

Reproduction sur d'autres sites interdite mais lien vers le document accepté :
<http://www.irdes.fr/documentation/veille-bibliographique-en-economie-de-la-sante.html>

Any and all reproduction is prohibited but direct link to the document is accepted:
<http://www.irdes.fr/english/documentation/watch-on-health-economics-literature.html>

DOC VEILLE

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

21 février 2014 / February, the 21st, 2014

Réalisée par le centre de documentation de l'Irdes, Doc Veille, publication bi-mensuelle, rassemble de façon thématique les résultats de la veille documentaire en économie de la santé : articles, littérature grise, rapports...

Vous pouvez accéder à la version électronique des articles sur notre portail EJS (à l'exception des revues françaises) :

<http://ejournals.ebsco.com/Home.asp> (**Accès réservé à l'Irdes**)

Les autres documents sont soit accessibles en ligne, soit consultables à la documentation (voir mention à la fin de la notice). Aucune photocopie ne sera délivrée par courrier.

Un historique des Doc Veille se trouve sur le web de l'Irdes :

<http://www.irdes.fr/documentation/veille-bibliographique-en-economie-de-la-sante.html>

Produced by the Irdes documentation centre, Doc Veille, a bimonthly publication, presents with a thematic classification the results of the documentary monitoring in health economics: articles, grey literature, reports...

You can access to the electronic version of articles on our EJS portal (except for the French journals): <http://ejournals.ebsco.com/Home.asp> (**Access limited to Irdes team**).

Other documents are accessible online, either available for consultation at the documentation center (see mention at the end of the notice). Requests for photocopies or scans of documents will not be answered. Doc Veille's archives are located on the Irdes website:

<http://www.irdes.fr/english/documentation/watch-on-health-economics-literature.html>

Contenu

Economie de la santé / Health Economics	6
Hierro L.A., Gomez-Alvarez R., Atienza P. (2014). A consistent decomposition of the redistributive, vertical, and horizontal effects of health care finance by factor components.....	6
Helmut H., Bernd T. (2014). Health care and ideology: a reconsideration of political determinants of public health care in the OECD	6
Etat de santé / Health Status	6
Lee H., Vlaev I., King D., Mayer E., Darzi A., Dolan P. (2013). Subjective well-being and the measurement of quality in healthcare.	6
Garcia M. (2014). Mortality rates or sociomedical indicators? The work of the League of Nations on standardizing the effects of the Great Depression on health	7
Rey G., Jouglu E. (2014). Are alcohol-attributable mortality estimates reliable	7
Géographie de la santé / Geography of Health	7
Rushton C. (2013). Whose place is it anyway? Representational politics in a place-based health initiative.	7
Sundmacher L., Busse R. (2014). Geographic variation in health care-A special issue on the 40th anniversary of "Small area variation in health care delivery".	8
Bernal-Delgado E., Garcia-Armesto S., Peiro S. (2014). Atlas of Variations in Medical Practice in Spain: The Spanish National Health Service under scrutiny.....	8
Gusmano M.K., Weisz D., Rodwin V.G., Lang J., Qian M., Bocquier A., Moysan V., Verger P. (2014). Disparities in access to health care in three French regions	8
Eibich P., Ziebarth N.R. (2014). Analyzing regional variation in health care utilization using (rich) household microdata.....	8
Schang L., Morton A., Dasilva P., Bevan G. (2014). From data to decisions? Exploring how healthcare payers respond to the NHS Atlas of Variation in Healthcare in England.	9
Exeter D.J., Rodgers S., Sabel C.E. (2014). "Whose data is it anyway?" The implications of putting small area-level health and social data online	9
Reschovsky J.D., Hadley J., O'Malley A.J., Landon B.E. (2014). Geographic Variations in the Cost of Treating Condition-Specific Episodes of Care among Medicare Patients.	10
Storm I., Harting J., Stronks K., Schuit A.J. (2014). Measuring stages of health in all policies on a local level: The applicability of a maturity model	10
Hôpital / Hospitals	10

(2012). Hospitalisations sensibles aux soins de premiers recours (HSPR) en Ile-de-France : une perspective d'Outre-Atlantique.....	10
Tran Ba Loc P., Jeandemange S., Nisand G. (2014). Evolution de valorisation d'un service : effet volume ou effet tarif ?.....	11
(2014). Tarification à l'activité et GRH en santé.....	11
Rode G. (2014). Financement SSR : pour un modèle reposant sur la Classification internationale du fonctionnement.....	11
Meacock R., Kristensen S.r.R., Sutton M. (2014). The cost-effectiveness of using financial incentives to improve provider quality: a framework and application.....	11
Kaarboe O., Carlsen F. (2014). Waiting times and socioeconomic status: evidence from Germany	12
Nigam A., Huising R., Golden B. (2014). Improving Hospital Efficiency.	12
Carey K. , Lin M.Y. (2014). Hospital Length of Stay and Readmission.	12
Frakt A.B. (2014). The end of hospital cost shifting and the quest for hospital productivity	13
Delabriere I., Delzenne E., Gaxatte C., Puisieux F. (2014). [Discharge from hospital into nursing home: Conditions and quality of transmissions].	13
Anema H.A., Van der Veer S.N., Kievit J., Krol-Warmerdam E., Fischer C., Steyerberg E., Dongelmans D.A., Reidinga A.C., Klazinga N.S., de Keizer N.F. (2014). Influences of definition ambiguity on hospital performance indicator scores: examples from The Netherlands.....	13
Médicaments / Pharmaceuticals.....	14
Clerc M.E., Juillard-Condât B., Legal R., Thao Khamsing W. (2012). Trente ans de dépenses de médicaments antihypertenseurs en France : une analyse rétrospective sur la période 1980-2010	14
Thao Khamsing W., Juillard-Condât B. (2012). Comparaison des ventes de médicaments antihypertenseurs dans cinq pays européens en 2009.....	14
Sorek G. (2014). Price control for medical innovations in a life perspective.....	14
Vooren K., Duranti S., Kurto A, Garattini L. (2014). A Critical Systematic Review of Budget Impact Analyses on Drugs in the EU Countries.....	15
Böhm K., Landwehr C., Steiner N.. (2014). What explains enerosity in the public financing of high-tech drugs? An empirical investigation of 25 OECD countries and 11 controversial drugs.....	15
Méthodologie – Statistique / Methodology – Statistics.....	15
Augustijn E.W., Zurita-Milla R. (2013). Self-organizing maps as an approach to exploring spatiotemporal diffusion patterns.....	15

William C. (2014). Propensity-Score Matching in Economic Analyses: Comparison with Regression Models, Instrumental Variables, Residual Inclusion, Differences-in-Differences, and Decomposition Methods	16
Politique de santé / Health Policy.....	16
Fraenkel L. (2013). Incorporating patients' preferences into medical decision making...	16
Noelker L.S., Browdie R. (2014). Sidney Katz, MD: A New Paradigm for Chronic Illness and Long-Term Care	17
Corallo A.N., Croxford R., Goodman D.C., Bryan E.L., Srivastava D., Stukel T.A. (2014). A systematic review of medical practice variation in OECD countries.....	17
Prévision – Evaluation / Prevision – Evaluation.....	17
Contandriopoulos D., Champagne F., Denis J.L. (2014). The multiple causal pathways between performance measures' use and effects.....	17
Psychiatrie / Psychiatry	18
Cambier G., Bougerol T., Micheletti P. (2014). Enquête qualitative sur la loi du 5 juillet 2011 en psychiatrie	18
Fakra E., Belzeaux R., Pringuey D., Cermolacce M., Correard N., Micoulaud-Franchi J.A., Azorin J.M. (2013). [Mixed states and schizophrenia].....	18
Pringuey D., Cherikh F., Giordana B., Fakra E., Dassa D., Cermolacce M., Belzeaux R., Maurel M., Azorin J.M. (2013). [Mixed states: Evolution of classifications	19
Economou M., Madianos M., Peppou L.E., Souliotis K., Patelakis A., Stefanis C. (2014). Cognitive social capital and mental illness during economic crisis: A nationwide population-based study in Greece	19
Soins de santé primaires / Primary Health Care	19
Contandriopoulos D., Perroux M. (2013). Fee Increases and Target Income Hypothesis: Data from Quebec on Physicians' Compensation and Service Volumes	20
Baron R.J., Davis K. (2013). Accelerating the Adoption of High-Value Primary Care : A New Provider Type under Medicare?	20
Feng Y., Ma A., Farrar S., Sutton M. (2013). The tougher the better: an economic analysis of increased payment thresholds on the performance of general practices.....	20
McCullough L.B. (2013). The professional medical ethics model of decision making under conditions of clinical uncertainty.	20
Kringos D.S., Boerma W.G., van der Zee J., Groenewegen P.P. (2013). Political, cultural and economic foundations of primary care in Europe	20
Greenhalgh T., Stones R., Swinglehurst D. (2014). Choose and Book: A sociological analysis of 'resistance' to an expert system	21

Graetz I., Reed M., Shortell S.M., Rundall T.G., Bellows J., Hsu J. (2014). The Association between EHRs and Care Coordination Varies by Team Cohesion	21
Van Dijk C.E., Verheij R.A., Te B.H., Spreeuwenberg P., Groenewegen P.P., de Bakker D.H. (2014). Changes in the remuneration system for general practitioners: effects on contact type and consultation length	22
Mead H., Andres E., Regenstein M. (2014). Underserved patients' perspectives on patient-centered primary care: does the patient-centered medical home model meet their needs	22
Stange K. (2014). How does provider supply and regulation influence health care markets? Evidence from nurse practitioners and physician assistants.....	22
Heikkila T.J., Hyppola H., Aine T., Halila H., Vanska J., Kujala S., Virjo I., Mattila K. (2014). How do doctors choose where they want to work? - Motives for choice of current workplace among physicians registered in Finland 1977-2006.....	23
Kardakis T., Weinehall L., Jerden L., Nystrom M.E., Johansson H. (2014). Lifestyle interventions in primary health care: professional and organizational challenges	23
Peersman W., Pasteels I., Cambier D., De Maesener J., Willems S. (2014). Validity of self-reported utilization of physician services: a population study	24
Systèmes de santé / Health Care Systems	24
Lostao L., Blane D., Gimeno D., Netuveli G., Regidor E. (2014). Socioeconomic patterns in use of private and public health services in Spain and Britain: implications for equity in health care	24
Epstein A.M., Jha A.K., Orav E.J., Liebman D.L., Audet A.M., Zezza M.A., Guterman S. (2014). Analysis of early accountable care organizations defines patient, structural, cost, and quality-of-care characteristics.	24
Meltzer D.O., Chung J.W. (2014). The population value of quality indicator reporting: a framework for prioritizing health care performance measures	25
Travail et santé / Occupational Health	25
Bahu M., Mermilliod C., Volkoff S. (2012). Conditions de travail pénibles au cours de la vie professionnelle et état de santé après 50 ans	25
Polidano C., Vu H. (2013). Differential labour market impacts from disability onset.	26
Rumball-Smith J., Barthold D., Nandi A., Heymann J. (2014). Diabetes associated with early labor-force exit: a comparison of sixteen high-income countries	26
Arends I., Bultmann U., Nielsen K., Van Rhenen W., de Boer M.R., Van der Klink J.J. (2014). Process evaluation of a problem solving intervention to prevent recurrent sickness absence in workers with common mental disorders	26
Thielen K., Nygaard E., Andersen I., Diderichsen F. (2014). Employment consequences of depressive symptoms and work demands individually and combined.....	27

Economie de la santé / Health Economics

Hierro L.A., Gomez-Alvarez R., Atienza P. (2014). A consistent decomposition of the redistributive, vertical, and horizontal effects of health care finance by factor components. *Health Economics*, 23 (1) : 117-121.

Abstract: In studies on the redistributive, vertical, and horizontal effects of health care financing, the sum of the contributions calculated for each financial instrument does not equal the total effects. As a consequence, the final calculations tend to be overestimated or underestimated. The solution proposed here involves the adaptation of the Shapley value to achieve additive results for all the effects and reveals the relative contributions of different instruments to the change of whole-system equity. An understanding of this change would help policy makers attain equitable health care financing. We test the method with the public finance and private payments of health care systems in Denmark and the Netherlands.

Helmut H., Bernd T. (2014). Health care and ideology: a reconsideration of political determinants of public health care in the OECD. *Health Economics*, 23 (2) : 225-240

Abstract: In this article, we examined if partisan ideology and electoral motives influence public healthcare expenditure (HCE) in countries of the Organization for Economic Cooperation and Development. We distinguished between the effects on the growth of the expenditures and its adjustment to violations of a long-run equilibrium linking HCE with macroeconomic and demographic trends. Regarding the influence of partisan ideology, we found that if governments are sufficiently long in power, right-wing governments spend less on public health than their left-wing counterparts. Furthermore, if a right-wing party governs without coalition partners, it responds more strongly to deviations from the long-run HCE equilibrium than left-wing governments. With regard to electoral motives, we found that health expenditure increases in years of elections. Independent of their partisan ideology, single-party (minority) governments induce higher (lower) growth of public HCE. Each of these political factors by its own may increase (decrease) HCE growth by approximately one percentage point. Given an average annual growth of HCE of approximately 4.1%, political factors turn out to be important determinants of trends in public HCE.

Etat de santé / Health Status

Lee H., Vlaev I., King D., Mayer E., Darzi A., Dolan P. (2013). Subjective well-being and the measurement of quality in healthcare. *Soc Sci Med*, 99 27-34.

Abstract: Quality continues to be placed at the heart of discussions about healthcare. This raises important questions about precisely what quality care is, and how it should be measured. An overall measure of subjective well-being (SWB) that assesses and joins up different stages of the treatment process, and the different people affected, could potentially be used to capture the full impact of quality care throughout the entire treatment process. This article presents a temporal model through which SWB links all stages in the treatment and care process, thus allowing the overall quality of care to be determined and valued according to its direct effect on people's lives. Drawing on existing medical and behavioural studies, we populate this model with evidence that demonstrates how SWB is affected at different points along the patient pathway. SWB is shown to have an effect on outcomes at all stages of the treatment experience and improved health and quality outcomes are shown to consistently enhance SWB. Furthermore, SWB measures are shown to be a suitable

method to value the impact of healthcare on the families and carers of patients and, in this way, can join up health outcomes to show wider effects of treatment on patients' lives. Measuring an individual's SWB throughout his or her treatment experience can enable a full appraisal of the quality of care that they receive. This will facilitate service improvements at the micro level and help value treatments for resource allocation purposes at the macro level.

Garcia M. (2014). Mortality rates or sociomedical indicators? The work of the League of Nations on standardizing the effects of the Great Depression on health. *Health Policy Plan*, 29 (1) : 1-11.

Abstract: This article explores the first international effort by the League of Nations Health Organization (LNHO) to standardize the study of the effects of the economic crisis of the 1930s on health. Instead of analysing this effort with the benefit of hindsight, this article takes into account the actors' perspectives and, therefore, it relies on the documents produced by the LNHO and public health experts of the 1930s, as well as on the historical scholarship on this subject. This article shows that, despite the declining death rates in Europe and in the US during the crisis, the LNHO considered that death rates concealed a more subtle effect of the crisis on health; hence, they launched a project aimed at making the effect visible. It describes the LNHO programme and the guidelines and methods set out by the organization in 1932 to observe this subtle effect through sociomedical investigations. The results of these surveys are summarized and the article discusses how the eugenic arguments used to explain them were not accepted by the LNHO. The article also shows how some members of the LNHO considered the results of the sociomedical surveys inconclusive and questioned the usefulness of socioeconomic indicators; in so doing, they raised concerns about the intervention of the LNHO in national matters and about the risks of crossing the established limits between science and politics. This article shows that an historical analysis, which takes into account the points of view of the actors involved, illuminates the factors that led the LNHO to conclude that mortality rates were the best method for measuring the effects of the economic crisis on health and that, as they were declining, the Great Depression was not having any deleterious effect on public health.

Rey G., Jouglu E. (2014). Are alcohol-attributable mortality estimates reliable? *Eur J Public Health*, 24 (1) : 3-4

Géographie de la santé / Geography of Health

Rushton C. (2013). Whose place is it anyway? Representational politics in a place-based health initiative. *Health Place*, 26C 100-109.

Abstract: The association between place and poor health, such as chronic disease, is well documented and in recent years has given rise to public health strategies such as place-based initiatives (PBIs). This article reports on the emergence of one such initiative in Australia, in regions identified as culturally diverse and socially disadvantaged. The study draws on the intellectual resources provided by governmentality and actor-network theory to provide insights into the reasons why community actors were excluded from a new governance body established to represent their interests. Risk-thinking and representational politics determined who represented whom in the PBI partnership. Paradoxically, actors representing 'community', identified as being 'at risk', were excluded from the partnership during its translation because they were also identified as being 'a risk'. As a consequence, contrary to federal government health and social policy in Australia, it was state government

interests rather than the interests of community actors that influenced decisions made in relation to local health planning and the allocation of resources.

Sundmacher L., Busse R. (2014). Geographic variation in health care-A special issue on the 40th anniversary of "Small area variation in health care delivery". *Health Policy*, 114 (1) : 3-4.

Bernal-Delgado E., Garcia-Armesto S., Peiro S. (2014). Atlas of Variations in Medical Practice in Spain: The Spanish National Health Service under scrutiny. *Health Policy*, 114 (1) : 15-30.

Abstract: Early in the 2000s, a countrywide health services research initiative was launched under the acronym of Atlas VPM: Atlas of Variations in Medical Practice in the Spanish National Health System. This initiative aimed at describing systematic and unwarranted variations in medical practice at geographic level-building upon the seminal experience of the Dartmouth Atlas of Health Care. The paper aims at explaining the Spanish Atlas experience, built upon the pioneer Dartmouth inspiration. A few selected examples will be used along the following sections to illustrate the outlined conceptual framework, the different factors that may affect variation, and some methodological challenges.

Gusmano M.K., Weisz D., Rodwin V.G., Lang J., Qian M., Bocquier A., Moysan V., Verger P. (2014). Disparities in access to health care in three French regions. *Health Policy*, 114 (1) : 31-40.

Abstract: OBJECTIVES: This paper compares access to primary and specialty care in three metropolitan regions of France: Ile de France (IDF), Nord-Pas-de-Calais (NPC) and Provence-Alpes-Cote d'Azur (PACA); and identifies the factors that contribute to disparities in access to care within and among these regions. METHODS: To assess access to primary care, we compare variation among residence-based, age-adjusted hospital discharge rates for ambulatory care sensitive conditions (ASC). To assess access on one dimension of specialty care, we compare residence-based, age-adjusted hospital discharge rates for revascularization - bypass surgery and angioplasty - among patients diagnosed with ischemic heart disease (IHD). In addition, for each region we rely on a multilevel generalized linear mixed effect model to identify a range of individual and area-level factors that affect the discharge rates for ASC and revascularization. RESULTS: In comparison with other large metropolitan regions, in France, access to primary care is greater in Paris and its surrounding region (IDF) than in NPC but worse than in PACA. With regard to revascularization, after controlling for the burden of IHD, use of services is highest in PACA followed by IDF and NPC. In all three regions, disparities in access are much greater for revascularization than for ASC. Residents of low-income areas and those who are treated in public hospitals have poorer access to primary care and revascularizations. In addition, the odds of hospitalization for ASC and revascularization are higher for men. Finally, people who are treated in public hospitals, have poorer access to primary care and revascularization services than those who are admitted for ASC and revascularization services in private hospitals. CONCLUSIONS: Within each region, we find significant income disparities among geographic areas in access to primary care as well as revascularization. Even within a national health insurance system that minimizes the financial barriers to health care and has one of the highest rates of spending on health care in Europe, the challenge of minimizing these disparities remains.

Eibich P., Ziebarth N.R. (2014). Analyzing regional variation in health care utilization using (rich) household microdata. *Health Policy*, 114 (1) : 41-53.

Abstract: This paper exploits rich SOEP microdata to analyze state-level variation in health care utilization in Germany. Unlike most studies in the field of the Small Area Variation (SAV)

literature, our approach allows us to net out a large array of individual-level and state-level factors that may contribute to the geographic variation in health care utilization. The raw data suggest that state-level hospitalization rates vary from 65 to 165 percent of the national mean. Ambulatory doctor visits range from 90 to 120 percent of the national mean. Interestingly, in the former GDR states, doctor visit rates are significantly below the national mean, while hospitalization rates lie above the national mean. The significant state-level differences vanish once we control for individual-level socio-economic characteristics, the respondents' health status, their health behavior as well as supply-side state-level factors.

Schang L., Morton A., Dasilva P., Bevan G. (2014). From data to decisions? Exploring how healthcare payers respond to the NHS Atlas of Variation in Healthcare in England. *Health Policy*, 114 (1) : 79-87.

Abstract: PURPOSE: Although information on variations in health service performance is now more widely available, relatively little is known about how healthcare payers use this information to improve resource allocation. We explore to what extent and how Primary Care Trusts (PCTs) in England have used the NHS Atlas of Variation in Healthcare, which has highlighted small area variation in rates of expenditure, activity and outcome. METHODS: Data collection involved an email survey among PCT Chief Executives and a telephone follow-up to reach non-respondents (total response: 53 of 151 of PCTs, 35%). 45 senior to mid-level staff were interviewed to probe themes emerging from the survey. The data were analysed using a matrix-based Framework approach. FINDINGS: Just under half of the respondents (25 of 53 PCTs) reported not using the Atlas, either because they had not been aware of it, lacked staff capacity to analyse it, or did not perceive it as applicable to local decision-making. Among the 28 users, the Atlas served as a prompt to understand variations and as a visual tool to facilitate communication with clinicians. Achieving clarity on which variations are unwarranted and agreeing on responsibilities for action appeared to be important factors in moving beyond initial information gathering towards decisions about resource allocation and behaviour change. CONCLUSIONS: Many payers were unable to use information on small area variations in expenditure, activity and outcome. To change this what is additionally required are appropriate tools to understand causes of unexplained variation, in particular unwarranted variation, and enable remedial actions to be prioritised in terms of their contribution to population health.

Exeter D.J., Rodgers S., Sabel C.E. (2014). "Whose data is it anyway?" The implications of putting small area-level health and social data online. *Health Policy*, 114 (1) : 88-96.

Abstract: Data from electronic patient management systems, routine national health databases, and social administrative systems have increased significantly over the past decade. These data are increasingly used to create maps and analyses communicating the geography of health and illness. The results of these analyses can be easily disseminated on the web often without due consideration for the identification, access, ethics, or governance, of these potentially sensitive data. Lack of consideration is currently proving a deterrent to many organisations that might otherwise provide data to central repositories for invaluable social science and medical research. We believe that exploitation of such data is needed to further our understanding of the determinants of health and inequalities. Therefore, we propose a geographical privacy-access continuum framework, which could guide data custodians in the efficient dissemination of data while retaining the confidentiality of the patients/individuals concerned. We conclude that a balance of restriction and access is needed allowing linkage of multiple datasets without disclosure, enabling researchers to gather the necessary evidence supporting policy changes or complex environmental and behavioural health interventions.

Reschovsky J.D., Hadley J., O'Malley A.J., Landon B.E. (2014). Geographic Variations in the Cost of Treating Condition-Specific Episodes of Care among Medicare Patients. *Health Services Research*, 49 (1) : 32-51.

Abstract: OBJECTIVES: To measure geographic variations in treatment costs for specific conditions, explore the consistency of these patterns across conditions, and examine how service mix and population health factors are associated with condition-specific and total area costs. DATA SOURCES: Medicare claims for 1.5 million elderly beneficiaries from 60 community tracking study (CTS) sites who received services from 5,500 CTS Physician Survey respondents during 2004-2006. STUDY DESIGN: Episodes of care for 10 costly and common conditions were formed using Episode Treatment Group grouper software. Episode and total annual costs were calculated, adjusted for price, patient demographics, and comorbidities. We correlated episode costs across sites and examined whether episode service mix and patient health were associated with condition-specific and total per-beneficiary costs. PRINCIPAL FINDINGS: Adjusted episode costs varied from 34 to 68 percent between the most and least expensive site quintiles. Area mean costs were only weakly correlated across conditions. Hospitalization rates, surgery rates, and specialist involvement were associated with site episode costs, but local population health indicators were most related to site total per-beneficiary costs. CONCLUSIONS: Population health appears to drive local per-beneficiary Medicare costs, whereas local practice patterns likely influence condition-specific episode costs. Reforms should be flexible to address local conditions and practice patterns.

Storm I., Harting J., Stronks K., Schuit A.J. (2014). Measuring stages of health in all policies on a local level: The applicability of a maturity model. *Health Policy*, 114 (2-3) : 183-191.

Abstract: OBJECTIVES: Many local governments are trying to establish health in all policies (HiAP), but no sensitive tool is available to measure HiAP growth processes. This study explores the applicability of a general maturity model to classify stages of HiAP and to characterize its manifestations and conditions. METHODS: Based on other maturity models we have developed a maturity model for HiAP (MM-HiAP), which consists of six maturity levels and 14 corresponding key characteristics. This model was applied to assess HiAP growth processes within 16 municipalities in the Netherlands. We used municipal policies on health inequalities as a case. Empirical data was gathered based on document analysis, a questionnaire and interviews. RESULTS: Using this model we were able to classify HiAP growth processes by several characteristics, such as the recognition of the importance of HiAP (Stage I; four municipalities), HiAP described in policy documents and collaboration with sectors present (Stage II; seven municipalities), concrete collaboration agreements and structural consultations forms (Stage III; four municipalities), and a broad, shared vision on HiAP (Stage IV; two municipalities). Examples of necessary conditions were sufficient support and resources. CONCLUSIONS: This study shows that it is possible to apply a maturity model to classify stages of HiAP in municipalities. Use of the MM-HiAP as a formal measuring instrument depends on further operationalization and validation.

Hôpital / Hospitals

(2012). Hospitalisations sensibles aux soins de premiers recours (HSPR) en Ile-de-France : une perspective d'Outre-Atlantique. *Revue Française des Affaires Sociales*, (3) : 109-125.

Abstract: Cet article présente un indicateur, les « hospitalisations sensibles aux soins de premier recours » (HSPR), utilisé aux États-Unis et dans d'autres pays de l'OCDE pour évaluer dans quelle mesure les soins de premier recours sont accessibles et permettent une prise en charge adaptée des pathologies avant qu'elles ne nécessitent des traitements à l'hôpital. Sur la base d'une étude conduite en Île-de-France à partir de données hospitalières et du Programme de médicalisation des systèmes d'information (PMSI), cet indicateur permet d'identifier les zones où les HSPR semblent particulièrement nombreuses et ces hospitalisations potentiellement évitables. Les facteurs susceptibles d'expliquer ces disparités (facteurs individuels et facteurs contextuels propres au lieu de résidence) sont analysés grâce à une régression logistique : les résidents des zones du dernier quartile de revenu et les patients hospitalisés dans des établissements publics rencontrent davantage de difficultés d'accès aux soins de premier recours, ce qui soulève une question importante pour les politiques de santé : faut-il imputer le nombre élevé de HSPR à un recours aux soins tardif ou au fait que le système de soins n'est pas organisé pour cibler les populations à risque ?

Tran Ba Loc P., Jeandemange S., Nisand G. (2014). Evolution de valorisation d'un service : effet volume ou effet tarif ? *Journal de Gestion et d'Economie médicale*, 31 (5) : 317-326.

(2014). Tarification à l'activité et GRH en santé. *Revue Hospitalière de France*, (555) : 14-15.

Abstract: Quelles approches ont deux établissements publics de santé, de tailles différentes, des effets de la tarification à l'activité (T2A) sur la gestion des ressources humaines (GRH) ? Le centre hospitalier universitaire de Rouen et le centre hospitalier de Dieppe apportent une vision partagée.

<http://www.revue-hospitaliere.fr/Revue/Revue-Hospitaliere-de-France/Revue/555/Dossier-des-Ressources-humaines-2013/Tarification-a-l-activite-et-GRH-en-sante>

Rode G. (2014). Financement SSR : pour un modèle reposant sur la Classification internationale du fonctionnement. *Revue Hospitalière de France*, (555) :

Abstract: Le financement des établissements de soins de suite et réadaptation (SSR) fait l'objet de travaux conduits par la Direction de l'offre de soins (DGOS) et l'Agence technique de l'information sur l'hospitalisation (ATIH) en vue de proposer un modèle de financement à échéance du 1er janvier 2016. Les enjeux sont importants, le sujet complexe. Quelle stratégie définir? Quel modèle de rémunération? Les facteurs de complexité sont à prendre en compte, ainsi que les disparités régionales, les évolutions des modes de prise en charge et la diversité des acteurs. ----- Pr Gilles RODE Service de médecine physique et de réadaptation, hôpital Henry-Gabrielle, Hospices civils de Lyon. Président de la Société française de médecine physique et de réadaptation (SOFMER).

<http://www.revue-hospitaliere.fr/Revue/Revue-Hospitaliere-de-France/Revue/555/Dossier-des-Ressources-humaines-2013/Tarification-a-l-activite-et-GRH-en-sante>

Meacock R., Kristensen S.r.R., Sutton M. (2014). The cost-effectiveness of using financial incentives to improve provider quality: a framework and application. *Health Economics*, 23 (1) : 1-13.

Abstract: Despite growing adoption of pay-for-performance (P4P) programmes in health care, there is remarkably little evidence on the cost-effectiveness of such schemes. We review the limited number of previous studies and critique the frameworks adopted and the narrow range of costs and outcomes considered, before proposing a new more

comprehensive framework, which we apply to the first P4P scheme introduced for hospitals in England. We emphasise that evaluations of cost-effectiveness need to consider who the residual claimant is on any cost savings, the possibility of positive and negative spillovers, and whether performance improvement is a transitory or investment activity. Our application to the Advancing Quality initiative demonstrates that the incentive payments represented less than half of the -ú13m total programme costs. By generating approximately 5200 quality-adjusted life years and -ú4.4m of savings in reduced length of stay, we find that the programme was a cost-effective use of resources in its first 18 months. Copyright © 2013 John Wiley & Sons, Ltd.

Kaarboe O., Carlsen F. (2014). Waiting times and socioeconomic status: evidence from Germany. *Health Economics*, 23 (1) : 93-107.

Abstract: We investigate whether socioeconomic status, measured by income and education, affects waiting time when controls for severity and hospital-specific conditions are included. We also examine which aspects of the hospital supply (attachment to local hospital, traveling time, or choice of hospital) matter most for unequal treatment of different socioeconomic groups. The study uses administrative data from all elective inpatient and outpatient stays in somatic hospitals in Norway. The main results are that we find very little indication of discrimination with regard to income and education when both severity and aspects of hospital supply are controlled for. This result holds for both men and women. Copyright © 2013 John Wiley & Sons, Ltd.

Nigam A., Huising R., Golden B. (2014). Improving Hospital Efficiency. *Medical Care Research and Review*, 71 (1) : 21-42.

Abstract: Improving hospital efficiency is a critical goal for managers and policy makers. We draw on participant observation of the perioperative coaching program in seven Ontario hospitals to develop knowledge of the process by which the content of change initiatives to increase hospital efficiency is defined. The coaching program was a change initiative involving the use of external facilitators with the goal of increasing perioperative efficiency. Focusing on the role of subjective understandings in shaping initiatives to improve efficiency, we show that physicians, nurses, administrators, and external facilitators all have differing frames of the problems that limit efficiency, and propose different changes that could enhance efficiency. Dynamics of strategic and contested framing ultimately shaped hospital change commitments. We build on work identifying factors that enhance the success of change efforts to improve hospital efficiency, highlighting the importance of subjective understandings and the politics of meaning-making in defining what hospitals change.

Carey K. , Lin M.Y. (2014). Hospital Length of Stay and Readmission. *Medical Care Research and Review*, 71 (1) : 99-111.

Abstract: This article is an investigation into the relationship between length of stay and readmission within 30 days of discharge from an acute care hospitalization. We estimated probability models for heart attack and for heart failure patients using generalized estimating techniques applied to hospital administrative data from California for calendar year 2008. The key independent variable was length of stay in the initial hospitalization. We found negative associations between length of stay and readmission probability, particularly in the case of heart attack. Simulated values of predicted readmissions based on a 1-day increase in length of stay yielded estimated reductions in readmission rates in the 7% to 18% range for heart attack patients and the 1% to 8% range for heart failure patients. Increasing length of stay for some patients may be a means of improving quality of care by reducing readmission during the 30-day postdischarge period.

Frakt A.B. (2014). The end of hospital cost shifting and the quest for hospital productivity. *Health Services Research*, 49 (1) : 1-10.

Delabriere I., Delzenne E., Gaxatte C., Puisieux F. (2014). [Discharge from hospital into nursing home: Conditions and quality of transmissions]. *Presse Med*, 43 (1) : e1-e7.

Abstract: CONTEXT: Nursing home residents are very old, with multiple comorbidities and disabled for activities of daily living (ADLs). Therefore, they have a higher risk of accidents as falls or fractures or acute diseases as infections, which require hospitalization. Care's coordination and sharing of informations between hospitals and nursing homes are often insufficient even with agreements. Thus, discharge to nursing homes after hospitalization may be difficult for old patients because of incomplete oral or written transmissions. OBJECTIVE: To examine both protocols and the quality of the return to the nursing homes after an hospitalization for old residents. METHOD: A prospective multicenter study done by collecting data about consecutive returns into their nursing home after an hospitalization of more than 24hours of nursing home residents aged 65 years and more. RESULTS: Twenty-eight nursing homes of the North of France were enrolled in the study. During the 3 months period of the study, 246 discharges after an hospitalization of 24hours or more were registered. 225 residents (165 women and 60 men), mean age 85.0+/-7.2, were concerned. Most of them were ADLs disabled, with a dementia for 47.1% of them. The average length of hospitalization was 11.6 days. At the end of hospitalization, the notification of return, which was made only in 82% of cases, was announced in average 1.3 days before the discharge. Unfortunately, in 32% of cases, the notification was made the day of the discharge. Residents went back home indifferently any day of the week but more often the Friday and less often the weekend. The day and the hour of the planned discharge were respected in 79.1% of cases. In most cases, nursing home caregivers have considered that the clinical status was stable or improved compared to the previous one. However in 28% of cases, a loss of autonomy was found. Medical doctors wrote a letter of discharge in 85.8% of cases. Nurses gave written transmissions only in 41.9% of cases. CONCLUSION: Many points concerning discharge from hospital, about old people living in nursing home, have to be improved: oral transmissions about patient's status, notification of the return, discharge's letter, nurse's transmissions and assessment of the loss of autonomy

Anema H.A., Van der Veer S.N., Kievit J., Krol-Warmerdam E., Fischer C., Steyerberg E., Dongelmans D.A., Reidinga A.C., Klazinga N.S., de Keizer N.F. (2014). Influences of definition ambiguity on hospital performance indicator scores: examples from The Netherlands. *Eur J Public Health*, 24 (1) : 73-78.

Abstract: Research objective: Reliable and unambiguously defined performance indicators are fundamental to objective and comparable measurements of hospitals' quality of care. In two separate case studies (intensive care and breast cancer care), we investigated if differences in definition interpretation of performance indicators affected the indicator scores. Design: Information about possible definition interpretations was obtained by a short telephone survey and a Web survey. We quantified the interpretation differences using a patient-level dataset from a national clinical registry (Case I) and a hospital's local database (Case II). In Case II, there was additional textual information available about the patients' status, which was reviewed to get more insight into the origin of the differences. Participants: For Case I, we investigated 15 596 admissions of 33 intensive care units in 2009. Case II consisted of 144 admitted patients with a breast tumour surgically treated in one hospital in 2009. RESULTS: In both cases, hospitals reported different interpretations of the indicators, which lead to significant differences in the indicator values. Case II revealed that these differences could be explained by patient-related factors such as severe comorbidity and patients' individual preference in surgery date. Conclusions: With this article, we hope to increase the awareness on pitfalls regarding the indicator definitions and the quality of the

underlying data. To enable objective and comparable measurements of hospitals' quality of care, organizations that request performance information should formalize the indicators they use, including standardization of all data elements of which the indicator is composed (procedures, diagnoses).

Médicaments / Pharmaceuticals

Clerc M.E., Juillard-Condat B., Legal R., Thao Khamsing W. (2012). Trente ans de dépenses de médicaments antihypertenseurs en France : une analyse rétrospective sur la période 1980-2010. *Revue Française des Affaires Sociales*, (3) : 69-88.

Abstract: En 2010, le marché des antihypertenseurs représentait en valeur plus de 2 milliards d'euros, soit près de 10 % du marché total du médicament en ville. Entre 1980 et 2010, ce marché a connu une croissance annuelle moyenne de +5,2 % par an. L'objectif de cet article est d'analyser l'évolution de la consommation d'antihypertenseurs en France sur une période longitudinale de trente ans. Cette analyse cherche à décomposer l'évolution des dépenses d'antihypertenseurs, en mettant en évidence l'impact de l'évolution des prix, des quantités et de la structure de consommation. Les résultats font apparaître une tendance à la diminution des prix, contrebalancée par une forte augmentation des volumes, qui inclut des modifications profondes de la structure de consommation des antihypertenseurs. Ces tendances observées peuvent être mises en parallèle avec les différents mécanismes de régulation des dépenses pharmaceutiques qui se sont succédé sur la période considérée.

Thao Khamsing W., Juillard-Condat B. (2012). Comparaison des ventes de médicaments antihypertenseurs dans cinq pays européens en 2009. *Revue Française des Affaires Sociales*, (3) : 89-108.

Abstract: Cet article propose une comparaison internationale de la dépense de médicaments antihypertenseurs dans cinq pays européens (France, Allemagne, Espagne, Italie, Royaume-Uni). Dans un premier temps, des indicateurs globaux de consommation d'antihypertenseurs sont présentés : dépense et nombre d'unités standards par habitant, nombre de traitements journaliers pour 1000 habitants et par jour, et coût moyen d'une unité standard. Dans un deuxième temps, les hétérogénéités de consommation observées sont analysées plus finement, en prenant comme référence la France, et en calculant des indices de prix, de quantité et de structure. Dans un troisième temps, les indices de structure sont eux-mêmes décomposés selon une partition par classe thérapeutique, puis selon le statut générique. Les résultats obtenus mettent en évidence un niveau de prix et surtout une structure de consommation génériques/princeps défavorables pour la France.

Sorek G. (2014). Price control for medical innovations in a life perspective. *Health Economics*, 23 (1) : 108-116.

Abstract: We study the market for new medical technologies from a life cycle perspective, incorporating the fact that healthcare utilization is biased towards old age. Contrary to conventional wisdom, we find that price controls on medical innovations can expand investment in medical R&D and results in Pareto superior social outcomes, a consequence of the price controls' ability to increase saving. Importantly, this finding occurs only when the price cap regime is extensive: selective regulation on few technologies - such as pharmaceuticals alone - have the conventional negative effect on innovation.

Vooren K., Duranti S., Kurto A, Garattini L. (2014). A Critical Systematic Review of Budget Impact Analyses on Drugs in the EU Countries. *Applied Health Economics and Health Policy*, 12 (1) : 33-40.

Abstract: Budget impact analysis (BIA) is a relatively recent technique that is supposed to be complementary to more established economic evaluations (EEs). We reviewed the BIAs published on drugs in the EU since December 2008, to assess whether these studies have improved in quality in the last few years. We conducted a literature search on the international databases PubMed and EMBASE. The selected articles were screened using a two-step approach to assess (1) their main methodological characteristics and (2) the level of adherence to the latest BIA definition. The assessment was made by two independent reviewers and any disagreement was resolved through discussion. Eventually, 17 articles were reviewed. Thirteen referred to a stand-alone BIA not accompanying a full EE, only nine focused on a new treatment, 15 were sponsored by the manufacturer of the drug of reference, all but one claiming savings for healthcare budgets. The quality of methods was poor in many of the studies, and only a few of them attempted to estimate real local costs in a credible way. Therefore, the crucial items that in theory make a BIA different from other types of EEs were often the major points of weakness of the studies reviewed. Our review confirmed that the BIA is not yet a well-established technique in the literature and many published studies still fail to reach an acceptable quality. In particular, BIAs funded by pharmaceutical companies appear to be tailored to show short-term savings induced by new, highly priced products.

Böhm K., Landwehr C., Steiner N.. (2014). What explains generosity in the public financing of high-tech drugs? An empirical investigation of 25 OECD countries and 11 controversial drugs. *Journal of European Social Policy*, 24 (1) : 39-55.

Abstract: In times of increasing cost pressures, public healthcare systems in Organisation for Economic Co-operation and Development (OECD) countries face the question of whether and to which extent new high-tech drugs are to be financed within their public healthcare systems. Systematic empirical research that explains across-country variation in these decisions is, however, almost non-existent. We analyse an original dataset that contains coverage decisions for 11 controversial drugs in 25 OECD countries using multilevel modelling. Our results indicate that the generosity with which controversial new drugs are publicly financed is unrelated to a country's wealth and general expenditure levels for healthcare. However, healthcare systems financed through social insurance contributions tend to be more generous than tax-financed ones. Moreover, we uncover evidence suggesting that the institutional characteristics of the decision-making process matter systematically for decisions on whether to finance controversial drugs.

Méthodologie – Statistique / Methodology – Statistics

Augustijn E.W., Zurita-Milla R. (2013). Self-organizing maps as an approach to exploring spatiotemporal diffusion patterns. *Int J Health Geogr.*, 12 60.

Abstract: BACKGROUND: Self-organizing maps (SOMs) have now been applied for a number of years to identify patterns in large datasets; yet, their application in the spatiotemporal domain has been lagging. Here, we demonstrate how spatialtemporal disease diffusion patterns can be analysed using SOMs and Sammon's projection. METHODS: SOMs were applied to identify synchrony between spatial locations, to group

epidemic waves based on similarity of diffusion pattern and to construct sequence of maps of synoptic states. The Sammon's projection was used to create diffusion trajectories from the SOM output. These methods were demonstrated with a dataset that reports Measles outbreaks that took place in Iceland in the period 1946-1970. The dataset reports the number of Measles cases per month in 50 medical districts. RESULTS: Both stable and incidental synchronisation between medical districts were identified as well as two distinct groups of epidemic waves, a uniformly structured fast developing group and a multiform slow developing group. Diffusion trajectories for the fast developing group indicate a typical diffusion pattern from Reykjavik to the northern and eastern parts of the island. For the other group, diffusion trajectories are heterogeneous, deviating from the Reykjavik pattern. CONCLUSIONS: This study demonstrates the applicability of SOMs (combined with Sammon's Projection and GIS) in spatiotemporal diffusion analyses. It shows how to visualise diffusion patterns to identify (dis)similarity between individual waves and between individual waves and an overall time-series performing integrated analysis of synchrony and diffusion trajectories.

William C. (2014). Propensity-Score Matching in Economic Analyses: Comparison with Regression Models, Instrumental Variables, Residual Inclusion, Differences-in-Differences, and Decomposition Methods. *Applied Health Economics and Health Policy*, 12 (1) : 7-18.

Abstract: This paper examines the use of propensity score matching in economic analyses of observational data. Several excellent papers have previously reviewed practical aspects of propensity score estimation and other aspects of the propensity score literature. The purpose of this paper is to compare the conceptual foundation of propensity score models with alternative estimators of treatment effects. References are provided to empirical comparisons among methods that have appeared in the literature. These comparisons are available for a subset of the methods considered in this paper. However, in some cases, no pairwise comparisons of particular methods are yet available, and there are no examples of comparisons across all of the methods surveyed here. Irrespective of the availability of empirical comparisons, the goal of this paper is to provide some intuition about the relative merits of alternative estimators in health economic evaluations where nonlinearity, sample size, availability of pre/post data, heterogeneity, and missing variables can have important implications for choice of methodology. Also considered is the potential combination of propensity score matching with alternative methods such as differences-in-differences and decomposition methods that have not yet appeared in the empirical literature.

Politique de santé / Health Policy

Fraenkel L. (2013). Incorporating patients' preferences into medical decision making. *Med Care Res Rev*, 70 (1 Suppl) : 80S-93S.

Abstract: Current models of care emphasize the importance of including patients' values in the decision-making process. This is particularly important for decisions for which there are few data supporting a clear strategy or treatment choice. Constructing preferences for complex decisions requires that patients be able to consider multiple trade-offs between specific risks and benefits. Several marketing research techniques have been recently applied to health care settings to facilitate this process. Most can be programmed to generate patients' preferences or priorities, which can then be used to improve patient-physician communication. In this article, we will describe some of the currently available approaches

that have been successfully used in the health care setting. We provide case examples to illustrate the potential value of adopting each of these approaches in clinical practice.

Noelker L.S., Browdie R. (2014). Sidney Katz, MD: A New Paradigm for Chronic Illness and Long-Term Care. *The Gerontologist*, 54 (1) : 13-20.

Abstract: Dr. Sidney Katz's legacy to the field of gerontology is internationally recognized as his success at developing standardized measures and processes, beginning with the activities of daily living index, for the functional assessment of older adults with chronic conditions necessitating long-term services and supports. That work served as the bedrock for his subsequent major accomplishments, which improved rehabilitation services through interdisciplinary team work and attention to the patient-family constellation; reformed the regulation of nursing homes, refocusing it on resident outcomes and quality of life; and promulgated the concept of active life expectancy as a new approach to measuring the quality of later life. Few other scholars and researchers in the history of the field of aging can claim one, much less multiple monumental contributions leading to major advances in the treatment of chronic illness and the quality of long-term care.

Corallo A.N., Croxford R., Goodman D.C., Bryan E.L., Srivastava D., Stukel T.A. (2014). A systematic review of medical practice variation in OECD countries. *Health Policy*, 114 (1) : 5-14.

Abstract: BACKGROUND: Major variations in medical practice have been documented internationally. Variations raise questions about the quality, equity, and efficiency of resource allocation and use, and have important implications for health care and health policy. OBJECTIVE: To perform a systematic review of the peer-reviewed literature on medical practice variations in OECD countries. METHODS: We searched MEDLINE to find publications on medical practice variations in OECD countries published between 2000 and 2011. We present an overview of the characteristics of published studies as well as the magnitude of variations for select high impact conditions. RESULTS: A total of 836 studies were included. Consistent with the gray literature, there were large variations across regions, hospitals and physician practices for almost every condition and procedure studied. Many studies focused on high-impact conditions, but very few looked at the causes or outcomes of medical practice variations. CONCLUSION: While there were an overwhelming number of publications on medical practice variations the coverage was broad and not often based on a theoretical construct. Future studies should focus on conditions and procedures that are clinically important, policy relevant, resource intensive, and have high levels of public awareness. Further study of the causes and consequences of variations is important.

Prévision – Evaluation / Prevision – Evaluation

Contandriopoulos D., Champagne F., Denis J.L. (2014). The multiple causal pathways between performance measures' use and effects. *Med Care Res Rev*, 71 (1) : 3-20.

Abstract: In recent decades, there has been a growing interest in the design and implementation of systems using public reporting of performance measures to improve performance. In their simplest form, such interventions rest on the market-based logic of consumers using publicly released information to modify their behavior, thereby penalizing poor performers. However, evidence from large-scale efforts to use public reporting of performance measures as an instrumental performance improvement tool suggests that the causal mechanisms involved are much more complex. This article offers a typology of four

different plausible causal pathways linking public reporting of performance measures and performance improvement. This typology rests on a variety of conceptual models and a review of available empirical evidence. We then use this typology to discuss the core elements that need to be taken into account in efforts to use public reporting of performance measures as a performance improvement tool.

Psychiatrie / Psychiatry

Cambier G., Bougerol T., Micheletti P. (2014). Enquête qualitative sur la loi du 5 juillet 2011 en psychiatrie. *Santé Publique*, 25 (6) : 793-802.

Abstract: La loi du 5 juillet 2011 «relative aux droits et à la protection des personnes faisant l'objet de soins psychiatriques et aux modalités de leur prise en charge?» a été fortement critiquée et souvent rejetée, avant puis lors de sa parution. Elle est appliquée depuis le mois d'août 2011. Notre étude a pour objectif de décrire et de croiser les perceptions de cette loi par des acteurs de terrain, après six mois d'application. Cette étude qualitative réalisée en Isère et en Savoie auprès de vingt-quatre acteurs de proximité concernés par la loi - recrutés parmi des psychiatres, juges, patients et familles - montre que cette loi n'est pas globalement remise en cause en pratique et qu'elle apporte des avantages : regard extérieur d'un juge, période d'observation initiale, soins rapides aux personnes isolées en cas de péril imminent, amélioration du suivi ambulatoire sous contrainte. Mais la loi du 5 juillet 2011 entraîne aussi de nombreuses difficultés : les sorties d'essai de moyenne durée ont été fortement limitées dans le texte initial?; l'articulation entre univers judiciaire et médical est complexe ; les moyens manquent ; les audiences sont problématiques car précoces, publiques, et parfois réalisées en dehors des établissements hospitaliers ; les certificats médicaux sont trop nombreux ; certaines parties du texte ne sont pas claires. Comme c'est déjà le cas pour une partie d'entre elles (loi du 23 septembre 2013), ces difficultés gagneraient à être travaillées pour une meilleure application de la loi.

Fakra E., Belzeaux R., Pringuey D., Cermolacce M., Correard N., Micoulaud-Franchi J.A., Azorin J.M. (2013). [Mixed states and schizophrenia]. *Encéphale*, 39 Suppl 3 139-144.

Abstract: Because of their compilation of contrasted symptoms and their variable clinical presentation, mixed episodes have been withdrawn from the DSM. However, mixed states question not only the bonds between depression and mania, but also the distinction between bipolar disorders and schizophrenia. Indeed, doubts about the dichotomy introduced by Kraepelin between bipolar disorders and schizophrenia is as old as the nosology itself, as attest the later works of this author revealing his hesitations on his own classification. But findings here reviewed issued from recent technical advances, particularly in the imaging and genetic fields, offer a better understanding of the boundaries between these two disorders. Yet, when confronted to an acute episode, clinicians may find it challenging to distinguish a mixed state from a schizophrenic relapse. Indeed, there is no pathognomonic manifestation allowing to retain a diagnosis with confidence. The physician will therefore have to identify a pattern of signs, which will orient his assessment with no certainty. Thus, negative rather than affective or psychotic symptomatology appears to be useful in discriminating schizophrenia (or schizoaffective) disorders from mixed mania. However, a conclusion during this acute stage appears in definitive a formal exercise, first because the final diagnosis will only be ascertained once the symptoms are amended, and second because, according to our classifications, a mood episode, including mania and mixed mania, can be observed without ruling out the diagnosis of schizophrenia.

Pringuey D., Cherikh F., Giordana B., Fakra E., Dassa D., Cermolacce M., Belzeaux R., Maurel M., Azorin J.M. (2013). [Mixed states: Evolution of classifications]. *Encéphale*, 39 Suppl 3 134-138.

Abstract: The nosological position of mixed states has followed the course of classifying methods in psychiatry, the steps of the invention of the clinic, progress in the organization of care, including the discoveries of psychopharmacology. The clinical observation of a mixture of symptoms emerging from usually opposite clinical conditions is classical. In the 70s, a syndromic specification fixed the main symptom combinations but that incongruous assortment failed to stabilize the nosological concept. Then stricter criteriology was proposed. To be too restrictive, a consensus operates a dimensional opening that attempts to meet the pragmatic requirements of nosology validating the usefulness of the class system. This alternation between rigor of categorization and return to a more flexible criteriological option reflects the search for the right balance between nosology and diagnosis. The definition of mixed states is best determined by their clinical and prognostic severity, related to the risk of suicide, their lower therapeutic response, the importance of their psychiatric comorbidities, anxiety, emotional lability, alcohol abuse. Trying to compensate for the lack of categorical definitions and better reflecting the clinical field problems, new definitions complement criteriology with dimensional aspects, particularly taking into account temperaments.

Economou M., Madianos M., Peppou L.E., Souliotis K., Patelakis A., Stefanis C. (2014). Cognitive social capital and mental illness during economic crisis: A nationwide population-based study in Greece. *Soc Sci Med*, 100 141-147.

Abstract: The ongoing financial crisis in Greece has yielded adverse effects on the mental health of the population. In this context, the particular study investigates the link between two indices of cognitive social capital; namely interpersonal and institutional trust, and the presence of major depression and generalized anxiety disorder. A random and representative sample of 2256 respondents took part in a cross-sectional nationwide telephone survey the time period February-April 2011 (Response Rate = 80.5%), after being recruited from the national phone number databank. Major depression and generalized anxiety disorder were assessed with the Structured Clinical Interview, while for interpersonal and institutional trust the pertinent questions of the European Social Survey were utilized. Socio-demographic variables were also encompassed in the research instrument, while participants' degree of financial strain was assessed through the Index of Personal Economic Distress. Both interpersonal and institutional trust were found to constitute protective factors against the presence of major depression, but not against generalized anxiety disorder for people experiencing low economic hardship. Nonetheless, in people experiencing high financial strain, interpersonal and institutional trust were not found to bear any association with the presence of the two disorders. Consistent with these, the present study shows that the effect of social capital on mental health is not uniform, as evident by the different pattern of results for the two disorders. Furthermore, cognitive social capital no longer exerts its protective influence on mental health if individuals experience high economic distress. As a corollary of this, interventions aiming at mitigating the mental health effects of economic downturns cannot rely solely on the enhancement of social capital, but also on alleviating economic burden.

Soins de santé primaires / Primary Health Care

Contandriopoulos D., Perroux M. (2013). Fee Increases and Target Income Hypothesis: Data from Quebec on Physicians' Compensation and Service Volumes. *Healthcare Policy*, 9 (2) : 30-35.

Abstract: Recent years have witnessed important public investments in physicians' compensation across Canada. The current paper uses data from Quebec to assess the impact of those investments on the volumes of services provided to the population. While total physician compensation costs, average physician compensation and average unit cost per service all rose extremely fast, the total number of services, number of services per capita and average number of services per physician either stagnated or declined. This pattern is compatible with the economic target income hypothesis and raises important policy questions.

Baron R.J., Davis K. (2013). Accelerating the Adoption of High-Value Primary Care : A New Provider Type under Medicare?. *New England Journal of Medicine*, 370 (2) : 99-101. <http://dx.doi.org/10.1056/NEJMp1314933>

Feng Y., Ma A., Farrar S., Sutton M. (2013). The tougher the better: an economic analysis of increased payment thresholds on the performance of general practices. *Health Economics*, ahead of pub.

Abstract: We investigate whether and how a change in performance-related payment motivated General Practitioners (GPs) in Scotland. We evaluate the effect of increases in the performance thresholds required for maximum payment under the Quality and Outcomes Framework in April 2006. A difference-in-differences estimator with fixed effects was employed to examine the number of patients treated under clinical indicators whose payment schedules were revised and to compare these with the figures for those indicators whose schedules remained unchanged. The results suggest that the increase in the maximum performance thresholds increased GPs' performance by 1.77% on average. Low-performing GPs improved significantly more (13.22%) than their high-performing counterparts (0.24%). Changes to maximum performance thresholds are differentially effective in incentivising GPs and could be used further to raise GPs' performance across all indicators.

McCullough L.B. (2013). The professional medical ethics model of decision making under conditions of clinical uncertainty. *Med Care Res Rev*, 70 (1 Suppl) : 141S-158S.

Abstract: The professional medical ethics model of decision making may be applied to decisions clinicians and patients make under the conditions of clinical uncertainty that exist when evidence is low or very low. This model uses the ethical concepts of medicine as a profession, the professional virtues of integrity and candor and the patient's virtue of prudence, the moral management of medical uncertainty, and trial of intervention. These features combine to justifiably constrain clinicians' and patients' autonomy with the goal of preventing nondeliberative decisions of patients and clinicians. To prevent biased recommendations by the clinician that promote such nondeliberative decisions, medically reasonable alternatives supported by low or very low evidence should be offered but not recommended. The professional medical ethics model of decision making aims to improve the quality of decisions by reducing the unacceptable variation that can result from nondeliberative decision making by patients and clinicians when evidence is low or very low.

Kringos D.S., Boerma W.G., van der Zee J., Groenewegen P.P. (2013). Political, cultural and economic foundations of primary care in Europe. *Soc Sci Med*, 99 9-17.

Abstract: This article explores various contributing factors to explain differences in the strength of the primary care (PC) structure and services delivery across Europe. Data on the strength of primary care in 31 European countries in 2009/10 were used. The results showed

that the national political agenda, economy, prevailing values, and type of healthcare system are all important factors that influence the development of strong PC. Wealthier countries are associated with a weaker PC structure and lower PC accessibility, while Eastern European countries seemed to have used their growth in national income to strengthen the accessibility and continuity of PC. Countries governed by left-wing governments are associated with a stronger PC structure, accessibility and coordination of PC. Countries with a social-security based system are associated with a lower accessibility and continuity of PC; the opposite is true for transitional systems. Cultural values seemed to affect all aspects of PC. It can be concluded that strengthening PC means mobilising multiple leverage points, policy options, and political will in line with prevailing values in a country.

Greenhalgh T., Stones R., Swinglehurst D. (2014). Choose and Book: A sociological analysis of 'resistance' to an expert system ? *Social Science & Medicine*, 104 210-219.

Abstract: In 2004, the English Department of Health introduced a technology (Choose and Book) designed to help general practitioners and patients book hospital outpatient appointments. It was anticipated that remote booking would become standard practice once technical challenges were overcome. But despite political pressure and financial incentives, Choose and Book remained unpopular and was generally used reluctantly if at all. Policymakers framed this as a problem of 'clinician resistance'. We considered Choose and Book from a sociological perspective. Our dataset, drawn from a qualitative study of computer use in general practice, comprised background documents, field notes, interviews, clinical consultations (directly observed and videotaped) and naturally occurring talk relating to referral to hospital in four general practices. We used strong structuration theory, Giddens' conceptualisation of expert systems, and sensitivity to other sociological perspectives on technology, institutions and professional values to examine the relationship between the external environment, the evolving technology and actions of human agents (GPs, administrators, managers and patients). Choose and Book had the characteristics of an expert system. It served to 'empty out' the content of the consultation as the abstract knowledge it contained was assumed to have universal validity and to over-ride the clinician's application of local knowledge and practical wisdom. Sick patients were incorrectly assumed to behave as rational choosers, able and willing to decide between potential options using abstracted codified information. Our analysis revealed four foci of resistance: to the policy of choice that Choose and Book symbolised and purported to deliver; to accommodating the technology's socio-material constraints; to interference with doctors' contextual judgements; and to adjusting to the altered social relations consequent on its use. We conclude that 'resistance' is a complex phenomenon with socio-material and normative components; it is unlikely to be overcome using the behaviourist techniques recommended in some health informatics and policy literature.

Graetz I., Reed M., Shortell S.M., Rundall T.G., Bellows J., Hsu J. (2014). The Association between EHRs and Care Coordination Varies by Team Cohesion. *Health Services Research*, 49 (1pt2) : 438-452.

Abstract: Objective To examine whether primary care team cohesion changes the association between using an integrated outpatient-inpatient electronic health record (EHR) and clinician-rated care coordination across delivery sites. Study Design Self-administered surveys of primary care clinicians in a large integrated delivery system, collected in 2005 (N = 565), 2006 (N = 678), and 2008 (N = 626) during the staggered implementation of an integrated EHR (2005-2010), including validated questions on team cohesion. Using multivariable regression, we examined the combined effect of EHR use and team cohesion on three dimensions of care coordination across delivery sites: access to timely and complete information, treatment agreement, and responsibility agreement. Principal Findings Among clinicians working in teams with higher cohesion, EHR use was associated with

significant improvements in reported access to timely and complete information (53.5 percent with EHR vs. 37.6 percent without integrated-EHR), agreement on treatment goals (64.3 percent vs. 50.6 percent), and agreement on responsibilities (63.9 percent vs. 55.2 percent, all $p < .05$). We found no statistically significant association between use of the integrated-EHR and reported care coordination in less cohesive teams. Conclusion The association between EHR use and reported care coordination varied by level of team cohesion. EHRs may not improve care coordination in less cohesive teams.

Van Dijk C.E., Verheij R.A., Te B.H., Spreeuwenberg P., Groenewegen P.P., de Bakker D.H. (2014). Changes in the remuneration system for general practitioners: effects on contact type and consultation length. *Eur J Health Econ*, 15 (1) : 83-91.

Abstract: In The Netherlands, the remuneration system for GPs changed in 2006. Before the change, GPs received a capitation fee for publicly insured patients and fee for service (FFS) for privately insured patients. In 2006, a combined system was introduced for all patients, with elements of capitation as well as FFS. This created a unique opportunity to investigate the effects of the change in the remuneration system on contact type and consultation length. Our hypothesis was that for former publicly insured patients the change would lead to an increase in the proportion of home visits, a decrease in the proportion of telephone consultations and an increase in consultation length relative to formerly privately insured patients. Data were used from electronic medical records from 36 to 58 Dutch GP practices and from 532,800 to 743,961 patient contacts between 2002 and 2008 for contact type data. For consultation length, 1,994 videotaped consultations were used from 85 GP practices in 2002 and 499 consultations from 16 GP practices in 2008. Multilevel multinomial regression analysis was used to analyse consultation type. Multilevel logistic and linear regression analyses were used to examine consultation length. Our study shows that contact type and consultation length were hardly affected by the change in remuneration system, though the proportion of home visits slightly decreased for privately insured patients compared with publicly insured patients. Declaration behaviour regarding telephone consultations did change; GP practices more consistently declared telephone consultations after 2006.

Mead H., Andres E., Regenstein M. (2014). Underserved patients' perspectives on patient-centered primary care: does the patient-centered medical home model meet their needs? *Med Care Res Rev*, 71 (1) : 61-84.

Abstract: The patient-centered medical home (PCMH) has gained significant interest as a delivery system model that can improve health care quality while reducing costs. This study uses focus groups to investigate underserved, chronically ill patients' preferences for care and develops a patient-centered framework of priorities. Seven major priorities were identified: (a) communication and partnership, (b) affordable care, (c) coordinated care, (d) personal responsibility, (e) accessible care, (f) education and support resources, and (g) the essential role of nonphysician providers in supporting their care. Using the framework, we analyzed the PCMH joint principals as developed by U.S. medical societies to identify where the PCMH model could be improved to better meet the needs of these patients. Four of the seven patient priorities were identified as not present in or supported by current PCMH joint principles. The study discusses how the PCMH model can better address the needs of low-income, disadvantaged patients.

Stange K. (2014). How does provider supply and regulation influence health care markets? Evidence from nurse practitioners and physician assistants. *J Health Econ*, 33 1-27.

Abstract: Nurse practitioners (NPs) and physician assistants (PAs) now outnumber family practice doctors in the United States and are the principal providers of primary care to many

communities. Recent growth of these professions has occurred amidst considerable cross-state variation in their regulation, with some states permitting autonomous practice and others mandating extensive physician oversight. I find that expanded NP and PA supply has had minimal impact on the office-based healthcare market overall, but utilization has been modestly more responsive to supply increases in states permitting greater autonomy. Results suggest the importance of laws impacting the division of labor, not just its quantity.

Heikkilä T.J., Hyppölä H., Aine T., Halila H., Vanska J., Kujala S., Virjo I., Mattila K. (2014). How do doctors choose where they want to work? - Motives for choice of current workplace among physicians registered in Finland 1977-2006. *Health Policy*, 114 (2-3) : 109-117.

Abstract: Though there are a number of studies investigating the career choices of physicians, there are only few concerning doctors' choices of workplace. A random sample (N=7758) of physicians licensed in Finland during the years 1977-2006 was surveyed. Respondents were asked: "To what extent did the following motives affect your choice of your current workplace?" Respondents were grouped based on several background variables. The groups were used as independent variables in univariate analysis of covariance (ANCOVA). The factors Good workplace, Career and professional development, Non-work related issues, Personal contacts and Salary were formed and used as dependent variables. There were significant differences between groups of physicians, especially in terms of gender, working sector and specialties. The association of Good workplace, Career and professional development, and Non-work related issues with the choice of a workplace significantly decreased with age. Female physicians were more concerned with Career and professional development and Non-work related issues. Since more females are entering the medical profession and there is an ongoing change of generations, health care organizations and policy makers need to develop a new philosophy in order to attract physicians. This will need to include more human-centric management and leadership, better possibilities for continuous professional development, and more personalized working arrangements depending on physician's personal motives.

Kardakis T., Weinehall L., Jerden L., Nystrom M.E., Johansson H. (2014). Lifestyle interventions in primary health care: professional and organizational challenges. *Eur J Public Health*, 24 (1) : 79-84.

Abstract: BACKGROUND: Interventions that support patient efforts at lifestyle changes that reduce tobacco use, hazardous use of alcohol, unhealthy eating habits and insufficient physical activity represent important areas of development for health care. Current research shows that it is challenging to reorient health care toward health promotion. The aim of this study was to explore the extent of health care professional work with lifestyle interventions in Swedish primary health care, and to describe professional knowledge, attitudes and perceived organizational support for lifestyle interventions. METHODS: The study is based on a cross-sectional Web-based survey directed at general practitioners, other physicians, residents, public health nurses and registered nurses (n = 315) in primary health care. RESULTS: Fifty-nine percent of the participants indicated that lifestyle interventions were a substantial part of their duties. A majority (77%) would like to work more with patient lifestyles. Health professionals generally reported a thorough knowledge of lifestyle intervention methods for disease prevention. Significant differences between professional groups were found with regard to specific knowledge and extent of work with lifestyle interventions. Alcohol was the least addressed lifestyle habit. Management was supportive, but structures to sustain work with lifestyle interventions were scarce, and a need for national guidelines was identified. CONCLUSIONS: Health professionals reported thorough knowledge and positive attitudes toward lifestyle interventions. When planning for further implementation of lifestyle interventions in primary health care, differences between

professional groups in knowledge, extent of work with promotion of healthy lifestyles and lifestyle issues and provision of organizational support such as national guidelines should be considered.

Peersman W., Pasteels I., Cambier D., De Maesener J., Willems S. (2014). Validity of self-reported utilization of physician services: a population study. *Eur J Public Health*, 24 (1) : 91-97.

Abstract: BACKGROUND: Health care utilization is of central interest in epidemiology, and most of the studies rely on self-report. The objectives of this study were to assess the validity of self-reported utilization of general practitioner and specialist physician by correlating self-reported utilization with registered services utilization, and to determine the factors related to that validity. METHODS: The 1997 Belgian National Health Interview Survey (BNHIS) was linked with registered medical utilization data provided by the Belgian Health Insurance Funds. Valid information on general practitioner and specialist physician utilization during the past 2 months was found for 5869 participants at the BNHIS who were aged ≥ 25 years. Intra-class correlation coefficients were used to determine the rate of agreement, and multinomial logistic regression to model factors influencing under- and over-reporting. RESULTS: The results demonstrated a substantial agreement between the self-reported and registered general practitioner contacts, and only a minor bias was found towards under-reporting. There was no significant difference between mean self-reported and registered specialist physician utilization, but the agreement was rather moderate. Gender, age, country of birth, self-rated health, number of chronic illnesses, having functional limitations and having mental health problems, were associated with under- and/or over-reporting. CONCLUSION: Studies that aim to compare the utilization of different socio-demographic groups have to take into account that the reporting errors vary by respondents characteristics.

Systèmes de santé / Health Care Systems

Lostao L., Blane D., Gimeno D., Netuveli G., Regidor E. (2014). Socioeconomic patterns in use of private and public health services in Spain and Britain: implications for equity in health care. *Health Place*, 25 19-25.

Abstract: This paper estimates the pattern of private and public physician visits and hospitalisation by socioeconomic position in two countries in which private healthcare expenditure constitutes a different proportion of the total amount spent on health care: Britain and Spain. Private physician visits and private hospitalisations were quantitatively more important in Spain than in Britain. In both countries, the use of private services showed a direct socioeconomic gradient. In Spain, the use of public GPs and public specialists tends to favour the worst-off, but no significant differences were observed in public hospitalisation. In Britain, with some exceptions, no significant socioeconomic differences were observed in the use of public health care services. The different pattern observed in the use of public specialist services may be due to the high frequency of visits to private specialists in Spain.

Epstein A.M., Jha A.K., Orav E.J., Liebman D.L., Audet A.M., Zezza M.A., Guterman S. (2014). Analysis of early accountable care organizations defines patient, structural, cost, and quality-of-care characteristics. *Health Aff.(Millwood.)*, 33 (1) : 95-102.

Abstract: Accountable care organizations (ACOs) have attracted interest from many policy makers and clinical leaders because of their potential to improve the quality of care and reduce costs. Federal ACO programs for Medicare beneficiaries are now up and running, but little information is available about the baseline characteristics of early entrants. In this descriptive study we present data on the structural and market characteristics of these early ACOs and compare ACOs' patient populations, costs, and quality with those of their non-ACO counterparts at baseline. We found that ACO patients were more likely than non-ACO patients to be older than age eighty and had higher incomes. ACO patients were less likely than non-ACO patients to be black, covered by Medicaid, or disabled. The cost of care for ACO patients was slightly lower than that for non-ACO patients. Slightly fewer than half of the ACOs had a participating hospital. Hospitals that were in ACOs were more likely than non-ACO hospitals to be large, teaching, and not-for-profit, although there was little difference in their performance on quality metrics. Our findings can be useful in interpreting the early results from the federal ACO programs and in establishing a baseline to assess the programs' development.

Meltzer D.O., Chung J.W. (2014). The population value of quality indicator reporting: a framework for prioritizing health care performance measures. *Health Aff.(Millwood.)*, 33 (1) : 132-139.

Abstract: The Agency for Healthcare Research and Quality (AHRQ) National Healthcare Quality and Disparities Reports contain more than 250 quality indicators, such as whether a patient with a suspected heart attack received an aspirin. The Department of Health and Human Services National Quality Measures Clearinghouse identifies more than 2,100 such indicators. Because resources for making quality improvements are limited, there is a need to prioritize among these indicators. We propose an approach to assess how reporting specific quality indicators would change care to improve the length and quality of life of the US population. Using thirteen AHRQ quality indicators with readily available data on the benefits of indicator reporting, we found that seven of them account for 93 percent of total benefits, while the remaining six account for only 7 percent of total benefits. Use of a framework such as this could focus resources on indicators having the greatest expected impact on population health.

Travail et santé / Occupational Health

Bahu M., Mermilliod C., Volkoff S. (2012). Conditions de travail pénibles au cours de la vie professionnelle et état de santé après 50 ans. *Revue Française des Affaires Sociales*, (4) : 107-136.

Abstract: Dans quelles conditions les expositions à des conditions de travail pénibles physiquement ont-elles une influence sur la santé ? Les auteurs se sont appuyés sur les résultats de l'enquête Santé et itinéraire professionnel (SIP) pour répondre à cette question. SIP (1^{re} vague) a été réalisée en face à face fin 2006 sur un échantillon représentatif de la population générale métropolitaine de 13 700 personnes de 20 à 74 ans, actives et inactives. Elle comprend notamment un recueil rétrospectif de la biographie professionnelle et un relevé plus détaillé de leur état de santé au moment de l'enquête. Une analyse multivariée sur la population de plus de 50 ans confirme l'effet des expositions étudiées (travail de nuit, travail répétitif, travail physiquement exigeant et exposition aux produits nocifs) sur la santé. Elle fait apparaître un double effet protecteur du niveau de diplôme à la fois en termes de risque d'exposition et d'apparition de limitations d'activité. L'introduction de la durée des expositions dans l'analyse fait apparaître un mécanisme sélectif (dit « effet du travailleur sain

») particulièrement net pour le travail de nuit. Enfin, le cumul des expositions a un effet significatif sur la dégradation de la santé, à âge et diplôme identiques.

Polidano C., Vu H. (2013). Differential labour market impacts from disability onset. *Health Economics*, ahead of pub.

Abstract: We estimate the causal labour market impacts of disability onset by gender, age and education levels up to 4 years after onset using longitudinal data from the Household Income and Labour Dynamics Australia survey and difference-in-difference propensity score matching techniques. We find lasting negative impacts on employment, especially full-time employment, which is due more to reduced movement into full-time employment than downshifting from full-time to part-time work following onset. Those without post-school education qualifications are particularly vulnerable to the impacts of onset and are more likely to be out of work and on income support than those with qualifications up to 4 years after onset, due in part because they have greater difficulty adjusting.

Rumball-Smith J., Barthold D., Nandi A., Heymann J. (2014). Diabetes associated with early labor-force exit: a comparison of sixteen high-income countries. *Health Aff.(Millwood.)*, 33 (1) : 110-115.

Abstract: The economic burden of diabetes and the effects of the disease on the labor force are of substantial importance to policy makers. We examined the impact of diabetes on leaving the labor force across sixteen countries, using data about 66,542 participants in the Survey of Health, Ageing and Retirement in Europe; the US Health and Retirement Survey; or the English Longitudinal Study of Ageing. After matching people with diabetes to those without the disease in terms of age, sex, and years of education, we used Cox proportional hazards analyses to estimate the effect of diabetes on time of leaving the labor force. Across the sixteen countries, people diagnosed with diabetes had a 30 percent increase in the rate of labor-force exit, compared to people without the disease. The costs associated with earlier labor-force exit are likely to be substantial. These findings further support the value of greater public- and private-sector investment in preventing and managing diabetes.

Arends I., Bultmann U., Nielsen K., Van Rhenen W., de Boer M.R., Van der Klink J.J. (2014). Process evaluation of a problem solving intervention to prevent recurrent sickness absence in workers with common mental disorders. *Soc Sci Med*, 100 123-132.

Abstract: Common mental disorders (CMDs) are a major cause of sickness absence. Twenty to 30% of the workers who return to work after sickness absence due to CMDs experience recurrent sickness absence. We developed the Stimulating Healthy participation And Relapse Prevention (SHARP)-at work intervention, a problem solving intervention delivered by occupational physicians (OPs), to prevent recurrent sickness absence in this worker population in The Netherlands. A process evaluation was conducted alongside a cluster-randomised controlled trial to (1) evaluate whether the SHARP-at work intervention was implemented according to the protocol and differed from treatment in the control group, and (2) to investigate the relationship between the key elements of the intervention and the effect outcome (i.e. recurrent sickness absence). We collected process data for both the intervention and control group on recruitment, reach, dose delivered, dose received, fidelity, context and satisfaction. Data on recurrent sickness absence was collected through the registry system of the collaborating occupational health service. The study was performed in the Netherlands, and between 2010 and 2012, 154 OPs and 158 participants participated. Compared to the control group, participants in the intervention group more frequently had two or more consultations with the OP (odds ratio [OR] = 3.2, 95% confidence interval [CI] = 1.2-8.8) and completed more assignments (OR = 33.8, 95% CI = 10.4-109.5) as

recommended in the intervention protocol. OPs and participants were satisfied with the intervention and rated it as applicable. Several individual intervention components were linked to the effect outcome. The process evaluation showed that the SHARP-at work intervention was conducted according to the protocol for the majority of the participants and well-received by OPs and participants. Furthermore, the intervention differed from treatment in the control group. Overall, the results provide support for implementing the intervention in practice.

Thielen K., Nygaard E., Andersen I., Diderichsen F. (2014). Employment consequences of depressive symptoms and work demands individually and combined. *Eur J Public Health*, 24 (1) : 34-39.

Abstract: BACKGROUND: Denmark, like other Western countries, is recently burdened by increasingly high social spending on employment consequences caused by ill mental health. This might be the result of high work demands affecting persons with ill mental health. Therefore, this study assesses to what extent depressive symptoms and high work demands, individually and combined, have an effect on employment consequences. METHODS: We conducted a population-based 7-year longitudinal follow-up study with baseline information from the year 2000 on socio-demographics, lifestyle, depressive symptoms and work demands. In total, 5785 employed persons, aged 40 and 50 years, were included. Information about employment status, sick leave and work disability was obtained from registers. Logistic regression models were used to measure separate and combined effects of depressive symptoms and work demands on job change, unemployment and sick leave during 2001-02 and work disability during 2003-07. RESULTS: After adjustment for covariates, high physical work demands and depressive symptoms had a graded effect on subsequent unemployment, sick leave and permanent work disability. Persons with both depressive symptoms and high physical demands had the highest risks, especially for sick leave, but the combined effect did not exceed the product of single effects. Persons who perceived high amount of work changed job significantly more frequently. CONCLUSION: Persons with depressive symptoms might have an increased risk of negative employment consequences irrespective of the kind and amount of work demands. This might be an effect on the level of work ability in general as well as partly the result of health selection and co-morbidity.