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15 janvier 2016 / January the 15th, 2016

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Assurance maladie / Health Insurance

Fox, A. M. and M. R. Reich (2015). "The Politics of Universal Health Coverage in Low- and Middle-Income Countries: A Framework for Evaluation and Action." J Health Polit Policy Law 40(5): 1023-1060.

Universal health coverage has recently become a top item on the global health agenda pressed by multilateral and donor organizations, as disenchantment grows with vertical, disease-specific health programs. This increasing focus on universal health coverage has brought renewed attention to the role of domestic politics and the interaction between domestic and international relations in the health reform process. This article proposes a theory-based framework for analyzing the politics of health reform for universal health coverage, according to four stages in the policy cycle (agenda setting, design, adoption, and implementation) and four variables that affect reform (interests, institutions, ideas, and ideology). This framework can assist global health policy researchers, multilateral organization officials, and national policy makers in navigating the complex political waters of health reforms aimed at achieving universal health coverage. To derive the framework, we critically review the theoretical and applied literature on health policy reform in developing countries and illustrate the framework with examples of health reforms moving toward universal coverage in low- and middle-income countries. We offer a series of lessons stemming from these experiences to date.

Grogan, C. M. (2015). "Encouraging Competition and Cooperation: The Affordable Care Act's Contradiction?" J Health Polit Policy Law 40(4): 633-638.

This introductory essay to JHPPL's special issue on accountable care organizations (ACOs) presents the broader themes addressed in the issue, including (1) a central tension between cooperation versus competition in health care markets with regard to how to bring about improved quality, lower costs, and better access; (2) US regulatory policy - whether it will be able to achieve the appropriate balance in health care markets under which ACOs could realize expected outcomes; and (3) ACO realities - whether ACOs will be able to overcome or further embed existing inequities in US health care markets.

Layton, T. J. and A. M. Ryan (2015). "Higher Incentive Payments in Medicare Advantage's Pay-for-Performance Program Did Not Improve Quality But Did Increase Plan Offerings." Health Serv Res.

OBJECTIVE: To evaluate the effects of the size of financial bonuses on quality of care and the number of plan offerings in the Medicare Advantage Quality Bonus Payment Demonstration. **DATA SOURCES:** Publicly available data from CMS from 2009 to 2014 on Medicare Advantage plan quality ratings, the counties in the service area of each plan, and the benchmarks used to construct plan payments. **STUDY DESIGN:** The Medicare Advantage Quality Bonus Payment Demonstration began in 2012. Under the Demonstration, all Medicare Advantage plans were eligible to receive bonus payments based on plan-level quality scores (star ratings). In some counties, plans were eligible to receive bonus payments that were twice as large as in other counties. We used this variation in incentives to evaluate the effects of bonus size on star ratings and the number of plan offerings in the Demonstration using a differences-in-differences identification strategy. We used matching to create a comparison group of counties that did not receive double bonuses but had similar levels of the pre-intervention outcomes. **PRINCIPAL FINDINGS:** Results from the difference-in-differences analysis suggest that the receipt of double bonuses was not associated with an increase in star ratings. In the matched sample, the receipt of double bonuses was associated with a

statistically insignificant increase of +0.034 (approximately 1 percent) in the average star rating ($p > .10$, 95 percent CI: -0.015, 0.083). In contrast, the receipt of double bonuses was associated with an increase in the number of plans offered. In the matched sample, the receipt of double bonuses was associated with an overall increase of +0.814 plans (approximately 5.8 percent) ($p < .05$, 95 percent CI: 0.078, 1.549). We estimate that the double bonuses increased payments by \$3.43 billion over the first 3 years of the Demonstration. CONCLUSIONS: At great expense to Medicare, double bonuses in the Medicare Advantage Quality Bonus Payment Demonstration were not associated with improved quality but were associated with more plan offerings.

Roland, M. and R. A. Dudley (2015). "How Financial and Reputational Incentives Can Be Used to Improve Medical Care." Health Serv Res.

OBJECTIVES: Narrative review of the impact of pay-for-performance (P4P) and public reporting (PR) on health care outcomes, including spillover effects and impact on disparities. PRINCIPAL FINDINGS: The impact of P4P and PR is dependent on the underlying payment system (fee-for-service, salary, capitation) into which these schemes are introduced. Both have the potential to improve care, but they can also have substantial unintended consequences. Evidence from the behavioral economics literature suggests that individual physicians will vary in how they respond to incentives. We also discuss issues to be considered when including patient-reported outcome measures (PROMs) or patient-reported experience measures into P4P and PR schemes. CONCLUSION: We provide guidance to payers and policy makers on the design of P4P and PR programs so as to maximize their benefits and minimize their unintended consequences. These include involving clinicians in the design of the program, taking into account the payment system into which new incentives are introduced, designing the structure of reward programs to maximize the likelihood of intended outcomes and minimize the likelihood of unintended consequences, designing schemes that minimize the risk of increasing disparities, providing stability of incentives over some years, and including outcomes that are relevant to patients' priorities. In addition, because of the limitations of PR and P4P as effective interventions in their own right, it is important that they are combined with other policies and interventions intended to improve quality to maximize their likely impact.

Wen, H., et al. (2015). "Effect of Medicaid Expansions on Health Insurance Coverage and Access to Care among Low-Income Adults with Behavioral Health Conditions." Health Serv Res.

OBJECTIVE: To examine the effect of Medicaid expansions on health insurance coverage and access to care among low-income adults with behavioral health conditions. DATA SOURCES/STUDY SETTING: Nine years (2004-2012) of individual-level cross-sectional data from a restricted-access version of National Survey on Drug Use and Health. STUDY DESIGN: A quasi-experimental difference-in-differences design comparing outcomes among residents in 14 states that implemented Medicaid expansions for low-income adults under the Section 1115 waiver with those residing in the rest of the country. DATA COLLECTION/EXTRACTION METHODS: The analytic sample includes low-income adult respondents with household incomes below 200 percent of the federal poverty level who have a behavioral health condition: approximately 28,400 low-income adults have past-year serious psychological distress and 24,900 low-income adults have a past-year substance use disorder (SUD). PRINCIPAL FINDINGS: Among low-income adults with behavioral health conditions, Medicaid expansions were associated with a reduction in the rate of uninsurance ($p < .05$), a reduction in the probability of perceiving an unmet need for mental health (MH) treatment ($p < .05$) and for SUD treatment ($p < .05$), as well as an increase in the probability of receiving MH treatment ($p < .01$). CONCLUSIONS: The ongoing implementation of

Medicaid expansions has the potential to improve health insurance coverage and access to care for low-income adults with behavioral health conditions.

Economie de la santé / Health Economics

Conrad, D. A. (2015). "The Theory of Value-Based Payment Incentives and Their Application to Health Care." Health Serv Res. 9 nov.

OBJECTIVES: To present the implications of agency theory in microeconomics, augmented by behavioral economics, for different methods of value-based payment in health care; and to derive a set of future research questions and policy recommendations based on that conceptual analysis. **DATA SOURCES:** Original literature of agency theory, and secondarily behavioral economics, combined with applied research and empirical evidence on the application of those principles to value-based payment. **STUDY DESIGN:** Conceptual analysis and targeted review of theoretical research and empirical literature relevant to value-based payment in health care. **PRINCIPAL FINDINGS:** Agency theory and secondarily behavioral economics have powerful implications for design of value-based payment in health care. To achieve improved value-better patient experience, clinical quality, health outcomes, and lower costs of care-high-powered incentives should directly target improved care processes, enhanced patient experience, and create achievable benchmarks for improved outcomes. Differing forms of value-based payment (e.g., shared savings and risk, reference pricing, capitation, and bundled payment), coupled with adjunct incentives for quality and efficiency, can be tailored to different market conditions and organizational settings. **CONCLUSIONS:** Payment contracts that are "incentive compatible"-which directly encourage better care and reduced cost, mitigate gaming, and selectively induce clinically efficient providers to participate-will focus differentially on evidence-based care processes, will right-size and structure incentives to avoid crowd-out of providers' intrinsic motivation, and will align patient incentives with value. Future research should address the details of putting these and related principles into practice; further, by deploying these insights in payment design, policy makers will improve health care value for patients and purchasers.

Iversen, T., et al. (2015). "Comparative Analysis of Treatment Costs in EUROHOPE." Health Econ 24 Suppl 2: 5-22.

This study examines the challenges of estimating risk-adjusted treatment costs in international comparative research, specifically in the European Health Care Outcomes, Performance, and Efficiency (EuroHOPE) project. We describe the diverse format of resource data and challenges of converting these data into resource use indicators that allow meaningful cross-country comparisons. The three cost indicators developed in EuroHOPE are then described, discussed, and applied. We compare the risk-adjusted mean treatment costs of acute myocardial infarction for four of the seven countries in the EuroHOPE project, namely, Finland, Hungary, Norway, and Sweden. The outcome of the comparison depends on the time perspective as well as on the particular resource use indicator. We argue that these complementary indicators add to our understanding of the variation in resource use across countries. Copyright (c) 2015 John Wiley & Sons, Ltd.

Lehnert, T., et al. (2015). "Health burden and costs of obesity and overweight in Germany: an update." Eur J Health Econ 16(9): 957-967.

In 2011, Konnopka et al. (Eur J Health Econ 12:345-352, 2011) published a top-down cost of illness study on the health burden, and direct and indirect costs of morbidity and mortality

attributable to excess weight (BMI ≥ 25 kg/m²) in Germany in 2002. The objective of the current study was to update the 2002 estimates to the year 2008. To simplify comparisons, we closely followed the methods and assumptions of the original study, using 2008 data for most input parameters (e.g. prevalence, mortality, resource use, costs). Excess weight related deaths increased by 31 % (from 36,653 to 47,964) and associated years of potential life lost (from 428,093 to 588,237) and quality adjusted life years lost (from 367,722 to 505,748) by about 37 %, respectively. Excess weight caused euro16,797 million in total costs in 2008 (+70 %), of which euro8,647 million were direct costs (corresponding to 3.27 % of total German health care expenditures in 2008). About 73 % (euro12,235 million) of total excess weight related costs were attributable to obesity (BMI ≥ 30 kg/m²). The main drivers of direct costs were endocrinological (44 %) and cardiovascular (38 %) diseases. Indirect costs amounted to euro8,150 million in 2008 (+62 %), of which about two-thirds were indirect costs from unpaid work. The great majority of indirect costs were due to premature mortality (euro5,669 million). The variation of input parameters (univariate sensitivity analyses) resulted in attributable costs between euro8,978 million (-47 % compared to base case) and euro25,060 million (+49 %). The marked increase in excess weight related costs can largely be explained by increases in the prevalence of overweight and obesity, and to a lesser extent from increases in resource consumption, as well as increases in (unit) costs and wages (comprising 5.5 % inflation).

Sepehri, A. (2015). "A Critique of Grossman's Canonical Model of Health Capital." *Int J Health Serv* 45(4): 762-778.

In the health economics literature, the demand for health and market health inputs is dominated by adaptations of Grossman's health capital model. The model has been widely used to explore a wide range of issues related to health, socioeconomic inequalities in health, demand for medical care, health preventions, occupational choice, and retirement decisions. The commodity of health is viewed as a durable capital stock that yields a flow of healthy time or illness-free time, that depreciates with age, and that can be augmented with the help of market health inputs and own time. The purpose of this article is to provide a comprehensive critical review of the model. Underlying Grossman's model are a faulty conceptual framework and assumptions that tend to exaggerate the degree of control consumers/patients may have over their state of health and survival. The assumption of full information about one's state of health and the efficacy of various health inputs abstracts away from the problems posed by the agency relationship under uncertainty and informational asymmetry. Grossman's individualistic and mechanistic view of health strips health capital and its production of much of their biological/physiological content and their interactions with the individual's social and physical environment.

Smith, J., et al. (2015). "Parameter Heterogeneity In Breast Cancer Cost Regressions - Evidence From Five European Countries." *Health Econ* 24 Suppl 2: 23-37.

We investigate parameter heterogeneity in breast cancer 1-year cumulative hospital costs across five European countries as part of the EuroHOPE project. The paper aims to explore whether conditional mean effects provide a suitable representation of the national variation in hospital costs. A cohort of patients with a primary diagnosis of invasive breast cancer (ICD-9 codes 174 and ICD-10 C50 codes) is derived using routinely collected individual breast cancer data from Finland, the metropolitan area of Turin (Italy), Norway, Scotland and Sweden. Conditional mean effects are estimated by ordinary least squares for each country, and quantile regressions are used to explore heterogeneity across the conditional quantile distribution. Point estimates based on conditional mean effects provide a good approximation of treatment response for some key demographic and diagnostic specific variables (e.g. age and ICD-10 diagnosis) across the conditional quantile distribution. For

many policy variables of interest, however, there is considerable evidence of parameter heterogeneity that is concealed if decisions are based solely on conditional mean results. The use of quantile regression methods reinforce the need to consider beyond an average effect given the greater recognition that breast cancer is a complex disease reflecting patient heterogeneity. Copyright (c) 2015 John Wiley & Sons, Ltd.

Speight, N. (2015). "Abolishing the internal market to save NHS costs." *BMJ* 351.

Nigel Speight, paediatrician¹Durham, UKspeight{at}doctors.org.ukHam clearly describes the scale of the financial crisis facing the NHS and rightly points out that a greater proportion of Gross Domestic Product could easily be justified in helping to resolve some of these problems.¹However, one easy solution is already available, ...

Géographie de la santé / Geography of Health

Heijink, R., et al. (2015). "A Window on Geographic Variation in Health Care: Insights from EuroHOPE." *Health Econ* 24 Suppl 2: 164-177.

The aim of EuroHOPE was to provide new evidence on the performance of healthcare systems, using a disease-based approach, linkable patient-level data and internationally standardized methods. This paper summarizes its main results. In the seven EuroHOPE countries, the Acute Myocardial Infarction (AMI), stroke and hip fracture patient populations were similar with regard to age, sex and comorbidity. However, non-negligible geographic variation in mortality and resource use was found to exist. Survival rates varied to similar extents between countries and regions for AMI, stroke, hip fracture and very low birth weight. Geographic variation in length of stay differed according to type of disease. Regression analyses showed that only a small part of geographic variation could be explained by demand and supply side factors. Furthermore, the impact of these factors varied between countries. The findings show that there is room for improvement in performance at all levels of analysis and call for more in-depth disease-based research. In using international patient-level data and a standardized methodology, the EuroHOPE approach provides a promising stepping-stone for future investigations in this field. Still, more detailed patient and provider information, including outside of hospital care, and better data sharing arrangements are needed to reach a more comprehensive understanding of geographic variations in health care. Copyright (c) 2015 John Wiley & Sons, Ltd.

Shulman, H., et al. (2015). "A comparison of small-area hospitalisation rates, estimated morbidity and hospital access." *Health Place* 36: 134-144.

Published data on hospitalisation rates tend to reveal marked spatial variations within a city or region. Such variations may simply reflect corresponding variations in need at the small-area level. However, they might also be a consequence of poorer accessibility to medical facilities for certain communities within the region. To help answer this question it is important to compare these variable hospitalisation rates with small-area estimates of need. This paper first maps hospitalisation rates at the small-area level across the region of Yorkshire in the UK to show the spatial variations present. Then the Health Survey of England is used to explore the characteristics of persons with heart disease, using chi-square and logistic regression analysis. Using the most significant variables from this analysis the authors build a spatial microsimulation model of morbidity for heart disease for the Yorkshire region. We then compare these estimates of need with the patterns of hospitalisation rates seen across the region.

Hôpital / Hospitals

Angelé-Halgand, N. (2015). "T2A et réification du social dans le soins : la résilience organisationnelle comme piste de solution ?" Journal de Gestion et d'Economie Médicales 33(2): 103-106.

Cseh, A., et al. (2015). "Hospital Utilization and Universal Health Insurance Coverage: Evidence from the Massachusetts Health Care Reform Act." Appl Health Econ Health Policy 13(6): 627-635.

OBJECTIVE: The Affordable Care Act is currently in the roll-out phase. To gauge the likely implications of the national policy we analyze how the Massachusetts Health Care Reform Act impacted various hospitalization outcomes in each of the 25 major diagnostic categories (MDC). METHODS: We utilize a difference-in-difference approach to identify the impact of the Massachusetts reform on insurance coverage and patient outcomes. This identification is achieved using six years of data from the Nationwide Inpatient Sample from the Healthcare Cost and Utilization Project. We report MDC-specific estimates of the impact of the reform on insurance coverage and type as well as length of stay, number of diagnoses, and number of procedures. RESULTS: The requirement of universal insurance coverage increased the probability of being covered by insurance. This increase was in part a result of an increase in the probability of being covered by Medicaid. The percentage of admissions covered by private insurance fell. The number of diagnoses rose as a result of the law in the vast majority of diagnostic categories. Our results related to length of stay suggest that looking at aggregate results hides a wealth of information. The most disparate outcomes were pregnancy related. The length of stay for new-born babies and neonates rose dramatically. In aggregate, this increase serves to mute decreases across other diagnoses. Also, the number of procedures fell within the MDCs for pregnancy and child birth and that for new-born babies and neonates. CONCLUSIONS: The Massachusetts Health Care Reform appears to have been effective at increasing insurance take-up rates. These increases may have come at the cost of lower private insurance coverage. The number of diagnoses per admission was increased by the policy across nearly all MDCs. Understanding the changes in length of stay as a result of the Massachusetts reform, and perhaps the Affordable Care Act, requires MDC-specific analysis. It appears that the most important distinction to make is to differentiate care related to new-born babies and neonates from that related to other diagnostic categories.

Debreuve-Theresette, A., et al. (2015). "[Patients' satisfaction and waiting time in oncology day care centers in Champagne-Ardenne]." Rev Epidemiol Sante Publique 63 (6) : 381-6

AIM: Quality of life of patients suffering from cancer may be influenced by the way healthcare is organized and by patient experiences. Nowadays, chemotherapy is often provided in day care centers. This study aimed to assess patient waiting time and satisfaction in oncology day care centers in Champagne-Ardenne, France. METHODS: This cross-sectional survey involved all patients receiving ambulatory chemotherapy during a one-week period in day care centers of Champagne-Ardenne public and private healthcare institutions participating in the study. Sociodemographic, medical and outpatient data were collected. Patient satisfaction was measured using the Out-Patsat35 questionnaire. RESULTS: Eleven (out of 16) oncology day care centers and 441 patients participated in the study. Most of the

patients were women (n=252, 57.1%) and the mean age was 61+/-12 years. The mean satisfaction score was 82+/-14 (out of 100) and the mean waiting time between the assigned appointment time and administration of chemotherapy was 97+/-60min. **CONCLUSION:** This study has shown that waiting times are important. However, patients are satisfied with the healthcare organization, especially regarding nursing support. Early preparation of chemotherapy could improve these parameters.

Falstie-Jensen, A. M., et al. (2015). "Is compliance with hospital accreditation associated with length of stay and acute readmission? A Danish nationwide population-based study." *Int J Qual Health Care* 27(6): 450-457.

OBJECTIVE: To examine the association between compliance with hospital accreditation and length of stay (LOS) and acute readmission (AR). **DESIGN:** A nationwide population-based follow-up study from November 2009 to December 2012. **SETTING:** Public, non-psychiatric Danish hospitals. **PARTICIPANTS:** In-patients admitted with one of 80 diagnoses. **INTERVENTION:** Accreditation by the first version of The Danish Healthcare Quality Programme. Using an on-site survey, surveyors assessed the level of compliance with the standards. The hospital was awarded either fully (n = 11) or partially accredited (n = 20). **MAIN OUTCOME MEASURES:** LOS including transfers between hospitals and all-cause AR within 30 days after discharge. The Cox Proportional Hazard regression was used to compute hazard ratios (HRs) adjusted for potential confounding factors and cluster effect at hospital level. **RESULTS:** For analyses of LOS, 275 589 in-patients were included of whom 266 532 were discharged alive and included in the AR analyses. The mean LOS was 4.51 days (95% confidence interval (CI): 4.46-4.57) at fully and 4.54 days (95% CI: 4.50-4.57) at partially accredited hospitals, respectively. After adjusting for confounding factors, the adjusted HR for time to discharge was 1.07 (95% CI: 1.01-1.14). AR within 30 days after discharge was 13.70% (95% CI: 13.45-13.95) at fully and 12.72% (95% CI: 12.57-12.86) at partially accredited hospitals, respectively, corresponding to an adjusted HR of 1.01 (95% CI: 0.92-1.10). **CONCLUSION:** Admissions at fully accredited hospitals were associated with a shorter LOS compared with admissions at partially accredited hospitals, although the difference was modest. No difference was observed in AR within 30 days after discharge.

Gervais, A. (2015). "Financement par la T2A, vision médicale hospitalière." *Journal de Gestion et d'Economie Médicales* 33(2): 117-122.

Hakkinen, U., et al. (2015). "Outcome, Use of Resources and Their Relationship in the Treatment of AMI, Stroke and Hip Fracture at European Hospitals." *Health Econ* 24 Suppl 2: 116-139.

The aim of the present study was to compare the quality (survival), use of resources and their relationship in the treatment of three major conditions (acute myocardial infarction (AMI), stroke and hip fracture), in hospitals in five European countries (Finland, Hungary, Italy, Norway and Sweden). The comparison of quality and use of resources was based on hospital-level random effects models estimated from patient-level data. After examining quality and use of resources separately, we analysed whether a cost-quality trade-off existed between the hospitals. Our results showed notable differences between hospitals and countries in both survival and use of resources. Some evidence would support increasing the horizontal integration: higher degrees of concentration of regional AMI care were associated with lower use of resources. A positive relation between cost and quality in the care of AMI patients existed in Hungary and Finland. In the care of stroke and hip fracture, we found no evidence of a cost-quality trade-off. Thus, the cost-quality association was inconsistent and prevailed for certain treatments or patient groups, but not in all countries. Copyright (c) 2015 John Wiley & Sons, Ltd.

Harrison, R., et al. (2015). "The missing evidence: a systematic review of patients' experiences of adverse events in health care." *Int J Qual Health Care* 27(6): 423-441.

PURPOSE: Preventable patient harm due to adverse events (AEs) is a significant health problem today facing contemporary health care. Knowledge of patients' experiences of AEs is critical to improving health care safety and quality. A systematic review of studies of patients' experiences of AEs was conducted to report their experiences, knowledge gaps and any challenges encountered when capturing patient experience data. **DATA SOURCES:** Key words, synonyms and subject headings were used to search eight electronic databases from January 2000 to February 2015, in addition to hand-searching of reference lists and relevant journals. **STUDY SELECTION:** Titles and abstracts of publications were screened by two reviewers and checked by a third. Full-text articles were screened against the eligibility criteria. **DATA EXTRACTION:** Data on design, methods and key findings were extracted and collated. **RESULTS:** Thirty-three publications demonstrated patients identifying a range of problems in their care; most commonly identified were medication errors, communication and coordination of care problems. Patients' income, education, health burden and marital status influence likelihood of reporting. Patients report distress after an AE, often exacerbated by receiving inadequate information about the cause. Investigating patients' experiences is hampered by the lack of large representative patient samples, data over sufficient time periods and varying definitions of an AE. **CONCLUSION:** Despite the emergence of policy initiatives to enhance patient engagement, few studies report patients' experiences of AEs. This information must be routinely captured and utilized to develop effective, patient-centred and system-wide policies to minimize and manage AEs.

Hirsch, M., et al. (2015) "The medical response to multisite terrorist attacks in Paris." *The Lancet*, 24 nov..

Kim, H., et al. (2015). "Predictors and outcomes of unplanned readmission to a different hospital." *Int J Qual Health Care* 27(6): 512-518.

OBJECTIVES: To examine patient, hospital and market factors and outcomes associated with readmission to a different hospital compared with the same hospital. **DESIGN:** A population-based, secondary analysis using multilevel causal modeling. **SETTING:** Acute care hospitals in California in the USA. **PARTICIPANTS:** In total, 509 775 patients aged 50 or older who were discharged alive from acute care hospitals (index hospitalizations), and 59 566 who had a rehospitalization within 30 days following their index discharge. **INTERVENTION:** No intervention. **MAIN OUTCOME MEASUREMENTS:** Thirty-day unplanned readmissions to a different hospital compared with the same hospital and also the costs and health outcomes of the readmissions. **RESULTS:** Twenty-one percent of patients with a rehospitalization had a different-hospital readmission. Compared with the same-hospital readmission group, the different-hospital readmission group was more likely to be younger, male and have a lower income. The index hospitals of the different-hospital readmission group were more likely to be smaller, for-profit hospitals, which were also more likely to be located in counties with higher competition. The different-hospital readmission group had higher odds for in-hospital death (8.1 vs. 6.7%; $P < 0.0001$) and greater readmission hospital costs (\$15 671.8 vs. \$14 286.4; $P < 0.001$) than the same-hospital readmission group. **CONCLUSIONS:** Patient, hospital and market characteristics predicted different-hospital readmissions compared with same-hospital readmissions. Mortality and cost outcomes were worse among patients with different-hospital readmissions. Strategies for better care coordination targeting people at risk for different-hospital readmissions are necessary.

Kittelsen, S. A., et al. (2015). "Costs and Quality at the Hospital Level in the Nordic

Countries." Health Econ 24 Suppl 2: 140-163.

This article develops and analyzes patient register-based measures of quality for the major Nordic countries. Previous studies show that Finnish hospitals have significantly higher average productivity than hospitals in Sweden, Denmark, and Norway and also a substantial variation within each country. This paper examines whether quality differences can form part of the explanation and attempts to uncover quality-cost trade-offs. Data on costs and discharges in each diagnosis-related group for 160 acute hospitals in 2008-2009 were collected. Patient register-based measures of quality such as readmissions, mortality (in hospital or outside), and patient safety indices were developed and case-mix adjusted. Productivity is estimated using bootstrapped data envelopment analysis. Results indicate that case-mix adjustment is important, and there are significant differences in the case-mix adjusted performance measures as well as in productivity both at the national and hospital levels. For most quality indicators, the performance measures reveal room for improvement. There is a weak but statistically significant trade-off between productivity and inpatient readmissions within 30 days but a tendency that hospitals with high 30-day mortality also have higher costs. Hence, no clear cost-quality trade-off pattern was discovered. Patient registers can be used and developed to improve future quality and cost comparisons. Copyright (c) 2015 John Wiley & Sons, Ltd.

Kristensen, S., et al. (2015). "Quality management and perceptions of teamwork and safety climate in European hospitals." Int J Qual Health Care 27(6): 498-505.

OBJECTIVE: This study aimed to investigate the associations of quality management systems with teamwork and safety climate, and to describe and compare differences in perceptions of teamwork climate and safety climate among clinical leaders and frontline clinicians. **METHOD:** We used a multi-method, cross-sectional approach to collect survey data of quality management systems and perceived teamwork and safety climate. Our data analyses included descriptive and multilevel regression methods. **SETTING AND PARTICIPANTS:** Data on implementation of quality management system from seven European countries were evaluated including patient safety culture surveys from 3622 clinical leaders and 4903 frontline clinicians. **MAIN OUTCOME MEASURES:** Perceived teamwork and safety climate. **RESULTS:** Teamwork climate was reported as positive by 67% of clinical leaders and 43% of frontline clinicians. Safety climate was perceived as positive by 54% of clinical leaders and 32% of frontline clinicians. We found positive associations between implementation of quality management systems and teamwork and safety climate. **CONCLUSIONS:** Our findings, which should be placed in a broader clinical quality improvement context, point to the importance of quality management systems as a supportive structural feature for promoting teamwork and safety climate. To gain a deeper understanding of this association, further qualitative and quantitative studies using longitudinally collected data are recommended. The study also confirms that more clinical leaders than frontline clinicians have a positive perception of teamwork and safety climate. Such differences should be accounted for in daily clinical practice and when tailoring initiatives to improve teamwork and safety climate.

Medin, E., et al. (2015). "European Regional Differences in All-Cause Mortality and Length of Stay for Patients with Hip Fracture." Health Econ 24 Suppl 2: 53-64.

The objective of this study was to compare healthcare performance for the surgical treatment of hip fractures across and within Finland, Hungary, Italy, the Netherlands, Norway, Scotland, and Sweden. Differences in age-adjusted and sex-adjusted 30-day and one-year all-cause mortality rates following hip fracture, as well as the length of stay of the first hospital episode in acute care and during a follow up of 365 days, were investigated, and associations between selected country-level and regional-level factors with mortality and length of stay were assessed. Hungary showed the highest one-year mortality rate (mean

39.7%) and the lowest length of stay in one year (12.7 days), whereas Italy had the lowest one-year mortality rate (mean 19.1 %) and the highest length of stay (23.3 days). The observed variations were largely explained by country-specific effects rather than by regional-level factors. The results show that there should still be room for efficiency gains in the acute treatment of hip fracture, and clinicians, healthcare managers, and politicians should learn from best practices. This study demonstrates that an international comparison of acute hospital care is possible using pooled individual-level administrative data. Copyright (c) 2015 John Wiley & Sons, Ltd.

Moisson, J.C. (2015). "La prise en compte des ressources humaines dans l'Etude Nationale de Coûts." *Journal de Gestion et d'Economie Médicales* 33(2): 97-132.

Peltola, M., et al. (2015). "Individual and Regional-level Factors Contributing to Variation in Length of Stay After Cerebral Infarction in Six European Countries." *Health Econ* 24 Suppl 2: 38-52.

Using patient-level data for cerebral infarction cases in 2007, gathered from Finland, Hungary, Italy, the Netherlands, Scotland and Sweden, we studied the variation in risk-adjusted length of stay (LoS) of acute hospital care and 1-year mortality, both within and between countries. In addition, we analysed the variance of LoS and associations of selected regional-level factors with LoS and 1-year mortality after cerebral infarction. The data show that LoS distributions are surprisingly different across countries and that there is significant deviation in the risk-adjusted regional-level LoS in all of the countries studied. We used negative binomial regression to model the individual-level LoS, and random intercept models and ordinary least squares regression for the regional-level analysis of risk-adjusted LoS, variance of LoS, 1-year risk-adjusted mortality and crude mortality for a period of 31-365 days. The observed variations between regions and countries in both LoS and mortality were not fully explained by either patient-level or regional-level factors. The results indicate that there may exist potential for efficiency gains in acute hospital care of cerebral infarction and that healthcare managers could learn from best practices. Copyright (c) 2015 John Wiley & Sons, Ltd.

Pezzin, L. E., et al. (2015). "Reexamining the Relationship of Breast Cancer Hospital and Surgical Volume to Mortality: An Instrumental Variable Analysis." *Med Care* 53(12): 1033-1039.

OBJECTIVE: To reexamine the relationship of hospital and surgical volume to all-cause and breast cancer-specific mortality, taking into account the potential selection bias in patients treated at high-volume centers or by high-volume surgeons. DATA SOURCES: Elderly (65+) women with early-stage, incident breast cancer surgery in 2003. STUDY DESIGN: A population-based, prospective survey study. METHODS: Two-stage, instrumental variable regression models. PRINCIPAL FINDINGS: Women treated in high-volume hospitals were significantly less likely to die of any cause by 5 years after surgery, even after adjustments for self-selection and a number of other factors. The relationship was larger and more significant for breast cancer-specific mortality. Although the general pattern of better mortality outcomes held for moderately sized hospitals, the relationships were not statistically significant. In contrast, there was no relationship of surgeon volume with all-cause or breast cancer-specific mortality. CONCLUSIONS: Hospital volume, but not surgeon volume, is associated with better survival among women with breast cancer. The magnitude of the potential improvement was substantial and comparable with the benefit conferred by many systemic therapies. These findings highlight the importance of accounting for patient self-selection in volume-outcome analyses, and provide support for policy initiatives aimed at regionalizing breast cancer care in the United States.

Sundmacher, L., et al. "Which hospitalisations are ambulatory care-sensitive, to what degree, and how could the rates be reduced? Results of a group consensus study in Germany." *Health Policy* 119(11): 1415-1423.

The paper proposed as core list a subset of 22 ACSC diagnosis covering 90% of all consented 40 ACSH and conditions with a higher than 85% estimated degree of preventability. Of all 18.6 million German hospital cases in the year 2012, the panellists considered 5.04 million hospitalisations (27%) to be sensitive to ambulatory care, of which 3.72 (20%) were estimated to be actually preventable. Among the core ACSC, the preventability ranged from 58% for gonarthrosis to 94% for dental diseases, with an average preventability of 75% across all diagnosis groups. The most often mentioned strategy for reducing ACSH was improving continuous care.

Warner, L. S. H., et al. (2015). "The Most Crowded US Hospital Emergency Departments Did Not Adopt Effective Interventions To Improve Flow, 2007–10." *Health Affairs* 34(12): 2151-2159.

Emergency department (ED) crowding adversely affects patient care and outcomes. Despite national recommendations to address crowding, it persists in most US EDs today. Using nationally representative data, we evaluated the use of interventions to address crowding in US hospitals in the period 2007–10. We examined the relationship between crowding within an ED itself, measured as longer ED lengths-of-stay, and the number of interventions adopted. In our study period the average number of interventions adopted increased from 5.2 to 6.6, and seven of the seventeen studied interventions saw a significant increase in adoption. In general, more crowded EDs adopted greater numbers of interventions than less crowded EDs. However, in the most crowded quartile of EDs, a large proportion had not adopted effective interventions: 19 percent did not use bedside registration, and 94 percent did not use surgical schedule smoothing. Thus, while adoption of strategies to reduce ED crowding is increasing, many of the nation's most crowded EDs have not adopted proven interventions.

Inégalités de santé / Health Inequalities

Bronnum-Hansen, H., et al. (2015). "Educational inequalities in health expectancy during the financial crisis in Denmark." *Int J Public Health* 60(8): 927-935.

OBJECTIVES: To investigate educational differentials in health expectancy among 50-year-old Danes before and during the financial crisis. METHODS: Nationwide register data on mortality were combined with data from SHARE surveys in 2006/2007 and 2010/2011 to estimate disability-free life expectancy (DFLE) and expected lifetime in self-rated good health by educational level. RESULTS: The difference in life expectancy between 50-year-old men and women with high and low educational levels increased by 0.3 and 0.8 years, respectively. The overall educational differentials in DFLE did not change much for women, whereas for men the tendency was that DFLE increased for those with high educational level and decreased for those with less education ascending the difference by almost 2 years (from 5.9 to 7.8 years), although the difference was not statistically significant. The educational disparity in expected lifetime in self-rated good health increased by 1.3 years for men and 1.2 years for women. CONCLUSIONS: The social inequality in DFLE for men and expected lifetime in self-rated good health for both genders increased slightly during the short period. The financial crisis did not seem to indicate a change in the persistent trend of the widening social gap.

Dijkstra, A., et al. (2015). "Can selective migration explain why health is worse in regions with population decline? : A study on migration and self-rated health in the Netherlands." *Eur J Public Health* 25(6): 944-950.

BACKGROUND: Health disparities between population declining and non-declining areas have received little attention, even though population decline is an established phenomenon in Europe. Selective migration, in which healthier people move out of deprived areas, can possibly explain worse health in declining regions. We assessed whether selective migration can explain the observed worse average health in declining regions as compared with non-declining regions in the Netherlands. METHODS: Combining data from the Dutch Housing and Living Survey held in 2002 and 2006 with Dutch registry data, we studied the relation between health status and migration in a 5-year period at the individual level by applying logistic regression. In our sample of 130 600 participants, we compared health status, demographic and socioeconomic factors of movers and stayers from declining and non-declining regions. RESULTS: People in the Netherlands who migrated are healthier than those staying behind [odds ratio (OR): 1.80]. This effect is larger for persons moving out of declining regions (OR: 1.76) than those moving into declining regions (OR: 1.47). When controlled for demographic and socioeconomic characteristics, these effects are not significant. Moreover, only a small part of the population migrates out of (0.29%) or into (0.25%) declining regions in the course of 5 years. CONCLUSION: Despite the relation between health and migration, the effect of selective migration on health differences between declining and non-declining regions in the Netherlands is small. Both health and migration are complexly linked with socioeconomic and demographic factors.

Fouweather, T., et al. (2015). "Comparison of socio-economic indicators explaining inequalities in Healthy Life Years at age 50 in Europe: 2005 and 2010." *Eur J Public Health* 25(6): 978-983.

BACKGROUND: The first estimates of Healthy Life Years at age 50 (HLY50) across the EU25 countries in 2005 showed substantial variation in healthy ageing. We investigate whether factors contributing to HLY50 inequalities have changed between 2005 and 2010. METHODS: HLY50 for each country and year were calculated using Sullivan's method, applying the age-specific prevalence of activity limitation from the European Union Statistics on Income and Living Conditions (EU-SILC) survey to life tables. Inequalities in life expectancy at age 50 (LE50) and HLY50 between countries were defined as the difference between the maximum and minimum LE50 or HLY50. Relationships between HLY50 and macro-level socio-economic indicators were investigated using meta-regression. Men and women were analysed separately. RESULTS: Between 2005 and 2010 HLY50 inequalities for both men and women in Europe increased. In 2005 and 2010 HLY50 inequalities exceeded LE50 inequalities, particularly in the established EU15 countries in 2010 where HLY50 inequalities (men: 10.7 years; women: 12.5 years) were four times greater for men and three times for women than LE50 inequalities (men: 2.4 years; women: 4.1 years). Only material deprivation significantly explained variation in EU25 HLY50 in both years with, additionally, long-term unemployment in 2010. CONCLUSIONS: Our results suggest that inequalities in HLY50 across Europe are large, increasing and partly explained by levels of material deprivation. Moreover long-term unemployment has become more influential in explaining variation in HLY50 between 2005 and 2010.

Goldstein, L. B., et al. (2009). "Stroke-related knowledge among uninsured Latino immigrants in Durham County, North Carolina." *J Stroke Cerebrovasc Dis* 18(3): 229-231.

BACKGROUND: Knowledge of stroke risk factors and symptoms is a necessary prerequisite

for improving prevention and reducing treatment delays. Little is known about stroke-related knowledge among the US immigrant Latino population. METHODS: A previously published stroke knowledge survey was translated into Spanish and administered orally to a convenience sample of 76 Latino Spanish-speaking clients of a community-based health care management program for uninsured residents of Durham County, North Carolina, between January and March 2007. RESULTS: Of respondents, 81% could not correctly name a single stroke risk factor, 57% could not correctly identify a stroke symptom, and only 45% said they would telephone emergency services (dial 9-1-1), call an ambulance, or go to a hospital if they or a family member were having a stroke. However, 80% of respondents knew that a stroke could be prevented, and 86% knew that a stroke could be treated. CONCLUSION: Stroke-related knowledge may be particularly poor in the uninsured Latino immigrant population. Novel approaches will be needed to improve awareness and prevention in this high-risk group.

Gotsens, M., et al. (2015). "Health inequality between immigrants and natives in Spain: the loss of the healthy immigrant effect in times of economic crisis." *Eur J Public Health* 25(6): 923-929.

BACKGROUND: The immigrant population living in Spain grew exponentially in the early 2000s but has been particularly affected by the economic crisis. This study aims to analyse health inequalities between immigrants born in middle- or low-income countries and natives in Spain, in 2006 and 2012, taking into account gender, year of arrival and socioeconomic exposures. METHODS: Study of trends using two cross-sections, the 2006 and 2012 editions of the Spanish National Health Survey, including residents in Spain aged 15-64 years (20 810 natives and 2950 immigrants in 2006, 14 291 natives and 2448 immigrants in 2012). Fair/poor self-rated health, poor mental health (GHQ-12 > 2), chronic activity limitation and use of psychotropic drugs were compared between natives and immigrants who arrived in Spain before 2006, adjusting robust Poisson regression models for age and socioeconomic variables to obtain prevalence ratios (PR) and 95% confidence interval (CI). RESULTS: Inequalities in poor self-rated health between immigrants and natives tend to increase among women (age-adjusted PR₂₀₀₆ = 1.39; 95% CI: 1.24-1.56, PR₂₀₁₂ = 1.56; 95% CI: 1.33-1.82). Among men, there is a new onset of inequalities in poor mental health (PR₂₀₀₆ = 1.10; 95% CI: 0.86-1.40, PR₂₀₁₂ = 1.34; 95% CI: 1.06-1.69) and an equalization of the previously lower use of psychotropic drugs (PR₂₀₀₆ = 0.22; 95% CI: 0.11-0.43, PR₂₀₁₂ = 1.20; 95% CI: 0.73-2.01). CONCLUSIONS: Between 2006 and 2012, immigrants who arrived in Spain before 2006 appeared to worsen their health status when compared with natives. The loss of the healthy immigrant effect in the context of a worse impact of the economic crisis on immigrants appears as potential explanation. Employment, social protection and re-universalization of healthcare would prevent further deterioration of immigrants' health status.

Kentikelenis, A., et al. (2015). "How do economic crises affect migrants' risk of infectious disease? A systematic-narrative review." *Eur J Public Health* 25(6): 937-944.

BACKGROUND: It is not well understood how economic crises affect infectious disease incidence and prevalence, particularly among vulnerable groups. Using a susceptible-infected-recovered framework, we systematically reviewed literature on the impact of the economic crises on infectious disease risks in migrants in Europe, focusing principally on HIV, TB, hepatitis and other STIs. METHODS: We conducted two searches in PubMed/Medline, Web of Science, Cochrane Library, Google Scholar, websites of key organizations and grey literature to identify how economic changes affect migrant populations and infectious disease. We perform a narrative synthesis in order to map critical pathways and identify

hypotheses for subsequent research. RESULTS: The systematic review on links between economic crises and migrant health identified 653 studies through database searching; only seven met the inclusion criteria. Fourteen items were identified through further searches. The systematic review on links between economic crises and infectious disease identified 480 studies through database searching; 19 met the inclusion criteria. Eight items were identified through further searches. The reviews show that migrant populations in Europe appear disproportionately at risk of specific infectious diseases, and that economic crises and subsequent responses have tended to exacerbate such risks. Recessions lead to unemployment, impoverishment and other risk factors that can be linked to the transmissibility of disease among migrants. Austerity measures that lead to cuts in prevention and treatment programmes further exacerbate infectious disease risks among migrants. Non-governmental health service providers occasionally stepped in to cater to specific populations that include migrants. CONCLUSIONS: There is evidence that migrants are especially vulnerable to infectious disease during economic crises. Ring-fenced funding of prevention programs, including screening and treatment, is important for addressing this vulnerability.

Kroger, H., et al. (2015). "What causes health inequality? A systematic review on the relative importance of social causation and health selection." Eur J Public Health 25(6): 951-960.

BACKGROUND: The social gradient in health is one of the most reliable findings in public health research. The two competing hypotheses that try to explain this gradient are known as the social causation and the health selection hypothesis. There is currently no synthesis of the results of studies that test both hypotheses. METHODS: We provide a systematic review of the literature that has addressed both the health selection and social causation hypotheses between 1994 and 2013 using seven databases following PRISMA rules. RESULTS: The search strategy resulted in 2952 studies, of which, we included 34 in the review. The synthesis of these studies suggests that there is no general preference for either of the hypotheses (12 studies for social causation, 10 for health selection). However, both a narrative synthesis as well as meta-regression results show that studies using indicators for socio-economic status (SES) that are closely related to the labor market find equal support for health selection and social causation, whereas indicators of SES like education and income yield results that are in favor of the social causation hypothesis. High standards in statistical modeling were associated with more support for health selection. CONCLUSIONS: The review highlights the fact that the causal mechanisms behind health inequalities are dependent on whether or not the dimension being analyzed closely reflects labor market success. Additionally, further research should strive to improve the statistical modeling of causality, as this might influence the conclusions drawn regarding the relative importance of health selection and social causation.

Lamkaddem, M., et al. (2015). "Health changes of refugees from Afghanistan, Iran and Somalia: the role of residence status and experienced living difficulties in the resettlement process." Eur J Public Health 25(6): 917-922.

INTRODUCTION: Worldwide, refugees show a poorer mental and physical health than the populations among which they resettle. Little is known about the factors influencing health after resettlement. We examined the development of mental and physical health of refugees. As experienced living difficulties might decrease with obtaining a residence permit, we expected this to play a central role in health improvement after resettlement. METHODS: A two-wave study conducted in the Netherlands among a cohort of 172 recent (n = 68) and longstanding (n = 104) permit holders from Afghanistan, Iran and Somalia between 2003 and 2011. Multivariate mediation analyses were conducted for the effect of changes in living

difficulties on the association between change in status and changes in health. Health outcomes were self-reported general health, number of chronic conditions, PTSD and anxiety/depression. RESULTS: Recent permit holders had larger decreases in PTSD score (-0.402, CI -0.612; -0.192) and anxiety/depression score (-0.298, CI -0.464; -0.132), and larger improvements in self-rated general health between T1 and T2 (0.566, CI 0.183; 0.949) than longstanding permit holders. This association was not significant for changes in number of chronic conditions. Mediation analyses showed that the effect of getting a residence permit on health improvements transited through an improvement in living conditions, in particular employment and the presence of family/social support. CONCLUSION: These results suggest that change in residence permit is beneficial for health mainly because of the change in living difficulties. These results add up to the evidence on the role of social circumstances for refugees upon resettlement, and point at labour participation and social support as key mechanisms for health improvements.

Mulinari, S., et al. (2015). "Questioning the discriminatory accuracy of broad migrant categories in public health: self-rated health in Sweden." *Eur J Public Health* 25(6): 911-917.

BACKGROUND: Differences between natives and migrants in average risk for poor self-rated health (SRH) are well documented, which has lent support to proposals for interventions targeting disadvantaged minority groups. However, such proposals are based on measures of association that neglect individual heterogeneity around group averages and thereby the discriminatory accuracy (DA) of the categories used (i.e. their ability to discriminate the individuals with poor and good SRH, respectively). Therefore, applying DA measures rather than only measures of association our study revisits the value of broad native and migrant categorizations for predicting SRH. DESIGN, SETTING AND PARTICIPANTS: We analyzed 27 723 individuals aged 18-80 who responded to a 2008 Swedish public health survey. We performed logistic regressions to estimate odds ratios (ORs), predicted risks and the area under the receiver operating characteristic curve (AU-ROC) as a measure of epidemiological DA. RESULTS: Being born abroad was associated with higher odds of poor SRH (OR = 1.75), but the AU-ROC of this variable only added 0.02 units to the AU-ROC for age alone (from 0.53 to 0.55). The AU-ROC increased, but remained unsatisfactorily low (0.62), when available social and demographic variables were included. CONCLUSIONS: Our results question the use of broad native/migrant categorizations as instruments for forecasting individual SRH. Such simple categorizations have a very low DA and should be abandoned in public health practice. Measures of association and DA should be reported together whenever an intervention is being considered, especially in the area of ethnicity, migration and health.

Sorensen, K., et al. (2015). "Health literacy in Europe: comparative results of the European health literacy survey (HLS-EU)." *Eur J Public Health* 25(6): 1053-1058.

BACKGROUND: Health literacy concerns the capacities of people to meet the complex demands of health in modern society. In spite of the growing attention for the concept among European health policymakers, researchers and practitioners, information about the status of health literacy in Europe remains scarce. This article presents selected findings from the first European comparative survey on health literacy in populations. METHODS: The European health literacy survey (HLS-EU) was conducted in eight countries: Austria, Bulgaria, Germany, Greece, Ireland, the Netherlands, Poland and Spain (n = 1000 per country, n = 8000 total sample). Data collection was based on Eurobarometer standards and the implementation of the HLS-EU-Q (questionnaire) in computer-assisted or paper-assisted personal interviews. RESULTS: The HLS-EU-Q constructed four levels of health literacy: insufficient, problematic, sufficient and excellent. At least 1 in 10 (12%) respondents showed insufficient health literacy and almost 1 in 2 (47%) had limited (insufficient or problematic)

health literacy. However, the distribution of levels differed substantially across countries (29-62%). Subgroups within the population, defined by financial deprivation, low social status, low education or old age, had higher proportions of people with limited health literacy, suggesting the presence of a social gradient which was also confirmed by raw bivariate correlations and a multivariate linear regression model. DISCUSSION: Limited health literacy represents an important challenge for health policies and practices across Europe, but to a different degree for different countries. The social gradient in health literacy must be taken into account when developing public health strategies to improve health equity in Europe.

Médicaments / Pharmaceuticals

Ashworth, M., et al. (2016). "Antibiotic prescribing and patient satisfaction in primary care in England: cross-sectional analysis of national patient survey data and prescribing data." *British Journal of General Practice* 66 (642) : e40-6.

Background Concerns about adverse effects on patient satisfaction may be an important obstacle to attempts to curtail antibiotic prescribing. Aim To determine the relationship between antibiotic prescribing in general practice and reported patient satisfaction. Design and setting Retrospective cross-sectional study of general practices in England. Method Data were obtained from the General Practice Patient Survey (GPPS) in 2012 (2.7 million questionnaires in England; 982 999 responses; response rate 36%); the national Quality and Outcomes Framework dataset for England, 2011–2012 (8164 general practices); and general practice and demographic characteristics. Standardised measures of antibiotic prescribing volumes were obtained for each practice in England during 2012–2013, together with 12 other nationally available prescribing variables. The role of antibiotic prescribing volume was identified as a determinant of GPPS scores and adjusted for demographic and practice factors using multiple linear regression. Results The final dataset consisted of 7800 (95.5%) practices. A total of 33.7 million antibiotic prescriptions were issued to a registered population of 53.8 million patients. Antibiotic prescribing volume was a significant positive predictor of all 'doctor satisfaction' and 'practice satisfaction' scores in the GPPS, and was the strongest predictor of overall satisfaction out of 13 prescribing variables. A theoretical 25% reduction in antibiotic prescribing volume would be associated with 0.5–1.0% lower patient satisfaction scores, a drop of 3–6 centile points in national satisfaction ranking. Conclusion Patients were less satisfied in practices with frugal antibiotic prescribing. A cautious approach to antibiotic prescribing may require a trade-off in terms of patient satisfaction.

Chen, C. C. and S. H. Cheng (2015). "Potentially Inappropriate Medication and Health Care Outcomes: An Instrumental Variable Approach." *Health Serv Res*.

OBJECTIVE: To examine the effects of potentially inappropriate medication (PIM) use on health care outcomes in elderly individuals using an instrumental variable (IV) approach. DATA SOURCES/STUDY SETTING: Representative claim data from the universal health insurance program in Taiwan from 2007 to 2010. STUDY DESIGN: We employed a panel study design to examine the relationship between PIM and hospitalization. We applied both the naive generalized estimating equation (GEE) model, which controlled for the observed patient and hospital characteristics, and the two-stage residual inclusion (2SRI) GEE model, which further accounted for the unobserved confounding factors. The PIM prescription rate of the physician most frequently visited by each patient was used as the IV. PRINCIPAL FINDINGS: The naive GEE models indicated that patient PIM use was associated with a higher

likelihood of hospitalization (odds ratio [OR], 1.399; 95 percent confidence interval [CI], 1.363-1.435). Using the physician PIM prescribing rate as an IV, we identified a stronger significant association between PIM and hospitalization (OR, 1.990; 95 percent CI, 1.647-2.403). CONCLUSIONS: PIM use is associated with increased hospitalization in elderly individuals. Adjusting for unobserved confounders is needed to obtain unbiased estimates of the relationship between PIM and health care outcomes.

Degrassat-Théas, A., et al. "The "Temporary Recommendations for Use": A dual-purpose regulatory framework for off-label drug use in France." *Health Policy* 119(11): 1399-1405.

Kaiser, B. and C. Schmid (2016). "Does Physician Dispensing Increase Drug Expenditures? Empirical Evidence from Switzerland." *Health Econ* 25(1): 71-90.

This paper analyzes whether the opportunity for physicians to dispense drugs increases healthcare expenditures. We study the case of Switzerland, where dispensing physicians face financial incentives to overprescribe and sell more expensive pharmaceuticals. Using comprehensive physician-level data, we exploit the regional variation in the dispensing regime to estimate causal effects. The empirical strategy consists of a doubly-robust estimation that combines inverse probability weighting with regression. Our main finding suggests that dispensing leads to higher drug costs on the order of 34% per patient. Copyright © 2014 John Wiley & Sons, Ltd.

Robertson, H. D., et al. (2015). "The evolution of pharmaceutical care for drug misusers." *Family Practice* 32(6): 639-645.

Background. In the last 20 years, pharmaceutical care has evolved as a modus operandi for community pharmacy. This article tracks the development of pharmaceutical care for drug misusers since 1995 and considers the implications for pharmacy engagement with the wider care team. Objective. To survey current community pharmacy service provision for drug misusers, past training and future training needs and compare with data from previous years (1995, 2000 and 2006). Method. A cross-sectional postal questionnaire of pharmacy managers in Scotland (n = 1246), and telephone interviews with non-respondents. Results were compared with previous surveys. Results. The response rate was 70% (873) including 13.2% (164) by telephone. More pharmacies dispensed methadone in 2014 (88.5%) than previously, a significant increase across all time points (1995, 2000 and 2006) (P < 0.001). Most pharmacies (88.1%) had some drug misusers registered for the minor ailment scheme. In 2014, 43.4% of pharmacists always reported a drug misuser's non-attendance for opiate replacement treatment (ORT) to the prescriber (36.6% in 2006). If patient intoxication was suspected, medication was always withheld by 47.9% (27.5% in 2006). Pharmacists undertaking training in drug misuse and blood-borne diseases increased significantly since 1995, to 78.6% and 48.7%, respectively, in 2014 (P < 0.001). The preferred topic for future training was communication/engagement with other services. Conclusion. Pharmaceutical care for drug misusers has evolved from ORT supply to a more clinical approach. Pharmacists actively monitored ORT patients, managed their minor ailments and increasingly engaged with the wider care team.

Stafford, N. (2015). "German drug industry says pricing law is restricting access to some drugs." *BMJ* 351.

The German drug industry has appealed to the German government to reform its drug pricing law, saying that it is denying patients access to innovative drugs available in other European countries. The appeal was made by the Federal Association of the German Pharmaceutical Industry (BPI) at a press conference in Berlin to mark the fifth anniversary of

the approval of the law, which is widely known in Germany as AMNOG (ArzneiMittelmarkt-NeuOrdnungsGesetz; pharmaceuticals market reorganisation act). The main goal of AMNOG was to slow the rise in drug prices, but five years ago supporters of the law also said that it would encourage innovation, because it allows drug firms to charge higher prices for new drugs with proven "added benefits" compared with drugs already on the market.

Méthodologie – Statistique / Methodology - Statistics

Jackson, T., et al. "Australian diagnosis related groups: Drivers of complexity adjustment." *Health Policy* **119**(11): 1433-1441.

BACKGROUND: In undertaking a major revision to the Australian Refined Diagnosis Related Group (ARDRG) classification, we set out to contrast Australia's approach to using data on additional (not principal) diagnoses with major international approaches in splitting base or Adjacent Diagnosis Related Groups (ADRGs). **METHODS:** Comparative policy analysis/narrative review of peer-reviewed and grey literature on international approaches to use of additional (secondary) diagnoses in the development of Australian and international DRG systems. **ANALYSIS:** European and US approaches to characterise complexity of inpatient care are well-documented, providing useful points of comparison with Australia's. Australia, with good data sources, has continued to refine its national DRG classification using increasingly sophisticated approaches. Hospital funders in Australia and in other systems are often under pressure from provider groups to expand classifications to reflect clinical complexity. DRG development in most healthcare systems reviewed here reflects four critical factors: these socio-political factors, the quality and depth of the coded data available to characterise the mix of cases in a healthcare system, the size of the underlying population, and the intended scope and use of the classification. Australia's relatively small national population has constrained the size of its DRG classifications, and development has been concentrated on inpatient care in public hospitals. **DISCUSSION AND CONCLUSIONS:** Development of casemix classifications in health care is driven by both technical and socio-political factors. Use of additional diagnoses to adjust for patient complexity and cost needs to respond to these in each casemix application.

Politique de santé / Health Policy

Fouchard, A. (éd.), and Mouchard, P. (éd.) "Pertinence des soins et variations des pratiques médicales." *Actualité et Dossier en Santé Publique*(92): 10-58.

Karamanoli, E. (2015) "5 years of austerity takes its toll on Greek health care." *The Lancet* **386** (10010): 2239-2240.

Krasnik, A. (2015). "Categorizations of migrants and ethnic minorities-are they useful for decisions on public health interventions?" *Eur J Public Health* **25**(6): 907.

Parston, G., et al. (2015). "The Science And Art Of Delivery: Accelerating The Diffusion Of Health Care Innovation." *Health Affairs* **34**(12): 2160-2166.

There is a widely acknowledged time lag in health care between an invention or innovation and its widespread use across a health system. Much is known about the factors that can aid

the uptake of innovations within discrete organizations. Less is known about what needs to be done to enable innovations to transform large systems of health care. This article describes the results of in-depth case studies aimed at assessing the role of key agents and agencies that facilitate the rapid adoption of innovations. The case studies—from Argentina, England, Nepal, Singapore, Sweden, the United States, and Zambia—represent widely varying health systems and economies. The implications of the findings for policy makers are discussed in terms of key factors within a phased approach for creating a climate for change, engaging and enabling the whole organization, and implementing and sustaining change. Purposeful and directed change management is needed to drive system transformation.

Soins de santé primaires / Primary Health Care

Alexander, J. A., et al. (2015). "Implementation of Patient-Centered Medical Homes in Adult Primary Care Practices." *Med Care Res Rev* 72(4): 438-467.

There has been relatively little empirical evidence about the effects of patient-centered medical home (PCMH) implementation on patient-related outcomes and costs. Using a longitudinal design and a large study group of 2,218 Michigan adult primary care practices, our study examined the following research questions: Is the level of, and change in, implementation of PCMH associated with medical surgical cost, preventive services utilization, and quality of care in the following year? Results indicated that both level and amount of change in practice implementation of PCMH are independently and positively associated with measures of quality of care and use of preventive services, after controlling for a variety of practice, patient cohort, and practice environmental characteristics. Results also indicate that lower overall medical and surgical costs are associated with higher levels of PCMH implementation, although change in PCMH implementation did not achieve statistical significance.

Bryant, J., et al. (2015). "Is identification of smoking, risky alcohol consumption and overweight and obesity by General Practitioners improving? A comparison over time." *Family Practice* 32(6): 664-671.

Background. Detection of lifestyle risk factors by GPs is the first step required for intervention. Despite significant investment in preventive health care in general practice, little is known about whether GP detection of lifestyle risk factors have improved over time. **Objectives.** To examine whether sensitivity and specificity of GP detection of smoking, risky alcohol consumption and overweight and obesity has increased in patients presenting to see their GP, by comparing results from four Australian studies conducted between 1982 and 2011. **Methods.** Demographic characteristics of patient and GP samples and the prevalence, sensitivity and specificity of detection of each risk factor were extracted from published studies. Differences between GP and patient sample characteristics were examined. To identify trends over time in prevalence of risk factors, sensitivity and specificity of detection across studies and the Cochran–Armitage test for trend were calculated for each risk factor for the overall sample and by male and female subgroups. **Results.** There were no statistically significant changes in the sensitivity of GP detection of smoking or overweight or obesity over time. Specificity of detection of smoking increased from 64.7% to 98% ($P < 0.0001$) and decreased for overweight or obesity from 92% to 89% ($P = 0.01$). There was a small decrease in the sensitivity of detection of alcohol consumption ($P = 0.02$) and an increase in specificity ($P = 0.01$). **Conclusions.** Despite significant investment to increase GP detection and intervention for lifestyle risk factors, accurate detection of smoking, risky alcohol

consumption and overweight and obesity occurs for less than two-thirds of all patients.

Casanova, L., et al. (2015). "Factors associated with GPs' knowledge of their patients' socio-economic circumstances: a multilevel analysis." *Family Practice* 32(6): 652-658.

Background. To determine appropriate management for individual patients, GPs are supposed to use their knowledge of the patient's socio-economic circumstances. **Objective.** To analyse factors associated with GPs' knowledge of these circumstances. **Methods.** Observational survey of GPs who were internship supervisors in the Paris metropolitan area. Each of 52 volunteer GPs completed a self-administered questionnaire about their own characteristics and randomly selected 70 patients from their patient list. Their knowledge was analysed as the agreement between the patients' and GPs' responses to questions about the patients' socio-economic characteristics in questionnaires completed by both groups. The association between agreement and the GPs' characteristics was analysed with a multilevel model adjusted for age, sex and the duration of the GP-patient relationship. **Results.** Agreement varied according to the socio-economic characteristics considered (from 51% to 90%) and between GPs. Globally, the GPs overestimated their patients' socio-economic level. GP characteristics associated with better agreement were sex (female), long consultations, the use of paper records or an automatic reminder system and participation in continuing medical education and in meetings to discuss difficult cases. **Conclusion.** Knowledge of some patient characteristics, such as their complementary health insurance coverage or perceived financial situation, should be improved because their overestimation may lead to care that is too expensive and thus result in the patients' abandonment of the treatment. Besides determining ways to help GPs to organize their work more effectively, it is important to study methods to help doctors identify their patients' social-economic circumstances more accurately in daily practice.

Grant, R. and J. Parle (2015). "How to assess quality in primary care." *BMJ* 351.

In trying to assess quality in primary care we firmly believe that a paradigm shift in our thinking is needed. One way to do this would be to include positive health indicators in any quality assessment tool.(1,2). Such indicators could be used to change our perspective away from one mainly focusing on sickness and towards one that has more of a focus on health. The ultimate goal of any quality assurance system should be to increase health gain for the population served by the practice. Health promoting general practice is the gold standard for health promotion, and in order to become a health promoting practice, staff must undertake a commitment to fulfil the following three conditions: create a healthy working environment; integrate health promotion into practice activities; and establish alliances with other relevant institutions and groups within the community.

Hibbard, J. H., et al. (2015). "Does Compensating Primary Care Providers to Produce Higher Quality Make Them More or Less Patient Centric?" *Med Care Res Rev* 72(4): 481-495.

Both payment reform and patient engagement are key elements of health care reform. Yet the question of how incentivizing primary care providers (PCPs) on quality outcomes affects the degree to which PCPs are supportive of patient activation and patient self-management has received little attention. In this mixed-methods study, we use in-depth interviews and survey data from PCPs working in a Pioneer Accountable Care Organization that implemented a compensation model in which a large percentage of PCP salary is based on quality performance. We assess how much PCPs report focusing their efforts on supporting patient activation and self-management, and whether or not they become frustrated with patients who do not change their behaviors. The findings suggest that most PCPs do not see

the value in investing their own efforts in supporting patient self-management and activation. Most PCPs saw patient behavior as a major obstacle to improving quality and many were frustrated that patient behaviors affected their compensation.

Joyce, C. M., et al. (2015). "Changes in Doctors' Working Hours: A Longitudinal Analysis." *Med Care Res Rev* 72(5): 605-621.

The study examined changes in doctors' working hours and satisfaction with working hours over five time points and explored the influence of personal characteristics on these outcomes. Latent growth curve modeling was applied to Medicine in Australia: Balancing Employment and Life data, collected from 2008 to 2012. Findings showed that working hours significantly declined over time, with a greater decrease among males, older doctors, and doctors with fewer children. Satisfaction increased faster over time among specialists, doctors with poorer health, those whose partners did not work full-time, and those with older children. The more hours the doctors worked initially, the lower satisfaction reported, and the greater the increase in satisfaction. Findings are consistent with a culture change in the medical profession, whereby long working hours are no longer seen as synonymous with professionalism. This is important to take into account in projecting future workforce supply.

Le, J.V., et al. (2015). "How GPs implement clinical guidelines in everyday clinical practice—a qualitative interview study." *Family Practice* 32(6): 681-685.

Background. Clinical guidelines are considered to be essential for improving quality and safety of health care. However, interventions to promote implementation of guidelines have demonstrated only partial effectiveness and the reasons for this apparent failure are not yet fully understood. **Objective.** To investigate how GPs implement clinical guidelines in everyday clinical practice and how implementation approaches differ between practices. **Methods.** Individual semi-structured open-ended interviews with seven GPs who were purposefully sampled with regard to gender, age and practice form. Interviews were recorded, transcribed verbatim and then analysed using systematic text condensation. **Results.** Analysis of the interviews revealed three different approaches to the implementation of guidelines in clinical practice. In some practices the GPs prioritized time and resources on collective implementation activities and organized their everyday practice to support these activities. In other practices GPs discussed guidelines collectively but left the application up to the individual GP whilst others again saw no need for discussion or collective activities depending entirely on the individual GP's decision on whether and how to manage implementation. **Conclusion.** Approaches to implementation of clinical guidelines vary substantially between practices. Supporting activities should take this into account.

Luft, H. S. (2015). "Policy-Oriented Research on Improved Physician Incentives for Higher Value Health Care." *Health Serv Res*.

Policy makers (both public and private) are seeking ways to improve the value delivered within our health care system, that is, using fewer resources to provide the same benefit to patients, or using equivalent resources to provide more benefit. One strategy is to alter the predominant fee-for-service (FFS) economic incentives in the current system. To inform such policy changes, this paper identifies areas in which little is known about the effects of specific incentives (FFS, salary, etc.) on the two components of value: resource use and quality. Specific suggestions are offered regarding research that would be informative for policy makers, focusing on fundamental "building block" studies rather than overall evaluations of complex interventions, such as accountable care organizations. This research would better identify critical aspects of the FFS model and salary-based payments that are particularly problematic, as well as situations in which FFS or salary may be less problematic. The research would also explore when alternatives, such as episode-based payment might be

feasible, or simply be hypothetical solutions. The availability of electronic health record-based data in various delivery systems would allow many of these studies to be accomplished in 3-5 years with budgets manageable by public and private funding sources.

Macinko, J. and F. C. Guanais (2015). "Population experiences of primary care in 11 Organization for Economic Cooperation and Development countries." Int J Qual Health Care 27(6): 442-449.

OBJECTIVE: To develop a measure of individual user assessments of primary care and test its association with health system performance and quality indicators. DESIGN: Cross-sectional analysis of secondary survey data collected in 2013. SETTING: Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, the UK and the USA. STUDY PARTICIPANTS: 20 045 respondents. MAIN OUTCOME MEASURES: Individual report of financial protection (out of pocket expenses over USD 1000), lack of receipt of appropriate/timely care (use of the emergency room in the past 2 years, having consulted three or more doctors in the past year) and clinical prevention (blood pressure check in past year, cholesterol checked in the past 5 years, receipt of influenza vaccination in past year and report of any medical error). METHODS: A score of users' primary care experiences was constructed from 14 individual survey questions. Multivariable Poisson and augmented inverse-probability weighted regression assess the relationship between the primary care experience score and outcomes. RESULTS: Countries differed regarding the proportion of the population experiencing problems with primary care. In analyses controlling for age, sex, health status, chronic disease, income level and health insurance, users experiencing poorer primary care were significantly more likely to report significant out of pocket expenses, emergency room use in the past 2 years, having consulted more than three doctors in the past year, lower likelihood of blood pressure or cholesterol screening, an annual flu shot and higher reports of medical error. CONCLUSIONS: The measure of individual primary care experience can be used to differentiate among different country's primary care approaches and is strongly associated with overall health system performance and quality indicators.

Marchand O, et al. (2015). "Développement et fonctionnement des maisons de santé pluriprofessionnelles dans la région Rhône-Alpes." Santé Publique 27(4): 539-546.

Martinez-Gonzalez, N. A., et al. (2015). "Task-Shifting From Physicians to Nurses in Primary Care and its Impact on Resource Utilization: A Systematic Review and Meta-Analysis of Randomized Controlled Trials." Med Care Res Rev 72(4): 395-418.

Task-shifting from physicians to nurses has gained increasing interest in health policy but little is known about its efficiency. This systematic review was conducted to compare resource utilization with task-shifting from physicians to nurses in primary care. Literature searches yielded 4,589 citations. Twenty studies comprising 13,171 participants met the inclusion criteria. Meta-analyses showed nurses had more return consultations and longer consultations than physicians but were similar in their use of referrals, prescriptions, or investigations. The evidence has limitations, but suggests that the effects may be influenced by the utilization of resources, context of care, available guidance, and supervision. Cost data suggest physician-nurse salary and physician's time spent on supervision and delegation are important components of nurse-led care costs. More rigorous research involving a wider range of nurses from many countries is needed reporting detailed accounts of nurses' roles and competencies, qualifications, training, resources, time available for consultations, and all-cause costs.

Osborn, R., et al. (2015). "Primary Care Physicians In Ten Countries Report Challenges Caring For Patients With Complex Health Needs." Health Affairs 34(12): 2104-2112.

Industrialized countries face a daunting challenge in providing high-quality care for aging patients with increasingly complex health care needs who will need ongoing chronic care management, community, and social services in addition to episodic acute care. Our international survey of primary care doctors in the United States and nine other countries reveals their concern about how well prepared their practices are to manage the care of patients with complex needs and about their variable experiences in coordinating care and communicating with specialists, hospitals, home care, and social service providers. While electronic information exchange remains a challenge in most countries, a positive finding was the significant increase in the adoption of electronic health records by primary care doctors in the United States and Canada since 2012. Finally, feedback on job-related stress, perceptions of declining quality of care, and administrative burden signal the need to monitor front-line perspectives as health reforms are conceived and implemented.

Shaw, D. and P. Melton (2015). "Should GPs be paid to reduce unnecessary referrals?" *BMJ* 351.

Financial incentives work, but not usually as well as those introducing them hope for. Financial incentives can also have perverse or unintended consequences. Both of these are clear from extensive published research. So when 'pay for performance' is contemplated, the aim should be to design the scheme to maximise the benefits and minimise the risks. One fundamental principle in doing this is to ensure that professional and financial incentives are aligned as closely as possible. If doctors are incentivised to do things that they believe conflict with their professional duties, then the risk of perverse outcomes is inevitably increased. These well tested observations mean that the last thing the NHS should be doing is to pay doctors not to refer patients to hospital. If you were a patient, would you really want to visit a GP, thinking that his next skiing holiday might depend on him not referring you to a specialist? If variation in GPs' rates of referral is a problem, then there are better ways of addressing the issue.

Systèmes de santé / Health Systems

Agartan, T. I. (2015). "Explaining Large-Scale Policy Change in the Turkish Health Care System: Ideas, Institutions, and Political Actors." *J Health Polit Policy Law* 40(5): 971-999.

Explaining policy change has been one of the major concerns of the health care politics and policy development literature. This article aims to explain the specific dynamics of large-scale reforms introduced within the framework of the Health Transformation Program in Turkey. It argues that confluence of the three streams - problem, policy, and politics - with the exceptional political will of the Justice and Development Party's (JDP) leaders opened up a window of opportunity for a large-scale policy change. The article also underscores the contribution of recent ideational perspectives that help explain "why" political actors in Turkey would focus on health care reform, given that there are a number of issues waiting to be addressed in the policy agenda. Examining how political actors framed problems and policies deepens our understanding of the content of the reform initiatives as well as the construction of the need to reform. The article builds on the insights of both the ideational and institutionalist perspectives when it argues that the interests, aspirations, and fears of the JDP, alongside the peculiar characteristics of the institutional context, have shaped its priorities and determination to carry out this reform initiative.

Allin, S., et al. (2016). "The determinants of efficiency in the Canadian health care system." *Health Econ Policy Law* 11(1): 39-65.

In spite of the vast number of studies measuring economic efficiency in health care, there has been little take-up of this evidence by policy-makers to date. This study provides an illustration of how a system-level study drawing on best practice in empirical measurement of efficiency may be of practical use to health system decision makers and managers. We make use of the rich data available in Canada to undertake a robust two-stage data envelopment analysis to calculate efficiency at the regional (sub-provincial) level. Decisions about what the health system produces (the outcome to measure efficiency against) and what are the resources it has to produce that outcome were based on interviews and consultation with health system decision makers. Overall, we find large inefficiencies in the Canadian health care system, which could improve outcomes (here, measured as a reduction in treatable causes of death) by between 18 and 35% across our analyses. Also, we find that inefficiencies are the result of three main sets of factors that policy makers could pay attention to: management factors, such as hospital re-admissions; public health factors, such as obesity and smoking rates; and environmental factors such as the population's average income.

Belche, J. L., et al. (2015). "[From chronic disease to multimorbidity: Which impact on organization of health care]." *Presse Med* 44(11): 1146-1154.

Healthcare systems are concerned with the growing prevalence of chronic diseases. Single disease approach, based on the Chronic Care Model, is known to improve specific indicators for the targeted disease. However, the co-existence of several chronic disease, or multimorbidity, within a same patient is the most frequent situation. The fragmentation of care, as consequence of the single disease approach, has negative impact on the patient and healthcare professionals. A person centred approach is a method addressing the combination of health issues of each patient. The coordination and synthesis role is key to ensure continuity of care for the patient within a network of healthcare professionals from several settings of care. This function is the main characteristic of an organized first level of care.

Biller-Andorno, N. and T. Zeltner (2015). "Individual Responsibility and Community Solidarity — The Swiss Health Care System." *New England Journal of Medicine* 373(23): 2193-2197.

Feldman, R. (2015). "The Economics of Provider Payment Reform: Are Accountable Care Organizations the Answer?" *J Health Polit Policy Law* 40(4): 745-760.

A remarkable consensus has developed that the fee-for-service (FFS) approach for paying medical providers must be replaced. This payment approach is said to increase the volume of services without improving care coordination. In response to these calls, Medicare and private payers are experimenting with payment systems that combine the basic element of FFS - a fee for each service - with arrangements that allow providers to share the savings if they hold total spending per patient below a targeted amount. Medicare's accountable care organizations (ACOs) embody the shared savings approach to payment reform. Private payers have introduced total cost of care contracting (TCOC) in several locations. This article questions the consensus that FFS must go. If the fees are too high, then someone needs to "bite the bullet" and reduce fees in key areas. Hoping to control overspending by investment in ACOs is wishful thinking. I describe the theory and practice of shared savings payment systems and summarize recent TCOC contracting initiatives in the private sector. Medicare's shared savings approach is likely to be less effective than private contracts. Cutting providers'

fees would be more efficient. Finally, the new payment models in the Affordable Care Act will not ease the problem of high prices for private payers.

Gonçalves-Bradley, D. C., et al. (2015). "GPs' adherence to guidelines for structured assessments of stroke survivors in the community and care homes." *Family Practice* 32(6): 659-663.

Background. Clinical practice guidelines recommend that stroke survivors' needs be assessed at regular intervals after stroke. The extent to which GPs comply with national guidance particularly for patients in care homes who have greatest clinical complexity is unknown. Objectives. This study aimed to establish the current clinical practice in the UK of needs assessment by GPs for stroke survivors after hospital discharge for acute stroke. Methods. Cross-sectional online survey of current practice of GPs, using the national doctors.net network. Results. The survey was completed by 300 GPs who had on average been working for 14 years. The structured assessment of stroke survivors' needs was not offered by 31% of GPs, with no significant difference for level of provision in community or care home settings. The outputs of reviews were added to patients' notes by 89% of GPs and used to change management by 57%. Only half the GPs reported integrating the information obtained into care plans and only a quarter of GPs had a protocol for follow-up of identified needs. Analysis of free-text comments indicated that patients in some care homes may receive more regular and structured reviews. Conclusions. This survey suggests that at least one-third of GPs provide no formal review of the needs of stroke patients and that in only a minority are identified needs addressed in a structured way. Standardization is required for what is included in reviews and how needs are being identified and met.

Hellander, I. (2015). "The U.S. Health Care Crisis Five Years After Passage of the Affordable Care Act: A Data Snapshot." *Int J Health Serv* 45(4): 706-728.

Despite passage of the Affordable Care Act in 2010, the U.S. health care crisis continues. While coverage has been expanded, the reform will leave 27 million people uninsured in 2024, according to the Congressional Budget Office. Much of the new coverage is of low actuarial value with high cost-sharing requirements, creating barriers to access. Choice of physician is restricted to narrow networks of providers. Recent measures of uninsurance, underinsurance, access to care, and health care costs are given. Changes in Medicare, particularly privatization and the rise of specialty drug tiers that limit access to medically necessary medications, are reviewed. Data on a new wave of consolidation among hospitals, medical groups, insurers, and drug companies are presented. The rise of ultra-high-price drugs, such as Solvadi, is raising pharmaceutical costs, particularly in Medicaid, the program for low-income Americans. International health comparisons continue to show the United States performing poorly in relation to other countries. Recent polling data are presented, showing support for more fundamental reform.

Larsen, L. T. and D. Stone (2015). "Governing Health Care through Free Choice: Neoliberal Reforms in Denmark and the United States." *J Health Polit Policy Law* 40(5): 941-970.

We compare free choice reforms in Denmark and the United States to understand what ideas and political forces could generate such similar policy reforms in radically different political contexts. We analyze the two cases using our own interpretation of neoliberalism as having "two faces." The first face seeks to expand private markets and shrink the public sector; the second face seeks to strengthen the public sector's capacity to govern through incentives and competition. First, we show why these two most-different cases offer a useful comparison to understand similar policy tools. Second, we develop our theoretical framework of the two faces of neoliberalism. Third, we examine Denmark's introduction of a

free choice of hospitals in 2002, a policy that for the first time allowed some patients to receive care either in a public hospital outside their local area or in a private hospital. Fourth, we examine the introduction of free choice among private managed care plans into the US Medicare program in 1997. We show how policy makers in both countries used neoliberal reform as a mechanism to make their public health care sectors governable. Fifth, on the basis of our analysis, we draw five lessons about neoliberal policy reforms.

Scheffler, R. M. (2015). "Accountable Care Organizations: Integrated Care Meets Market Power." *J Health Polit Policy Law* 40(4): 639-645.

Will accountable care organizations (ACOs) deliver high-quality care at lower costs? Or will their potential market power lead to higher prices and lower quality? ACOs appear in various forms and structures with financial and clinical integration at their core; however, the tools to assess their quality and the incentive structures that will determine their success are still evolving. Both market forces and regulatory structures will determine how these outcomes emerge. This introduction reviews the evidence presented in this special issue to tackle this thorny trade-off. In general the evidence is promising, but the full potential of ACOs to improve the health care delivery system is still uncertain. This introductory review concludes that the current consensus is to let ACOs grow, anticipating that they will make a contribution to improve our poor-quality and high-cost delivery system.

Shortell, S. M., et al. (2015). "Accountable Care Organizations: The National Landscape." *J Health Polit Policy Law* 40(4): 647-668.

There are now more than seven hundred accountable care organizations (ACOs) in the United States. This article describes some of their most salient characteristics including the number and types of contracts involved, organizational structures, the scope of services offered, care management capabilities, and the development of a three-category taxonomy that can be used to target technical assistance efforts and to examine performance. The current evidence on the performance of ACOs is reviewed. Since California has the largest number of ACOs (N=67) and a history of providing care under risk-bearing contracts, some additional assessments of quality and patient experience are made between California ACOs and non-ACO provider organizations. Six key issues likely to affect future ACO growth and development are discussed, and some potential "diagnostic" indicators for assessing the likelihood of potential antitrust violations are presented.

Yeager, V. A., et al. (2015). "Analyzing Determinants of Hospitals' Accountable Care Organizations Participation: A Resource Dependency Theory Perspective." *Med Care Res Rev* 72(6): 687-706.

Accountable care organizations (ACOs) are rapidly being implemented across the United States, but little is known about what environmental and organizational factors are associated with hospital participation in ACOs. Using resource dependency theory, this study examines external environmental characteristics and organizational characteristics that relate to hospital participation in Medicare ACOs. Results indicate hospitals operating in more munificent environments (as measured by income per capita: $\beta = 0.00002$, $p < .05$) and more competitive environments (as measured by Health Maintenance Organization penetration: $\beta = 1.86$, $p < .01$) are more likely to participate in ACOs. Organizational characteristics including hospital ownership, health care system membership, electronic health records implementation, hospital type, percentage of Medicaid inpatient discharge, and number of nursing home beds per 1,000 population over 65 are also related to ACO participation. Should the anticipated benefits of ACOs be realized, findings from this study can guide strategies to encourage hospitals that have not gotten involved in ACOs.

Travail et santé / Occupational Health

Banerjee, S., et al. (2015). "Effects of Psychiatric Disorders on Labor Market Outcomes: A Latent Variable Approach Using Multiple Clinical Indicators." Health Econ.

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.

Vieillessement / Ageing

Arnold, C. and M. Lelièvre (2015). "Niveau de vie et pauvreté des personnes âgées de 1996 à 2012." Retraite et société 70(1): 17-40.

Cette étude procède à un état des lieux de la situation économique et sociale des personnes âgées, à travers notamment leurs conditions de vie et leur niveau de vie. Elle livre de nombreux enseignements, avec comme fait majeur que cette population devient plus hétérogène au fur et à mesure qu'elle s'étend. Ce résultat est tiré de l'analyse des éléments constitutifs et des mécanismes à l'œuvre dans la détermination du niveau de vie de ces populations dont les cohortes sont atteintes différemment par les réformes du système de retraite. En ce sens, ce travail apporte des matériaux empiriques de nature à éclairer la réflexion sur un des enjeux du système de retraite : l'équité entre les assurés, qu'ils relèvent de générations différentes ou qu'ils appartiennent à la même génération. À cet égard, il entend nourrir les débats dans un domaine moins exploré à ce jour, celui des inégalités pouvant exister au sein même de la population âgée. En contrepoint, la question de la pauvreté est interrogée à l'aune d'un système de retraite déjà très mature et qui a fait l'objet de nombreuses adaptations dans un contexte démographique et économique en évolution.

Bremer, P., et al. "Informal dementia care: Consequences for caregivers' health and health care use in 8 European countries." Health Policy 119(11): 1459-1471.

Bultez, J.-P., et al. (2015). "Précarité des retraités en France et en Europe." Retraite et société 70(1): 129-134.

Ranci, R. and Pavolin. E. (2015). "Not all that glitters is gold: Long-term care reforms in the last two decades in Europe." Journal of European Social Policy 25(3): 270-285.

This article explores changes that took place in long-term care (LTC) policies during the last two decades in six European welfare states. In this regard, it addresses three issues: (1) why reforms took place, (2) the main actors and coalitions driving this process and the institutional mechanisms at work and (3) the main outcomes of reform processes. In order to analyse the development of LTC policies, the article applies theoretical concepts of historical institutionalism. Our interpretation is that institutional change in LTC policy has taken place through a protracted institutional dynamic in which continuity and discontinuity are inextricably linked and where tensions and contradictions have played a crucial role. With regard to outcomes, the article analyses coverage and citizens' social rights, working conditions in the care sector and trajectories of de-/re-familization of care. The final impact is that the level of universalism has generally increased in Europe, but that in part it has adopted a new form of 'restricted universalism', characterized by universal entitlements to LTC benefits constrained by limitations in provision due to financial constraints and budget ceilings.

Campéon, A. (2015). "Les mondes ordinaires de la précarité et de la solitude au grand âge." *Retraite et société* 70(1): 83-104.

Le vieillissement de la population confronte nos sociétés à une situation jusque-là inédite, source d'importants enjeux politiques, économiques et sociaux. La mise en forme de ces enjeux a été consacrée par le rapport Laroque en 1962 qui fait office de point de départ à la définition d'une politique vieillesse en France. À l'époque, l'objectif était d'améliorer les conditions de vie, marquées pour beaucoup par la pauvreté, l'isolement social ou encore une santé « déficiente ». Cinquante ans plus tard, force est de constater que la situation socio-économique des personnes âgées s'est nettement améliorée. Cette évolution, qui a permis de sortir la vieillesse de son ancienne condition « misérable » dénoncée par Simone de Beauvoir (1970), ne doit cependant pas faire oublier qu'il subsiste des inégalités importantes. Celles-ci ont bien sûr des conséquences sur le processus de vieillissement et induisent des comportements et, plus globalement encore, des modes de vie différenciés. Dans cet article, nous nous proposons de revenir plus précisément sur ces conditions d'existence en situation de précarité, en nous intéressant particulièrement aux trajectoires sociales et aux expériences des femmes âgées.

Denayrolles, É. and M. Guilain (2015). "Retraite anticipée pour carrière longue : 10 années d'évolutions réglementaires." *Retraite et société* 70(1): 151-166.

George Grech, A. (2015). "Appréhender les effets des réformes en Europe sur l'adéquation des retraites." *Retraite et société* 70(1): 41-60.

De nombreuses évaluations des réformes des retraites ont été réalisées en prenant d'abord en considération la baisse attendue des dépenses. Cependant, leurs effets en termes d'adéquation, qui se mesurent habituellement par les taux de remplacement théoriques, suscitent un intérêt croissant, particulièrement dans les institutions internationales. Dans cet article, nous montrons que si les taux de remplacement théoriques sont très utiles pour l'analyse transnationale, ils présentent néanmoins des défauts majeurs. En tant qu'indicateurs à un instant T , ils ne permettent pas d'expliquer les conséquences de l'indexation sur la valeur relative des prestations tout au long de la retraite. De plus, ils sont généralement fondés sur des hypothèses non représentatives, notamment celle d'une carrière complète avec un salaire moyen. Ces défauts sont par ailleurs amplifiés par le type des réformes récemment mises en place en Europe et par l'allongement de l'espérance de vie. Nous pensons que l'utilisation d'indicateurs fondés sur des estimations du patrimoine retraite, appelé aussi « équivalent patrimonial des droits à la retraite » à partir d'hypothèses plus réalistes, permettrait de mieux appréhender les effets des réformes sur l'adéquation des

retraites. En observant dix pays européens qui ont mis en œuvre d'importantes réformes dans les années 1990 et au début des années 2000, on constate que les régimes sont devenus beaucoup moins généreux, ce qui les rend moins efficaces dans la lutte contre la pauvreté. En outre, les mesures visant à renforcer le lien entre les prestations et les cotisations soulèvent des préoccupations quant à la situation des femmes et des personnes à faible revenu.

Hourriez, J.-M. (2015). "Les revenus des retraités." *Retraite et société* 70(1): 139-150.

MacLeod, K. E., et al. (2015). "Missed or Delayed Medical Care Appointments by Older Users of Nonemergency Medical Transportation." *The Gerontologist* 55(6): 1026-1037.

Purpose of the Study: This study identified factors associated with canceling nonemergency medical transportation appointments among older adult Medicaid patients. Design and Methods: Data from 125,913 trips for 2,913 Delaware clients were examined. Mediation analyses, as well as, multivariate logistic regressions were conducted. Results: Over half of canceled trips were attributed to client reasons (e.g., no show, refusal). Client characteristics (e.g., race, sex, functional status) were associated with cancelations; however, these differed based on the cancellation reason. Regularly scheduled trips were less likely to be canceled. Implications: The evolving American health care system may increase service availability. Additional policies can improve service accessibility and overcome utilization barriers.

Ruggiano, N., et al. (2015). "Engaging in Coordination of Health and Disability Services as Described by Older Adults: Processes and Influential Factors." *The Gerontologist* 55(6): 1015-1025.

Purpose of the Study: There is little consensus on the definition and design of effective care coordination for older adults with chronic conditions, and the majority of care coordination models minimize the role and voice of older patients. Our objectives are to examine how older adults perceive and engage in the process of care coordination of health and disability support services and the factors that influence their engagement. Design and Methods: Thirty-seven older adults with chronic conditions and 9 geriatric case managers participated in semi structured interviews that focused on older adults' experiences with self-managing and coordinating their health and support services. Interview data were systematically analyzed for themes. Results: The interview data revealed that involving older adults in care coordination is a complex, multistage process, conceptualized as making self-health assessments, making informed decisions about care, and executing and coordinating care. The findings indicate that a number of factors facilitate older adults' decision and capacity to become involved in the coordination of their care, including their perceptions about how their condition impacted their everyday lives, and availability of intrinsic resources, tangible resources, and social network. Low perceptions of control over health and lack of such resources constrain their involvement. Implications: Practitioners may facilitate older adults' involvement in care coordination by using language with older patients that emphasizes psychosocial experiences in addition to medical symptomatology. They may also provide targeted support for patients with limited facilitating factors to promote involvement at multiple stages of the care coordination process.