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DOC VEILLE

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Assurance maladie / Health Insurance

Cimas, M., et al. (2016). "Healthcare coverage for undocumented migrants in Spain: Regional differences after Royal Decree Law 16/2012." *Health Policy* 120(4): 384-395.

The implementation of the Spanish RDL 16/2012 which took away healthcare coverage for undocumented migrant arose huge differences among regions. In decentralized health systems, within-country differences in access and/or entitlement can be as relevant as those reported among countries. Central controversial regulations, such as policies of healthcare exclusion, may be useless if regional authorities have power to overcome them.

Kaestner, R. et Lubotsky, D. (2016). "Health Insurance and Income Inequality." *Journal of Economic Perspectives* 30(2): 53-78.

Lé, G., et al. (2016). "Can service integration work for universal health coverage? Evidence from around the globe." *Health Policy* 120(4): 406-419.

Empirical impacts of integration experiments were explored through a global review. Positive outcomes identified for patients and clinicians without extra costs. Incremental improvements so integration should not be considered a game-changer.

Economie de la santé / Health Economics

Dieleman, J. L., et al. (2016). "National spending on health by source for 184 countries between 2013 and 2040." *The Lancet*(Ahead of print).

Background : A general consensus exists that as a country develops economically, health spending per capita rises and the share of that spending that is prepaid through government or private mechanisms also rises. However, the speed and magnitude of these changes vary substantially across countries, even at similar levels of development. In this study, we use past trends and relationships to estimate future health spending, disaggregated by the source of those funds, to identify the financing trajectories that are likely to occur if current policies and trajectories evolve as expected.

Evans, T. et Pablos-Méndez, A. (2016). "Shaping of a new era for health financing." *The Lancet*(Ahead of print).

Geue, C., et al. (2016). "Geographic variation of inpatient care costs at the end of life." *Age and Ageing* 45(3): 376-381.

Background: costs incurred at the end of life are a main contributor to healthcare expenditure. Urban-rural inequalities in health outcomes have been demonstrated. Issues around geographical patterning of the association between time-to-death and expenditure remain under-researched. It is unknown whether differences in outcomes translate into differences in costs at the end of life. Methods: we used a large representative sample of the Scottish population obtained from death records linked to acute inpatient care episodes. We performed retrospective analyses of costs and recorded the most frequent reasons for the last hospital admission. Using a two-part model, we estimated the probability of healthcare utilisation and costs for those patients who incurred positive costs. Results: effects of geography on costs were similar across diagnoses. We did not observe a clear gradient for costs, which were lower in other urban areas compared with large urban areas. Patients from remote and very remote areas incurred higher costs than patients from large, urban areas. The main driver of increased costs was increased length of stay. Conclusions: our results provide evidence of additional costs associated with remote locations. If length of stay and costs are to be reduced, alternative care provision is required in rural areas. Lower costs in other urban areas compared with large urban areas may be due to urban centres incurring higher costs through case-mix and clinical practice. If inequalities are driven by hospital admission, for an end of life scenario, care delivered closer to home

or home-based care seems intuitively attractive and potentially cost-saving.

Stadhouders, N., et al. (2016). "Policy options to contain healthcare costs: a review and classification." Health Policy **120**(5): 486-494.

We identify 2250 cost containment policies from the literature.?We categorize 41 policy groups into four primary cost containment targets.?Prices and budgets are targeted less often than volumes and market.?Differences in policy suggestions between countries contradict health system characteristics.?Implementation could cause health system convergence, except for the US.

Stollenwerk, B., et al. (2016). "Cost-of-illness studies based on massive data: a prevalence-based, top-down regression approach." Eur J Health Econ **17**(3): 235-244.

Despite the increasing availability of routine data, no analysis method has yet been presented for cost-of-illness (COI) studies based on massive data. We aim, first, to present such a method and, second, to assess the relevance of the associated gain in numerical efficiency. We propose a prevalence-based, top-down regression approach consisting of five steps: aggregating the data; fitting a generalized additive model (GAM); predicting costs via the fitted GAM; comparing predicted costs between prevalent and non-prevalent subjects; and quantifying the stochastic uncertainty via error propagation. To demonstrate the method, it was applied to aggregated data in the context of chronic lung disease to German sickness funds data (from 1999), covering over 7.3 million insured. To assess the gain in numerical efficiency, the computational time of the innovative approach has been compared with corresponding GAMS applied to simulated individual-level data. Furthermore, the probability of model failure was modeled via logistic regression. Applying the innovative method was reasonably fast (19 min). In contrast, regarding patient-level data, computational time increased disproportionately by sample size. Furthermore, using patient-level data was accompanied by a substantial risk of model failure (about 80 % for 6 million subjects). The gain in computational efficiency of the innovative COI method seems to be of practical relevance. Furthermore, it may yield more precise cost estimates.

Tsiachristas, A., et al. (2016). "Impact of financial agreements in European chronic care on health care expenditure growth." Health Policy **120**(4): 420-430.

PFC appeared to substantially decrease outpatient expenditure growth. PFP has the strongest ability to tackle the growth of hospital expenditure. All-inclusive financial agreements decrease the growth of outpatient expenditure. Financial agreements are powerful tools to integrate care and control healthcare expenditure growth. A blended payment scheme is likely to control healthcare expenditure growth the most.

Van Mosseveld, C., et al. (2016). "How to ensure quality of health accounts." Health Policy **120**(5): 544-551.

Health Accounts integrates scattered data from different sources, objectives, formats and content. Each of the four key activities involves elements of quality. Policy relevant results and cooperation of all stakeholders are essential. Indicators can be used to monitor the quality results and its improvement. Quality of Health Accounts is difficult to achieve but feasible.

Etat de santé / Health Status

(2016). "Multimorbidity in Europe and other stories." BMJ **353**.

A survey of people aged ≥ 50 in 16 European countries finds that over a third had two or more chronic health conditions, ranging from 24.7% in Switzerland to 51% in Hungary (Age Ageing doi:10.1093/ageing/afw044). Multimorbidity also increased with age in this representative sample of 56 427 people (median age 66). Across Europe, multimorbidity is associated with greater healthcare utilisation, worse self reported health status, depression, and reduced functional capacity. The challenge of providing better, joined-up management can be met only within stronger primary care

systems. So show me again Reproducibility lies at the heart of science: hence the Royal Society's motto "nullius in verba" (don't take anyone's word for it). In 2012 the world was briefly shocked when Begley and Ellis reported that scientists ...

Karanikolos, M., et al. (2016). "Effects of the Global Financial Crisis on Health in High-Income Oecd Countries: A Narrative Review." *International Journal of Health Services* **46**(2): 208-240.

A growing body of evidence documents how economic crises impact aspects of health across countries and over time. We performed a systematic narrative review of the health effects of the latest economic crisis based on studies of high-income countries. Papers published between January 2009 and July 2015 were selected based on review of titles and abstracts, followed by a full text review conducted by two independent reviewers. Ultimately, 122 studies were selected and their findings summarized. The review finds that the 2008 financial crisis had negative effects on mental health, including suicide, and to a varying extent on some non-communicable and communicable diseases and access to care. Although unhealthy behaviors such as hazardous drinking and tobacco use appeared to decline during the crisis, there have been increases in some groups, typically those already at greatest risk. The health impact was greatest in countries that suffered the largest economic impact of the crisis or prolonged austerity. The Great Recessions in high-income countries have had mixed impacts on health. They tend to be worse when economic impacts are more severe, prolonged austerity measures are implemented, and there are pre-existing problems of substance use among vulnerable groups.

Legido-Quigley, H. et Greer, S. L. (2016). "Austerity, Health, and the Eurozone." *International Journal of Health Services* **46**(2): 203-207.

Géographie de la santé / Geography of Health

Sundmacher, L. et Ozegowski, S. (2016). "Regional distribution of physicians: the role of comprehensive private health insurance in Germany." *The European Journal of Health Economics* **17**(4): 443-451.

In recent years, the co-existence in Germany of two parallel comprehensive insurance systems—statutory health insurance (SHI) and private health insurance (PHI)—has been posited as a possible cause of a persistent unequal regional distribution of physicians. The present study investigates the effect of the proportion of privately insured patients on the density of SHI-licensed physicians, while controlling for regional variations in the average income from SHI patients.

Wang, V., et al. (2016). "Impacts of Geographic Distance on Peritoneal Dialysis Utilization: Refining Models of Treatment Selection." *Health Services Research*: n/a-n/a.

Objective To examine the relationship between distance to dialysis provider and patient selection of dialysis modality, informed by the absolute distance from a patient's home and relative distance of alternative modalities. Data Sources U.S. Renal Data System. Study Design About 70,131 patients initiating chronic dialysis and 4,795 dialysis facilities in 2006. The primary outcome was patient utilization of peritoneal dialysis (PD). Independent variables included absolute distance between patients' home and the nearest hemodialysis (HD) facility, relative distance between patients' home and nearest PD versus nearest HD facilities, and their interaction. Logistic regression was used to model distance on PD use, controlling for patient and market characteristics. Principal Findings Nine percent of incident dialysis patients used PD in 2006. There was a positive, nonlinear relationship between absolute distance to HD services and PD use ($p < .0001$), with the magnitude of the effect increasing at greater distances. In terms of relative distance, odds of PD use increased if a PD facility was closer or the same distance as the nearest HD facility ($p = .006$). Interaction of distance measures to dialysis facilities was not significant. Conclusions Analyses of patient choice between alternative treatments should model distance to reflect all relevant dimensions of geographic access to treatment options.

Hôpital / Hospitals

Das, A., et al. (2016). "Adding A Spending Metric To Medicare's Value-Based Purchasing Program Rewarded Low-Quality Hospitals." *Health Affairs* 35(5): 898-906.

In fiscal year 2015 the Centers for Medicare and Medicaid Services expanded its Hospital Value-Based Purchasing program by rewarding or penalizing hospitals for their performance on both spending and quality. This represented a sharp departure from the program's original efforts to incentivize hospitals for quality alone. How this change redistributed hospital bonuses and penalties was unknown. Using data from 2,679 US hospitals that participated in the program in fiscal years 2014 and 2015, we found that the new emphasis on spending rewarded not only low-spending hospitals but some low-quality hospitals as well. Thirty-eight percent of low-spending hospitals received bonuses in fiscal year 2014, compared to 100 percent in fiscal year 2015. However, low-quality hospitals also began to receive bonuses (0 percent in fiscal year 2014 compared to 17 percent in 2015). All high-quality hospitals received bonuses in both years. The Centers for Medicare and Medicaid Services should consider incorporating a minimum quality threshold into the Hospital Value-Based Purchasing program to avoid rewarding low-quality, low-spending hospitals.

Gulland, A. (2016). "High volume emergency surgery units do not improve outcomes, report finds." *BMJ* 353.

The move to centralised services for emergency general surgery would not improve outcomes or reduce mortality rates, a report has found.¹ The Nuffield Trust looked at the problems facing emergency general surgery and found that the "widely held perception that centralisation will drive up quality" did not hold true. It found that there was no clear relationship between the number of procedures performed and surgical outcomes. The report, commissioned by the Royal College of Surgeons of England, found that there was little variation in mortality between sites that performed a large number of procedures and those ...

Krinsky, S., et al. (2016). "Variation in Payment Rates under Medicare's Inpatient Prospective Payment System." *Health Services Research*: n/a-n/a.

Objective To measure variation in payment rates under Medicare's Inpatient Prospective Payment System (IPPS) and identify the main payment adjustments that drive variation. Data Sources/Study Setting Medicare cost reports for all Medicare-certified hospitals, 1987–2013, and Dartmouth Atlas geographic files. Study Design We measure the Medicare payment rate as a hospital's total acute inpatient Medicare Part A payment, divided by the standard IPPS payment for its geographic area. We assess variation using several measures, both within local markets and nationally. We perform a factor decomposition to identify the share of variation attributable to specific adjustments. We also describe the characteristics of hospitals receiving different payment rates and evaluate changes in the magnitude of the main adjustments over time. Data Collection/Extraction Methods Data downloaded from the Centers for Medicare and Medicaid Services, the National Bureau of Economic Research, and the Dartmouth Atlas. Principal Findings In 2013, Medicare paid for acute inpatient discharges at a rate 31 percent above the IPPS base. For the top 10 percent of discharges, the mean rate was double the IPPS base. Variations were driven by adjustments for medical education and care to low-income populations. The magnitude of variation has increased over time. Conclusions Adjustments are a large and growing share of Medicare hospital payments, and they create significant variation in payment rates.

Kristensen, S. R., et al. (2016). "Who to pay for performance? The choice of organisational level for hospital performance incentives." *The European Journal of Health Economics* 17(4): 435-442.

Financial incentives for quality improvement in hospital care [known as pay for performance (P4P)] can be directed to either the hospital level or redistributed to the department level. Theoretically, performance payments distributed to lower organisational levels are more effective in increasing

performance than payments directed to the hospital level, but the empirical evidence for this expectation is scarce. This paper compares the performance of hospital departments at hospitals that do and do not redistribute performance payments to the department level. We study a Danish P4P scheme to provide patients with case managers. Applying difference in differences analysis, we estimate a 5 percentage points higher performance at hospital departments that are subject to a direct financial incentive. Our results suggest that payers can improve the effectiveness of P4P payments by distributing payments to the department level rather than the hospital level.

Soril, L. J. J., et al. (2016). "Characteristics of frequent users of the emergency department in the general adult population: A systematic review of international healthcare systems." *Health Policy* 120(5): 452-461.

Small proportion of frequent emergency department users account for high healthcare costs. We performed a systematic review of the published literature characterizing frequent users. Twenty cohort studies characterizing frequent users in 5 healthcare systems were identified. Similar demographic, clinical and resource use characteristics were observed across systems. International knowledge translation may help development of interventions and health policies.

Weeks, W. B., et al. (2016). "Rates of admission for ambulatory care sensitive conditions in France in 2009–2010: trends, geographic variation, costs, and an international comparison." *The European Journal of Health Economics* 17(4): 453-470.

Admissions for ambulatory care sensitive conditions (ACSCs) are considered preventable and indicators of poor access to primary care. We wondered whether per-capita rates of admission for ACSCs in France demonstrated geographic variation, were changing, were related to other independent variables, or were comparable to those in other countries; further, we wanted to quantify the resources such admissions consume.

Zuckerman, R. B., et al. (2016). "Readmissions, Observation, and the Hospital Readmissions Reduction Program." *New England Journal of Medicine* 374(16): 1543-1551.

Inégalités de santé / Health Inequalities

Casey, R. (2015). "Disability and unmet health care needs in Canada: a longitudinal analysis." *Disabil Health J* 8(2): 173-181.

BACKGROUND: The rate of unmet health care needs is quite high for the general population in Canada; however, the rate is even higher for the subset of people with disabilities. To date, there is a gap in the research utilizing longitudinal data to measure the unmet health care needs of Canadians.

OBJECTIVE/HYPOTHESIS: The purpose of this research is to compare the rate of unmet health care needs of people with disabilities to people without disabilities over 15 years. **METHODS:** Longitudinal data from waves 1 to 8 (1994/95 to 2008/09) of the National Population Health Survey in Canada (NPHS) were analyzed using a growth curve modeling approach. **RESULTS:** Respondents with disabilities have two to three times the rate of unmet health care needs compared to respondents without disabilities. Unmet health care needs increase over time, and at a faster rate for all disability types except work-related disability. Personal reasons for unmet health care needs decrease over time and there is no significant difference between respondents with disabilities and respondents without disabilities. The opposite was found for structural reasons, which increase over time, and, people with disabilities have higher rates of structural-based unmet health care needs (45% higher) at baseline.

CONCLUSIONS: The incidence of disability in the population increases over time while at the same time the rate of unmet health care needs are higher for people with disabilities. The combination of these factors suggests that, in the absence of intervention, Canadians can expect more unmet health care needs in the future.

Clarke, J. M. (2016). "Stop denying migrants their fundamental right to healthcare." *BMJ* 353.

Undocumented migrants have particular healthcare needs, including those related to torture, but countries are restricting access. Many people think that all migrants to Europe have meaningful access to healthcare. As article 35 of the European Union's Charter of Fundamental Rights recognises, "Everyone has the right of access to preventive health care and the right to benefit from medical treatment".¹ But the reality is different: as the European Parliament acknowledged in 2013, "Access to the most basic healthcare services, such as emergency care, is severely limited, if not impossible, for undocumented migrants on account of the identification requirement, the high price of treatment and the fear of being detected and reported to the authorities." Two thirds of the 15 648 migrants attending clinics throughout Europe in 2014 run by the charity ...

Jenny, C., et al. (2016). "Restricting Access to Health Care to Immigrants in Barcelona: A Mixed-Methods Study With Immigrants Who Have Experienced an Infectious Disease."

International Journal of Health Services **46**(2): 241-261.

Austerity policies implemented in Spain in response to the ongoing economic crisis may have detrimental consequences for the health of immigrant populations and for public health in general. A mixed-methods study by the Public Health Agency of Barcelona and the University of Michigan indicates that the Real Decreto-ley 16/2012 (RDL) threatens the health of individuals and the population, especially in the case of infectious diseases. The study sought to determine the percentage of foreign-born persons with an infectious disease who had an Individual Health Card (IHC) prior to the RDL and to determine whether foreign-born persons with an infectious disease in Barcelona encountered problems accessing health care after the RDL. Results indicate that immigrants used the IHC to seek medical attention for infectious diseases and chronic conditions. Results also show that 66% of respondents, including 54% of unemployed respondents, 3% of respondents working without contracts, and those in informal employment (9%), may be at risk of losing at least part of their health coverage. Universal health care access in Spain has been crucial for the control of communicable diseases among immigrant populations. Reducing access to a significant percentage of the total population may have deleterious effects on public health.

Mackenbach, J. P., et al. (2016). "Changes in mortality inequalities over two decades: register based study of European countries." BMJ **353**.

Objective : To determine whether government efforts in reducing inequalities in health in European countries have actually made a difference to mortality inequalities by socioeconomic group.
Design Register based study. Data source: Mortality data by level of education and occupational class in the period 1990-2010, usually collected in a census linked longitudinal study design. We compared changes in mortality between the lowest and highest socioeconomic groups, and calculated their effect on absolute and relative inequalities in mortality (measured as rate differences and rate ratios, respectively). Setting All European countries for which data on socioeconomic inequalities in mortality were available for the approximate period between years 1990 and 2010. These included Finland, Norway, Sweden, Scotland, England and Wales (data applied to both together), France, Switzerland, Spain (Barcelona), Italy (Turin), Slovenia, and Lithuania. Results Substantial mortality declines occurred in lower socioeconomic groups in most European countries covered by this study. Relative inequalities in mortality widened almost universally, because percentage declines were usually smaller in lower socioeconomic groups. However, as absolute declines were often smaller in higher socioeconomic groups, absolute inequalities narrowed by up to 35%, particularly among men. Narrowing was partly driven by ischaemic heart disease, smoking related causes, and causes amenable to medical intervention. Progress in reducing absolute inequalities was greatest in Spain (Barcelona), Scotland, England and Wales, and Italy (Turin), and absent in Finland and Norway. More detailed studies preferably using individual level data are necessary to identify the causes of these variations.
Conclusions Over the past two decades, trends in inequalities in mortality have been more favourable in most European countries than is commonly assumed. Absolute inequalities have decreased in several countries, probably more as a side effect of population wide behavioural changes and improvements in prevention and treatment, than as an effect of policies explicitly aimed at reducing health inequalities.

Médicaments / Pharmaceuticals

Bosch-Lenders, D., et al. (2016). "Factors associated with appropriate knowledge of the indications for prescribed drugs among community-dwelling older patients with polypharmacy." *Age and Ageing* 45(3): 402-408.

Background: polypharmacy contributes to patients' non-adherence with physicians' prescriptions. Patients' knowledge about the indications for their medicines is one of the factors influencing adherence. Objective: to identify factors associated with appropriate knowledge about the indications for drugs prescribed to older patients with polypharmacy. Methods: in a primary care setting, using home interviews and postal questionnaires, patients aged 60 and over who were taking five or more prescribed drugs simultaneously were asked about their medication. Multiple logistic regression analysis was used to evaluate the association (odds ratio, OR) between medication knowledge and explanatory variables like medication use, sex, age, living situation and educational level. Results: seven hundred and fifty-four participants (mean age 73.2 years) reported an average daily intake of nine (SD 3.0) prescribed drugs. Only 15% of the patients were able to recall the indication for each of their prescribed drugs. Variables that were negatively associated with correct reporting of all indications were taking many prescribed drugs (e.g. ≥10 versus ≤5: OR 0.05), age 80 years or over (versus 60–69 years: OR 0.47) and male sex (OR 0.53). Patients living with a partner were more knowledgeable than patients living alone (OR 2.11). We did not find an association with educational level. Conclusion: among older patients using five or more prescribed drugs, there was little understanding of the indications for their drugs, especially among patients taking the highest number of drugs, patients aged 80 or over, and men. Patients living independently with a partner were more knowledgeable than others.

Garattini, L., et al. (2016). "Pharmaceutical Price Schemes in Europe: Time for a 'Continental' One?" *PharmacoEconomics* 34(5): 423-426.

Méthodologie – Statistique / Methodology - Statistics

Graham, C. (2016). "Incidence and impact of proxy response in measuring patient experience: secondary analysis of a large postal survey using propensity score matching." *International Journal for Quality in Health Care* 28(2): 246-252.

Objective To determine whether use of proxy respondents in a patient experience survey was related to patient characteristics, and to compare patient and proxy responses. Design Secondary analysis, using propensity score matching, of the NHS adult inpatient survey, a large cross-sectional survey. Setting Hospitals ($n = 161$) providing inpatient services in England in 2011. Participants The survey received 70 863 responses: 10 661 (15.6%) involved proxy respondents in some way. Intervention None. Main Outcome Measures Prevalence of proxy response was explored by patient demographic characteristics. Responses were compared using seven composite domains and one overall rating. Cases involving proxy responses were matched to similar independent responses via propensity score matching and mean scores compared using t-tests. Results Use of proxy respondents was common, with 15.7% of responses involving a proxy in some way: higher than in other similar collections internationally. Proxy response was more common for some patient groups, such as older people and those from black and minority ethnic groups. Reports made by or with the assistance of proxy respondents were markedly less positive than those from patients completing the survey unaided. This pattern was consistent across all tested variables, although the biggest differences were observed for a subjective 'overall rating' question. Conclusions The prevalence of proxy response varied according to patient characteristics, but proxies were consistently less positive than patients responding unaided. Possible explanations include genuine differences in care, differential health outcomes or differences in perceptions. Patient experience surveys should collect information on use of proxy respondents to enable more refined analysis.

Moraros, J., et al. (2016). "Lean interventions in healthcare: do they actually work? A systematic literature review." *International Journal for Quality in Health Care* 28(2): 150-165.

Purpose Lean is a widely used quality improvement methodology initially developed and used in the automotive and manufacturing industries but recently expanded to the healthcare sector. This systematic literature review seeks to independently assess the effect of Lean or Lean interventions on worker and patient satisfaction, health and process outcomes, and financial costs. Data sources We conducted a systematic literature review of Medline, PubMed, Cochrane Library, CINAHL, Web of Science, ABI/Inform, ERIC, EMBASE and SCOPUS. Study selection Peer reviewed articles were included if they examined a Lean intervention and included quantitative data. Methodological quality was assessed using validated critical appraisal checklists. Publicly available data collected by the Saskatchewan Health Quality Council and the Saskatchewan Union of Nurses were also analysed and reported separately. Data extraction Data on design, methods, interventions and key outcomes were extracted and collated. Results of data synthesis Our electronic search identified 22 articles that passed methodological quality review. Among the accepted studies, 4 were exclusively concerned with health outcomes, 3 included both health and process outcomes and 15 included process outcomes. Our study found that Lean interventions have: (i) no statistically significant association with patient satisfaction and health outcomes; (ii) a negative association with financial costs and worker satisfaction and (iii) potential, yet inconsistent, benefits on process outcomes like patient flow and safety. Conclusion While some may strongly believe that Lean interventions lead to quality improvements in healthcare, the evidence to date simply does not support this claim. More rigorous, higher quality and better conducted scientific research is required to definitively ascertain the impact and effectiveness of Lean in healthcare settings.

Pollack, C. E., et al. (2016). "Measuring Care Continuity: A Comparison of Claims-based Methods." *Medical Care* 54(5): e30-e34.

Background: Assessing care continuity is important in evaluating the impact of health care reform and changes to health care delivery. Multiple measures of care continuity have been developed for use with claims data. Objective: This study examined whether alternative continuity measures provide distinct assessments of coordination within predefined episodes of care. Research Design and Subjects: This was a retrospective cohort study using 2008–2009 claims files for a national 5% sample of beneficiaries with congestive heart failure, chronic obstructive pulmonary disease, and diabetes mellitus. Measures: Correlations among 4 measures of care continuity—the Bice-Boxerman Continuity of Care Index, Herfindahl Index, usual provider of care, and Sequential Continuity of Care Index—were derived at the provider- and practice-levels. Results: Across the 3 conditions, results on 4 claims-based care coordination measures were highly correlated at the provider-level (Pearson correlation coefficient $r=0.87\text{--}0.98$) and practice-level ($r=0.75\text{--}0.98$). Correlation of the results was also high for the same measures between the provider- and practice-levels ($r=0.65\text{--}0.92$). Conclusions: Claims-based care continuity measures are all highly correlated with one another within episodes of care.

Watson, V., et al. (2016). "Discrete Choice Experiment Response Rates: A Meta-analysis." *Health Economics*: Ahead of print.

This paper uses meta-regression analysis to test how aspects of discrete choice experiment (DCE) study design influence survey response rates. DCEs are a survey-based method used to elicit preferences for health and health care and are prone to survey errors of coverage, sampling, non-response and measurement. However, research on DCE response rates is lacking. Our analysis is motivated by a social exchange theory of survey response. We find that DCE response rates are related to the survey's cognitive burden and the relevance to the surveyed population. Copyright © 2016 John Wiley & Sons, Ltd.

Politique de santé / Health Policy

Bréchot, C. (2016). "The Institut Pasteur International Network: a century-old global public health powerhouse." The Lancet: Ahead of print.

Casasuss, B. (2016). "Profile: Institut Pasteur, Paris, France." The Lancet. Ahead of print.

Hollande, F. (2016). "Towards a global agenda on health security." The Lancet: Ahead of print.

Milstein, R. et Blankart, C. R. (2016). "The Health Care Strengthening Act: The next level of integrated care in Germany." Health Policy **120(5): 445-451.**

?2015 Health Care Strengthening Act promotes the establishment of integrated care programs through a number of measures. An innovation fund totaling EUR 300 million annually has been established for start-up funding of innovative integrated care programs, and administrative barriers have been lowered. Germany has succeeded in creating a fruitful environment for integrated care programs but information on quality and costs of existing programs are often unavailable.

Scott, L. G., et al. (2016). "The New Political Economy of Health Care in the European Union: The Impact of Fiscal Governance." International Journal of Health Services **46(2): 262-282.**

We argue that the political economy of health care in the European Union is being changed by the creation of a substantial new apparatus of European fiscal governance. A series of treaties and legal changes since 2008 have given the European Union new powers and duties to enforce budgetary austerity in the member states, and this apparatus of fiscal governance has already extended to include detailed and sometimes coercive policy recommendations to member states about the governance of their health care systems. We map the structures of this new fiscal governance and the way it purports to affect health care decision making.

Sidibé, M. (2016). "Democratising the global health agenda: why we need France." The Lancet.

Prévision – Evaluation / Prevision - Evaluation

Cabrera-Barona, P., et al. (2016). "Multiscale evaluation of an urban deprivation index: Implications for quality of life and healthcare accessibility planning." Applied Geography **70: 1-10.**

Deprivation indices are widely used to identify areas characterized by above average social and/or material disadvantages. Especially spatial approaches have become increasingly popular since they enable decision makers to identify priority areas and to allocate their resources accordingly. An array of methods and spatial reporting units have been used to analyze and report deprivation in previous studies. However, a comparative analysis and assessment of the implications of the choice of the reporting unit for quality of life and health care accessibility planning is still missing. Based on a set of ten socioeconomic and health-related indicators, we constructed a weighted deprivation index for the urban area of Quito, Ecuador, using four different reporting units, including census blocks, census tracts, and two units based on the automatic zoning procedure (AZP). Spatial statistics and metrics are used to compare the resulting units, and a participatory expert-based approach is applied to evaluate their suitability for decision making processes. Besides structural differences regarding their size and shape, no strongly marked statistical or qualitative differences were found in the four analyzed spatial representations of deprivation. The four representations revealed similar spatial patterns of deprivation, with higher levels of deprivation in the peripheries of the city, especially in the southern and north-western parts. The study also suggests that census blocks, due to their fine spatial resolution, were considered most useful for quality of life and health care accessibility planning by local stakeholders.

Clegg, A., et al. (2016). "Development and validation of an electronic frailty index using routine primary care electronic health record data." Age and Ageing **45(3): 353-360.**

Background: frailty is an especially problematic expression of population ageing. International guidelines recommend routine identification of frailty to provide evidence-based treatment, but currently available tools require additional resource. Objectives: to develop and validate an electronic frailty index (eFI) using routinely available primary care electronic health record data. Study design and setting: retrospective cohort study. Development and internal validation cohorts were established using a randomly split sample of the ResearchOne primary care database. External validation cohort established using THIN database. Participants: patients aged 65–95, registered with a ResearchOne or THIN practice on 14 October 2008. Predictors: we constructed the eFI using the cumulative deficit frailty model as our theoretical framework. The eFI score is calculated by the presence or absence of individual deficits as a proportion of the total possible. Categories of fit, mild, moderate and severe frailty were defined using population quartiles. Outcomes: outcomes were 1-, 3- and 5-year mortality, hospitalisation and nursing home admission. Statistical analysis: hazard ratios (HRs) were estimated using bivariate and multivariate Cox regression analyses. Discrimination was assessed using receiver operating characteristic (ROC) curves. Calibration was assessed using pseudo-R² estimates. Results: we include data from a total of 931,541 patients. The eFI incorporates 36 deficits constructed using 2,171 CTV3 codes. One-year adjusted HR for mortality was 1.92 (95% CI 1.81–2.04) for mild frailty, 3.10 (95% CI 2.91–3.31) for moderate frailty and 4.52 (95% CI 4.16–4.91) for severe frailty. Corresponding estimates for hospitalisation were 1.93 (95% CI 1.86–2.01), 3.04 (95% CI 2.90–3.19) and 4.73 (95% CI 4.43–5.06) and for nursing home admission were 1.89 (95% CI 1.63–2.15), 3.19 (95% CI 2.73–3.73) and 4.76 (95% CI 3.92–5.77), with good to moderate discrimination but low calibration estimates. Conclusions: the eFI uses routine data to identify older people with mild, moderate and severe frailty, with robust predictive validity for outcomes of mortality, hospitalisation and nursing home admission. Routine implementation of the eFI could enable delivery of evidence-based interventions to improve outcomes for this vulnerable group.

Goodwin, E. et Green, C. (2016). "A Systematic Review of the Literature on the Development of Condition-Specific Preference-Based Measures of Health." *Appl Health Econ Health Policy* 14(2): 161-183.

BACKGROUND: Health state utility values (HSUVs) are required to calculate quality-adjusted life-years (QALYs). They are frequently derived from generic preference-based measures of health. However, such generic measures may not capture health attributes of relevance to specific conditions. In such cases, a condition-specific preference-based measure (CSPBM) may be more appropriate. OBJECTIVE: This systematic review aimed to identify all published accounts of developing CSPBMs to describe and appraise the methods used. METHOD: We undertook a systematic search (of Embase, MEDLINE, PsycINFO, Web of Science, the Cochrane Library, CINAHL, EconLit, ASSIA and the Health Management Information Consortium database) to identify published accounts of CSPBM development up to July 2015. Studies were reviewed to investigate the methods used to design classification systems, estimate HSUVs, and validate the measures. RESULTS: A total of 86 publications were identified, describing 51 CSPBMs. Around two-thirds of these were QALY measures; the remainder were designed for clinical decision making only. Classification systems for 33 CSPBMs were derived from existing instruments; 18 were developed de novo. HSUVs for 34 instruments were estimated using a 'composite' approach, involving statistical modelling; the remainder used a 'decomposed' approach based on multi-attribute utility theory. Half of the papers that described the estimation of HSUVs did not report validating their measures. CONCLUSION: Various methods have been used at all stages of CSPBM development. The choice between developing a classification system de novo or from an existing instrument may depend on the availability of a suitable existing measure, while the choice between a decomposed or composite approach appears to be determined primarily by the purpose for which the instrument is designed. The validation of CSPBMs remains an area for further development.

Psychiatrie / Psychiatry

Joubert, F., et al. (2016). "Hospitalisations sans consentement en psychiatrie : analyse comparative

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chez les personnes résidant ou non en zones urbaines sensibles." *Santé Publique* **28**(1): 61-69.
Cairn : <https://www.cairn.info/revue-sante-publique-2016-1-page-61.htm>

Soins de santé primaires / Primary Health Care

Chiu, H.-C., et al. (2016). "Patient assessment of diabetes care in a pay-for-performance program."

International Journal for Quality in Health Care **28**(2): 183-190.

Objective Few studies address quality of care in pay-for-performance (P4P) programs from the perspective of patients' perceptions. This study aimed to examine and compare the patient assessment of diabetes chronic care as perceived by diabetic patients enrolled and not enrolled in a P4P program from the patients' self-reported perspectives. Design A cross-sectional study with case and comparison group design. Setting A large-scale survey was conducted from February to November 2013 in 18 healthcare institutions in Taiwan. Participants A total of 1458 P4P (n = 1037) and non-P4P (n = 421) diabetic patients participated in this large survey. The Chinese version of the Patient Assessment of Chronic Illness Care (PACIC) instrument was used and patients' clinical outcome data (e.g. HbA1c, LDL) were collected. Intervention None. Main Outcome Measures Five subscales from the PACIC were measured, including patient activation, delivery system design/system support, goal setting/tailoring, problem solving/contextual and follow-up/coordination. Patient clinical outcomes were also measured. Multiple linear regression and logistic regression models were used and controlled for patient demographic and health institution characteristics statistically. Results After adjusting for covariates, P4P patients had higher overall scores on the PACIC and five subscales than non-P4P patients. P4P patients also had better clinical processes of care (e.g. HbA1c test) and intermediate outcomes. Conclusions Patients who participated in the program likely received better patient-centered care given the original Chronic Care Model. Better perceptions of diabetic care assessment also better clinical outcomes. The PACIC instrument can be used for the patient assessment of chronic care in a P4P program.

Julio, H.-M., et al. (2016). "Health Care Austerity Measures in Times of Crisis: The Perspectives of Primary Health Care Physicians in Madrid, Spain." International Journal of Health Services **46**(2): 283-299.

The current financial crisis has seen severe austerity measures imposed on the Spanish health care system, including reduced public spending, copayments, salary reductions, and reduced services for undocumented migrants. However, the impacts have not been well-documented. We present findings from a qualitative study that explores the perceptions of primary health care physicians in Madrid, Spain. This article discusses the effects of austerity measures implemented in the public health care system and their potential impacts on access and utilization of primary health care services. This is the first study, to our knowledge, exploring the health care experiences during the financial crisis of general practitioners in Madrid, Spain. The majority of participating physicians disapproved of austerity measures implemented in Spain. The findings of this study suggest that undocumented migrants should regain access to health care services; copayments should be minimized and removed for patients with low incomes; and health care professionals should receive additional help to avoid burnout. Failure to implement these measures could result in the quality of health care further deteriorating and could potentially have long-term negative consequences on population health.

McWilliams, J. M., et al. (2016). "Early Performance of Accountable Care Organizations in Medicare." New England Journal of Medicine **0**(0): null.

O'Donnell, C. A., et al. (2016). "Reducing the health care burden for marginalised migrants: The potential role for primary care in Europe." Health Policy **120**(5): 495-508.

Increasing diversity and numbers of marginalised migrants a feature across Europe. Entitlement to care, access and use of co-payments add to their care seeking burden. Strong primary care systems may mitigate that burden. External forces, such as austerity, must not be allowed to reduce migrant's

access to primary care. Policies improving entitlement and reducing the impact of financial burdens could improve access to primary care for migrants.

Rechel, B., et al. (2016). "Public reporting on quality, waiting times and patient experience in 11 high-income countries." *Health Policy* 120(4): 377-383.

Public reporting of waiting times and patient experience are common. Composite measures of quality of hospital care are only used in one of 11 countries. Reporting of outcomes of individual physicians is also uncommon.

Systèmes de santé / Health Systems

Baron, E. (2016). "Liberté;égalité, fraternité et santé." *The Lancet*: head of print.

Barros, P. P., et al. (2016). "Competition among health care providers: helpful or harmful?" *Eur J Health Econ* 17(3): 229-233.

Delfraissy, J.-F., et al. (2016). "REACTing: the French response to infectious disease crises." *The Lancet*.

Horton, R. et Ceschia, A. (2016). "France: a philosophy for health." *The Lancet*.

Toth, F. (2016). "Classification of healthcare systems: Can we go further?" *Health Policy* 120(5): 535-543.

A new framework to classify healthcare systems is presented. A distinction can be made between integrated and separated provision systems. There are no pure systems: all national healthcare systems are hybrids. Healthcare systems are segmented according to various criteria.

Travail et santé / Occupational Health

Andersen, I., et al. (2016). "Increasing illness among people out of labor market – A Danish register-based study." *Social Science & Medicine* 156: 21-28.

In spite of decades of very active labor market policies, 25% of Denmark's population in the working ages are still out-of-work. The aim of this study was to investigate whether that is due to consistent or even increasing prevalence of ill health. For the period of 2002–2011, we investigated if i) the prevalence of four chronic diseases (cardiovascular disease, diabetes, cancer and mental disorders) among those out-of-work had changed, ii) the occurrence of new cases of those diseases were higher among those who were already out-of-work, or iii) if non-health-related benefits were disproportionately given to individuals recently diagnosed with a disease compared to those without disease. The study was register-based and comprised all Danish residents aged 20–60. During the study period, the prevalence of cardiovascular diseases and mental disorders increased among both employed and non-employed people. The increased prevalence for mental disorder was particularly high among people receiving means-tested benefits. Disease incidence was higher among people outside rather than inside the labor market, especially for mental disorders. Employed people with incident diseases had an unsurprisingly increased risk of leaving the labor market. However, a high proportion of people with incident mental disorders received low level means-tested benefits in the three years following this diagnosis, which is concerning. Men treated for mental disorders in 2006 had high excess probability of receiving a cash-benefit, OR = 4.83 (4.53–5.14) for the period 2007–2010. The estimates were similar for women.

Pandey, J. et Singh, M. (2016). "Donning the mask: effects of emotional labour strategies on burnout and job satisfaction in community healthcare." *Health Policy and Planning* 31(5): 551-562.

Emotional labour involves management of one's emotions to match the demands of their roles. This emotion display involves just expression (surface-level emotional labour) or experience in addition to expression (deep-level emotional labour) of the desired emotions. Emotional labour is required in the effective, efficient and successful healthcare service delivery. Burnout associated with emotional labour is an important factor that decides how satisfied frontline service providers with their job are. This empirical study investigates the link between surface and deep-level emotional labour, burnout and job satisfaction in women community health workers from India. Our results from the structural equation modelling of 177 accredited social health activists (ASHAs) indicate a negative relation between surface and deep-level emotional labour, clearly demarcating them as two different strategies for performance of emotional labour in community health care setting. Surface-level emotional labour is associated with higher job satisfaction, and burnout partially mediates this relation. Deep-level emotional labour is associated with lower job satisfaction; burnout fully mediates this relation. Qualitative post hoc analysis based on interviews of 10 ASHAs was done to understand the findings of the quantitative study. Surface-level emotional labour was found to be a more desirable strategy for community health care workers for the effective and efficient performance of their work roles. Our results have a significant contribution to design, redesign, and improvement of employment practices in community healthcare. This study brings forth the neglected issues of emotions and their implications for these healthcare workers in low and middle-income countries who are a vital link that delivers healthcare to weaker section of the society. The findings have relevance not merely for the individual providing this service but the beneficiary and the organization that facilitates this delivery. Interventions based on demographic, community, national and occupational factors have also been presented.

Vieillissement / Ageing

Brooks-Carthon, J. M., et al. (2016). "Unmet Nursing Care Linked to Rehospitalizations Among Older Black AMI Patients: A Cross-Sectional Study of US Hospitals." *Medical Care* 54(5): 457-465.

Background: Recent studies suggest that nurses may be unable to complete all aspects of necessary care due to a lack of time. Research is needed to determine whether unmet nursing care contributes to disparities in readmissions for vulnerable populations. **Objectives:** To examine differences in the relationship between nursing care left undone and acute myocardial infarction readmissions among older black patients compared with older white patients. **Research Design:** Cross-sectional analysis of multiple datasets, including: 2006 to 2007 administrative discharge data, a survey of registered nurses, and the American Hospital Association Annual Survey. Risk-adjusted logistic regression models were used to estimate the association between care left undone and 30-day readmission. Interactions were used to examine the moderating effect of care left undone on readmission by race. **Results:** The sample included 69,065 patients in 253 hospitals in California, New Jersey, and Pennsylvania. Older black patients were 18% more likely to experience a readmission after adjusting for patient and hospital characteristics and more likely to be in hospitals where nursing care was often left undone. Black patients were more likely to be readmitted when nurses were unable to talk/comfort patients [odds ratio (OR), 1.09; 95% confidence interval (CI), 1.01–1.19], complete documentation (OR, 1.16; 95% CI, 1.01–1.32), or administer medications in a timely manner (OR, 1.26; 95% CI, 1.09–1.46). **Conclusions:** Unmet nursing care is associated with readmissions for older black patients following acute myocardial infarction. Investment in nursing resources to improve the delivery of nursing care may decrease disparities in readmission.