

**Reproduction sur d'autres sites interdite mais lien vers le document accepté :**  
<http://www.irdes.fr/documentation/veille-bibliographique-en-economie-de-la-sante.html>

**Any and all reproduction is prohibited but direct link to the document is accepted:**  
<http://www.irdes.fr/english/documentation/watch-on-health-economics-literature.html>

## DOC VEILLE

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

**4 décembre 2015 / December the 4th, 2015**

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/documentation/veille-bibliographique-en-economie-de-la-sante.html>

Produced by the Irdes documentation centre, Doc Veille, a bimonthly publication, presents by theme the latest articles and reports in health economics: both peer-reviewed and grey literature.

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/english/documentation/watch-on-health-economics-literature.html>

#### Contacts

Espace documentation : [documentation@irdes.fr](mailto:documentation@irdes.fr)  
Marie-Odile Safon : [safon@irdes.fr](mailto:safon@irdes.fr)  
Véronique Suhard : [suhard@irdes.fr](mailto:suhard@irdes.fr)

## Sommaire

<b>Assurance maladie / Health Insurance .....</b>	<b>7</b>
Boes, S. and M. Gerfin (2015). "Does Full Insurance Increase the Demand for Health Care?" .....	7
Franc, C., et al. (2015). "Supplemental Health Insurance and Healthcare Consumption—A Dynamic Approach to Moral Hazard." .....	7
Ghai, M. (2015). "A model for universal social security coverage: The experience of the BRICS countries." .....	7
<b>Economie de la santé / Health Economics.....</b>	<b>7</b>
Wang, F. (2015). "More Health Expenditure, Better Economic Performance? Empirical Evidence From OECD Countries." .....	7
Zweifel, P. (2015). "Rationing of health care: is there an economic rationality to it?" .....	8
<b>Etat de santé / Health Status.....</b>	<b>8</b>
Antonakakis, N. and A. Collins (2015). "The impact of fiscal austerity on suicide mortality: Evidence across the 'Eurozone periphery'." .....	8
Barlow, P., et al. (2015). "Austerity, precariousness, and the health status of Greek labour market participants: Retrospective cohort analysis of employed and unemployed persons in 2008-2009 and 2010-2011." .....	8
<b>Géographie de la santé / Geography of Health.....</b>	<b>9</b>
Foley, R. and T. Kistemann (2015). "Blue space geographies: Enabling health in place." ..	9
Lin, S. W., et al. (2015). "New indices for home nursing care resource disparities in rural and urban areas, based on geocoding and geographic distance barriers: a cross-sectional study." .....	9
Santana, P., et al. (2015). "Suicide in Portugal: Spatial determinants in a context of economic crisis." .....	10
Tatalovich, Z., et al. (2015). "Geographic disparities in late stage breast cancer incidence: results from eight states in the United States." .....	10
Yasaitis, L. C., et al. (2015). "Comparison of estimation methods for creating small area rates of acute myocardial infarction among Medicare beneficiaries in California." .....	10
<b>Hôpital / Hospitals .....</b>	<b>11</b>
Basu, J., et al. (2015). "Hospital Readmission Rates in U.S. States: Are Readmissions Higher Where More Patients with Multiple Chronic Conditions Cluster?" .....	11

Clark, D. E., et al. (2015). "A Multistate Model Predicting Mortality, Length of Stay, and Readmission for Surgical Patients." .....	11
Dugan, J. (2015). "Trends in Managed Care Cost Containment: An Analysis of the Managed Care Backlash." .....	11
Escobar, G. J., et al. (2015). "Nonelective Rehospitalizations and Postdischarge Mortality: Predictive Models Suitable for Use in Real Time." .....	11
Garcia-Villar, J. and A. Lopez-Nicolas (2015). "Who is afraid of smoking bans? An evaluation of the effects of the Spanish clean air law on expenditure at hospitality venues." .....	12
Kmietowicz, Z. (2015). "Emergency care specialists renew call for out-of-hours services to be located in hospitals." .....	12
(2015/08-09). "Les nouveaux territoires de l'hôpital : dossier." .....	12
<b>Inégalités de santé / Health Inequalities.....</b>	<b>12</b>
Bouchard, L., et al. (2015). "Corrigendum to 'Research on health inequalities: A bibliometric analysis (1966–2014)'.....	12
Bouchard, L., et al. (2015). "Research on health inequalities: A bibliometric analysis (1966–2014)." .....	12
Callander, E. J. and D. J. Schofield (2015). "Multidimensional Poverty and Health Status as a Predictor of Chronic Income Poverty." .....	13
Jutz, R. (2015). "The role of income inequality and social policies on income-related health inequalities in Europe." .....	13
Knapp, M. (2015). "Reflecting on 'An economic model of social capital and health'." .....	13
Newbold, K. B. and D. Simone (2015). "Comparing disability amongst immigrants and native-born in Canada." .....	13
Ro, A. and G. Bostean (2015). "Duration of U.S. stay and body mass index among Latino and Asian immigrants: A test of theoretical pathways." .....	14
<b>Médicaments / Pharmaceuticals.....</b>	<b>14</b>
(2015). "Prescription informatisée : quelle sécurité ?" .....	14
Aidan, H. and G. Paul (2015). "Canada's New Generic Pricing Policy: A Reasoned Approach to a Challenging Problem." .....	14
Gidengil, C. A., et al. (2015). "The Volume-Quality Relationship in Antibiotic Prescribing: When More Isn't Better." .....	14
Neena, L. C. and J. H. Marcus (2011). "An Evidence-Based Policy Prescription for an Aging Population." .....	15

Van der Wardt, V. (2015). "Should guidance for the use of antihypertensive medication in older people with frailty be different?" .....	15
Wilmoth, D. R. (2015). "Reconciling Estimates of the Value to Firms of Reduced Regulatory Delay in the Marketing of Their New Drugs." .....	15
<b>Méthodologie – Statistique / Methodology - Statistics .....</b>	<b>15</b>
Batinti, A. (2015). "On Medical Progress and Health Care Demand: A Ces Perspective Using the Grossman Model of Health Status." .....	15
Stevenson, A. and A. Roberts (2015)? "Estimating Lifetime Costs of Social Care. A Bayesian Approach. using Linked Administrative Datasets from three Geographical Areas." .....	16
Valente, T. W., et al. (2015). "Diffusion of innovations theory applied to global tobacco control treaty ratification." .....	16
<b>Politique de santé / Health Policy .....</b>	<b>16</b>
Gilbert, R., et al. (2015). "The market in healthcare data." BMJ 351. ....	16
Girerd-Genessay, I. and P. Michel (2015). "[Should we establish patient safety leadership walkrounds? A systematic review]." .....	17
Torun, P., et al. (2015). "Can health indicators help policy-makers? Experience from European system of urban health indicators (EURO-URHIS)." .....	17
Ugur, Z. B. (2015). "Does Presumed Consent Save Lives? Evidence from Europe." .....	17
Zelmer, J. (2015). "From Global to Local: Inequalities in Health and Healthcare." .....	17
<b>Prévision - Evaluation .....</b>	<b>18</b>
Krol, M. and W. Brouwer (2015). "Unpaid work in health economic evaluations." .....	18
<b>Prévention / Prevention .....</b>	<b>18</b>
Garbacz (L.), J. Y., Alla (F.), et al. (2015). "Impact de l'éducation thérapeutique sur les habitudes de vie : perception des patients et de leurs proches." .....	18
Schwarz, J. L., et al. (2015). "Development and Psychometric Assessment of the Healthcare Provider Cultural Competence Instrument." .....	18
Carson S.R. and S. Tara (2014). "A Novel Community-Based Model to Enhance Health Promotion, Risk Factor Management and Chronic Disease Prevention." .....	18
<b>Psychiatrie / Psychiatry.....</b>	<b>19</b>
Golberstein, E. and G. Gonzales (2015). "The Effects of Medicaid Eligibility on Mental Health Services and Out-of-Pocket Spending for Mental Health Services." .....	19

Wykes, T., et al. "Mental health research priorities for Europe." .....	19
<b>Soins de santé primaires / Primary Health Care.....</b>	<b>19</b>
Atella, V. and F. d'Amico (2015). "Who is responsible for your health: is it you, your doctor or the new technologies?" .....	19
Dusheiko, M., et al. (2015). "Quality of Disease Management and Risk of Mortality in English Primary Care Practices." .....	20
Kmietowicz, Z. (2015). "Primary care commissioners need five year budgets to transform care, says report." .....	20
Lugo-Palacios, D. G. and J. Cairns (2015). "Using ambulatory care sensitive hospitalisations to analyse the effectiveness of primary care services in Mexico." .....	20
Pruvot (J.), C. M., Dambricourt (P.A.), et al. (2015). "Influence du médecin généraliste dans la promotion du primo-don du sang chez les patients.".....	20
Pruvot, J., et al. (2015). "[Non-donor patients' opinions about general practitioners' influence on first blood donation]." .....	20
Rosenthal, M. B., et al. (2015). "Impact of the Rochester Medical Home Initiative on Primary Care Practices, Quality, Utilization, and Costs." .....	21
Schmid, C. (2015). "Consumer Health Information and the Demand for Physician Visits."21	
<b>Systèmes de santé / Health Systems .....</b>	<b>21</b>
Caswell, K. J. and S. K. Long (2015). "The Expanding Role of Managed Care in the Medicaid Program: Implications for Health Care Access, Use, and Expenditures for Nonelderly Adults." .....	21
Ham, C. (2015). "The three crises facing the NHS in England." .....	22
Liaropoulos, L. and I. Goranitis (2015). "Health care financing and the sustainability of health systems.".....	22
Sommers, B. D. "Health Care Reform's Unfinished Work — Remaining Barriers to Coverage and Access.".....	22
<b>Travail et santé / Occupational Health .....</b>	<b>22</b>
Givord, P. and C. Marbot (2015). .....	22
Kivimäki, M., et al. "Long working hours and risk of coronary heart disease and stroke: a systematic review and meta-analysis of published and unpublished data for 603 838 individuals.".....	23
<b>Vieillissement / Ageing .....</b>	<b>23</b>

Andrew, V. W. (2011). "Population Pressures, System-Level Inertia and Healthy Aging Policy Revisited." .....	23
George, A. H. (2011). "Integrated Care for the Frail Elderly." .....	23
Margaret, M. (2011). "Is It Time to Implement a Value-for-Money Approach in Healthcare of the Elderly?" .....	23
Widagdo, I. S., et al. (2015). "Predictive performance of four frailty measures in an older Australian population." .....	23

## Assurance maladie / Health Insurance

**Boes, S. and M. Gerfin (2015). "Does Full Insurance Increase the Demand for Health Care?"** *Health Economics, Ahead of print*

We estimate the causal impact of having full health insurance on healthcare expenditures. We take advantage of a unique quasi-experimental setup in which deductibles and co-payments were zero in a managed care plan and nonzero in regular insurance, until a policy change forced all individuals with an active plan to cover a minimum amount of their expenses. Using panel data and a nonlinear difference-in-differences strategy, we find a demand elasticity of about -0.14 comparing full insurance with the cost-sharing model and a significant upward shift in the likelihood to generate costs.

Copyright © 2015 John Wiley & Sons, Ltd.

**Franc, C., et al. (2015). "Supplemental Health Insurance and Healthcare Consumption—A Dynamic Approach to Moral Hazard."** *Health Economics, Ahead of print*

We analyze the existence and persistence of moral hazard over time to test the assumption of pent-up demand. We consider the effects of supplemental health insurance provided by a private insurer when added to compulsory public insurance that is already supplemented by private insurance. Using original panel data from a French mutuelle, we study the influence of insurance on all of the dimensions of healthcare expenditures: (1) the probability of using health care, (2) the number of uses conditional on use, and (3) the per unit cost of care. To conduct this study, we control, to the extent possible, for endogeneity because of adverse selection using the characteristics of our panel data. Our study allows us to confirm a positive and significant effect of the extra complementary health insurance on healthcare consumption, primarily in terms of the probability of using care. More interestingly, our results show that these effects are principally transitory mainly for the probability of using dental care and optical care and depend on income. Finally, we show that individuals did not postpone health care before enrollment. Copyright © 2015 John Wiley & Sons, Ltd.

**Ghai, M. (2015). "A model for universal social security coverage: The experience of the BRICS countries."** *International Social Security Review* 68(3): 99-118.

Un modèle de couverture de sécurité sociale universelle: l'expérience des pays du groupe BRICS Les pays du groupe BRICS ont réalisé des progrès importants en matière d'extension de la sécurité sociale. Cependant, beaucoup reste à faire avant d'atteindre l'objectif d'une sécurité sociale universelle complète. En se fondant sur l'expérience des politiques menées par les pays du groupe BRICS, l'article explore de quelle manière il est possible d'utiliser les dispositifs actuels de sécurité sociale pour élaborer des politiques efficaces visant à l'universalisation de la sécurité sociale. Les grands principes d'un cadre visant à combler le déficit de couverture sociale y sont identifiés. Ces principes sont ensuite mis en relation de façon à la fois complémentaire et additionnelle afin de développer un cadre permettant d'élaborer des politiques pour combler les lacunes et parvenir à une sécurité sociale qui soit universelle.

## Economie de la santé / Health Economics

**Wang, F. (2015). "More Health Expenditure, Better Economic Performance? Empirical Evidence From OECD Countries."** *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 52.

Recent economic downturns have led many countries to reduce health spending dramatically, with the World Health Organization raising concerns over the effects of this, in particular among the poor and vulnerable. With the provision of appropriate health care, the population of a country could have better health, thus strengthening the nation's human capital, which could contribute to economic growth through improved productivity. How much should countries spend on health care? This study aims to estimate the optimal health care expenditure in a growing economy. Applying the experiences

of countries from the Organization for Economic Co-Operation and Development (OECD) over the period 1990 to 2009, this research introduces the method of system generalized method of moments (GMM) to derive the design of the estimators of the focal variables. Empirical evidence indicates that when the ratio of health spending to gross domestic product (GDP) is less than the optimal level of 7.55%, increases in health spending effectively lead to better economic performance. Above this, more spending does not equate to better care. The real level of health spending in OECD countries is 5.48% of GDP, with a 1.87% economic growth rate. The question which is posed by this study is a pertinent one, especially in the current context of financially constrained health systems around the world. The analytical results of this work will allow policymakers to better allocate scarce resources to achieve their macroeconomic goals.

**Zweifel, P. (2015). "Rationing of health care: is there an economic rationality to it?"** *Eur J Health Econ* 16(8): 797-800.

The point of departure of this Editorial is the fact that we all are engaged in self-rationing in our everyday lives. We would like to spend more money on all sorts of nice things and devote more time to our cherished activities. Imposed rationing is characteristic of wartime governments, who seek to prevent the rich from gobbling up the resources left by the army. Since the publication in 1987 of David Callahan's Setting Limits: Medical Goals in an Aging Society (Callahan, Setting limits: medical goals in an aging society, Simon & Schuster, New York, 1987), rationing of health care has become a widely debated issue (the Internet is full of pertinent entries). While rationing has also been addressed by health economists, there are three puzzling observations. First, Callahan (Callahan, Setting limits: medical goals in an aging society, Simon & Schuster, New York, 1987) wrote for an American audience whereas rationing was introduced by the British National Health Service (NHS) well before 1987, with little debate. Second, the economic theory of rationing had been laid out by James Tobin [Ectrical 20(4): 521-533, 1952] as early as 1952-but health economists seem to have neglected his groundwork when writing about rationing. Third, they accept government-imposed rationing as inevitable in the case of health care, as though the self-rationing alternative was unavailable. An attempt is made here to provide rational explanations for these puzzles.

## Etat de santé / Health Status

**Antonakakis, N. and A. Collins (2015). "The impact of fiscal austerity on suicide mortality: Evidence across the 'Eurozone periphery'."** *Social Science & Medicine* 145: 63-78.

While linkages between some macroeconomic phenomena and suicides in some countries have been explored, only two studies, hitherto, have established a causal relationship between fiscal austerity and suicide, albeit in a single country. The aim of this study is to provide the first systematic multiple-country evidence of a causal relationship of fiscal austerity on time-, gender-, and age-specific suicide mortality across five Eurozone peripheral countries, namely Greece, Ireland, Italy, Portugal and Spain over the period 1968–2012, while controlling for various socioeconomic differences. The impact of fiscal adjustments is found to be gender-, age- and time-specific. Specifically, fiscal austerity has short-, medium- and long-run suicide increasing effects on the male population in the 65–89 age group. A 1% reduction in government spending is associated with a 1.38%, 2.42% and 3.32% increase in the short-, medium- and long-run, respectively, of male suicides rates in the 65–89 age group in the Eurozone periphery. These results are highly robust to alternative measures of fiscal austerity. Improved labour market institutions help mitigate the negative effects of fiscal austerity on suicide mortality.

**Barlow, P., et al. (2015). "Austerity, precariousness, and the health status of Greek labour market participants: Retrospective cohort analysis of employed and unemployed persons in 2008-2009 and 2010-2011."** *J Public Health Policy* 36(4): 452-468.

Greece implemented the deepest austerity package in Europe during the Great Recession (from 2008), including reductions in severance pay and redundancy notice periods. To evaluate whether these

measures worsened labour market participants' health status, we compared changes in self-reported health using two cohorts of employed individuals in Greece from the European Union Statistics on Income and Living Conditions. During the initial recession (2008-2009) we found that self-reported health worsened both for those remaining in employment and those who lost jobs. Similarly, during the austerity programme (2010-2011) people who lost jobs experienced greater health declines. Importantly, individuals who remained employed in 2011 were also 25 per cent more likely to experience a health decline than in 2009. These harms appeared concentrated in people aged 45-54 who lost jobs. Our study moves beyond existing findings by demonstrating that austerity both exacerbates the negative health consequences of job loss and worsens the health of those still employed.

## Géographie de la santé / Geography of Health

**Foley, R. and T. Kistemann (2015). "Blue space geographies: Enabling health in place."** *Health Place* **35:** 157-165.

Drawing from research on therapeutic landscapes and relationships between environment, health and wellbeing, we propose the idea of 'healthy blue space' as an important new development. Complementing research on healthy green space, blue space is defined as; 'health-enabling places and spaces, where water is at the centre of a range of environments with identifiable potential for the promotion of human wellbeing'. Using theoretical ideas from emotional and relational geographies and critical understandings of salutogenesis, the value of blue space to health and wellbeing is recognised and evaluated. Six individual papers from five different countries consider how health can be enabled in mixed blue space settings. Four sub-themes; embodiment, inter-subjectivity, activity and meaning, document multiple experiences within a range of healthy blue spaces. Finally, we suggest a considerable research agenda - theoretical, methodological and applied - for future work within different forms of blue space. All are suggested as having public health policy relevance in social and public space.

**Lin, S. W., et al. (2015). "New indices for home nursing care resource disparities in rural and urban areas, based on geocoding and geographic distance barriers: a cross-sectional study."** *Int J Health Geogr* **14(1):** 28.

**BACKGROUND:** Aging in place is the crucial object of long-term care policy worldwide. Approximately 15.6-19.4 % of people aged 15 or above live with a disability, and 15.3 % of them have moderate or severe disabilities. The allocation of home nursing care services is therefore an important issue. Service providers in Taiwan vary substantially across regions, and between rural and urban areas. There are no appropriate indices for describing the capacity of providers that it is due to the distances from care recipients. This study therefore aimed to describe and compare distance barriers for home nursing care providers using indices of the "profit willing distance" and the "tolerance limited distance". **METHODS:** This cross-sectional study was conducted during 2012 and 2013 using geocoding and a geographic information system to identify the distance from the providers' locations to participants' homes in urban (Taipei City) and rural (Hualien County) areas in Taiwan. Data were collected in-person by professionals in Taiwanese hospitals using the World Health Organization Disability Assessment Schedule 2.0. The indices were calculated using regression curves, and the first inflection points were determined as the points on the curves where the first and second derivatives equaled 0. **RESULTS:** There were 5627 participants from urban areas and 956 from rural areas. In urban areas, the profit willing distance was 550-600 m, and we were unable to identify them in rural areas. This demonstrates that providers may need to supply services even when there is little profit. The tolerance limited distance were 1600-1650 m in urban areas and 1950-2000 m in rural areas. In rural areas, 33.3 % of those living inside the tolerance limited distance and there was no provider within this distance, but this figure fell to just 13.9 % in urban areas. There were strong disparities between urban and rural areas in home nursing care resource allocation. **CONCLUSIONS:** Our new "profit willing distance" and the "tolerance limited distance" are considered to be clearer and more equitable than other evaluation indices. They have practical application in considering resource

distribution issues around the world, and in particular the rural-urban disparities for public resource.

**Santana, P., et al. (2015). "Suicide in Portugal: Spatial determinants in a context of economic crisis."** *Health Place* 35: 85-94.

This study compares the existing statistical association between suicide mortality and the characteristics of places of residence (municipalities), before and during the current economic crisis, in Portugal. We found that (1) the traditional culture-based North/South pattern of suicidal behaviour has faded away, while the socioeconomic urban/rural divide has become more pronounced; (2) suicide is associated with higher levels of rurality and material deprivation; and (3) recent shifts in suicidal trends may result from the current period of crisis. Strategies targeting rural areas combined with public policies that address area deprivation may have important implications for tackling suicide.

**Tatalovich, Z., et al. (2015). "Geographic disparities in late stage breast cancer incidence: results from eight states in the United States."** *Int J Health Geogr* 14(1): 31.

**BACKGROUND:** Late stage of cancer at diagnosis is an important predictor of cancer mortality. In many areas worldwide, cancer registry systems, available data and mapping technologies can provide information about late stage cancer by geographical regions, offering valuable opportunities to identify areas where further investigation and interventions are needed. The current study examined geographical variation in late stage breast cancer incidence across eight states in the United States with the objective to identify areas that might benefit from targeted interventions. **METHODS:** Data from the Surveillance Epidemiology and End Results Program on late stage breast cancer incidence was used as dependent variable in regression analysis and certain factors known to contribute to high rates of late stage cancer (socioeconomic characteristics, health insurance characteristics, and the availability and utilization of cancer screening) as covariates. Geographic information systems were used to map and highlight areas that have any combination of high late stage breast cancer incidence and significantly associated risk factors. **RESULTS:** The differences in mean rates of late stage breast cancer between eight states considered in this analysis are statistically significant. Factors that have statistically negative association with late stage breast cancer incidence across the eight states include: density of mammography facilities, percent population with Bachelor's degree and English literacy while percent black population has statistically significant positive association with late stage breast cancer incidence. **CONCLUSIONS:** This study describes geographic disparities in late stage breast cancer incidence and identifies areas that might benefit from targeted interventions. The results suggest that in the eight US states examined, higher rates of late stage breast cancer are more common in areas with predominantly black population, where English literacy, percentage of population with college degree and screening availability are low. The approach described in this work may be utilized both within and outside US, wherever cancer registry systems and technologies offer the same opportunity to identify places where further investigation and interventions for reducing cancer burden are needed.

**Yasaitis, L. C., et al. (2015). "Comparison of estimation methods for creating small area rates of acute myocardial infarction among Medicare beneficiaries in California."** *Health Place* 35: 95-104.

Creating local population health measures from administrative data would be useful for health policy and public health monitoring purposes. While a wide range of options - from simple spatial smoothers to model-based methods - for estimating such rates exists, there are relatively few side-by-side comparisons, especially not with real-world data. In this paper, we compare methods for creating local estimates of acute myocardial infarction rates from Medicare claims data. A Bayesian Monte Carlo Markov Chain estimator that incorporated spatial and local random effects performed best, followed by a method-of-moments spatial Empirical Bayes estimator. As the former is more complicated and time-consuming, spatial linear Empirical Bayes methods may represent a good alternative for non-specialist investigators.

## Hôpital / Hospitals

**Basu, J., et al. (2015). "Hospital Readmission Rates in U.S. States: Are Readmissions Higher Where More Patients with Multiple Chronic Conditions Cluster?"** *Health Services Research*: Ahead of print.

**Research Objective** This study examines small area variations in readmission rates to assess whether higher readmission rate in an area is associated with higher clusters of patients with multiple chronic conditions. **Study Design** The study uses hospital discharge data of adult (18+) patients in 6 U.S. states for 2009 from the Healthcare Cost and Utilization Project of the Agency for Healthcare Research and Quality, linked to contextual and provider data from Health Resources and Services Administration. A multivariate cross sectional design at primary care service area (PCSA) level is used. **Principal Findings** Adjusting for area characteristics, the readmission rates were significantly higher in PCAs having higher proportions of patients with 2–3 chronic conditions and those with 4+ chronic conditions, compared with areas with a higher concentration of patients with 0–1 chronic conditions. **Conclusions** Using small area analysis, the study shows that areas with higher concentration of patients with increased comorbid conditions are more likely to have higher readmission rates.

**Clark, D. E., et al. (2015). "A Multistate Model Predicting Mortality, Length of Stay, and Readmission for Surgical Patients."** *Health Services Research*: Ahead of print.

**Objective** Simultaneously evaluate postoperative mortality, length of stay (LOS), and readmission. **Data Source** National Surgical Quality Improvement Program (NSQIP). **Design** Retrospective cohort. **Methods** Data from elective general surgical patients were obtained from the 2012 NSQIP Participant Use File. For each postoperative day, each patient's state was classified as index hospitalization, discharged home, discharged to long-term care (LTC), readmitted, or dead. Transition rates were estimated using exponential regression, assuming constant rates for specified time periods. These estimates were combined into a multistate model, simulated results of which were compared to observed outcomes. **Findings** Age, comorbidities, more complex procedures, and longer index LOS were associated with lower rates of discharge home and higher rates of death, discharge to LTC, and readmission. The longer patients had been discharged, the less likely they were to die or be readmitted. The model predicted 30-day mortality 0.38 percent (95 percent CI: 0.36–0.41), index LOS 2.85 days (95 percent CI: 2.83–2.86), LTC discharge 2.76 percent (95 percent CI: 2.69–2.82), and readmissions 5.53 percent (95 percent CI: 5.43–5.62); observed values were 0.39 percent, 2.82 days, 2.87 percent, and 5.70 percent, respectively. **Conclusions** Multistate models can simultaneously predict postoperative mortality, LOS, discharge destination, and readmissions, which allows multidimensional comparison of surgical outcomes.

**Dugan, J. (2015). "Trends in Managed Care Cost Containment: An Analysis of the Managed Care Backlash."** *Health Economics* 24(12): 1604-1618.

Consumer dissatisfaction with the quality and limitations of managed health care led to rapid disenrollment from managed care plans and demands for regulation between 1998 and 2003. Managed care organizations, particularly health maintenance organizations (HMOs), now face quality and coverage mandates that restrict them from using their most aggressive strategies for managing costs. This paper examines the effect of this backlash on managed care's ability to contain costs among short-term, non-federal hospitals between 1998 and 2008. The results show that the impact of increased HMO penetration on inpatient costs reversed over the study period, but HMOs were still effective at containing outpatient costs. These findings have important policy implications for understanding the continuing role that HMOs should play in cost containment policy and for understanding how effective the latest wave of cost containment institutions may perform in heavily regulated markets. Copyright © 2014 John Wiley & Sons, Ltd.

**Escobar, G. J., et al. (2015). "Nonelective Rehospitalizations and Postdischarge Mortality: Predictive Models Suitable for Use in Real Time."** *Medical Care* 53(11): 916-923.

**Background:** Hospital discharge planning has been hampered by the lack of predictive models.

**Objective:** To develop predictive models for nonelective rehospitalization and postdischarge mortality

suitable for use in commercially available electronic medical records (EMRs). Design: Retrospective cohort study using split validation. Setting: Integrated health care delivery system serving 3.9 million members. Participants: A total of 360,036 surviving adults who experienced 609,393 overnight hospitalizations at 21 hospitals between June 1, 2010 and December 31, 2013. Main Outcome Measure: A composite outcome (nonelective rehospitalization and/or death within 7 or 30 days of discharge). Results: Nonelective rehospitalization rates at 7 and 30 days were 5.8% and 12.4%; mortality rates were 1.3% and 3.7%; and composite outcome rates were 6.3% and 14.9%, respectively. Using data from a comprehensive EMR, we developed 4 models that can generate risk estimates for risk of the combined outcome within 7 or 30 days, either at the time of admission or at 8 AM on the day of discharge. The best was the 30-day discharge day model, which had a c-statistic of 0.756 (95% confidence interval, 0.754–0.756) and a Nagelkerke pseudo-R<sup>2</sup> of 0.174 (0.171–0.178) in the validation dataset. The most important predictors—a composite acute physiology score and end of life care directives—accounted for 54% of the predictive ability of the 30-day model. Incorporation of diagnoses (not reliably available for real-time use) did not improve model performance. Conclusions: It is possible to develop robust predictive models, suitable for use in real time with commercially available EMRs, for nonelective rehospitalization and postdischarge mortality.

**Garcia-Villar, J. and A. Lopez-Nicolas (2015). "Who is afraid of smoking bans? An evaluation of the effects of the Spanish clean air law on expenditure at hospitality venues." *Eur J Health Econ* 16(8): 813-834.**

**BACKGROUND:** In January 2011 Spain modified clean air legislation in force since 2006, removing all existing exceptions applicable to hospitality venues. Although this legal reform was backed by all political parties with parliamentary representation, the government's initiative was contested by the tobacco industry and its allies in the hospitality industry. One of the most voiced arguments against the reform was its potentially disruptive effect on the revenue of hospitality venues. This paper evaluates the impact of this reform on household expenditure at restaurants and bars and cafeterias. **METHODS AND EMPIRICAL STRATEGY:** We used household expenditure micro-data for years 2006–2012 to estimate models for the probability of observing expenditures and the expected level of expenditure. We applied a before-after analysis with a wide range of controls for confounding factors and a flexible modeling of time effects in order to identify the effects of the reform. **RESULTS:** Our results suggest that the reform caused a 2 % reduction in the proportion of households containing smokers but did not cause reductions in households' expenditures on restaurant services or on bars and cafeteria services.

**Kmietowicz, Z. (2015). "Emergency care specialists renew call for out-of-hours services to be located in hospitals." *BMJ* 351.**

Out-of-hours urgent and emergency primary care services should be located in hospital emergency departments with immediate effect, specialists have said. In a joint position statement the Royal College of Emergency Medicine and Urgent Health UK, the federation of social enterprise providers of unscheduled primary care, said that the move would secure safer, simpler, and more effective access for patients with urgent healthcare needs outside normal GP clinic hours. Chris Moulton, vice president of the Royal College of Emergency Medicine, said, "Recent research by the Royal College of Emergency Medicine has confirmed that around ...

**(2015/08-09). "Les nouveaux territoires de l'hôpital : dossier." *Gestions Hospitalières*(548): 412-443.**

## Inégalités de santé / Health Inequalities

**Bouchard, L., et al. (2015). "Corrigendum to 'Research on health inequalities: A bibliometric analysis (1966–2014)' [Soc. Sci. Med. 141 (2015) 100–108]." *Social Science & Medicine* 145: 140.**

**Bouchard, L., et al. (2015). "Research on health inequalities: A bibliometric analysis (1966–2014)."**

Social Science & Medicine **141**: 100-108.

The objective of this study is to report on research production and publications on health inequalities through a bibliometric analysis covering publications from 1966 to 2014 and a content analysis of the 25 most-cited papers. A database of 49,294 references was compiled from the search engine Web of Science. The first article appears in 1966 and deals with equality and civil rights in the United States and the elimination of racial discrimination in access to medical care. By 2003, the term disparity has gained in prominence relative to the term inequality which was initially elected by the researchers. Marmot's 1991 article is one of the five papers with the largest number of citations and contributes to the central perspective of social determinants of health and the British influence on the international status of research on social inequalities of health.

**Callander, E. J. and D. J. Schofield (2015). "Multidimensional Poverty and Health Status as a Predictor of Chronic Income Poverty."** Health Econ **24**(12): 1638-1643.

Longitudinal analysis of Wave 5 to 10 of the nationally representative Household, Income and Labour Dynamics in Australia dataset was undertaken to assess whether multidimensional poverty status can predict chronic income poverty. Of those who were multidimensionally poor (low income plus poor health or poor health and insufficient education attainment) in 2007, and those who were in income poverty only (no other forms of disadvantage) in 2007, a greater proportion of those in multidimensional poverty continued to be in income poverty for the subsequent 5 years through to 2012. People who were multidimensionally poor in 2007 had 2.17 times the odds of being in income poverty each year through to 2012 than those who were in income poverty only in 2005 (95% CI: 1.23-3.83). Multidimensional poverty measures are a useful tool for policymakers to identify target populations for policies aiming to improve equity and reduce chronic disadvantage. Copyright (c) 2014 John Wiley & Sons, Ltd.

**Jutz, R. (2015). "The role of income inequality and social policies on income-related health inequalities in Europe."** Int J Equity Health **14**(1): 117.

INTRODUCTION: The aim of the paper is to examine the role of income inequality and redistribution for income-related health inequalities in Europe. This paper contributes in two ways to the literature on macro determinants of socio-economic inequalities in health. First, it widens the distinctive focus of the research field on welfare state regimes to quantifiable measures such as social policy indicators. Second, looking at income differences completes studies on socio-economic health inequalities, which often analyse health inequalities based on educational differences. METHODS: Using data from the European Values Study (2008/2009), 42 European countries are available for analysis. Country characteristics are derived from SWIID, Eurostat, and ILO and include indicators for income inequality, social policies, and economic performance. The data is analysed by using a two-step hierarchical estimation approach: At the first step-the individual level-the effect of household income on self-assessed health is extracted and introduced as an indicator measuring income-related health inequalities at the second step, the country-level. RESULTS: Individual-level analyses reveal that income-related health inequalities exist all across Europe. Results from country-level analyses show that higher income inequality is significantly positively related to higher health inequalities while social policies do not show significant relations. Nevertheless, the results show the expected negative association between social policies and health inequalities. Economic performance also has a reducing influence on health inequalities. In all models, income inequality was the dominating explanatory effect for health inequalities. CONCLUSIONS: The analyses indicate that income inequality has more impact on health inequalities than social policies. On the contrary, social policies seemed to matter to all individuals regardless of socio-economic position since it is significantly positively linked to overall population health. Even though social policies are not significantly related to health inequalities, the power of public redistribution to impact health inequalities should not be downplayed. Social policies as a way of public redistribution are a possible instrument to reduce income inequalities which would in turn lead to a reduction in health inequalities.

**Knapp, M. (2015). "Reflecting on "An economic model of social capital and health'."** Health Econ Policy Law **10**(4): 411-417.

**Newbold, K. B. and D. Simone (2015). "Comparing disability amongst immigrants and native-born"**

Pôle documentation de l'Irdes / Irdes Documentation centre – Marie-Odile Safon, Véronique Suhard

Page 13 sur 24

[www.irdes.fr/documentation/actualites.html](http://www.irdes.fr/documentation/actualites.html)

[www.irdes.fr/documentation/veille-bibliographique-en-economie-de-la-sante.html](http://www.irdes.fr/documentation/veille-bibliographique-en-economie-de-la-sante.html)

[www.irdes.fr/english/documentation/watch-on-health-economics-literature.html](http://www.irdes.fr/english/documentation/watch-on-health-economics-literature.html)

***in Canada.*** Social Science & Medicine **145**: 53-62.

Given high levels of immigration into Canada and the associated requirement to understand the health needs of new arrivals, an extensive literature has developed over the past decade that has explored immigrant health issues, including the 'healthy immigrant effect'. Surprisingly, however, issues of disability within the immigrant population have received much less attention. Using data from Statistics Canada, 2006a, 2006b Participation and Activity Limitation Survey (PALS), this paper examines disability and its covariates amongst immigrants relative to non-immigrants in Canada. Compared with their native-born counterparts, recent immigrant arrivals (within the past 10 years) were less likely to report disability and less likely to report a severe disability than the native-born. However, differences in the rates and covariates of disabilities between males and female immigrants were observed, which are partially explained by socioeconomic and sociodemographic effects. The conclusion explores potential reasons why differentials in disability rates are observed, and points to future research directions.

***Ro, A. and G. Bostean (2015). "Duration of U.S. stay and body mass index among Latino and Asian immigrants: A test of theoretical pathways."*** Soc Sci Med **144**: 39-47.

Studies find that longer-term immigrants have higher body mass index (BMI) than their more recently arrived counterparts. Most interpretations of these health patterns by duration of U.S. residence rely on theories of immigrant integration; they posit that with increasing time in the United States, immigrants incorporate economically, socially, and culturally into aspects of U.S. society, and that these changes impact health. Few studies empirically examine whether these aspects of integration are indeed mediators of the association between duration of U.S. stay and BMI, and if their patterns differ across immigrant subgroups. This study examines data from the National Latino and Asian American Survey, using path analytic methods to simultaneously test six hypothesized mediators between duration and BMI: household income, English language ability, ethnic identity, family cohesion, acculturative stress and discrimination for both Latino and Asian immigrants, stratified by gender. We find little evidence for an association between duration and BMI for either Latino or Asian men. For women, duration and BMI have a significant and positive relationship, although the pathways differ between the two ethnic groups. For Latina women, household income and acculturative stress are significant indirect pathways, although they work in opposing directions. For Asian women, English proficiency and discrimination are significant indirect pathways. Our findings reveal complex pathways between duration and BMI that vary by ethnicity and gender and highlight limitations in the negative acculturation theory, which suggests that exposure to the United States should have a net negative impact on health. In contrast, our findings suggest that not all groups show declining health with longer duration, as measured by BMI, and that integration processes do not always translate into health differences in the expected directions. Future research on duration patterns may need to consider alternative explanations beyond incorporation-based processes, such as cross-national health theories or age, period, cohort effects.

## Médicaments / Pharmaceuticals

***(2015). "Prescription informatisée : quelle sécurité ?"*** Revue Prescrire **35**(384): 775-780.***Aidan, H. and G. Paul (2015). "Canada's New Generic Pricing Policy: A Reasoned Approach to a Challenging Problem."*** Healthcare Policy **11**(1): 10-14.

Alberta, quickly followed by other Canadian provinces, has introduced a new pricing model for generic drugs, in which prices are inversely related to the number of generic manufacturers of the drug. This paper examines the rationale for the new policy.

***Gidengil, C. A., et al. (2015). "The Volume-Quality Relationship in Antibiotic Prescribing: When More Isn't Better."*** INQUIRY: The Journal of Health Care Organization, Provision, and Financing **52**.

For many surgeries and high-risk medical conditions, higher volume providers provide higher quality

care. The impact of volume on more common medical conditions such as acute respiratory infections (ARIs) has not been examined. Using electronic health record data for adult ambulatory ARI visits, we divided primary care physicians into ARI volume quintiles. We fitted a linear regression model of antibiotic prescribing rates across quintiles to assess for a significant difference in trend. Higher ARI volume physicians had lower quality across a number of domains, including higher antibiotic prescribing rates, higher broad-spectrum antibiotic prescribing, and lower guideline concordance. Physicians with a higher volume of cases manage ARI very differently and are more likely to prescribe antibiotics. When they prescribe an antibiotic for a diagnosis for which an antibiotic may be indicated, they are less likely to prescribe guideline-concordant antibiotics. Given that high-volume physicians account for the bulk of ARI visits, efforts targeting this group are likely to yield important population effects in improving quality.

***Neena, L. C. and J. H. Marcus (2011). "An Evidence-Based Policy Prescription for an Aging Population."*** *HealthcarePapers* 11(1): 8-18.

<p>In this paper, the authors provide a policy prescription for Canada's aging population. They question the appropriateness of predictions about the lack of sustainability of our healthcare system. The authors note that aging per se will only have a modest impact on future healthcare costs, and that other factors such as increased medical interventions, changes in technology and increases in overall service use will be the main cost drivers. They argue that, to increase value for money, government should validate, as a priority, integrated systems of care delivery for older adults and recognize such systems as a major component of Canada's healthcare system, along with hospitals, primary care and public/population health. They also note a range of mechanisms to enhance such systems going forward. The authors present data and policy commentary on the following topics: ageism, healthy communities, prevention, unpaid caregivers and integrated systems of care delivery.</p>

***Van der Wardt, V. (2015). "Should guidance for the use of antihypertensive medication in older people with frailty be different?"*** *Age and Ageing* 44(6): 912-913.

***Wilmoth, D. R. (2015). "Reconciling Estimates of the Value to Firms of Reduced Regulatory Delay in the Marketing of Their New Drugs."*** *Health Economics* 24(12): 1651-1656.

The prescription drug user fee program provides additional resources to the US Food and Drug Administration at the expense of regulated firms. Those resources accelerate the review of new drugs. Faster approvals allow firms to realize profits sooner, and the program is supported politically by industry. However, published estimates of the value to firms of reduced regulatory delay vary dramatically. It is shown here that this variation is driven largely by differences in methods that correspond to differences in implicit assumptions about the effects of reduced delay. Theoretical modeling is used to derive an equation describing the relationship between estimates generated using different methods. The method likely to yield the most accurate results is identified. A reconciliation of published estimates yields a value to a firm for a one-year reduction in regulatory delay at the time of approval of about \$60 million for a typical drug. Published 2015. This article is a U.S. Government work and is in the public domain in the USA.

## Méthodologie – Statistique / Methodology - Statistics

***Batinti, A. (2015). "On Medical Progress and Health Care Demand: A Ces Perspective Using the Grossman Model of Health Status."*** *Health Econ* 24(12): 1632-1637.

I propose an application of the pure-consumption version of the Grossman model of health care demand, where utility depends on consumption and health status and health status on medical care and health technology. I derive the conditions under which an improvement in health care technology leads to an increase/decrease in health care consumption. In particular, I show how the direction of the effect depends on the relationship between the constant elasticity of substitution parameters of the utility and health production functions. I find that, under the constancy assumption, the ratio of

the two elasticity of substitution parameters determines the direction of a technological change on health care demand. On the other hand, the technology share parameter in the health production function contributes to the size but not to the direction of the technological effect. I finally explore how the ratio of the elasticity of substitution parameters work in measurement and practice and discuss how future research may use the theoretical insight provided here. Copyright (c) 2014 John Wiley & Sons, Ltd.

***Stevenson, A. and A. Roberts (2015)? "Estimating Lifetime Costs of Social Care. A Bayesian Approach. using Linked Administrative Datasets from three Geographical Areas." Health Econ 24(12): 1573-1587***

We estimated lifetime costs of publicly funded social care, covering services such as residential and nursing care homes, domiciliary care and meals. Like previous studies, we constructed microsimulation models. However, our transition probabilities were estimated from longitudinal, linked administrative health and social care datasets, rather than from survey data. Administrative data were obtained from three geographical areas of England, and we estimated transition probabilities in each of these sites flexibly using Bayesian methods. This allowed us to quantify regional variation as well as the impact of structural and parameter uncertainty regarding the transition probabilities. Expected lifetime costs at age 65 were pound 20,200-27,000 for men and pound 38,700-49,000 for women, depending on which of the three areas was used to calibrate the model. Thus, patterns of social care spending differed markedly between areas, with mean costs varying by almost pound 10,000 (25%) across the lifetime for people of the same age and gender. Allowing for structural and parameter uncertainty had little impact on expected lifetime costs, but slightly increased the risk of very high costs, which will have implications for insurance products for social care through increasing requirements for capital reserves. Copyright (c) 2014 John Wiley & Sons, Ltd.

***Valente, T. W., et al. (2015). "Diffusion of innovations theory applied to global tobacco control treaty ratification." Social Science & Medicine 145: 89-97.***

This study applies diffusion of innovations theory to understand network influences on country ratification of an international health treaty, the Framework Convention for Tobacco Control (FCTC). From 2003 to 2014 approximately 90% of United Nations member countries ratified the FCTC. We hypothesized that communication between tobacco control advocates on GLOBALink, a 7000-member online communication forum in existence from 1992 to 2012, would be associated with the timing of treaty ratification. We further hypothesized dynamic network influences such that external influence decreased over time, internal influence increased over time, and the role of opinion leader countries varied over time. In addition we develop two concepts: Susceptibility and influence that uncover the micro-level dynamics of network influence. Statistical analyses lend support to the influence of co-subscriptions on GLOBALink providing a conduit for inter-country influences on treaty ratification and some support for the dynamic hypotheses. Analyses of susceptibility and infection indicated particularly influential countries. These results have implications for the study of policy diffusion as well as dynamic models of behavior change.

## Politique de santé / Health Policy

***Gilbert, R., et al. (2015). "The market in healthcare data." BMJ 351.***

Seriously inhibiting research Healthcare generates a vast rainforest of data that could be used more widely for research if barriers to access could be overcome. One barrier is cost. Government and commercial traders in the precious hardwoods of healthcare data charge five or six figure sums per year for data access. Other barriers include the slow, tortuous application processes that are driven by rigid rules, often arbitrarily applied. These barriers obstruct access to more affordable data from the Health and Social Care Information Centre (HSCIC), the Office for National Statistics, the Healthcare Quality Improvement Partnership, and Public Health England. A fundamental problem with all these

data suppliers is the lack of incentives to provide data for research. Although the research might save lives through improving services or developing new tests or treatments, denying access carries no penalties. HSCIC has a growing backlog of more than 200 applications, but queues for data from the other suppliers are rarely recorded. We see little attempt to quantify the research not done, the ...

**Girerd-Genessay, I. and P. Michel (2015). "[Should we establish patient safety leadership walkrounds? A systematic review]." *Rev Epidemiol Santé Publique* **63**(5): 315-323.**

**BACKGROUND:** Used for over a decade, patient safety leadership walkrounds (PSLWs) is a managerial method designed to enhance the implementation of safety measures in hospitals. In order to determine the effect of PSLWs in French hospitals, we reviewed the literature on participant perceptions and the impact of PSLW on the overall culture of safety. **METHODS:** We conducted a systematic review of articles assessing the impact of PSLWs on the culture of safety (comparative studies) or the perceptions of caregivers and managers (qualitative studies). **RESULTS:** Five studies investigating safety culture and three studies investigating participant perception were identified. PSLWs were associated with an improvement in safety culture and the overall safety climate. The presence of caregivers during the PSLWs was important to achieve improvement. PSLWs improved the dialogue between caregivers and managers, and improved knowledge on care safety. Some problems concerning managerial PSLW attendance and counter-productive attitudes have occasionally been reported. **CONCLUSION:** PSLWs improve safety culture. Their effectiveness depends on the way they are implemented. They should initially be tested in France to ensure their feasibility and acceptability in our healthcare system.

**Torun, P., et al. (2015). "Can health indicators help policy-makers? Experience from European system of urban health indicators (EURO-URHIS)." *The European Journal of Public Health* [Ahead of Print]**

**Background:** This paper proposes that Population Impact Measures (PIMs), the Population Impact Number of Eliminating a Risk Factor over a time period (PIN-ER-t) and the number of events prevented in your population (NEPP), can assist in policy making as they include relevant information which describes the impact or benefits to the population of risk factors and interventions. In this study, we explore the utilization of the indicators from European System of Urban Health Indicators System to produce the two PIMs. **Methods:** We identified from the indicators list the health determinants, health status and health interventions which can be linked, and searched Medline for evidence of association. We then investigated whether the type of frequency measure available for the indicator match with the measure used in PIMs, and explored data availability for the City of Manchester (UK) as an urban area. **Results:** Of the 39 indicators relevant to socio-economic factors, health determinants and health status, it was possible to calculate the population impact of a risk factor, i.e. the PIN-ER-t, for only six associations, and the population impact of health interventions, i.e. NEPP, for only one out of the three listed indicators, as the relevant health conditions were not included. **Conclusions:** The results of this study suggest that if an indicator system is intended to play a part in the policy making process, then the method of presentation to policy-makers should be decided before setting up the system, as it is likely that some indicators which would be essential might not be available.

**Ugur, Z. B. (2015). "Does Presumed Consent Save Lives? Evidence from Europe." *Health Economics* **24**(12): 1560-1572.**

One policy tool that could affect organ donation rates is legislative defaults. In this study, we examine how presumed consent impacts cadaveric donations and kidney transplantations, using a panel dataset from the EU-27 countries plus Croatia in the period 2000–2010. We find that presumed consent countries have 28% to 32% higher cadaveric donation and 27% to 31% higher kidney transplant rates in comparison to informed consent countries, after accounting for potential confounding factors. After studying willingness to donate one's organs and registering preferences for organ donation, we find that presumed consent could increase cadaveric donation rates, because people fail to register their preferences and many have no preference for organ donation. Copyright © 2014 John Wiley & Sons, Ltd.

**Zelmer, J. (2015). "From Global to Local: Inequalities in Health and Healthcare." *Healthcare Policy* **11**(1): 6-9.**

## Prévision - Evaluation

**Krol, M. and W. Brouwer (2015). "Unpaid work in health economic evaluations."** *Soc Sci Med* **144**:

127-137.

Given its societal importance, unpaid work should be included in economic evaluations of health care technology aiming to take a societal perspective. However, in practice this does not often appear to be the case. This paper provides an overview of the current place of unpaid work in economic evaluations in theory and in practice. It does so first by summarizing recommendations regarding the inclusion of unpaid labor reported in health economic textbooks and national guidelines for economic evaluations. In total, three prominent health economic text-books were studied and 28 national health economic guidelines. The paper, moreover, provides an overview of the instruments available to measure lost unpaid labor and reports on a review of the place of unpaid labor in applied economic evaluations in the area of rheumatoid arthritis. The review was conducted by examining methodology of evaluations published between 1 March 2008 and 1 March 2013. The results of this study show that little guidance is offered regarding the inclusion of unpaid labor in economic evaluations in textbooks and guidelines. The review identified five productivity costs instruments including questions about unpaid work and 33 economic evaluations of treatments for rheumatoid arthritis of which only one included unpaid work. The results indicate that unpaid work is rarely included in applied economic evaluations of treatments for rheumatoid arthritis, despite this disease expecting to be associated with lost unpaid work. Given the strong effects of certain diseases and treatments on the ability to perform unpaid work, unpaid work currently receives less attention in economic evaluations than it deserves.

## Prévention / Prevention

**Garbacz (L.), J. Y., Alla (F.), et al. (2015). "Impact de l'éducation thérapeutique sur les habitudes de vie : perception des patients et de leurs proches."** *Santé Publique* **27**(4): 463-470.

**Schwarz, J. L., et al. (2015). "Development and Psychometric Assessment of the Healthcare Provider Cultural Competence Instrument."** *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* **52**.

This study presents the measurement properties of 5 scales used in the Healthcare Provider Cultural Competence Instrument (HPCCI). The HPCCI measures a health care provider's cultural competence along 5 primary dimensions: (1) awareness/sensitivity, (2) behaviors, (3) patient-centered communication, (4) practice orientation, and (5) self-assessment. Exploratory factor analysis demonstrated that the 5 scales were distinct, and within each scale items loaded as expected. Reliability statistics indicated a high level of internal consistency within each scale. The results indicate that the HPCCI effectively measures the cultural competence of health care providers and can provide useful professional feedback for practitioners and organizations seeking to increase a practitioner's

**Carson S.R. and S. Tara (2014). "A Novel Community-Based Model to Enhance Health Promotion, Risk Factor Management and Chronic Disease Prevention."** *Healthcare Quarterly* **17**(3): 48-54.

Chronic disease is a highly expensive but preventable problem to the healthcare system. Evidence suggests that impacting modifiable behaviours and risk management factors in the areas of physical inactivity, unhealthy diet, stress and obesity can alleviate the burden of chronic disease problem to a large extent. Despite this recognition, the challenge is embedding these recognized priorities into the community and in primary care in a sustainable and meaningful manner. Primary Health Care in Capital Health responded to this challenge by developing and implementing a free, interprofessional and community-based service, namely, the Community Health Teams (CHTs), that offers health and wellness, risk factor management, wellness navigation and behaviour-based programming. In this paper, the development and implementation of the CHTs are discussed. Preliminary outcomes for the

model are significant and promising. Formal and large-scale studies are planned to validate these outcomes with additional research rigour.

## Psychiatrie / Psychiatry

**Golberstein, E. and G. Gonzales (2015). "The Effects of Medicaid Eligibility on Mental Health Services and Out-of-Pocket Spending for Mental Health Services."** *Health Serv Res.* [Ahead of Print]

**OBJECTIVE:** Millions of low-income Americans will gain health insurance through Medicaid under the Affordable Care Act. This study assesses the impact of previous Medicaid expansions on mental health services utilization and out-of-pocket spending. **DATA SOURCES:** Secondary data from the 1998-2011 Medical Expenditure Panel Survey Household Component merged with National Health Interview Survey and state Medicaid eligibility rules data. **STUDY DESIGN:** Instrumental variables regression models were used to estimate the impact of expanded Medicaid eligibility on health insurance coverage, mental health services utilization, and out-of-pocket spending for mental health services. **DATA EXTRACTION METHODS:** Person-year files were constructed including adults ages 21-64 under 300 percent of the Federal Poverty Level. **PRINCIPAL FINDINGS:** Medicaid expansions significantly increased health insurance coverage and reduced out-of-pocket spending on mental health services for low-income adults. Effects of expanded Medicaid eligibility on out-of-pocket spending were strongest for adults with psychological distress. Expanding Medicaid eligibility did not significantly increase the use of mental health services. **CONCLUSIONS:** Previous Medicaid eligibility expansions did not substantially increase mental health service utilization, but they did reduce out-of-pocket mental health care spending.

**Wykes, T., et al. "Mental health research priorities for Europe."** *The Lancet Psychiatry* 2(11): 1036-1042.

Mental and brain disorders represent the greatest health burden to Europe not only for directly affected individuals, but also for their caregivers and the wider society. They incur substantial economic costs through direct (and indirect) health-care and welfare spending, and via productivity losses, all of which substantially affect European development. Funding for research to mitigate these effects lags far behind the cost of mental and brain disorders to society. Here, we describe a comprehensive, coordinated mental health research agenda for Europe and worldwide. This agenda was based on systematic reviews of published work and consensus decision making by multidisciplinary scientific experts and affected stakeholders (more than 1000 in total): individuals with mental health problems and their families, health-care workers, policy makers, and funders. We generated six priorities that will, over the next 5?10 years, help to close the biggest gaps in mental health research in Europe, and in turn overcome the substantial challenges caused by mental disorders.

## Soins de santé primaires / Primary Health Care

**Atella, V. and F. d'Amico (2015). "Who is responsible for your health: is it you, your doctor or the new technologies?"** *Eur J Health Econ* 16(8): 835-846.

The aim of the paper is to disentangle the roles that patients, physicians and technology can have on patient health outcomes. The analysis focuses on patients suffering from hypercholesterolemia. Using a large and detailed dataset of patients collected by the Italian College of General Practitioners (SIMG) over the period 2001-2006, we observe the existence of heterogeneity in the time needed to reach an optimal level of health stock. We firstly explore whether patients recovering faster exhibit lower hospitalization rates. Secondly, we study the determinants of the speed of recovery to a good health status. Results suggest that a 10 % increase in the speed of recovery reduces hospitalization rates by 1 % in the general sample and by 1.25 % in patients in primary prevention. Furthermore, we show that

recovering to a good health status is a multifaceted phenomenon, with technology explaining from 54 to 68 % of the total effect.

**Dusheiko, M., et al. (2015). "Quality of Disease Management and Risk of Mortality in English Primary Care Practices."** *Health Services Research* **50**(5): 1452-1471.

Objective To investigate whether better management of chronic conditions by family practices reduces mortality risk. Data Two random samples of 5 million patients registered with over 8,000 English family practices followed up for 4 years (2004/5–2007/8). Measures of the quality of disease management for 10 conditions were constructed for each family practice for each year. The outcome measure was an indicator taking the value 1 if the patient died during a specified year, 0 otherwise. Study Design Cross-section and multilevel panel data multiple logistic regressions were estimated. Covariates included age, gender, morbidity, hospitalizations, attributed socio-economic characteristics, and local health care supply measures. Principal Findings Although a composite measure of the quality of disease management for all 10 conditions was significantly associated with lower mortality, only the quality of stroke care was significant when all 10 quality measures were entered in the regression. Conclusions The panel data results suggest that a 1 percent improvement in the quality of stroke care could reduce the annual number of deaths in England by 782 [95 percent CI: 423, 1140]. A longer study period may be necessary to detect any mortality impact of better management of other conditions.

**Kmietowicz, Z. (2015). "Primary care commissioners need five year budgets to transform care, says report."** *BMJ* **351**.

Commissioners in primary care need greater freedom and a reformed NHS payment system to improve care of patients, their representative body has said in a new report. NHS Clinical Commissioners, which represents 86% of England's clinical commissioning groups (CCGs), said that primary care needed flexibility to plan for the next five years—not for one year at a time, as at present—with funding in five year cycles. National short term priorities, such as winter pressure and targets on the time from referral to treatment, introduced to get “a grip ...

**Lugo-Palacios, D. G. and J. Cairns (2015). "Using ambulatory care sensitive hospitalisations to analyse the effectiveness of primary care services in Mexico."** *Soc Sci Med* **144**: 59-68.

Ambulatory care sensitive hospitalisations (ACSH) have been widely used to study the quality and effectiveness of primary care. Using data from 248 general hospitals in Mexico during 2001-2011 we identify 926,769 ACSHs in 188 health jurisdictions before and during the health insurance expansion that took place in this period, and estimate a fixed effects model to explain the association of the jurisdiction ACSH rate with patient and community factors. National ACSH rate increased by 50%, but trends and magnitude varied at the jurisdiction and state level. We find strong associations of the ACSH rate with socioeconomic conditions, health care supply and health insurance coverage even after controlling for potential endogeneity in the rolling out of the insurance programme. We argue that the traditional focus on the increase/decrease of the ACSH rate might not be a valid indicator to assess the effectiveness of primary care in a health insurance expansion setting, but that the ACSH rate is useful when compared between and within states once the variation in insurance coverage is taken into account as it allows the identification of differences in the provision of primary care. The high heterogeneity found in the ACSH rates suggests important state and jurisdiction differences in the quality and effectiveness of primary care in Mexico.

**Pruvot (J.), C. M., Dambricourt (P.A.), et al. (2015). "Influence du médecin généraliste dans la promotion du primo-don du sang chez les patients."** *Revue d'Epidémiologie et de Santé Publique* **63**(5): 326-331.

**Pruvot, J., et al. (2015). "[Non-donor patients' opinions about general practitioners' influence on first blood donation]."** *Rev Epidemiol Sante Publique* **63**(5): 326-331.

BACKGROUND: Needs for labile blood products are continuously increasing in France. National self-sufficiency is currently achieved because important promotional efforts for blood donation have resulted in more than three million donations per year. Despite the peculiar relationship general

practitioners (GPs) have with every patient and with public health actions, GPs are not included in the blood donation promotion chain. In this study, the main goal was to determine, from a non-donor patient's point of view, whether a discussion with their GP could be an efficient tool in blood donation promotion. The study was also designed to identify barriers to donation and information patients would expect from their GPs in such a discussion. METHODS: This was an epidemiological analytical cross-sectional and multicenter study. All patients aged 18 to 70 years attending a GP's clinic in Nord-Pas-de-Calais was asked to complete a seven-item closed-question survey. The primary endpoint was the percentage of patients who stated that the discussion with their GP could be an efficient tool for promoting blood donation. RESULTS: One thousand and forty-eight surveys were included in the analysis. Four hundred and fifty of the 660 non-donors interviewed (68.2 %) declared that a discussion with their GP could encourage them in the blood donation process. Non-donors declared that lack of time was the main barrier (33.5 %) and that they expected information from their GP about when and where they could donate blood (40.3 %). CONCLUSION: Many non-donor patients attending primary care clinics declare that a discussion with their GP could encourage them to make a blood donation and therefore significantly increase the number of potential donors.

**Rosenthal, M. B., et al. (2015). "Impact of the Rochester Medical Home Initiative on Primary Care Practices, Quality, Utilization, and Costs." *Medical Care* 53(11): 967-973.**

**Background:** Patient-centered medical homes (PCMH) may improve the quality of primary care while reducing costs and utilization. Early evidence on the effectiveness of PCMH has been mixed.

**Objectives:** We analyze the impact of a PCMH intervention in Rochester NY on costs, utilization, and quality of care. **Research Design:** A propensity score-matched difference-in-differences analysis of the effect of the PCMH intervention relative to a comparison group of practices. Qualitative interviews with PCMH practice managers on their experiences and challenges with PCMH practice transformation. **Subjects:** Seven pilot practices and 61 comparison practices (average of 36,531 and 30,192 attributed member months per practice, respectively). Interviews with practice leaders at all pilot sites. **Measures:** Individual HEDIS quality measures of preventive care, diabetes care, and care for coronary artery disease. Utilization measures of hospital use, office visits, imaging and laboratory tests, and prescription drug use. Cost measures are inpatient, prescription drug, and total spending. **Results:** After 3 years, PCMH practices reported decreased ambulatory care sensitive emergency room visits and use of imaging tests, and increased primary care visits and laboratory tests. Utilization of prescription drugs increased but drug spending decreased. PCMH practices reported increased rates of breast cancer screening and low-density lipid screening for diabetes patients, and decreased rates of any prevention quality indicator. **Conclusions:** The PCMH model leads to significant changes in patient care, with reductions in some services and increases in others. This study joins a growing body of work that finds no effect of PCMH transformation on total health care spending.

**Schmid, C. (2015). "Consumer Health Information and the Demand for Physician Visits." *Health Econ* 24 (12): 1619-1631.**

The present study empirically investigates the effect of consumer health information on the demand for physician visits. Using a direct information measure based on questions from the Swiss Health Survey, we estimate a Poisson hurdle model for office visits. We find that information has a negative effect on health care utilization, contradicting previous findings in the literature. We consider differences in the used information measures to be the most likely explanation for the different findings. However, our results suggest that increasing consumer health information has the potential to reduce health care expenditures. Copyright (c) 2014 John Wiley & Sons, Ltd.

## Systèmes de santé / Health Systems

**Caswell, K. J. and S. K. Long (2015). "The Expanding Role of Managed Care in the Medicaid Program: Implications for Health Care Access, Use, and Expenditures for Nonelderly Adults." *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 52.**

States increasingly use managed care for Medicaid enrollees, yet evidence of its impact on health care outcomes is mixed. This research studies county-level Medicaid managed care (MMC) penetration and health care outcomes among nonelderly disabled and nondisabled enrollees. Results for nondisabled adults show that increased penetration is associated with increased probability of an emergency department visit, difficulty seeing a specialist, and unmet need for prescription drugs, and is not associated with reduced expenditures. We find no association between penetration and health care outcomes for disabled adults. This suggests that the primary gains from MMC may be administrative simplicity and budget predictability for states rather than reduced expenditures or improved access for individuals.

***Ham, C. (2015). "The three crises facing the NHS in England." BMJ 351.***

Chris Ham, chief executive1King's Fund, London, UKc.ham{at}kingsfund.org.ukMinisters need to be honest with the public about the consequences for patient careThe NHS in England is in crisis. For now the crisis is financial, with providers in deficit by almost £1bn (£1,4bn; \$1.5bn) at the end of the first quarter of this financial year.<sup>1 2</sup> It will soon extend to patient care as waiting times—already under huge pressure—lengthen and providers look for ways to cut costs. Before long, the crisis will become political as the government decides what to do about funding in this parliament.None of this is surprising. Regular surveys by the King's Fund of NHS finance directors have shown growing concerns about funding and performance and increasing pessimism about the future.<sup>3</sup> And the fund's recent submission to the government's spending review shows how this is already affecting patient care.<sup>4</sup> The government can't claim it wasn't warned, but it has been much too slow to act.The hard question is what to do now, with care and cost pressures set to increase as winter approaches. In the short term, it will not be possible to get budgets back into balance because NHS providers have to meet demanding targets for patient care ...

***Liaropoulos, L. and I. Goranitis (2015). "Health care financing and the sustainability of health systems."*** *International Journal for Equity in Health* 14(1): 80.

The economic crisis brought an unprecedented attention to the issue of health system sustainability in the developed world. The discussion, however, has been mainly limited to "traditional" issues of cost-effectiveness, quality of care, and, lately, patient involvement. Not enough attention has yet been paid to the issue of who pays and, more importantly, to the sustainability of financing. This fundamental concept in the economics of health policy needs to be reconsidered carefully. In a globalized economy, as the share of labor decreases relative to that of capital, wage income is increasingly insufficient to cover the rising cost of care. At the same time, as the cost of Social Health Insurance through employment contributions rises with medical costs, it imperils the competitiveness of the economy. These reasons explain why spreading health care cost to all factors of production through comprehensive National Health Insurance financed by progressive taxation of income from all sources, instead of employer-employee contributions, protects health system objectives, especially during economic recessions, and ensures health system sustainability.

***Sommers, B. D. "Health Care Reform's Unfinished Work — Remaining Barriers to Coverage and Access."*** *New England Journal of Medicine* 0[Epub ahead of print].

## Travail et santé / Occupational Health

***Givord, P. and C. Marbot (2015). "Does the cost of child care affect female labor market participation? An evaluation of a French reform of childcare subsidies."*** *Labour Economics* 36: 99-111.

This study evaluates the short-run impact of an increase in childcare subsidies on the use of paid childcare and the participation rate of mothers of preschool children. We use a natural experiment provided by the PAJE, a French reform in family allowances introduced in 2004. This reform temporarily creates discrepancies in the childcare subsidies received by families according to the year

of birth of the children. We apply a difference-in-differences strategy on exhaustive French fiscal data that provide information on gross income as well as on the use of paid childcare services between 2005 and 2008. We use the fact that the new policy results in a significant increase in the use of paid childcare services. The effect on the labor force participation of mothers is significant but of a smaller magnitude. The highest impact is observed for mothers of large families.

**Kivimäki, M., et al. "Long working hours and risk of coronary heart disease and stroke: a systematic review and meta-analysis of published and unpublished data for 603 838 individuals." *The Lancet* 386(10005): 1739-1746.**

Background Long working hours might increase the risk of cardiovascular disease, but prospective evidence is scarce, imprecise, and mostly limited to coronary heart disease. We aimed to assess long working hours as a risk factor for incident coronary heart disease and stroke.

## Vieillissement / Ageing

**Andrew, V. W. (2011). "Population Pressures, System-Level Inertia and Healthy Aging Policy Revisited." *HealthcarePapers* 11(1): 41-45.**

Chappell and Hollander provide support for a set of policy directives formulated for an aging population. An integrated continuum of care model is the fulcrum of the policy prescription, given evidence-based support for its cost-effectiveness; improved quality of care and quality of life; and the success of similar models found in Denmark, Japan and other countries. This commentary addresses the underlying assumptions of these policy recommendations, identifies the major barriers to their implementation and suggests solutions. Improving our understanding of the dynamics of population aging as it relates to health and healthcare use is a necessary requirement to reaching the aims set out by the authors.</p>

**George, A. H. (2011). "Integrated Care for the Frail Elderly." *HealthcarePapers* 11(1): 62-68.**

Chronic disease management initiatives have thus far focused on single disease entities. The challenge of an aging population is the occurrence of multiple diseases, complicated by geriatric syndromes, in the same person. The term frailty is used to denote such persons, who are more vulnerable to poor health outcomes when challenged by a health stressor. In this paper, it is argued that frailty is a chronic condition and thus requires a chronic disease management approach. Hospital-based and community interventions for managing frail seniors are discussed, with a focus on enhancing primary care, and with appropriate and targeted support from geriatric specialists in the form of capacity building as well as direct clinical service. Finally, a model for integrating individual geriatric interventions into a broader system is proposed.

**Margaret, M. (2011). "Is It Time to Implement a Value-for-Money Approach in Healthcare of the Elderly?" *HealthcarePapers* 11(1): 25-29.**

This commentary addresses several issues raised by Chappell and Hollander in their review of policy issues that should be addressed to improve care for the elderly in Canada. First, the author takes some issue with the suggestion that the continuing care system needs to be re-validated. The data seem to indicate that the issue is not re-validation of the system but, rather, operational reform of the current system. Thus, the recommendation to focus on improving integrated care for seniors, which is a process measure, is a very timely one. Then the author raises the question of recommending a value-for-money approach to care of the elderly. Although fraught with problems and a lack of data, increasing numbers of researchers and others are suggesting that there is a need to question how we are spending scarce resources. A value-for-money policy would contribute evidence about the most effective use of services for older people.

**Widagdo, I. S., et al. (2015). "Predictive performance of four frailty measures in an older Australian population." *Age and Ageing* 44(6): 967-972.**

Background: there are several different frailty measures available for identifying the frail elderly. However, their predictive performance in an Australian population has not been examined. Objective: to examine the predictive performance of four internationally validated frailty measures in an older Australian population. Methods: a retrospective study in the Australian Longitudinal Study of Ageing (ALSA) with 2,087 participants. Frailty was measured at baseline using frailty phenotype (FP), simplified frailty phenotype (SFP), frailty index (FI) and prognostic frailty score (PFS). Odds ratios (OR) were calculated to measure the association between frailty and outcomes at Wave 3 including mortality, hospitalisation, nursing home admission, fall and a combination of all outcomes. Predictive performance was measured by assessing sensitivity, specificity, positive and negative predictive values (PPV and NPV) and likelihood ratio (LR). Area under the curve (AUC) of dichotomised and the multilevel or continuous model of the measures was examined. Results: prevalence of frailty varied from 2% up to 49% between the measures. Frailty was significantly associated with an increased risk of any outcome, OR (95% confidence interval) for FP: 1.9 (1.4–2.8), SFP: 3.6 (1.5–8.8), FI: 3.4 (2.7–4.3) and PFS: 2.3 (1.8–2.8). PFS had high sensitivity across all outcomes (sensitivity: 55.2–77.1%). The PPV for any outcome was highest for SFP and FI (70.8 and 69.7%, respectively). Only FI had acceptable accuracy in predicting outcomes, AUC: 0.59–0.70. Conclusions: being identified as frail by any of the four measures was associated with an increased risk of outcomes; however, their predictive accuracy varied.