results and have not included comorbid depression management or specifically focused on improving patient-reported outcomes. The Patient Centered Disease Management (PCDM) trial was designed to test the effectiveness of collaborative care disease management in improving health status (symptoms, functioning, and quality of life) in patients with HF who reported poor HF-specific health status. Methods/design: Patients with a HF diagnosis at four VA Medical Centers were identified through population-based sampling. Patients with a Kansas City Cardiomyopathy Questionnaire (KCCQ, a measure of HF-specific health status) score of < 60 (heavy symptom burden and impaired quality of life) were invited to enroll in the PCDM trial. Enrolled patients were randomized to receive usual care or the PCDM intervention, which included: (1) collaborative care management by VA clinicians including a nurse, cardiologist, internist, and psychiatrist, who worked with patients and their primary care providers to provide guideline-concordant care management, (2) home telemonitoring and guided patient self-management support, and (3) screening and treatment for comorbid depression. The primary study outcome is change in overall KCCQ score. Secondary outcomes include depression, medication adherence, guideline-based care, hospitalizations, and mortality. DISCUSSION: The PCDM trial builds on previous studies of HF disease management by prioritizing patient health status, implementing a collaborative care model of health care delivery, and addressing depression, a key barrier to optimal disease management. The study has been designed as an 'effectiveness trial' to support broader implementation in the healthcare system if it is successful. Trial registration: Unique identifier:

**Glennard A.H. (2013). Productivity and patient satisfaction in primary care-Conflicting or compatible goals? *Health Policy*, 111 (2) : 157-165.**

Abstract: Following recent reforms in Swedish primary care, providers are accountable to both citizens and county councils, in their role as payers. Productivity and quality measurement is fundamental for ensuring health care providers accountability to payers and that resources are spent as intended. The purpose was to study productivity and patient satisfaction in Swedish primary care. One measure of productivity capturing volume of visits and one measure capturing individual's judgment about the quality of services in relation to allocated resources was estimated. The potential conflict between the two measures and variation with respect to different factors was analyzed. There was a great variation in both measures of productivity. No conflict between the two measures of productivity was found. Thus, most providers could increase their volume of services without adverse effects for the quality and vice versa. Providers are however faced with different conditions. Traditional productivity measures are not enough to assess whether allocated resources are used according to set priorities and generates value for money. Information about the length and content of visits and the distribution of services produced is also needed, in particular to assess if resources allocated based on expected great needs among certain groups actually benefits those individuals. Effects of services produced are also needed. This is particularly important to assess if resources allocated based on expected great needs among certain groups actually benefits those individuals.

## Systèmes de santé / Health Systems

**White J. (2013). The 2010 U.S. health care reform: approaching and avoiding how other countries finance health care. *Health Economics, Policy and Law*, 8 (03) : 289-315.**

**Conti M.S. (2013). Effect of medicaid disease management programs on emergency admissions and inpatient costs. *Health Services Research*, 48 (4) : 1359-1374.**

Abstract: OBJECTIVE: To determine the impact of state Medicaid diabetes disease management programs on emergency admissions and inpatient costs. DATA: National InPatient Sample sponsored by the Agency for Healthcare Research and Quality Project for the years from 2000 to 2008 using 18 states. STUDY DESIGN: A difference-in-difference methodology compares costs and number of

emergency admissions for Washington, Texas, and Georgia, which implemented disease management programs between 2000 and 2008, to states that did not undergo the transition to managed care (N = 103). DATA EXTRACTION: Costs and emergency admissions were extracted for diabetic Medicaid enrollees diagnosed in the reform and non-reform states and collapsed into state and year cells. PRINCIPAL FINDINGS: In the three treatment states, the implementation of disease management programs did not have statistically significant impacts on the outcome variables when compared to the control states. CONCLUSIONS: States that implemented disease management programs did not achieve improvements in costs or the number of emergency of admissions; thus, these programs do not appear to be an effective way to reduce the burden of this chronic disease.

**Ozawa S., Sripad P. (2013). How do you measure trust in the health system? A systematic review of the literature.** *Social Science & Medicine*, 91 (0) : 10-14.

Abstract: People's trust in the health system plays a role in explaining one's access to and utilization of medical care, adherence to medications, continuity of care, and even self-reported health status. Yet it is not easy to find trust measures and understand what they are measuring. A systematic review of scales and indices identified 45 measures of trust within the health system with an average of 12 questions each, which quantified levels of trust among various relationships across the health system. Existing evidence was narrow in scope, where half examined the relationship between doctors/nurses and patients, and the majority were designed, tested and validated in the United States. We a health systems trust content area framework, where we identified that honesty, communication, confidence and competence were captured frequently in these measures, with less focus on concepts such as fidelity, system trust, confidentiality and fairness. Half of the measures employed a qualitative method in the design of these measures and 33% were pilot tested. Reporting of test-retest reliability and inter-rater reliability were less common. This review identifies a need to develop measurements of trust beyond doctor-patient relationships and outside of U.S. contexts, and strengthen the rigor of existing trust measures. Greater development and use of trust measures in the health system could improve monitoring and evaluation efforts, which may in turn result in better health outcomes.

**Missinne S., Meuleman B, Bracke P (2013). The popular legitimacy of European healthcare systems: A multilevel analysis of 24 countries.** *Journal of European Social Policy*, 23 (3) : 231-247.

Abstract: This paper provides an empirical study of the between-individual and between-country differences in the popular legitimacy of European healthcare systems. In order to explain two dimensions of popular legitimacy (satisfaction and support for state responsibility), we assess the impact of self-interest motives (income and personal health), ideology (egalitarianism) and institutional arrangements (level of service provision, and private and government health expenditure). For this purpose, data from the European Social Survey Round 4 (ESS-4, 2008–2009) are analysed by means of multilevel models. Universal high support for state responsibility is found, while satisfaction varies considerably, with particularly low levels found in Eastern European and former Soviet Union countries. It appears that individuals are not guided by self-interest motives and ideology alone. In addition to these factors interacting, the results suggest that state-provided healthcare might be in everyone's interest. Introducing a patient perspective could advance our understanding of healthcare legitimacy.

## Travail et santé / Occupational Health

**Van Hal L., Meershoek A., Nijhuis F., Horstman K. (2013). Disembodied abilities: Sick role and participation in an activating return-to-work practices.** *Social Science & Medicine*, (Ahead of pub) :

Abstract: In an active welfare states, labour participation is regarded essential for being part of and contributing to society. In the striving for an increase in labour participation of people who were considered (partly) disabled for work, not "disabilities", but abilities are put centre stage in vocational rehabilitation programmes. In this article we explore what this change in focus means in practice. We do this by investigating tensions experienced by participants of vocational rehabilitation practices that aim at facilitating return-to-work for people with disabilities. Our analysis derives from stories that

clients and professionals told about daily experiences with disability, vocational rehabilitation and (labour) participation. These stories illustrate the logic embedded in vocational rehabilitation practices. Our analysis demonstrates that this logic, that focuses on will power, stable abilities and employability, hampers the realization of labour participation for a part of the population. We conclude that a logic of embodiment in which lived experiences of clients are acknowledged and in which it is explored what clients are concretely able to do in a specific context may be better equipped to facilitate return-to-work.

## Vieillesse / Ageing

**Vayssette P. (2013). Expérimentation Paerpa : 8 régions retenues.** *Réseaux, Santé et Territoire*, (50) : 10-13.

Abstract: Marisol Touraine a annoncé au salon de l'autonomie la liste des régions retenues pour les projets pilotes Paerpa au nombre de huit, avec un décalage au 1er janvier 2014 pour trois d'entre elles. Ces expérimentations doivent permettre de nouvelles organisations des acteurs pour fluidifier le parcours de soins des personnes âgées et une approche du financement d'un parcours de patient au lieu de successions d'actes de professionnels de santé.