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Assurance maladie / Health Insurance

Grunow M., Nuscheler R. (2014). Public and private health insurance in Germany: the ignored risk selection problem. *Health Economics*, 23 (6) : 670-687.

Abstract: We investigate risk selection between public and private health insurance in Germany. With risk-rated premiums in the private system and community-rated premiums in the public system, advantageous selection in favor of private insurers is expected. Using 2000 to 2007 data from the German Socio-Economic Panel Study (SOEP), we find such selection. While private insurers are unable to select the healthy upon enrollment, they profit from an increase in the probability to switch from private to public health insurance of those individuals who have experienced a negative health shock. To avoid distorted competition between the two branches of health care financing, risk-adjusted transfers from private to public insurers should be instituted.

<http://dx.doi.org/10.1002/hec.2942>

Economie de la santé / Health Economics

Van M.H., Kim Phuong N.T., Saksena P., James C.D., Xu K. (2013). Financial burden of household out-of-pocket health expenditure in Viet Nam: findings from the National Living Standard Survey 2002-2010. *Soc Sci Med*, 96 258-263.

Abstract: In Viet Nam, household direct out-of-pocket (OOP) health expenditure as a share of the total health expenditure has been always high, ranging from 50% to 70%. The high share of OOP expenditure has been linked to different inequity problems such as catastrophic health expenditure (households must reduce their expenditure on other necessities) and impoverishment. This paper aims to examine catastrophic and poverty impacts of household out-of-pocket health expenditure in Viet Nam over time and identify socio-economic indicators associated with them. Data used in this research were obtained from a nationally representative household survey, Viet Nam Living Standard Survey 2002, 2004, 2006, 2008 and 2010. The findings revealed that there were problems in health care financing in Viet Nam - many households encountered catastrophic health expenditure and/or were pushed into poverty due to health care payments. The issues were pervasive over time. Catastrophic expenditure and impoverishment problems were more common among the households who had more elderly people and those located in rural areas. Importantly, the financial protection aspect of the national health insurance schemes was still modest. Given these findings, more attention is needed on developing methods of financial protection in Viet Nam.

Atella V., Conti V. (2014). The effect of age and time to death on primary care costs: the Italian experience. *Social Science & Medicine*, (Ahead of pub).

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

Géographie de la santé / Geography of Health

Scott A., Witt J., Humphreys J., Joyce C., Kalb G., Jeon S.H., McGrail M. (2013). Getting doctors into the bush: general practitioners' preferences for rural location. *Soc Sci Med*, 96 33-44.

Abstract: A key policy issue in many countries is the maldistribution of doctors across geographic areas, which has important effects on equity of access and health care costs. Many government programs and incentive schemes have been established to encourage doctors to practise in rural

areas. However, there is little robust evidence of the effectiveness of such incentive schemes. The aim of this study is to examine the preferences of general practitioners (GPs) for rural location using a discrete choice experiment. This is used to estimate the probabilities of moving to a rural area, and the size of financial incentives GPs would require to move there. GPs were asked to choose between two job options or to stay at their current job as part of the Medicine in Australia: Balancing Employment and Life (MABEL) longitudinal survey of doctors. 3727 GPs completed the experiment. Sixty five per cent of GPs chose to stay where they were in all choices presented to them. Moving to an inland town with less than 5000 population and reasonable levels of other job characteristics would require incentives equivalent to 64% of current average annual personal earnings (\$116,000). Moving to a town with a population between 5000 and 20,000 people would require incentives of at least 37% of current annual earnings, around \$68,000. The size of incentives depends not only on the area but also on the characteristics of the job. The least attractive rural job package would require incentives of at least 130% of annual earnings, around \$237,000. It is important to begin to tailor incentive packages to the characteristics of jobs and of rural areas.

Minton J. (2014). Real geographies and virtual landscapes: Exploring the influence on place and space on mortality Lexis surfaces using shaded contour maps.

Spatial and Spatio-temporal Epidemiology, (0).

<http://www.sciencedirect.com/science/article/pii/S1877584514000173>

Hôpital / Hospitals

Secanell M., Groene O., Arah O.A., et al., (2014) Deepening our understanding of quality improvement in Europe (DUQuE): overview of a study of hospital quality management in seven countries. *International Journal for Quality in Health Care*, 26 (suppl 1) : 5-15.

Abstract: Introduction and Objective This paper provides an overview of the DUQuE (Deepening our Understanding of Quality Improvement in Europe) project, the first study across multiple countries of the European Union (EU) to assess relationships between quality management and patient outcomes at EU level. The paper describes the conceptual framework and methods applied, highlighting the novel features of this study. Design DUQuE was designed as a multi-level cross-sectional study with data collection at hospital, pathway, professional and patient level in eight countries. Setting and Participants We aimed to collect data for the assessment of hospital-wide constructs from up to 30 randomly selected hospitals in each country, and additional data at pathway and patient level in 12 of these 30. Main outcome measures A comprehensive conceptual framework was developed to account for the multiple levels that influence hospital performance and patient outcomes. We assessed hospital-specific constructs (organizational culture and professional involvement), clinical pathway constructs (the organization of care processes for acute myocardial infarction, stroke, hip fracture and deliveries), patient-specific processes and outcomes (clinical effectiveness, patient safety and patient experience) and external constructs that could modify hospital quality (external assessment and perceived external pressure). Results Data was gathered from 188 hospitals in 7 participating countries. The overall participation and response rate were between 75% and 100% for the assessed measures. Conclusions This is the first study assessing relation between quality management and patient outcomes at EU level. The study involved a large number of respondents and achieved high response rates. This work will serve to develop guidance in how to assess quality management and makes recommendations on the best ways to improve quality in healthcare for hospital stakeholders, payers, researchers, and policy makers throughout the EU.

http://intqhc.oxfordjournals.org/content/26/suppl_1/5.abstract

Sunol R., Wagner C., Arah O.A., et al. (2014) Evidence-based organization and patient safety strategies in European hospitals. *International Journal for Quality in Health Care*, 26 (suppl 1) : 47-55.

Abstract: Objective To explore how European hospitals have implemented patient safety strategies (PSS) and evidence-based organization of care pathway (EBOP) recommendations and examine the extent to which implementation varies between countries and hospitals. Design Mixed-method

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multilevel cross-sectional design in seven countries as part of the European Union-funded project "Deepening our Understanding of Quality improvement in Europe" (DUQuE). Setting and participants Seventy-four acute care hospitals with 292 departments managing acute myocardial infarction (AMI), hip fracture, stroke, and obstetric deliveries. Main outcome measure Five multi-item composite measures one generic measure for PSS and four pathway-specific measures for EBOP. Results Potassium chloride had only been removed from general medication stocks in 9.4-30.5% of different pathways wards and patients were adequately identified with wristband in 43.0-59.7%. Although 86.3% of areas treating AMI patients had immediate access to a specialist physician, only 56.0% had arrangements for patients to receive thrombolysis within 30 min of arrival at the hospital. A substantial amount of the total variance observed was due to between-hospital differences in the same country for PSS (65.9%). In EBOP, between-country differences play also an important role (10.1% in AMI to 57.1% in hip fracture). Conclusions There were substantial gaps between evidence and practice of PSS and EBOP in a sample of European hospitals and variations due to country differences are more important in EBOP than in PSS, but less important than within-country variations. Agencies supporting the implementation of PSS and EBOP should closely re-examine the effectiveness of their current strategies.

http://intqhc.oxfordjournals.org/content/26/suppl_1/47.abstract

Groene O., Sunol R., Klazinga N.S., et al. (2014) Involvement of patients or their representatives in quality management functions in EU hospitals: implementation and impact on patient-centred care strategies. *International Journal for Quality in Health Care*, 26 (suppl 1) : 81-91.

Abstract: Objective The objective of this study was to describe the involvement of patients or their representatives in quality management (QM) functions and to assess associations between levels of involvement and the implementation of patient-centred care strategies. Design A cross-sectional, multilevel study design that surveyed quality managers and department heads and data from an organizational audit. Setting Randomly selected hospitals (n = 74) from seven European countries (The Czech Republic, France, Germany, Poland, Portugal, Spain and Turkey). Participants Hospital quality managers (n = 74) and heads of clinical departments (n = 262) in charge of four patient pathways (acute myocardial infarction, stroke, hip fracture and deliveries) participated in the data collection between May 2011 and February 2012. Main Outcome Measures Four items reflecting essential patient-centred care strategies based on an on-site hospital visit: (1) formal survey seeking views of patients and carers, (2) written policies on patients' rights, (3) patient information literature including guidelines and (4) fact sheets for post-discharge care. The main predictors were patient involvement in QM at the (i) hospital level and (ii) pathway level. Results Current levels of involving patients and their representatives in QM functions in European hospitals are low at hospital level (mean score 1.6 on a scale of 0 to 5, SD 0.7), but even lower at departmental level (mean 0.6, SD 0.7). We did not detect associations between levels of involving patients and their representatives in QM functions and the implementation of patient-centred care strategies; however, the smallest hospitals were more likely to have implemented patient-centred care strategies. Conclusions There is insufficient evidence that involving patients and their representatives in QM leads to establishing or implementing strategies and procedures that facilitate patient-centred care; however, lack of evidence should not be interpreted as evidence of no effect.

http://intqhc.oxfordjournals.org/content/26/suppl_1/81.abstract

Shaw C.D., Groene O., Botje D., et al. (2014). The effect of certification and accreditation on quality management in 4 clinical services in 73 European hospitals.

International Journal for Quality in Health Care, 26 (suppl 1) : 100-107.

Abstract: Objective To investigate the relationship between ISO 9001 certification, healthcare accreditation and quality management in European hospitals. Design A mixed method multi-level cross-sectional design in seven countries. External teams assessed clinical services on the use of quality management systems, illustrated by four clinical pathways. Setting and Participants Seventy-three acute care hospitals with a total of 291 services managing acute myocardial infarction (AMI), hip fracture, stroke and obstetric deliveries, in Czech Republic, France, Germany, Poland, Portugal, Spain and Turkey. Main Outcome Measure Four composite measures of quality and safety [specialized expertise and responsibility (SER), evidence-based organization of pathways (EBOP), patient safety strategies (PSS) and clinical review (CR)] applied to four pathways. Results Accreditation in isolation

showed benefits in AMI and stroke more than in deliveries and hip fracture; the greatest significant association was with CR in stroke. Certification in isolation showed little benefit in AMI but had more positive association with the other conditions; greatest significant association was in PSS with stroke. The combination of accreditation and certification showed least benefit in EBOP, but significant benefits in SER (AMI), in PSS (AMI, hip fracture and stroke) and in CR (AMI and stroke). Conclusions Accreditation and certification are positively associated with clinical leadership, systems for patient safety and clinical review, but not with clinical practice. Both systems promote structures and processes, which support patient safety and clinical organization but have limited effect on the delivery of evidence-based patient care. Further analysis of DUQuE data will explore the association of certification and accreditation with clinical outcomes.

http://intqhc.oxfordjournals.org/content/26/suppl_1/100.abstract

Groene O., Kristensen S., Arah O.A., et al. (2014). Feasibility of using administrative data to compare hospital performance in the EU. *International Journal for Quality in Health Care*, 26 (suppl 1) : 108-115.

Abstract: Objective To describe hospitals' organizational arrangements relevant to the abstraction of administrative data, to report on the completeness of administrative data collected and to assess associations between organizational arrangements and completeness of data submission. Design A cross-sectional study design utilizing administrative data. Setting and Participants Randomly selected hospitals from seven European countries (The Czech Republic, France, Germany, Poland, Portugal, Spain, and Turkey). Main Outcome Measures Completeness of data submission for four quality indicators: mortality after acute myocardial infarction, stroke and hip fractures and complications after normal delivery. Results In general, hospitals were able to produce data on the four indicators required for this research study. A substantial proportion had missing data on one or more data items. The proportion of hospitals that was able to produce more detailed indicators of relevance for quality monitoring and improvement was low and ranged from 40.1% for thrombolysis performed on patients with acute ischemic stroke to 63.8% for hip-fracture operations performed within 48 h after admission for patients aged 65 or older. National factors were strong predictors of data completeness on the studied indicators. Conclusions At present, hospital administrative databases do not seem to be an appropriate source of information for comparison of hospital performance across the countries of the EU. However, given that this is a dynamic field, changes to administrative databases may make this possible in the near future. Such changes could be accelerated by an in-depth comparative analysis of the issues of using administrative data for comparisons of hospital performances in EU countries.

http://intqhc.oxfordjournals.org/content/26/suppl_1/108.abstract

Stargardt T., Schreyoqq J., Kondofersky I. (2014). Measuring the relationship between costs and outcomes: the example of acute myocardial infarction in german hospitals. *Health Economics*, 23 (6) : 653-669.

Abstract: In this paper, we propose a methodological approach to measure the relationship between hospital costs and health outcomes. We propose to investigate the relationship for each condition or disease area by using patient-level data. We examine health outcomes as a function of costs and other patient-level variables by using the following: (1) two-stage residual inclusion with Murphy Topel adjustment to address costs being endogenous to health outcomes, (2) random-effects models in both stages to correct for correlation between observation, and (3) Cox proportional hazard models in the second stage to ensure that the available information is exploited. To demonstrate its application, data on mortality following hospital treatment for acute myocardial infarction (AMI) from a large German sickness fund were used. Provider reimbursement was used as a proxy for treatment costs. We relied on the Ontario Acute Myocardial Infarction Mortality Prediction Rules as a disease-specific risk-adjustment instrument. A total of 12,284 patients with treatment for AMI in 2004–2006 were included. The results showed a reduction in hospital costs by 1% to increase the hazard of dying, that is, mortality, by 0.43%. The negative association between costs and mortality confirms that decreased resource input leads to worse outcomes for treatment after AMI.

<http://dx.doi.org/10.1002/hec.2941>

Carey K. (2014). Measuring the hospital length of stay/readmission cost trade-off under a bundled payment mechanism. *Health Economics*, Ahead of pub.

Abstract: If patients are discharged from the hospital prematurely, many may need to return within a short period of time. This paper investigates the relationship between length of stay and readmission within 30 days of discharge from an acute care hospitalization. It applies a two-part model to data on Medicare patients treated for heart attack in New York state hospitals during 2008 to obtain the expected cost of readmission associated with length of stay. The expected cost of a readmission is compared with the marginal cost of an additional day in the initial stay to examine the cost trade-off between an extra day of care and the expected cost of readmission. The cost of an additional day of stay was offset by expected cost savings from an avoided readmission in the range of 15% to 65%. Results have implications for payment reform based on bundled payment reimbursement mechanisms.

<http://dx.doi.org/10.1002/hec.3061>

Cunningham R. (2014). The payment reform paradox. *Health Aff.(Millwood.)*, 33 (5) : 735-738.

Abstract: New payment and delivery models have left hospitals asking: "What is the reward for cost-reducing innovation?"

Bazzoli G.J., Fareed N., Waters T.M. (2014). Hospital financial performance in the recent recession and implications for institutions that remain financially weak. *Health Aff.(Millwood.)*, 33 (5) : 739-745.

Abstract: The recent recession had a profound effect on all sectors of the US economy, including health care. We examined how private hospitals fared through the recession and considered how changes in their financial health may affect their ability to respond to future industry challenges. We categorized 2,971 private short-term general medical or surgical hospitals (both nonprofit and for-profit) according to their pre-recession financial health and safety-net status, and we examined their operational status changes and operating and total financial margins during 2006-11. We found that hospitals that were financially weak before the recession remained so during and after the recession. The total margins of nonprofit hospitals (both safety-net and other institutions) declined in 2008 but returned to their pre-recession levels by 2011. The recession did not create additional fiscal pressure on hospitals that were previously financially weak or in safety-net roles. However, both groups continue to have notable financial deficiencies that could limit their abilities to meet the growing demands on the industry.

Munnich E.L., Parente S.T. (2014). Procedures take less time at ambulatory surgery centers, keeping costs down and ability to meet demand up. *Health Aff.(Millwood.)*, 33 (5) : 764-769.

Abstract: During the past thirty years outpatient surgery has become an increasingly important part of medical care in the United States. The number of outpatient procedures has risen dramatically since 1981, and the majority of surgeries performed in the United States now take place in outpatient settings. Using data on procedure length, we show that ambulatory surgery centers (ASCs) provide a lower-cost alternative to hospitals as venues for outpatient surgeries. On average, procedures performed in ASCs take 31.8 fewer minutes than those performed in hospitals—a 25 percent difference relative to the mean procedure time. Given the rapid growth in the number of surgeries performed in ASCs in recent years, our findings suggest that ASCs provide an efficient way to meet future growth in demand for outpatient surgeries and can help fulfill the Affordable Care Act's goals of reducing costs while improving the quality of health care delivery.

Nagasako E.M., Reidhead M., Waterman B., Claiborne D.W. (2014). Adding socioeconomic data to hospital readmissions calculations may produce more useful results. *Health Aff.(Millwood.)*, 33 (5) : 786-791.

Abstract: To better understand the degree to which risk-standardized thirty-day readmission rates may be influenced by social factors, we compared results for hospitals in Missouri under two types of models. The first type of model is currently used by the Centers for Medicare and Medicaid Services for public reporting of condition-specific hospital readmission rates of Medicare patients. The second type of model is an "enriched" version of the first type of model with census tract-level socioeconomic

data, such as poverty rate, educational attainment, and housing vacancy rate. We found that the inclusion of these factors had a pronounced effect on calculated hospital readmission rates for patients admitted with acute myocardial infarction, heart failure, and pneumonia. Specifically, the models including socioeconomic data narrowed the range of observed variation in readmission rates for the above conditions, in percentage points, from 6.5 to 1.8, 14.0 to 7.4, and 7.4 to 3.7, respectively. Interestingly, the average readmission rates for the three conditions did not change significantly between the two types of models. The results of our exploratory analysis suggest that further work to characterize and report the effects of socioeconomic factors on standardized readmission measures may assist efforts to improve care quality and deliver more equitable care on the part of hospitals, payers, and other stakeholders.

Gao C., Xu F., Liu G.G. (2014). Payment reform and changes in health care in China. *Soc Sci Med*, 111 10-16.

Abstract: This paper is intended to assess the primary effects on cost, utilization and quality of care from payment reform of capitation and open enrollment in Changde city, Hunan Province of China. Open enrollment policy was introduced to deal with possible cream skimming associated with capitation. Based on the longitudinal Urban Resident Basic Medical Insurance (URBMI) Household Survey, this study analyses the URBMI data through a set of regression models. The original data included over five thousand inpatient admissions during the study period between 2008 and 2010. The study finds the payment reform to reduce its inpatient out-of-pocket cost by 19.7%, out-of-pocket ratio by 9.5%, and length of stay by 17.7%. However, the total inpatient cost, drug cost ratio, treatment effect, and patient satisfaction showed little difference between Fee-For-Service and capitation models. We conclude that the payment reform in Changde did not reduce overall inpatient expenditure, but it decreased the financial risk and length of stay of inpatient patients without compromising quality of care. The findings would contribute to the health care payment literatures from developing countries and open further research tracks on the ability of open enrollment to compensate for capitation drawbacks.

Tambor M., Pavlova M., Rechel B., Golinowska S., Sowada C., Groot W. (2014). The inability to pay for health services in Central and Eastern Europe: evidence from six countries. *Eur J Public Health*, 24 (3) : 378-385.

Abstract: BACKGROUND: Out-of-pocket payments for health services constitute a major financial burden for patients in Central and Eastern European (CEE) countries. Individuals who are unable to pay use different coping strategies (e.g. borrowing money or foregoing service utilization), which can have negative consequences on their health and social welfare. This article explores patients' inability to pay for outpatient and hospital services in six CEE countries: Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine. METHODS: The analysis is based on quantitative data collected in 2010 in nationally representative surveys. Two indicators of inability to pay were considered: the need to borrow money or sell assets and foregoing service utilization. Statistical analyses were applied to investigate associations between the indicators of inability to pay and individual characteristics. RESULTS: Patient payments are most common in Bulgaria, Ukraine, Romania and Lithuania and often include informal payments. Romanian and, particularly, Ukrainian patients most often face difficulties to pay for health services (with approximately 40% of Ukrainian payers borrowing money or selling assets to cover hospital payments and approximately 60% of respondents who need care foregoing services). Inability to pay mainly affects those with poor health and low incomes. CONCLUSION: Widespread patient payments constitute a major financial barrier to health service use in CEE. There is a need to formalize them where they are informal and to take measures to protect vulnerable population groups, especially those with limited possibilities to deal with payment difficulties.

Ryan A., Sutton M., Doran T. (2014). Does winning a pay-for-performance bonus improve subsequent quality performance? Evidence from the Hospital Quality Incentive Demonstration. *Health Serv Res*, 49 (2) : 568-587.

Abstract: OBJECTIVE: To test whether receiving a financial bonus for quality in the Premier Hospital Quality Incentive Demonstration (HQID) stimulated subsequent quality improvement. DATA: Hospital-level data on process-of-care quality from Hospital Compare for the treatment of acute myocardial

infarction (AMI), heart failure, and pneumonia for 260 hospitals participating in the HQID from 2004 to 2006; receipt of quality bonuses in the first 3 years of HQID from the Premier Inc. website; and hospital characteristics from the 2005 American Hospital Association Annual Survey. **STUDY DESIGN:** Under the HQID, hospitals received a 1 percent bonus on Medicare payments for scoring between the 80th and 90th percentiles on a composite quality measure, and a 2 percent bonus for scoring at the 90th percentile or above. We used a regression discontinuity design to evaluate whether hospitals with quality scores just above these payment thresholds improved more in the subsequent year than hospitals with quality scores just below the thresholds. In alternative specifications, we examined samples of hospitals scoring within 3, 5, and 10 percentage point "bandwidths" of the thresholds. We used a Generalized Linear Model to estimate whether the relationship between quality and lagged quality was discontinuous at the lagged thresholds required for quality bonuses. **PRINCIPAL FINDINGS:** There were no statistically significant associations between receipt of a bonus and subsequent quality performance, with the exception of the 2 percent bonus for AMI in 2006 using the 5 percentage point bandwidth (0.8 percentage point increase, $p < .01$), and the 1 percent bonus for pneumonia in 2005 using all bandwidths (3.7 percentage point increase using the 3 percentage point bandwidth, $p < .05$). **CONCLUSIONS:** We found little evidence that hospitals' receipt of quality bonuses was associated with subsequent improvement in performance. This raises questions about whether winning in pay-for-performance programs, such as Hospital Value-Based Purchasing, will lead to subsequent quality improvement.

Inégalités de santé / Health Inequalities

Bednall T.C., Bove L.L., Cheetham A., Murray A.L. (2013). A systematic review and meta-analysis of antecedents of blood donation behavior and intentions. *Soc Sci Med*, 96 86-94.

Abstract: This meta-analysis sought to identify the strongest antecedents of blood donation behavior and intentions. It synthesized the results of 24 predictive correlational studies of donation behavior and 37 studies of donation intentions. The antecedents were grouped into six research programs: (1) the Theory of Planned Behavior (TPB) and its extensions, (2) prosocial motivation, (3) affective expectations, (4) donor site experience, (5) past donation behavior, and (6) donor demographics. Antecedent categories were cross-validated by multiple coders, and combined effect sizes were analyzed using a random-effects model. For donation behavior, medium positive associations were found with five of the constructs from the extended TPB: intentions to donate, perceived behavioral control, attitude toward donation, self-efficacy and donor role identity. Other antecedents displaying a positive association with donation behavior included anticipated regret for not donating, number of past donations and donor age. Donor experiences at the collection site in the form of temporary deferral or adverse reactions had a medium negative association with behavior. For donation intentions, strong positive associations were observed for perceived behavioral control, attitude, self-efficacy, role identity and anticipated regret. Medium positive associations were observed for personal moral norm, subjective norm, satisfaction, and service quality. All other potential antecedents had weak or non-significant associations with behavior and intentions. Several of these associations were moderated by between-study differences, including donor experience, the period of data collection in which donation behavior was observed, and the use of a nominal (yes/no return) versus a ratio measure of donation behavior. Collectively, the results underscore the importance of enhancing donors' attitudes towards donation and building their perceived behavioral control and self-efficacy to donate. Further, minimizing the risk of adverse reactions and enacting re-recruitment policies for temporarily deferred donors will help protect future donation behavior. Implications of these findings for blood collection agencies and researchers are discussed.

Cullati S. (2014). The influence of work-family conflict trajectories on self-rated health trajectories in Switzerland: A life course approach. *Soc Sci Med*, 113C 23-33.

Abstract: Self-rated health (SRH) trajectories tend to decline over a lifetime. Moreover, the Cumulative Advantage and Disadvantage (CAD) model indicates that SRH trajectories are known to consistently

diverge along socioeconomic positions (SEP) over the life course. However, studies of working adults to consider the influence of work and family conflict (WFC) on SRH trajectories are scarce. We test the CAD model and hypothesise that SRH trajectories diverge over time according to socioeconomic positions and WFC trajectories accentuate this divergence. Using longitudinal data from the Swiss Household Panel (N = 2327 working respondents surveyed from 2004 to 2010), we first examine trajectories of SRH and potential divergence over time across age, gender, SEP and family status using latent growth curve analysis. Second, we assess changes in SRH trajectories in relation to changes in WFC trajectories and divergence in SRH trajectories according to gender, SEP and family status using parallel latent growth curve analysis. Three measures of WFC are used: exhaustion after work, difficulty disconnecting from work, and work interference in private family obligations. The results show that SRH trajectories slowly decline over time and that the rate of change is not influenced by age, gender or SEP, a result which does not support the CAD model. SRH trajectories are significantly correlated with exhaustion after work trajectories but not the other two WFC measures. When exhaustion after work trajectories are taken into account, SRH trajectories of higher educated people decline slower compared to less educated people, supporting the CAD hypothesis.

Antonakakis N., Collins A. (2014). The impact of fiscal austerity on suicide: On the empirics of a modern Greek tragedy. *Soc Sci Med*, 112 39-50.

Abstract: Suicide rates in Greece (and other European countries) have been on a remarkable upward trend following the global recession of 2008 and the European sovereign debt crisis of 2009. However, recent investigations of the impact on Greek suicide rates from the 2008 financial crisis have restricted themselves to simple descriptive or correlation analyses. Controlling for various socio-economic effects, this study presents a statistically robust model to explain the influence on realised suicidality of the application of fiscal austerity measures and variations in macroeconomic performance over the period 1968-2011. The responsiveness of suicide to levels of fiscal austerity is established as a means of providing policy guidance on the extent of suicide behaviour associated with different fiscal austerity measures. The results suggest (i) significant age and gender specificity in these effects on suicide rates and that (ii) remittances have suicide-reducing effects on the youth and female population. These empirical regularities potentially offer some guidance on the demographic targeting of suicide prevention measures and the case for 'economic' migration.

Baumbach A., Gulis G. (2014). Impact of financial crisis on selected health outcomes in Europe. *Eur J Public Health*, 24 (3) : 399-403.

Abstract: BACKGROUND: A number of health outcomes were affected by previous financial crises, e.g. suicides, homicides and transport accident mortality. Aim of this study was to analyse the effects of the current financial crisis on selected health outcomes at population level in Europe. METHODS: A mixed approach of ecologic and time trend design was applied, including correlation analysis. For eight countries, data on the economic situation (unemployment rate and economic growth) and health indicators (overall mortality, suicide and transport accident mortality) was drawn from EUROSTAT database for 2000-10. Spearman's rank correlation was applied to analyse the influence of social protection on the association between exposure and outcome variables. RESULTS: The financial crisis had no visible effect on overall mortality in any of the eight countries until 2010. Transport accident mortality decreased in all eight countries, in the range of 18% in Portugal to 52% in Slovenia. In contrast, suicide mortality increased in Germany (+5.3%), Portugal (+5.2%), Czech Republic (+7.6%), Slovakia (+22.7%) and Poland (+19.3%). The effect of unemployment on suicide is higher in countries with lower social spending (Spearman's $r = -0.83$). DISCUSSION: Clear cause-effect relations could not be established owing to the ecological study design and issues concerning data availability. However, there are clear changes in suicide and transport accident mortality after onset of the crisis, and findings are consistent with previous work. As part of this work, a comprehensive framework was developed, which can be applied to analyse health effects of financial crises in more detail.

Bartoll X., Palencia L., Malmusi D., Suhrcke M., Borrell C. (2014). The evolution of mental health in Spain during the economic crisis. *Eur J Public Health*, 24 (3) : 415-418.

Abstract: We analyse how mental health and socioeconomic inequalities in the Spanish population aged 16-64 years have changed between 2006-2007 and 2011-2012. We observed an increase in the prevalence of poor mental health among men (prevalence ratio = 1.15, 95% CI 1.04-1.26], especially among those aged 35-54 years, those with primary and secondary education, those from semi-qualified social classes and among breadwinners. None of these associations remained after adjusting for working status. The relative index of inequality by social class increased for men from 1.02 to 1.08 (P = 0.001). We observed a slight decrease in the prevalence of poor mental health among women (prevalence ratio = 0.92, 95% CI 0.87-0.98), without any significant change in health inequality.

De Vogli R., Vieno A., Lenzi M. (2014). Mortality due to mental and behavioral disorders associated with the Great Recession (2008-10) in Italy: a time trend analysis. *Eur J Public Health*, 24 (3) : 419-421.

Abstract: We estimated the proportion of deaths due to mental and behavioral disorders attributable to the Great Recession (2008-10) in Italy. Data on standardized death rates due to mental and behavioral disorders per 100 000 from 2000 to 2010 were provided by the Italian Health for All database. There were an additional 0.303 per 100 000 deaths per year (95% CI: 0.192, 0.478; P = 0.001) because of the crisis. Each annual decrease of euro1000 in gross domestic product per capita was associated with an increase of 0.126 per 100 000 (95% CI: 0.046, 0.205; P = 0.004) deaths; every annual 1% increase in unemployment corresponded to an increase of 0.074 per 100 000 (95% CI: 0.032, 0.117; P = 0.002) deaths.

Dujardin C., Lorant V., Thomas I. (2014). Self-assessed health of elderly people in Brussels: Does the built environment matter? *Health Place*, 27 59-67.

Abstract: The living environment plays a key role in the "Aging in Place" strategy. We studied the influence of the built environment on the health status of elderly people living in Brussels. Using census and geo-coded data, we analysed whether built environment factors were associated with poor self-assessed health status and functional limitations of elderly residents (aged 65 and over). We concluded that evidence of such an association is weak and vulnerable to the composition of the neighbourhood.

Lee S., Chen L., He X., Miller M.J., Juon H.S. (2013). A cluster analytic examination of acculturation and health status among Asian Americans in the Washington DC metropolitan area, United States. *Soc Sci Med*, 96 17-23.

Abstract: Previous studies reported mixed findings on the relationship between acculturation and health status among Asian Americans due to different types of acculturation measures used or different Asian subgroups involved in various studies. We aim to fill the gap by applying multiple measures of acculturation in a diverse sample of Asian subgroups. A cross sectional study was conducted among Chinese, Korean and Vietnamese Americans in Washington D.C. Metropolitan Area to examine the association between health status and acculturation using multiple measures including the Suinn-Lew Asian Self-Identity Acculturation (SL-ASIA) scale, clusters based on responses to SL-ASIA, language preference, length of stay, age at arrival in the United States and self-identity. Three clusters (Asian (31%); Bicultural (47%); and American (22%)) were created by using a two-step hierarchical method and Bayesian Information Criterion values. Across all the measures, more acculturated individuals were significantly more likely to report good health than those who were less acculturated after adjusting for covariates. Specifically, those in the American cluster were 3.8 times (95% Confidence Interval (CI): 2.2, 6.6) more likely and those in the Bicultural cluster were 1.7 times more likely (95% CI: 1.1, 2.4) to report good health as compared to those in the Asian cluster. When the conventional standardized SL-ASIA summary score (range:-1.4 to 1.4) was used, a one point increase was associated with 2.2 times greater odds of reporting good health (95% CI: 1.5, 3.2). However, the interpretation may be challenging due to uncertainty surrounding the meaning of a one point increase in SL-ASIA summary score. Among all the measures used, acculturation clusters better approximated the acculturation process and provided us with a more accurate test of the association in the population. Variables included in this measure were more relevant for our study sample and may have worked together to capture the multifaceted acculturation process.

Vander Ploeg K.A., Maximova K., McGavock J., Davis W., Veugelers P. (2014). Do school-based physical activity interventions increase or reduce inequalities in health? *Social Science & Medicine*, 112 (0) : 80-87.
<http://www.sciencedirect.com/science/article/pii/S0277953614002639>

Wang L. (2014). Immigrant health, socioeconomic factors and residential neighbourhood characteristics: A comparison of multiple ethnic groups in Canada. *Applied Geography*, 51 (0) : 90-98.
<http://www.sciencedirect.com/science/article/pii/S0143622814000605>

Mackenbach J.P., Kulhanova I., Bopp M., Deboosere P., et al. (2014). Variations in the relation between education and cause-specific mortality in 19 European populations: a test of the fundamental causes theory of social inequalities in health. *Social Science & Medicine*, (Ahead of pub) :
<http://www.sciencedirect.com/science/article/pii/S0277953614003153>

Richardson E.A., Pearce J., Mitchell R., Shortt N.K., Tunstall H. (2014). Have regional inequalities in life expectancy widened within the European Union between 1991 and 2008? *Eur J Public Health*, 24 (3) : 357-363.

Abstract: BACKGROUND: Health inequalities have widened within and between many European countries over recent decades, but Europe-wide sub-national trends have been largely overlooked. For regions across the European Union (EU), we assess how geographical inequalities (i.e., between regions) and sociospatial inequalities (i.e., between regions grouped by an area-level measure of average household income) in male and female life expectancy have changed between 1991 and 2008. METHODS: Household income, life expectancy at birth and population count data were obtained for 129 regions (level 2 Nomenclature of Statistical Territorial Units, 'NUTS') in 13 European countries with 1991-2008 data (2008 population = 272 million). We assessed temporal changes in the range of life expectancies, for all regions and for Western and Eastern European regions separately. RESULTS: Between 1991 and 2008, the geographical range of life expectancies found among European regions remained relatively constant, with the exception of life expectancy among male Eastern Europeans, for whom the range widened by 2.8 years. Sociospatial inequalities in life expectancy (1999-2008 data only) remained constant for all regions combined and for Western Europe, but more than doubled in size for male Eastern Europeans. For female Eastern Europeans, life expectancy was unrelated to regional household income. CONCLUSIONS: Regional life-expectancy inequalities in the EU have not narrowed over 2 decades, despite efforts to reduce them. Household income differences across European regions may partly explain these inequalities. As inequalities transcend national borders, reduction efforts may require EU-wide coordination in addition to national efforts.

Niedzwiedz C.L., Katikireddi S.V., Pell J.P., Mitchell R. (2014). Socioeconomic inequalities in the quality of life of older Europeans in different welfare regimes. *Eur J Public Health*, 24 (3) : 364-370.

Abstract: BACKGROUND: Whether socioeconomic inequalities in health and well-being persist into old age and are narrower in more generous welfare states is debated. We investigated the magnitude of socioeconomic inequality in the quality of life of Europeans in early old age and the influence of the welfare regime type on these relationships. METHODS: Data from individuals aged 50-75 years (n = 16 074) residing in 13 European countries were derived from Waves 2 and 3 of the Survey of Health, Ageing and Retirement in Europe. Slope indices of inequality (SII) were calculated for the association between socioeconomic position and CASP-12, a measure of positive quality of life. Multilevel linear regression was used to assess the overall relationship between socioeconomic position and quality of life, using interaction terms to investigate the influence of the type of welfare regime (Southern, Scandinavian, Post-communist or Bismarckian). RESULTS: Socioeconomic inequalities in quality of life were narrowest in the Scandinavian and Bismarckian regimes, and were largest by measures of current wealth. Compared with the Scandinavian welfare regime, where narrow inequalities in quality of life by education level were found in both men (SII = 0.02, 95% CI: -1.09 to 1.13) and women (SII = 1.11, 95% CI: 0.05-2.17), the difference in quality of life between the least and most educated was

particularly wide in Southern and Post-communist regimes. **CONCLUSION:** Individuals in more generous welfare regimes experienced higher levels of quality of life, as well as narrower socioeconomic inequalities in quality of life.

Jordan K.P., Hayward R., Roberts E., Edwards J.J., Kadam U.T. (2014). The relationship of individual and neighbourhood deprivation with morbidity in older adults: an observational study. *Eur J Public Health*, 24 (3) : 396-398.

Abstract: The objective was to determine the relative association of social class and neighbourhood deprivation with primary care consultation for eight morbidities. In 18 047 survey responders aged ≥ 50 years, living in more deprived neighbourhoods was independently associated with new consultation for chronic obstructive pulmonary disease, ischaemic heart disease, diabetes, asthma and depression. Lower social class was associated with diabetes and chronic obstructive pulmonary disease. No such associations were found with otitis media, osteoarthritis or upper respiratory tract infection. These findings suggest a role of social environment in certain morbidities and indicate the importance of identifying and acting on neighbourhood deprivation to reduce health inequalities.

Médicaments / Pharmaceuticals

Meyer F. (2014). Conference 2 : l'évolution des critères d'évaluation des médicaments en France et en Europe. *Med Sci (Paris)*, 30 24-25.
<http://dx.doi.org/10.1051/medsci/201430s106>

Jung K., Feldman R., McBean A.M. (2014). Nonlinear pricing in drug benefits and medication use: the case of statin compliance in medicare part d. *Health Serv Res*, 49 (3) : 910-928.

Abstract: **OBJECTIVE:** To examine how enrollees' statin compliance responds to expected prices in Medicare Part D, which features a nonlinear price schedule due to a coverage gap. **DATA SOURCES/STUDY SETTING:** Prescription Drug Event data for a 5 percent random sample of Medicare Advantage Prescription Drug Plan enrollees in 2008 who did not receive a low-income subsidy. **STUDY DESIGN:** We analyze statin compliance prior to the coverage gap, where the "effective price" is higher than the actual copayment for drugs because consumers anticipate that more spending will make them more likely to reach the gap. We construct each enrollee's effective price as her expected price at the end of the year, which is the weighted average between pre-gap and in-gap copayments with the weight being the predicted probability of hitting the gap. Compliance is defined as at least 80 percent of days covered. **PRINCIPAL FINDINGS:** Part D enrollees' pre-gap statin compliance decreases by 3.7-4.7 percentage points for a \$10 increase in the effective price. **CONCLUSION:** The presence of a coverage gap decreases statin compliance prior to the gap, suggesting that incorporating expected future prices is important to assess the full impact of cost sharing on drug compliance under nonlinear price schedules.

Hoffmann K., Ristl R., Heschl L., Stelzer D., Maier M. (2014). Antibiotics and their effects: what do patients know and what is their source of information? *Eur J Public Health*, 24 (3) : 502-507.

Abstract: **BACKGROUND:** The Eurobarometer 2010 report on antimicrobial resistance included a survey on the knowledge of Europeans about antibiotics. Austria was ranked at the bottom of the EU27 countries. Based on these alarming results, it was the aim of this study to analyse demographic characteristics of patients and general practitioners in Austria to assess possible predictors for this outcome as well as to assess the main source of information related to antibiotics. **METHODS:** This cross-sectional study was conducted within the context of the European APRES project. An additional 12-item questionnaire was developed asking for the knowledge about antibiotics, demographic data and the source of information. Statistical analyses included subgroup analyses and linear mixed

regression models. RESULTS: Overall, 3280 questionnaires were analysed. On average, 2.78 (standard deviation 1.69) out of the six knowledge questions were answered correctly. The main predictors for a low knowledge score were low educational level, age, speaking another language than German and male sex. In all, 55.6% of the participants marked the general practitioner as main source of information. However, the source was less important for the knowledge score than their highest educational level. CONCLUSION: The Eurobarometer report result for Austrians could be confirmed and important associations and predictors could be identified: a multifaceted and evidence informed strategy is needed to improve the situation, which should both focus on target-group-specific interventions at the individual level to increase the knowledge of people with the highest needs as well as on strengthening the primary health care and educational sector at the system level.

Méthodologie – Statistique / Methodology – Statistics

Cheek E., Rajkumar C. (2014). How to present statistics in medical journals. *Age and Ageing*, 43 (3) : 306-308.

<http://ageing.oxfordjournals.org/content/43/3/306.short>

Varian H.R. (2014). Big Data: New Tricks for Econometrics. *Journal of Economic Perspectives*, 28 (2) : 3-28.

Abstract: Computers are now involved in many economic transactions and can capture data associated with these transactions, which can then be manipulated and analyzed. Conventional statistical and econometric techniques such as regression often work well, but there are issues unique to big datasets that may require different tools. First, the sheer size of the data involved may require more powerful data manipulation tools. Second, we may have more potential predictors than appropriate for estimation, so we need to do some kind of variable selection. Third, large datasets may allow for more flexible relationships than simple linear models. Machine learning techniques such as decision trees, support vector machines, neural nets, deep learning, and so on may allow for more effective ways to model complex relationships. In this essay, I will describe a few of these tools for manipulating and analyzing big data. I believe that these methods have a lot to offer and should be more widely known and used by economists.

<http://www.aeaweb.org/articles.php?doi=10.1257/jep.28.2.3>

Erdem S., Campbell D., Hole A.R. (2014). Accounting for attribute-level non-attendance in a health choice experiment does it matter? *Health Economics*, Ahead of pub.

Abstract: An extensive literature has established that it is common for respondents to ignore attributes of the alternatives within choice experiments. In most of the studies on attribute non-attendance, it is assumed that respondents consciously (or unconsciously) ignore one or more attributes of the alternatives, regardless of their levels. In this paper, we present a new line of enquiry and approach for modelling non-attendance in the context of investigating preferences for health service innovations. This approach recognises that non-attendance may not just be associated with attributes but may also apply to the attribute's levels. Our results show that respondents process each level of an attribute differently: while attending to the attribute, they ignore a subset of the attribute's levels. In such cases, the usual approach of assuming that respondents either attend to the attribute or not, irrespective of its levels, is erroneous and could lead to misguided policy recommendations. Our results indicate that allowing for attribute-level non-attendance leads to substantial improvements in the model fit and has an impact on estimated marginal willingness to pay and choice predictions.

<http://dx.doi.org/10.1002/hec.3059>

Ali M.S., Groenwold R.H., Klungel O.H. (2014). Propensity score methods and unobserved covariate imbalance: comments on "squeezing the balloon". *Health Serv Res*, 49 (3) : 1074-1082.

Abstract: In their recent Health Services Research article titled "Squeezing the Balloon: Propensity Scores and Unmeasured Covariate Balance," Brooks and Ohsfeldt (2013) addressed an important topic on the balancing property of the propensity score (PS) with respect to unmeasured covariates. They concluded that PS methods that balance measured covariates between treated and untreated subjects exacerbate imbalance in unmeasured covariates that are unrelated to measured covariates. Furthermore, they emphasized that for PS algorithms, an imbalance on unmeasured covariates between treatment and untreated subjects is a necessary condition to achieve balance on measured covariates between the groups. We argue that these conclusions are the results of their assumptions on the mechanism of treatment allocation. In addition, we discuss the underlying assumptions of PS methods, their advantages compared with multivariate regression methods, as well as the interpretation of the effect estimates from PS methods.

Meng T., Chen H. (2014). A multilevel analysis of social capital and self-rated health: Evidence from China. *Health Place*, 27 38-44.

Abstract: We investigate relationship between social capital and self-rated health (SRH) in urban and rural China. Using a nationally representative data collected in 2005, we performed multilevel analyses. The social capital indicators include bonding trust, bridging trust, social participation and Chinese Communist Party membership. Results showed that only trust was beneficial for SRH in China. Bonding trust mainly promoted SRH at individual level and bridging trust mainly at county level. Moreover, the individual-level bridging trust was only positively associated with SRH of urban residents, which mirrored the urban-rural dual structure in China. We also found a cross-level interaction effect of bonding trust in urban area. In a county with high level of bonding trust, high-bonding-trust individuals obtained more health benefit than others; in a county with low level of bonding trust, the situation was the opposite.

Politique de santé / Health Policy

Cornelissen E., Mitton C., Davidson A., Reid C., Hole R., Visockas A.M., Smith N. (2014). Determining and broadening the definition of impact from implementing a rational priority setting approach in a healthcare organization. *Social Science & Medicine*, (Ahead of pub).

<http://www.sciencedirect.com/science/article/pii/S0277953614003219>

Albrecht T. (2014). Accession to the European Union-an opportunity and a challenge for health systems and public health. *Eur J Public Health*, 24 (3) : 353. PM:24668558

Prévention / Prevention

Yaqub O., Castle-Clarke S., Sevdalis N., Chataway J. (2014). Attitudes to vaccination: A critical review. *Soc Sci Med*, 112C 1-11.

Abstract: This paper provides a consolidated overview of public and healthcare professionals' attitudes towards vaccination in Europe by bringing together for the first time evidence across various vaccines, countries and populations. The paper relies on an extensive review of empirical literature published in English after 2009, as well as an analysis of unpublished market research data from member companies of Vaccines Europe. Our synthesis suggests that hesitant attitudes to vaccination are prevalent and may be increasing since the influenza pandemic of 2009. We define hesitancy as an expression of concern or doubt about the value or safety of vaccination. This means that hesitant

attitudes are not confined only to those who refuse vaccination or those who encourage others to refuse vaccination. For many people, vaccination attitudes are shaped not just by healthcare professionals but also by an array of other information sources, including online and social media sources. We find that healthcare professionals report increasing challenges to building a trustful relationship with patients, through which they might otherwise allay concerns and reassure hesitant patients. We also find a range of reasons for vaccination attitudes, only some of which can be characterised as being related to lack of awareness or misinformation. Reasons that relate to issues of mistrust are cited more commonly in the literature than reasons that relate to information deficit. The importance of trust in the institutions involved with vaccination is discussed in terms of implications for researchers and policy-makers; we suggest that rebuilding this trust is a multi-stakeholder problem requiring a co-ordinated strategy.

Mead E.L., Rimal R.N., Ferrence R., Cohen J.E. (2014). Understanding the sources of normative influence on behavior: The example of tobacco. *Social Science & Medicine*, (Ahead of pub) : <http://www.sciencedirect.com/science/article/pii/S0277953614003244>

Lakerveld J., Verstrate L., Bot S.D., Kroon A., Baan C.A., Brug J., Jansen A.P., Droomers M., Abma T., Stronks K., Nijpels G. (2014). Environmental interventions in low-SES neighbourhoods to promote healthy behaviour: enhancing and impeding factors. *Eur J Public Health*, 24 (3) : 390-395.

Abstract: BACKGROUND: Social and physical environments are important drivers of socioeconomic inequalities in health behaviour. Although many interventions aiming to improve such environments are being implemented in underprivileged neighbourhoods, implementation processes are rarely studied. Acquiring insight into successful implementation may improve future interventions. The present study aimed to investigate factors influencing the reach, effectiveness, adoption, implementation and maintenance (RE-AIM) of social and physical environmental interventions aimed at promoting healthy behaviour in underprivileged neighbourhoods in The Netherlands. METHODS: A large set of theory-based factors of successful implementation was assessed for 18 implemented interventions in three underprivileged neighbourhoods. Expert and target group panels scored the RE-AIM dimensions for each intervention. We analyzed the statistical significance of associations between theory-based factors and the actual RE-AIM in a statistical model, to identify factors associated with increased RE-AIM. RESULTS: Six factors were identified: effectiveness and implementation success were higher when the target group was involved in the planning process, whereas maintenance increased in the absence of competition with other projects. If the current situation was inventoried during intervention development, the effectiveness, adoption and implementation were higher. These dimensions were also higher when the target group was informed before implementation. Involvement of the target group during implementation resulted in higher reach, effectiveness and adoption. Finally, lack of intervention staff worsened the reach. DISCUSSION: This study contributes to the evidence base for effective implementation of environmental measures aimed at promoting healthy behaviours. In particular, interventions in which the target group was involved in the implementation process were associated with higher RE-AIM outcomes.

Psychiatrie / Psychiatry

Hanandita W., Tampubolon G. (2014). Does poverty reduce mental health? An instrumental variable analysis. *Soc Sci Med*, 113C 59-67.

Abstract: That poverty and mental health are negatively associated in developing countries is well known among epidemiologists. Whether the relationship is causal or associational, however, remains an open question. This paper aims to estimate the causal effect of poverty on mental health by exploiting a natural experiment induced by weather variability across 440 districts in Indonesia (N = 577,548). Precipitation anomaly in two climatological seasons is used as an instrument for poverty

status, which is measured using per capita household consumption expenditure. Results of an instrumental variable estimation suggest that poverty causes poor mental health: halving one's consumption expenditure raises the probability of suffering mental illness by 0.06 point; in terms of elasticity, a 1% decrease in consumption brings about 0.62% more symptoms of common mental disorders. This poverty effect is approximately five times stronger than that obtained prior to instrumenting and is robust to alternative distributional assumption, model specification, sample stratification and estimation technique. An individual's mental health is also negatively correlated with district income inequality, suggesting that income distribution may have a significant influence upon mental health over and above the effect of poverty. The findings imply that mental health can be improved not only by influencing individuals' health knowledge and behaviour but also by implementing a more equitable economic policy.

Robert G., Martinez J.M., Garcia A.M., Benavides F.G., Ronda E. (2014). From the boom to the crisis: changes in employment conditions of immigrants in Spain and their effects on mental health. *Eur J Public Health*, 24 (3) : 404-409.

Abstract: BACKGROUND: Migrant workers have been one of the groups most affected by the economic crisis. This study evaluates the influence of changes in employment conditions on the incidence of poor mental health of immigrant workers in Spain, after a period of 3 years, in context of economic crisis. METHODS: Follow-up survey was conducted at two time points, 2008 and 2011, with a reference population of 318 workers from Colombia, Ecuador, Morocco and Romania residing in Spain. Individuals from this population who reported good mental health in the 2008 survey (n = 214) were interviewed again in 2011 to evaluate their mental health status and the effects of their different employment situations since 2008 by calculating crude and adjusted odds ratios (aORs) for sociodemographic and employment characteristics. FINDINGS: There was an increased risk of poor mental health in workers who lost their jobs (aOR = 3.62, 95%CI: 1.64-7.96), whose number of working hours increased (aOR = 2.35, 95%CI: 1.02-5.44), whose monthly income decreased (aOR = 2.75, 95%CI: 1.08-7.00) or who remained within the low-income bracket. This was also the case for people whose legal status (permission for working and residing in Spain) was temporary or permanent compared with those with Spanish nationality (aOR = 3.32, 95%CI: 1.15-9.58) or illegal (aOR = 17.34, 95%CI: 1.96-153.23). In contrast, a decreased risk was observed among those who attained their registration under Spanish Social Security system (aOR = 0.10, 95%CI: 0.02-0.48). CONCLUSION: There was an increase in poor mental health among immigrant workers who experienced deterioration in their employment conditions, probably influenced by the economic crisis.

Soins de santé primaires / Primary Health Care

Gort M., Broekhuis M., Regts G. (2013). How teams use indicators for quality improvement - a multiple-case study on the use of multiple indicators in multidisciplinary breast cancer teams. *Soc Sci Med*, 96 69-77.

Abstract: A crucial issue in healthcare is how multidisciplinary teams can use indicators for quality improvement. Such teams have increasingly become the core component in both care delivery and in many quality improvement methods. This study aims to investigate the relationships between (1) team factors and the way multidisciplinary teams use indicators for quality improvement, and (2) both team and process factors and the intended results. An in-depth, multiple-case study was conducted in the Netherlands in 2008 involving four breast cancer teams using six structure, process and outcome indicators. The results indicated that the process of using indicators involves several stages and activities. Two teams applied a more intensive, active and interactive approach as they passed through these stages. These teams were perceived to have achieved good results through indicator use compared to the other two teams who applied a simple control approach. All teams experienced some difficulty in integrating the new formal control structure, i.e. measuring and managing performance, in their operational task, and in using their 'new' managerial task to decide as a team what and how to improve. Our findings indicate the presence of a network of relationships between team factors, the controllability and actionability of indicators, the indicator-use process, and the

intended
PM:24034953

results.

Ishikawa H., Hashimoto H., Kiuchi T. (2013). The evolving concept of "patient-centeredness" in patient-physician communication research. *Soc Sci Med*, 96 147-153.

Abstract: Over the past few decades, the concept of "patient-centeredness" has been intensively studied in health communication research on patient-physician interaction. Despite its popularity, this concept has often been criticized for lacking a unified definition and operationalized measurement. This article reviews how health communication research on patient-physician interaction has conceptualized and operationalized patient-centered communication based on four major theoretical perspectives in sociology (i.e., functionalism, conflict theory, utilitarianism, and social constructionism), and discusses the agenda for future research in this field. Each theory addresses different aspects of the patient-physician relationship and communication from different theoretical viewpoints. Patient-centeredness is a multifaceted construct with no single theory that can sufficiently define the whole concept. Different theoretical perspectives of patient-centered communication can be selectively adopted according to the context and nature of problems in the patient-physician relationship that a particular study aims to explore. The present study may provide a useful framework: it offers an overview of the differing models of patient-centered communication and the expected roles and goals in each model; it does so toward identifying a communication model that fits the patient and the context and toward theoretically reconstructing existing measures of patient-centered communication. Furthermore, although patient-centered communication has been defined mainly from the viewpoint of physician's behaviors aimed at achieving patient-centered care, patient competence is also required for patient-centered communication. This needs to be examined in current medical practice.

Gervits M., Anderson M. (2014). Community-Oriented Primary Care (COPC) in Barcelona, Spain: An Urban COPC Experience. *International Journal of Health Services*, 44 (2) : 383-398.

Abstract: Community-oriented primary care (COPC) integrates comprehensive primary care with community health. Although it has had limited application in the United States, this model has been widely promoted among urban family physicians in Barcelona, Spain. This article describes the current status of COPC in four community clinics in Barcelona. Data were derived from a site visit that included direct observation and interviews with professionals involved in community health. The interviews explored how COPC has been implemented in each of the four primary care centers. We found that the degree to which COPC is practiced is quite varied and that it often coexists with other community health programs. A number of obstacles, including lack of support and funding from the government and lack of motivation and participation among health professionals, make practicing COPC in Barcelona a challenge. Despite these obstacles, COPC is flourishing in Barcelona. This experience may offer guidance for COPC implementation in the United States and other countries. <http://ejournals.ebsco.com/direct.asp?ArticleID=4A8994AA898F50B14273>

Huang X., Rosenthal M.B. (2014). Transforming Specialty Practice - The Patient-Centered Medical Neighborhood.. *New England Journal of Medicine*, 370 (15) : 1376-1379. <http://dx.doi.org/10.1056/NEJMp1315416>

Huang X., Rosenthal M.B. (2014). Transforming specialty practice--the patient-centered medical neighborhood. *New England Journal of Medicine*, 370 (15) : 1376-1379. PM:24716678

Unverzagt S., Oemler M., Braun K., Klement A. (2014). Strategies for guideline implementation in primary care focusing on patients with cardiovascular disease: a systematic review. *Fam Pract*, 31 (3) : 247-266.

Abstract: BACKGROUND: Guidelines should reduce inappropriate practice and improve the efficiency of treatment. Not only methodological quality but also acceptance and successful implementation in daily practice are crucial for the benefit on patients. Focusing on cardiovascular diseases (CVD), it is still unclear which implementation strategy can improve physician adherence to the recommendations

of guidelines in primary care. **METHODS:** We conducted a systematic review on randomized controlled trials about guideline implementation strategies on CVD. Medline, Embase, CENTRAL, conference proceedings and registers of ongoing studies were searched. **RESULTS:** Eighty-four trials met our predefined inclusion criteria, of them 54 trials compared unimodal strategies and 30 multimodal strategies to usual care. Concerning unimodal strategies, 15 trials investigated provider reminder systems, 3 audit and feedback, 15 provider education, 4 patient education, 5 promotion of self-management and 14 organizational change. The strongest benefit of a unimodal implementation strategy was found due to organizational change (odds ratio 1.96; 95% CI 1.4 to 2.75), followed by patient education, provider education and provider reminder systems. Trials on the efficacy of audit and feedback and patient self-management showed differing results or small advantages in terms of physician adherence. Multimodal interventions showed almost similar effect measures and ranking of strategies. **CONCLUSION:** The use of implementation strategies for the distribution of guidelines on CVD can be convincingly effective on physician adherence, regardless whether based on a unimodal or multimodal design. Three distinct strategies should be well considered in such an attempt: organizational changes in the primary care team, patient education and provider education.

Heponiemi T., Elovainio M., Pesseau J., Eccles M.P. (2014). General practitioners' psychosocial resources, distress, and sickness absence: a study comparing the UK and Finland. *Fam Pract*, 31 (3) : 319-324.

Abstract: **BACKGROUND:** Many countries, including the UK and Finland, face difficulties in recruiting GPs and one reason for these difficulties may be due to negative psychosocial work environments. **OBJECTIVE:** To compare psychosocial resources (job control and participative safety), distress and sickness absences between GPs from the UK and those from Finland. We also examined differences in how psychosocial resources are associated with distress and sickness absence and how distress is associated with sickness absence for both countries. **METHODS:** Two independent cross-sectional surveys conducted in general practice in the UK and Finland. Analyses of covariance were used for continuous outcome variables and logistic regression for dichotomized variable (sickness absence) adjusted for gender, qualification year and response format. **RESULTS:** UK GPs reported more opportunities to control their work and had higher levels of participative safety but were more distressed than Finnish GPs. Finnish GPs were 2.3 (95% confidence interval = 1.8-3.1) times more likely to report sickness absence spells than UK GPs. Among Finnish GPs, job control opportunities and high participative safety were associated with lower levels of distress, but not among UK GPs. Among UK GPs, higher distress was associated with 2.1 (95% confidence interval = 1.3-3.6) times higher likelihood of sickness absence spells, but among Finnish GPs there were no such association. **CONCLUSION:** In Finland, primary health care organizations should try to improve participative safety and increase control opportunities of physicians to decrease GP distress, whereas in the UK, other work or private life factors may be more important.

Systèmes de santé / Health Systems

Rao B., Hellander I (2014). The Widening U.S. Health Care Crisis Three Years After the Passage of Obamacare. *International Journal of Health Services*, 44 (2) : 215-232.

Abstract: This report presents information on the state of the U.S. health system in 2012 and early 2013, specifically the period prior to the implementation of the individual mandate and full rollout of the Affordable Care Act's online health exchanges. The authors include data on the uninsured and underinsured and their access to health care, on socioeconomic inequality in health care, the rising costs of the U.S. health system, and the role of corporate money in health care, with special reference to the pharmaceutical industry. They also provide updates on Medicare health maintenance organizations, Medicaid, and a prelude to the complete implementation of the Affordable Care Act. In addition, the authors include some results from public opinion polls on health systems and international system comparisons. The article concludes with an assessment of the rapid consolidation in the delivery of health care being driven by the Affordable Care Act.

<http://ejournals.ebsco.com/direct.asp?ArticleID=48C9B5FEE14725765D59>

Chaufan C (2014). Is the Swiss Health Care System a Model for the United States?

International Journal of Health Services, 44 (2) : 255-267.

Abstract: Both supporters and critics of the Patient Protection and Affordable Care Act (ACA) have argued that it is similar to Switzerland's Federal Law on Health Insurance (LAMal), which currently governs Swiss health care, and have either praised or condemned the ACA on the basis of this alleged similarity. I challenge these observers on the grounds that they overlook critical problems with the Swiss model, such as its inequities in access, and critical differences between it and the ACA, such as the roots in, and continuing commitment to, social insurance of the Swiss model. Indeed, the daunting challenge of attempting to impose the tightly regulated model of operation of the Swiss model on mega-corporations like UnitedHealth, WellPoint, or Aetna is likely to trigger no less ferocious resistance than a fully public, single-payer system would. I also conclude that the ACA might unravel in ways unintended or even opposed by its designers and supporters, as employers, confronted with ever-rising costs, retreat from sponsoring insurance, and workers react in outrage as they confront the unaffordable underinsurance mandated by the ACA. A new political and ideological landscape may then ensue that finally ushers in a truly national health program.

<http://ejournals.ebsco.com/direct.asp?ArticleID=44A3A66BF94A73E599CC>

Roland M., Campbell S. (2014). Successes and Failures of Pay for Performance in the United Kingdom. *New England Journal of Medicine*, 370 (20) : 1944-1949.

Abstract: In 2004, the United Kingdom introduced a large pay-for-performance program, which tied 25% of family practitioners' income to quality incentive payments. The authors review the changes made to the program and its successes and failures since it was introduced a decade ago.

<http://dx.doi.org/10.1056/NEJMhpr1316051>

Luck J., Peabody J.W., DeMaria L.M., Alvarado C.S., Menon R. (2014). Patient and Provider Perspectives on Quality and Health System Effectiveness in a Transition Economy: Evidence from Ukraine. *Social Science & Medicine*, (Ahead of pub).

<http://www.sciencedirect.com/science/article/pii/S0277953614003281>

Travail et santé / Occupational Health

Van Hal L., Meershoek A., Nijhuis F., Horstman K. (2013). Disembodied abilities: sick role and participation in 'activating' return-to-work practices. *Soc Sci Med*, 96 9-16.

Abstract: In 'active welfare states', labour participation is regarded essential for being part of and contributing to society. In the striving for an increase in labour participation of people who were considered (partly) disabled for work, not 'disabilities', but 'abilities' are put centre stage in vocational rehabilitation programmes. In this article we explore what this change in focus means in practice. We do this by investigating tensions experienced by participants of vocational rehabilitation practices that aim at facilitating return-to-work for people with disabilities. Our analysis derives from stories that clients and professionals told about daily experiences with disability, vocational rehabilitation and (labour) participation. These stories illustrate the logic embedded in vocational rehabilitation practices. Our analysis demonstrates that this logic, that focuses on will power, stable abilities and employability, hampers the realization of labour participation for a part of the population. We conclude that a logic of embodiment in which lived experiences of clients are acknowledged and in which it is explored what clients are concretely able to do in a specific context may be better equipped to facilitate return-to-work.

Toch M., Bambra C., Lunau T., et al. (2014). All Part of the Job? The Contribution of the Psychosocial and Physical Work Environment to Health Inequalities in Europe and the European Health Divide. *International Journal of Health Services*, 44 (2) : 285-305.

Abstract: This study is the first to examine the contribution of both psychosocial and physical risk factors to occupational inequalities in self-assessed health in Europe. Data from 27 countries were obtained from the 2010 European Working Conditions Survey for men and women aged 16 to 60 (n = 21,803). Multilevel logistic regression analyses (random intercept) were applied, estimating odds ratios of reporting less than good health. Analyses indicate that physical working conditions account for a substantial proportion of occupational inequalities in health in both Central/Eastern and Western Europe. Physical, rather than psychosocial, working conditions seem to have the largest effect on self-assessed health in manual classes. For example, controlling for physical working conditions reduced the inequalities in the prevalence of "less than good health" between the lowest (semi- and unskilled manual workers) and highest (higher controllers) occupational groups in Europe by almost 50 percent (Odds Ratio 1.87, 95% Confidence Interval 1.62-2.16 to 1.42, 1.23-1.65). Physical working conditions contribute substantially to health inequalities across "post-industrial" Europe, with women in manual occupations being particularly vulnerable, especially those living in Central/Eastern Europe. An increased political and academic focus on physical working conditions is needed to explain and potentially reduce occupational inequalities in health.

<http://ejournals.ebsco.com/direct.asp?ArticleID=484792515C7065FAC82A>

Strandh M., Winefield A., Nilsson K., Hammarstrom A. (2014). Unemployment and mental health scarring during the life course. *Eur J Public Health*, 24 (3) : 440-445.

Abstract: BACKGROUND: There has been little research on the long-term relationship between unemployment experiences and mental health over the life course. This article investigates the relationship between youth unemployment as well as that of unemployment experiences during later periods and mental health at ages 16, 21, 30 and 42 years. METHODS: The study makes use of the 'Northern Swedish Cohort' (NSC), a 27-year prospective cohort study. The cohort, investigated at ages 16, 18, 21, 30 and 42 years, consisted of all graduates from compulsory school in an industrial town in Sweden. Of the original 1083 participants, 94.3% of those still alive were still participating at the 27-year follow up. Mental health, measured through a three-item index of nervous symptoms, depressive symptoms and sleeping problems, was analysed using a repeated measures linear mixed models approach using ages 16, 21, 30 and 43 years. Unemployment exposure was measured as exposure to at least a 6-month spell during three periods; 18-21, 21-30 and 30-42 years. RESULTS: Youth unemployment was shown to be significantly connected with poorer mental health at all three target ages, 21, 30 and 42 years. Later singular unemployment experiences did not appear to have the same long-term negative effects. There was however an accumulation in poorer mental health among respondents with unemployment experiences during two, and even more so three, of the periods. CONCLUSION: There are long-term mental health scarring effects of exposure to youth unemployment and multiple exposure to unemployment during the life course.

Vieillessement / Ageing

Senior H.E.J., Parsons M., Kerse N., Chen M.H., Jacobs S., Hoorn S.V., Anderson C.S. (2014). Promoting independence in frail older people: a randomised controlled trial of a restorative care service in New Zealand. *Age and Ageing*, 43 (3) : 418-424.

Abstract: Background: frail older people often require tailored rehabilitation in order to remain at home, especially following a period of hospitalisation. Restorative care services aim to enhance an older person's ability to remain improve physical functioning, either at home or in residential care but evidence of their effectiveness is limited. Objective: to evaluate the effectiveness of a restorative care service on institutional-free survival and health outcomes in frail older people referred for needs assessment in New Zealand .Methods: a randomised controlled trial of restorative care or usual care in 105 older people at risk of permanent residential who were follow-up over 24 months. The

restorative care service was delivered in short-stay residential care facilities and at participants' residences with the aim of reducing the requirement for permanent residential care. It included a comprehensive geriatric assessment and care plan developed and delivered, initially by a multi-disciplinary team and subsequently by home care assistants. Results: compared with usual care, there was a non-significant absolute risk reduction of 14.3% for death or permanent residential care (8.8% for residential care and 7.2% for death alone) for the restorative care approach. There was no difference in levels of burden among caregivers. Conclusions: restorative care models that utilise case management and multi-disciplinary care may positively impact on institutional-free survival for frail older people without adversely impacting on the health of caregivers. <http://ageing.oxfordjournals.org/content/43/3/418.abstract>

Umstatt M.R., Janke M.C., Beaujean A.A. (2014). Predictors of Older Adults' Personal and Community Mobility: Using a Comprehensive Theoretical Mobility Framework. *The Gerontologist*, 54 (3) : 398-408.

Abstract: Purpose of the Study: Forty-six percent of older adults report limitations in their mobility, and maintaining mobility is considered an important factor in keeping adults independent and active in later life. This study tests a comprehensive theoretical framework of mobility (Webber, S. C., Porter, M. M., & Menec, V. H. [2010]. Mobility in older adults: A comprehensive framework. *The Gerontologist*, 50[4], 443-450. doi:10.1093/geront/gnq013) identifying multiple determinants that additively influence mobility (financial, psychosocial, environmental, physical, and cognitive), as well as cross-cutting influences of gender, culture, and biography. Design and methods: Structural equation modeling was used to examine several models of mobility using data from 6,112 respondents in the Health and Retirement Study (mean age: 74.74, 85% white, 41% male, 57% married). Results: The original measurement model fit the data well. When both personal and community mobility were simultaneously predicted, only the physical, cognitive, psychosocial, and environmental determinants were retained in the independent models. Age and marital status also predicted personal and community mobility. Although most of these relationships were in the expected direction, interestingly when both forms of mobility were included in the model, poorer cognitive ability was associated with greater personal mobility in the final model. Implications : Results indicate the importance of accounting for and examining comprehensive models of mobility. The factors affecting older adults' mobility are complex, and these relationships need to be explored in more depth to ensure the maintenance of individuals' independence and quality of life.

Eissens van der Laan MR, van Offenbeek M.A., Broekhuis H., Slaets J.P. (2014). A person-centred segmentation study in elderly care: Towards efficient demand-driven care. *Soc Sci Med*, 113C 68-76.

Abstract: Providing patients with more person-centred care without increasing costs is a key challenge in healthcare. A relevant but often ignored hindrance to delivering person-centred care is that the current segmentation of the population and the associated organization of healthcare supply are based on diseases. A person-centred segmentation, i.e., based on persons' own experienced difficulties in fulfilling needs, is an elementary but often overlooked first step in developing efficient demand-driven care. This paper describes a person-centred segmentation study of elderly, a large and increasing target group confronted with heterogeneous and often interrelated difficulties in their functioning. In twenty-five diverse healthcare and welfare organizations as well as elderly associations in the Netherlands, data were collected on the difficulties in biopsychosocial functioning experienced by 2019 older adults. Data were collected between March 2010 and January 2011 and sampling took place based on their (temporarily) living conditions. Factor Mixture Model was conducted to categorize the respondents into segments with relatively similar experienced difficulties concerning their functioning. First, the analyses show that older adults can be empirically categorized into five meaningful segments: feeling vital; difficulties with psychosocial coping; physical and mobility complaints; difficulties experienced in multiple domains; and feeling extremely frail. The categorization seems robust as it was replicated in two population-based samples in the Netherlands. The segmentation's usefulness is discussed and illustrated through an evaluation of the alignment between a segment's unfulfilled biopsychosocial needs and current healthcare utilization. The set of person-centred segmentation variables provides healthcare providers the option to perform a more comprehensive first triage step than only a disease-based one. The outcomes of this first step could guide a focused and, therefore, more efficient second triage step. On a local or regional level, this

person-centred segmentation provides input information to policymakers and care providers for the demand-driven allocation of resources.

Wysocki A., Kane R.L., Golberstein E., Dowd B., Lum T., Shippee T. (2014). The Association between Long-Term Care Setting and Potentially Preventable Hospitalizations among Older Dual Eligibles. *Health Serv Res*, 49 (3) : 778-797.

Abstract: Objective: To compare the probability of experiencing a potentially preventable hospitalization (PPH) between older dual eligible Medicaid home and community-based service (HCBS) users and nursing home residents. Data Sources: Three years of Medicaid and Medicare claims data (2003-2005) from seven states, linked to area characteristics from the Area Resource File. Study Design: A primary diagnosis of an ambulatory care sensitive condition on the inpatient hospital claim was used to identify PPHs. We used inverse probability of treatment weighting to mitigate the potential selection of HCBS versus nursing home use. Principal Findings: The most frequent conditions accounting for PPHs were the same among the HCBS users and nursing home residents and included congestive heart failure, pneumonia, chronic obstructive pulmonary disease, urinary tract infection, and dehydration. Compared to nursing home residents, elderly HCBS users had an increased probability of experiencing both a PPH and a non-PPH. Conclusions: HCBS users' increased probability for potentially and non-PPHs suggests a need for more proactive integration of medical and long-term care.

Zantinge E.M., van den Berg M., Smit H.A., Picavet H.S. (2014). Retirement and a healthy lifestyle: opportunity or pitfall? A narrative review of the literature. *Eur J Public Health*, 24 (3) : 433-439.

Abstract: Background: Retirement is a life-course transition in late adult life that is marked by major changes that may affect healthy lifestyles. Our aim is to give an overview of the current knowledge on changes in smoking, alcohol consumption, physical activity and dietary habits during the transition to retirement. This may provide clues to a better targeting and timing of preventive activities at older age. Methods: Literature search in Medline, Scopus, Embase, PsycInfo, Social SciSearch and SciSearch limited to English-language papers published between 2001 and May 2013. Results of 20 original papers are summarized in a narrative review. RESULTS: Some studies report an increase in alcohol consumption after retirement, whereas others found a decrease or no change at all. Those who retired involuntarily tended to increase their alcohol consumption, whereas retirees who quit voluntarily did not change their alcohol consumption. Leisure-time physical activity seems to increase slightly after retirement, especially moderately intensive physical activity. This increase does not compensate the loss of work-related physical activity such as the work itself or work-related transportation. The studies on changes in smoking and dietary habits were too limited to draw conclusions. Conclusions: The transition to retirement is accompanied with both favourable and unfavourable lifestyle changes, depending on the type of lifestyle, lifestyle indicator and the personal situation of the retiree. The (pre-) retirement period may well offer a suitable opportunity for preventive action, for example in pre-retirement programmes, planning or other retirement-related support.