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Contacts

Espace documentation : documentation@irdes.fr

Marie-Odile Safon : safon@irdes.fr

Véronique Suhard : suhard@irdes.fr

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Assurance maladie / Health Insurance

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Economie de la santé / Health Economics

Angelis, A., et al. (2014). "Socio-economic burden of rare diseases: A systematic review of cost of illness evidence." *Health Policy*. [Epub ahead of print]

Cost-of-illness studies, the systematic quantification of the economic burden of diseases on the individual and on society, help illustrate direct budgetary consequences of diseases in the health system and indirect costs associated with patient or carer productivity losses. In the context of the BURQOL-RD project ("Social Economic Burden and Health-Related Quality of Life in patients with Rare Diseases in Europe") we studied the evidence on direct and indirect costs for 10 rare diseases (Cystic Fibrosis [CF], Duchenne Muscular Dystrophy [DMD], Fragile X Syndrome [FXS], Haemophilia, Juvenile Idiopathic Arthritis [JIA], Mucopolysaccharidosis [MPS], Scleroderma [SCL], Prader-Willi Syndrome [PWS], Histiocytosis [HIS] and Epidermolysis Bullosa [EB]). A systematic literature review of cost of illness studies was conducted using a keyword strategy in combination with the names of the 10 selected rare diseases. Available disease prevalence in Europe was found to range between 1 and 2 per 100,000 population (PWS, a sub-type of Histiocytosis, and EB) up to 42 per 100,000 population (Scleroderma). Overall, cost evidence on rare diseases appears to be very scarce (a total of 77 studies were identified across all diseases), with CF (n=29) and Haemophilia (n=22) being relatively well studied, compared to the other conditions, where very limited cost of illness information was available. In terms of data availability, total lifetime cost figures were found only across four diseases, and total annual costs (including indirect costs) across five diseases. Overall, data availability was found to correlate with the existence of a pharmaceutical treatment and indirect costs tended to account for a significant proportion of total costs. Although methodological variations prevent any detailed comparison between conditions and based on the evidence available, most of the rare diseases examined are associated with significant economic burden, both direct and indirect.

Carpenter, A., et al. (2015). "Affordability of out-of-pocket health care expenses among older Australians." *Health Policy*. [Epub ahead of print]

Australia has universal health insurance, and provides price concessions on health care and prescription pharmaceuticals through government subsidies. However Australia ranks among the highest OECD nations for out-of-pocket health care spending. With high prevalence of

multimorbidity (27% aged 65 and over have 2 or more long-term health conditions) older Australians may face a severe financial burden from out-of-pocket health expenses. We surveyed 4574 members of National Seniors Australia aged 50 years or more on their inability to pay out-of-pocket health-related expenses across categories of medical consultations and tests, medications, dental appointments, allied health appointments (e.g. physiotherapy, podiatry) and transport to medical appointments or tests. Almost 4% of those surveyed were unable to afford out-of-pocket costs in at least one category of health care expenses in the previous 3 months. The odds of being unable to afford out-of-pocket medical costs increased with the number of chronic medical conditions (3 conditions: OR 3.05, 95% CI 1.17-6.30; 4 or more conditions: OR 3.45, 95% CI 1.34-7.28, compared with no chronic medical conditions). Despite Australia's universal health insurance, and safety nets for medical and pharmaceutical contributions, older Australians with multiple chronic conditions are at risk of being unable to afford out-of-pocket health care expenses.

Doty, P., et al. (2015). "Long-Term Care Financing: Lessons From France." The Milbank Quarterly 93(2): 359-391.

Policy Points: France's model of third-party coverage for long-term services and supports (LTSS) combines a steeply income-adjusted universal public program for people 60 or older with voluntary supplemental private insurance. French and US policies differ: the former pay cash; premiums are lower; and take-up rates are higher, in part because employer sponsorship, with and without subsidization, is more common—but also because coverage targets higher levels of need and pays a smaller proportion of costs. Such inexpensive, bare-bones private coverage, especially if marketed as a supplement to a limited public benefit, would be more affordable to those Americans currently most at risk of “spending down” to Medicaid. Policy Points: France's model of third-party coverage for long-term services and supports (LTSS) combines a steeply income-adjusted universal public program for people 60 or older with voluntary supplemental private insurance. French and US policies differ: the former pay cash; premiums are lower; and take-up rates are higher, in part because employer sponsorship, with and without subsidization, is more common—but also because coverage targets higher levels of need and pays a smaller proportion of costs. Such inexpensive, bare-bones private coverage, especially if marketed as a supplement to a limited public benefit, would be more affordable to those Americans currently most at risk of “spending down” to Medicaid. An aging population leads to a growing demand for long-term services and supports (LTSS). In 2002, France introduced universal, income-adjusted, public long-term care coverage for adults 60 and older, whereas the United States funds means-tested benefits only. Both countries have private long-term care insurance (LTCI) markets: American policies create alternatives to out-of-pocket spending and protect purchasers from relying on Medicaid. Sales, however, have stagnated, and the market's viability is uncertain. In France, private LTCI supplements public coverage, and sales are growing, although its potential to alleviate the long-term care financing problem is unclear. We explore whether France's very different approach to structuring public and private financing for long-term care could inform the United States' long-term care financing reform efforts. We consulted insurance experts and conducted a detailed review of public reports, academic studies, and other documents to understand the public and private LTCI systems in France, their advantages and disadvantages, and the factors affecting their development. France provides universal public coverage for paid assistance with functional dependency for people 60 and older. Benefits are steeply income adjusted and amounts are low. Nevertheless, expenditures have exceeded projections, burdening local governments. Private supplemental insurance covers 11% of French, mostly middle-income adults (versus 3% of Americans 18 and older). Whether policyholders will maintain employer-sponsored coverage after retirement is not known. The government's interest in pursuing an explicit public/private

partnership has waned under President François Hollande, a centrist socialist, in contrast to the previous center-right leader, President Nicolas Sarkozy, thereby reducing the prospects of a coordinated public/private strategy. American private insurers are showing increasing interest in long-term care financing approaches that combine public and private elements. The French example shows how a simple, cheap, cash-based product can gain traction among middle-income individuals when offered by employers and combined with a steeply income-adjusted universal public program. The adequacy of such coverage, however, is a concern.

Gopffarth, D., et al. (2015). "Determinants of Regional Variation in Health Expenditures in Germany." *Health Econ.* [Epub ahead of print]

Health care expenditure in Germany shows clear regional differences. Such geographic variations are often seen as an indicator for inefficiency. With its homogeneous health care system, low co-payments and uniform prices, Germany is a particularly suited example to analyse regional variations. We use data for the year 2011 on expenditure, utilization of health services and state of health in Germany's statutory health insurance system. This data, which originate from a variety of administrative sources and cover about 90% of the population, are enriched with a wealth of socio-economic variables, data on pollutants, prices and individual preferences. State of health and demography explains 55% of the differences as measured by the standard deviation while all control variables account for a total of 72% of the differences at county level. With other measures of variation, we can account for an even greater proportion. A higher proportion of variation than usually supposed can thus be explained. Whilst this study cannot quantify inefficiencies, our results contradict the thesis that regional variations reflect inefficiency. Copyright (c) 2015 John Wiley & Sons, Ltd.

Etat de santé / Health Status

Kowal, P., et al. "Multimorbidity: health care that counts "past one" for 1.2 billion older adults." *The Lancet* 385(9984): 2252-2253.

Banerjee, S. "Multimorbidity: health care that counts "past one" for 1.2 billion older adults – Author's reply." *The Lancet* 385(9984): 2253-2254.

Géographie de la santé / Geography of Health

Bocquier, A., et al. (2015). "[Relevance of the health insurance databases to study spatial disparities in asthma prevalence: A study in southeastern France]." *Rev Epidemiol Santé Publique* 63(3): 155-162.

BACKGROUND: Data on asthma prevalence at a small-area level would be useful to set up and monitor French local public health policies. This study, based on drug reimbursement databases in southeastern France, aimed to (1) compare asthma-like disorders prevalence estimated by using three different indicators; (2) study sociodemographic characteristics associated with these indicators; (3) verify whether these indicators are equivalent to study geographical disparities of the asthma-like disorders prevalence at a small-area level.

METHODS: The study was conducted among the beneficiaries of the National Health Insurance Fund aged 18-44 years residing in southeastern France in 2010 (n=1,371,816). Using data on asthma drugs reimbursements (therapeutic class R03), we built three indicators to assess asthma-like disorders prevalence: at least 1, 2 or 3 purchase(s) in 2010. We analyzed sociodemographic characteristics associated with these indicators, and their geographical disparities at a small-area level using multilevel logistic regression models. **RESULTS:** The crude asthma-like disorders prevalence varied between 2.6 % and 8.4 % depending on the indicator. It increased with age, was higher for women than for men, and among low-income people for all three indicators. We measured significant geographical disparities. Areas with high prevalence rates were the same regardless of the indicator. **CONCLUSION:** The indicators built in this study can be useful to identify high prevalence areas. They could contribute to launch discussion on environmental health issues at the local level.

Elek, P., et al. (2015). "Effects of Geographical Accessibility on the Use of Outpatient Care Services: Quasi-Experimental Evidence from Panel Count Data." Health Econ. [Epub ahead of print]

In 2010-2012, new outpatient service locations were established in Hungarian micro-regions, which had lacked such capacities before. We exploit this quasi-experiment to estimate the effect of geographical accessibility on outpatient case numbers using both individual-level and semi-aggregate panel data. We find a 24-27 per cent increase of case numbers as a result of the establishments. Our specialty-by-specialty estimates imply that a 1-min reduction of travel time to the nearest outpatient unit increases case numbers for example by 0.9 per cent in internal care and 3.1 per cent in rheumatology. The size of the new outpatient capacities has a separate effect, raising the possibility of the presence of supplier-induced demand. By combining a fixed-effects logit and a fixed-effects truncated Poisson estimator, we decompose the effects into increases in the probability of ever visiting a doctor on the one hand and an increase of the frequency of visits on the other hand. We find that new visits were dominant in the vast majority of specialties, whereas both margins were important for example in rheumatology. Finally, we demonstrate the usefulness of the fixed-effects truncated Poisson estimator in modelling count data by examining its robustness by simulations. Copyright (c) 2015 John Wiley & Sons, Ltd.

Ripley, D. C., et al. (2015). "How does geographic access affect in-hospital mortality for veterans with acute ischemic stroke?" Med Care 53(6): 501-509.

OBJECTIVE: To examine the relationship between estimated travel time to admitting hospital and mortality for veterans with acute ischemic stroke, controlling for patient demographic, clinical, facility-level variables, as well as select in-hospital treatments and procedures.

METHODS: A longitudinal observational population-based study. Information on all veterans discharged from a Veterans Administration Medical Center (VAMC) with an ischemic stroke diagnosis between October 1, 2006 and September 30, 2008 were examined. A total of 10,430 patients met the inclusion criteria for the study. Unadjusted differences between patients who died during the hospital stay versus those patients who were discharged alive, used chi analyses or Student t tests, as appropriate. Multivariable logistic regression was used to control for confounding effects of patient, treatment, and facility characteristics to examine the relationship between travel time and the bivariate outcome of in-hospital mortality. **RESULTS:** Travel time to the admitting VAMC, our primary variable of interest regarding the effect on in-hospital mortality, after adjusting for the patient, treatment, and facility characteristics showed that longer travel times significantly increased the odds of in-hospital mortality. Travel times ≥ 90 minutes had increased odds of in-hospital mortality (OR=1.476; 95% CI, 1.067-2.042) as compared with < 30 minutes. **CONCLUSIONS:** Even after adjusting for the confounding effects of patient, treatment, and facility characteristics, travel

time from home to admitting VAMC was significantly associated with in-hospital mortality.

Hôpital / Hospitals

Burns, L. R., et al. (2015). "Is the system really the solution? Operating costs in hospital systems." *Med Care Res Rev* 72(3): 247-272.

Hospital system formation has recently accelerated. Executives emphasize scale economies that lower operating costs, a claim unsupported in academic research. Do systems achieve lower costs than freestanding facilities, and, if so, which system types? We test hypotheses about the relationship of cost with membership in systems, larger systems, and centralized and local hub-and-spoke systems. We also test whether these relationships have changed over time. Examining 4,000 U.S. hospitals during 1998 to 2010, we find no evidence that system members exhibit lower costs. However, members of smaller systems are lower cost than larger systems, and hospitals in centralized systems are lower cost than everyone else. There is no evidence that the system's spatial configuration is associated with cost, although national system hospitals exhibit higher costs. Finally, these results hold over time. We conclude that while systems in general may not be the solution to lower costs, some types of systems are.

Carey, K. (2015). "Measuring the hospital length of stay/readmission cost trade-off under a bundled payment mechanism." *Health Econ* 24(7): 790-802.

If patients are discharged from the hospital prematurely, many may need to return within a short period of time. This paper investigates the relationship between length of stay and readmission within 30 days of discharge from an acute care hospitalization. It applies a two-part model to data on Medicare patients treated for heart attack in New York state hospitals during 2008 to obtain the expected cost of readmission associated with length of stay. The expected cost of a readmission is compared with the marginal cost of an additional day in the initial stay to examine the cost trade-off between an extra day of care and the expected cost of readmission. The cost of an additional day of stay was offset by expected cost savings from an avoided readmission in the range of 15% to 65%. Results have implications for payment reform based on bundled payment reimbursement mechanisms. Copyright (c) 2014 John Wiley & Sons, Ltd.

Cram, P. (2015). "Assessing Hospital Productivity." *Health Affairs* 34(6): 1069.

Friese, C. R., et al. (2015). "Hospitals In 'Magnet' Program Show Better Patient Outcomes On Mortality Measures Compared To Non-'Magnet' Hospitals." *Health Affairs* 34(6): 986-992.

Hospital executives pursue external recognition to improve market share and demonstrate institutional commitment to quality of care. The Magnet Recognition Program of the American Nurses Credentialing Center identifies hospitals that epitomize nursing excellence, but it is not clear that receiving Magnet recognition improves patient outcomes. Using Medicare data on patients hospitalized for coronary artery bypass graft surgery, colectomy, or lower extremity bypass in 1998–2010, we compared rates of risk-adjusted thirty-day mortality and failure to rescue (death after a postoperative complication) between Magnet and non-Magnet hospitals matched on hospital characteristics. Surgical patients treated in Magnet hospitals, compared to those treated in non-Magnet hospitals, were 7.7 percent less likely to die within thirty days and 8.6 percent less likely to die after a postoperative complication. Across the thirteen-year study period, patient outcomes were significantly

better in Magnet hospitals than in non-Magnet hospitals. However, outcomes did not improve for hospitals after they received Magnet recognition, which suggests that the Magnet program recognizes existing excellence and does not lead to additional improvements in surgical outcomes.

Goldman, L. E., et al. (2015). "Effect of Present-on-Admission (POA) Reporting Accuracy on Hospital Performance Assessments Using Risk-Adjusted Mortality." *Health Serv Res* 50(3): 922-938.

OBJECTIVE: To evaluate how the accuracy of present-on-admission (POA) reporting affects hospital 30-day acute myocardial infarction (AMI) mortality assessments. **DATA SOURCES:** A total of 2005 California patient discharge data (PDD) and vital statistics death files. **STUDY DESIGN:** We compared hospital performance rankings using an established model assessing hospital performance for AMI with (1) a model incorporating POA indicators of whether a secondary condition was a comorbidity or a complication of care, and (2) a simulation analysis that factored POA indicator accuracy into the hospital performance assessment. For each simulation, we changed POA indicators for six major acute risk factors of AMI mortality. The probability of POA being changed depended on patient and hospital characteristics. **PRINCIPAL FINDINGS:** Comparing the performance rankings of 268 hospitals using the established model with that using the POA indicator, 67 hospitals' (25 percent) rank differed by ≥ 10 percent. POA reporting inaccuracy due to overreporting and underreporting had little additional impact; POA overreporting contributed to 4 percent of hospitals' difference in rank compared to the POA model and POA underreporting contributed to < 1 percent difference. **CONCLUSION:** Incorporating POA indicators into risk-adjusted models of AMI care has a substantial impact on hospital rankings of performance that is not primarily attributable to inaccuracy in POA hospital reporting.

Henke, R. M., et al. (2015). "Patient factors contributing to variation in same-hospital readmission rate." *Med Care Res Rev* 72(3): 338-358.

The Centers for Medicare & Medicaid Services Hospital Readmission Reduction Program and the Centers for Medicare & Medicaid Innovations Bundled Payments for Care Improvement Initiative hold hospitals accountable for readmissions that occur at other hospitals. A few studies have described the extent to which hospital readmissions occur at the original place of treatment (i.e., same-hospital readmissions). This study uses data from 16 states to describe variation in same-hospital readmissions by patient characteristics across multiple conditions. We found that the majority of 30-day readmissions occur at the same hospital, although rates varied considerably by condition. A significant number of hospitals had very low rates of same-hospital readmissions, meaning that the majority of their readmissions went to other hospitals. Future research should examine why some hospitals are able to retain patients for a same-hospital readmission and others are not.

Kilaru, A. S., et al. (2015). "Do hospital service areas and hospital referral regions define discrete health care populations?" *Med Care* 53(6): 510-516.

BACKGROUND: Effective measurement of health care quality, access, and cost for populations requires an accountable geographic unit. Although Hospital Service Areas (HSAs) and Hospital Referral Regions (HRRs) have been extensively used in health services research, it is unknown whether these units accurately describe patterns of hospital use for patients living within them. **OBJECTIVES:** To evaluate the ability of HSAs, HRRs, and counties to define discrete health care populations. **RESEARCH DESIGN:** Cross-sectional geographic analysis of hospital admissions. **SUBJECTS:** All hospital admissions during the year 2011 in Washington, Arizona, and Florida. **MEASURES:** The main outcomes of interest were 3 metrics that describe patient movement across HSA, HRR, and county boundaries: localization index, market share index, and net patient flow. Regression models tested the association of these metrics with

different HSA characteristics. RESULTS: For 45% of HSAs, fewer than half of the patients were admitted to hospitals located in their HSA of residence. For 16% of HSAs, more than half of the treated patients lived elsewhere. There was an equivalent degree of movement across county boundaries but less movement across HRR boundaries. Patients living in populous, urban HSAs with multiple, large, and teaching hospitals tended to remain for inpatient care. Patients admitted through the emergency department tended to receive care at local hospitals relative to other patients. CONCLUSIONS: HSAs and HRRs are geographic units commonly used in health services research yet vary in their ability to describe where patients receive hospital care. Geographic models may need to account for differences between emergent and nonemergent care.

Kim, Y. S., et al. (2015). "Medicare Payment Policy Creates Incentives For Long-Term Care Hospitals To Time Discharges For Maximum Reimbursement." *Health Affairs* 34(6): 907-915.

Long-term care hospitals are postacute care facilities for patients requiring extended hospital-level care. These facilities are reimbursed by Medicare under a prospective payment system with a short-stay outlier policy, which results in substantially lower payments for patients discharged before a diagnosis-related group-specific short-stay threshold. Using Medicare data, we examined the impact of the short-stay policy on lengths-of-stay and Medicare reimbursement among patients in long-term care hospitals who require prolonged mechanical ventilation. After accounting for case-mix and facility-level differences, we found that discharges for reasons other than death in the period 2005–10 were most likely to occur on the day of or immediately after the short-stay threshold; this held true regardless of facility ownership. In contrast, live discharges in 2002—the year before the prospective payment system started phasing out cost-based payment—were evenly distributed around the day that later became the short-stay threshold. Our findings confirm that the short-stay outlier payment policy created a strong financial incentive for long-term care hospitals to time patient discharges to maximize Medicare reimbursement. The results suggest that the new very-short-stay policy implemented in December 2012 could have a similar effect.

Moulin, S. and D. Leys (2015). "[Improvement of stroke management: The most important might still have to come]." *Presse Med* 44(5): 499-501.

Muller, R. W. and G. B. Kruse (2015). "Commentary on "is the system really the solution? Operating costs in hospital systems": limits to system efficiency in centralized hospital systems: illustration from the university of Pennsylvania health system." *Med Care Res Rev* 72(3): 273-276.

Romley, J. A., et al. (2015). "Hospital Productivity: The Authors Reply." *Health Affairs* 34(6): 1069.

Solberg, L. I. (2015). "Preventable hospital admissions: are they?" *Fam Pract* 32(3): 245-246.

Tefera, L., et al. (2015). "Medicare's Hospital Value-Based Purchasing Program." *Health Affairs* 34(6): 1070.

Inégalités de santé / Health Inequalities

Lee, S. Y., et al. (2014). "Unmet healthcare needs depending on employment status." *Health Policy*. [Epub ahead of print]

OBJECTIVES: The purpose of study is to find relevance between unmet healthcare needs and employment status and if factors have relevance to unmet healthcare needs due to "economic burden" and "no time to spare". **METHODS:** The study conducted a survey of 9163 respondents who said they needed a medical treatment or checkup were asked why the need for care was unmet. **RESULTS:** 22.9% of the respondents said they did not receive a medical treatment or checkup they needed at least once. The rate of unmet healthcare needs caused by "economic burden" was higher among temporary workers (ORs=2.13), day workers (ORs=1.92). However, the rate of unmet needs due to "no time to spare" was lower for temporary workers (ORs=.58) than for regular workers, studies (ORs=.33), housework (ORs=.26), early retirement (ORs=.19) and disease or injury (ORs=.07). **CONCLUSION:** Non-regular waged workers were more likely to have an unmet need for healthcare due to "economic burden" than regular waged workers. On the other hand, regular waged workers were less likely to receive necessary healthcare services due to "no time to spare" than non-regular waged workers and economically inactive people.

Kinge, J. M., et al. (2015). "Income related inequalities in avoidable mortality in Norway: A population-based study using data from 1994-2011." Health Policy. [Epub ahead of print]

OBJECTIVE: The aim of this study was to measure income-related inequalities in avoidable, amenable and preventable mortality in Norway over the period 1994-2011. **METHODS:** We undertook a register-based population study of Norwegian residents aged 18-65 years between 1994 and 2011, using data from the Norwegian Income Register and the Cause of Death Registry. Concentration indices were used to measure income-related inequalities in avoidable, amenable and preventable mortality for each year. We compared the trend in income-related inequality in avoidable mortality with the trend in income inequality, measured by the Gini coefficient for income. **RESULTS:** Avoidable, amenable and preventable deaths in Norway have declined over time. There were persistent pro-poor socioeconomic inequalities in avoidable, amenable and preventable mortality, and the degree of inequality was larger in preventable mortality than in amenable mortality throughout the period. The income-avoidable mortality association was positively correlated with income inequalities in avoidable mortality over time. There was little or no relationship between variations in the Gini coefficient due to tax reforms and socioeconomic inequalities in avoidable mortality. **CONCLUSIONS:** Income-related inequalities in avoidable, amenable and preventable mortality have remained relatively constant between 1994 and 2011 in Norway. They were mainly correlated with the relationship between income and avoidable mortality rather than with variations in the Gini coefficient of income inequality.

Maheswaran, H., et al. (2015). "Self-reported health and socio-economic inequalities in England, 1996-2009: Repeated national cross-sectional study." Social Science & Medicine 136-137(0): 135-146.

Tackling social inequalities in health has been a priority for recent UK governments. We used repeated national cross-sectional data for 155,311 participants (aged ≥ 16 years) in the Health Survey of England to examine trends in socio-economic inequalities in self-reported health over a recent period of sustained policy focus by successive UK governments aimed at tackling social inequalities in health. Socio-economic related inequalities in self-reported health were estimated using the Registrar General's occupational classification (1996-2009), and for sensitivity analyses, the National Statistics Socio-Economic Classification (NS-SEC; 2001-2011). Multi-level regression was used to evaluate time trends in General Health Questionnaire (GHQ-12) scores and bad or very bad self-assessed health (SAH), as well as EQ-5D utility scores. The study found that the probability of reporting GHQ-12 scores ≥ 4 and ≥ 1 was higher in those from lower social classes, and decreased for all social classes between 1997 and 2009. For SAH, the probability of reporting bad or very bad health remained

relatively constant for social class I (professional) [0.028 (95%CI: 0.026, 0.029) in 1996 compared to 0.028 (95%CI: 0.024, 0.032) in 2009], but increased in lower social classes, with the greatest increase observed amongst those in social class V (unskilled manual) [0.089 (95%CI: 0.085, 0.093) in 1996 compared to 0.155 (95%CI: 0.141, 0.168) in 2009]. EQ-5D utility scores were lower for those in lower social classes, but remained comparable across survey years. In sensitivity analyses using the NS-SEC, health outcomes improved from 2001 to 2011, with no evidence of widening socio-economic inequalities. Our findings suggest that socio-economic inequalities have persisted, with evidence of widening for some adverse self-reported health outcomes.

Maynou, L., et al. (2015). "Health inequalities in the European Union: an empirical analysis of the dynamics of regional differences." *Eur J Health Econ* 16(5): 543-559.

In a panel setting, we analyse the speed of (beta) convergence of (cause-specific) mortality and life expectancy at birth in EU countries between 1995 and 2009. Our contribution is threefold. First, in contrast to earlier literature, we allow the convergence rate to vary, and thereby uncover significant differences in the speed of convergence across time and regions. Second, we control for spatial correlations across regions. Third, we estimate convergence among regions, rather than countries, and thereby highlight noteworthy variations within a country. Although we find (beta) convergence on average, we also identify significant differences in the catching-up process across both time and regions. Moreover, we use the coefficient of variation to measure the dynamics of dispersion levels of mortality and life expectancy (sigma convergence) and, surprisingly, find no reduction, on average, in dispersion levels. Consequently, if the reduction of dispersion is the ultimate measure of convergence, then, to the best of our knowledge, our study is the first that shows a lack of convergence in health across EU regions.

Taha, N., et al. (2015). "How portable is social security for migrant workers? A review of the literature." *International Social Security Review* 68(1): 95-118.

This article reviews the recent literature on existing mechanisms that allow for the portability of social security entitlements for migrant workers and finds that North–North migrants have the best access to portability. There is limited coordination between origin and destination countries regarding the portability of social entitlements of South–North migrants. These migrants are dealing with discourses and policies that treat them as second class citizens, even as they are providing much-needed labour to their host countries. South–South migrants are seeing new regional mechanisms addressing portability. However, many of the impacts of these mechanisms are not yet known. Other knowledge gaps on portability relate to internal and South–South migration, the role of gender and other social identities, migrants' occupations as well as their legal immigration status.

Quel est le degré de transférabilité des droits des travailleurs migrants en matière de sécurité sociale? Une analyse bibliographique Cet article passe en revue les études récentes sur les mécanismes existants qui permettent la transférabilité des droits des travailleurs migrants en matière de sécurité sociale. Il montre que les migrants Nord-Nord sont ceux qui bénéficient du meilleur accès à la transférabilité de leurs droits. En ce qui concerne les migrants Sud-Nord, la coordination entre pays d'origine et pays d'accueil est limitée dans le domaine de la transférabilité de leurs droits sociaux. Ces migrants font face à des discours et des politiques qui les traitent comme des citoyens de second rang, alors même qu'ils fournissent aux pays d'accueil une main d'œuvre dont ils grand besoin. Quant aux migrants Sud-Sud, ils voient émerger de nouveaux mécanismes régionaux qui tiennent compte de la transférabilité de leurs droits, mais l'impact de ces mécanismes est encore largement méconnu. Le déficit de connaissances sur la transférabilité des droits des migrants en matière de sécurité sociale concerne également les migrations internes et les migrations Sud-Sud, le rôle du genre et des

autres éléments constitutifs de l'identité sociale, la nature des emplois occupés par les migrants, ainsi que les spécificités de leur statut juridique au regard de l'immigration.

Médicaments / Pharmaceuticals

Aaltonen, K., et al. (2015). "Cost-related barriers to use of health services and prescription medicines in Finland: a cross-sectional survey." *Eur J Public Health* 25(3): 368-372.

BACKGROUND: The objective was to examine cost-related barriers to using health services and prescription medicines in Finland. METHODS: A survey that examined adults' experiences of and opinions about the social security system was mailed to a random population-based sample of 5000 Finns aged 18-74 years. The survey assessed households' cost-related barriers to use of health services, prescription medicines and social assistance in the past year. The responses were adjusted for sociodemographic and health predictors by weighting and logistic regression. RESULTS: Responses were received from 1770 households. In total, 18% had experienced at least one cost-related barrier; 11% did not fill a prescription, 8% did not go to hospital and 13% went without another form of treatment. Of respondents diagnosed with a disabling illness or impairment, 32% reported at least one cost-related barrier. Households with below-average income reported barriers twice as often as above-average income households, after adjusting for age and health. Lower income [lowest tertile, odds ratio (OR) 5.0 compared with highest tertile], fair/poor self-assessed health (fair/poor OR 7.1 compared with very good/good), younger age (18-34 years OR 3.8 compared with 65-74 years), lower education (primary OR 1.6 compared with tertiary) and female gender (OR 1.4) were significantly associated with more frequent cost-related barriers. Overall, 34% of households who encountered cost-related barriers had applied for and 17% had received social assistance. CONCLUSIONS: Cost-related barriers were common among respondents with low income and/or poor health. These barriers may thus have a role in creating inequities in access to health care in Finland.

Augustin, J., et al. (2015). "A regional analysis of outpatient antibiotic prescribing in Germany in 2010." *Eur J Public Health* 25(3): 397-399.

The aim of this study was to investigate whether the previously reported regional variation in outpatient antimicrobial use density in Germany has persisted or changed over time and has been similar for both children and adults. Antibiotic [at least 1 Anatomical Therapeutic Chemical (ATC) Code 'J01' drug] prescription prevalence data for the year 2010 were analysed for 17 regions. The overall age-standardized antibiotic prescription prevalence ranged between 25.0 and 36.6% in the different regions. Regional prescription patterns for children differed from those seen in adults. Age-specific differences in antibiotic prescription prevalence need to be considered when comparing antibiotic consumption between regions.

Jodar-Sanchez, F., et al. (2015). "Cost-Utility Analysis of a Medication Review with Follow-Up Service for Older Adults with Polypharmacy in Community Pharmacies in Spain: The conSIGUE Program." *Pharmacoeconomics* 33(6): 599-610.

BACKGROUND: The concept of pharmaceutical care is operationalized through pharmaceutical professional services, which are patient-oriented to optimize their pharmacotherapy and to improve clinical outcomes. OBJECTIVE: The objective of this study was to estimate the incremental cost-effectiveness ratio (ICER) of a medication review with follow-up (MRF) service for older adults with polypharmacy in Spanish community pharmacies against the alternative of having their medication dispensed normally.

METHODS: The study was designed as a cluster randomized controlled trial, and was carried out over a time horizon of 6 months. The target population was older adults with polypharmacy, defined as individuals taking five or more medicines per day. The study was conducted in 178 community pharmacies in Spain. Cost-utility analysis adopted a health service perspective. Costs were in euros at 2014 prices and the effectiveness of the intervention was estimated as quality-adjusted life-years (QALYs). In order to analyze the uncertainty of ICER results, we performed a non-parametric bootstrapping with 5000 replications. **RESULTS:** A total of 1403 older adults, aged between 65 and 94 years, were enrolled in the study: 688 in the intervention group (IG) and 715 in the control group (CG). By the end of the follow-up, both groups had reduced the mean number of prescribed medications they took, although this reduction was greater in the IG (0.28 +/- 1.25 drugs; $p < 0.001$) than in the CG (0.07 +/- 0.95 drugs; $p = 0.063$). Older adults in the IG saw their quality of life improved by 0.0528 +/- 0.20 ($p < 0.001$). In contrast, the CG experienced a slight reduction in their quality of life: 0.0022 +/- 0.24 ($p = 0.815$). The mean total cost was <euro>977.57 +/- 1455.88 for the IG and <euro>1173.44 +/- 3671.65 for the CG. In order to estimate the ICER, we used the costs adjusted for baseline medications and QALYs adjusted for baseline utility score, resulting in a mean incremental total cost of <euro>250.51 +/- 148.61 (95 % CI -541.79 to 40.76) and a mean incremental QALY of 0.0156 +/- 0.004 (95 % CI 0.008-0.023). Regarding the results from the cost-utility analysis, the MRF service emerged as the dominant strategy. **CONCLUSION:** The MRF service is an effective intervention for optimizing prescribed medication and improving quality of life in older adults with polypharmacy in community pharmacies. The results from the cost-utility analysis suggest that the MRF service is cost effective.

Kuschel, B. M., et al. (2015). "The risk of fall injury in relation to commonly prescribed medications among older people-a Swedish case-control study." *Eur J Public Health* 25(3): 527-532.

BACKGROUND: Older people not only consume more medication but they also represent a group at high risk for adverse effects such as injurious falls. This study examines the association between the medications most commonly prescribed to older people in Sweden and fall injuries. **METHODS:** This is a population-based, matched, case-control study of 64 399 persons aged ≥ 65 years in Sweden admitted to hospital because of a fall injury between March 2006 and December 2009, and four controls per case matched by gender, date of birth and place of residence. The prevalence of the 20 most commonly prescribed medications was compiled for the 30-day period before the index date. The association between those medications and injurious falls was estimated with odds ratios and corresponding 95% confidence intervals using conditional logistic regression. **RESULTS:** Ten of the top 20 most commonly prescribed medications, and in particular the three medications affecting the central nervous system (CNS), significantly increased the risk of fall injuries (highest for opioids and antidepressants) but not the seven cardiovascular ones, who had a protective effect (lowest for angiotensin converting enzyme inhibitors and selective calcium channel blockers). **CONCLUSIONS:** The adverse effect of several commonly prescribed medications may seriously threaten their positive effects on the well-being and quality of life of older people. Their association with injurious falls is of particular concern as falls are prevalent and often leading to severe consequences. This needs to be acknowledged so physicians and patients can make informed decisions when prescribing and using them.

Weber, K., et al. (2015). "[Mapping of risks related to medication care in nursing homes: An overview in Alsace - France]." *Rev Epidemiol Santé Publique* 63(3): 163-172.

BACKGROUND: Medication care of patients in nursing homes involves a complex circuit whose related risks need to be identified. The aim of this study was first to map risks related to medication care in a representative panel of nursing homes under contract with

community pharmacies in Alsace, then to propose improvement action plans to remedy the weaknesses identified. **METHODS:** This study was conducted on a representative sample of 23 nursing homes in Alsace in 2014. A self-assessment questionnaire (Interdiag EHPAD), divided into 7 fields and made up of 198 questions, was completed by each of the 23 nursing homes during multidisciplinary meetings that were organized by the OMEDIT (Observatoire du médicament, des dispositifs médicaux et de l'innovation thérapeutique of Alsace). The percentages of controlled risks were calculated for each of the 7 fields of the medication circuit, both at nursing home and regional levels. Similarly, the percentages of non-controlled risks were calculated for each of the 198 items. **RESULTS:** Considering the 7 fields, regional percentages of controlled risks varied from 63% to 85%. The field relative to drug supply was the best controlled, while that relative to prevention was the least controlled. Considering the 198 items, 30 important vulnerability points were identified, among which stand out: failure to report and to analyze adverse drug events, lack of involvement of general practitioner in nursing homes through collaborative approaches and transcription by nurse staff of oral or handwritten prescriptions in medical software. The analysis of those items led to the proposal of 13 improvement actions. **CONCLUSION:** The study pointed out mainly difficulties linked to the absence of suitable risk management policies and the lack of adjustment between nursing home staffs and general practitioners. In contrast, it revealed that the collaboration between nursing homes and community pharmacies was successful overall. Finally, we hope that this multi-center study, that led to identify concrete proposals, will help nursing homes to improve the quality of medication care for their residents.

Politique de santé / Health Policy

Haeder, S. F. and D. L. Weimer (2015). "You Can't Make Me Do It, but I Could Be Persuaded: A Federalism Perspective on the Affordable Care Act." *J Health Polit Policy Law* 40(2): 281-323.

The Affordable Care Act (ACA) seeks to change fundamentally the US health care system. The responses of states have been diverse and changing. What explains these diverse and dynamic responses? We examine the decision making of states concerning the creation of Pre-existing Condition Insurance Plan programs and insurance marketplaces and the expansion of Medicaid in historical context. This frames our analysis and its implications for future health reform in broader perspective by identifying a number of characteristics of state-federal grants programs: (1) slow and uneven implementation; (2) wide variation across states; (3) accommodation by the federal government; (4) ideological conflict; (5) state response to incentives; (6) incomplete take-up rates of eligible individuals; and (7) programs as stepping-stones and wedges. Assessing the implementation of the three main components of the ACA, we find that partisanship exerts significant influence, yet less so in the case of Medicaid expansion. Moreover, factors specific to the insurance market also play an important role. Finally, we conclude by applying the themes to the ACA and offer an outlook for its continuing implementation. Specifically, we expect a gradual move toward universal state participation in the ACA, especially with respect to Medicaid expansion.

Ongaro, E., et al. (2015). "The fiscal crisis in the health sector: Patterns of cutback management across Europe." *Health Policy*. [Epub ahead of print]

PURPOSE: The article investigates trends in health sector cutback management strategies occurred during the ongoing financial and fiscal crisis across Europe. **SETTING:** A European-wide survey to top public healthcare managers was conducted in ten different countries to

understand their perception about public sector policy reactions to the financial and economic crisis; answers from 760 respondents from the healthcare sector (30.7% response rate) were analyzed. METHOD: A multinomial logistic regression was used to assess the characteristics of respondents, countries' institutional healthcare models and the trend in public health resources availability during the crisis associated to the decision to introduce unselective cuts, targeted cuts or efficiency savings measures. RESULTS: Differentiated responses to the fiscal crisis that buffeted public finances were reported both across and within countries. Organizational position of respondents is significant in explaining the perceived cutback management approach introduced, where decentralized positions detect a higher use of linear cuts compared to their colleagues working in central level organizations. Compared to Bismark-like systems Beveridge-like ones favour the introduction of targeted cuts. Postponing the implementation of new programmes and containing expenses through instruments like pay freezes are some of the most popular responses adopted, while outright staff layoffs or reduction of frontline services have been more selectively employed. CONCLUSION: To cope with the effects of the fiscal crisis healthcare systems are undergoing important changes, possibly also affecting the scope of universal coverage.

Schwettmann, L. (2015). "Decision solution, data manipulation and trust: The (un-)willingness to donate organs in Germany in critical times." *Health Policy*. [Epub ahead of print]

In 2011 and 2012 a change of rules and a data-manipulation scandal focused German public attention on organ donation. This increased citizens' background knowledge as well as their willingness to respond to surveys. The present study is an effort to seize this research opportunity and to create evidence on which policy recommendations can be conceivably based. It uses data from two major representative surveys from 2011 to 2012 to address four central questions: Which characteristics, experiences and attitudes correlate with the written or unwritten willingness of individuals to donate (WTD) their own organs post-mortem? How has the WTD changed over time? To what extent does the WTD depend on normative trust? Which factors correlate with trust? The data is analyzed through summary statistics and regression models. Several hypotheses regarding factors connected with the WTD are confirmed in the survey results. Altruistic motives, relevant knowledge and trust are decisive. The special role of trust is corroborated by the data. As current German politics prevents the introduction of post-mortem donation incentives, potential policy making proposals are restricted to institutional changes to regain trust including the implementation of an organ donor registry and the advancement of counselling talks with general practitioners.

Tapia Granados, J. A. and J. M. Rodriguez (2015). "Health, economic crisis, and austerity: A comparison of Greece, Finland and Iceland." *Health Policy* [Epub ahead of print].

Reports have attributed a public health tragedy in Greece to the Great Recession and the subsequent application of austerity programs. It is also claimed that the comparison of Greece with Iceland and Finland-where austerity policies were not applied-reveals the harmful effect of austerity on health and that by protecting spending in health and social budgets, governments can offset the harmful effects of economic crises on health. We use data on life expectancy, mortality rates, incidence of infectious diseases, rates of vaccination, self-reported health and other measures to examine the evolution of population health and health services performance in Greece, Finland and Iceland since 1990-2011 or 2012-the most recent years for which data are available. We find that in the three countries most indicators of population health continued improving after the Great Recession started. In terms of population health and performance of the health care system, in the period after 2007 for which data are available, Greece did as good as Iceland and Finland. The evidence does not support the claim that there is a health crisis in Greece. On the basis of the extant

evidence, claims of a public health tragedy in Greece seem overly exaggerated.

Prévention / Prévention

Bussiere, C., et al. (2015). "Screening for cervical cancer: What are the determinants among adults with disabilities living in institutions? Findings from a National Survey in France." *Health Policy* : 19 (6) : 794-801.

OBJECTIVES: To explore the rate and determinants of the likelihood of cervical cancer screening participation among disabled women living in institutions in France. **METHODS:** The data source was the French national Health and Disability Survey-Institutions Section, 2009. Disability severity was assessed by scoring mobility and cognitive limitations. Chi-square tests revealed the significant factors associated with the screening rates; these factors were used in a multivariate logistic regression of Pap-test use within the 3 years prior to the interview (n=1052, women aged 20-65 years living in institutions for disabled adults). **RESULTS:** The cervical cancer screening rate was particularly low in this population. After adjusting for all other covariates, women with more severe degrees of mobility or cognitive limitations had a lower likelihood of receiving a Pap test. Our findings also showed that being socially isolated, illiterate or underweight significantly decreased screening participation. **CONCLUSION:** Even in institutions, disability severity remains a barrier to cancer screening. Given the increasing prevalence of disabling conditions and cancers, and the lack of previous studies on this specific topic, our findings are highly important from a policy point of view. These findings should alert health authorities to increase their efforts to provide medical care for institutionalized people with disabilities.

Prévision – Evaluation / Prevision - Evaluation

Beijersbergen, M. D., et al. (2015). "Psychometric properties of the consumer quality index to assess shelter and community care services." *Eur J Public Health* 25(3): 378-384.

BACKGROUND: Our aim was to design a valid and reliable consumer quality index (CQI) specifically suited to assess the experiences that homeless people, homeless youth, and abused women have with shelter and community care services. **METHODS:** A pilot CQI questionnaire was constructed on the basis of literature study, focus group discussions with clients, concept mapping by clients and shelter workers, and a pre-pilot study. The pilot questionnaire was completed by 762 clients using shelter facilities for homeless people, homeless youth or abused women. Psychometric and multilevel analyses were performed to optimize the instrument and determine its validity, reliability and discriminative power. **RESULTS:** The preparatory research had revealed seven primary focus topics, all of which were incorporated into the pilot questionnaire. Psychometric analyses resulted in four reliable scales, one of which applied only to clients in residential, day or night shelter programs. The final instrument consisted of 42 items for community care clients and 52 for clients using residential facilities, and day and night shelters; 32 and 42 such items pertained to client experiences. **CONCLUSION:** The consumer quality index for shelter and community care services (CQI-SCCS) is a valid, reliable instrument for assessing the quality of these services. It provides guidance to facilities in quality maintenance and improvement, and it is useful in determining quality differences in facilities for homeless people and homeless youth.

Bernard, P. (2014). "[The effectiveness and lessons learned from UK exercise referral systems]." Santé Publique 26(5): 647-654.

INTRODUCTION: UK Exercise Referral Systems (ERS) have been developed to encourage physical activity in the general population. This systematic review investigated the effectiveness and cost-effectiveness of ERS. Identification of factors influencing ERS uptake, adherence and success were also investigated. METHODS: Studies were identified from Medline, Cochrane and Pascal and bibliographies of relevant papers. Interventions providing access to ERS (randomized controlled trials or controlled trials), experimental or qualitative studies, and meta-analyses were included. RESULTS: Twenty six studies met the inclusion criteria. Compared with usual care, ERS showed an increased number of participants who achieved 90-150 minutes of physical activity of at least moderate intensity per week. However, no significant difference in long-term outcomes (e.g., quality of life, body mass index, glycated haemoglobin, anxiety) were identified between ERS and comparator groups. Cost-effectiveness analysis suggested that ERS were more cost-effective for participants with co-morbid medical conditions. A higher adherence rate was associated with better effectiveness of ERS. DISCUSSION: Limited evidence supports the efficacy of ERS to increase physical activity or improve health outcomes. This evidence-based analysis could support the development of effective ERS in France.

Husereau, D., et al. (2015). "How do economic evaluations inform health policy decisions for treatment and prevention in Canada and the United States?" Appl Health Econ Health Policy 13(3): 273-279.

Canadian and US health systems have often been characterized as having vastly different approaches to the financing and delivery of healthcare, with Canada portrayed as more reliant on rationing based on costs. In this article, we examine the similarities and differences between the two countries, the evolution and current role of health economic evaluation, and the roles played by health economists. We suggest both countries have similarly used economic evaluation to a limited extent for drug and immunization decisions, with variability in use more of a reflection of the incompleteness of both systems and their inherent institutional barriers rather than political ideology.

Soins de santé primaire / Primary Health Care

Routelous C. ; Lapointe L. ; Wedel I. (2015). "Le rôle des passeurs de frontières dans la mise en place de collaboration pluridisciplinaire en médecine. ." Journal de Gestion et d'Economie Médicales 32(7-8): 481-499.

Abrahamsson, B., et al. (2015). "To recommend the local primary health-care centre or not: what importance do patients attach to initial contact quality, staff continuity and responsive staff encounters?" International Journal of Quality in Health Care 27 (3) : 196-200

Objective This study aims to examine the circumstances associated with patients' tendencies to recommend a primary care centre, based on four hypotheses, the initial contact's quality, care relationship continuity, treatment encounter responsiveness and whether the significance of encounter responsiveness differs depending on whether the patient has been seeing a nurse or physician. Design The study is based on the patient' self-reported responses, retrieved from the Swedish National Patient Survey. The design is cross-sectional,

and data were analysed using a binary logistic regression. Setting Data were collected from three primary healthcare centres in the region of Västra Götaland, Sweden. Participants A total of 362 patients (62% females) having visited any of three publicly run healthcare centres in September 2010 constitute the analytical sample. Participants were fairly evenly distributed across all age groups. Main Outcome Measures Recommendation was captured by patients' binary responses to the question: Would you recommend the visited primary healthcare centre? Results The hypotheses involving initial contact quality, care relationship continuity and treatment encounter responsiveness were supported by the analyses. The latter was strongly associated with patient tendency to recommend the primary healthcare centre. However, the profession (nurse or physician) involved in the treatment encounter made no difference for the predictive significance of encounter responsiveness for a patient's tendency to recommend the healthcare centre. Conclusions Striving for stable and responsive patient/staff relationships and an open approach towards patients are potentially successful strategies for primary healthcare centres seeking to attract new patients and maintain current ones.

Carryer, J. and J. Yarwood "The nurse practitioner role: Solution or servant in improving primary health care service delivery." Collegian 22(2): 169-174.

In New Zealand, as in many other countries, the demand for health services is escalating as chronic disease, population ageing and health disparities increase. It has been argued that a more comprehensive primary health care approach is needed combining biomedical approaches with a social determinants and social justice based approach. The contemporary development of the nurse practitioner (NP) role in New Zealand (NZ) offers the possibility of taking up a more critical approach to strengthen and extend primary health care services (PHC). Nurse practitioners could simply be utilised to shore up the nature and style of existing primary care (PC) service configurations or, more usefully, they could lead a revolution in traditional approaches towards genuine primary health care delivery.

Glied, S. A., et al. (2015). "Understanding Pay Differentials Among Health Professionals, Nonprofessionals, And Their Counterparts In Other Sectors." Health Affairs 34(6): 929-935.

About half of the \$2.1 trillion of US health services spending constitutes compensation to employees. We examined how the wages paid to health-sector employees compared to those paid to workers with similar qualifications in other sectors. Overall, we found that health care workers are paid only slightly more than workers elsewhere in the US economy, but the patterns are starkly different for nonprofessional and professional employees. Nonprofessional health care workers earn slightly less than their counterparts elsewhere in the economy. By contrast, the average nurse earns about 40 percent more than the median comparable worker in a different sector. The average physician earns about 50 percent more than a comparable worker in another sector of the economy, and this differential has increased sharply since 1993. Cost containment is likely to lead to reductions in the earnings of health care professionals, but it will also require using fewer or less skilled employees to produce a given service.

Kert, S., et al. (2015). "A cross-sectional study of socio-demographic factors associated with patient access to primary care in Slovenia." Int J Equity Health 14(1): 39.

INTRODUCTION: Primary care (PC) is the provision of universally accessible, integrated, person-centred, comprehensive health and community services. Professionals active in primary care teams include family physicians and general practitioners (FP/GPs). There is concern in Slovenia that the current economic crisis might change the nature of PC services. Access, one of the most basic requirements of general practice, is universal in Slovenia, which is one of the smallest European countries; under national law, compulsory health

insurance is mandatory for its citizens. Our study examined access to PC in Slovenia during a time of economic crisis as experienced and perceived by patients between 2011 and 2012, and investigated socio-demographic factors affecting access to PC in Slovenia. METHODS: Data were collected as a part of a larger international study entitled Quality and Costs of Primary Care in Europe (QUALICOPC) that took place during a period of eight months in 2011 and 2012. 219 general practices were included; in each, the aim was to evaluate 10 patients. Dependent variables covered five aspects of access to PC: communicational, cultural, financial, geographical and organizational. 15 socio-demographic factors were investigated as independent variables. Descriptive statistics, factor analysis and multilevel analysis were applied. RESULTS: There were 1,962 patients in the final sample, with a response rate of 89.6%. The factors with the most positive effect on access to PC were financial and cultural; the most negative effects were caused by organizational problems. Financial difficulties were not a significant socio-demographic factor. Greater frequency of visits improves patients' perception of communicational and cultural access. Deteriorating health conditions are expected to lower perceived geographical access. Patients born outside Slovenia perceived better organizational access than patients born in Slovenia. CONCLUSIONS: Universal medical insurance in Slovenia protects most patients from PC inaccessibility. However, problems perceived by patients may indicate the need for changes in the organization of PC.

Kralewski, J., et al. (2015). "The relationships of physician practice characteristics to quality of care and costs." Health Serv Res 50(3): 710-729.

BACKGROUND: Medical group practices are central to many of the proposals for health care reform, but little is known about the relationship between practice-level characteristics and the quality and cost of care. METHODS: Practice characteristics from a 2009 national survey of 211 group practices were linked to Medicare claims data for beneficiaries attributed to the practices. Multivariate regression was used to examine the relationship between practice characteristics and claims-computable measures of screening and monitoring, avoidable utilization, risk-adjusted per-beneficiary per-year (PBPY) costs, and the practice's net revenue. RESULTS: Several characteristics of group practices are predictive of screening and monitoring measures. Those measures, in turn, are predictive of lower values of avoidable utilization measures that contribute to higher PBPY costs. The effects of group practice characteristics on avoidable utilization, cost, and practice net revenue appear to work primarily through improved screening and monitoring. CONCLUSIONS: Practice characteristics influence costs indirectly through a set of statistically significant relationships among screening and monitoring measures and avoidable utilization. However, these relationships are not the only pathways connecting practice characteristics to cost and those additional pathways contain substantial "noise" adding uncertainty to the estimated direct effects. Some of the attributes thought to be important characteristics of accountable care organizations and medical homes appear to be associated with lower quality and no improvement in cost.

McMorrow, S., et al. (2015). "Primary Care Providers Ordered Fewer Preventive Services For Women With Medicaid Than For Women With Private Coverage." Health Affairs 34(6): 1001-1009.

As the number of beneficiaries in the Medicaid program grows under the Affordable Care Act, with over half of the states opting to expand Medicaid eligibility, it is important to understand more about the care provided to Medicaid patients. Using visit-level data for 2006–10 from the National Ambulatory Medical Care Survey, we examined the provision of recommended preventive services to women with Medicaid and those with private insurance at visits to primary care providers in private office-based practices. We found that after patient and provider characteristics were controlled for, Medicaid-insured visits were less

likely than privately insured visits to include several preventive services, including clinical breast exams and Pap tests. The differences in provision of services by payer were generally driven by the differences in care at visits classified as preventive and at visits to obstetrician-gynecologists. Further investigation is required to determine what may be driving the differences in content of care across payers and their implications for quality of care.

Merilind, E., et al. (2015). "The influence of performance-based payment on childhood immunisation coverage." *Health Policy*.

BACKGROUND: Pay-for-performance, also called the quality system (QS) in Estonia, was implemented in 2006 and one indicator for achievement is the childhood immunisation coverage rate. The WHO vaccination coverage in Europe for diphtheria, tetanus and pertussis, and measles in children aged around one year old should meet or exceed 90 per cent. **METHODS:** The study was conducted using a database from the Estonian Health Insurance Fund. The study compared childhood immunisation coverage rates of all Estonian family physicians in two groups, joined and not joined to the quality system during the observation period 2006-2012. Immunisation coverage was calculated as the percentage of persons in the target age group who received a vaccine dose by a given age. The target level of immunisations in Estonia is set at 90 per cent and higher. **RESULTS:** Immunisation coverage rates of family doctors (FD) in Estonia showed significant differences between two groups of doctors: joined to the quality system and not joined. Doctors joined to the quality system met the 90 per cent vaccination criterion more frequently compared to doctors not joined to the quality system. Doctors not joined to the quality system were below the 90 per cent vaccination criterion in all vaccinations listed in the Estonian State Immunisation Schedule. **CONCLUSION:** Pay-for-performance as a financial incentive encourages higher levels of childhood immunisations.

Solorio, R., et al. (2015). "Impact of a chronic care coordinator intervention on diabetes quality of care in a community health center." *Health Serv Res* 50(3): 730-749.

PURPOSE: To evaluate the impact of a clinic-based chronic care coordinator (CCC) intervention on quality of diabetes care, health outcomes and health service utilization within six community health centers serving predominantly low-income Hispanic and non-Hispanic white patients. **METHODS:** We used a retrospective cohort study design with a 12-month pre- and 12-month postintervention analysis to evaluate the effect of the CCC intervention and examined: (1) the frequency of testing for glycosylated hemoglobin (HbA1C), cholesterol LDL level, and microalbumin screen and frequency of retinal and foot exam; (2) outcomes for HbA1C levels, lipid, and blood pressure control; and (3) health care service utilization. Patients with diabetes who received the CCC intervention (n = 329) were compared to a propensity score adjusted control group who are not exposed to the CCC intervention (n = 329). All of the data came from Electronic Medical Record. Four separate sets of analyses were conducted to demonstrate the effect of propensity score matching on results. **RESULTS:** The CCC intervention led to improvements in process measures, including more laboratory checks for HbA1C levels, microalbuminuria screens, retinal and foot exams and also increased primary care visits. However, the intervention did not improve metabolic control. **CONCLUSIONS:** CCC interventions offer promise in improving process measures within community health centers but need to be modified to improve metabolic control.

Stuart, M. and M. Weinrich (2004). "Integrated health system for chronic disease management: lessons learned from France." *Chest* 125(2): 695-703.

Rated number one in overall health system performance by the World Health Organization, the French spend less than half the amount on annual health care per capita that the United States spends. One contributing factor may be the attention given to chronic care. Since the

mid-1900s, the French have developed regional community-based specialty systems for patients with chronic respiratory insufficiency or failure. COPD is the major cause of respiratory failure, the fourth leading cause of death in the United States, and its prevalence is increasing. Despite the clinical success of home mechanical ventilation and the potential for cost savings, providing such services in the United States remains a challenge. Lessons from France can inform the development of cost-effective chronic care models in the United States. In this article, we review the French experience in the context of the United States Supreme Court's *Olmstead* decision, mandating that people in "more restrictive settings" such as nursing homes be offered community-based supports. We suggest that regional demonstration projects for patients with chronic respiratory failure or insufficiency can provide an important step in the development of effective chronic care systems in the United States.

Traynor, M., et al. (2015). "Occupational closure in nursing work reconsidered: UK health care support workers and assistant practitioners: A focus group study." *Social Science & Medicine* 136–137(0): 81-88.

In healthcare, occupational groups have adopted tactics to maintain autonomy and control over their areas of work. Witz described a credentialist approach to occupational closure adopted by nursing in the United Kingdom during the 19th and early 20th centuries. However, the recent advancement of assistant, 'non-qualified' workers by governments and managers forms part of a reconfiguration of traditional professional work. This research used focus groups with three cohorts of healthcare support workers undertaking assistant practitioner training at a London university from 2011 to 13 (6 groups, n = 59). The aim was to examine how these workers positioned themselves as professionals and accounted for professional boundaries. A thematic analysis revealed a complex situation in which participants were divided between articulating an acceptance of a subordinate role within traditional occupational boundaries and a usurpatory stance towards these boundaries. Participants had usually been handpicked by managers and some were ambitious and confident in their abilities. Many aspired to train to be nurses claiming that they will gain recognition that they do not currently get but which they deserve. Their scope of practice is based upon their managers' or supervisors' perception of their individual aptitude rather than on a credentialist claim. They 'usurp' nurses' claim to be the healthcare worker with privileged access to patients, saying they have taken over what nursing has considered its core work, while nurses abandon it for largely administrative roles. We conclude that the participants are the not unwilling agents of a managerially led project to reshape the workforce that cuts across existing occupational boundaries.

Systèmes de santé / Health Systems

Angus, H. and A. Greenberg (2014). "Can better care for complex patients transform the health system?" *Healthc Pap* 14(2): 9-19.

The idea that a health system can recover significant value by focusing on better care management for a relatively small cohort of high needs patients has taken flight. Given a poor fiscal outlook, and anticipating the growing number of people who will come to rely on the healthcare delivery system, health system leaders are keen to seize opportunities to find greater value within the existing health system investment. This paper discusses what it means to be a so-called "high cost user," and how health systems have approached improving care and services for this population. It also describes Ontario's particular

experience in launching the Health Links initiative as a "ground game" for health system transformation.

Bevan, G. (2015). "Incentives and models of governance." *Health Econ Policy Law* **10**(3): 345-350.

This short commentary on Oliver's review of incentives relates that review to four models of governance: Trust and Altruism (T&A), Choice and Competition (C&C), Naming and Shaming (N&S) and Targets and Terror (T&T).

Doran, T. (2015). "Incentivising improvements in health care delivery: a response to Adam Oliver." *Health Econ Policy Law* **10**(3): 351-356.

Financial and reputational incentives are increasingly common components in strategies to performance manage the medical profession. Judging the impacts of incentives is challenging, however, and the science of framework design remains in its infancy. Oliver's taxonomy therefore offers a useful and timely guide to the approaches that are most likely to be successful (and unsuccessful) in the field of health care. The use of incentives to date has focused on process measures and a narrow range of outcomes, a pragmatic approach that has produced some substantial quality gains within the constraints of existing health care systems. Improvement of specific technical aspects of quality may, however, have been achieved at the expense of trust, cooperation and benevolence. Deficits in these indispensable virtues will undermine any attempt to performance manage the medical and allied professions.

Gok, M. S. and E. Altindag (2015). "Analysis of the cost and efficiency relationship: experience in the Turkish pay for performance system." *Eur J Health Econ* **16**(5): 459-469.

This paper analyzes the effects of the pay for performance (PFP) system on the efficiencies of public and private hospitals in Turkey. In order to evaluate these effects, we examine the relationship between hospital efficiency and health care costs in Turkey, and address the impact of the PFP system on the efficiencies of public and private hospitals. In an effort to analyze the efficiencies of public and private hospitals, this study uses data envelopment analysis. The Malmquist Productivity Index is also used to analyze the patterns of efficiency change for the study years from 2001 to 2008. This study shows that health care costs and hospital efficiency are negatively correlated for private hospitals, while they are positively correlated for public hospitals. In other words, increased health care costs might reduce efficiency in private hospitals in contrast to public hospitals. Our findings also indicate that average efficiencies of public hospitals tend to increase, particularly during the implementation period of PFP system. The efficiency trend of private hospitals, conversely, decreased in the latter periods of the PFP system. Suggestions for improvement are provided to the health care policy makers regarding the impact of health care reforms on public and private hospitals.

Oliver, A. (2015). "Incentivising improvements in health care delivery." *Health Econ Policy Law* **10**(3): 327-343.

This Special Section of Health Economics, Policy and Law begins with an article on the different ways in which one might incentivise improved performance among health care providers. I asked five experts on performance management, Gwyn Bevan, Tim Doran, Peter Smith, Sandra Tanenbaum and Karsten Vrangbaek, to write brief reactions to the article and to the notion of performance management in health care in general. The commentators were given an open remit to be as critical as they wished to be, and their reactions can be found in the pages that follow. I would like to thank Albert Weale for reviewing all of the articles, and Katie Brennan for serving as the catalyst for this collection.

Pichlhofer, O. and M. Maier (2015). "Unregulated access to health-care services is associated with overutilization-lessons from Austria." *Eur J Public Health* 25(3): 401-403.

The Austrian health-care system is characterized by free provider choice and uncontrolled access to all levels of care. Using primary data, the ECOHCARE study shows that hospitalization rates for the secondary and tertiary care levels in Austria are both 4.4 times higher than those reported from the USA using a similar methodology. At the same time, essential functions of the primary care sector are weak. We propose that regulating access to secondary and tertiary care and restricting free provider choice to the primary care level would both reverse over utilization and strengthen the primary care sector.

Shmueli, A., et al. (2015). "Managed care in four managed competition OECD health systems." *Health Policy*.

Managed care emerged in the American health system in the 1980s as a way to manage suppliers' induced demand and to contain insurers' costs. While in Israel the health insurers have always been managed care organizations, owning health care facilities, employing medical personnel or contracting selectively with independent providers, European insurers have been much more passive, submitting themselves to collective agreements between insurers' and providers' associations, accompanied by extensive government regulation of prices, quantities, and budgets. With the 1990s reforms, and the introduction of risk-adjusted "managed competition", a growing pressure to allow the European insurers to manage their own care - including selective contracting with providers - has emerged, with varying speed of the introduction of policy changes across the individual countries. This paper compares experiences with managed care in Israel, The Netherlands, Germany and Switzerland since the 1990s. After a brief description of the health insurance markets in the four countries, we focus comparatively on the emergence of managed care in the markets for ambulatory care and inpatient market care. We conclude with an evaluation of the current situation and a discussion of selected health policy issues.

Stock, S. (2015). "Integrated ambulatory specialist care--Germany's new health care sector." *N Engl J Med* 372(19): 1781-1785.

Vrangbaek, K. (2015). "Commentary to Adam Oliver's 'Incentivising improvements in health care delivery'." *Health Econ Policy Law* 10(3): 367-371.

The commentary discusses key issues for assessment of performance management within health care. It supports the ambition to develop more realistic understandings of performance management based on insights from behavioral economics as suggested by Adam Oliver. However, it also points to several pitfalls and potential risks to consider when doing so. The commentary concludes that this is a promising field, but further research is needed to support the development of policy instruments.

Vieillesse / Ageing

Buthion V., Godé C.. (2015). "Les proches-aidants, quels rôles dans la coordination du parcours de soins ?" *Journal de Gestion et d'Economie Médicales* 32(7-8): 501-519.

Nadash, P., et al. (2012). "European long-term care programs: lessons for community living assistance services and supports?" *Health Serv Res* 47(1 Pt 1): 309-328.

OBJECTIVE: To uncover lessons from abroad for Community Living Assistance Services and

Supports (CLASS), a federally run voluntary public long-term care (LTC) insurance program created under the Accountable Care Act of 2010. DATA SOURCES: Program administrators and policy researchers from Austria, England, France, Germany, and the Netherlands. STUDY DESIGN: Qualitative methods focused on key parameters of cash for care: how programs set benefit levels; project expenditures; control administrative costs; regulate the use of benefits; and protect workers. DATA COLLECTION/EXTRACTION METHODS: Structured discussions were conducted during an international conference of LTC experts, followed by personal meetings and individual correspondence. PRINCIPAL FINDINGS: Germany's self-financing mandate and tight targeting of benefits have resulted in a solvent program with low premiums. Black markets for care are likely in the absence of regulation; France addresses this via a unique system ensuring legal payment of workers. CONCLUSIONS: Programs in the five countries studied have lessons, both positive and negative, relevant to CLASS design.

Spetz, J., et al. (2015). "Future Demand For Long-Term Care Workers Will Be Influenced By Demographic And Utilization Changes." Health Affairs 34(6): 936-945.

A looming question for policy makers is how growing diversity of the US elderly population and greater use of home and community-based services will affect demand for long-term care workers. We used national surveys to analyze current use and staffing of long-term care, project demand for long-term care services and workers through 2030, and assess how projections varied if we changed assumptions about utilization patterns. If current trends continue, the occupations anticipated to grow the most over the period are counselors and social workers (94 percent), community and social services workers (93 percent), and home health and personal care aides (88 percent). Alternative projections were computed for scenarios that assumed changing racial and ethnic patterns of long-term care use or shifts toward noninstitutional care. For instance, if Hispanics used services at the same rate as non-Hispanic blacks, the projected demand for long-term care workers would be 5 percent higher than if current trends continued. If 20 percent of nursing home care were shifted to home health services, total employment growth would be about 12 percent lower. Demographic and utilization changes would have little effect on projections of robust long-term care employment growth between now and 2030. Policy makers and educators should redouble efforts to create and sustainably fund programs to recruit, train, and retain long-term care workers.