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Assurance maladie / Health Insurance

Jones D.K., Bradley K.W., Oberlander J. (2014). Pascal's Wager: health insurance exchanges, Obamacare, and the Republican dilemma. *J Health Polit.Policy Law*, 39 (1) : 97-137.

Abstract: Enactment of the Patient Protection and Affordable Care Act (ACA) created a dilemma for Republican policy makers at the state level. States could maximize control over decision making and avoid federal intervention by establishing their own health insurance exchanges. Yet GOP leaders feared that creating exchanges would entrench a law they intensely opposed and undermine legal challenges to the ACA. Republicans' calculations were further complicated by uncertainty over the Supreme Court's ruling on the ACA's constitutionality and the outcome of the November 2012 elections. In the first year of operation, only seventeen states and the District of Columbia chose to design and implement their own exchanges; another six partnered with the federal government, and twenty-seven states ceded control to Washington. Out of thirty states with Republican governors in 2013, only four launched their own exchange. Why did many Republican-led states that initially appeared open to establishing exchanges ultimately reverse course? Drawing on interviews with state policy makers and secondary data, we trace the evolution of Republican responses to the exchange dilemma during 2010-13. We explore how exchanges became controversial and explain why so few Republican-led states opted for their own exchange, focusing on the intensifying resistance to Obamacare amid a rightward shift in state politics, partisan polarization, and uncertainty over the ACA's fate.

Economie de la santé / Health Economics

Simou E., Koutsogeorgou E. (2014). Effects of the economic crisis on health and healthcare in Greece in the literature from 2009 to 2013: A systematic review. *Health Policy*, 115 (2-3) : 111-119.

Abstract: BACKGROUND: Due to the current economic crisis in Greece, effects on health and healthcare have been reported. The aim of this study was to present a systematic overview of the consequences that the financial crisis has had for health and healthcare in Greece. METHODS: Systematic literature review was conducted in order to identify articles that were published from January 2009 to March 2013 and explicitly referred to the effects of economic crisis on health or healthcare, in Greece. Data extraction and synthesis was performed with the use of thematic analysis. FINDINGS: Thirty-nine studies were considered for further analyses. Various existing and potential relevant effects were identified, including reductions in public health expenditure and changes in healthcare services and the pharmaceutical market, with an increasing number of admissions in public healthcare sector, and efficiency and organizational-related issues being evident, overall. Indications were found for post-crisis deterioration of public health with increasing rates of mental health, suicides, and epidemics, and deterioration of self-rated health. CONCLUSION: The recent efforts to reform the Greek National Health System have been focusing mainly on short-term effects by reducing expenditure, while the measures imposed seem to have dubious long-term consequences for Greek public health and healthcare.

Kalseth J., Halvorsen T., Kalseth B., Sarheim A.K., Peltola M., Kautiainen K., Hakkinen U., Medin E., Lundgren J., Rehnberg C., Masdottir B.B., Heimisdottir M., Bjarnadottir H.H., Kotlum J.E., Kilsmark J., Halsteinli V. (2014). Cross-country comparisons of health-care costs: The case of cancer treatment in the Nordic countries. *Health Policy*, 115 (2-3) : 172-179.

Abstract: The objective of this study is to perform a cross-country comparison of cancer treatment costs in the Nordic countries, and to demonstrate the added value of decomposing documented costs in interpreting national differences. The study is based on individual-level data from national patient and prescription drug registers, and data on cancer prevalence from the NORDCAN database. Hospital costs were estimated on the basis of information on diagnosis-related groups (DRG) cost weights and national unit costs. Differences in per capita costs were decomposed into two stages: stage one separated the price and volume components, and stage two decomposed the volume component, relating the level of activity to service needs and availability. Differences in the per capita costs of cancer treatment between the Nordic countries may be as much as 30 per cent. National differences in the costs of treatment mirror observed differences in total health care costs. Differences in health care costs between countries may relate to different sources of variation with different policy implications. Comparisons of per capita spending alone can be misleading if the purpose is to evaluate, for example, differences in service provision and utilisation. The decomposition analysis helps to identify the relative influence of differences in the prevalence of cancer, service utilisation and productivity.

Mitton C., Dionne F., Donaldson C. (2014). Managing healthcare budgets in times of austerity: the role of program budgeting and marginal analysis. *Appl. Health Econ Health Policy*, 12 (2) : 95-102.

Abstract: Given limited resources, priority setting or choice making will remain a reality at all levels of publicly funded healthcare across countries for many years to come. The pressures may well be even more acute as the impact of the economic crisis of 2008 continues to play out but, even as economies begin to turn around, resources within healthcare will be limited, thus some form of rationing will be required. Over the last few decades, research on healthcare priority setting has focused on methods of implementation as well as on the development of approaches related to fairness and legitimacy and on more technical aspects of decision making including the use of multi-criteria decision analysis. Recently, research has led to better understanding of evaluating priority setting activity including defining 'success' and articulating key elements for high performance. This body of research, however, often goes untapped by those charged with making challenging decisions and as such, in line with prevailing public sector incentives, decisions are often reliant on historical allocation patterns and/or political negotiation. These archaic and ineffective approaches not only lead to poor decisions in terms of value for money but further do not reflect basic ethical conditions that can lead to fairness in the decision-making process. The purpose of this paper is to outline a comprehensive approach to priority setting and resource allocation that has been used in different contexts across countries. This will provide decision makers with a single point of access for a basic understanding of relevant tools when faced with having to make difficult decisions about what healthcare services to fund and what not to fund. The paper also addresses several key issues related to priority setting including how health technology assessments can be used, how performance can be improved at a practical level, and what ongoing resource management practice should look like. In terms of future research, one of the most important areas of priority setting that needs further attention is how best to engage public members.

Andersen L.B. (2014). Health care cost containment in Denmark and Norway: a question of relative professional status? *Health Econ Policy Law*, 9 (2) : 169-191.

Abstract: The demand for publicly subsidized health care services is insatiable, but the costs can be contained in different ways: formal rules can limit access to and the number of subsidized services, demand and supply can be regulated through the price mechanism, the relevant profession can contain the costs through state-sanctioned self-regulation, and other professions can contain the costs (e.g. through referrals). The use of these cost containment measures varies between countries, depending on demand and supply factors, but the relative professional status of the health professions may help explain why different countries use cost containment measures differently for different services. This article compares cost containment measures in Denmark and Norway because these countries vary with regard to the professional status of the medical profession relative to other health care providers, while other relevant variables are approximately similar. The investigation is based on formal agreements and rules, historical documents, existing analyses and an analysis of 360 newspaper articles. It shows that high relative professional status seems to help professions to avoid user fees, steer clear of regulation from other professions and regulate the services produced by

others. This implies that relative professional status should be taken into consideration in analyses of health care cost containment.

Hatz M.H., Leidl R., Yates N.A., Stollenwerk B. (2014). A systematic review of the quality of economic models comparing thrombosis inhibitors in patients with acute coronary syndrome undergoing percutaneous coronary intervention. *Pharmacoeconomics*, 32 (4) : 377-393.

Abstract: BACKGROUND: Thrombosis inhibitors can be used to treat acute coronary syndromes (ACS). However, there are various alternative treatment strategies, of which some have been compared using health economic decision models. OBJECTIVE: To assess the quality of health economic decision models comparing thrombosis inhibitors in patients with ACS undergoing percutaneous coronary intervention, and to identify areas for quality improvement. DATA SOURCES: The literature databases MEDLINE, EMBASE, EconLit, National Health Service Economic Evaluation Database (NHS EED), Database of Abstracts of Reviews of Effects (DARE) and Health Technology Assessment (HTA). STUDY APPRAISAL AND SYNTHESIS METHODS: A review of the quality of health economic decision models was conducted by two independent reviewers, using the Philips checklist. RESULTS: Twenty-one relevant studies were identified. Differences were apparent regarding the model type (six decision trees, four Markov models, eight combinations, three undefined models), the model structure (types of events, Markov states) and the incorporation of data (efficacy, cost and utility data). Critical issues were the absence of particular events (e.g. thrombocytopenia, stroke) and questionable usage of utility values within some studies. LIMITATIONS: As we restricted our search to health economic decision models comparing thrombosis inhibitors, interesting aspects related to the quality of studies of adjacent medical areas that compared stents or procedures could have been missed. CONCLUSIONS: This review identified areas where recommendations are indicated regarding the quality of future ACS decision models. For example, all critical events and relevant treatment options should be included. Models also need to allow for changing event probabilities to correctly reflect ACS and to incorporate appropriate, age-specific utility values and decrements when conducting cost-utility analyses.

Gyrd-Hansen D., Jensen M.L., Kjaer T. (2014). Framing the willingness-to-pay question: impact on response patterns and mean willingness to pay. *Health Econ*, 23 (5) : 550-563.

Abstract: In this study, respondents were randomly allocated to three variants of the payment card format and an open-ended format in order to test for convergent validity. The aim was to test whether preferences (as measured by willingness to pay additional tax) would be affected by framing the willingness-to-pay question differently. Results demonstrated that valuations were highly sensitive to whether respondents were asked to express their maximum willingness to pay per month or per year. Another important finding is that the introduction of a binary response filter prior to the payment card follow-up tends to eliminate the positive aspects of introducing a payment card and produces response patterns that are much in line with those of the open-ended contingent valuation format. However, although a filter will impact on the distribution of willingness-to-pay bids and on the rate of zero and protest bids, the overall impact on the welfare estimate is minor. The outcomes of this study indicate that valuations in the stated preference literature may be, at least in part, a function of the instrument designed to obtain the valuations.

Etat de santé / Health Status

Asztalos M., Huybrechts I., Temme E., Van Oyen H., Vandevijvere S. (2014). Association of physical activity, waist circumference and body mass index with subjective health among Belgian adults. *Eur J Public Health*, 24 (2) : 205-209.

Abstract: Background: The present study aimed to explore associations of physical activity (PA), waist circumference (WC) and body mass index (BMI) with subjective health in a nationally representative sample of Belgian adults. Methods: Data from the 2004 Belgian Food Consumption Survey were used. A face-to-face questionnaire about sociodemographic and socioeconomic characteristics, general health, subjective health, lifestyle and PA was completed. Weight and height were self-reported, and WC was measured in orthostatic position. PA was assessed by the short International PA Questionnaire. Results: In total, 3208 individuals (49.9% women) were included in the study. About 41.3% of the Belgian population did not meet the minimum recommendations for PA, whereas 24.8% of the population engaged in health-enhancing PA. In total, 29.5% of the population was overweight, 10.1% was obese and 33.2% of the population had an excessive WC. About 23.6% of the population rated their health as poor. Obese individuals were significantly less likely to report good subjective health than those with normal BMI [odds ratio (OR) = 0.538; 95% confidence interval (CI): 0.390-0.742]. This association was also identified for men and women separately. Further, both individuals who participated in health-enhancing PA and those who participated in recommended PA reported significantly better subjective health than insufficiently active individuals (OR = 2.533; 95% CI: 1.952-3.287 and OR = 1.543; 95% CI: 1.256-1.894, respectively). Conclusions: A strong association was found between PA and subjective health, and in addition, a significant negative association was found between BMI and subjective health. There was no relationship between WC and subjective health among Belgian adolescents and adults.

Witvliet M.I., Arah O.A., Stronks K., Kunst A.E. (2014). Examining self-rated health of young Central and Eastern Europeans in the context of other world regions. *Eur J Public Health*, 24 (2) : 314-321.

Abstract: BACKGROUND: Poor health is more prevalent in the East of Europe as compared with the West. This variation is often attributed to Soviet communism. Few studies investigate this health discrepancy within young adults who were children during this period. We studied the health of young adults by examining variations between world regions in general health between generations (18-65+). The individual and contextual mechanisms that might influence their health were also investigated. METHODS: World Health Survey data were analysed on young adults aged 18-34 (n = 91 823) and their elders aged 35+ (n = 132 362) from 59 countries. Main outcome was self-reported general health. Multi-level logistic regression was used to assess associations between general health and regions, while accounting for individual- and country-level socio-economic factors across age ranges. RESULTS: The prevalence of poor health was much higher for young adults in the Former Soviet Union region than in Western Europe, with the Central European region being in-between. This pattern remained even after full adjustments, for the Former Soviet Union citizens [odds ratio 4.26 (95% confidence interval 1.77-10.24)] and for Central Europeans [odds ratio 1.73 (95% confidence interval 0.90-3.32)] as compared with Western Europe. Age-specific analyses showed East-West health differences usually being larger as age increases (up to 65+). This age pattern seemed reversed for the South-West divide. CONCLUSIONS: The East-West health gap seems more pronounced for the Former Soviet Union young adults, rather than Central Europeans. It appears as though young adults from Central Europe might have been somewhat insulated from the ill-health effects of communism. PM:23531521

Hoffmann R., Borsboom G., Saez M., Dell'olmo M.M., Burstrom B., Corman D., Costa C., Deboosere P., Dominguez-Berjon M.F., Dzurova D., Gandarillas A., Gotsens M., Kovacs K., Mackenbach J., Martikainen P., Maynou L., Morrison J., Palencia L., Perez G., Pikhart H., Rodriguez-Sanz M., Santana P., Saurina C., Tarkiainen L., Borrell C. (2014). Social differences in avoidable mortality between small areas of 15 European cities: an ecological study. *Int J Health Geogr.*, 13 (1) : 8.

Abstract: BACKGROUND: Health and inequalities in health among inhabitants of European cities are of major importance for European public health and there is great interest in how different health care systems in Europe perform in the reduction of health inequalities. However, evidence on the spatial distribution of cause-specific mortality across neighbourhoods of European cities is scarce. This study presents maps of avoidable mortality in European cities and analyses differences in avoidable mortality between neighbourhoods with different levels of deprivation. METHODS: We determined the level of mortality from 14 avoidable causes of death for each neighbourhood of 15 large cities in different European regions. To address the problems associated with Standardised Mortality Ratios for

small areas we smooth them using the Bayesian model proposed by Besag, York and Mollie. Ecological regression analysis was used to assess the association between social deprivation and mortality. RESULTS: Mortality from avoidable causes of death is higher in deprived neighbourhoods and mortality rate ratios between areas with different levels of deprivation differ between gender and cities. In most cases rate ratios are lower among women. While Eastern and Southern European cities show higher levels of avoidable mortality, the association of mortality with social deprivation tends to be higher in Northern and lower in Southern Europe. CONCLUSIONS: There are marked differences in the level of avoidable mortality between neighbourhoods of European cities and the level of avoidable mortality is associated with social deprivation. There is no systematic difference in the magnitude of this association between European cities or regions. Spatial patterns of avoidable mortality across small city areas can point to possible local problems and specific strategies to reduce health inequality which is important for the development of urban areas and the well-being of their inhabitants.

PM:24618273

Géographie de la santé / Geography of Health

Brondeel R. (2014). Utilisation des services de santé publique autour de la résidence et autour du lieu de travail: l'influence de l'accessibilité spatiale. *Revue d'Epidémiologie et de Santé Publique*, 62 (2) : 167.

Dewulf B., Neutens T., De Weerd Y, Van de Weghe N. (2013). Accessibility to primary health care in Belgium: an evaluation of policies awarding financial assistance in shortage areas. *BMC Fam Pract*, 14 (1) : 122.

Abstract: BACKGROUND: In many countries, financial assistance is awarded to physicians who settle in an area that is designated as a shortage area to prevent unequal accessibility to primary health care. Today, however, policy makers use fairly simple methods to define health care accessibility, with physician-to-population ratios (PPRs) within predefined administrative boundaries being overwhelmingly favoured. Our purpose is to verify whether these simple methods are accurate enough for adequately designating medical shortage areas and explore how these perform relative to more advanced GIS-based methods. METHODS: Using a geographical information system (GIS), we conduct a nation-wide study of accessibility to primary care physicians in Belgium using four different methods: PPR, distance to closest physician, cumulative opportunity, and floating catchment area (FCA) methods. RESULTS: The official method used by policy makers in Belgium (calculating PPR per physician zone) offers only a crude representation of health care accessibility, especially because large contiguous areas (physician zones) are considered. We found substantial differences in the number and spatial distribution of medical shortage areas when applying different methods. CONCLUSIONS: The assessment of spatial health care accessibility and concomitant policy initiatives are affected by and dependent on the methodology used. The major disadvantage of PPR methods is its aggregated approach, masking subtle local variations. Some simple GIS methods overcome this issue, but have limitations in terms of conceptualisation of physician interaction and distance decay. Conceptually, the enhanced 2-step floating catchment area (E2SFCA) method, an advanced FCA method, was found to be most appropriate for supporting areal health care policies, since this method is able to calculate accessibility at a small scale (e.g., census tracts), takes interaction between physicians into account, and considers distance decay. While at present in health care research methodological differences and modifiable areal unit problems have remained largely overlooked, this manuscript shows that these aspects have a significant influence on the insights obtained. Hence, it is important for policy makers to ascertain to what extent their policy evaluations hold under different scales of analysis and when different methods are used.

De Pietri D. (2013). Use of indicators of geographical accessibility to primary health care centers in addressing inequities. *Rev Panam Salud Publica*, 34 (6) :

Abstract: OBJECTIVE: Characterize geographical indicators in relation to their usefulness in measuring regional inequities, identify and describe areas according to their degree of geographical accessibility to primary health care centers (PHCCs), and detect populations at risk from the perspective of access to primary care. METHODS: Analysis of spatial accessibility using geographic information systems (GIS) involved three aspects: population without medical coverage, distribution of PHCCs, and the public transportation network connecting them. RESULTS: The development of indicators of demand (real, potential, and differential) and analysis of territorial factors affecting population mobility enabled the characterization of PHCCs with regard to their environment, thereby contributing to local and regional analysis and to the detection of different zones according to regional connectivity levels. CONCLUSIONS: Indicators developed in a GIS environment were very useful in analyzing accessibility to PHCCs by vulnerable populations. Zoning the region helped identify inequities by differentiating areas of unmet demand and fragmentation of spatial connectivity between PHCCs and public transportation.

Vogt V., Siegel M., Sundmacher L. (2014). Examining regional variation in the use of cancer screening in Germany. *Social Science & Medicine*, In press

Abstract: The detection of cancer in its early latent stages can improve a patient's chances of recovery and thereby reduce the overall burden of the disease. Cancer screening services are, however, only used by a small part of the population and utilization rates vary widely amongst the 402 German districts. This study examines to which extent geographic variation in the use of cancer screening can be explained by accessibility of these services and by spillover effects between adjacent areas, while controlling for a wide range of covariates. District level data on cancer screening utilization rates were calculated for breast, cervical, prostate, skin, and colorectal cancers using German data provided by the National Association of Statutory Health Insurance Physicians (Kassenärztliche Bundesvereinigung - KBV) between 2008 and 2011. We estimated the impact of health service variables on cancer screening utilization using spatial and non-spatial regression models. Spatial autocorrelation in the residuals was estimated using Moran's I statistic. After controlling for socioeconomic and other regional covariates, screening rates for breast, prostate, skin, and colorectal cancers are significantly higher in areas with higher physician density. The utilization of Pap-tests, skin cancer screening and colonoscopies is inversely related with average travel time to physicians. The coefficients for the spatial lag are significant and positive in all models. The positive spatial lags indicate that screening utilization rates are determined by knowledge spillovers between neighboring districts. In terms of public policy, our study demonstrates the potential to increase the use of cancer screening services through improving knowledge regarding cancer screening and by ensuring patient access to cancer screening services.

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

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

patient and hospital characteristics but also by larger social and economic factors that characterize geographic areas.
PM:24673560

Hôpital / Hospitals

Januleviciute J., Askildsen J.E., Kaarboe O., Holmas T.H., Sutton M. (2013). The impact of different prioritisation policies on waiting times: case studies of Norway and Scotland. *Soc Sci Med*, 97 1-6.

Abstract: We investigate the distributional consequences of two different waiting times initiatives, one in Norway, and one in Scotland. The primary focus of Scotland's recent waiting time reforms, introduced in 2003, and modified in 2005 and 2007, has been on reducing maximum waiting times through the imposition of high profile national targets accompanied by increases in resources. In Norway, the focus of the reform introduced in September 2004, has been on assigning patients referred to hospital a maximum waiting time based on disease severity, the expected benefit and the cost-effectiveness of the treatment. We use large, national administrative datasets from before and after each of these reforms and assign priority groups based on the maximum waiting times stipulated in medical guidelines. The analysis shows that the lowest priority patients benefited most from both reforms. This was at the cost of longer waiting times for patients that should have been given higher priority in Norway, while Scotland's high priority patients remained unaffected.

Weaver F.M., Weaver B.A. (2014). Does availability of informal care within the household impact hospitalisation? *Health Econ Policy Law*, 9 (1) : 71-93.

Abstract: This study assesses the effect of having informal support available at home on inpatient care use in Switzerland. The main contributions are to consider the availability of care regardless of its source, measured by multiple-adult living arrangements, and to examine this effect by type of inpatient care and source of potential support. A two-part model with region and time fixed effects is estimated to determine the impact of informal care availability on the likelihood of hospitalisation and length of stay, conditional on hospitalisation. The analysis is conducted on a sample of individuals aged 18+ from four waves of the Swiss Household Panel survey (2004-2007). Overall, availability of informal care has no impact on the likelihood of hospitalisation but does significantly reduce length of stay by 1.9 days. Available support has no effect on the shortest stays (up to 10 days), but has a significant impact on acute care stays up to 30 days and longer stays. Additionally, the effect does not significantly vary whether the source of informal support is a spouse only, a spouse and other adults, or other adults only. These results indicate that social changes leading to an expansion in the proportion of one-person households may increase future inpatient care use.

Ryan A., Sutton M., Doran T. (2014). Does Winning a Pay-for-Performance Bonus Improve Subsequent Quality Performance? Evidence from the Hospital Quality Incentive Demonstration. *Health Services Research*, 49 (2) : 568-587.

Abstract: Objective To test whether receiving a financial bonus for quality in the Premier Hospital Quality Incentive Demonstration (HQID) stimulated subsequent quality improvement. Data Hospital-level data on process-of-care quality from Hospital Compare for the treatment of acute myocardial infarction (AMI), heart failure, and pneumonia for 260 hospitals participating in the HQID from 2004 to 2006; receipt of quality bonuses in the first 3 years of HQID from the Premier Inc. website; and hospital characteristics from the 2005 American Hospital Association Annual Survey. Study Design Under the HQID, hospitals received a 1 percent bonus on Medicare payments for scoring between the 80th and 90th percentiles on a composite quality measure, and a 2 percent bonus for scoring at the 90th percentile or above. We used a regression discontinuity design to evaluate whether hospitals with quality scores just above these payment thresholds improved more in the subsequent year than hospitals with quality scores just below the thresholds. In alternative specifications, we examined

samples of hospitals scoring within 3, 5, and 10 percentage point “bandwidths” of the thresholds. We used a Generalized Linear Model to estimate whether the relationship between quality and lagged quality was discontinuous at the lagged thresholds required for quality bonuses. Principal Findings There were no statistically significant associations between receipt of a bonus and subsequent quality performance, with the exception of the 2 percent bonus for AMI in 2006 using the 5 percentage point bandwidth (0.8 percentage point increase, $p < .01$), and the 1 percent bonus for pneumonia in 2005 using all bandwidths (3.7 percentage point increase using the 3 percentage point bandwidth, $p < .05$). Conclusions : We found little evidence that hospitals' receipt of quality bonuses was associated with subsequent improvement in performance. This raises questions about whether winning in pay-for-performance programs, such as Hospital Value-Based Purchasing, will lead to subsequent quality improvement.

<http://dx.doi.org/10.1111/1475-6773.12097>

Vogl M. (2014). Hospital financing: Calculating inpatient capital costs in Germany with a comparative view on operating costs and the English costing scheme. *Health Policy*, 115 (2-3) : 141-151.

Abstract: OBJECTIVES: The paper analyzes the German inpatient capital costing scheme by assessing its cost module calculation. The costing scheme represents the first separated national calculation of performance-oriented capital cost lump sums per DRG. METHODS: The three steps in the costing scheme are reviewed and assessed: (1) accrual of capital costs; (2) cost-center and cost category accounting; (3) data processing for capital cost modules. The assessment of each step is based on its level of transparency and efficiency. A comparative view on operating costing and the English costing scheme is given. RESULTS: Advantages of the scheme are low participation hurdles, low calculation effort for G-DRG calculation participants, highly differentiated cost-center/cost category separation, and advanced patient-based resource allocation. The exclusion of relevant capital costs, nontransparent resource allocation, and unclear capital cost modules, limit the managerial relevance and transparency of the capital costing scheme. CONCLUSIONS: The scheme generates the technical premises for a change from dual financing by insurances (operating costs) and state (capital costs) to a single financing source. The new capital costing scheme will intensify the discussion on how to solve the current investment backlog in Germany and can assist regulators in other countries with the introduction of accurate capital costing.

Endrei D., Zemplyeni A., Molics B., Agoston I., Boncz I. (2014). The effect of performance-volume limit on the DRG based acute care hospital financing in Hungary. *Health Policy*, 115 (2-3) : 152-156.

Abstract: OBJECTIVES: The aim of our paper is to analyse the effect of the so-called performance volume limit (PVL) financing method on acute hospital care. DATA AND METHODS: The data were derived from the nationwide administrative dataset of the National Health Insurance Fund Administration (OEP) covering the period 2003-2008. We analysed the trends in the DRG cost-weights, number of cases, case-mix, and average length of stay. We calculated the average annual reimbursement rate per DRG cost-weight with and without the application of PVL degression according to the hospital type and medical professions. RESULTS: Our results showed that although the national case mix (i.e., the sum of all of the DRG cost-weights produced in one year) did not change between 2003-2006, the trend of the annual number of cases increased, and the average length of stay decreased. During 2007-2008, a significant decline was found in each indicator. The introduction of the PVL resulted in a health insurance budget saving of 1.9% in 2004, 2.6% in 2005, 3.4% in 2006, 5.6% in 2007, and 3.2% in 2008. We found the lowest reimbursement rate per DRG cost-weight at the university medical schools (HUF 138,200 or euro 550) and children's hospitals (HUF 132,547 or euro 528), whereas the highest was at the county hospitals (HUF 143,451 or euro 571) and city hospitals (HUF 142, 082 or euro 565). CONCLUSIONS: The implementation of the PVL reduced the acute care hospital activity and reimbursement. The effect of the PVL was different on the different types of hospitals, and it had a serious disadvantageous effect on the university medical schools and children's hospitals.

Fourie C., Biller-Andorno N., Wild V. (2014). Systematically evaluating the impact of diagnosis-related groups (DRGs) on health care delivery: A matrix of ethical implications. *Health Policy*, 115 (2-3) : 157-164.

Abstract: Swiss hospitals were required to implement a prospective payment system for reimbursement using a diagnosis-related groups (DRGs) classification system by the beginning of 2012. Reforms to a health care system should be assessed for their impact, including their impact on ethically relevant factors. Over a number of years and in a number of countries, questions have been raised in the literature about the ethical implications of the implementation of DRGs. However, despite this, researchers have not attempted to identify the major ethical issues associated with DRGs systematically. To address this gap in the literature, we have developed a matrix for identifying the ethical implications of the implementation of DRGs. It was developed using a literature review, and empirical studies on DRGs, as well as a review and analysis of existing ethics frameworks. The matrix consists of the ethically relevant parameters of health care systems on which DRGs are likely to have an impact; the ethical values underlying these parameters; and examples of specific research questions associated with DRGs to illustrate how the matrix can be applied. While the matrix has been developed in light of the Swiss health care reform, it could be used as a basis for identifying the ethical implications of DRG-based systems worldwide and for highlighting the ethical implications of other kinds of provider payment systems (PPS).

Kato N., Kondo M., Okubo I., Hasegawa T. (2014). Length of hospital stay in Japan 1971-2008: Hospital ownership and cost-containment policies. *Health Policy*, 115 (2-3) : 180-188.

Abstract: The average length of stay (LOS) is considered one of the most significant indicators of hospital management. The steep decline in the average LOS among Japanese hospitals since the 1980s is considered to be due to cost-containment policies directed at reducing LOS. Japan's hospital sector is characterised by a diversity of ownership types. We took advantage of this context to examine different hospital behaviours associated with ownerships types. Analysing government data published from 1971 to 2008 for the effect of a series of cost-containment policies aimed at reducing LOS revealed distinctly different paths behind the declines in LOS between privately owned and publicly owned hospitals. In the earlier years, private hospitals focused on providing long-term care to the elderly, while in the later years, they made a choice between providing long-term care and providing acute care with reduced LOS and bonus payments. By contrast, the majority of public hospitals opted to provide acute care with reduced LOS in line with public targets.

Shmueli A., Savage E. (2014). Private and public patients in public hospitals in Australia. *Health Policy*, 115 (2-3) : 189-195.

Abstract: INTRODUCTION: The nature of the private-public mix in health insurance and in health care is a major issue in most health systems. OBJECTIVE: To compare the hospitalization characteristics of private and public patients hospitalized in public hospitals. METHODS: We focused on planned, overnight and same-day admissions, discharged during 2004-2005 from the public New South Wales hospitals, and run fixed-effects regressions in order to identify the effect of accommodation status (private/public) on the hospitalization characteristics. RESULTS: Private patients have one third less waiting days than public patients, and they are assigned higher urgency of admission. Length of stay and length of visit are both unrelated to the accommodation status, however, private patients tend to have more hours in ICU and more procedures performed during the hospitalization. In-hospital mortality and the number of transfers (wards) are not affected by the accommodation status. CONCLUSIONS: Private patients are treated differently than public patients in public hospitals, reinforcing the private health insurance-related inequity in inpatient care identified by others. Two health policy issues emerge from the findings: the role of private health insurance in the Australian socialized medicine system, and in particular, in the public hospitals; and the way public hospitals are reimbursed for private patients.

Finocchiaro C.M., Guccio C., Pignataro G., Rizzo I. (2014). The effects of reimbursement mechanisms on medical technology diffusion in the hospital sector in the Italian NHS. *Health Policy*, 115 (2-3) : 215-229.

Abstract: OBJECTIVES: The aim of this study was to investigate how the differences across the regional reimbursement mechanisms and in particular the use of the DRGs impact on the level in the high technology equipment diffusion. METHODS: Based on hospital sector data at a regional level we build up indicators to measure the regional diffusion of high technological medical equipment in the

period 1997-2007. These indicators are regressed on regional healthcare characteristics to investigate the relationship between the different reimbursement systems offered by Italian regions and the level of high technological medical equipment. RESULTS: Our results suggest that the per-case payment system is generally associated with a lower level of regional technology endowment per million of inhabitants, especially for the complex and expensive medical equipments. CONCLUSIONS: Our findings cast some doubts that an effective regulation of reimbursement mechanisms cannot limit the excessive diffusion of medical equipment that is a relevant driver of the increase in expenditure. PM:24393709

Di Giorgio L., Filippini M., Masiero G. (2014). Implications of global budget payment system on nursing home costs. *Health Policy*, 115 (2-3) : 237-248.

Abstract: Pressure on health care systems due to the increasing expenditures of the elderly population is pushing policy makers to adopt new regulation and payment schemes for nursing home services. We consider the behavior of nonprofit nursing homes under different payment schemes and empirically investigate the implications of prospective payments on nursing home costs under tightly regulated quality aspects. To evaluate the impact of the policy change introduced in 2006 in Southern Switzerland - from retrospective to prospective payment - we use a panel of 41 homes observed over a 10-years period (2001-2010). We employ a fixed effects model with a time trend that is allowed to change after the policy reform. There is evidence that the new payment system slightly reduces costs without impacting quality.

Burgess J.F., Hockenberry J.M. (2014). Can all cause readmission policy improve quality or lower expenditures? A historical perspective on current initiatives. *Health Econ Policy Law*, 9 (2) : 193-213.

Abstract: All-cause readmission to inpatient care is of wide policy interest in the United States and a number of other countries (Centers for Medicare and Medicaid Services, in the United Kingdom by the National Centre for Health Outcomes Development, and in Australia by the Australian Institute of Health and Welfare). Contemporary policy efforts, including high powered incentives embedded in the current US Hospital Readmission Reduction Program, and the organizationally complex interventions derived in anticipation of this policy, have been touted based on potential cost savings. Strong incentives and resulting interventions may not enjoy the support of a strong theoretical model or the empirical research base that are typical of strong incentive schemes. We examine the historical broad literature on the issue, lay out a 'full' conceptual organizational model of patient transitions as they relate to the hospital, and discuss the strengths and weaknesses of previous and proposed policies. We use this to set out a research and policy agenda on this critical issue rather than attempt to conduct a comprehensive structured literature review. We assert that researchers and policy makers should consider more fundamental societal issues related to health, social support and health literacy if progress is going to be made in reducing readmissions.

Hentschker C., Mennicken R. (2014). The volume-outcome-relationship and minimum volume standards to empirical evidence for Germany. *Health Economics*, Ahead of pub.

Abstract: For decades, there is an ongoing discussion about the quality of hospital care leading i.a. to the introduction of minimum volume standards in various countries. In this paper, we analyze the volume-outcome relationship for patients with intact abdominal aortic aneurysm and hip fracture. We define hypothetical minimum volume standards in both conditions and assess consequences for access to hospital services in Germany. The results show clearly that patients treated in hospitals with a higher case volume have on average a significant lower probability of death in both conditions. Furthermore, we show that the hypothetical minimum volume standards do not compromise overall access measured with changes in travel times.

<http://dx.doi.org/10.1002/hec.3051>

Inégalités de santé / Health Inequalities

Hudson D.L., Puterman E., Bibbins-Domingo K., Matthews K.A., Adler N.E. (2013). Race, life course socioeconomic position, racial discrimination, depressive symptoms and self-rated health. *Soc Sci Med*, 97 7-14.

Abstract: Greater levels of socioeconomic position (SEP) are generally associated with better health. However results from previous studies vary across race/ethnicity and health outcomes. Further, the majority of previous studies do not account for the effects of life course SEP on health nor the effects of racial discrimination, which could moderate the effects of SEP on health. Using data from the Coronary Artery Risk Development in Young Adults (CARDIA) study, we examined the relationship between a life course SEP measure on depressive symptoms and self-rated health. A life course SEP was constructed for each participant, using a framework that included parental education and occupation along with respondents' highest level of education and occupation. Interaction terms were created between life course SEP and racial discrimination to determine whether the association between SEP and health was moderated by experiences of racial discrimination. Analyses revealed that higher levels of life course SEP were inversely related to depressive symptoms. Greater life course SEP was positively associated with favorable self-rated health. Racial discrimination was associated with more depressive symptoms and poorer self-rated health. Analyses indicated a significant interaction between life course SEP and racial discrimination on depressive symptoms in the full sample. This suggested that for respondents with greater levels of SEP, racial discrimination was associated with reports of more depressive symptoms. Future research efforts should be made to examine whether individuals' perceptions and experiences of racial discrimination at the interpersonal and structural levels limits their ability to acquire human capital as well as their advancement in education and occupational status.

Baeten S., Van Ourti T, Van Doorslaer E. (2013). The socioeconomic health gradient across the life cycle: what role for selective mortality and institutionalization? *Soc Sci Med*, 97 66-74.

Abstract: Several studies have documented the now fairly stylized fact that health inequalities by income differ across the age distribution: in cross-sections the health gap between rich and poor tends to widen until about age 50 and then declines at higher ages. It has been suggested that selective mortality and institutionalization could be important factors driving the convergence at higher ages. We use eight waves of a health survey linked to four registries (on mortality, hospitalizations, (municipal) residence status and taxable incomes) to test this hypothesis. We construct life cycle profiles of health for birth year/gender/income groups from the health surveys (based on 128,689 observations) and exploit the registries to obtain precise estimates of individual probabilities of mortality and institutionalization using a seven year observation period for 2,521,122 individuals. We generate selection corrected health profiles using an inverse probability weighting procedure and find that attrition is indeed not random: older, poorer and unhealthier individuals are significantly more likely not to survive the next year and to be admitted to an institution. While these selection effects are very significant, they are not very large. We therefore reject the hypothesis that selective dropout is an important determinant of the differential health trajectories by income over the life course in the Netherlands.

Eriksson M., Emmelin M. (2013). What constitutes a health-enabling neighborhood? A grounded theory situational analysis addressing the significance of social capital and gender. *Soc Sci Med*, 97 112-123.

Abstract: Variations in health between neighborhoods are well known and the conceptualization of social capital has contributed to an understanding of how contextual factors influence these differences. Studies show positive health-effects from living in high social capital areas, at least for some population sub-groups. The aim of this qualitative study was to understand what constitutes a 'health-enabling' neighborhood. It follows up results from a social capital survey in northern Sweden indicating that the health effects of living in a high social capital neighborhood is gendered in favor of

women. A grounded theory situational analysis of eight focus group discussions--four with men and four with women--illustrated similar and different positions on how neighborhood characteristics influence health. A neighborhood, where people say hi to each other ("hi-factor") and where support between neighbors exist, were factors perceived as positive for health by all, as was a good location, neighborhood greenness and proximity to essential arenas. Women perceived freedom from demands, feeling safe and city life as additional health enabling factors. For men freedom to do what you want, a sense of belonging, and countryside life were important. To have burdensome neighbors, physical disturbances and a densely living environment were perceived as negative for health in both groups while demands for a well styled home and feeling unsafe were perceived as negative for health among women. Neighborhood social capital, together with other elements in the living environment, has fundamental influence on people's perceived health. Our findings do not confirm that social capital is more important for women than for men but that distinctive form of social capital differ in impact. Investing in physical interventions, such as planning for meeting places, constructing attractive green areas, and making neighborhoods walking-friendly, may increase human interactions that is instrumental for social capital and is likely to have health promoting effects for all.

Monstad K., Engesaeter L.B., Espehaug B. (2014). Waiting time and socioeconomic status-an individual-level analysis. *Health Econ*, 23 (4) : 446-461.

Abstract: Waiting time is a rationing mechanism that is used in publicly funded healthcare systems. From an equity viewpoint, it is regarded as preferable to co-payments. However, long waits are an indication of poor quality of service. To our knowledge, this analysis is the first to benefit from individual-level data from administrative registers to investigate the relationship between waiting time, income, and education. Furthermore, it makes use of an extensive set of medical information that serves as indicators of patient need. Differences in waiting time by socioeconomic status are detected. For men, there is a statistically highly significant negative association between income and waiting time, driven by men in the highest income group, which constitutes 12% of all men. More educated women, that is, those having an education above compulsory schooling, experience lower waiting time than their fellow sisters with the lowest level of education.

Rocco L., Fumagalli E., Suhrcke M. (2014). From social capital to health - and back. *Health Econ*, 23 (5) : 586-605.

Abstract: We assess the causal relationship between health and social capital, measured by generalized trust, both at the individual and the community level. The paper contributes to the literature in two ways: it tackles the problems of endogeneity and reverse causation between social capital and health by estimating a simultaneous equation model, and it explicitly accounts for mis-reporting in self-reported trust. The inter-relationship is tested using data from the first four waves of the European Social Survey for 25 European countries, supplemented by regional data from Eurostat. Our estimates show that a causal and positive relationship between self-perceived health and social capital does exist and that it acts in both directions. In addition, the magnitude of the structural coefficients suggests that individual social capital is a strong determinant of health, whereas community level social capital plays a considerably smaller role in determining health.

Médicaments / Pharmaceuticals

Kelton C.M., Chang L.V., Guo J.J., Yu Y., Berry E.A., Bian B., Heaton P.C. (2014). Firm- and Drug-Specific Patterns of Generic Drug Payments by US Medicaid Programs: 1991-2008. *Appl. Health Econ Health Policy*, 12 (2) : 165-177.

Abstract: BACKGROUND: The entry of generic drugs into markets previously monopolized by patented, branded drugs often represents large potential savings for healthcare payers in the USA. OBJECTIVES: Our objectives were to describe and explain the trends in drug reimbursement by public Medicaid programmes post-generic entry for as many drug markets and for as long a time period as possible. METHODS: The data were the Medicaid State Drug Utilization Data maintained by Pôle documentation de l'Irdes / Irdes Documentation centre - Safon M.-O., Suhard V.

the Centers for Medicare and Medicaid Services. Quarterly utilization and expenditure data from 1991 to 2008 were extracted for 83 drugs, produced by 229 firms, that experienced initial generic entry between 1992 and 2004. A relative 'price' for a specific drug, firm and quarter was constructed as Medicaid reimbursement per unit (e.g. tablet, capsule or vial) divided by average reimbursement per unit for the branded drug the year before entry. Fixed-effects models controlling for time-, firm- and drug-specific differences were estimated to explain reimbursement. RESULTS: Twelve quarters after generic entry, 18 % of drugs had average per-unit reimbursement less than 50 % of the original branded-drug reimbursement. For each additional firm manufacturing the drug, reimbursement per unit, relative to the pre-generic-entry branded-drug reimbursement, was estimated to fall by 17 ($p < 0.01$) and 3 ($p < 0.01$) percentage points for generic and branded-drug companies, respectively. Each additional quarter post-generic entry brought a 2 ($p < 0.01$) percentage point drop in relative reimbursement. CONCLUSIONS: State Medicaid programmes generally have been able to obtain relief from high drug prices following patent expirations for many branded-drug medications by adjusting reimbursement following the expanded competition in the pharmaceutical market.

Broom A., Broom J., Kirby E. (2014). Cultures of resistance? A Bourdieusian analysis of doctors' antibiotic prescribing. *Social Science & Medicine*, In press

Abstract: The prospect of an 'antimicrobial perfect storm' in the coming decades through the emergence and proliferation of multi-resistant organisms has become an urgent public health concern. With limited drug discovery solutions foreseeable in the immediate future, and with evidence that resistance can be ameliorated by optimisation of prescribing, focus currently centres on antibiotic use. In hospitals, this is manifest in the development of stewardship programs that aim to alter doctors' prescribing behaviour. Yet, in many clinical contexts, doctors' antibiotic prescribing continues to elude best practice. In this paper, drawing on qualitative interviews with 30 Australian hospital-based doctors in mid-2013, we draw on Bourdieu's theory of practice to illustrate that 'sub-optimal' antibiotic prescribing is a logical choice within the *habitus* of the social world of the hospital. That is, the rules of the game within the *field* are heavily weighted in favour of the management of immediate clinical risks, reputation and concordance with peer practice vis-à-vis longer-term population consequences. Antimicrobial resistance is thus a principal of limited significance in the hospital. We conclude that understanding the habitus of the hospital and the logics underpinning practice is a critical step toward developing governance practices that can respond to clinically 'sub-optimal' antibiotic use.

<http://www.sciencedirect.com/science/article/pii/S0277953614001993>

Vandoros S. (2014). Therapeutic substitution post-patent expiry: the cases of ace inhibitors and proton pump inhibitors. *Health Econ*, 23 (5) : 621-630.

Abstract: This paper examines whether there is a switch in total (originator and generic) consumption after generic entry from molecules that face generic competition towards other molecules of the same class, which are still in-patent. Data from six European countries for the time period 1991 to 2006 are used to study the cases of angiotensin-converting enzyme inhibitors and proton pump inhibitors. Empirical evidence shows that patent expiry of captopril and enalapril led to a switch in total (off-patent originator and generic) consumption towards other in-patent angiotensin-converting enzyme inhibitors, whereas patent expiry of omeprazole led to a switch in consumption towards other proton pump inhibitors. This phenomenon makes generic policies ineffective and results in an increase in pharmaceutical expenditure due to the absence of generic alternatives in the market of in-patent molecules.

Méthodologie – Statistique / Methodology – Statistics

Christensen A.I., Ekholm O., Glumer C., Juel K. (2014). Effect of survey mode on response patterns: comparison of face-to-face and self-administered modes in health surveys. *Eur J Public Health*, 24 (2) : 327-332.

Abstract: BACKGROUND: While face-to-face interviews are considered the gold standard of survey modes, self-administered questionnaires are often preferred for cost and convenience. This article examines response patterns in two general population health surveys carried out by face-to-face interview and self-administered questionnaire, respectively. METHOD: Data derives from a health interview survey in the Region of Southern Denmark (face-to-face interview) and The Danish Health and Morbidity Survey 2010 (self-administered questionnaire). Identical questions were used in both surveys. Data on all individuals were obtained from administrative registers and linked to survey data at individual level. Multiple logistic regression analyses were used to examine the effect of survey mode on response patterns. RESULTS: The non-response rate was higher in the self-administered survey (37.9%) than in the face-to-face interview survey (23.7%). Marital status, ethnic background and highest completed education were associated with non-response in both modes. Furthermore, sex and age were associated with non-response in the self-administered mode. No significant mode effects were observed for indicators related to use of health services, but significant mode effects were observed for indicators related to self-reported health-related quality of life, health behaviour, social relations and morbidity (long-standing illness). CONCLUSIONS: The same factors were generally associated with non-response in both modes. Indicators based on factual questions with simple answers categories were overall more comparable according to mode than indicators based on questions that involved more subjective assessments. Other measures such as efficiency and cost-effectiveness of the mode should also be considered when determining the most appropriate form of data collection.

Chen J., Vargas-Bustamante A., Mortensen K., Thomas S.B. (2014). Using Quantile Regression to Examine Health Care Expenditures during the Great Recession. *Health Services Research*, 49 (2) : 705-730.

Abstract: OBJECTIVE: To examine the association between the Great Recession of 2007-2009 and health care expenditures along the health care spending distribution, with a focus on racial/ethnic disparities. DATA SOURCES/STUDY SETTING: Secondary data analyses of the Medical Expenditure Panel Survey (2005-2006 and 2008-2009). STUDY DESIGN: Quantile multivariate regressions are employed to measure the different associations between the economic recession of 2007-2009 and health care spending. Race/ethnicity and interaction terms between race/ethnicity and a recession indicator are controlled to examine whether minorities encountered disproportionately lower health spending during the economic recession. PRINCIPAL FINDINGS: The Great Recession was significantly associated with reductions in health care expenditures at the 10th-50th percentiles of the distribution, but not at the 75th-90th percentiles. Racial and ethnic disparities were more substantial at the lower end of the health expenditure distribution; however, on average the reduction in expenditures was similar for all race/ethnic groups. The Great Recession was also positively associated with spending on emergency department visits. CONCLUSION: This study shows that the relationship between the Great Recession and health care spending varied along the health expenditure distribution. More variability was observed in the lower end of the health spending distribution compared to the higher end.

Politique de santé / Health Policy

Rosenkotter N., Brand H., McKee M., Riley N., Verma A., Verschuur M. (2014). The realisation of a European health information system--time to get the politicians

involved. *Eur J Public Health*, 24 (2) : 184-185.

Tolonen H., Koponen P., Mindell J., Mannisto S., Kuulasmaa K. (2014). European Health Examination Survey- towards a sustainable monitoring system. *Eur J Public Health*, 24 (2) : 338-344.

Abstract: **BACKGROUND:** Health examination surveys (HESs), including both questionnaire and physical measurements, and in most cases also collection of biological samples, can provide objective health indicators. This information complements data from health interview surveys and administrative registers, and is important for evidence-based planning of health policies and prevention activities. HESs are valuable data sources for research. The first national HESs in Europe were conducted in the late 1950s and early 1960s. They have recently been carried out in an increasing number of countries, but there has been no joint standardization between the countries. **METHODS:** The European Health Examination Survey Pilot Project was conducted in 2009-2012. The European Health Examination Survey Pilot Reference Centre was established and pilot surveys were conducted in 12 countries. **RESULTS:** European standardized protocols for key measurements on main chronic disease risk factors (height, weight, waist circumference, blood pressure, blood lipids and fasting glucose or HbA1c) were prepared. European-level training and external quality assessment were organized. Although the level of earlier experience, infrastructures, economic status and cultural settings varied between the pilot countries, it was possible to standardize measurements of HESs across the populations. Obtaining high participation rates was challenging. **CONCLUSION:** HESs provide high-quality and representative population data to support policy decisions and research. For future national HESs, centralized coordination, training and external quality assessment are needed to ensure comparability of the results. Further studies on effects of different survey methods on comparability of the results and on recruitment and motivation of survey participants are needed.

Prévision - Evaluation / Prevision – Evaluation

Marsh K., Lanitis T., Neasham D., Orfanos P., Caro J. (2014). Assessing the value of healthcare interventions using multi-criteria decision analysis: a review of the literature. *Pharmacoeconomics*, 32 (4) : 345-365.

Abstract: The objective of this study is to support those undertaking a multi-criteria decision analysis (MCDA) by reviewing the approaches adopted in healthcare MCDAs to date, how these varied with the objective of the study, and the lessons learned from this experience. Searches of EMBASE and MEDLINE identified 40 studies that provided 41 examples of MCDA in healthcare. Data were extracted on the objective of the study, methods employed, and decision makers' and study authors' reflections on the advantages and disadvantages of the methods. The recent interest in MCDA in healthcare is mirrored in an increase in the application of MCDA to evaluate healthcare interventions. Of the studies identified, the first was published in 1990, but more than half were published since 2011. They were undertaken in 18 different countries, and were designed to support investment (coverage and reimbursement), authorization, prescription, and research funding allocation decisions. Many intervention types were assessed: pharmaceuticals, public health interventions, screening, surgical interventions, and devices. Most used the value measurement approach and scored performance using predefined scales. Beyond these similarities, a diversity of different approaches were adopted, with only limited correspondence between the approach and the type of decision or product. Decision makers consulted as part of these studies, as well as the authors of the studies are positive about the potential of MCDA to improve decision making. Further work is required, however, to develop guidance for those undertaking MCDA.

Wisloff T., Hagen G., Hamidi V., Movik E., Klemp M., Olsen J.A. (2014). Estimating QALY Gains in Applied Studies: A Review of Cost-Utility Analyses Published in 2010. *Pharmacoeconomics*, 32 (4) : 367-375.

Abstract: Reimbursement agencies in several countries now require health outcomes to be measured in terms of quality-adjusted life-years (QALYs), leading to an immense increase in publications reporting QALY gains. However, there is a growing concern that the various 'multi-attribute utility' (MAU) instruments designed to measure the Q in the QALY yield disparate values, implying that results from different instruments are incommensurable. By reviewing cost-utility analyses published in 2010, we aim to contribute to improved knowledge on how QALYs are currently calculated in applied analyses; how transparently QALY measurement is presented; and how large the expected incremental QALY gains are. We searched Embase, MEDLINE and NHS EED for all cost-utility analyses published in 2010. All analyses that had estimated QALYs gained from health interventions were included. Of the 370 studies included in this review, 48 % were pharmacoeconomic evaluations. Active comparators were used in 71 % of studies. The median incremental QALY gain was 0.06, which translates to 3 weeks in best imaginable health. The EQ-5D-3L is the dominant instrument used. However, reporting of how QALY gains are estimated is generally inadequate. In 55 % of the studies there was no reference to which MAU instrument or direct valuation method QALY data came from. The methods used for estimating expected QALY gains are not transparently reported in published papers. Given the wide variation in utility scores that different methodologies may assign to an identical health state, it is important for journal editors to require a more transparent way of reporting the estimation of incremental QALY gains.

Pauly M. (2014). Cost-effectiveness analysis and insurance coverage: solving a puzzle. *Health Econ*, In press

Abstract: The conventional model for the use of cost-effectiveness analysis for health programs involves determining whether the cost per unit of effectiveness of the program is lower than some socially determined maximum acceptable cost per unit of effectiveness. If a program is better by this criterion, the policy implication is that it should be implemented by full coverage of its cost by insurance; if not, the program should not be implemented. This paper examines the unanswered question of how cost-effectiveness analysis should be performed and interpreted when insurance coverage may involve cost sharing. It explores the question of how cost sharing should be related to the magnitude of a cost-effectiveness ratio. A common view that cost sharing should vary inversely with program cost-effectiveness is shown to be incorrect. A key issue in correct analysis is whether there is heterogeneity in marginal effectiveness of care that cannot be perceived by the social planner but is known by the demander. It is possible that some programs that would fail the social efficiency test at full coverage will be acceptable with positive cost sharing. Combining individual and social preferences affects both the choice of programs and the extent of cost sharing.

Psychiatrie / Psychiatry

Padmanathan P., De Silva M.J. (2013). The acceptability and feasibility of task-sharing for mental healthcare in low and middle income countries: a systematic review. *Soc Sci Med*, 97 82-86.

Abstract: Task-sharing has frequently been proposed as a strategy to overcome human resource shortages in order to scale up mental health care. Although evidence suggests this approach is effective, to date no review has been conducted to assess its acceptability and feasibility among service users and health care practitioners. This review summarises current findings and provides evidence-based recommendations to improve the success and sustainability of task-sharing approaches. All study designs were included and both qualitative and quantitative data were extracted and reviewed using a comparative thematic analysis. In total, 21 studies were included, nine of which were of strong or adequate quality and twelve of unknown quality. The review highlighted that task-sharing is not an outright solution for overcoming human resource shortages in low and middle income

countries. A number of factors need to be considered in order for task-sharing to be acceptable and feasible, for example the incidence of distress experienced by the task-sharing workforce, their self-perceived level of competence, the acceptance of the workforce by other health care professionals and the incentives provided to ensure workforce retention. As the main barrier to addressing these is a lack of resources, an increased investment in mental health care is essential in order to ensure that task-sharing interventions are successful and sustainable.

Gidding L.G., Spigt M.G., Dinant G.J. (2014). Stepped collaborative depression care: primary care results before and after implementation of a stepped collaborative depression programme. *Family Practice*, 31 (2) : 180-192.

Abstract: Background. Numerous intensive research projects to assess the effects of stepped collaborative care (SCC) for depressed patients have been reported in primary care, yet it is unclear how SCC is sustained in usual care. Objective. To assess how SCC for depression is actually being used and how it performs in usual primary care by studying medical data that are routinely collected in family practice, outside the research setting. Methods. Retrospective before and after comparison of electronic medical records (EMR) regarding the implementation of an SCC depression programme in a large primary care organization from 2003 to 2012. Depression care parameters included prevalences, minimal interventions, Beck Depression Inventory-2 (BDI-2), antidepressants, referrals to psychologists and psychiatrists and primary health care consumption. Results. After programme implementation, differentiation between levels of depression severity increased, more patients were treated with minimal interventions and more patients were monitored with BDI-2. These effects occurred in both nonseverely and severely depressed patients, although they were larger for patients registered as nonseverely depressed. Antidepressant prescription rates and referral rates seemed not to have been influenced by the SCC programme. Health care consumption of the depressed patients increased significantly. Conclusions. The depression care parameters changed to a different extent and at a different pace than after previous implementation initiatives. Future research should identify whether SCC uptake in primary care is best enhanced by intensive external guidance or by making care providers themselves responsible for the implementation. Analyses of EMR can be valuable in monitoring the implementation effects, especially after research projects are completed.
<http://fampra.oxfordjournals.org/content/31/2/180.abstract>

Nicaise P., Dubois V., Lorant V. (2014). Mental health care delivery system reform in Belgium: The challenge of achieving deinstitutionalisation whilst addressing fragmentation of care at the same time. *Health Policy*, 115 (2-3) : 120-127.

Abstract: Most mental health care delivery systems in welfare states currently face two major issues: deinstitutionalisation and fragmentation of care. Belgium is in the process of reforming its mental health care delivery system with the aim of simultaneously strengthening community care and improving integration of care. The new policy model attempts to strike a balance between hospitals and community services, and is based on networks of services. We carried out a content analysis of the policy blueprint for the reform and performed an ex-ante evaluation of its plan of operation, based on the current knowledge of mental health service networks. When we examined the policy's multiple aims, intermediate goals, suggested tools, and their articulation, we found that it was unclear how the new policy could achieve its goals. Indeed, deinstitutionalisation and integration of care require different network structures, and different modes of governance. Furthermore, most of the mechanisms contained within the new policy were not sufficiently detailed. Consequently, three major threats to the effectiveness of the reform were identified. These were: issues concerning the relationship between network structure and purpose, the continued influence of hospitals despite the goal of deinstitutionalisation, and the heterogeneity in the actual implementation of the new policy.

Soins de santé primaires / Primary Health Care

Tschudi-Madsen H., Kjeldsberg M., Natvig B., Ihlebaek C., Straand J., Bruusgaard D. (2014). Medically unexplained conditions considered by patients in general practice. *Family Practice*, 31 (2) : 156-163.

Abstract: Background. Patients frequently present with multiple and “unexplained” symptoms, often resulting in complex consultations. To better understand these patients is a challenge to health care professionals, in general, and GPs, in particular. Objectives. In our research on symptom reporting, we wanted to explore whether patients consider that they may suffer from conditions commonly regarded as unexplained, and we explored associations between these concerns and symptom load, life stressors and socio-demographic factors. Methods. Consecutive, unselected patients in general practice completed questionnaires addressing eight conditions commonly regarded as unexplained (amalgam poisoning, Candida syndrome, fibromyalgia, food intolerance, electromagnetic hypersensitivity, burnout syndrome, chronic fatigue syndrome and irritable bowel syndrome). With logistic regression, we analysed associations with symptom load, burden of life stressors with negative impact on present health and socio-demographic variables. Results. Out of the 909 respondents (response rate = 88.8%), 863 had complete data. In total, 39.6% of patients had considered that they may suffer from one or more unexplained conditions (UCs). These concerns were strongly and positively associated with recent symptom load and number of life stressors. If we excluded burnout and food intolerance, corresponding associations were found. Conclusion. Patients frequently considered that they may suffer from UCs. The likelihood of such concerns strongly increased with an increasing symptom load and with the number of life stressors with negative impact on present health. Hence, the number of symptoms may be a strong indicator of whether patients consider their symptoms part of such often controversial multisymptom conditions.

<http://fampra.oxfordjournals.org/content/31/2/156.abstract>

Dahlhaus A., Vanneman N., Guethlin C., Behrend J., Siebenhofer A. (2014). German general practitioners' views on their involvement and role in cancer care: a qualitative study. *Family Practice*, 31 (2) : 209-214.

Abstract: Background. The multidisciplinary and sequential nature of cancer care makes continuity of care for patients difficult. Cancer patients have often known their general practitioners (GPs) for years and are often in constant contact with them. Objective(s). We examined German GPs' views on their involvement in the care of cancer patients. Methods. We conducted semi-structured interviews with 30 German GPs. Purposeful sampling was applied to secure maximum heterogeneity. Interviews were recorded, transcribed and then analyzed using qualitative content analysis according to Mayring. Results. GPs perceive a clear involvement in the latter phase of cancer care but a mainly sporadic role (as and when required) in earlier phases. They think that greater care contributions from GPs are generally beneficial to cancer patients, as their ability to take the patient's history, surroundings and co-morbidities into account enables them to provide more patient-centred care. GPs want to stay involved and to know how their cancer patients are progressing, and they complain about slow or non-existent information sharing between providers, as well as insufficient care coordination. They proactively try to overcome these obstacles through direct contact with patients and physicians, and by building networks of trusted care providers. Conclusions. Given their long-lasting and close relationships with cancer patients, GPs are in a position to accompany them throughout the whole process of cancer care. However, such general involvement is as yet uncommon. Shared care models may have the potential to take into account the complementary character of primary and specialist care.

<http://fampra.oxfordjournals.org/content/31/2/209.abstract>

Kantarevic J., Kralj B. (2014). Risk selection and cost shifting in a prospective physician payment system: Evidence from Ontario. *Health Policy*, 115 (2-3) : 249-257.

Abstract: We study the risk-selection and cost-shifting behavior of physicians in a unique capitation payment model in Ontario, using the incentive to enroll and care for complex and vulnerable patients as a case study. This incentive, which is incremental to the regular capitation payment, ceases after

the first year of patient enrollment and may therefore impact on the physician's decision to continue to enroll the patient. Furthermore, because the enrolled patients in Ontario can seek care from any provider, the enrolling physician may shift some treatment costs to other providers. Using longitudinal administrative data and a control group of physicians in the fee-for-service model who were eligible for the same incentive, we find no evidence of either patient 'dumping' or cost shifting. These results highlight the need to re-examine the conventional wisdom about risk selection for physician payment models that significantly deviate from the stylized capitation model.

Higgins A., Porter S., O'Halloran P. (2014). General practitioners' management of the long-term sick role. *Soc Sci Med*, 107 52-60.

Abstract: In this paper, we use qualitative research techniques to examine the role of general practitioners in the management of the long-term sickness absence. In order to uncover the perspectives of all the main agents affected by the actions of general practitioners, a case study approach focusing on one particular employment sector, the public health service, is adopted. The role of family physicians is viewed from the perspectives of health service managers, occupational health physicians, employees/patients, and general practitioners. Our argument is theoretically framed by Talcott Parsons's model of the medical contribution to the sick role, along with subsequent conceptualisations of the social role and position of physicians. Sixty one semi-structured interviews and three focus group interviews were conducted in three Health and Social Care Trusts in Northern Ireland between 2010 and 2012. There was a consensus among respondents that general practitioners put far more weight on the preferences and needs of their patients than they did on the requirements of employing organisations. This was explained by respondents in terms of the propinquity and longevity of relationships between doctors and their patients, and by the ideology of holistic care and patient advocacy that general practitioners viewed as providing the foundations of their approach to patients. The approach of general practitioners was viewed negatively by managers and occupational health physicians, and more positively by general practitioners and patients. However, there is some evidence that general practitioners would be prepared to forfeit their role as validators of sick leave. Given the imperatives of both state and capital to reduce the financial burden of long-term sickness, this preparedness puts into doubt the continued role of general practitioners as gatekeepers to legitimate long-term sickness absence.

Amico P.R., Chilingirian J.A., Van Hasselt M. (2014). Community health center efficiency: the role of grant revenues in health center efficiency. *Health Services Research*, 49 (2) : 666-682.

Abstract: **OBJECTIVE:** To test the relationship between external environments, organizational characteristics, and technical efficiency in federally qualified health centers (FQHCs). We tested the relationship between grant revenue and technical efficiency in FQHCs. **DATA SOURCES/STUDY DESIGN:** Secondary data were collected in each year from the Uniform Data System (UDS) on 644 eligible U.S.-based FQHCs between 2005 and 2007. The study employs a retrospective longitudinal cohort design with instrumental variables. **PRINCIPAL FINDINGS:** Increased grant revenues did not increase the probability that a health center would be on the efficiency frontier. However, increased grant revenues had a negative association with technical efficiency for health centers that were not fully efficient. **CONCLUSION:** If all health centers were operating efficiently, anywhere from 39 to 45 million patient encounters could have been delivered instead of the actual total of 29 million in 2007. Policy makers should consider tying grant revenues to performance indicators, and future work is needed to understand the mechanisms through which diseconomies of scale are present in FQHCs.

Barroux G. (2014). La relation médecin-patient dans les consultations épistolaires (XVIe-XVIIIe-siècle). *Med Sci (Paris)*, 30 (3) : 311-318.

Abstract: Les consultations épistolaires qui constituent un pan important de la littérature médicale, particulièrement entre les XVI^e et XVIII^e siècles, apportent une série de témoignages irremplaçables de la manière dont les médecins suivaient leurs patients à distance, en lien avec des médecins qui, eux, se trouvaient au chevet de leur malade ou leur rendaient régulièrement visite. Ces témoignages sont d'ordre scientifique, puisqu'ils montrent comment diagnostiquent, pronostiquent et prescrivent des médecins illustres comme Fernel, Chirac ou, plus tard, Barthez et Tissot, ou moins connus comme Le Thieullier par exemple. Ils sont d'ordre littéraire, car chaque médecin possède un style, et l'écriture de

telles lettres suit souvent des codes. Ils sont d'ordre anthropologique, dans la mesure où une conception de l'homme, malade, patient, avec ses caractères, ses expériences, son vécu, est restituée sous la forme de récits.

<http://dx.doi.org/10.1051/medsci/20143003020>

Systèmes de santé / Health Systems

Clemens T., Michelsen K., Brand H. (2014). Supporting health systems in Europe: added value of EU actions? *Health Econ Policy Law*, 9 (1) : 49-69.

Abstract: Since the start of the economic crisis, the European Union's (EU's) predominant discourse has been austerity and fiscal consolidation. The detrimental effects on Europe's health systems and the health status of its citizens are well described. However, little is known about the emerging EU-level initiatives to support national health systems handle the challenges of efficient care provision and system reorganisation aimed to meet their future needs. This review analyses the manner, conditions and prospects of such EU support. First, health system objectives are increasingly entering the EU health policy agenda. Second, professional and patient mobility provisions may support member states (MS) in coping with crisis related health challenges but can potentially exacerbate them at the same time. Third, in recent initiatives health system goals are more closely tied to the EU's economic growth narrative. And fourth, health system issues are taken up in existing EU-level structures for debate and exchange between MS. In addition, the design of some policies may have the potential to intensify socioeconomic and health inequalities rather than ameliorate them.

Travail et santé / Occupational Health

Tessier P., Sultan-Taieb H., Barnay T. (2014). Worker replacement and cost-benefit analysis of life-saving health care programs, a precautionary note. *Health Econ Policy Law*, 9 (2) : 215-229.

Abstract: The assumption according to which ill individuals can be replaced at work that underpins the 'friction cost method' (FCM) to value productivity costs has been primarily discussed within the framework of cost-utility analysis. This paper investigates the consequences of this assumption for cost-benefit analysis (CBA). It makes three contributions. First, it provides the first analytical account of the overall consequences of ill worker replacement on social welfare and it analyzes the associated compensation effects within a CBA framework. Second, it highlights a double counting problem that arises when ill worker replacement is assumed in the CBA of life-saving health care programs. To the best of our knowledge, no satisfactory solution to this problem has yet been provided in the literature. Third, this paper suggests and discusses two original ways to address this double counting issue. One consists in adjusting value of a statistical life estimations for the well-being provided by future incomes. Another possibility lies in the estimation of marginal rates of substitution between health and wealth so as to directly monetize the value of life over and above consumption. We show that both solutions raise unresolved questions that should be addressed in future research to enable appropriate use of the FCM in CBA.

Leguevaques J., Carol C., Letrilliart L. (2014). [Nosological and functional justifications for sick leave: A cross-sectional study in the Rhone district]. *Rev Epidemiol Santé Publique*, 62 (2) : 145-152.

Abstract: BACKGROUND: Although sick leave has significant medical and economic stakes, justifications for sick leave are poorly known in France. Our objective was to describe the medical justifications for sick leave, in nosological, functional and contextual terms. METHODS: Cross-

sectional study, based on 1,143 sick leave certificates collected by the Health Insurance Fund of the Rhone district in February 2011. The medical justifications for sick leave were classified and coded in nosological terms according to the International Classification of Primary Care (ICPC-2) and in functional and contextual terms according to the "AT-CIF questionnaire", derived from the International Classification of Functioning (ICF). RESULTS: Among the 1,073 sick leaves containing a medical justification (93.9%), 757 (70.5%) could be classified only according to the ICPC-2 and 316 (29.5%) according to both the ICPC-2 and the AT-CIF questionnaires. The health problems most frequently reported in sick leave justifications concerned, in order of decreasing frequency: respiratory (26.9%), psychological (13.7%), or digestive (12.1%) systems; general problems (10.7%); pregnancy (3.5%); the neurological system (2.9%). Furthermore, 346 functional deficiencies, five restrictions of activity and one environmental barrier were identified. CONCLUSION: Sick leave certificates almost always provide justifications for sick leave in nosological terms, but in less than one third of certificates provide information in functional or contextual terms. Training practitioners to make functional and contextual assessments may allow them to more optimally decide on the indication and the duration of sick leave, and facilitate communication around the patient.

Vieillessement / Aging

Etman A., Kamphuis C.B., Prins R.G., Burdorf A., Pierik F.H., Van Lenthe F.J. (2014). Characteristics of residential areas and transportational walking among frail and non-frail Dutch elderly: does the size of the area matter? *Int J Health Geogr.*, 13 (1) : 7.

Abstract: BACKGROUND: A residential area supportive for walking may facilitate elderly to live longer independently. However, current evidence on area characteristics potentially important for walking among older persons is mixed. This study hypothesized that the importance of area characteristics for transportational walking depends on the size of the area characteristics measured, and older person's frailty level. METHODS: The study population consisted of 408 Dutch community-dwelling persons aged 65 years and older participating in the Elderly And their Neighborhood (ELANE) study in 2011-2012. Characteristics (aesthetics, functional features, safety, and destinations) of areas surrounding participants' residences ranging from a buffer of 400 meters up to 1600 meters (based on walking path networks) were linked with self-reported transportational walking using linear regression analyses. In addition, interaction effects between frailty level and area characteristics were tested. RESULTS: An increase in functional features (e.g. presence of sidewalks and benches) within a 400 meter buffer, in aesthetics (e.g. absence of litter and graffiti) within 800 and 1200 meter buffers, and an increase of one destination per buffer of 400 and 800 meters were associated with more transportational walking, up to 2.89 minutes per two weeks (CI 1.07-7.32; $p < 0.05$). No differences were found between frail and non-frail elderly. CONCLUSIONS: Better functional and aesthetic features, and more destinations in the residential area of community-dwelling older persons were associated with more transportational walking. The importance of area characteristics for transportational walking differs by area size, but not by frailty level. Neighbourhood improvements may increase transportational walking among older persons, thereby contributing to living longer independently.