

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

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

DOC VEILLE

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

6 novembre 2015 / November the 6th, 2015

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

Vous pouvez accéder à la version électronique des articles sur notre portail EJS (à l'exception des revues françaises) :

<http://ejournals.ebsco.com/Home.asp> (Accès réservé à l'Irdes)

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

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

<http://www.irdes.fr/documentation/veille-bibliographique-en-economie-de-la-sante.html>

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

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

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

<http://www.irdes.fr/english/documentation/watch-on-health-economics-literature.html>

Contacts

Espace documentation : documentation@irdes.fr

Marie-Odile Safon : safon@irdes.fr

Véronique Suhard : suhard@irdes.fr

Sommaire

Assurance maladie / Health Insurance	6
McMorrow, S., et al. (2015). "Uninsurance Disparities Have Narrowed For Black And Hispanic Adults Under The Affordable Care Act."	6
Persad, G. (2015). "Priority Setting, Cost-Effectiveness, and the Affordable Care Act." ..	6
Van de Ven, W. P., et al. (2015). "Risk Selection Threatens Quality Of Care For Certain Patients: Lessons From Europe's Health Insurance Exchanges."	6
Economie de la santé / Health Economics.....	7
Laurendeau, C., et al. (2015). "[Management and costs of chronic pulmonary obstructive disease in France in 2011]."	7
Etat de santé / Health Status.....	7
Jørgensen, P., et al. (2015). "Diagnostic labelling influences self-rated health. A prospective cohort study: the HUNT Study, Norway."	7
Krueger, P. M., et al. (2015). "Democracy and self-rated health across 67 countries: A multilevel analysis."	8
Masedo-Gutierrez, A. I. and B. Moreno-Kustner (2015). "Economic crisis and mortality by suicide: two concepts hard to link."	8
Ribassin-Majed, L. and C. Hill (2015). "Trends in tobacco-attributable mortality in France."	8
Géographie de la santé / Geography of Health.....	8
Toivakka, M., et al. (2015). "Do the classification of areas and distance matter to the assessment results of achieving the treatment targets among type 2 diabetes patients?"	8
Hôpital / Hospitals	9
Alfonsi, P. (2015). "[Major surgery in two days of hospitalization]."	9
Bogh, S. B., et al. (2015). "Accreditation and improvement in process quality of care: a nationwide study."	9
Buja, A., et al. (2015). "Are hospital process quality indicators influenced by socio-demographic health determinants."	10
Carls, G. S., et al. (2015). "The Relationship between Local Economic Conditions and Acute Myocardial Infarction Hospital Utilization by Adults and Seniors in the United States, 1995-2011."	10

Cohen, D., et al. (2015). "Does Higher Spending Improve Survival Outcomes for Myocardial Infarction?	11
Cremonesi, P., et al. (2015). "The Robustness and Effectiveness of the Triage System at Times of Overcrowding and the Extra Costs due to Inappropriate Use of Emergency Departments."	11
Hollenbeck, B. K., et al. (2015). "Ambulatory Surgery Centers and Their Intended Effects on Outpatient Surgery."	12
Jian, W., et al. (2015). "Payment Reform Pilot In Beijing Hospitals Reduced Expenditures And Out-Of-Pocket Payments Per Admission."	12
Kmietowicz, Z. (2015). "Emergency readmissions are highest in patients discharged at weekends."	12
Lelong, A., et al. (2015). "A quality indicator can be biased by intra-hospital heterogeneity: the case for quality of patient record keeping in France."	13
Nizard, J. (2015). "[Working time of trainees. France will jump off the cliff at the last moment]."	13
Petersen, G. S., et al. (2015). "Cancer patients' preferences of care within hospitals: a systematic literature review."	13
Inégalités de santé / Health Inequalities.....	14
Hoffmann, R., et al. (2015). "Obesity and the potential reduction of social inequalities in mortality: evidence from 21 European populations	14
Newton, J. N., et al. "Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013."	14
Ponzio, M., et al. (2015). "Unmet care needs of people with a neurological chronic disease: a cross-sectional study in Italy on Multiple Sclerosis."	14
Siegel, M., et al. (2015). "Individual Income, Area Deprivation, and Health: Do Income-Related Health Inequalities Vary by Small Area Deprivation?"	15
Médicaments / Pharmaceuticals.....	15
Belfodil, F., et al. (2015). "[Medication review by pharmacist-geriatrician collaboration for elderly inpatients: The absence of drug indication is the main target]."	15
Kamerow, D. (2015). "What's happening to cheap generic drugs?"	15
Méthodologie – Statistique / Methodology - Statistics	16
Arrighi, Y., et al. (2015). "The non-take up of long-term care benefit in France: A pecuniary motive?"	16
Guerard, B., et al. (2015). "The Influence of Respondent Characteristics on the Validity of Self-Reported Survey Responses."	16

Politique de santé / Health Policy	16
Mackenbach, J. P. and M. McKee (2015). "Government, politics and health policy: A quantitative analysis of 30 European countries."	16
Muth, C. and P. P. Glasziou (2015). "Guideline recommended treatments in complex patients with multimorbidity."	17
Psychiatrie / Psychiatry.....	17
Vidon G. (2015/09). "Quelle place pour les soins sans consentement en ambulatoire ? À propos de l'enquête IDF sur les programmes de soins. ."	17
Masson, M. (2015). "[Editorial: About the French translation of the DSM-5]."	18
Sun, K. S., et al. (2015). "Managing common mental health problems: contrasting views of primary care physicians and psychiatrists."	18
Soins de santé primaires / Primary Health Care.....	18
Astier-Peña, M. P., et al. (2015). "Are Spanish primary care professionals aware of patient safety?"	18
Austin, D. R. and L. C. Baker (2015). "Less Physician Practice Competition Is Associated With Higher Prices Paid For Common Procedures."	19
Aysola, J., et al. (2015). "Patient-centered Medical Homes and Access to Services for New Primary Care Patients."	19
Decker, S. L. (2015). "Acceptance of New Medicaid Patients by Primary Care Physicians and Experiences with Physician Availability among Children on Medicaid or the Children's Health Insurance Program."	20
Dusheiko, M., et al. (2015). "Quality of Disease Management and Risk of Mortality in English Primary Care Practices."	20
Kmietowicz, Z. (2015). "New GP contract will replace targets with seven day working."	20
Olthof, M., et al. (2015). "Towards a differentiated capitation system: relation between patient characteristics, contacts and costs."	20
Peckham, S., et al. (2015). Health Services and Delivery Research. The organisation and delivery of health improvement in general practice and primary care: a scoping study.	21
Sinnige, J., et al. (2015). "Multimorbidity patterns in a primary care population aged 55 years and over."	22
Wallace, E., et al. (2015). "Managing patients with multimorbidity in primary care."	22
Systèmes de santé / Health Policy	22
Atun, R. (2015). "Transforming Turkey's Health System — Lessons for Universal Coverage."	22

Mechanic, R. E. (2015). "Mandatory Medicare Bundled Payment — Is It Ready for Prime Time?"22

Travail et santé / Occupational Health23

Givord, P. and C. Marbot (2015). "Does the cost of child care affect female labor market participation? An evaluation of a French reform of childcare subsidies.....23

Hamad, R., et al. (2015). "The Effects of Job Insecurity on Health Care Utilization: Findings from a Panel of U.S. Workers."23

Huijts, T., et al. (2015). "The impacts of job loss and job recovery on self-rated health: testing the mediating role of financial strain and income."23

Lengagne, P. (2015). "Experience Rating and Work-Related Health and Safety."24

Toge, A. G. and M. Blekesaune (2015). "Unemployment transitions and self-rated health in Europe: A longitudinal analysis of EU-SILC from 2008 to 2011."24

Wubulhasimu, P., et al. (2015). "Does living longer in good health facilitate longer working lives? The relationship between disability and working lives."24

Vieillessement / Ageing25

Ferraro, K. F. and L. R. Wilkinson (2015). "Alternative Measures of Self-Rated Health for Predicting Mortality Among Older People: Is Past or Future Orientation More Important?"25

Friedman, E. M., et al. (2015). "US Prevalence And Predictors Of Informal Caregiving For Dementia."25

Grabowski, D. C., et al. (2015). "Integrated Payment And Delivery Models Offer Opportunities And Challenges For Residential Care Facilities."25

Kasper, J. D., et al. (2015). "The Disproportionate Impact Of Dementia On Family And Unpaid Caregiving To Older Adults."26

Madero-Cabib, I. and L. Kaeser (2015). "How voluntary is the active ageing life? A life-course study on the determinants of extending careers."26

Kaeser L., Roch P.A. (2015). "Le vieillissement actif: élaboration, légitimation et tentatives de diffusion d'un référentiel transversal en Europe."26

Assurance maladie / Health Insurance

McMorrow, S., et al. (2015). "Uninsurance Disparities Have Narrowed For Black And Hispanic Adults Under The Affordable Care Act." *Health Aff (Millwood)* 34(10): 1774-1778.

Black and Hispanic adults have long experienced higher uninsurance rates than white adults. Under the Affordable Care Act, differences in uninsurance rates have narrowed for both black and Hispanic adults compared to their white counterparts, but Hispanics continue to face large gaps in coverage.

Persad, G. (2015). "Priority Setting, Cost-Effectiveness, and the Affordable Care Act." *Am J Law Med* 41(1): 119-166.

The Affordable Care Act (ACA) may be the most important health law statute in American history, yet much of the most prominent legal scholarship examining it has focused on the merits of the court challenges it has faced rather than delving into the details of its priority-setting provisions. In addition to providing an overview of the ACA's provisions concerning priority setting and their developing interpretations, this Article attempts to defend three substantive propositions. First, I argue that the ACA is neither uniformly hostile nor uniformly friendly to efforts to set priorities in ways that promote cost and quality. Second, I argue that the ACA does not take a single, unified approach to priority setting; rather, its guidance varies depending on the aspect of the healthcare system at issue (Patient Centered Outcomes Research Institute, Medicare, essential health benefits) and the factors being excluded from priority setting (age, disability, life expectancy). Third, I argue that cost-effectiveness can be achieved within the ACA's constraints, but that doing so will require adopting new approaches to cost-effectiveness and priority setting. By limiting the use of standard cost-effectiveness analysis, the ACA makes the need for workable rivals to cost-effectiveness analysis a pressing practical concern rather than a mere theoretical worry.

Van de Ven, W. P., et al. (2015). "Risk Selection Threatens Quality Of Care For Certain Patients: Lessons From Europe's Health Insurance Exchanges." *Health Aff (Millwood)* 34(10): 1713-1720.

Experience in European health insurance exchanges indicates that even with the best risk-adjustment formulas, insurers have substantial incentives to engage in risk selection. The potentially most worrisome form of risk selection is skimping on the quality of care for underpriced high-cost patients—that is, patients for whom insurers are compensated at a rate lower than the predicted health care expenses of these patients. In this article we draw lessons for the United States from twenty years of experience with health insurance exchanges in Europe, where risk selection is a serious problem. Mistakes by European legislators and inadequate evaluation criteria for risk selection incentives are discussed, as well as strategies to reduce risk selection and the complex trade-off among selection (through quality skimping), efficiency, and affordability. Recommended improvements to the risk-adjustment process in the United States include considering the adoption of risk adjusters used in Europe, investing in the collection of data, using a permanent form of risk sharing, and replacing the current premium "band" restrictions with more flexible restrictions. Policy makers need to understand the complexities of regulating competitive health insurance markets and to prevent risk selection that threatens the provision of good-quality care for underpriced high-cost patients.

Economie de la santé / Health Economics

Laurendeau, C., et al. (2015). "[Management and costs of chronic pulmonary obstructive disease in France in 2011]." *Rev Mal Respir* 32(7): 682-691.

OBJECTIVES: To estimate the prevalence of treated chronic obstructive pulmonary disease (COPD) and its associated costs by stage of severity. **METHODS:** The study was conducted on the 2011 data of the french general beneficiary sample database (EGB). EGB is a 1/97th sample of the whole population of the beneficiaries of the main compulsory national health insurances. COPD cases and the level of severity of the disease have been identified using new algorithms established from the available parameters in EGB. Costs were estimated using a collective perspective. **RESULTS:** The minimal prevalence of treated COPD was estimated at 3.8% in patients of 40 years and older and 1.9% regardless of the age of individuals. This population was predominantly male (58.2%) with a mean age of 68.8 years (+/-12.7). A total of 6.2% of patients had a health-care utilization suggestive of a very severe stage of COPD and 8.1%, 13.8% and 71.9% suggestive of severe, moderate and mild stages respectively. Over one year, 28.8% of patients visited a specialist respiratory physician, 5.0% were hospitalized (>=24h) for COPD and 6.7% died. Patients experienced an average of 1.7 (+/-1.5) exacerbations per year and only 61.4% received specific pharmacological treatment for COPD during the year. The average yearly health-care cost of a patient with COPD was estimated at euro9382, with euro5342 directly related to COPD. **CONCLUSION:** This study based on medico-administrative databases confirms the high epidemiological and economic burden of COPD in France.

Etat de santé / Health Status

Jørgensen, P., et al. (2015). "Diagnostic labelling influences self-rated health. A prospective cohort study: the HUNT Study, Norway." *Family Practice* 32(5): 492-499.

Background. Studies have shown an independent association between poor self-rated health (SRH) and increased mortality. Few studies, however, have investigated any possible impact on SRH of diagnostic labelling. **Objective.** To test whether SRH differed in persons with known and unknown hypothyroidism, diabetes mellitus (DM) or hypertension, opposed to persons without these conditions, after 11-year follow-up. **Methods.** Prospective population-based cohort study in North-Trøndelag County, Norway, HUNT2 (1995–97) to HUNT3 (2006–08). All inhabitants aged 20 years and older were invited. The response rate was 69.5% in HUNT2 and 54.1% in HUNT3. In total, 34144 persons aged 20–70 years were included in the study population. The outcome was poor SRH. **Results.** Persons with known disease had an increased odds ratio (OR) to report poor SRH at follow-up; figures ranging from 1.11 (0.68–1.79) to 2.52 (1.46–4.34) (men with hypothyroidism kept out owing to too few numbers). However, in persons not reporting, but having laboratory results indicating these diseases (unknown disease), no corresponding associations with SRH were found. Contrary, the OR for poor SRH in women with unknown hypothyroidism and unknown hypertension was 0.64 (0.38–1.06) and 0.89 (0.79–1.01), respectively. **Conclusions.** Awareness opposed to ignorance of hypothyroidism, DM and hypertension seemed to be associated with poor perceived health, suggesting that diagnostic labelling could have a negative effect on SRH. This relationship needs to be tested more thoroughly in future research but should be kept in mind regarding the benefits of early diagnosing of diseases.

Krueger, P. M., et al. (2015). "Democracy and self-rated health across 67 countries: A multilevel analysis." *Soc Sci Med* 143: 137-144.

Existing research has found a positive association between countries' level of democratic governance and the health of their populations, although that research is limited by the use of data from small numbers of high-income countries or aggregate data that do not assess individual-level health outcomes. We extend prior research by using multilevel World Health Survey (2002-2004) data on 313,554 individuals in 67 countries, and find that the positive association between democratic governance and self-rated health persists after adjusting for both individual- and country-level confounders. However, the mechanisms linking democracy and self-rated health remain unclear. Individual-level measures of socioeconomic status, and country-level measures of economic inequality and investments in public health and education, do not significantly mediate the association between democratic governance and self-rated health. The persistent association between democratic governance and health suggests that the political organization of societies may be an important upstream determinant of population health.

Masedo-Gutierrez, A. I. and B. Moreno-Kustner (2015). "Economic crisis and mortality by suicide: two concepts hard to link." *The European Journal of Public Health* 25(5): 900-900.

Bernal et al.¹ have reported an increase in suicide rates in working age men in Andalusia (Spain), due to the financial crisis. Alameda Palacios et al.² analysed the evolution of suicide rates in Andalusia between 1975 and 2012 and unemployment rates (used as an indicator of the financial crisis) but no relationship between the two was proven. They concluded that the economy did not have an impact ...

Ribassin-Majed, L. and C. Hill (2015). "Trends in tobacco-attributable mortality in France." *The European Journal of Public Health* 25(5): 824-828.

Background: In 2010, the prevalence of tobacco use in France was 33% and reached 39% in the population aged 18–44. The purpose of this article is to describe the trends in tobacco-attributable mortality in France between 1980 and 2010. Methods: Using data from the national mortality statistics and relative risks of death, we estimated the tobacco-attributable fractions (AF) by sex and age using the method developed by Peto et al. and used recently by the World Health Organization with improved relative risk estimates. The tobacco-attributable mortality by age and sex is obtained by multiplying the AFs by the number of deaths. They are estimated in 5-year intervals from 1980 to 2010. Results: In 2010, a total of 78 000 deaths were attributable to tobacco use in France. The number of deaths attributable to tobacco use among men decreased from 66 000 deaths in 1985 to 59 000 deaths in 2010, and the tobacco-AF decreased from 23% in 1985 to 21% in 2010. The number of deaths attributable to tobacco use among women increased from 2700 in 1980 (1% of all deaths) to 19 000 in 2010 (7% of all deaths). In the population aged 35–69, one in three deaths among men and one in seven deaths among women are attributable to tobacco use. Conclusion: While tobacco-attributable mortality among men has been declining during the past three decades, it has increased dramatically among women. Thus, effective preventive measures are urgently needed to stem the tobacco epidemic.

Géographie de la santé / Geography of Health

Toivakka, M., et al. (2015). "Do the classification of areas and distance matter to the assessment results of achieving the treatment targets among type 2 diabetes patients?" *Int J Health*

Geogr 14(1): 27.

BACKGROUND: Type 2 diabetes is a major health concern all over the world. The prevention of diabetes is important but so is well-balanced diabetes care. Diabetes care can be influenced by individual and neighborhood socio-economic factors and geographical accessibility to health care services. The aim of the study is to find out whether two different area classifications of urban and rural areas give different area-level results of achieving the targets of control and treatment among type 2 diabetes patients exemplified by a Finnish region. The study exploits geo-referenced patient data from a regional primary health care patient database combined with postal code area-level socio-economic variables, digital road data and two grid based classifications of areas: an urban-rural dichotomy and a classification with seven area types. **METHODS:** The achievement of control and treatment targets were assessed using the patient's individual laboratory data among 9606 type 2 diabetes patients. It was assessed whether hemoglobin A1c (HbA1c) was controlled and whether the recommended level of HbA1c was achieved in patients by different area classes and as a function of distance. Chi square test and logistic regression analysis were used for testing. **RESULTS:** The study reveals that area-level inequalities exist in the care of type 2 diabetes in a detailed 7-class area classification but if the simple dichotomy of urban and rural is applied differences vanish. The patient's gender and age, area-level education and the area class they belonged to were associated with achievements of control and treatment targets. Longer distance to health care services was not a barrier to good achievements of control or treatment targets. **CONCLUSIONS:** A more detailed grid-based area classification is better for showing spatial differences in the care of type 2 diabetes patients. Inequalities exist but it would be misleading to state that the differences are simply due to urban or rural location or due to distance. From a planning point of view findings suggest that detailed geo-coded patient information could be utilized more in resourcing and targeting the health care services to find the area-level needs of care and to improve the cost-efficient allocation of resources.

Hôpital / Hospitals

Alfonsi, P. (2015). "[Major surgery in two days of hospitalization]." *Presse Med* 44(9): 883-888.

A reduction to 2 days the length of stay after a major surgery is possible by enhancing patient empowerment and decreasing morbidity. A rapid patient's empowerment is obtained by the use of means that reduce the impact of the surgical stress and facilitate the recovery. The decrease in postoperative morbidity is obtained by improving the perioperative quality of care. All of these means are gathered in enhanced recovery programs that are clinical pathways designed by a multidisciplinary and multiprofessional team. Regular audits are mandatory for the sustainability of these programs. Organization of a network between hospital and out-of-hospital caregivers is important in order to secure the patient's return home.

Bogh, S. B., et al. (2015). "Accreditation and improvement in process quality of care: a nationwide study." *Int J Qual Health Care* 27(5): 336-343.

OBJECTIVE: To examine whether performance measures improve more in accredited hospitals than in non-accredited hospital. **DESIGN AND SETTING:** A historical follow-up study was performed using process of care data from all public Danish hospitals in order to examine the development over time in performance measures according to participation in accreditation programs. **PARTICIPANTS:** All patients admitted for acute stroke, heart failure

or ulcer at Danish hospitals. INTERVENTION: Hospital accreditation by either The Joint Commission International or The Health Quality Service. MEASUREMENTS: The primary outcome was a change in opportunity-based composite score and the secondary outcome was a change in all-or-none scores, both measures were based on the individual processes of care. These processes included seven processes related to stroke, six processes to heart failure, four to bleeding ulcer and four to perforated ulcer. RESULTS: A total of 27 273 patients were included. The overall opportunity-based composite score improved for both non-accredited and accredited hospitals (13.7% [95% CI 10.6; 16.8] and 9.9% [95% 5.4; 14.4], respectively), but the improvements were significantly higher for non-accredited hospitals (absolute difference: 3.8% [95% 0.8; 8.3]). No significant differences were found at disease level. The overall all-or-none score increased significantly for non-accredited hospitals, but not for accredited hospitals. The absolute difference between improvements in the all-or-none score at non-accredited and accredited hospitals was not significant (3.2% [95% - 3.6; 9.9]). CONCLUSIONS: Participating in accreditation was not associated with larger improvement in performance measures for acute stroke, heart failure or ulcer.

Buja, A., et al. (2015). "Are hospital process quality indicators influenced by socio-demographic health determinants." *The European Journal of Public Health* 25(5): 759-765.

Background: This population-level health service study aimed to address whether hospitals assure the same quality of care to people in equal need, i.e. to see if any associations exist between social determinants and adherence to four hospital process indicators clearly identified as being linked to better health outcomes for patients. Participants: This was a retrospective cohort study based on administrative data collected in the Veneto Region (northeast Italy). We included residents of the Veneto Region hospitalized for ST-segment elevation myocardial infarction (STEMI) or acute myocardial infarction (AMI), hip fracture, or cholecystitis, and women giving birth, who were discharged from any hospital operating under the Veneto Regional Health Service between January 2012 and December 2012. Method: The following quality indicator rates were calculated: patients with STEMI-AMI treated with percutaneous coronary intervention, elderly patients with hip fractures who underwent surgery within 48 h of admission, laparoscopic cholecystectomies and women who underwent cesarean section. A multilevel, multivariable logistic regression analyses were conducted to test the association between age, gender, formal education or citizenship and the quality of hospital care processes. Results: All the inpatient hospital care process quality indicators measured were associated with an undesirable number of disparities concerning the social determinants. Conclusion: Monitoring the evidence-based hospital health care process indicators reveals undesirable disparities. Administrative data sets are of considerable practical value in broad-based quality assessments and as a screening tool, also in the health disparities domain.

Carls, G. S., et al. (2015). "The Relationship between Local Economic Conditions and Acute Myocardial Infarction Hospital Utilization by Adults and Seniors in the United States, 1995-2011." *Health Serv Res* 50(5): 1688-1709.

OBJECTIVE: To assess the association between aggregate unemployment and hospital discharges for acute myocardial infarction (AMI) among adults and seniors, 1995-2011. DATA SOURCES/STUDY SETTING: Community hospital discharge data from states collected for the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID) and economic data from the Bureau of Labor Statistics, 1995-2011. STUDY DESIGN: Quarterly time series study of unemployment and aggregate hospital discharges in local areas using fixed effects to control for differences between local areas. DATA COLLECTION/EXTRACTION METHODS: Secondary data on inpatient stays and unemployment rates aggregated to micropolitan and metropolitan areas. PRINCIPAL FINDINGS: For both adults and seniors, a 1 percentage point

increase in the contemporaneous unemployment rate was associated with a statistically significant 0.80 percent (adults) to 0.96 percent (seniors) decline in AMI hospitalization during the first half of the study but was unrelated to the economic cycle in the second half of the study period. CONCLUSIONS: The study found evidence that the aggregate relationship between health and the economy may be shifting for cardiovascular events, paralleling recent research that has shown a similar shift for some types of mortality (Ruhm 2013), self-reported health, and inpatient use among seniors (McInerney and Mellor 2012).

Cohen, D., et al. (2015). "Does Higher Spending Improve Survival Outcomes for Myocardial Infarction? Examining the Cost-Outcomes Relationship Using Time-Varying Covariates." *Health Serv Res* 50(5): 1589-1605.

OBJECTIVES: Previous patient-level acute myocardial infarction (AMI) research has found higher hospital spending to be associated with improved survival; however, survivor-treatment selection bias traditionally has been overlooked. The purpose of this study was to examine the AMI cost-outcome relationship, taking into account this form of bias. DATA SOURCES: Hospital Discharge Abstract data tracked costs for AMI hospitalizations. Ontario Vital Statistics data tracked patient mortality. STUDY DESIGN: A standard Cox survival model was compared to an extended Cox model using hospital costs as a time-varying covariate to examine the impact of cost on 1-year survival in a cohort of 30,939 first-time AMI patients in Ontario, Canada, from 2007 to 2010. PRINCIPAL FINDINGS: Higher patient-level AMI spending decreased the hazard of dying (Standard Model: log-cost hazard ratio: 0.513, 95 percent CI: 0.479-0.549; Extended Model: log-cost hazard ratio: 0.700, 95 percent CI: 0.645-0.758); however, the protective effect was overestimated by 62 percent when survivor-treatment bias was overlooked. In the extended model, a 10 percent increase in spending was associated with a 3.6 percent decrease in hazard of death. CONCLUSION: The findings of this study suggest that if survivor-treatment bias is overlooked, future research may materially overstate the protective effect of patient-level spending on outcomes.

Cremonesi, P., et al. (2015). "The Robustness and Effectiveness of the Triage System at Times of Overcrowding and the Extra Costs due to Inappropriate Use of Emergency Departments." *Appl Health Econ Health Policy* 13(5): 507-514.

BACKGROUND: Overcrowding is one of the most harmful problems for Emergency Department (ED) management and the correct estimation of time resource absorption by each type of patient plays a strategic role in dealing with overcrowding and correctly programming ED activity. OBJECTIVE: We aimed to investigate how overcrowding may affect urgent patients' waiting times (i.e., the robustness of the triage patient priority system) and to evaluate the extra costs due to inappropriate use of EDs. METHODS: Data referring to 54,254 patients who accessed the ED of a major Italian hospital in 2011 were analyzed to study patient flows and overcrowding. To define an average per-patient cost, according to the severity of his or her health condition, the 2010 profit and loss account of the aforementioned hospital was studied and the time devoted by physicians to each type of patient was estimated by means of a self-reported survey. RESULTS: Empirical findings confirm a positive correlation between overcrowding and the time a patient has to wait before receiving treatment. This effect is relevant only for non-urgent patients who are responsible for the overcrowding itself. However, urgent patients' waiting times do not increase in the presence of overcrowding, confirming that the triage priority system is robust against the overcrowding situation. The analysis estimates, using 2010 data, that the actual per patient cost incurred by the hospital when treating white-coded patients is, on average, 36.54 euros; a green code costs 93.17, yellow 170.62, and red 227.62. It emerges that 4 % of all the personnel costs are attributable to white color-code assistance, 67 % to green codes, 23 % to yellow codes, and the remaining 6 % to red codes. CONCLUSION: The

implementation of effective policies intended to improve both efficiency and quality in providing emergency health services has to deal with the systemic problem of inappropriate use of EDs. Policy-makers should be aware of the fact that there is a considerable portion of ED demand for assistance that is inappropriate and that oversizing EDs with respect to the true, appropriate, urgent patients' demands, could bring about a further and undesirable rise in inappropriate assistance demands and, therefore, an increase in ED costs that are not consistent with their objectives.

Hollenbeck, B. K., et al. (2015). "Ambulatory Surgery Centers and Their Intended Effects on Outpatient Surgery." *Health Serv Res* 50(5): 1491-1507.

OBJECTIVES: To assess the impact of ambulatory surgery centers (ASCs) on rates of hospital-based outpatient procedures and adverse events. **DATA SOURCES:** Twenty percent national sample of Medicare beneficiaries. **STUDY DESIGN:** A retrospective study of beneficiaries undergoing outpatient surgery between 2001 and 2010. Health care markets were sorted into three groups—those with ASCs, those without ASCs, and those where one opened for the first time. Generalized linear mixed models were used to assess the impact of ASC opening on rates of hospital-based outpatient surgery, perioperative mortality, and hospital admission. **PRINCIPAL FINDINGS:** Adjusted hospital-based outpatient surgery rates declined by 7 percent, or from 2,333 to 2,163 procedures per 10,000 beneficiaries, in markets where an ASC opened for the first time ($p < .001$ for test between slopes). Within these markets, procedure use at ASCs outpaced the decline observed in the hospital setting. Perioperative mortality and admission rates remained flat after ASC opening (both $p > .4$ for test between slopes). **CONCLUSIONS:** The opening of an ASC in a Hospital Service Area resulted in a decline in hospital-based outpatient surgery without increasing mortality or admission. In markets where facilities opened, procedure growth at ASCs was greater than the decline in outpatient surgery use at their respective hospitals.

Jian, W., et al. (2015). "Payment Reform Pilot In Beijing Hospitals Reduced Expenditures And Out-Of-Pocket Payments Per Admission." *Health Aff (Millwood)* 34(10): 1745-1752.

In 2009 China announced plans to reform provider payment methods at public hospitals by moving from fee-for-service (FFS) to prospective and aggregated payment methods that included the use of diagnosis-related groups (DRGs) to control health expenditures. In October 2011 health policy makers selected six Beijing hospitals to pioneer the first DRG payment system in China. We used hospital discharge data from the six pilot hospitals and eight other hospitals, which continued to use FFS and served as controls, from the period 2010-12 to evaluate the pilot's impact on cost containment through a difference-in-differences methods design. Our study found that DRG payment led to reductions of 6.2 percent and 10.5 percent, respectively, in health expenditures and out-of-pocket payments by patients per hospital admission. We did not find evidence of any increase in hospital readmission rates or cost shifting from cases eligible for DRG payment to ineligible cases. However, hospitals continued to use FFS payments for patients who were older and had more complications than other patients, which reduced the effectiveness of payment reform. Continuous evidence-based monitoring and evaluation linked with adequate management systems are necessary to enable China and other low- and middle-income countries to broadly implement DRGs and refine payment systems.

Kmietowicz, Z. (2015). "Emergency readmissions are highest in patients discharged at weekends." *BMJ* 351.

The chances of needing emergency readmission to hospital are higher among patients who are discharged over the weekend than those sent home during the week, experimental figures have shown. Data from 2014 collected by the Health and Social Care Information

Centre (HSCIC)¹ showed that the rate of emergency readmissions within seven days of discharge increased over the week, from a low of 3.6% on Mondays and Tuesdays to 4.8% on Saturdays and 5.8% on Sundays. But wide variation occurred across trusts.

Lelong, A., et al. (2015). "A quality indicator can be biased by intra-hospital heterogeneity: the case for quality of patient record keeping in France." The European Journal of Public Health 25(5): 787-791.

Background: Since 2008, French health institutions providing medical, surgical and obstetrical care are assessed on the basis of a set of quality indicators. The French National Authority for Health developed a survey design in which 80 records are randomly selected from each institution. The main aim was to assess the effects of internal heterogeneity of a hospital that comprises several units. The survey method is based on the hypothesis of intra-institution homogeneity, which overlooks the fact that in wide hospitals homogeneity is related to departments and thus leads to overall intra-hospital heterogeneity. Methods: Simulated databases were created to modelise the heterogeneity of our hospital and computed to assess the reliance of indicator measurement. We used real data from a large teaching hospital having internal heterogeneity related to each department. Results: Variance under heterogeneity was greater than under homogeneity (3- to 18-fold) leading to an increased size of the confidence interval (CI) (at 95%) from 9 (given Haute Autorité de Santé sources) to 22 (for greatest internal heterogeneity). Conclusions: The variations in a quality indicator can be explained by intra-institution heterogeneity and are not related to changes in the quality policy of the hospitals and may lead to errors in terms of pay for performance.

Nizard, J. (2015). "[Working time of trainees. France will jump off the cliff at the last moment]." Presse Med 44(9): 881-882.

Petersen, G. S., et al. (2015). "Cancer patients' preferences of care within hospitals: a systematic literature review." Int J Qual Health Care 27(5): 384-395.

PURPOSE: Knowledge about cancer patients' preferences in health care is important because it enables care to be patient centered. However, the literature does not provide an overview. The aim of this study was to identify the dimensions of hospital-based cancer care that patients evaluate the most important using Patient-rated importance as a method. DATA SOURCE: PubMed was searched in 2013/2014. STUDY SELECTION: Studies were identified, if they were in accordance with specific search terms and focused on hospital-based cancer care. Totally, 11 studies were found. DATA EXTRACTION: The 11 studies comprised a total of 598 items. Of these, 592 items were categorized into 19 care dimensions. The highest rated quartile of items was identified as care elements patients evaluated to be the most important. Identification of the most important dimensions was done by calculating the percentages of items within each dimension that were within the highest quartile. RESULTS OF DATA SYNTHESIS: The 11 studies varied a lot in regard to aim and patient characteristics. The three most important dimensions were as follows: Rapid diagnosis and treatment; High professional standard; and Information about treatment and side(effects)/consequences. Within four dimensions, Psychosocial support, Physical facilities, Waiting time and Transparency in care, no items were within the highest quartile. CONCLUSION: Patient-rated importance was a useful method in identifying the care patients preferred. Due to a limited number of studies and great diversity within studies evaluated, interpretation of results should be cautious. However, it seems that cancer patients treated in hospitals with a curative intent find treatment-related information, professional standard and short delay of diagnosis and treatment most important.

Inégalités de santé / Health Inequalities

Hoffmann, R., et al. (2015). "Obesity and the potential reduction of social inequalities in mortality: evidence from 21 European populations." The European Journal of Public Health 25(5): 849-856.

Background: Obesity contributes considerably to the problem of health inequalities in many countries, but quantitative estimates of this contribution and to what extent it is modifiable are scarce. We identify the potential for reducing educational inequalities in all-cause and obesity-related mortality in 21 European populations, by modifying educational differences in obesity and overweight. Methods: Prevalence data and mortality data come from 21 European populations. Mortality rate ratios come from literature reviews. We use the population attributable fraction (PAF) to estimate the impact of scenario-based changes in the social distribution of obesity on educational inequalities in mortality. Results: An elimination of differences in obesity between educational groups would decrease relative inequality in all-cause mortality between those with high and low education by up to 12% for men and 42% for women. About half of the relative inequality in mortality could be reduced for some causes of death in several countries, often in southern Europe. Absolute inequalities in all-cause mortality would be reduced by up to 69 (men) and 67 (women) deaths per 100 000 person-years. Conclusion: The potential reduction of health inequality by an elimination of social inequalities in obesity might be substantial. The reductions differ by country, cause of death and gender, suggesting that the priority given to obesity as an entry-point for tackling health inequalities should differ between countries and gender.

Newton, J. N., et al. "Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013." The Lancet.

Background : In the Global Burden of Disease Study 2013 (GBD 2013), knowledge about health and its determinants has been integrated into a comparable framework to inform health policy. Outputs of this analysis are relevant to current policy questions in England and elsewhere, particularly on health inequalities. We use GBD 2013 data on mortality and causes of death, and disease and injury incidence and prevalence to analyse the burden of disease and injury in England as a whole, in English regions, and within each English region by deprivation quintile. We also assess disease and injury burden in England attributable to potentially preventable risk factors. England and the English regions are compared with the remaining constituent countries of the UK and with comparable countries in the European Union (EU) and beyond.

Ponzo, M., et al. (2015). "Unmet care needs of people with a neurological chronic disease: a cross-sectional study in Italy on Multiple Sclerosis." The European Journal of Public Health 25(5): 775-780.

Background: Community-based studies are required to accurately describe the supportive services needed by people with multiple sclerosis (MS). Methods: A total of 1205 people with MS participated in a cross-sectional study evaluating their unmet health and social care needs through a questionnaire collecting information used in the study. It was specifically developed by a multi-disciplinary team. Results: Overall, 79% of the responders declared at least one health or social care needs. The most prevalent health care need was the psychological support (27.5%), whereas the transport was the social care need more frequent (over 41%) in our sample. The multivariate analysis highlighted that unmet health care needs depended mainly on clinical factors such as disease stage, influenced by disease duration, and disability degree, whereas the social care needs were related to both clinical

and socio-demographic factors. Conclusion: These findings suggest that MS needs significantly change over time during the disease development and to find the best way to personalize PwMS management is crucial. Moreover, more public funding directed at improving the health-related quality of life of people with MS is needed. For this reason, we think that these results will provide important information and baseline data on how to build the national service strategies thereby making healthcare planning more efficient.

Siegel, M., et al. (2015). "Individual Income, Area Deprivation, and Health: Do Income-Related Health Inequalities Vary by Small Area Deprivation?" *Health Econ* 24(11): 1523-1530.

This paper aims to explore potential associations between health inequalities related to socioeconomic deprivation at the individual and the small area level. We use German cross-sectional survey data for the years 2002 and 2006, and measure small area deprivation via the German Index of Multiple Deprivation. We test the differences between concentration indices of income-related and small area deprivation related inequalities in obesity, hypertension, and diabetes. Our results suggest that small area deprivation and individual income both yield inequalities in health favoring the better-off, where individual income-related inequalities are significantly more pronounced than those related to small area deprivation. We then apply a semiparametric extension of Wagstaff's corrected concentration index to explore how individual-level health inequalities vary with the degree of regional deprivation. We find that the concentration of obesity, hypertension, and diabetes among lower income groups also exists at the small area level. The degree of deprivation-specific income-related inequalities in the three health outcomes exhibits only little variations across different levels of multiple deprivation for both sexes. Copyright (c) 2014 John Wiley & Sons, Ltd.

Médicaments / Pharmaceuticals

Belfodil, F., et al. (2015). "[Medication review by pharmacist-geriatrician collaboration for elderly inpatients: The absence of drug indication is the main target]." *Presse Med* 44(9): 956-958.

Kamerow, D. (2015). "What's happening to cheap generic drugs?" *BMJ* 351.

Clever business deals lead to big profits on older generic drugs. When I was in medical school in the 1970s I learned all I thought I needed to know about generic drugs from the esteemed (and wonderfully named) pharmacologist Louis Lasagna.¹ He taught us not to worry too much about bioequivalence and save our patients some money by prescribing generics most of the time. Exceptions were rare, such as digoxin, where bioavailability variations could actually be clinically important. Good advice. Patients could save money on generics because drug pricing used to follow a fairly predictable path. Drugs were expensive when first introduced and under patent. They became less expensive once the patent expired and generic versions were introduced. When there were more generic versions and a little time had passed, drugs often became very inexpensive, with the price drifting down as more and more generics (and new patented competitors) hit the market. The word "market" should be underscored here, because drug prices (as opposed to most of the rest of healthcare costs) usually followed the laws of supply and demand. More versions of the ...

Méthodologie – Statistique / Methodology - Statistics

Arrighi, Y., et al. (2015). "The non-take up of long-term care benefit in France: A pecuniary motive?" *Health Policy* **119**(10): 1338-1348.

With aging populations, European countries face difficult challenges. In 2002, France implemented a public allowance program (APA) offering financial support to the disabled elderly for their long-term care (LTC) needs. Although currently granted to 1.2 million people, it is suspected that some of those eligible do not claim it-presenting a non-take-up behavior. The granting of APA is a decentralized process, with 94 County Councils (CC) managing it, with wide room for local interpretation. This spatial heterogeneity in the implementation of the program creates the conditions for a "quasi-natural experiment", and provides the opportunity to study the demand for APA in relation to variations in CCs' "generosity" in terms of both eligibility and subsidy rate for LTC. We use a national health survey and administrative data in a multilevel model controlling for geographical, cultural and political differences between counties. The results show that claiming for APA is associated with the "generosity" of CCs: the population tends to apply less for the allowance if the subsidy rate is in average lower. This pecuniary trade-off, revealed by our study, can have strong implications for the well-being of the elderly and their relatives.

Guerard, B., et al. (2015). "The Influence of Respondent Characteristics on the Validity of Self-Reported Survey Responses." *Health Services Research*: n/a-n/a.

Objective To examine concordance between member self-reports and the organization's administrative claims data for two key health factors: number of chronic conditions, and number of prescription drugs. Data Medicare Advantage plan claims data and member survey data from 2011 to 2012. Design Mailed surveys to 15,000 members, enrolled minimum 6 months, drawn from a random sample of primary care physician practices with at least 200 members. Methods Descriptive statistics were generated for extent of concordance. Multivariable logistic regressions were used to analyze the association of selected respondent characteristics with likelihood of concordance. Findings Concordance for number of chronic conditions was 58.4 percent, with 27.3 percent under-reporting, 14.2 percent over-reporting. Concordance for number of prescription drugs was 56.6 percent with 38.9 percent under-reporting, 4.5 percent over-reporting. Number of prescriptions and assistance in survey completion were associated with higher likelihood of concordance for chronic conditions. Assistance in survey completion and number of chronic conditions were associated with higher concordance, and age and number of prescriptions were associated with lower concordance, for prescription drugs. Conclusions Self-reported number of chronic conditions and prescription medications are not in high concordance with claims data. Health care researchers and policy makers using patient self-reported data should be aware of these potential biases.

Politique de santé / Health Policy

Mackenbach, J. P. and M. McKee (2015). "Government, politics and health policy: A quantitative analysis of 30 European countries." *Health Policy* **119**(10): 1298-1308.

Public health policies are often dependent on political decision-making, but little is known of the impact of different forms of government on countries' health policies. In this exploratory study we studied the association between a wide range of process and outcome indicators of

health policy and four groups of political factors (levels of democracy, e.g. voice and accountability; political representation, e.g. voter turnout; distribution of power, e.g. constraints on the executive; and quality of government, e.g. absence of corruption) in contemporary Europe. DATA AND METHODS: Data on 15 aspects of government and 18 indicators of health policy as well as on potential confounders were extracted from harmonized international data sources, covering 30 European countries and the years 1990-2010. In a first step, multivariate regression analysis was used to relate cumulative measures of government to indicators of health policy, and in a second step panel regression with country fixed effects was used to relate changes in selected measures of government to changes in indicators of health policy. RESULTS: In multivariate regression analyses, measures of quality of democracy and quality of government had many positive associations with process and outcome indicators of health policy, while measures of distribution of power and political representation had few and inconsistent associations. Associations for quality of democracy were robust against more extensive control for confounding variables, including tests in panel regressions with country fixed effects, but associations for quality of government were not. CONCLUSIONS: In this period in Europe, the predominant political influence on health policy has been the rise of levels of democracy in countries in the Central & Eastern part of the region. In contrast to other areas of public policy, health policy does not appear to be strongly influenced by institutional features of democracy determining the distribution of power, nor by aspects of political representation. The effect of quality of government on health policy warrants more study.

Muth, C. and P. P. Glasziou (2015). "Guideline recommended treatments in complex patients with multimorbidity." *BMJ* 351.

New evidence is reassuring, but every patient is different. Multimorbidity is an increasing problem for both clinicians and patients. Aging populations, the increased complexity of managing chronic illness, and the tendency of guidelines to focus on a single disease have created a "perfect storm" of treatment burden. Consider the following patient: "Mrs S is a 79 year old woman with osteoporosis, osteoarthritis, type 2 diabetes mellitus, hypertension, and chronic obstructive pulmonary disease who takes 12 separate drugs in 19 doses five times during a typical day. A drug review revealed three drug-disease interactions, nine drug-drug interactions, and eight potential drug-food interactions." With this hypothetical case, a decade ago one study showed that the application of multiple guidelines to a patient with multimorbidity creates three problems¹: firstly, as comorbidity is a common reason for exclusion in clinical trials it is not known whether treatment effects in patients with multimorbidity are equivalent to those in patients with single diseases.^{2 3} Secondly, the application of multiple disease oriented guidelines bears the risks of potentially harmful interactions between diseases and treatments.^{4 5} Thirdly, an uncritical application of multiple guidelines adds to the burden of ...

Psychiatrie / Psychiatry

Vidon G. (2015/09). "Quelle place pour les soins sans consentement en ambulatoire ? À propos de l'enquête IDF sur les programmes de soins. ." *Information Psychiatrique* 91(7).

L'apparition des soins sans consentement en ambulatoire (ou programmes de soins, PS) depuis la loi du 5 juillet 2011 a introduit une nouvelle modalité thérapeutique qui n'est pas sans soulever de nombreuses interrogations à différents niveaux : cliniques et thérapeutiques mais aussi éthiques et surtout de résultats. Une étude observationnelle a été

menée auprès des secteurs d'Île-de-France (145 secteurs) avec pour buts de déterminer – deux ans après l'entrée en jeu de la loi – comment ils sont mis en place, à quels types de patients ils s'adressent et comment ils se déroulent. Sont également étudiés les facteurs services impliqués dans leur initiation, ainsi que les contenus et le déroulement des PS. Cette enquête, qui a rencontré un taux de réponse élevé (76 %), a permis d'enregistrer que cette nouvelle forme de soins est bien intégrée par les acteurs de terrain.

Masson, M. (2015). "[Editorial: About the French translation of the DSM-5]." *Encéphale* 41(4)

Sun, K. S., et al. (2015). "Managing common mental health problems: contrasting views of primary care physicians and psychiatrists." *Family Practice* 32(5): 538-544.

Background. Recent studies have reported a lack of collaboration and consensus between primary care physicians (PCPs) and psychiatrists. Objective. To compare the views of PCPs and psychiatrists on managing common mental health problems in primary care. Methods. Four focus group interviews were conducted to explore the in-depth opinions of PCPs and psychiatrists in Hong Kong. The acceptance towards the proposed collaborative strategies from the focus groups were investigated in a questionnaire survey with data from 516 PCPs and 83 psychiatrists working in public and private sectors. Results. In the focus groups, the PCPs explained that several follow-up sessions to build up trust and enable the patients to accept their mental health problems were often needed before making referrals. Although some PCPs felt capable of managing common mental health problems, they had limited choices of psychiatric drugs to prescribe. Some public PCPs experienced the benefits of collaborative care, but most private PCPs perceived limited support from psychiatrists. The survey showed that around 90% of PCPs and public psychiatrists supported setting up an agreed protocol of care, management of common mental health problems by PCPs, and discharging stabilized patients to primary care. However, only around 54–67% of private psychiatrists supported different components of these strategies. Besides, less than half of the psychiatrists agreed with setting up a support hotline for the PCPs to consult them. Conclusions. The majority of PCPs and psychiatrists support management of common mental health problems in primary care, but there is significantly less support from the private psychiatrists.

Soins de santé primaires / Primary Health Care

Astier-Peña, M. P., et al. (2015). "Are Spanish primary care professionals aware of patient safety?" *The European Journal of Public Health* 25(5): 781-787.

Background: Knowledge about safety culture improves patient safety (PS) in health-care organizations. The first contact a patient has with health care occurs at the primary level. We conducted a survey to measure patient safety culture (PSC) among primary care professionals (PCPs) of health centres (HCs) in Spain and analyzed PS dimensions that influence PSC. Methods: We used Agency for Healthcare Research and Quality (AHRQ) Medical Office Survey on Patient Safety Culture translated and validated into Spanish to conduct a cross-sectional anonymous postal survey. We randomly selected a sample of 8378 PCPs at 289 HCs operated by 17 Regional Health Services. Statistical analysis was performed on sociodemographic variables, survey items, PS dimensions and a patient safety synthetic index (PSSI), calculated as average score of the items per dimension, to identify potential predictors of PSC. We used AHRQ data to conduct international comparison. Results: A total of 4344 PCPs completed the questionnaire. The response rate was 55.69%. Forty-two

percent were general practitioners, 34.9% nurses, 18% administrative staff and 4.9% other professionals. The highest scoring dimension was 'PS and quality issues' 4.18 (4.1–4.20) 'Work pressure and pace' was the lowest scored dimension with 2.76 (2.74–2.79). Professionals over 55 years, with managerial responsibilities, women, nurses and administrative staff, had better PSSI scores. Professionals with more than 1500 patients and working for more than 11 years at primary care had lower PSSI scores. Conclusions: This is the first national study to measure PSC in primary care in Spain. Results may reflect on-going efforts to build a strong PSC. Further research into its association with safety outcomes and patients' perceptions is required.

Austin, D. R. and L. C. Baker (2015). "Less Physician Practice Competition Is Associated With Higher Prices Paid For Common Procedures." *Health Aff (Millwood)* 34(10): 1753-1760.

Concentration among physician groups has been steadily increasing, which may affect prices for physician services. We assessed the relationship in 2010 between physician competition and prices paid by private preferred provider organizations for fifteen common, high-cost procedures to understand whether higher concentration of physician practices and accompanying increased market power were associated with higher prices for services. Using county-level measures of the concentration of physician practices and county average prices, and statistically controlling for a range of other regional characteristics, we found that physician practice concentration and prices were significantly associated for twelve of the fifteen procedures we studied. For these procedures, counties with the highest average physician concentrations had prices 8-26 percent higher than prices in the lowest counties. We concluded that physician competition is frequently associated with prices. Policies that would influence physician practice organization should take this into consideration.

Aysola, J., et al. (2015). "Patient-centered Medical Homes and Access to Services for New Primary Care Patients." *Med Care* 53(10): 857-862.

BACKGROUND: Recent efforts to revitalize primary care have centered on the patient-centered medical home (PCMH). Although enhanced access is an integral component of the PCMH model, the effect of PCMHs on access to primary care services is understudied. **OBJECTIVE:** To determine whether PCMH practices are associated with better access to new appointments for nonelderly adults by direct measurement. **RESEARCH DESIGN:** We estimated the relationship between practice PCMH status and access to care in multivariate regression models, adjusting for a robust set of patient, practice, and geographic characteristics; using data on 11,347 simulated patient calls to 7266 primary care practices across 10 US states merged with data on PCMH practices. **PARTICIPANTS:** Trained field staff posing as patients (age younger than 65 y) seeking a new primary care appointment with varying insurance status (private, Medicaid, or self-pay). **MEASURES:** Our primary predictor was practice PCMH status and our primary outcome was the ability of simulated patients to schedule a new appointment. Secondary outcomes included the number of days to that appointment; availability of after-hour appointments; and an appointment with an ongoing primary care provider. **RESULTS:** Of the 7266 practices contacted for an appointment, 397 (5.5%) were National Committee for Quality Assurance-recognized PCMHs. In adjusted analyses, callers to PCMH practices compared with non-PCMH practices were more likely to schedule a new appointment (adjusted odds ratio=1.26 (95% CI, 1.01-1.58); P=0.04] and be offered after-hour appointments [adjusted odds ratio=1.36 (95% CI, 1.04-1.75); P=0.02]. **DISCUSSION:** PCMH practices maybe associated with better access to new primary care appointments for nonelderly adults, those most likely to gain insurance under the Affordable Care Act.

Decker, S. L. (2015). "Acceptance of New Medicaid Patients by Primary Care Physicians and Experiences with Physician Availability among Children on Medicaid or the Children's Health Insurance Program." *Health Serv Res* 50(5): 1508-1527.

OBJECTIVE: To estimate the relationship between physicians' acceptance of new Medicaid patients and access to health care. DATA SOURCES: The National Ambulatory Medical Care Survey (NAMCS) Electronic Health Records Survey and the National Health Interview Survey (NHIS) 2011/2012. STUDY DESIGN: Linear probability models estimated the relationship between measures of experiences with physician availability among children on Medicaid or the Children's Health Insurance Program (CHIP) from the NHIS and state-level estimates of the percent of primary care physicians accepting new Medicaid patients from the NAMCS, controlling for other factors. PRINCIPAL FINDINGS: Nearly 16 percent of children with a significant health condition or development delay had a doctor's office or clinic indicate that the child's health insurance was not accepted in states with less than 60 percent of physicians accepting new Medicaid patients, compared to less than 4 percent in states with at least 75 percent of physicians accepting new Medicaid patients. Adjusted estimates and estimates for other measures of access to care were similar. CONCLUSIONS: Measures of experiences with physician availability for children on Medicaid/CHIP were generally good, though better in states where more primary care physicians accepted new Medicaid patients.

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

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

Kmietowicz, Z. (2015). "New GP contract will replace targets with seven day working." *BMJ* 351.

Zosia Kmietowicz¹The BMJ GPs in the United Kingdom will be offered a new contract, with scaled-back targets in exchange for seven day services, the government has announced. The prime minister, David Cameron, said on the BBC's current affairs Andrew Marr Show on 4 October that the government would be publishing a new GP contract "to get rid of the box ticking and the form filling and to focus on making sure people in our country can get access to a GP on a seven day a week basis, 8 am to 8 pm." The BMA condemned the government for announcing the new GP contract with no prior discussion with the association and no regard to the problems facing primary care. The new contract, which will be voluntary, will ...

Olthof, M., et al. (2015). "Towards a differentiated capitation system: relation between patient characteristics, contacts and costs." *Family Practice* 32(5): 545-550.

Background and objective. A new payment system could curb primary health care costs. A

differentiated capitation system based on patient characteristics could be the best mix for payment. To test the feasibility of such a system, we examined the number of contacts between patients and general practitioners (GPs), the related costs and the relationship with age, sex and comorbidity. Methods. A retrospective observational study included 29304 primary care patients in the Netherlands. Age, sex and comorbidity were related to number of contacts per patients per year and costs using a negative binomial regression analysis. Results. Males, younger patients and patients with no comorbidities visit their GP least often. Medically unexplained physical symptoms, diabetes and severe back complaints generate the most contacts; diabetes is specifically related to higher costs. Conclusion. Several patient characteristics are related to the number of contacts patients have with their GP and the consecutive remuneration. This study can be used as an input to create a differentiated capitation system.

Peckham, S., et al. (2015). Health Services and Delivery Research. The organisation and delivery of health improvement in general practice and primary care: a scoping study. Southampton (UK), NIHR Journals Library

This project examines the organisation and delivery of health improvement activities by and within general practice and the primary health-care team. The project was designed to examine who delivers these interventions, where they are located, what approaches are developed in practices, how individual practices and the primary health-care team organise such public health activities, and how these contribute to health improvement. Our focus was on health promotion and ill-health prevention activities. The aim of this scoping exercise was to identify the current extent of knowledge about the health improvement activities in general practice and the wider primary health-care team. The key objectives were to provide an overview of the range and type of health improvement activities, identify gaps in knowledge and areas for further empirical research. Our specific research objectives were to map the range and type of health improvement activity undertaken by general practice staff and the primary health-care team based within general practice; to scope the literature on health improvement in general practice or undertaken by health-care staff based in general practice and identify gaps in the evidence base; to synthesise the literature and identify effective approaches to the delivery and organisation of health improvement interventions in a general practice setting; and to identify the priority areas for research as defined by those working in general practice. We undertook a comprehensive search of the literature. We followed a staged selection process involving reviews of titles and abstracts. This resulted in the identification of 1140 papers for data extraction, with 658 of these papers selected for inclusion in the review, of which 347 were included in the evidence synthesis. We also undertook 45 individual and two group interviews with primary health-care staff. Many of the research studies reviewed had some details about the type, process or location, or who provided the intervention. Generally, however, little attention is paid in the literature to examining the impact of the organisational context on the way services are delivered or how this affects the effectiveness of health improvement interventions in general practice. We found that the focus of attention is mainly on individual prevention approaches, with practices engaging in both primary and secondary prevention. The range of activities suggests that general practitioners do not take a population approach but focus on individual patients. However, it is clear that many general practitioners see health promotion as an integral part of practice, whether as individual approaches to primary or secondary health improvement or as a practice-based approach to improving the health of their patients. Our key conclusion is that there is currently insufficient good evidence to support many of the health improvement interventions undertaken in general practice and primary care more widely. Future research on health improvement in general practice and by the primary health-care team needs to move beyond clinical research to include delivery systems and be

conducted in a primary care setting. More research needs to examine areas where there are chronic disease burdens - cancer, dementia and other disabilities of old age. Reviews should be commissioned that examine the whole prevention pathway for health problems that are managed within primary care drawing together research from general practice, pharmacy, community engagement, etc. The National Institute for Health Research Health Services and Delivery Research programme.

Sinnige, J., et al. (2015). "Multimorbidity patterns in a primary care population aged 55 years and over." *Family Practice* 32(5): 505-513.

Background. To support the management of multimorbid patients in primary care, evidence is needed on prevalent multimorbidity patterns. Objective. To identify the common and distinctive multimorbidity patterns. Methods. Clinical data of 120480 patients (≥55 years) were extracted from 158 general practices in 2002–11. Prevalence rates of multimorbidity were analyzed (overall, and for 24 chronic diseases), adjusted for practice, number of diseases and patients' registration period; differentiated between patients 55–69 and ≥70 years. To investigate multimorbidity patterns, prevalence ratios (prevalence rate index-disease group divided by that in the non-index-disease group) were calculated for patients with heart failure, diabetes mellitus, migraine or dementia. Results. Multiple membership multilevel models showed that the overall adjusted multimorbidity rate was 86% in patients with ≥1 chronic condition, varying from 70% (migraine) to 98% (heart failure), 38% had ≥4 chronic diseases. In patients 55–69 years, 83% had multimorbidity. Numerous significant prevalence ratios were found for disease patterns in heart failure patients, ranging from 1.2 to 7.7, highest ratio for chronic obstructive pulmonary disease-cardiac dysrhythmia. For diabetes mellitus, dementia or migraine patients highest ratios were for heart failure-visual disorder (2.1), heart failure-depression (3.9) and depression-back/neck disorder (2.1), respectively (all P-values <0.001). Conclusions. Multimorbidity management in general practice can be reinforced by knowledge on the clinical implications of the presence of the comprehensive disease patterns among the elderly patients, and those between 55 and 69 years. Guideline developers should be aware of the complexity of multimorbidity. As a consequence of this complexity, it is even more important to focus on what matters to a patient with multimorbidity in general practice.

Wallace, E., et al. (2015). "Managing patients with multimorbidity in primary care." *BMJ* 350.

Multimorbidity is commonly defined as the presence of two or more chronic medical conditions in an individual and it can present several challenges in care particularly with higher numbers of coexisting conditions and related polypharmacy. Practices should actively identify patients with complex multimorbidity and adopt a policy of continuity of care for these patients by assigning them a named doctor. The adoption of a policy for routine extended consultations should be considered for particularly complex patients or the introduction of occasional "specific extended consultations." allowing protected time to deal with problems encountered in the management of chronic diseases.

Systèmes de santé / Health Policy

Atun, R. (2015). "Transforming Turkey's Health System — Lessons for Universal Coverage." *New England Journal of Medicine* 373(14): 1285-1289.

Mechanic, R. E. (2015). "Mandatory Medicare Bundled Payment — Is It Ready for Prime Time?"

New England Journal of Medicine **373**(14): 1291-1293.

Travail et santé / Occupational Health

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

This study evaluates the short-run impact of an increase in childcare subsidies on the use of paid childcare and the participation rate of mothers of preschool children. We use a natural experiment provided by the PAJE, a French reform in family allowances introduced in 2004. This reform temporarily creates discrepancies in the childcare subsidies received by families according to the year of birth of the children. We apply a difference-in-differences strategy on exhaustive French fiscal data that provide information on gross income as well as on the use of paid childcare services between 2005 and 2008. We use the fact that the new policy results in a significant increase in the use of paid childcare services. The effect on the labor force participation of mothers is significant but of a smaller magnitude. The highest impact is observed for mothers of large families.

Hamad, R., et al. (2015). "The Effects of Job Insecurity on Health Care Utilization: Findings from a Panel of U.S. Workers." Health Services Research: n/a-n/a.

Objective To examine the impacts of job insecurity during the recession of 2007–2009 on health care utilization among a panel of U.S. employees. **Data Sources/Study Setting** Linked administrative and claims datasets on a panel of continuously employed, continuously insured individuals at a large multisite manufacturing firm that experienced widespread layoffs (N = 9,486). **Study Design** We employed segmented regressions to examine temporal discontinuities in utilization during 2006–2012. To assess the effects of job insecurity, we compared individuals at high- and low-layoff plants. Because the dataset includes multiple observations for each individual, we included individual-level fixed effects. **Principal Findings** We found discontinuous increases in outpatient (3.5 visits/month/10,000 individuals, $p = .002$) and emergency (0.4 visits/month/10,000 individuals, $p = .05$) utilization in the panel of all employees. Compared with individuals at low-layoff plants, individuals at high-layoff plants decreased outpatient utilization (–4.0 visits/month/10,000 individuals, $p = .008$), suggesting foregone preventive care, with a marginally significant increase in emergency utilization (0.4 visits/month/10,000 individuals, $p = .08$). **Conclusions** These results suggest changes in health care utilization and potentially adverse impacts on employee health in response to job insecurity during the latest recession. This study contributes to our understanding of the impacts of economic crises on the health of the U.S. working population.

Huijts, T., et al. (2015). "The impacts of job loss and job recovery on self-rated health: testing the mediating role of financial strain and income." The European Journal of Public Health **25**(5): 801-806.

Background: Is regaining a job sufficient to reverse the harmful impacts on health of job loss during the Great Recession? We tested whether unemployed persons who found work within 1 year of job loss experienced a full recovery of their health. Additionally, we tested the mediating role of financial strain and household income. **Methods:** Linear regression models were used to assess the effects of job loss and recovery on self-rated health using the longitudinal EU-SILC, covering individuals from 27 European countries. We constructed a

baseline of employed persons ($n = 70\,611$) in year 2007. We evaluated income and financial strain as potential mediating factors. Results: Job loss was associated with worse self-rated health in both men ($\beta = 0.12$, 95%CI: 0.09–0.15) and women ($\beta = 0.13$, 95%CI: 0.10–0.16). Financial strain explains about one-third of the association between job loss and health, but income did not mediate this relation. Women who regained employment within 1 year after job loss were found to be similarly healthy to those who did not lose jobs. In contrast, men whose employment recovered had an enduring health disadvantage compared with those who had not lost jobs ($\beta = 0.11$, 95%CI: 0.05–0.16). Unemployment cash benefits mitigated financial strain but were too low to substantially reduce perceived financial strain among men. Conclusions: Men and women's health appears to suffer equally from job loss but differs in recovery. For men, employment recovery was insufficient to alleviate financial strain and associated health consequences, whereas in women regaining employment leads to health recovery.

Lengagne, P. (2015). "Experience Rating and Work-Related Health and Safety." Journal of Labor Research: 1-29.

In the area of Workers Compensation Insurance schemes, experience rating (ER) is a common incentive tool, in many countries. Premiums paid by firms are experience rated, which should encourage them to improve working conditions and reduce work-related injuries and disabilities. Using sectorial data for industry and construction sectors in 2005, this article provides empirical insights into the influence of ER on work-related health and safety in the context of the French jurisdiction. We examine the relationship between firm premium rate variations and adverse working conditions indicators, controlling for observables, assuming the hypothesis of an asymmetric firm response to premium increases and decreases. The results are consistent with the hypothesis that ER is a lever to improve working conditions and reduce work-related injury rates. Further investigation is needed to understand the influence of ER on firm behavior.

Toge, A. G. and M. Blekesaune (2015). "Unemployment transitions and self-rated health in Europe: A longitudinal analysis of EU-SILC from 2008 to 2011." Soc Sci Med **143: 171-178.**

The Great Recession of 2008 has led to elevated unemployment in Europe and thereby revitalised the question of causal health effects of unemployment. This article applies fixed effects regression models to longitudinal panel data drawn from the European Union Statistics on Income and Living Conditions for 28 European countries from 2008 to 2011, in order to investigate changes in self-rated health around the event of becoming unemployed. The results show that the correlation between unemployment and health is partly due to a decrease in self-rated health as people enter unemployment. Such health changes vary by country of domicile, and by individual age; older workers have a steeper decline than younger workers. Health changes after the unemployment spell reveal no indication of adverse health effects of unemployment duration. Overall, this study indicates some adverse health effects of unemployment in Europe - predominantly among older workers.

Wubulhasimu, P., et al. (2015). "Does living longer in good health facilitate longer working lives? The relationship between disability and working lives." The European Journal of Public Health **25(5): 791-795.**

Background: Improvements in life expectancy have fuelled debates about the statutory retirement age in many European countries. This article contributes to this debate by investigating how changes in disability may influence both employment outcomes and disability-free life expectancy. Methods: We used data from the European Community Household Panel to estimate the impact of disability incidence on labour supply by country using propensity score techniques. In a second step, we translated the estimated effects of

disability incidence into effects on working life expectancy as well as disability-free life expectancy using multi-state life tables. Results: Results from the matching analysis show that individuals who become disabled are more likely to leave the labour market. However, the size of the effect is much weaker than a simple descriptive analysis suggests and varies by country. A 10% decrease in disability incidence results in increases in disability-free life expectancy and working life expectancy of respectively 0.6 and 0.07 years on average. Conclusion: A large part of the differences in employment between disabled and non-disabled individuals is not due to a causal effect of disability on employment. Policies that reduce disability incidence increase disability-free life expectancy but have only a limited impact on working life expectancy.

Vieillesse / Ageing

Ferraro, K. F. and L. R. Wilkinson (2015). "Alternative Measures of Self-Rated Health for Predicting Mortality Among Older People: Is Past or Future Orientation More Important?" The Gerontologist 55(5): 836-844.

Purpose: The purpose of this study was to compare the prognostic validity of alternative measures of health ratings, including those that tap temporal reflections, on adult mortality. Design and Methods: The study uses a national sample of 1,266 Americans 50–74 years old in 1995, with vital status tracked through 2005, to compare the effect of 3 types of health ratings on mortality: conventional indicator of self-rated health (SRH), age comparison form of SRH, and health ratings that incorporate temporal dimensions. Logistic regression was used to estimate the odds of mortality associated with alternative health ratings while adjusting for health conditions, lifestyle factors, and status characteristics and resources. Results: Self-rated health was a consistent predictor of mortality, but the respondent's expected health rating—10 years in the future—was an independent predictor. Future health expectations were more important than past (recalled change) in predicting mortality risk: People with more negative expectations of future health were less likely to survive. Implications: The findings reveal the importance of future time perspective for older people and suggest that it is more useful to query older people about their future health expectations than about how their health has changed.

Friedman, E. M., et al. (2015). "US Prevalence And Predictors Of Informal Caregiving For Dementia." Health Aff (Millwood) 34(10): 1637-1641.

In 2010, 5.5 million US adults ages seventy and older received informal care, including 3.6 million with cognitive impairment or probable dementia. Adults with probable dementia received 171 hours of monthly informal care, versus 89 hours for cognitively impaired adults without dementia and 66 hours for cognitively normal adults.

Grabowski, D. C., et al. (2015). "Integrated Payment And Delivery Models Offer Opportunities And Challenges For Residential Care Facilities." Health Aff (Millwood) 34(10): 1650-1656.

Under health care reform, new financing and delivery models are being piloted to integrate health and long-term care services for older adults. Programs using these models generally have not included residential care facilities. Instead, most of them have focused on long-term care recipients in the community or the nursing home. Our analyses indicate that individuals living in residential care facilities have similarly high rates of chronic illness and Medicare utilization when compared with matched individuals in the community and nursing home, and rates of functional dependency that fall between those of their counterparts in the other

two settings. These results suggest that the residential care facility population could benefit greatly from models that coordinated health and long-term care services. However, few providers have invested in the infrastructure needed to support integrated delivery models. Challenges to greater care integration include the private-pay basis for residential care facility services, which precludes shared savings from reduced Medicare costs, and residents' preference for living in a home-like, noninstitutional environment.

Kasper, J. D., et al. (2015). "The Disproportionate Impact Of Dementia On Family And Unpaid Caregiving To Older Adults." Health Aff (Millwood) 34(10): 1642-1649.

The number of US adults ages sixty-five and older who are living with dementia is substantial and expected to grow, raising concerns about the demands that will be placed on family members and other unpaid caregivers. We used data from the 2011 National Health and Aging Trends Study and its companion study, the National Study of Caregiving, to investigate the role of dementia in caregiving. We found that among family and unpaid caregivers to older noninstitutionalized adults, one-third of caregivers, and 41 percent of the hours of help they provide, help people with dementia, who account for about 10 percent of older noninstitutionalized adults. Among older adults who receive help, the vast majority in both community and residential care settings other than nursing homes rely on family or unpaid caregivers (more than 90 percent and more than 80 percent, respectively), regardless of their dementia status. Caregiving is most intense, however, to older adults with dementia in community settings and from caregivers who are spouses or daughters or who live with the care recipient.

Madero-Cabib, I. and L. Kaeser (2015). "How voluntary is the active ageing life? A life-course study on the determinants of extending careers." European Journal of Ageing: 1-13.

In Switzerland, as in many other European states, there is an increasing emphasis in public policy on promoting later retirement from the labour market. But this accelerating drive in Swiss policy-making to extend occupational activity does not mean that every worker is currently likely to retire late, nor does it imply that all those who do retire late do so voluntarily. This article uses a life-course approach, first to study the determinants of late retirement, and secondly to analyse whether the decision to postpone retirement is made voluntarily or involuntarily. Both objectives are addressed on the basis of data from the Swiss survey Vivre/Leben/Vivere. The results of logistic regression modelling indicate that, whereas self-employed and more highly educated individuals are more likely to retire late, people with access to private pension funds and workers who have benefited from periods of economic growth have a lower tendency to retire late. Regarding voluntariness, those who are more likely to opt for voluntary late retirement tend to be Swiss citizens, more highly educated, and also benefited from periods of economic expansion, while the self-employed, men and widowed individuals leaving the labour market late tend to do so involuntarily. In conclusion, the article discusses the absence of a social inequality debate in the design of active ageing policies

Kaeser L., Roch P.A. (2015). "Le vieillissement actif: élaboration, légitimation et tentatives de diffusion d'un référentiel transversal en Europe." Critique internationale,(68): 145-169.

Le rôle endossé par la Commission européenne dans le processus de diffusion du vieillissement actif permet de comprendre comment est élaboré et légitimé le quasi-consensus politique relatif à la nécessité de maintenir en activité les personnes âgées pour répondre au « problème » du vieillissement. L'émergence de la notion de vieillissement actif au regard des politiques sociales internationales est présentée dans un but de contextualisation et de mise en sens. Sont identifiés les organisations internationales et leur rôle dans la définition du vieillissement actif en fonction de leur place dans le champ des

politiques sociales internationales. Le volet empirique se focalise sur les mécanismes que la CE met en place pour légitimer et diffuser la notion de vieillissement actif. Cette contribution mobilise les méthodes de l'analyse de contenu et de l'analyse lexicométrique, et s'appuie sur des matériaux différenciés et illustratifs des modes d'élaboration et de diffusion adoptés par la CE. Il est ainsi démontré que l'efficacité aussi bien technique que politique du référentiel transversal du vieillissement actif vient de ce qu'il est présenté comme une solution positive et consensuelle par l'évasion des déterminants sociaux inhérents au processus du vieillissement.