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DOC VEILLE

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

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Contacts

Espace documentation : documentation@irdes.fr

Marie-Odile Safon : safon@irdes.fr

Véronique Suhard : suhard@irdes.fr

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Assurance maladie / Health Insurance

Anand, P. (2016). "Health Insurance Costs and Employee Compensation: Evidence from the National Compensation Survey." Health Econ : Ahead of print, Dec 27.

This paper examines the relationship between rising health insurance costs and employee compensation. I estimate the extent to which total compensation decreases with a rise in health insurance costs and decompose these changes in compensation into adjustments in wages, non-health fringe benefits, and employee contributions to health insurance premiums. I examine this relationship using the National Compensation Survey, a panel dataset on compensation and health insurance for a sample of establishments across the USA. I find that total hourly compensation reduces by \$0.52 for each dollar increase in health insurance costs. This reduction in total compensation is primarily in the form of higher employee premium contributions, and there is no evidence of a change in wages and non-health fringe benefits. These findings show that workers are absorbing at least part of the increase in health insurance costs through lower compensation and highlight the importance of examining total compensation, and not just wages, when examining the relationship between health insurance costs and employee compensation. Copyright (c) 2016 John Wiley & Sons, Ltd.

Graves, J. A. and P. Mishra (2016). "The Evolving Dynamics of Employer-Sponsored Health Insurance: Implications for Workers, Employers, and the Affordable Care Act." Milbank Q 94(4): 736-767.

Economie de la santé / Health Economics

Markovitz, A. A. and A. M. Ryan (2016). "Pay-for-Performance: Disappointing Results or Masked Heterogeneity?" Med Care Res Rev. : Ahead of print, Jan 07.

Research on the effects of pay-for-performance (P4P) in health care indicates largely disappointing results. This central finding, however, may mask important heterogeneity in the effects of P4P. We conducted a literature review to assess whether hospital and physician performance in P4P vary by patient and catchment area factors, organizational and structural capabilities, and P4P program characteristics. Several findings emerged: organizational size, practice type, teaching status, and physician age and gender modify performance in P4P. For physician practices and hospitals, a higher proportion of poor and minority patients is consistently associated with worse performance. Other theoretically influential characteristics-including information technology and staffing levels-yield mixed results. Inconsistent and contradictory effects of bonus likelihood, bonus size, and marginal costs on performance in P4P suggest organizations have not responded strategically to financial incentives. We conclude that extant heterogeneity in the effects of P4P does not fundamentally alter current assessments about its effectiveness.

Rocco, P., et al. (2017). "The New Politics of US Health Care Prices: Institutional Reconfiguration and the Emergence of All-Payer Claims Databases." J Health Polit Policy Law 42(1): 5-52.

Prices are a significant driver of health care cost in the United States. Existing research on the politics of health system reform has emphasized the limited nature of policy entrepreneurs' efforts at solving the problem of rising prices through direct regulation at the state level. Yet this literature fails to account for how change agents in the states gradually reconfigured the politics of prices, forging new, transparency-based policy instruments called all-payer claims databases (APCDs), which are designed to empower consumers, purchasers, and states to make informed market and policy choices. Drawing on pragmatist institutional theory, this article shows how APCDs emerged as the dominant model for reforming health care prices. While APCD advocates faced significant institutional barriers to policy change, we show how they reconfigured existing ideas, tactical repertoires, and legal-technical

infrastructures to develop a politically and technologically robust reform. Our analysis has important implications for theories of how change agents overcome structural barriers to health reform.

Verma, R., et al. (2017). "Impact of State Public Health Spending on Disease Incidence in the United States from 1980 to 2009." *Health Serv Res* 52(1): 176-190.

OBJECTIVE: To understand the relationship between state-level spending by public health departments and the incidence of three vaccine preventable diseases (VPDs): mumps, pertussis, and rubella in the United States from 1980 to 2009. **DATA SOURCES:** This study uses state-level public health spending data from The Census Bureau and annual mumps, pertussis, and rubella incidence counts from the University of Pittsburgh's project Tycho. **STUDY DESIGN:** Ordinary least squares (OLS), fixed effects, and random effects regression models were tested, with results indicating that a fixed effects model would be most appropriate model for this analysis. **PRINCIPAL FINDINGS:** Model output suggests a statistically significant, negative relationship between public health spending and mumps and rubella incidence. Lagging outcome variables indicate that public health spending actually has the greatest impact on VPD incidence in subsequent years, rather than the year in which the spending occurred. Results were robust to models with lagged spending variables, national time trends, and state time trends, as well as models with and without Medicaid and hospital spending. **CONCLUSION:** Our analysis indicates that there is evidence of a significant, negative relationship between a state's public health spending and the incidence of two VPDs, mumps and rubella, in the United States.

Géographie de la santé / Geography of Health

Aubert, F., et al. (2016). "Quelle place pour les espaces ruraux dans le millefeuille territorial ?". In : Campagnes contemporaines. Quae éditions : 117.

Badland, H., et al. (2017). "Examining associations between area-level spatial measures of housing with selected health and wellbeing behaviours and outcomes in an urban context." *Health & Place* 43: 17-24.

Adequate and affordable housing is a major social determinant of health; yet no work has attempted to conceptually map and spatially test area-level measures of housing with selected health and wellbeing outcomes. Sourcing data from 7,753 adults from Melbourne, Australia, we tested associations between area-level measures of housing density, tenure, and affordability with individual-level measures of neighbourhood safety, community satisfaction, and self-rated health. Compared with the reference groups, the odds of: feeling unsafe was higher for residents living in areas with less affordable housing; community dissatisfaction was ~30% higher in those living in areas with >36% residential properties assigned as rentals, and was significantly higher in the least affordable areas (OR =1.57). Compared with the reference groups, as dwelling density, proportion of rental properties, and housing unaffordability increased, the odds of reporting poorer self-rated health increased; however these associations did not always reach statistical significance. This work highlights the benefits of evidenced-based planning spatial measures to support health and wellbeing.

Barczak, A. and M. Hilal (2016). "L'accès aux commerces et services dans les territoires de vie du quotidien." In : Campagnes contemporaines. Quae éditions : 97.

Caldwell, J. T., et al. (2017). "Racial and ethnic residential segregation and access to health care in rural areas." *Health & Place* 43: 104-112.

This study examined the relationship between racial/ethnic residential segregation and access to health care in rural areas. Data from the Medical Expenditure Panel Survey were merged with the American Community Survey and the Area Health Resources Files. Segregation was operationalized using the isolation index separately for African Americans and Hispanics. Multi-level logistic regression with random intercepts estimated four outcomes. In rural areas, segregation contributed to worse

access to a usual source of health care but higher reports of health care needs being met among African Americans (Adjusted Odds Ratio [AOR]: 1.42, CI: 0.96-2.10) and Hispanics (AOR: 1.25, CI: 1.05-1.49). By broadening the spatial scale of segregation beyond urban areas, findings showed the complex interaction between social and spatial factors in rural areas.

Doyle, J. M. and R. A. Streeter (2017). "Veterans' Location in Health Professional Shortage Areas: Implications for Access to Care and Workforce Supply." *Health Serv Res* 52 Suppl 1: 459-480.

OBJECTIVE: To describe the distribution of Veterans in areas of the United States where there are potentially inadequate supplies of health professionals, and to explore opportunities suggested by this distribution for fostering health workforce flexibility. DATA SOURCES: County-level data from the 2015-2016 Health Resources and Services Administration's (HRSA's) Area Health Resources Files (AHRF) were used to estimate Veteran populations in HRSA-designated health professional shortage areas (HPSAs). This information was then linked to 2015 VA health facility information from the Department of Veterans Affairs. STUDY DESIGN: Potential Veteran populations living in Shortage Area Counties with no VHA facilities were estimated, and the composition of these populations was explored by Census division and state. PRINCIPAL FINDINGS: Nationwide, approximately 24 percent of all Veterans and 23 percent of Veterans enrolled in VHA health care live in Shortage Area Counties. These estimates mask considerable variation across states. CONCLUSIONS: An examination of Veterans residing in Shortage Area Counties suggests extensive maldistribution of health services across the United States and the continued need to find ways to improve health care access for all Veterans. Effective avenues for doing so may include increasing health workforce flexibility through expansion of nurse practitioner scopes of practice.

Streeter, R. A., et al. (2017). "Perspectives: Using Results from HRSA's Health Workforce Simulation Model to Examine the Geography of Primary Care." *Health Serv Res* 52 Suppl 1: 481-507.

OBJECTIVE: Inform health planning and policy discussions by describing Health Resources and Services Administration's (HRSA's) Health Workforce Simulation Model (HWSM) and examining the HWSM's 2025 supply and demand projections for primary care physicians, nurse practitioners (NPs), and physician assistants (PAs). DATA SOURCES: HRSA's recently published projections for primary care providers derive from an integrated microsimulation model that estimates health workforce supply and demand at national, regional, and state levels. PRINCIPAL FINDINGS: Thirty-seven states are projected to have shortages of primary care physicians in 2025, and nine states are projected to have shortages of both primary care physicians and PAs. While no state is projected to have a 2025 shortage of primary care NPs, many states are expected to have only a small surplus. CONCLUSIONS: Primary care physician shortages are projected for all parts of the United States, while primary care PA shortages are generally confined to Midwestern and Southern states. No state is projected to have shortages of all three provider types. Projected shortages must be considered in the context of baseline assumptions regarding current supply, demand, provider-service ratios, and other factors. Still, these findings suggest geographies with possible primary care workforce shortages in 2025 and offer opportunities for targeting efforts to enhance workforce flexibility.

Wang, V., et al. (2017). "Impacts of Geographic Distance on Peritoneal Dialysis Utilization: Refining Models of Treatment Selection." *Health Serv Res* 52(1): 35-55.

OBJECTIVE: To examine the relationship between distance to dialysis provider and patient selection of dialysis modality, informed by the absolute distance from a patient's home and relative distance of alternative modalities. DATA SOURCES: U.S. Renal Data System. STUDY DESIGN: About 70,131 patients initiating chronic dialysis and 4,795 dialysis facilities in 2006. The primary outcome was patient utilization of peritoneal dialysis (PD). Independent variables included absolute distance between patients' home and the nearest hemodialysis (HD) facility, relative distance between patients' home and nearest PD versus nearest HD facilities, and their interaction. Logistic regression was used to model distance on PD use, controlling for patient and market characteristics. PRINCIPAL FINDINGS: Nine percent of incident dialysis patients used PD in 2006. There was a positive, nonlinear relationship between absolute distance to HD services and PD use ($p < .0001$), with the magnitude of the effect

increasing at greater distances. In terms of relative distance, odds of PD use increased if a PD facility was closer or the same distance as the nearest HD facility ($p = .006$). Interaction of distance measures to dialysis facilities was not significant. CONCLUSIONS: Analyses of patient choice between alternative treatments should model distance to reflect all relevant dimensions of geographic access to treatment options.

Hôpital / Hospitals

Choury, J. P. and D. Graimaud (2016/06). "La laïcité dans les établissements de santé." Actualité et Dossier en Santé publique(95): 5-10.

La laïcité s'est progressivement imposée en Europe, mais elle diffère en fonction de l'histoire de chaque pays qui la constitue. La France se distingue par l'intensité qu'a revêtue cette question et par l'affirmation de son identité laïque dès l'article 1 de la Constitution de la Ve République.

Emmert, M., et al. (2017). "Public reporting of hospital quality shows inconsistent ranking results." Health Policy 121(1): 17-26.

BACKGROUND: Evidence from the US has demonstrated that hospital report cards might generate confusion for consumers who are searching for a hospital. So far, little is known regarding hospital ranking agreement on German report cards as well as underlying factors creating disagreement. OBJECTIVE: This study examined the consistency of hospital recommendations on German hospital report cards and discussed underlying reasons for differences. METHODS: We compared hospital recommendations for three procedures on four German hospital report cards. The agreement between two report cards was determined by Cohen's-Kappa. Fleiss' kappa was applied to evaluate the overlap across all four report cards. RESULTS: Overall, 43.40% of all hospitals were labeled equally as low, middle, or top performers on two report cards (hip replacement: 43.2%; knee replacement: 42.8%; percutaneous coronary intervention: 44.3%). In contrast, 8.5% of all hospitals were rated a top performer on one report card and a low performer on another report card. The inter-report card agreement was slight at best between two report cards ($kappa_{max}=0.148$) and poor between all four report cards ($kappa_{max}=0.111$). CONCLUSIONS: To increase the benefit of public reporting, increasing the transparency about the concept of - medical - "quality" that is represented on each report card seems to be important. This would help patients and other consumers use the report cards that most represent one's individual preferences.

Kenkmann, A., et al. (2017). "Negotiating and valuing spaces: The discourse of space and 'home' in care homes." Health & Place 43: 8-16.

This paper examines how space in care homes is experienced and negotiated by people who live and work in them. The analysis of qualitative data of five in-depth case studies of care homes in England revealed three key ways in which space is negotiated: a) the way in which values affect interactions inside versus outside the care home environment, b) the negotiation of boundaries and domains within the homes, and c) the sense of being at 'home'. The paper illuminates how the design of the buildings and organisational factors can reinforce or bridge dichotomies between inside and outside spaces. Residents' abilities to re-negotiate boundaries, domains and communal spaces within homes are shown to be affected by organisational factors such as priorities of staff members. Despite 'home' being a common discourse, the spaces within care homes were often organised, ordered and experienced as two distinct, co-present worlds: the dwelling place of residents and the workplace of staff.

Schussler-Fiorenza Rose, S. M., et al. (2017). "Potentially Avoidable Hospitalizations among People at Different Activity of Daily Living Limitation Stages." Health Serv Res 52(1): 132-155.

OBJECTIVE: To determine whether higher activity of daily living (ADL) limitation stages are associated

with increased risk of hospitalization, particularly for ambulatory care sensitive (ACS) conditions. DATA SOURCE: Secondary data analysis, including 8,815 beneficiaries from 2005 to 2006 Medicare Current Beneficiary Survey (MCBS). STUDY DESIGN: ADL limitation stages (0-IV) were determined at the end of 2005. Hospitalization rates were calculated for 2006 and age adjusted using direct standardization. Multivariate negative binomial regression, adjusting for baseline demographic and health characteristics, with the outcome hospitalization count was performed to estimate the adjusted rate ratio of ACS and non-ACS hospitalizations for beneficiaries with ADL stages > 0 compared to beneficiaries without limitations. DATA COLLECTION: Baseline ADL stage and health conditions were assessed using 2005 MCBS data and count of hospitalization determined using 2006 MCBS data. PRINCIPAL FINDINGS: Referenced to stage 0, the adjusted rate ratios (95 percent confidence interval) for stage I to stage IV ranged from 1.9 (1.4-2.5) to 4.1 (2.2-7.8) for ACS hospitalizations compared with from 1.6 (1.3-1.9) to 1.8 (1.4-2.5) for non-ACS hospitalizations. CONCLUSIONS: Hospitalization rates for ACS conditions increased more dramatically with ADL limitation stage than did rates for non-ACS conditions. Adults with ADL limitations appear particularly vulnerable to potentially preventable hospitalizations for conditions typically manageable in ambulatory settings.

Taille, C., et al. (2017). "Enquête de pratique sur l'organisation de la prise en charge de l'asthme sévère dans des centres universitaires français." *Revue des Maladies Respiratoires* 34(S): 41A.

Il est recommandé par la plupart des sociétés savantes de créer une filière de soins spécialisée pour la prise en charge de l'asthme sévère afin d'améliorer le diagnostic et le traitement de ces patients. En France, l'organisation d'un tel réseau de soins n'est pas encore formalisée. Nous avons souhaité connaître l'organisation et les moyens actuellement disponibles pour la prise en charge de l'asthme sévère dans des services hospitalo-universitaires plus particulièrement impliqués dans la prise en charge de l'asthme sévère en France. Méthodes : Enquête de pratique nationale, multicentrique, descriptive, réalisée en 2015. Un questionnaire en 23 points a été adressé par voie électronique au responsable de chaque centre. Résultats : Onze centres d'adultes et 4 centres de pédiatrie ont répondu à l'enquête. La file active de patients suivis est en moyenne de 151 [50–350] par centre, avec en moyenne 48 nouveaux patient/an/centre. Treize (87 %) centres organisent des réunions de concertation sur l'asthme sévère (moyenne 3,9 réunions/an). Les explorations disponibles dans les centres sont l'endoscopie bronchique (100 %), l'expectoration induite (73 %), la mesure du FeNO (91 %), le test d'hyperventilation (82 %). La prise en charge des allergies alimentaires est faite dans 91 % des centres et des allergies cutanées dans 82 %. Un programme d'éducation thérapeutique dédié à l'asthme sévère a été mis en place dans 83 % des centres, concernant en moyenne 65 adultes et 167 enfants/centre. La plupart des comorbidités de l'asthme sont prises en charge par des collaborateurs internes au centre, à part le syndrome d'hyperventilation et la dysfonction des cordes vocales qui sont adressés dans 20 % des cas à des centres compétents externes à l'hôpital. Tous les centres adultes ont participé à un essai clinique (phase 2, 3 ou académique) dans les 2 années précédentes, avec 798 patients adultes inclus au total sur cette période. Cinq centres pratiquaient la thermoplastie en 2015. Conclusion : Les moyens techniques dont disposent les centres hospitalo-universitaires spécifiquement impliqués dans la prise en charge de l'asthme sévère et ayant répondu à l'enquête sont assez homogènes. Comprendre pourquoi le nombre de patients adressés dans ces centres est faible, comparativement à la population d'asthmatiques sévères attendue, devrait aider à organiser une filière de soins « asthme sévère » en France. Cette enquête a été réalisée grâce au soutien du laboratoire AstraZeneca.

Winblad, U., et al. (2017). "ACO-Affiliated Hospitals Reduced Rehospitalizations From Skilled Nursing Facilities Faster Than Other Hospitals." *Health Aff (Millwood)* 36(1): 67-73.

Medicare's more than 420 accountable care organizations (ACOs) provide care for a considerable percentage of the elderly in the United States. One goal of ACOs is to improve care coordination and thereby decrease rates of rehospitalization. We examined whether ACO-affiliated hospitals were more effective than other hospitals in reducing rehospitalizations from skilled nursing facilities. We found a general reduction in rehospitalizations from 2007 to 2013, which suggests that all hospitals made efforts to reduce rehospitalizations. The ACO-affiliated hospitals, however, were able to reduce rehospitalizations more quickly than other hospitals. The reductions suggest that ACO-affiliated

hospitals are either discharging to the nursing facilities more effectively compared to other hospitals or targeting at-risk patients better, or enhancing information sharing and communication between hospitals and skilled nursing facilities. Policy makers expect that reducing readmissions to hospitals will generate major savings and improve the quality of life for the frail elderly. However, further work is needed to investigate the precise mechanisms that underlie the reduction of readmissions among ACO-affiliated hospitals.

Inégalités de santé / Health Inequalities)

Sannino, N., et al. (2016/09). "Comment améliorer les parcours de soins des publics précaires ? Le point de vue des usagers." *Actualité et Dossier en Santé Publique*(96): 4-8.

Les difficultés d'accès aux soins rencontrées par les personnes en situation de précarité sont-elles spécifiques ou identiques à celles des autres usagers ? C'est l'objet d'une étude qualitative commanditée par la DGOS, dont cet article fait l'analyse.

Médicaments / Pharmaceuticals

Sinnott, S. J., et al. (2017). "The international generalisability of evidence for health policy: A cross country comparison of medication adherence following policy change." *Health Policy* **121(1): 27-34.**

Copayments for prescriptions may increase morbidity and mortality via reductions in adherence to medications. Relevant data can inform policy to minimise such unintended effects. We explored the generalisability of evidence for copayments by comparing two international copayment policies, one in Massachusetts and one in Ireland, to assess whether effects on medication adherence were comparable. We used national prescription data for public health insurance programmes in Ireland and Medicaid data in the U.S. New users of oral anti-hypertensive, anti-hyperlipidaemic and diabetic drugs were included (total n=14,259 in U.S. and n=43,843 in Ireland). We examined changes in adherence in intervention and comparator groups in each setting using segmented linear regression with generalised estimating equations. In Massachusetts, a gradual decrease in adherence to anti-hypertensive medications of -1% per month following the policy occurred. In contrast, the response in Ireland was confined to a -2.9% decrease in adherence immediately following the policy, with no further decrease over the 8 month follow-up. Reductions in adherence to oral diabetes drugs were larger in the U.S. group in comparison to the Irish group. No difference in adherence changes between the two settings for anti-hyperlipidaemic drugs occurred. Evidence on cost-sharing for prescription medicines is not 'one size fits all'. Time since policy implementation and structural differences between health systems may influence the differential impact of copayment policies in international settings.

Siorat, V., et al. (2017). "[Impact of the expiry of the patent on quality and price of medicines at hospital: Study of five anticancer drugs from 2008 to 2015 at the Assistance publique-Hopitaux de Paris]." *Ann Pharm Fr* **75(1): 59-66.**

OBJECTIVES: Anticancer drugs were in 2005 the first expenditure item of the hospital drugs. Ten years later, it is noted that the placing on the market of generic drugs has led to a strong decrease of their price. To determine whether this decrease comes at the expense of product quality, a price-quality ratio trend study of five anticancer drugs was performed at AP-HP. METHOD: This work concerns docetaxel, oxaliplatin, gemcitabine, irinotecan and paclitaxel, and focus on the transition period between monopoly conditions and competitive situation (2008 to 2015). The price is set by calculating the cost per milligram of each specialty. Quality is evaluated by the average of quality marks obtained during the analysis of the tenders received in the purchasing procedures on four assessment criteria:

ready for use form, stability of the solution after dilution, safety use and labeling. RESULTS: Between 2008 and 2015, the price per milligram of these anticancer drugs decreases, following the placing on the market of generic drugs. The quality of the tenders is maintained and even improved in many cases. On average, generic rating quality, lower than that of the originators in 2008, are now the highest. CONCLUSION: This study allows an objective basis of the effects of the drop in patent originator medicines. The placing on the market of generic drugs has a double positive result for the buyer: strong price cuts, parallel to the quality improvement, through the example of five anticancer drugs studied.

Méthodologie – Statistique / Methodology - Statistics

(2016/12). "8e Colloque de données de santé en vie réelle (AFCROs ADELFI)." Revue d'Épidémiologie et de Santé Publique 64(Supplément 6): S287-S314.

Bautista, M. A., et al. (2016). "Instruments Measuring Integrated Care: A Systematic Review of Measurement Properties." Milbank Q 94(4): 862-917.

Policy Points: Investigations on systematic methodologies for measuring integrated care should coincide with the growing interest in this field of research. A systematic review of instruments provides insights into integrated care measurement, including setting the research agenda for validating available instruments and informing the decision to develop new ones. This study is the first systematic review of instruments measuring integrated care with an evidence synthesis of the measurement properties. We found 209 index instruments measuring different constructs related to integrated care; the strength of evidence on the adequacy of the majority of their measurement properties remained largely unassessed. CONTEXT: Integrated care is an important strategy for increasing health system performance. Despite its growing significance, detailed evidence on the measurement properties of integrated care instruments remains vague and limited. Our systematic review aims to provide evidence on the state of the art in measuring integrated care. METHODS: Our comprehensive systematic review framework builds on the Rainbow Model for Integrated Care (RMIC). We searched MEDLINE/PubMed for published articles on the measurement properties of instruments measuring integrated care and identified eligible articles using a standard set of selection criteria. We assessed the methodological quality of every validation study reported using the COSMIN checklist and extracted data on study and instrument characteristics. We also evaluated the measurement properties of each examined instrument per validation study and provided a best evidence synthesis on the adequacy of measurement properties of the index instruments. FINDINGS: From the 300 eligible articles, we assessed the methodological quality of 379 validation studies from which we identified 209 index instruments measuring integrated care constructs. The majority of studies reported on instruments measuring constructs related to care integration (33%) and patient-centered care (49%); fewer studies measured care continuity/comprehensive care (15%) and care coordination/case management (3%). We mapped 84% of the measured constructs to the clinical integration domain of the RMIC, with fewer constructs related to the domains of professional (3.7%), organizational (3.4%), and functional (0.5%) integration. Only 8% of the instruments were mapped to a combination of domains; none were mapped exclusively to the system or normative integration domains. The majority of instruments were administered to either patients (60%) or health care providers (20%). Of the measurement properties, responsiveness (4%), measurement error (7%), and criterion (12%) and cross-cultural validity (14%) were less commonly reported. We found <50% of the validation studies to be of good or excellent quality for any of the measurement properties. Only a minority of index instruments showed strong evidence of positive findings for internal consistency (15%), content validity (19%), and structural validity (7%); with moderate evidence of positive findings for internal consistency (14%) and construct validity (14%). CONCLUSIONS: Our results suggest that the quality of measurement properties of instruments measuring integrated care is in need of improvement with the less-studied constructs and domains to become part of newly developed instruments.

Enders, D., et al. (2017). "The Potential of High-Dimensional Propensity Scores in Health Services Research: An Exemplary Study on the Quality of Care for Elective Percutaneous Coronary Interventions." *Health Serv Res.* : Ahead of print, Jan 16.

OBJECTIVE: Evaluating the potential of the high-dimensional propensity score (HDPS) to control for residual confounding in studies analyzing quality of care based on administrative health insurance data. DATA SOURCE: Secondary data from 2004 to 2009 from three German statutory health insurance providers. STUDY DESIGN: We conducted a retrospective cohort study in patients with elective percutaneous coronary interventions (PCIs) and compared the mortality risk between the in- and outpatient setting using Cox regression. Adjustment for predefined confounders was performed using conventional propensity score (PS) techniques. Further, an HDPS was calculated based on predefined and empirically selected confounders from the database. PRINCIPAL FINDINGS: Conventional PS methods showed a decreased mortality risk for outpatient compared to inpatient PCIs, while trimming of patients with nonoverlap in the HDPS distribution and weighting resulted in a comparable risk. Most comorbidities were less prevalent in the HDPS-trimmed population compared to the original one. CONCLUSION: The HDPS methodology may reduce residual confounding by rendering the studied cohort more comparable through restriction. However, results cannot be generalized for the entire study population. To provide unbiased results, full assessment of all unmeasured confounders from proxy information in the database would be necessary.

Fraher, E. P., et al. (2017). "A Methodology for Using Workforce Data to Decide Which Specialties and States to Target for Graduate Medical Education Expansion." *Health Serv Res* **52 Suppl 1: 508-528.**

OBJECTIVE: To outline a methodology for allocating graduate medical education (GME) training positions based on data from a workforce projection model. DATA SOURCES: Demand for visits is derived from the Medical Expenditure Panel Survey and Census data. Physician supply, retirements, and geographic mobility are estimated using concatenated AMA Masterfiles and ABMS certification data. The number and specialization behaviors of residents are derived from the AAMC's GMETrack survey. DESIGN: We show how the methodology could be used to allocate 3,000 new GME slots over 5 years-15,000 total positions-by state and specialty to address workforce shortages in 2026. EXTRACTION METHODS: We use the model to identify shortages for 19 types of health care services provided by 35 specialties in 50 states. PRINCIPAL FINDINGS: The new GME slots are allocated to nearly all specialties, but nine states and the District of Columbia do not receive any new positions. CONCLUSIONS: This analysis illustrates an objective, evidence-based methodology for allocating GME positions that could be used as the starting point for discussions about GME expansion or redistribution.

Standfield, L. B., et al. (2017). "An empirical comparison of Markov cohort modeling and discrete event simulation in a capacity-constrained health care setting." *Eur J Health Econ* **18(1): 33-47.**

OBJECTIVES: To empirically compare Markov cohort modeling (MM) and discrete event simulation (DES) with and without dynamic queuing (DQ) for cost-effectiveness (CE) analysis of a novel method of health services delivery where capacity constraints predominate. METHODS: A common data-set comparing usual orthopedic care (UC) to an orthopedic physiotherapy screening clinic and multidisciplinary treatment service (OPSC) was used to develop a MM and a DES without (DES-no-DQ) and with DQ (DES-DQ). Model results were then compared in detail. RESULTS: The MM predicted an incremental CE ratio (ICER) of \$495 per additional quality-adjusted life-year (QALY) for OPSC over UC. The DES-no-DQ showed OPSC dominating UC; the DES-DQ generated an ICER of \$2342 per QALY. CONCLUSIONS: The MM and DES-no-DQ ICER estimates differed due to the MM having implicit delays built into its structure as a result of having fixed cycle lengths, which are not a feature of DES. The non-DQ models assume that queues are at a steady state. Conversely, queues in the DES-DQ develop flexibly with supply and demand for resources, in this case, leading to different estimates of resource use and CE. The choice of MM or DES (with or without DQ) would not alter the reimbursement of OPSC as it was highly cost-effective compared to UC in all analyses. However, the modeling method

may influence decisions where ICERs are closer to the CE acceptability threshold, or where capacity constraints and DQ are important features of the system. In these cases, DES-DQ would be the preferred modeling technique to avoid incorrect resource allocation decisions.

Thayssen, S., et al. (2017). "General practitioners' experience of using a questionnaire when assessing cancer patients' needs: a qualitative study." *Fam Pract* 34(1): 114-118.

BACKGROUND: International guidelines recommend health care professionals to use supportive tools like questionnaires when assessing cancer patients' needs. Little is known about GPs' perspectives and experience in this regard. **OBJECTIVE:** To examine how GPs experience to involve a short questionnaire, completed by patients' prior to a consultation, when addressing the patients' problems and needs. The aim is to contribute to the knowledge concerning the use of questionnaires as part of clinical cancer care in general practice. **METHODS:** Semi-structured individual interviews with 11 GPs in the Region of Southern Denmark purposefully sampled with regard to gender, years working in general practice and practice form. Interviews were analyzed using systematic text condensation. **RESULTS:** Most GPs found that using the questionnaire provided a supportive structure to the consultation. The questionnaire helped to bring forward issues of importance to the patients, which might otherwise not have been mentioned and enhanced a patient-centered approach. A few GPs found the use of the questionnaire to be restraining, detracting focus from the patient and impede usual practice. **CONCLUSIONS:** This study shows that using questionnaires may have the potential to improve clinical cancer care in general practice in relation to needs assessment of cancer patients and the results support current recommendations.

Van Dijk, I., et al. (2017). "Reliability and validity of the Dutch version of the Consultation and Relational Empathy Measure in primary care." *Fam Pract* 34(1): 119-124.

BACKGROUND: Empathy is an essential skill in doctor-patient communication with positive effects on compliance, patient satisfaction and symptom duration. There are no validated patient-rated empathy measures available in Dutch. **OBJECTIVE:** To investigate the validity and reliability of a Dutch version of the Consultation and Relational Empathy (CARE) Measure, a widely used 10-item patient-rated questionnaire of physician empathy. **METHODS:** After translation and back translation, the Dutch CARE Measure was distributed among patients from 19 general practitioners in 5 primary care centers. Tests of internal reliability and validity included Cronbach's alpha, item total correlations and factor analysis. Seven items of the QUality Of care Through the patient's Eyes (QUOTE) questionnaire assessing 'affective performance' of the physician were included in factor analysis and used to investigate convergent validity. **RESULTS:** Of the 800 distributed questionnaires, 655 (82%) were returned. Acceptability and face validity were supported by a low number of 'does not apply' responses (range 0.2%-11.9%). Internal reliability was high (Cronbach's alpha 0.974). Corrected item total correlations were at a minimum of 0.837. Factor analysis on the 10 items of the CARE Measure and 7 QUOTE items resulted in two factors (Eigenvalue > 1), the first containing the CARE Measure items and the second containing the QUOTE items. Convergent construct validity between the CARE Measure and QUOTE was confirmed with a modest positive correlation ($r = 0.34$, $n = 654$, $P < 0.001$). **CONCLUSION:** The findings support the preliminary validity and reliability of the Dutch CARE Measure. Future research is required to investigate divergent validity and discriminant ability between doctors.

Politique de santé / Health Policy

Lopez-Valcarcel, B. G. and P. Barber (2017). "Economic Crisis, Austerity Policies, Health and Fairness: Lessons Learned in Spain." *Appl Health Econ Health Policy* 15(1): 13-21.

This paper reviews economic and medical research publications to determine the extent to which the measures applied in Spain to control public health spending following the economic and financial crisis that began in 2008 have affected healthcare utilization, health and fairness within the public healthcare system. The majority of the studies examined focus on the most controversial cutbacks

that came into force in mid-2012. The conclusions drawn, in general, are inconclusive. The consequences of this new policy of healthcare austerity are apparent in terms of access to the system, but no systematic effects on the health of the general population are reported. Studies based on indicators of premature mortality, avoidable mortality or self-perceived health have not found clear negative effects of the crisis on public health. The increased demands for co-payment provoked a short-term cutback in the consumption of medicines, but this effect faded after 12-18 months. No deterioration in the health of immigrants after the onset of the crisis was unambiguously detected. The impact of the recession on the general population in terms of diseases associated with mental health is well documented; however, the high levels of unemployment are identified as direct causes. Therefore, social policies rather than measures affecting the healthcare system would be primarily responsible. In addition, some health problems have a clear social dimension, which seems to have become more acute during the crisis, affecting in particular the most vulnerable population groups and the most disadvantaged social classes, thus widening the inequality gap.

Nesson, E. (2017). "Heterogeneity in Smokers' Responses to Tobacco Control Policies." *Health Econ* 26(2): 206-225.

This paper uses unconditional quantile regression to estimate whether smokers' responses to tobacco control policies change across the distribution of smoking levels. I measure smoking behavior with the number of cigarettes smoked per day and also with serum cotinine levels, a continuous biomarker of nicotine exposure, using individual-level repeated cross-section data from the National Health and Nutrition Examination Surveys. I find that the cigarette taxes lead to reductions in both the number of cigarettes smoked per day and in smokers' cotinine levels. These reductions are most pronounced in the middle quantiles of both distributions in terms of marginal effects, but most pronounced in the lower quantiles in terms of tax elasticities. I do not find that higher cigarette taxes lead to statistically significant changes in the amount of nicotine smokers ingest from each cigarette. Copyright (c) 2015 John Wiley & Sons, Ltd.

Weill Glès, C. (2016/03). "Dix ans de lutte contre le cancer." *Actualité et Dossier en Santé publique*(94): 58p.

Depuis 2003, une approche intégrée de lutte contre le cancer a été adoptée à travers des plans successifs. Ce dossier fait une évaluation de ces plans et présente les avancées et les points qui restent à améliorer sur la base des pratiques exemplaires qui devraient être étendues.

Prévention / Prevention

Bucher, S., et al. (2017). "Time and feasibility of prevention in primary care." *Fam Pract* 34(1): 49-56.

BACKGROUND: Prevention is an essential task in primary care. According to primary care physicians (PCPs), lack of time is one of the principal obstacles to its performance. **OBJECTIVE:** To assess the feasibility of prevention in terms of time by estimating the time necessary to perform all of the preventive care recommended, separately from the PCPs and patient's perspectives, and to compare them to the amount of time available. **METHODS:** A review of the literature identified the prevention procedures recommended in France, the duration of each procedure and its recommended frequency, as well as PCPs' consultation time. A hypothetical patient panel size of 1000 patients, representative of the French population, served as the basis for our calculations of the annual time necessary for prevention for a PCP. The prevention time from the patient's perspective was estimated from data collected from a previous study of a panel of 3556 patients. **RESULTS:** For PCPs, the annual time necessary for all of the required preventive care was 250 hours, or 20% of their total patient time. For a patient, the annual time required for prevention during encounters with a PCP ranged from 9.7 to 26.4 minutes per year. The mean total encounter time was 75.9 minutes per year. Nearly 73% of patients had a prevention-to-care time ratio exceeding 15%. **CONCLUSION:** Feasibility thus differs substantially between patients. These differences correspond especially to disparities in the annual

care time used by each patient. Specific solutions should be developed according to the patients' utilization of care.

Jena, A. B., et al. (2017). "Screening Mammography for Free: Impact of Eliminating Cost Sharing on Cancer Screening Rates." *Health Serv Res* 52(1): 191-206.

OBJECTIVES: To study the impact of eliminating cost sharing for screening mammography on mammography rates in a large Medicare Advantage (MA) health plan which in 2010 eliminated cost sharing in anticipation of the Affordable Care Act mandate. **STUDY SETTING:** Large MA health maintenance organization offering individual-subscriber MA insurance and employer-supplemented group MA insurance. **STUDY DESIGN:** We investigated the impact on breast cancer screening of a policy that eliminated a \$20 copayment for screening mammography in 2010 among 53,188 women continuously enrolled from 2007 to 2012 in an individual-subscriber MA plan, compared with 42,473 women with employer-supplemented group MA insurance in the same health maintenance organization who had full screening coverage during this period. We used differences-in-differences analysis to study the impact of cost-sharing elimination on mammography rates. **PRINCIPAL FINDINGS:** Annual screening rates declined over time for both groups, with similar trends pre-2010 and a slower decline after 2010 among women whose copayments were eliminated. Among women aged 65-74 years in the individual-subscriber MA plan, 44.9 percent received screening in 2009 compared with 40.9 percent in 2012, while 49.5 percent of women in the employer-supplemented MA plan received screening in 2009 compared with 44.1 percent in 2012, that is, a difference-in-difference effect of 1.4 percentage points less decline in screening among women experiencing the cost-sharing elimination. Effects were concentrated among women without recent screening. There were no differences by neighborhood socioeconomic status or race/ethnicity. **CONCLUSIONS:** Eliminating cost sharing for screening mammography was associated with modestly lower decline in screening rates among women with previously low screening adherence.

Prévision – Evaluation / Prevision - Evaluation

François, P., et al. "Les outils d'évaluation des structures pluriprofessionnelles en soins primaires : revue systématique." *Revue d'Épidémiologie et de Santé Publique*.

Résumé : Position du problème Les regroupements pluriprofessionnels en soins primaires se développent dans de nombreux pays dont la France. Ces groupements apparaissent très hétérogènes quant au niveau d'intégration et de coopération interprofessionnelle. L'objectif de cette étude était de réaliser une revue systématique des instruments d'évaluation du développement organisationnel des structures de soins primaires. **Méthodes** La littérature scientifique a été recherchée dans la base de données Pubmed, la littérature grise a été recherchée sur Internet. Les données récoltées comportaient des informations sur les instruments d'évaluation : origine, contenu, mode d'utilisation, processus de validation. **Résultats** Soixante-cinq documents portant sur 16 instruments d'évaluation ont été retenus. Douze ont été développés en Amérique du Nord et quatre en Europe. Quatre instruments étaient des questionnaires d'évaluation, quatre des grilles d'accréditation et huit étaient des matrices de maturité. Les matrices de maturité étaient structurées en niveaux de développement organisationnel. Leur utilisation comportait une auto-évaluation individuelle par chaque professionnel, suivie par un consensus de groupe en présence d'un facilitateur externe. Les questionnaires d'évaluation et les grilles d'accréditation avaient des structures et des modes d'utilisation variables. Les instruments étaient structurés en 4 à 16 dimensions avec une médiane à 7. Six thématiques communes ont été identifiées : la gestion de la structure et de l'équipe, la démarche qualité, la gestion des données des patients, la coopération interprofessionnelle, l'accessibilité et la continuité des soins, et la formation. Les processus de validation des outils étaient très variables et le plus souvent incomplets. **Conclusion** Il existe un ensemble hétérogène d'instruments d'évaluation des structures de soins primaires. Ces instruments diffèrent par leur objectif, leur contenu et leur mode d'utilisation. On retrouve cependant des thématiques communes. Un questionnaire d'évaluation des regroupements pluriprofessionnels des soins primaires en langue française serait utile pour évaluer et suivre dans le

temps le développement organisationnel des centres, maisons et pôles de santé en France. Abstract Background Multiprofessional teams in primary care are developing in many countries including France. These groups appear very heterogeneous regarding the level of integration and interprofessional cooperation. A systematic review of the literature was performed to screen the instruments which assess the organizational development of primary care groups. Methods Scientific literature was searched in the Pubmed database, grey literature was searched for on the Internet. The documents were selected by two independent investigators. The collected data included information on assessment instruments: origin, content, method of use, and validation process. Results Sixty-five documents involving 16 assessment instruments were selected for the study. Twelve instruments have been developed in North America and 4 in Europe. Four instruments were evaluation questionnaires, 4 accreditation tools and 8 were maturity matrices. The maturity matrices were structured by levels of organizational development. Their use were effected by an individual self-assessment of each professional and then by consensus of the group in the presence of an external facilitator. The questionnaire and accreditation tools have organizations and use patterns variable. The number of questions ranged from 25 to 200 with a median of 80. The instruments were organized into 4 to 16 dimensions with a median of 7. Six common themes were identified: practice and staff management, quality development, data patient management, interprofessional cooperation, accessibility and continuity of care, and formation. The validation process of tools were variable and often incomplete. Conclusion The set of assessment tools for primary care group is heterogeneous in purpose, content and mode of use. However, common themes were found for all tools. An evaluation questionnaire, in French, would be useful to monitor over time and evaluate the organizational development of centers and health houses in France.

Psychiatrie / Psychiatry

Hatzenbuehler, M. L., et al. (2017). "Immigration policies and mental health morbidity among Latinos: A state-level analysis." *Social Science & Medicine* 174: 169-178.

Abstract : Rationale Despite abundant state-level policy activity in the U.S. related to immigration, no research has examined the mental health impact of the overall policy climate for Latinos, taking into account both inclusionary and exclusionary legislation. Objective To examine associations between the state-level policy climate related to immigration and mental health outcomes among Latinos. Methods We created a multi-sectoral policy climate index that included 14 policies in four domains (immigration, race/ethnicity, language, and agricultural worker protections). We then examined the relation of this policy climate index to two mental health outcomes (days of poor mental health and psychological distress) among Latinos from 31 states in the 2012 Behavioral Risk Factor Surveillance System (BRFSS), a population-based health survey of non-institutionalized individuals aged 18 years or older. Results Individuals in states with a more exclusionary immigration policy climate had higher rates of poor mental health days than participants in states with a less exclusionary policy climate (RR: 1.05, 95% CI: 1.00, 1.10). The association between state policies and the rate of poor mental health days was significantly higher among Latinos versus non-Latinos (RR for interaction term: 1.03, 95% CI: 1.01, 1.06). Furthermore, Latinos in states with a more exclusionary policy climate had 1.14 (95% CI: 1.04, 1.25) times the rate of poor mental health days than Latinos in states with a less exclusionary policy climate. Results were robust to individual- and state-level confounders. Sensitivity analyses indicated that results were specific to immigration policies, and not indicators of state political climate or of residential segregation. No relationship was observed between the immigration policy index and psychological distress. Conclusion These results suggest that restrictive immigration policies may be detrimental to the mental health of Latinos in the United States.

Soins de santé primaires / Primary Health Care

Brosig-Koch, J., et al. (2017). "The Effects of Introducing Mixed Payment Systems for Physicians: Experimental Evidence." *Health Econ* 26(2): 243-262.

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

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Mixed payment systems have become a prominent alternative to paying physicians through fee-for-service and capitation. While theory shows mixed payment systems to be superior, causal effects on physicians' behavior when introducing mixed systems are not well understood empirically. We systematically analyze the influence of fee-for-service, capitation, and mixed payment systems on physicians' service provision. In a controlled laboratory setting, we implement an exogenous variation of the payment method. Medical and non-medical students in the role of physicians in the lab (N = 213) choose quantities of medical services affecting patients' health outside the lab. Behavioral data reveal significant overprovision of medical services under fee-for-service and significant underprovision under capitation, although less than predicted when assuming profit maximization. Introducing mixed payment systems significantly reduces deviations from patient-optimal treatment. Although medical students tend to be more patient regarding, our results hold for both medical and non-medical students. Responses to incentive systems can be explained by a behavioral model capturing individual altruism. In particular, we find support that altruism plays a role in service provision and can partially mitigate agency problems, but altruism is heterogeneous in the population. Copyright (c) 2015 John Wiley & Sons, Ltd.

Detollenaere, J., et al. (2017). "Do We Reap What We Sow? Exploring the Association between the Strength of European Primary Healthcare Systems and Inequity in Unmet Need." *PLoS One* 12(1): e0169274.

Access to healthcare is inequitably distributed across different socioeconomic groups. Several vulnerable groups experience barriers in accessing healthcare, compared to their more wealthier counterparts. In response to this, many countries use resources to strengthen their primary care (PC) system, because in many European countries PC is the first entry-point to the healthcare system and plays a central role in the coordination of patients through the healthcare system. However it is unclear whether this strengthening of PC leads to less inequity in access to the whole healthcare system. This study investigates the association between strength indicators of PC and inequity in unmet need by merging data from the European Union Statistics on Income and Living Conditions database (2013) and the Primary Healthcare Activity Monitor for Europe (2010). The analyses reveal a significant association between the Gini coefficient for income inequality and inequity in unmet need. When the Gini coefficient of a country is one SD higher, the social inequity in unmet need in that particular country will be 4.960 higher. Furthermore, the accessibility and the workforce development of a country's PC system is inverse associated with the social inequity of unmet need. More specifically, when the access- and workforce development indicator of a country PC system are one standard deviation higher, the inequity in unmet healthcare needs are respectively 2.200 and 4.951 lower. Therefore, policymakers should focus on reducing income inequality to tackle inequity in access, and strengthen PC (by increasing accessibility and better-developing its workforce) as this can influence inequity in unmet need.

Holmes, G. M. and E. P. Fraher (2017). "Developing Physician Migration Estimates for Workforce Models." *Health Serv Res* 52 Suppl 1: 529-545.

OBJECTIVE: To understand factors affecting specialty heterogeneity in physician migration. DATA SOURCES/STUDY SETTING: Physicians in the 2009 American Medical Association Masterfile data were matched to those in the 2013 file. Office locations were geocoded in both years to one of 293 areas of the country. Estimated utilization, calculated for each specialty, was used as the primary predictor of migration. Physician characteristics (e.g., specialty, age, sex) were obtained from the 2009 file. Area characteristics and other factors influencing physician migration (e.g., rurality, presence of teaching hospital) were obtained from various sources. STUDY DESIGN: We modeled physician location decisions as a two-part process: First, the physician decides whether to move. Second, conditional on moving, a conditional logit model estimates the probability a physician moved to a particular area. Separate models were estimated by specialty and whether the physician was a resident. PRINCIPAL FINDINGS: Results differed between specialties and according to whether the physician was a resident in 2009, indicating heterogeneity in responsiveness to policies. Physician migration was higher between geographically proximate states with higher utilization for that specialty. CONCLUSIONS:

Models can be used to estimate specialty-specific migration patterns for more accurate workforce modeling, including simulations to model the effect of policy changes.

Hone, T., et al. (2017). "Effect of primary health care reforms in Turkey on health service utilization and user satisfaction." *Health Policy Plan* 32(1): 57-67.

Strengthening primary health care (PHC) is considered a priority for efficient and responsive health systems, but empirical evidence from low- and middle-income countries is limited. The stepwise introduction of family medicine across all 81 provinces of Turkey (a middle-income country) between 2005 and 2010, aimed at PHC strengthening, presents a natural experiment for assessing the effect of family medicine on health service utilization and user satisfaction. The effect of health system reforms, that introduced family medicine, on utilization was assessed using longitudinal, province-level data for 12 years and multivariate regression models adjusting for supply-side variables, demographics, socio-economic development and underlying yearly trends. User satisfaction with primary and secondary care services was explored using data from annual Life Satisfaction Surveys. Trends in preferred first point of contact (primary vs secondary, public vs. private), reason for choice and health services issues, were described and stratified by patient characteristics, provider type, and rural/urban settings. Between 2002 and 2013, the average number of PHC consultations increased from 1.75 to 2.83 per person per year. In multivariate models, family medicine introduction was associated with an increase of 0.37 PHC consultations per person ($P < 0.001$), and slower annual growth in PHC and secondary care consultations. Following family medicine introduction, the growth of PHC and secondary care consultations per person was 0.08 and 0.30, respectively, a year. PHC increased as preferred provider by 9.5% over 7 years with the reasons of proximity and service satisfaction, which increased by 14.9% and 11.8%, respectively. Reporting of poor facility hygiene, difficulty getting an appointment, poor physician behaviour and high costs of health care all declined ($P < 0.001$) in PHC settings, but remained higher among urban, low-income and working-age populations.

Ifediora, C. O. and G. D. Rogers (2017). "Levels and predictors of patient satisfaction with doctor home-visit services in Australia." *Fam Pract* 34(1): 63-70.

BACKGROUND: The Australian after-hours house-call (AHC) services has grown rapidly in the past few years. Even though recent studies have looked at aspects of the service as it concerns the medical personnel involved, no national study has explored patient satisfaction with the service. **OBJECTIVE:** This study aims to assess patient satisfaction with Australian AHC services and its predictors, with the hope of improving quality and patient outcomes. The findings might also have international relevance, given the developing nature of the AHC in most countries. **METHODS:** A cross-sectional survey of all 10838 patients known to have patronized the AHC service in Australia over a 1-week period. The main outcome measure was the Patient Satisfaction Questionnaire 18 (PSQ-18). **RESULTS:** A total of 1228 questionnaires were returned. General Satisfaction (GS) level was found to be 85.2% (mean 4.16/5). Other Scales of Satisfaction, in decreasing order, were 'Financial Aspects, FA' (87.4%; 4.36/5), 'Communication, CM' (87.3%; 4.18), 'Technical Quality, TA' (82.1%; 4.09), 'Time Spent with Doctor, TSD' (77.7%; 3.91), 'Interpersonal Manner, IM' (75.7%; 3.87) and 'Accessibility and Convenience, A&C' (72.9%; 3.82). The major predictor of increased satisfaction was the time it took the doctor to arrive, with increased satisfaction on GS ($T < 4$ hours; $P < 0.01$), IM ($T < 30$ minutes; $P = 0.03$), FA ($T < 2$ hours; $P = 0.01$), TSD ($T < 2$ hours; $P < 0.01$) and A&C ($T < 4$ hours; $P < 0.01$). Other positive predictors of aspects of satisfaction included 'being a student', 'age of patient ≤ 16 ' and 'being Australian born', while 'being on a pension' was negatively associated with Communication ($P = 0.03$). No associations were found with gender, marital status, employment status, family income or having children in the household. **CONCLUSIONS:** This study concludes that satisfaction in Australian AHC is high on all scales but recommends that the service providers should aim to attend to patients within 4 hours of their initial calls.

Kurtzman, E. T., et al. (2017). "Does the Regulatory Environment Affect Nurse Practitioners' Patterns of Practice or Quality of Care in Health Centers?" *Health Serv Res* 52 Suppl 1: 437-458.

OBJECTIVE: To examine the impact of state-granted nurse practitioner (NP) independence on patient-

level quality, service utilization, and referrals. DATA SOURCES/STUDY SETTING: The National Ambulatory Medical Care Survey's community health center (HC) subsample (2006-2011). Primary analyses included approximately 6,500 patient visits to 350 NPs in 220 HCs. STUDY DESIGN: Propensity score matching and multivariate regression analysis were used to estimate the impact of state-granted NP independence on each outcome, separately. Estimates were adjusted for sampling weights and NAMCS's complex design. DATA COLLECTION/EXTRACTION METHODS: Every "NP-patient visit unit" was isolated using practitioner and patient visit codes and, using geographic identifiers, assigned to its state-year and that state-year's level of NP independence based on scope of practice policies. Nine outcomes were specified using ICD-9 codes, standardized drug classification codes, and NAMCS survey items. PRINCIPAL FINDINGS: After matching, no statistically significant differences in quality were detected by states' independence status, although NP visits in states with prescriptive independence received more educational services (aIRR 1.66; 95 percent CI 1.09-2.53; $p = .02$) and medications (aIRR 1.26; 95 percent CI 1.04-1.53; $p = .02$), and NP visits in states with practice independence had a higher odds of receiving physician referrals (AOR 1.88; 95 percent CI 1.10-3.22; $p = .02$) than those in restricted states. CONCLUSIONS: Findings do not support a quality-scope of practice relationship.

Neil, A. L., et al. "The new Australian after-hours general practice incentive payment mechanism: equity for rural general practice?" *Health Policy* 120(7): 809-817.

In July 2015, a general practice incentive funding mechanism was introduced in Australia to reward general practices for providing after-hours care. The mechanism makes payments to practices on the basis of the (age-sex adjusted) number of patients seen by individual practices and service arrangements employed. The mechanism favours large urban practices and does not take into account the necessity of around-the-clock care provided by small rural practices. Insufficient consideration was given to regional specificity.

Skillman, M., et al. (2017). "Physician Engagement Strategies in Care Coordination: Findings from the Centers for Medicare & Medicaid Services' Health Care Innovation Awards Program." *Health Serv Res* 52(1): 291-312.

OBJECTIVE: To identify roles physicians assumed as part of new health care delivery models and related strategies that facilitated physician engagement across 21 Health Care Innovation Award (HCIA) programs. DATA SOURCES: Site-level in-depth interviews, conducted from 2014 to 2015 (N = 672) with program staff, leadership, and partners (including 95 physicians) and direct observations. STUDY DESIGN: NORC conducted a mixed-method evaluation, including two rounds of qualitative data collected via site visits and telephone interviews. DATA COLLECTION/EXTRACTION METHODS: We used qualitative thematic coding for data from 21 programs actively engaging physicians as part of HCIA interventions. PRINCIPAL FINDINGS: Establishing physician champions and ensuring an innovation-values fit between physicians and programs, including the strategies programs employed, facilitated engagement. Among engagement practices identified in this study, tailoring team working styles to meet physician preferences and conducting physician outreach and education were the most common successful approaches. CONCLUSIONS: We describe engagement strategies derived from a diverse range of programs. Successful programs considered physicians' values and engagement as components of process and policy, rather than viewing them as exogenous factors affecting innovation adoption. These types of approaches enabled programs to accelerate acceptance of innovations within organizations.

Systèmes de santé / Health Systems

Cole, M. B., et al. (2017). "At Federally Funded Health Centers, Medicaid Expansion Was Associated With Improved Quality Of Care." *Health Aff (Millwood)* 36(1): 40-48.

In 2014 many uninsured, low-income nonelderly adults gained access to health insurance in states that expanded Medicaid eligibility under the Affordable Care Act. Federally funded community health

centers were likely to be particularly affected by this expansion because many of their patients were uninsured and low income. We used a difference-in-differences approach to compare changes among 1,057 such centers in expansion versus nonexpansion states from 2011 to 2014, in terms of their patients' insurance coverage, the number of patients they served, and the quality of care they provided. Medicaid expansion was associated with large increases (12 percentage points) in Medicaid coverage and corresponding declines (11 percentage points) in uninsurance rates. The numbers of patients served increased in both expansion and nonexpansion states, and the magnitude of increase did not differ significantly between the groups of states. Medicaid expansion was associated with improved quality on four of eight measures examined: asthma treatment, Pap testing, body mass index assessment, and hypertension control. This analysis suggests that states' decisions about Medicaid expansion have important consequences for health center patients, with expansion improving treatment and outcomes of chronic disease and bolstering the use of recommended preventive services.

D'Aunno, T., et al. (2016). "Factors That Distinguish High-Performing Accountable Care Organizations in the Medicare Shared Savings Program." *Health Serv Res.* : Ahead of print, Dec 26.

OBJECTIVE: To identify factors that promote the effective performance of accountable care organizations (ACOs) in the Medicare Shared Savings Program. **DATA SOURCES/STUDY SETTING:** Data come from a convenience sample of 16 Medicare Shared Savings ACOs that were organized around large physician groups. We use claims data from the Center for Medicaid and Medicare Services and data from 60 interviews at three high-performing and three low-performing ACOs. **STUDY DESIGN:** Explanatory sequential design, using qualitative data to account for patterns observed in quantitative assessment of ACO performance. **DATA COLLECTION METHODS:** A total of 16 ACOs were first rank-ordered on measures of cost and quality of care; we then selected three high and three low performers for site visits; interview data were content-analyzed. **PRINCIPAL FINDINGS:** Results identify several factors that distinguish high- from low-performing ACOs: (1) collaboration with hospitals; (2) effective physician group practice prior to ACO engagement; (3) trusted, long-standing physician leaders focused on improving performance; (4) sophisticated use of information systems; (5) effective feedback to physicians; and (6) embedded care coordinators. **CONCLUSIONS:** Shorter interventions can improve ACO performance—use of embedded care coordinators and local, regional health information systems; timely feedback of performance data. However, longer term interventions are needed to promote physician-hospital collaboration and skills of physician leaders. CMS and other stakeholders need realistic timelines for ACO performance.

Kristensen, S. R. (2017). "Financial Penalties for Performance in Health Care." *Health Econ* 26(2): 143-148.

Phipps-Taylor, M. and S. M. Shortell (2016). "More Than Money: Motivating Physician Behavior Change in Accountable Care Organizations." *Milbank Q* 94(4): 832-861.

Technologies médicales- E-santé / Medical technologies – E-Health

Chauvin, J., et al. (2016). "Digital technologies for population health and health equity gains: the perspective of public health associations." *Journal of Public Health Policy* 37(2): 232-248.

Digital technology (DT) plays an increasingly important role in the health sector. This study explores how national public health associations (PHAs) use DT to achieve their mandate. The World Federation of Public Health Associations canvassed and conducted a semi-structured interview with its national public health association members about their use of DT, the challenges they encounter in using it, and their experiences and thoughts as to how to assess its impact, both organizationally as well as on population health and health equity. The study found that digital technology plays an important role in some PHAs, principally those in higher income countries. PHAs want to broaden their use within PHAs

and to assess how DT enables PHAs to achieve their organizational mandates and goals, including improved public health and health equity.

Chauvin, J. and L. Rispel (2016). "Digital technology, population health, and health equity." Journal of Public Health Policy 37(2): 145-153.

Frogner, B. K., et al. (2017). "The Association of Electronic Health Record Adoption with Staffing Mix in Community Health Centers." Health Serv Res 52 Suppl 1: 407-421.

OBJECTIVE: To assess how medical staffing mix changed over time in association with the adoption of electronic health records (EHRs) in community health centers (CHCs). STUDY SETTING: Community health centers within the 50 states and Washington, DC. STUDY DESIGN: Estimated how the change in the share of total medical staff full-time equivalents (FTE) by provider category between 2007 and 2013 was associated with EHR adoption using fractional multinomial logit. DATA COLLECTION: 2007-2013 Uniform Data System, an administrative data set of Section 330 federal grant recipients; and Readiness for Meaningful Use and HIT and Patient Centered Medical Home Recognition Survey responses collected from Section 330 recipients between December 2010 and February 2011. PRINCIPAL FINDINGS: Having an EHR system did significantly shift the share of workers over time between physicians and each of the other categories of health care workers. While an EHR system significantly shifted the share of physician and other medical staff, this effect did not significantly vary over time. CHCs with EHRs by the end of the study period had a relatively greater proportion of other medical staff compared to the proportion of physicians. CONCLUSIONS: Electronic health records appeared to influence staffing allocation in CHCs such that other medical staff may be used to support adoption of EHRs as well as be leveraged as an important care provider.

Graham, G. N., et al. (2016). "Population health-based approaches to utilizing digital technology: a strategy for equity." Journal of Public Health Policy 37(2): 154-166.

Health care disparities and high chronic disease rates burden many communities and disproportionately impact racial/ethnic populations in the United States. These disparities vary geographically, increase health care expenses, and result in shortened lifespans. Digital technologies may be one tool for addressing health disparities and improving population health by increasing individuals' access to health information—especially as most low-income U.S. residents gain access to smartphones. The Aetna Foundation partners with organizations to use digital technologies, including mobile applications, data collection, and related platforms, for learning and sharing. Projects range from the broad—childhood education, lifestyle modification, health IT training, and nutrition education, to the specific—local healthy foods, stroke rehabilitation, and collection of city-level data. We describe our approaches to grantmaking and discuss lessons learned and their implications. When combined with sound policy strategies, emerging, scalable, digital technologies will likely become powerful allies for improving health and reducing health disparities.

Leslie, M., et al. (2017). "An Ethnographic Study of Health Information Technology Use in Three Intensive Care Units." Health Serv Res. : Ahead of print, Jan 25.

OBJECTIVES: To identify the impact of a full suite of health information technology (HIT) on the relationships that support safety and quality among intensive care unit (ICU) clinicians. DATA SOURCES: A year-long comparative ethnographic study of three academic ICUs was carried out. A total of 446 hours of observational data was collected in the form of field notes. A subset of these observations-134 hours-was devoted to job-shadowing individual clinicians and conducting a time study of their HIT usage. PRINCIPAL FINDINGS: Significant variation in HIT implementation rates and usage was noted. Average HIT use on the two "high-use" ICUs was 49 percent. On the "low-use" ICU, it was 10 percent. Clinicians on the high-use ICUs experienced "silo" effects with potential safety and quality implications. HIT work was associated with spatial, data, and social silos that separated ICU clinicians from one another and their patients. Situational awareness, communication, and patient satisfaction were negatively affected by this siloing. CONCLUSIONS: HIT has the potential to

accentuate social and professional divisions as clinical communications shift from being in-person to electronically mediated. Socio-technically informed usability testing is recommended for those hospitals that have yet to implement HIT. For those hospitals already implementing HIT, we suggest rapid, locally driven qualitative assessments focused on developing solutions to identified gaps between HIT usage patterns and organizational quality goals.

Roldo, C., et al. (2017/01-02). "Ehpad-urgences : un dispositif de télémédecine pour une meilleure prise en charge du résident." *Techniques Hospitalières*(761): 6-10.

Travail et santé / Occupational Health

Banerjee, S., et al. (2017). "Effects of Psychiatric Disorders on Labor Market Outcomes: A Latent Variable Approach Using Multiple Clinical Indicators." *Health Econ* 26(2): 184-205.

In this paper, we estimate the effect of psychiatric disorders on labor market outcomes using a structural equation model with a latent index for mental illness, an approach that acknowledges the continuous nature of psychiatric disability. We also address the potential endogeneity of mental illness using an approach proposed by Lewbel (2012) that relies on heteroscedastic covariance restrictions rather than questionable exclusion restrictions for identification. Data come from the US National Comorbidity Survey - Replication and the National Latino and Asian American Study. We find that mental illness adversely affects employment and labor force participation and also reduces the number of weeks worked and increases work absenteeism. To assist in the interpretation of findings, we simulate the labor market outcomes of individuals meeting diagnostic criteria for mental disorder if they had the same mental health symptom profile as individuals not meeting diagnostic criteria. We estimate potential gains in employment for 3.5 million individuals, and reduction in workplace costs of absenteeism of \$21.6 billion due to the resultant improvement in mental health. Copyright (c) 2015 John Wiley & Sons, Ltd.

Brydsten, A., et al. (2017). "Does contextual unemployment matter for health status across the life course? A longitudinal multilevel study exploring the link between neighbourhood unemployment and functional somatic symptoms." *Health & Place* 43: 113-120.

This study examines whether neighbourhood unemployment is related to functional somatic symptoms, independently of the individual employment, across the life course and at four specific life course periods (age 16, 21, 30 and 42). Self-reported questioner data was used from a 26-year prospective Swedish cohort (n=1010) with complementary neighbourhood register data. A longitudinal and a set of age-specific cross-sectional hierarchical linear regressions was carried out. The results suggest that living in a neighbourhood with high unemployment has implications for residents' level of functional somatic symptoms, regardless of their own unemployment across time, particularly at age 30.

Pollak, C. (2017). "The impact of a sick pay waiting period on sick leave patterns." *Eur J Health Econ* 18(1): 13-31.

This article assesses how a waiting period for sick pay impacts sick leave patterns. In the French private sector, statutory sick benefits are granted after 3 days. However, 60 % of employers in this sector provide complementary sick pay to cover this waiting period. Linked employee-employer survey data compiled in 2009 are used to analyze the impact of this compensation on workers' sick leave behavior. The assessment isolates the insurance effect (moral hazard) from individual and environmental factors relating to sick leave (including health and working conditions). Results suggest that employees who are compensated during the 3-day waiting period are not more likely to have an absence. On the contrary, their sickness leaves are significantly shorter by 3 days on average. These results could be explained by consequences of presenteeism and ex post moral hazard when employees are exposed to a waiting period.

Rivera, B., et al. (2017). "Crisis, suicide and labour productivity losses in Spain." Eur J Health Econ 18(1): 83-96.

OBJECTIVES: Suicide became the first cause of death between the ages of 15 and 44 in Spain in the year 2013. Moreover, the suicide rate in Spain went up by more than 9 % with respect to the previous year. This increase could be related to the serious economic recession that Spain has been experiencing in recent years. In this sense, there is a lack of evidence to help assess to what extent these suicides have a social cost in terms of losses in human capital. Firstly, this article examines the relationship between the variables related to the economic cycle and the suicide rates in the 17 Spanish regions. Secondly, an estimate is made of the losses in labour productivity owing to these suicides. **METHODOLOGY:** In this article, panel data models are used to consider different variables related to the economic cycle. Demographic variables and the suicide rates for regions across Spain from 2002 to 2013 also come into play. The present and future production costs owing to premature death from suicide are calculated using a human capital model. These costs are valued from the gross salary that an individual no longer receives in the future at the very moment he or she leaves the labour market. **RESULTS:** The results provide a strong indication that a decrease in economic growth and an increase in unemployment negatively affect suicide rates. Due to suicide, 38,038 potential years of working life were lost in 2013. This has an estimated cost of over 565 million euros. **CONCLUSIONS:** The economic crisis endured by Spain in recent years has played a role in the higher suicide rates one can observe from the data in official statistics. From a social perspective, suicide is a public health problem with far-reaching consequences.

Vieillessement / Ageing

Christensen, H. K., et al. (2017). "Frailty characteristics and preventive home visits: an audit on elderly patients in Danish general practice." Fam Pract 34(1): 57-62.

AIM: Preventive home visits (PHVs) to frail elderly patients, provided by the GP, have been widely promoted in many health care systems, including the Danish system. This study investigates to what extent PHVs are provided to patients with characteristics of frailty. **METHODS:** During a four-week period, GPs and their staff in three different parts of Denmark filled in a questionnaire for each patient aged 75 years or older who attended the clinic or received a home visit. The association between 20 different frailty characteristics and the receipt of a PHV was assessed through logistic regression. **RESULTS:** A total of 73 GPs and 41 staff members sampled information about 3133 patients, of whom 332 patients (10.7%) had received a PHV within one year prior to their audit date. A PHV was closely associated with the patient's number of frailty characteristics. The adjusted odds ratios show that the receipt of a PHV was associated with a low walking distance 2.34 (1.65-3.31), dementia 3.35 (2.26-4.96), depression 2.24 (1.38-3.63) and a need for home care 3.40 (2.45-4.73), and increased with the GP's tendency to provide PHVs. **CONCLUSION:** Most PHV-receiving elderly patients have several characteristics of frailty, the most significant being impaired mobility, dementia, depression and a need for home care. PHVs are also more often provided to patients listed with a GP who has an overall high tendency to conduct these visits.