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Economie de la santé / Health Economics

Atella V., Conti V. (2014). The effect of age and time to death on primary care costs: The Italian experience. *Social Science & Medicine*, 114 (0) : 10-17.

Abstract: Abstract A large body of literature shows that time to death (TTD) is by far a better predictor of health spending than age. In this paper, we investigate if this finding holds true also in presence of primary care costs (pharmaceuticals, diagnostic tests and specialist visits) in Italy, where they represent an important share (about 30%) of the total health care expenditure (HCE). Our analysis is based on a large sample of the Italian population (about 750,000 individuals), obtained from the Health Search-SiSSI database, which contains patient-level data collected routinely by General Practitioners in Italy since 2002. We study individuals aged 19 and older, over the period 2006-2009. By means of a two-part model which accounts for the presence of zero expenditure, our findings show that age represents the most important driver of primary care costs in Italy, although TTD remains a good predictor. These results suggest that age and TTD can have a different role in shaping health care costs according to the component of health expenditure examined. Therefore, our advice to policy makers is to use disaggregated models to better disentangle these contributions and to produce more reliable health spending forecasts.

<http://www.sciencedirect.com/science/article/pii/S0277953614003232>

Chang S., He Y., Hsieh C.R. (2014). The determinants of health care expenditure toward the end of life: evidence from Taiwan. *Health Economics*, 23 (8) : 951-961.

Abstract: This paper empirically investigates the relationship between the health care expenditure of end-of-life patients and hospital characteristics in Taiwan where (i) hospitals of different ownership differ in their financial incentives; (ii) patients are free to choose their providers; and (iii) health care services are paid for by a single public payer on a fee-for-services basis with a global budget cap. Utilizing insurance claims for 11863 individuals who died during 2005-2007, we trace their hospital expenditures over the last 24 months of their lives. We find that end-of-life patients who are treated by private hospitals in general are associated with higher inpatient expenditures than those treated by public hospitals, while there is no significant difference in days of hospital stay. This finding is consistent with the difference in financial incentives between public and private hospitals in Taiwan. Nevertheless, we also find that the public-private differences vary across accreditation levels.

<http://dx.doi.org/10.1002/hec.2970>

Morgado S.M. (2014). Does health promote economic growth? Portuguese case study: from dictatorship to full democracy. *Eur J Health Econ*, 15 (6) : 591-598.

Abstract: This paper revisits the debate on health and economic growth (Deaton in *J Econ Lit* 51:113-158, 2003) focusing on the Portuguese case by testing the relationship between growth and health. We test Portuguese insights, using time series data from 1960 to 2005, taking into account different variables (life expectancy, labour, capital, infant mortality) and considering the years that included major events on the political scene, such as the dictatorship and a closed economy (1960-1974), a revolution (1974) and full democracy and an open economy (1975-2005), factors that influence major economic, cultural, social and political indicators. Therefore the analysis is carried out adopting Lucas' (*J Monet Econ* 22(1):3-42, 1988) endogenous growth model that considers human capital as one factor of production, it adopts a VAR (vector autoregressive) model to test the causality between growth and health. Estimates based on the VAR seem to confirm that economic growth influences the health process, but health does not promote growth, during the period under study.

Bates D.W., Saria S., Ohno-Machado L., Shah A., Escobar G. (2014). Big data in health care: using analytics to identify and manage high-risk and high-cost patients. *Health Aff. (Millwood.)*, 33 (7) : 1123-1131.

Abstract: The US health care system is rapidly adopting electronic health records, which will dramatically increase the quantity of clinical data that are available electronically. Simultaneously,

rapid progress has been made in clinical analytics-techniques for analyzing large quantities of data and gleaning new insights from that analysis-which is part of what is known as big data. As a result, there are unprecedented opportunities to use big data to reduce the costs of health care in the United States. We present six use cases-that is, key examples-where some of the clearest opportunities exist to reduce costs through the use of big data: high-cost patients, readmissions, triage, decompensation (when a patient's condition worsens), adverse events, and treatment optimization for diseases affecting multiple organ systems. We discuss the types of insights that are likely to emerge from clinical analytics, the types of data needed to obtain such insights, and the infrastructure-analytics, algorithms, registries, assessment scores, monitoring devices, and so forth-that organizations will need to perform the necessary analyses and to implement changes that will improve care while reducing costs. Our findings have policy implications for regulatory oversight, ways to address privacy concerns, and the support of research on analytics.

Danyliv A., Groot W., Gryga I., Pavlova M. (2014). Willingness and ability to pay for physician services in six Central and Eastern European countries. *Health Policy*, 117 (1) : 72-82.

Abstract: Patient charges for physician services are implemented in high-income countries and often are considered in the Central and Eastern Europe (CEE). However, there is no evidence on the potential consumption effects of service charges in these countries. This study provides evidence on the potential impact of patient charges on the consumption of specialized physician services in six CEE countries: Bulgaria, Hungary, Lithuania, Poland, Romania, and Ukraine. We apply a semi-parametric survival analysis to stated willingness and ability to pay (WATP) in order to identify potential demand pools and their price, income and age semi-elasticity. Data are collected through a survey held in 2010 among representative samples of about 1000 respondents in each country. Our results suggest that median WATP in the studied countries is comparable to the cost of the services. The obtained demand pools appear to be theoretically valid and externally consistent. They provide information on the shares of population that would be WATP certain fee levels, and their heterogeneity across socio-demographic groups gives an idea about the population groups that will need to be exempted.

Schleiniger R. (2014). Health care cost in Switzerland: Quantity- or price-driven? *Health Policy*, 117 (1) : 83-89.

Abstract: In Switzerland, per capita health care costs vary substantially from canton to canton and rise considerably and steadily from year to year. Since costs are equal to the product of quantities and prices, the question arises whether regional cost variations and cost increase over time are quantity- or price-driven. Depending on the answer, the containment of health care costs must be approached differently. This article examines the cost of mandatory health insurance in Switzerland for the period from 2004 to 2010 and breaks it down into quantity and price effects. The main result of the cross-section analysis reveals that regional cost differences are mainly due to quantity differences. Similarly, the longitudinal analysis shows that the cost increase across all health care services is primarily caused by increasing per capita quantities. Any attempt to contain costs must therefore focus primarily on the extent of medical care utilization, and the key challenge to be met is how to identify medical care services which do not have a positive effect on patients' health status.

Géographie de la santé / Geography of Health

Bréchat P.H., Bonal C., Guével M.R., et al. (2014). La planification régionale de la santé : technicisation ou politique de santé ? Regards croisés de deux générations. *Journal de Gestion et d'Economie Médicales*, 31 (7-8) : 405-428.

Sauleau E.A., Lefevre H., Handschumacher P. (2014). Approche géographique du recours aux soins en santé mentale. *de Gestion et d'Economie Médicales*, 31 (7-8) : 499-516.

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Fattore G., Petrarca G., Torbica A. (2014). Traveling for care: Inter-regional mobility for aortic valve substitution in Italy. *Health Policy*, 117 (1) : 90-97.

Abstract: Patient flows across the regions of the Italian National Health Service can shed light on patient mobility, including cross-border flows within the European Union. We used 2009 data on 11,531 NHS admissions for aortic valve replacement operations to measure the extent of inter-regional patient mobility and to determine whether resident and non-resident patients differ. We also investigated whether public and private hospitals behave differently in terms of attracting patients. For this major cardio-surgical intervention, patient mobility in Italy is substantial (13.6% of total admissions). Such mobility mainly involves patients moving from southern to northern regions, which often requires several hundred kilometers of travel and a transfer of financial resources from poorer to richer regions. Patients admitted in the regions where they reside are older than those admitted outside their regions (69.2 versus 65.6, $p < 0.0001$), and stay in hospital approximately 0.7 days longer (14.7 versus 14.0, $p = 0.017$). Compared to public hospitals, private hospitals are more likely to admit non-resident patients (OR between 2.1 and 4.4). The extent and direction of patients' mobility raise equity concerns, as receiving care in locations that are distant from home requires substantial financial and relational resources.

Haggerty J.L., Roberge D., Levesque J.F. (2014). An exploration of rural-urban differences in healthcare-seeking trajectories: Implications for measures of accessibility. *Health & Place*, 28 (0) : 92-98.

Abstract: Abstract Comparing accessibility between urban and rural areas requires measurement instruments that are equally discriminating in each context. Through focus groups we explored and compared care-seeking trajectories to understand context-specific accessibility barriers and facilitators. Rural care-seekers rely more on telephone access and experience more organizational accommodation but have fewer care options. Urban care-seekers invoke the barrier of distance more frequently. Four consequences of accessibility problems emerged across settings which could be used for valid comparisons of access: having to restart the care-seeking process, abandoning it, using emergency services for primary care, and health deterioration due to delay.

<http://www.sciencedirect.com/science/article/pii/S1353829214000410>

Hanlon N. (2014). Doing health geography with feeling. *Soc Sci Med*, 115 144-146.

Schootman M., Lian M., Pruitt S.L., Deshpande A.D., Hendren S., Mutch M., Jeffe D.B., Davidson N. (2014). Hospital and Geographic Variability in Thirty-Day All-Cause Mortality Following Colorectal Cancer Surgery. *Health Services Research*, 49 (4) : 1145-1164.

Abstract: Objective To assess hospital and geographic variability in 30-day mortality after surgery for CRC and examine the extent to which sociodemographic, area-level, clinical, tumor, treatment, and hospital characteristics were associated with increased likelihood of 30-day mortality in a population-based sample of older CRC patients. Data Sources/Study Setting Linked Surveillance Epidemiology End Results (SEER) and Medicare data from 47,459 CRC patients aged 66 years or older who underwent surgical resection between 2000 and 2005, resided in 13,182 census tracts, and were treated in 1,447 hospitals. Study Design An observational study using multilevel logistic regression to identify hospital- and patient-level predictors of and variability in 30-day mortality. Data Collection/Extraction Methods We extracted sociodemographic, clinical, tumor, treatment, hospital, and geographic characteristics from Medicare claims, SEER, and census data. Principal Findings Of 47,459 CRC patients, 6.6 percent died within 30-days following surgery. Adjusted variability in 30-day mortality existed across residential census tracts (predicted mortality range: 2.7-12.3 percent) and hospitals (predicted mortality range: 2.5-10.5 percent). Higher risk of death within 30-days was observed for CRC patients age 85+ (12.7 percent), census-tract poverty rate >20 percent (8.0 percent), two or more comorbid conditions (8.8 percent), stage IV at diagnosis (15.1 percent), undifferentiated tumors (11.6 percent), and emergency surgery (12.8 percent). Conclusions Substantial, but similar variability was observed across census tracts and hospitals in 30-day mortality following surgery for CRC in patients 66 years and older. Risk of 30-day mortality is driven not only by

patient and hospital characteristics but also by larger social and economic factors that characterize geographic areas.

<http://dx.doi.org/10.1111/1475-6773.12171a>

Henriquez-Sánchez P., Doreste-Alonso J., Martinez-González M.A., et al. (2014). Geographical and climatic factors and depression risk in the SUN project. *The European Journal of Public Health*, 24 (4) : 626-631.

Abstract: Background: Depression incidence has been related with seasonal periodicity and climate. The aim of the study was to estimate the possible association between depression and specific meteorological factors, namely temperature, light and rain. Methods: In total, 13 938 participants from the SUN (Seguimiento Universidad de Navarra) cohort study were included in the analysis. Subjects were classified according to daily mean temperature, number of daylight hours and amount of rain, by year, at their geographical area of residence, data supplied by the Spanish Agency of Meteorology. Participants were considered as incident cases of depression whenever they reported a physician diagnosis of depression or the use of antidepressant medication in any of the follow-up questionnaires. Cox regression models were fit to assess the relationship between climatic and geographical factors and the incidence of depression. Results: Male subjects living in the south and centre areas of Spain showed a higher risk to develop depression compared with those living in the north area (hazard ratio = 1.6, 95% CI = 1.16-2.23 and hazard ratio = 1.41, 95% CI = 1.06-1.87, respectively). Moreover, among males, a direct association between the number of daily light hours and mean temperature and the risk of depression was also found. For men, living in rainy areas was associated with a lower risk of developing depression. Conclusion: Our results suggest that climate-depression relationship is more complex than previously thought, and strongly different between men and women.

<http://eurpub.oxfordjournals.org/content/24/4/626.abstract>

Hôpital / Hospitals

Cartier T., Naiditch M., Lombrail P. (2014). [Avoidable hospitalizations: The sole responsibility of primary care?]. *Rev Epidemiol Sante Publique*, 62 (4) : 225-236

Abstract: BACKGROUND: Avoidable hospitalizations are used as a performance indicator of primary care in many countries. We investigate here the validity and usefulness of this measure both at a global scale and for the French healthcare system. METHODS: A scoping study was performed to take a critical look at this concept. The different uses of avoidable hospitalizations as an indicator have already been reported in two recent systematic literature reviews. RESULTS: Rates of avoidable hospitalizations seem to be far more correlated with the socioeconomic attributes of patients than with primary care supply. The few studies conducted in France confirm this international trend. Several weaknesses have been spotted in the building of this indicator: the choice of conditions that can be considered as sources of avoidable hospitalizations, their identification among hospitalization disease codes, the quality of hospital coding procedures, the ecological bias in the data collection of illustrative variables. CONCLUSION: Guidelines for improvement of this indicator are provided. In particular, we discuss the possibility of its use at the scale of the whole healthcare system.

Casey M.M., Hung P., Moscovice I., Prasad S. (2014). The Use of Hospitalists by Small Rural Hospitals: Results of a National Survey. *Med Care Res Rev*, 71 (4) : 356-366.

Abstract: Research on hospitalist programs has primarily focused on large, urban facilities. To fill a gap in the literature on hospitalist use in rural hospitals, the authors conducted a national survey of 402 rural hospitals with 100 or fewer beds that had reported having hospitalists. The survey examined reasons for using hospitalists, characteristics of hospitalist practices, and the impacts of hospitalist use in rural settings. Rural hospitals most commonly establish a hospitalist program to address medical staff requests, call coverage, and quality issues. Respondents report positive impacts of hospitalist programs on quality of care and primary care physician recruitment and retention, but mixed financial

impacts. Assessments of the impact of hospitalists in rural hospitals need to take into account the variety of practitioner specialties functioning as hospitalists, the amount of time they spend as hospitalists, and the multiple roles they play in the rural hospital and community.

Clemens T., Michelsen K., Commers M., Garel P., Dowdeswell B., Brand H. (2014). European hospital reforms in times of crisis: Aligning cost containment needs with plans for structural redesign? *Health Policy*, 117 (1) : 6-14.

Abstract: Hospitals have become a focal point for health care reform strategies in many European countries during the current financial crisis. It has been called for both, short-term reforms to reduce costs and long-term changes to improve the performance in the long run. On the basis of a literature and document analysis this study analyses how EU member states align short-term and long-term pressures for hospital reforms in times of the financial crisis and assesses the EU's influence on the national reform agenda. The results reveal that there has been an emphasis on cost containment measures rather than embarking on structural redesign of the hospital sector and its position within the broader health care system. The EU influences hospital reform efforts through its enhanced economic framework governance which determines key aspects of the financial context for hospitals in some countries. In addition, the EU health policy agenda which increasingly addresses health system questions stimulates the process of structural hospital reforms by knowledge generation, policy advice and financial incentives. We conclude that successful reforms in such a period would arguably need to address both the organisational and financing sides to hospital care. Moreover, critical to structural reform is a widely held acknowledgement of shortfalls in the current system and belief that new models of hospital care can deliver solutions to overcome these deficits. Advancing the structural redesign of the hospital sector while pressured to contain cost in the short-term is not an easy task and only slowly emerging in Europe.

Mariotti G., Siciliani L., Rebba V., Fellini R., Gentilini M., Benea G., Bertoli P., Bistolfi L., Brugaletta S., Camboa P., Casucci P., Dessi D., Faronato P., Galante M., Gioffredi A., Guarino T.M., Pofi E., Liva C. (2014). Waiting time prioritisation for specialist services in Italy: The homogeneous waiting time groups approach. *Health Policy*, 117 (1) : 54-63.

Abstract: The demand for referrals and diagnostic procedures in Italy has been rising constantly in recent years, making access to diagnostic services increasingly difficult with significant waiting times. A number of Health Authorities (known as Local Health Units) have responded by implementing formalised waiting-time prioritisation tools, giving rise to what are known as Homogeneous Waiting Groups (HWGs). The study describes the implementation of the HWG approach in Italy. This represents a promising tool for improving the prioritisation of patients waiting to see a specialist or to receive a diagnostic test. The study of the Italian HWG experience provides useful insights to improve the outpatient referral process for those countries where the demand prioritisation policies have focused more on inpatient care than outpatient specialist care and diagnostic services.

DuGoff E.H., Bekelman J.E., Stuart E.A., Armstrong K., Pollack C.E. (2014). Surgical Quality Is More Than Volume: The Association between Changing Urologists and Complications for Patients with Localized Prostate Cancer. *Health Services Research*, 49 (4) : 1165-1183.

Abstract: Objectives : To examine the association of changing urologists on surgical complications in men with prostate cancer. Data Sources/Study Setting : Registry and administrative claims data from the Surveillance, Epidemiology, and End Results-Medicare database from 1995 to 2005. Study Design : A cross-sectional observational study of men with prostate cancer who underwent radical prostatectomy. Methods : Subjects were classified as having "changed urologists" if they had a different urologist who diagnosed their cancer from the one who performed their surgery. "Doubly robust" propensity score weighted multivariable logistic regression models were used to investigate the effect of changing urologists on 30-day surgical complications, late urinary complications, and long-term incontinence. Principal Findings Men who changed urologists between diagnosis and treatment had significantly lower odds of 30-day surgical complications compared with men who did not change urologists (odds ratio: 0.82; 95 percent confidence interval: 0.76-0.89), after adjustment. Changing urologists was associated with lower risks of 30-day complications for both

black and white men compared with staying with the same urologist for their diagnosis and surgical treatment. Conclusions Urologist changing is associated with the observed variation in complications following radical prostatectomy. This may suggest that patients are responding to aspects of surgical quality not captured in surgical volume.

Inégalités de santé / Health Inequalities

Scodellaro C. (2014). La santé perçue aux âges élevés : des critères médicaux aux évaluations pratiques. *Retraite et Société*, (67) : 19-41.

Abstract: partir d'un matériau qualitatif, cet article analyse les indicateurs que mobilisent les personnes âgées de 65 ans et plus pour évaluer leur état de santé (santé perçue) et met en évidence certaines variations sociales. Critères médicaux et activités constituent les principaux types d'indicateurs. La mobilisation des premiers (jugement du médecin, maladies, facteurs de risque, médicaments, opérations) est davantage le fruit des rapports entretenus avec le monde médical, différenciés selon le milieu social, qu'un simple effet de la médicalisation du vieillissement. En outre, leur sens peut dépasser le cadre de la santé et porter sur la valeur sociale des individus, comme dans le cas des opérations. La santé perçue s'autonomise nettement des institutions médicales lorsque la santé est éprouvée à travers les activités, principalement le travail, la mobilité et les plaisirs corporels. Les conditions sociales et rapports sociaux dans lesquels s'inscrit la réalisation du travail domestique aussi bien que sa délégation s'avèrent déterminants. Effectué par manque d'aide, il détériore la santé perçue, ce qui concerne en particulier les femmes de milieu populaire. Sa délégation peut également être stigmatisante lorsque le conjoint « aide » sa femme dans un travail qui lui est assigné. Ces observations permettent de formuler une nouvelle hypothèse quant au paradoxe de la plus grande longévité des femmes et de leur moins bon état de santé.

Fouchard A., Brechat P.H., Castiel D., Pascal J., Sass C., Lebas J., Chauvin P. (2014). [Qualitative and quantitative comparisons of three individual deprivation scores for outpatients attending a free hospital care clinic in Paris.]. *Rev Epidemiol Santé Publique*, 62 (4) : 237-247

Abstract: BACKGROUND: Inequality in health care is a growing problem, leading to the development of different tools for the assessment of individual deprivation. In France, three tools are mainly used: Epices (which stands for "score for the evaluation of social deprivation and health inequities among the centers for medical examination"), a score called "Handicap social" and a screening tool built for medical consultations by Pascal et al. at Nantes' hospital. The purpose of this study was to make a metrological assessment of those tools and a quantitative comparison by using them on a single deprived population. METHODS: In order to assess the metrological properties of the three scores, we used the quality criteria published by Terwee et al. which are: content validity, internal consistency, criterion validity, construct validity, reproducibility (agreement and reliability), responsiveness, floor and ceiling effects and interpretability. For the comparison, we used data from the patients who had attended a free hospital outpatient clinic dedicated to socially deprived people in Paris, during one month in 2010. The "Handicap social" survey was first filled in by the 721 outpatients before being recoded to allow the comparison with the other scores. RESULTS: While the population of interest was quite well defined by all three scores, other quality criteria were less satisfactory. For this outpatient population, the "Handicap social" score classed 3.2% as non-deprived (class 1), 32.7% as socially deprived (class 2) and 64.7% as very deprived (class 3). With the Epices score, the rates of deprivation varied from 97.9% to 100% depending on the way the score was estimated. For the Pascal score, rates ranged from 83.4% to 88.1%. On a subgroup level, only the Pascal score showed statistically significant associations with gender, occupation, education and origin. CONCLUSION: These three scores have very different goal and meanings. They are not interchangeable. Users should be aware of their advantages and disadvantages in order to use them wisely. Much remains to be done to fully assess their metrological performances.

Finnigan R. (2014). Racial and ethnic stratification in the relationship between homeownership and self-rated health. *Soc Sci Med*, 115 72-81.

Abstract: Social scientists have long demonstrated that socioeconomic resources benefit health. More recently, scholars have begun to examine the potential stratification in the health returns different groups receive for a given resource. Motivated by fundamental cause theory, this paper examines homeownership as a salient health resource with potentially stratified benefits. Homeowners have significantly greater housing quality, wealth, neighborhood quality and integration, and physical and mental health than renters. However, there are compelling theoretical reasons to expect the health advantage of homeownership to be unequally distributed across racial and ethnic groups. Regression analyses of 71,874 household heads in the United States from the 2012 March Current Population Survey initially suggest all homeowners experience a significant health advantage. Further examination finds robust evidence for a homeowner health advantage among Whites, on par with the difference between the married and divorced. The advantage among minority households is considerably smaller, and not significant among Latinos or Asians. Conditioning on a broad array of observable characteristics, White homeowners emerge as exceptionally healthy compared to White renters and all minority groups. This leads to the unexpected finding that racial/ethnic differences in health are concentrated among homeowners. The findings demonstrate the interactive nature of racial/ethnic stratification in health through both access to and returns from socioeconomic resources.

Mackenbach J.P. (2014). Cultural values and population health: a quantitative analysis of variations in cultural values, health behaviours and health outcomes among 42 European countries. *Health & Place*, 28 (0) : 116-132.

Abstract: Variations in 'culture' are often invoked to explain cross-national variations in health, but formal analyses of this relation are scarce. We studied the relation between three sets of cultural values and a wide range of health behaviours and health outcomes in Europe. Cultural values were measured according to Inglehart's two, Hofstede's six, and Schwartz's seven dimensions. Data on individual and collective health behaviours (30 indicators of fertility-related behaviours, adult lifestyles, use of preventive services, prevention policies, health care policies, and environmental policies) and health outcomes (35 indicators of general health and of specific health problems relating to fertility, adult lifestyles, prevention, health care, and violence) in 42 European countries around the year 2010 were extracted from harmonized international data sources. Multivariate regression analysis was used to relate health behaviours to value orientations, controlling for socioeconomic confounders. In univariate analyses, all scales are related to health behaviours and most scales are related to health outcomes, but in multivariate analyses Inglehart's 'self-expression' (versus 'survival') scale has by far the largest number of statistically significant associations. Countries with higher scores on 'self-expression' have better outcomes on 16 out of 30 health behaviours and on 19 out of 35 health indicators, and variations on this scale explain up to 26% of the variance in these outcomes in Europe. In mediation analyses the associations between cultural values and health outcomes are partly explained by differences in health behaviours. Variations in cultural values also appear to account for some of the striking variations in health behaviours between neighbouring countries in Europe (Sweden and Denmark, the Netherlands and Belgium, the Czech Republic and Slovakia, and Estonia and Latvia). This study is the first to provide systematic and coherent empirical evidence that differences between European countries in health behaviours and health outcomes may partly be determined by variations in culture. Paradoxically, a shift away from traditional 'survival' values seems to promote behaviours that increase longevity in high income countries.

<http://www.sciencedirect.com/science/article/pii/S1353829214000628>

Horner-Johnson W., Dobbertin K., Lee J.C., Andresen E.M., the Expert Panel on Disability and Health Disparities (2014). Disparities in Health Care Access and Receipt of Preventive Services by Disability Type: Analysis of the Medical Expenditure Panel Survey. *Health Services Research*, Ahead of pub.

Abstract: Objective To examine differences in access to health care and receipt of clinical preventive services by type of disability among working-age adults with disabilities. Data Source Secondary analysis of Medical Expenditure Panel Survey (MEPS) data from 2002 to 2008. Study Design We conducted cross-sectional logistic regression analyses comparing people with different types of disabilities on health insurance status and type; presence of a usual source of health care; delayed or

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forgone care; and receipt of dental checkups and cancer screening. Data Collection We pooled annualized MEPS data files across years. Our analytic sample consisted of adults (18-64 years) with physical, sensory, or cognitive disabilities and nonmissing data for all variables of interest. Principal Findings Individuals with hearing impairment had better health care access and receipt than people with other disability types. People with multiple types of limitations were especially likely to have health care access problems and unmet health care needs. Conclusions There are differences in health care access and receipt of preventive care depending on what type of disability people have. More in-depth research is needed to identify specific causes of these disparities and assess interventions to address health care barriers for particular disability groups.

<http://dx.doi.org/10.1111/1475-6773.12195>

Subedi R.P., Rosenberg M.W. (2014). Determinants of the variations in self-reported health status among recent and more established immigrants in Canada. *Soc Sci Med*, 115 103-110.

Abstract: Studies have shown that immigrants are normally in better health on arrival compared to their Canadian-born counterparts. However, the health conditions of new immigrants deteriorate after a few years of their arrival in Canada. This phenomenon is popularly termed the "healthy immigrant effect" (HIE) in the immigrant health literature. Although different hypotheses have been proposed to understand HIE, the causes are subject to ongoing discussion. Unlike previous studies, this study explored the possible causes behind the variations in the health status of recent and more established immigrants comparing 2001 and 2010 Canadian Community Health Surveys (CCHS). Four different hypotheses - namely lifestyle change, barriers to health care services, poor social determinants of health, and work related stress - were tested to understand variations in health status. The study concludes that there is a statistically significant difference in the socioeconomic characteristics and health outcomes of immigrants having less than and more than 10 years of residency in Canada. Logistic regression models show that the health conditions of immigrants are associated with age, sex, ethnic origin, smoking habit, Body Mass Index (BMI), total household income, number of consultations made with a family doctor per year and work related stress.

Brown T., Platt S., Amos A. (2014). Equity impact of European individual-level smoking cessation interventions to reduce smoking in adults: a systematic review. *The European Journal of Public Health*, 24 (4) : 551-556.

Abstract: Background: Smoking is the leading cause of health inequalities in Europe. Adults from lower socioeconomic status (SES) groups are more likely to smoke and less likely to quit than adults from higher SES groups. Smoking cessation support is an important element of tobacco control; however, the equity impact of individual-level cessation support is uncertain. Methods: Systematic review of individual-level smoking cessation interventions delivered in European countries, reporting a smoking cessation outcome (quit) in adults of lower compared with higher SES. Equity impact was assessed as positive (reduced inequality), neutral (no difference by SES), negative (increased inequality) or unclear. Results: Twenty-nine studies were included using different types of support: behavioural and pharmacological (17); behavioural only (11), including specialist (5), brief advice (1), mass media (2), text-based (1) and Internet-based (2); and pharmacological only (1). The distribution of equity effects on quitting was 10 neutral, 18 negative and 1 unclear. Two national studies of UK National Health Service (NHS) stop-smoking services showed overall positive equity impact on smoking prevalence. The evidence suggests that UK NHS services that target low-SES smokers achieve a relatively higher service uptake among low-SES smokers, which can compensate for their lower quit rates. Conclusions: Untargeted smoking cessation interventions in Europe may have contributed to reducing adult smoking but are, on balance, likely to have increased inequalities in smoking. However, UK NHS stop-smoking services appear to reduce inequalities in smoking through increased relative reach through targeting services to low-SES smokers. More research is needed to strengthen the evidence-base for reducing smoking inequalities.

<http://eurpub.oxfordjournals.org/content/24/4/551.abstract>

Ikram U.Z., Kunst A.E., Lamkaddem M., Stronks K. (2014). The disease burden across different ethnic groups in Amsterdam, the Netherlands, 2011-2030. *The European Journal of Public Health*, 24 (4) : 600-605.

Abstract: Background: Current disease burden estimates do not provide evidence across different ethnic groups. This study aims to assess the disease burden as measured by the disability-adjusted life years (DALYs) for six ethnic groups in Amsterdam, the Netherlands, for 2011 and 2030. Methods: The DALYs were calculated by combining three components: disease-/sex-/age-specific DALYs per person; disease-specific relative risks (RRs) by ethnicity; and sex-/age-specific population sizes by ethnicity in Amsterdam in 2011 and 2030. Disease-specific DALYs were derived from the National Institute of Public Health. The RRs were obtained through a systematic review of studies published in 1997-2008. The population figures were gathered from the Statistics Netherlands and municipality of Amsterdam. Results: The findings suggest that cardiovascular diseases and anxiety and depressive disorders dominate disease burden in all ethnic groups in 2011 and 2030. In most of the non-Western ethnic minorities, diabetes mellitus is the strongest contributor to the disease burden. The total disease burden will increase more strongly in non-Western ethnic minorities than ethnic Dutch. The 2030 disease burden is estimated to be highest among Surinamese and Antilleans. Conclusions: In ethnic minorities, diabetes plays an important role in the disease burden, and the total disease burden will grow stronger than ethnic Dutch, resulting in a higher total disease burden for some ethnic groups in 2030. We encourage researchers to estimate the disease burden by ethnicity so that health priorities can be set in the fields of policy, health care and research.

<http://eurpub.oxfordjournals.org/content/24/4/600.abstract>

Médicaments / Pharmaceutical

Duffaud S., Liébart S (2014). Comment les médecins généralistes limitent-ils leurs prescriptions ? Etude qualitative par entretiens collectifs. *Santé publique*, (3) : 323-330.

Ainslie M.H. (2014). Adherence to Prescribing Recommendations Made on a Provincial Formulary. *Healthcare Policy*, 9 (4) : 20-30.

Abstract: <p>Guidance regarding appropriate and cost-effective use of prescription drugs is published in the Ontario Drug Benefit Formulary in the form of “therapeutic notes”. We conducted a cross-sectional study of all residents of Ontario aged 66 and older who received a new prescription for one of two drugs, aliskiren or sitagliptin, between December 1, 2008 and March 31, 2012 to determine how frequently such guidance is followed. Approximately half of initial prescriptions for aliskiren and sitagliptin were prescribed in a manner that did not conform to the therapeutic note recommendations (51.4% and 49.3%, respectively). Given this high rate of non-conformance, policy makers may wish to use other mechanisms to influence prescriber behaviour to improve the quality and efficiency of healthcare.</p>

<http://www.longwoods.com/product/23812>

Houy N., Jelovac I. (2014). Drug launch timing and international reference pricing. *Health Economics*, Ahead of pub.

Abstract: This paper analyzes the timing decisions of pharmaceutical firms to launch a new drug in countries involved in international reference pricing. We show three important features of launch timing when all countries refer to the prices in all other countries and in all previous periods of time. First, there is no withdrawal of drugs in any country and in any period. Second, whenever the drug is sold in a country, it is also sold in all countries with larger willingness to pay. Third, there is no strict incentive to delay the launch of a drug in any country. We then show that the first and third results continue to hold when the countries only refer to the prices of a subset of all countries in a transitive way and in any period. We also show that the second result continues to hold when the reference is on the last period prices only. Last, we show that the seller's profits increase as the sets of reference countries decrease with respect to inclusion.

<http://dx.doi.org/10.1002/hec.3078>

Shajarizadeh A., Hollis A. (2014). Price-cap regulation, uncertainty and the price evolution of new pharmaceuticals. *Health Economics*, Ahead of pub.

Abstract: This paper examines the effect of the regulations restricting price increases on the evolution of pharmaceutical prices. A novel theoretical model shows that this policy leads firms to price new drugs with uncertain demand above the expected value initially. Price decreases after drug launch are more likely, the higher the uncertainty. We empirically test the model's predictions using data from the Canadian pharmaceutical market. The level of uncertainty is shown to play a crucial role in drug pricing strategies.

<http://dx.doi.org/10.1002/hec.3075>

Martelli N., Van den Brink H. (2014). Special funding schemes for innovative medical devices in French hospitals: The pros and cons of two different approaches. *Health Policy*, 117 (1) : 1-5.

Abstract: Financing innovative medical devices is an important challenge for national health policy makers, and a crucial issue for hospitals. However, when innovative medical devices are launched on the European market there is generally little clinical evidence regarding both efficacy and safety, both because of the flaws in the European system for regulating such devices, and because they are at an early stage of development. To manage the uncertainty surrounding the reimbursement of innovation, several European countries have set up temporary funding schemes to generate evidence about the effectiveness of devices. This article explores two different French approaches to funding innovative in-hospital devices and collecting supplementary data: the coverage with evidence development (CED) scheme introduced under Article L. 165-1-1 of the French Social Security Code; and national programs for hospital-based research. We discuss pros and cons of both approaches in the light of CED policies in Germany and the UK. The CED policies for devices share common limitations. Thus, transparency of CED processes should be enhanced and decisions need to be made in a timely way. Finally, we think that closer collaboration between manufacturers, health authorities and hospitals is essential to make CED policies more operational.

Sinclair J.E., Aucott L.S., Lawton K., Reid I.C., Cameron I.M. (2014). The monitoring of longer term prescriptions of antidepressants: observational study in a primary care setting. *Family Practice*, 31 (4) : 419-426.

Abstract: Background. There is little evidence to guide the frequency of review for patients taking antidepressants in the longer term. Objectives. To measure the frequency with which patients on longer term courses of antidepressants have their treatment monitored in primary care and to identify patient characteristics associated with the frequency of monitoring. Methods. A cohort of patients who were receiving antidepressants continuously for at least two years was identified from four general practices. Data were collected from patients' general medical records. The dates of all GP consultations and whether they included a documented review of antidepressant therapy were recorded, along with patient characteristics hypothesized to influence the frequency of monitoring. Results. The frequency of antidepressant review consultations and proportion of participants being reviewed during a specific year of antidepressant therapy decreased with increasing year of antidepressant therapy. Individuals who receive antidepressants for an overt mental health reason; undergo more dose and drug changes; and who are referred to the community mental health team have their antidepressant therapy reviewed more often during the first five years of antidepressant therapy. Conclusion. As many patients on longer term courses of antidepressants are not being appropriately reviewed, a "chronic disease management approach" to depression in primary care is advocated.

<http://fampra.oxfordjournals.org/content/31/4/419.abstract>

Dunne S.S., Shannon B., Cullen W., Dunne C.P. (2014). Beliefs, perceptions and behaviours of GPs towards generic medicines. *Family Practice*, 31 (4) : 467-474.

Abstract: Background. To benefit from cost-savings associated with generic medicine use; in June 2013, Ireland introduced generic substitution and reference pricing. The attitudes and behaviours of health care professionals may influence successful implementation of such changes. Objectives. To

assess perceptions of GPs in Ireland regarding generic medicines in the time leading up to the enactment of the new legislation and for the first time in at least the prior decade. Methods. Detailed one-to-one semi-structured interviews performed with a representative cohort of 34 urban- and rural-based GPs in Ireland. Results. Thirty of the participating 34 GPs prescribed generic medicines actively. Predominantly, participants believed that generics worked as effectively, and were of the same quality, as originator medicines. However, 32 GPs reported receiving patient complaints regarding generics; almost a third reported complaints of increased or altered side effects. Thirty-two GPs stated that they would take a generic medicine, although one in seven would choose the originator if offered a choice. A minority of GPs were of the view that generics are manufactured to a poorer quality than originators and may be a risk to patient safety. Conclusion. This study of GPs' attitudes towards generic medicines in Ireland highlights that this key stakeholder group has generally positive attitudes towards both generic medicines and the new legislation. However, variable knowledge about generic medicines and concerns regarding patient experience, clinical effectiveness and manufacturing quality were identified. GPs' opinions could negatively influence patient opinions; enhancing such opinions may prove important in successfully implementing the new legislation.

<http://fampra.oxfordjournals.org/content/31/4/467.abstract>

Méthodologie – Statistique / Methodology - Statistics

(2014). Faisabilité et intérêt de l'appariement de données individuelles en médecine générale et de données de remboursement appliqué au diabète et à l'hypertension artérielle. *Santé publique*, (3) : 355-363.

Gu Y., Norman R., Viney R. (2014). Estimating Health State Utility values from discrete choice experiment's qaly space model approach. *Health Economics*, Ahead of pub.

Abstract: Using discrete choice experiments (DCEs) to estimate health state utility values has become an important alternative to the conventional methods of Time Trade-Off and Standard Gamble. Studies using DCEs have typically used the conditional logit to estimate the underlying utility function. The conditional logit is known for several limitations. In this paper, we propose two types of models based on the mixed logit: one using preference space and the other using quality-adjusted life year (QALY) space, a concept adapted from the willingness-to-pay literature. These methods are applied to a dataset collected using the EQ-5D. The results showcase the advantages of using QALY space and demonstrate that the preferred QALY space model provides lower estimates of the utility values than the conditional logit, with the divergence increasing with worsening health states.

<http://dx.doi.org/10.1002/hec.3066>

Longhurst C.A., Harrington R.A., Shah N.H. (2014). A 'green button' for using aggregate patient data at the point of care. *Health Aff. (Millwood.)*, 33 (7) : 1229-1235.

Abstract: Randomized controlled trials have traditionally been the gold standard against which all other sources of clinical evidence are measured. However, the cost of conducting these trials can be prohibitive. In addition, evidence from the trials frequently rests on narrow patient-inclusion criteria and thus may not generalize well to real clinical situations. Given the increasing availability of comprehensive clinical data in electronic health records (EHRs), some health system leaders are now advocating for a shift away from traditional trials and toward large-scale retrospective studies, which can use practice-based evidence that is generated as a by-product of clinical processes. Other thought leaders in clinical research suggest that EHRs should be used to lower the cost of trials by integrating point-of-care randomization and data capture into clinical processes. We believe that a successful learning health care system will require both approaches, and we suggest a model that resolves this escalating tension: a "green button" function within EHRs to help clinicians leverage aggregate patient data for decision making at the point of care. Giving clinicians such a tool would support patient care decisions in the absence of gold-standard evidence and would help prioritize clinical questions for which EHR-enabled randomization should be carried out. The privacy rule in the

Health Insurance Portability and Accountability Act (HIPAA) of 1996 may require revision to support this novel use of patient data.

Brennan N., Oelschlaeger A., Cox C., Tavenner M. (2014). Leveraging The Big-Data Revolution: CMS Is Expanding Capabilities To Spur Health System Transformation.

Health Aff.(Millwood.), 33 (7) : 1195-1202.

Abstract: As the largest single payer for health care in the United States, the Centers for Medicare and Medicaid Services (CMS) generates enormous amounts of data. Historically, CMS has faced technological challenges in storing, analyzing, and disseminating this information because of its volume and privacy concerns. However, rapid progress in the fields of data architecture, storage, and analysis-the big-data revolution-over the past several years has given CMS the capabilities to use data in new and innovative ways. We describe the different types of CMS data being used both internally and externally, and we highlight a selection of innovative ways in which big-data techniques are being used to generate actionable information from CMS data more effectively. These include the use of real-time analytics for program monitoring and detecting fraud and abuse and the increased provision of data to providers, researchers, beneficiaries, and other stakeholders.

Curtis L.H., Brown J., Platt R. (2014). Four health data networks illustrate the potential for a shared national multipurpose big-data network.

Health Aff.(Millwood.), 33 (7) : 1178-1186.

Abstract: Information in electronic health data that are drawn from large populations of patients is transforming health care, public health practice, and clinical research. This article describes our experience in developing data networks that repurpose electronic health records and administrative data. The four programs we feature are the Food and Drug Administration's Mini-Sentinel program (which focuses on medical product safety), the National Patient-Centered Clinical Research Network (PCORnet, comparative effectiveness research), the National Institutes of Health's Health Care Systems Research Collaboratory Distributed Research Network (biomedical research), and ESPnet (public health surveillance). Challenges to these uses of electronic health data include understanding the factors driving the collection, coding, and preservation of the data; the extensive customization of different systems that collect similar data; the fragmentation of the US health care delivery system and its records; and privacy and proprietary considerations. We view these four programs as examples of the first stage in the development of a shared national big-data resource that leverages the investments of many agencies and organizations for the benefit of multiple networks and users.

Krumholz H.M. (2014). Big data and new knowledge in medicine: the thinking, training, and tools needed for a learning health system.

Health Aff.(Millwood.), 33 (7) : 1163-1170.

Abstract: Big data in medicine-massive quantities of health care data accumulating from patients and populations and the advanced analytics that can give those data meaning-hold the prospect of becoming an engine for the knowledge generation that is necessary to address the extensive unmet information needs of patients, clinicians, administrators, researchers, and health policy makers. This article explores the ways in which big data can be harnessed to advance prediction, performance, discovery, and comparative effectiveness research to address the complexity of patients, populations, and organizations. Incorporating big data and next-generation analytics into clinical and population health research and practice will require not only new data sources but also new thinking, training, and tools. Adequately utilized, these reservoirs of data can be a practically inexhaustible source of knowledge to fuel a learning health care system.

Halamka J.D. (2014). Early experiences with big data at an academic medical center.

Health Aff.(Millwood.), 33 (7) : 1132-1138.

Abstract: Beth Israel Deaconess Medical Center (BIDMC), an academic health care institution affiliated with Harvard University, has been an early adopter of electronic applications since the 1970s. Various departments of the medical center and the physician practice groups affiliated with it have implemented electronic health records, filmless imaging, and networked medical devices to such an extent that data storage at BIDMC now amounts to three petabytes and continues to grow at a rate of 25 percent a year. Initially, the greatest technical challenge was the cost and complexity of data

storage. However, today the major focus is on transforming raw data into information, knowledge, and wisdom. This article discusses the data growth, increasing importance of analytics, and changing user requirements that have shaped the management of big data at BIDMC.

Roski J., Bo-Linn G.W., Andrews T.A. (2014). Creating value in health care through big data: opportunities and policy implications. *Health Aff.(Millwood.)*, 33 (7) : 1115-1122.

Abstract: Big data has the potential to create significant value in health care by improving outcomes while lowering costs. Big data's defining features include the ability to handle massive data volume and variety at high velocity. New, flexible, and easily expandable information technology (IT) infrastructure, including so-called data lakes and cloud data storage and management solutions, make big-data analytics possible. However, most health IT systems still rely on data warehouse structures. Without the right IT infrastructure, analytic tools, visualization approaches, work flows, and interfaces, the insights provided by big data are likely to be limited. Big data's success in creating value in the health care sector may require changes in current policies to balance the potential societal benefits of big-data approaches and the protection of patients' confidentiality. Other policy implications of using big data are that many current practices and policies related to data use, access, sharing, privacy, and stewardship need to be revised.

Fallik D. (2014). For big data, big questions remain. *Health Aff.(Millwood.)*, 33 (7) : 1111-1114.

Abstract: Medicare's release of practitioner payments highlights the strengths and weaknesses of digging into big data.

Lebreton E., Vincelet C., Chatignoux E., Menguy C., Crenn H.C., Fevrier Y.M., Zeitlin J. (2014). [Record linkage of hospital discharge data and first health certificates: A test in the Val d'Oise.]. *Rev Epidemiol Santé Publique*, 62 (4) : 257-266

Abstract: BACKGROUND: Our objective was to test the feasibility of an indirect linkage of data on births from health certificates (HC) with hospital discharge (HD) data. METHODS: The linkage was carried out for live births between April 1st and June 30th, 2011 in six of the nine maternity units in the district of Val d'Oise. The HC and HD had 3284 and 3550 births registered during this period, respectively. Linkage was conducted using variables available in both sources: number of fetuses, baby's birth date, gender, maternity unit of birth, maternal age, municipality of residence, gestational age and birth-weight. Two linkage methods were tested: a deterministic and a semi-deterministic method and a probabilistic approach. The latter method calculates a probability estimate for the strength of the relationship between two linked observations related to the discriminatory power and the error rate of the matched variables. For cases that were linked despite discordance on some of the matching variables, random samples of observations were checked against both HC and HD records to compute rates of false matches. RESULTS: The deterministic and semi-deterministic method linked 92.5% and 85.6% of observations in the HC and HD, respectively. The probabilistic method achieved a linkage rate of 99.6% for HC and 92.7% for HD. Cases only linked by the probabilistic method were more often preterm and had low birth-weight. Cases matched using the probabilistic method only had an error rate of 0.4% with 95% CI [0.2-0.6%]. CONCLUSION: Common items in the HC and HD make it possible to achieve a high rate of linkage. The probabilistic method links more births and, in particular, those at higher risk, and error rates were low.

Politique de santé / Health Policy

Kerr E.A., Riba M., Udow-Phillips M. (2014). Helping Health Service Researchers and Policy Makers Speak the Same Language. *Health Services Research*, Ahead of pub.

<http://dx.doi.org/10.1111/1475-6773.12198>

Howie L., Hirsch B., Locklear T., Abernethy A.P. (2014). Assessing the value of patient-generated data to comparative effectiveness research. *Health Aff.(Millwood.)*, 33 (7) : 1220-1228.

Abstract: The goal of comparative effectiveness research is to assess medical therapies and allow patients, health care providers, payers, and policy makers to make evidence-based decisions about the most appropriate therapies in routine clinical practice. To conduct this type of research and to inform health care delivery, data about the impact of interventions on patient outcomes are needed. Methods of generating evidence for comparative effectiveness research provide opportunities to engage patients and understand their experiences with illness and its treatment. In this article we assess the need for, uses of, and strengths and weaknesses of patient-generated data. We also review in brief federal and medical society efforts to create new streams of patient-generated data for clinical and research use. We observe that the key to high-quality patient-generated data is to have immediate and actionable data so that patients experience the importance of the data for their own care as well as research purposes. We conclude that leveraging the emerging wealth of "big data" being generated by patient-facing technologies such as systems to collect patient-reported outcomes data and patient-worn sensors is critical to developing the evidence base that informs decisions made by patients, providers, and policy makers in pursuit of high-value medical care.

Fleurence R.L., Beal A.C., Sheridan S.E., Johnson L.B., Selby J.V. (2014). Patient-powered research networks aim to improve patient care and health research. *Health Aff.(Millwood.)*, 33 (7) : 1212-1219.

Abstract: The era of big data, loosely defined as the development and analysis of large or complex data sets, brings new opportunities to empower patients and their families to generate, collect, and use their health information for both clinical and research purposes. In 2013 the Patient-Centered Outcomes Research Institute launched a large national research network, PCORnet, that includes both clinical and patient-powered research networks. This article describes these networks, their potential uses, and the challenges they face. The networks are engaging patients, family members, and caregivers in four key ways: contributing data securely, with privacy protected; including diverse and representative groups of patients in research; prioritizing research questions, participating in research, and disseminating results; and participating in the leadership and governance of patient-powered research networks. If technical, regulatory, and organizational challenges can be overcome, PCORnet will allow research to be conducted more efficiently and cost-effectively and results to be disseminated quickly back to patients, clinicians, and delivery systems to improve patient health.

Stryjewski T.P., Zhang F., Elliott D., Wharam J.F. (2014). Effect of Massachusetts Health Reform on Chronic Disease Outcomes. *Health Services Research*, Ahead of pub.

Abstract: Objective To determine whether Massachusetts Health Reform improved health outcomes in uninsured patients with hyperlipidemia, diabetes, or hypertension. Data Source Partners HealthCare Research Patient Data Registry (RPDR). Study Design We examined 1,463 patients with hyperlipidemia, diabetes, or hypertension who were uninsured in the 3-áyears before the 2006 Massachusetts Health Reform implementation. We assessed mean quarterly total cholesterol, glycosylated hemoglobin, and systolic blood pressure in the respective cohorts for five follow-up years compared with 3,448 propensity score-matched controls who remained insured for the full 8-year study period. We used person-level interrupted time series analysis to estimate changes in outcomes adjusting for sex, age, race, estimated household income, and comorbidity. We also analyzed the subgroups of uninsured patients with poorly controlled disease at baseline, no evidence of established primary care in the baseline period, and those who received insurance in the first follow-up year. Principal Findings In 5-áyears after Massachusetts Health Reform, patients who were uninsured at baseline did not experience detectable trend changes in total cholesterol (GêÆ0.39-ámg/dl per quarter, 95 percent confidence interval [GêÆ1.11 to 0.33]), glycosylated hemoglobin (GêÆ0.02 percent per quarter [GêÆ0.06 to 0.03]), or systolic blood pressure (GêÆ0.06-ámmHg per quarter [GêÆ0.29 to 0.18]). Analyses of uninsured patients with poorly controlled disease, no evidence of established primary care in the baseline period, and those who received insurance in the first follow-up year yielded similar findings. Conclusions Massachusetts Health Reform was not associated with improvements in hyperlipidemia, diabetes, or hypertension control after 5-áyears. Interventions

beyond insurance coverage might be needed to improve the health of chronically ill uninsured persons.

<http://dx.doi.org/10.1111/1475-6773.12196>

Prévention / Prevention

Colson S., Gentile S., Côte J, et al. (2014). Spécificités pédiatriques du concept d'éducation thérapeutique du patient : analyse de la littérature de 1998 à 2012. *Santé Publique*, (3) : 283-295.

Ansker F.G., Helgason A.R., Ahacic K. (2014). The beliefs about pros and cons of drinking and intention to change among hazardous and moderate alcohol users: a population-based cross-sectional study. *The European Journal of Public Health*, 24 (4) : 566-571.

Abstract: Background: Fundamental to supporting hazardous alcohol users are the rationales for reducing alcohol intake highlighted by the users themselves. This study analyses the relative importance of beliefs about pros and cons of drinking in relation to having an intention to reduce intake among both hazardous and moderate alcohol users. Methods: Intention to change was assessed in a representative sample of Stockholm's population (n = 4278, response rate 56.5%). Alcohol use was assessed using the Alcohol Use Disorders Identification Test measure. A decisional balance inventory was used to examine various beliefs about the pros and cons of drinking, which covered affect changes, social gains and losses, and possible adverse effects. Independent correlations were determined by logistic regression using a backward exclusion procedure (P > 0.05). Results: Higher ratings of importance were generally related to intent, whether or not the contrast was with having no intent or already having made a reduction. This was especially true for hazardous users. Only two beliefs were independently correlated with change among hazardous users: "Drinking could get me addicted" and "Drinking makes me more relaxed/less tense" (pseudo-R² < 0.1). Among moderate users, there was no uniform pattern in the relationships. Conclusions: Unexpectedly, hazardous users with an intent to change rated pro arguments as more important than those with no intent to change. Of the investigated pros and cons, only a few were independently related to intention to change drinking behaviour. These arguments provide interesting topics in consultations. Little support was found for any rational decision making behind the intention to reduce alcohol intake.

<http://eurpub.oxfordjournals.org/content/24/4/566.abstract>

Bittner M.I., Matthies E.F., Dalbokova D., Menne B. (2014). Are European countries prepared for the next big heat-wave? *The European Journal of Public Health*, 24 (4) : 615-619.

Abstract: Background: Heat-waves present severe dangers to populations'health. Due to climate change, an increase in the frequency and intensity of heat-waves is to be expected. Public health measures to prevent negative health effects have been developed in several member states of the World Health Organization (WHO) European Region over the past decade. Methods: This study presents the first comprehensive assessment of the development of heat preparedness planning in WHO European Region member states, using a unique methodology based on criteria developed and pre-tested by the WHO. This indicator-based approach is based on eight core elements that are crucial components of heat-health action plans. Results: Of 53 member states of the WHO European Region, 51 countries were included in the evaluation. Results show that 18 countries have developed heat-health action plans, whereas 33 others have not. The plans developed so far vary in the degree of comprehensiveness with regard to the core elements. Gaps in terms of plan coverage have predominantly been identified in the areas of (intersectorial) long-term measures, surveillance and plan evaluation. Conclusions: For better preparedness, it can be advocated for further improving, developing and implementing heat-wave preparedness planning and response in European countries. A focus should be placed on developing all elements and strong intersectorial coordination and cooperation as well as the successful implementation of surveillance and evaluation measures.

<http://eurpub.oxfordjournals.org/content/24/4/615.abstract>

Prévision – Evaluation / Prevision – Evaluation

Forder J., Malley J., Towers A.M., Netten A. (2014). Using cost-effectiveness estimates from survey data to guide commissioning: an application to home care. *Health Economics*, 23 (8) : 979-992.

Abstract: The aim is to describe and trial a pragmatic method to produce estimates of the incremental cost-effectiveness of care services from survey data. The main challenge is in estimating the counterfactual; that is, what the patient's quality of life would be if they did not receive that level of service. A production function method is presented, which seeks to distinguish the variation in care-related quality of life in the data that is due to service use as opposed to other factors. A problem is that relevant need factors also affect the amount of service used and therefore any missing factors could create endogeneity bias. Instrumental variable estimation can mitigate this problem. This method was applied to a survey of older people using home care as a proof of concept. In the analysis, we were able to estimate a quality-of-life production function using survey data with the expected form and robust estimation diagnostics. The practical advantages with this method are clear, but there are limitations. It is computationally complex, and there is a risk of misspecification and biased results, particularly with IV estimation. One strategy would be to use this method to produce preliminary estimates, with a full trial conducted thereafter, if indicated.

<http://dx.doi.org/10.1002/hec.2973>

Psychiatrie / Psychiatry

Mueser K.T., McGurk S.R. (2014). Supported employment for persons with serious mental illness: Current status and future directions. *Encephale*, 40 Suppl 2 S45-S56.

Abstract: The individual placement and supported (IPS) model of supported employment is the most empirically validated model of vocational rehabilitation for persons with schizophrenia or another serious mental illness. Over 18 randomized controlled trials have been conducted throughout the world demonstrating the effectiveness of supported employment at improving competitive work compared to other vocational programs: IPS supported employment is defined by the following principles: 1) inclusion of all clients who want to work; 2) integration of vocational and clinical services; 3) focus on competitive employment; 4) rapid job search and no required prevocational skills training; 5) job development by the employment specialist; 6) attention to client preferences about desired work and disclosure of mental illness to prospective employers; 7) benefits counseling; and 8) follow-along supports after a job is obtained. Supported employment has been successfully implemented in a wide range of cultural and clinical populations, although challenges to implementation are also encountered. Common challenges are related to problems such as the failure to access technical assistance, system issues, negative beliefs and attitudes of providers, funding restrictions, and poor leadership. These challenges can be overcome by tapping expertise in IPS supported employment, including standardized and tested models of training and consultation. Efforts are underway to increase the efficiency of training methods for supported employment and the overall program, and to improve its effectiveness for those clients who do not benefit. Progress in IPS supported employment offers people with a serious mental illness realistic hope for achieving their work goals, and taking greater control over their lives.

Soins de santé primaires / Primary Health Care

Legleye S., Bohet A., Razafindratsima N., Bajos N., Moreau C. (2014). A randomized trial of survey participation in a national random sample of general practitioners and gynecologists in France. *Rev Epidemiol Sante Publique*,

Abstract: BACKGROUND: Healthcare professionals play a critical role in women's choice of contraceptive methods. However, national surveys on sexual and reproductive health (SRH) among physicians are rare and present low participation rates. We conducted a randomized trial to test for the effectiveness of three interventions to improve survey participation of private physicians delivering reproductive health services in France. METHODS: The study comprised a national random sample of 500 general practitioners and 500 gynecologists working in private offices. All received a postal invitation to participate either by completing a paper, phone or online questionnaire. Physicians were randomly assigned to six groups to test for the effect of three interventions: a non-monetary incentive in the form of a scientific book, telephone contact, and the possibility of completing the questionnaire by phone. RESULTS: Overall, 362 questionnaires were collected (26 online, 2 by phone) and 58 physicians were ineligible. The completion rate increased from 26.7% in physicians who received no intervention to 42.7% in those who received the book and a phone call. The phone call increased the completion rate by 11% percentage points ($P=0.01$), while the book had no significant effect. Results from multivariate logistic regressions also indicate that gynecologists ($OR=1.6$) and female physicians ($OR=1.5$) were more likely to participate than others. CONCLUSION: The results suggest that phone calls substantially increase participation of physicians in sexual and reproductive health surveys but have little impact on sampling distortion. Differentials in response rates by physicians' characteristics should be considered in future SRH studies among physicians.

Fournier C. (2014). Concevoir une maison de santé pluri-professionnelle : paradoxes et enseignements d'une innovation en actes. *Sciences sociales et Santé*, 32 (2) : 67-94.

Lombrail P. (2014). Les maisons de santé pluri-professionnelles : penser localement, agir globalement ? Commentaire. *Sciences sociales et Santé*, 32 (2) : 97-108.

Brien S., Gheihman G., Yi-Ki Y., et al. (2014). A Scoping Review of Appropriateness of Care Research Activity in Canada from a Health System-Level Perspective. *Healthcare Policy*, 9 48-61.

Abstract: Introduction: Jurisdictions are increasingly focusing on appropriate use of healthcare services and interventions as a means to improve health system performance. Our objectives were to conduct a scoping review to (a) map Canadian research and related activity on system-level appropriateness of care and (b) create a resource database that could be used to inform evidence-based decision-making and future research priorities in this area. Methods: We searched Medline, EMBASE and CINAHL databases between 2003-2013 using terms including "appropriate," "inappropriate," "health technology assessment" and "cost-effectiveness." Articles were included if they were Canadian-based and relevant to our definition. The database search was complemented by a website search of relevant Canadian organizations. Results: 4,979 articles were identified through the literature search, and 103 articles relevant to system-level appropriateness of care across Canada were charted. Of these, 64 contained an evaluation of appropriateness, 30 used a method of cost-effectiveness or total cost impact analysis and 9 involved another methodology. The most common health service categories included drug therapy ($n=40$) and health service utilization ($n=33$). Fifty-eight websites were summarized containing material relevant to system-level appropriateness of care. Conclusion: Our review identifies Canadian research and related activity pertaining to appropriateness of healthcare from a system-level perspective and provides a useful resource both to support evidence-based decision-making and to guide future appropriateness research.

<http://www.longwoods.com/product/23773>

Ardeshir S. (2014). Income and Regional Gradients in Being without a Regular Doctor: Does the Slope of Gradients Decrease for Those with Greater Health Needs? *Healthcare Policy*, 9 (4) : 62-72.

Abstract: Objective: Income and regional gradients in being without a regular family doctor have been reported. The study objective was to assess the extent to which the slopes of both income and

regional gradients vary by individuals' health needs. Method: Using the Canadian Community Health Survey and multivariate regression analyses, the study examined the income and interprovincial variations in potential access among the healthy and less healthy populations. Results: The presence of chronic conditions was associated with lower variations in income-related potential access, with the income gradient flattening at the second-lowest income category. Similarly, the presence of two or more chronic conditions flattened interprovincial variations in potential access. Conclusions: The results suggest a greater equity in having a regular doctor on the basis of need. Systemic changes might be needed to enhance potential access among the vulnerable segment of the population.

<http://www.longwoods.com/product/23783>

Gill A., Kuluski K. Jaakkimainen L., et al. (2014). "Where Do We Go from Here?" Health System Frustrations Expressed by Patients with Multimorbidity, Their Caregivers and Family Physicians. *Healthcare Policy*, 9 (4) : 73-89.

Abstract: Objectives: This study explored the care challenges experienced by older patients with multimorbidity, their informal caregivers and family physicians. Approach: Semi-structured interviews were conducted with 27 patients, their informal caregivers and family physicians. Qualitative description was used to identify key themes in the interview transcripts. Results: Participants experienced many common challenges when managing multimorbidity, including a lack of decision-making support, poor communication and uncoordinated health services. Within these themes, unique perspectives specific to the role of being a patient, caregiver or family physician emerged. Conclusion: The study adds to a limited evidence base on the experience of patients with multimorbidity. By including the perspectives of their family caregivers and physicians, we provide important insight into the management of multimorbidity and recommend the uptake of specific strategies to address them.

<http://www.longwoods.com/product/23811>

Barham V., Milliken O. (2014). Payment mechanisms and the composition of physician practices: balancing cost-containment, access, and quality of care. *Health Economics*, Ahead of pub.

Abstract: We take explicit account of the way in which the supply of physicians and patients in the economy affects the design of physician remuneration schemes, highlighting the three-way trade-off between quality of care, access, and cost. Both physicians and patients are heterogeneous. Physicians choose both the number of patients and the quality of care to provide to their patients. When determining physician payment rates, the principal must ensure access to care for all patients. When physicians can adjust the number of patients seen, there is no incentive to over-treat. In contrast, altruistic physicians always quality stint: they prefer to add an additional patient, rather than to increase the quality of service provided. A mixed payment mechanism does not increase the quality of service provided with respect to capitation. Offering a menu of compensation schemes may constitute a cost-effective strategy for inducing physicians to choose a given overall caseload but may also generate difficulties with access to care for frail patients.

<http://dx.doi.org/10.1002/hec.3069>

Armeni P., Compagni A., Longo F. (2014). Multiprofessional Primary Care Units: What Affects the Clinical Performance of Italian General Practitioners? *Med Care Res Rev*, 71 (4) : 315-336.

Abstract: Multiprofessional primary care models promise to deliver better care and reduce waste. This study evaluates the impact of such a model, the primary care unit (PCU), on three outcomes. A multilevel analysis within a "pre- and post-PCU" study design and a cross-sectional analysis were conducted on 215 PCUs located in the Emilia-Romagna region in Italy. Seven dimensions captured a set of processes and services characterizing a well-functioning PCU, or its degree of vitality. The impact of each dimension on outcomes was evaluated. The analyses show that certain dimensions of PCU vitality (i.e., the possibility for general practitioners to meet and share patients) can lead to better outcomes. However, dimensions related to the interaction and the joint works of general practitioners with other professionals tend not to have a significant or positive impact. This suggests that more effort needs to be invested to realize all the potential benefits of the PCU's multiprofessional approach to care.

Gelly J., Le Bel J., Aubin-Auger I., Mercier A., Youssef E., Mentre F., Nougairede M., Letrilliart L., Duval X., the ECOGEN study group (2014). Profile of French general practitioners providing opportunistic primary preventive care - an observational cross-sectional multicentre study. *Family Practice*, 31 (4) : 445-452.

Abstract: Background. Preventive services provided opportunistically by GPs are insufficient. Reasons are most often gathered through GPs' self-reports, rather than through independent observation. Objective. To assess with passive observers, the degree to which French GPs opportunistically perform primary preventive care during routine consultation. Methods. Observational cross-sectional multicentre ancillary study of the French ECOGEN study. The study period extended from 28 November 2011 to 30 April 2012. The inclusion criteria were patients seen by GPs at surgery and home consultations in non-randomized pre-determined half-day blocks per week. The non-inclusion criteria were patient 'refusal and consultations initially focused on primary prevention in response to patient' request (ancillary study's specific criterion). Using passive observers, data were collected based on the second version of International Classification of Primary Care. Preventive consultations were defined if at least one problem/diagnosis was considered by consensus as definitely related to primary prevention. For each one of the 128 participating GPs, aggregation of data was performed from all his/her consultations. Determinants of the proportion of preventive consultations per GP were assessed by multivariate linear regression. Results. Considering 19003 consultations, the median proportion of preventive consultations per GP was 14.9% (range: 78.3%). It decreased with increased proportion of patients aged 18 or less ($P = 0.006$), with increased proportion of home visits ($P = 0.008$) and with increased proportion of consultations lasting under 10 minutes ($P = 0.02$). None of the GPs' personal characteristics were significantly associated. Conclusion. Primary preventive care activity was related to the characteristics of GPs' patients and practice organizational markers and not to GPs' personal characteristics.

<http://fampra.oxfordjournals.org/content/31/4/445.abstract>

Sinaiko A.D., Rosenthal M.B. (2014). The Impact of Tiered Physician Networks on Patient Choices. *Health Services Research*, 49 (4) : 1348-1363.

Abstract: Objective To assess whether patient choice of physician or health plan was affected by physician tier-rankings. Data Sources Administrative claims and enrollment data on 171,581 nonelderly beneficiaries enrolled in Massachusetts Group Insurance Commission health plans that include a tiered physician network and who had an office visit with a tiered physician. Study Design We estimate the impact of tier-rankings on physician market share within a plan of new patients and on the percent of a physician's patients who switch to other physicians with fixed effects regression models. The effect of tiering on consumer plan choice is estimated using logistic regression and a pre-post study design. Principal Findings Physicians in the bottom (least-preferred) tier, particularly certain specialist physicians, had lower market share of new patient visits than physicians with higher tier-rankings. Patients whose physician was in the bottom tier were more likely to switch health plans. There was no effect of tier-ranking on patients switching away from physicians whom they have seen previously. Conclusions The effect of tiering appears to be among patients who choose new physicians and at the lower end of the distribution of tiered physicians, rather than moving patients to the best performers. These findings suggest strong loyalty of patients to physicians more likely to be considered their personal doctor.

<http://dx.doi.org/10.1111/1475-6773.12165>

Li J., Hurley J., DeCicca P., Buckley G. (2014). Physician response to pay-for-performance: evidence from a natural experiment. *Health Economics*, 23 (8) : 962-978.

Abstract: This study exploits a natural experiment in the province of Ontario, Canada, to identify the impact of pay-for-performance (P4P) incentives on the provision of targeted primary care services and whether physicians' responses differ by age, size of patient population, and baseline compliance level. We use administrative data that cover the full population of Ontario and nearly all the services provided by primary care physicians. We employ a difference-in-differences approach that controls for selection on observables and selection on unobservables that may cause estimation bias. We implement a set of robustness checks to control for confounding from other contemporaneous interventions of the primary care reform in Ontario. The results indicate that responses were modest and that physicians responded to the financial incentives for some services but not others. The results

provide a cautionary message regarding the effectiveness of employing P4P to increase the quality of health care.

<http://dx.doi.org/10.1002/hec.2971>

Travail et santé / Occupational Health

Gusto G., Vol S., Lasfargues G., Guillaud C., Lantieri O., Tichet J. (2014). Deprivation and health risk indicators in full-time permanent workers. *The European Journal of Public Health*, 24 (4) : 585-594.

Abstract: Background: Association between deprivation and health is well established, particularly among unemployed or fixed-term contract or temporary contract subjects. This study aimed to assess if this relationship existed as well in full-time permanent workers. Methods: Biometrical, biological, behavioural and psychosocial health risk indicators and an individual deprivation score, the Evaluation of Precarity and Inequalities in Health Examination Centres score, were recorded from January 2007 to June 2008, in 34 905 full-time permanent workers aged 18-70 years, all volunteers for a free health examination. Comparisons of the behavioural, metabolic, cardiovascular and health risk indicators between quintiles of the deprivation score with adjustments on age and socioeconomic categories were made by covariance analysis or logistic regression. Results: For both genders, degradation of nutritional behaviours, metabolic and cardiovascular indicators and health appeared gradually with deprivation, even for deprivation score usually considered as an insignificant value. The absence of only one social support or one social network was associated with a degradation of health. Full-time permanent workers with the poorest health risk indicators had more frequent social exclusion signs. These results were independent of socioeconomic categories and age. Conclusion: Understanding how deprivation influences health status may lead to more effective interventions to reduce social inequalities in health. The deprivation Evaluation of Precarity and Inequalities in Health Examination Centres score is a relevant tool to detect subjects who could benefit from preventive interventions. Our findings suggest that this deprivation score should be used as a health risk indicator even in full-time permanent workers. Assessing deprivation is useful to design and evaluate specific intervention programmes.

<http://eurpub.oxfordjournals.org/content/24/4/585.abstract>

Mastekaasa A. (2014). The gender gap in sickness absence: long-term trends in eight European countries. *The European Journal of Public Health*, 24 (4) : 656-662.

Abstract: Background: Most studies show that women have considerably higher rates of sickness absence than men, but little is known on how the gender gap has developed over time. Methods: Data are taken from the EU Labour Force Surveys. The dependent variable is whether the respondent reports being away from work the entire reference week or not. Trends are shown from 1980 onwards. Poisson regression is used to estimate relative risks for women vs. men, with various sets of control variables. Results: Increasing gross differences in sickness absence between women and men are found in five countries: Spain, Ireland, France, Belgium and the UK. No trend in the gender gap is found in Netherlands and Portugal, and probably even in Italy. The trends in the gender gap have been largely the same for men and women without children at home as in the population as a whole. The trends are little affected by control for detailed occupation and industry. Conclusion: The gender gap in sickness absence has increased in five out of eight countries. This is not due to increased labour force participation by mothers of small children, and neither can it be explained as a result of changes in how women and men are distributed across occupations or industries.

<http://eurpub.oxfordjournals.org/content/24/4/656.abstract>

Gimeno D., Bültmann U., Benavides F.G., Alexanderson K., et al. (2014), Cross-national comparisons of sickness absence systems and statistics: towards common indicators. *The European Journal of Public Health*, 24 (4) : 663-666.

Abstract: We aimed to identify common elements in work sickness absence (SA) in Spain, Sweden and The Netherlands. We estimated basic statistics on benefits eligibility, SA incidence and duration

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and distribution by major diagnostics. The three countries offer SA benefits for at least 12 months and wage replacement, differing in who and when the payer assumes responsibility; the national health systems provide health care with participation from occupational health services. Episodes per 1000 salaried workers and episode duration varied by country; their distribution by diagnostic was similar. Basic and useful SA indicators can be constructed to facilitate cross-country comparisons.

<http://eurpub.oxfordjournals.org/content/24/4/663.abstract>

Vieillesse / Ageing

Olaroiu M., Ghinescu M., Naumov V., Brinza I., Van den Heuvel W. (2014). The psychometric qualities of the Groningen Frailty Indicator in Romanian community-dwelling old citizens. *Family Practice*, 31 (4) : 490-495.

Abstract: Background. Primary health care may play an important role in identifying persons at risk for frailty. The Groningen Frailty Indicator (GFI) is considered a valid instrument to assess frailty in old age. However, it is not tested yet in a different cultural context. The aim of this study is to analyse the construct, content and criterion validity of the GFI in independent-living old Romanians. Methods. Twenty-two GPs participated in this study. They have sent the GFI questionnaire to 215 patients of 65 years and over. The GPs assessed the frailty of the patients, independently from the questionnaire. Results. The mean age of the respondents was 74.9 years. The mean GFI score was 5.5 (SD 2.9). Three-quarters of the respondents fit into the "moderate" or "severe" frailty category. Citizens 80 years old and older scored higher in terms of frailty. Ninety-eight per cent of the respondents completed at least 75% of the GFI items. The construct validity was good (Cronbach's alpha 0.746). All the items contributed statistically significant to the total GFI score (content validity). The old citizens who were rated as frail by the GPs (criterion validity) had a higher GFI score Conclusion: This study showed the GFI to be a feasible and valid instrument to assess frailty in independent-living old Romanians. Compared with the Dutch old, the prevalence of frailty in independently living old Romanians is high. Further research is needed to determine the appropriate cut-off points in the GFI scores in different care systems.

<http://fampra.oxfordjournals.org/content/31/4/490.abstract>

Rodriguez M. (2014). Use of informal and formal care among community dwelling dependent elderly in Spain. *The European Journal of Public Health*, 24 (4) : 668-673.

Abstract: Background: Faced with increased public spending for care, knowledge of the determinants of the choices between informal and formal care is of particular importance for estimating the need for care in the future. Methods: Using a representative sample of Spanish dependent elderly from the Disabilities, Independence and Dependency Situations Survey (DIDSS) 2008, we compare the factors associated with the reception of informal, formal and mixed care. The study included 10 703 dependent persons living at home aged 65 years. Results: Overall, the percentage of those receiving only informal care was high in Spain, 47.5%. Formal care was most often received in combination with informal care (9.8%) than alone (4.9%). Five out of the seven factors analysed were found to influence the reception of all types of care: age, gender, income, self-rated health and suffering a chronic condition. Conclusions: There is a high coincidence among how factors affect the reception of care although some differences can be noted. Curiously, a high income level and the availability of informal care (as measured by living with a partner) can negatively affect the reception of only formal care. Living in a capital can also have an impact on the type of care a dependent elderly person receives.

<http://eurpub.oxfordjournals.org/content/24/4/668.abstract>