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## DOC VEILLE

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21 mars 2014 / March The 21st 2014

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## Assurance maladie / Health Insurance

**Van Kleef R.C., Van de Ven W.P., van Vliet R.C. (2013). Risk selection in a regulated health insurance market: a review of the concept, possibilities and effects.** *Expert Review of Pharmacoeconomics & Outcomes Research*, 13 (6) : 743-752.

Abstract: The Dutch basic health insurance is based on the principles of regulated competition. This implies that insurers and providers compete on price and quality while the regulator sets certain rules to achieve public objectives such as solidarity. Two regulatory aspects of this scheme are that insurers are not allowed to risk rate their premiums and are compensated for predictable variation in individual medical expenses (i.e., risk equalization). Research, however, indicates that the current risk equalization is imperfect, which confronts insurers and consumers with incentives for risk selection. The goal of this paper is to review the concept, possibilities and potential effects of risk selection in the Dutch basic health insurance. We conclude that the possibilities for risk selection are numerous and a potential threat to solidarity, efficiency and quality of care. Regulators should be aware that measurement of risk selection is a methodological and data-demanding challenge.

## Economie de la santé / Health Economics

**Franc C. (2014). Les comptes nationaux de la santé 2012 - Une stabilité d'apparence.** *Médecine Sciences*, 30 199-203.

**Reeves A., McKee M., Basu S., Stuckler D. (2014). The political economy of austerity and healthcare: Cross-national analysis of expenditure changes in 27 European nations 1995-2011.** *Health Policy*, 115 (1)

Abstract: Why have patterns of healthcare spending varied during the Great Recession? Using cross-national, harmonised data for 27 EU countries from 1995 to 2011, we evaluated political, economic, and health system determinants of recent changes to healthcare expenditure. Data from EuroStat, the IMF, and World Bank (2013 editions) were evaluated using multivariate random- and fixed-effects models, correcting for pre-existing time-trends. Reductions in government health expenditure were not significantly associated with magnitude of economic recessions (annual change in GDP,  $p=0.31$ , or cumulative decline,  $p=0.40$  or debt crises (measured by public debt as a percentage of GDP,  $p=0.38$  or per capita,  $p=0.83$ )). Nor did ideology of governing parties have an effect. In contrast, each \$100 reduction in tax revenue was associated with a \$2.72 drop in health spending (95% CI: \$1.03-4.41). IMF borrowers were significantly more likely to reduce healthcare budgets than non-IMF borrowers (OR=3.88, 95% CI: 1.95 -7.74), even after correcting for potential confounding by indication. Exposure to lending from international financial institutions, tax revenue falls, and decisions to implement cuts correlate more closely than underlying economic conditions or orientation of political parties with healthcare expenditure change in EU member states.

**Kronenberg C., Barros P.P. (2014). Catastrophic healthcare expenditure - Drivers and protection: The Portuguese case.** *Health Policy*, (115) 1))

Abstract: The objective of this paper is to assess the extent of catastrophic healthcare expenditure, which can lead to impoverishment, even in a country with a National Health Service, such as Portugal. The level of catastrophic healthcare expenditure will be identified before the determinants of these catastrophic payments are analyzed. Afterwards, the effects of existing exemptions to copayments in health care use will be tested and the relationship between catastrophe and impoverishment will be discussed. Catastrophe is calculated from the Portuguese Household Budget Surveys of 2000 and 2005, and then analyzed using logistic regression models. The results show that catastrophe due to healthcare out-of-pocket payments are a sizeable issue in Portugal. Exemptions from out-of-pocket expenses for medical care should be created to prevent vulnerable groups from facing catastrophic

healthcare spending. These vulnerable groups include children, people with disabilities and individuals suffering from chronic conditions. Disability proxies offer straightforward policy options for an exemption for the elderly with recognized disabilities. An exemption of retired people with disabilities is therefore recommended to policymakers as it targets a vulnerable group with high risk of facing catastrophic healthcare expenditure.

**Gopalan S.S., Mutasa R., Friedman J., Das A. (2014). Health sector demand-side financial incentives in low- and middle-income countries: A systematic review on demand- and supply-side effects. *Soc Sci Med*, 100 72-83.**

Abstract: Demand-side financial incentive (DSF) is an emerging strategy to improve health seeking behavior and health status in many low- and middle-income countries. This narrative synthesis assessed the demand- and supply-side effects of DSF. Forty one electronic data bases were searched to screen relevant experimental and quasi-experimental study designs. Out of the 64 selected papers, 28 were eligible for this review and they described 19 DSF initiatives across Asia, Africa and Latin America. There were three categories of initiatives, namely long-run multi-sectoral programs or LMPs (governmental); long-run health-exclusive programs (governmental); and short-run health-exclusive initiatives (both governmental and non-governmental). Irrespective of the nature of incentives and initiatives, all DSF programs could achieve their expected behavioral outcomes on healthcare seeking and utilization substantially. However, there existed a few negative and perverse outcomes on health seeking behavior and DSF's impact on continuous health seeking choices (e.g. bed net use and routine adult health check-ups) was mixed. Their effects on maternal health status, diarrhea, malaria and out-of-pocket expenditure were under-explored; while chronic non-communicable diseases were not directly covered by any DSF programs. DSF could reduce HIV prevalence and child deaths, and enhance nutritional and growth status of children. The direction and magnitude of their effects on health status was elastic to the evaluation design employed. On health system benefits, despite prioritizing on vulnerable groups, DSF's substantial effect on the poorest of the poor was mixed compared to that on the relatively richer groups. Though DSF initiatives intended to improve service delivery status, many could not optimally do so, especially to meet the additionally generated demand for care. Causal pathways of DSF's effects should be explored in-depth for mid-course corrections and cross-country learning on their design, implementation and evaluation. More policy-specific analyses on LMPs are needed to assess how 'multi-sectoral' approaches can be cost-effective and sustainable in the long run compared to 'health exclusive' incentives.

## Géographie de la santé / Geography of Health

**Gilles I., Bejaoui B., Courvoisier N., Clemence A. (2014). Inhabitants' and professionals' social representations of health determinants in a disadvantaged urban area in France: A qualitative analysis. *Rev Epidemiol Santé Publique*, 62 (1) : 5-14.**

Abstract: BACKGROUND AND OBJECTIVE: Access to care in French disadvantaged urban areas remains an issue despite the implementation of local healthcare structures. To understand this contradiction, we investigated social representations held by inhabitants of such areas, as well as those of social and healthcare professionals, regarding events or behaviours that can impact low-income individuals' health. METHOD: In the context of a health diagnosis, 288 inhabitants living in five disadvantaged districts of Aix-les-Bains, as well as 28 professionals working in these districts, completed an open-ended questionnaire. The two groups of respondents were asked to describe what could have an impact on health status from the inhabitants' point of view. The textual responses were analyzed using the Alceste method. RESULTS: We observed a number of differences in the way the inhabitants and professionals represented determinants of health in disadvantaged urban areas: the former proposed a representation mixing personal responsibility with physiological, social, familial, and professional aspects, whereas the latter associated health issues with marginalization (financial, drug, or alcohol problems) and personal responsibility. Both inhabitants and professionals mentioned control over events and lifestyle as determinants of health. DISCUSSION: The results are discussed

regarding the consequences of these different representations on the beneficiary - healthcare-provider relationship in terms of communication and trust.

**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.

**Di Matteo L. (2014). Physician numbers as a driver of provincial government health spending in Canadian health policy.** *Health Policy*, 115 (1)

Abstract: Physician spending is one of the fastest growing Canadian public sector health categories of recent years but despite their recent growth physician numbers are a relatively small contributor to the increases in total provincial government health expenditure. Regression models of the determinants of provincial government health spending are estimated and show physician numbers are a positive and significant driver of provincial government health care spending after controlling for other factors though the overall contribution is relatively small. From 1975 to 2009, the increases in physician numbers accounted for a range of 3.2-13.3 percent of the increase in real per capita total provincial government health expenditures ranging from a low of 1.9 to 7.6 percent for Manitoba to a high of 5.3 to 18.3 percent for Quebec. These are modest contributions to total health spending but vary more substantially across provinces when hospital and physician spending alone are considered particularly for Quebec and British Columbia. Nevertheless, these results suggest that physician numbers alone are a modest policy concern when it comes to restraining health costs and other factors such as utilization and fees are more important.

**Francese M., Romanelli M. (2014). Is there room for containing healthcare costs? An analysis of regional spending differentials in Italy.** *Eur J Health Econ*, 15 (2) : 117-132.

Abstract: This work aims at identifying the determinants of health spending differentials among Italian regions and at highlighting potential margins for savings. The analysis exploits a data set for the 21 Italian regions and autonomous provinces starting in the early 1990s and ending in 2006. After controlling for standard healthcare demand indicators, remaining spending differentials are found to be significant, and they appear to be associated with differences in the degree of appropriateness of treatments, health sector supply structure and social capital indicators. In general, higher regional expenditure does not appear to be associated with better reported or perceived quality in health services. In the regions that display poorer performances, inefficiencies appear not to be uniformly distributed among expenditure items. Overall, results suggest that savings could be achieved without reducing the amount of services provided to citizens. This seems particularly important given the expected rise in spending associated with the forecasted demographic developments.

## Hôpital / Hospitals

**Moisdon J.C. (2014). T2A : productivité et conditions de travail en établissements de santé.** *Revue Hospitalière de France*, (1) :

Abstract: Peu d'études, parmi les nombreuses évaluations de la tarification à l'activité (T2A), ont tenté d'appréhender la question relative aux gains de productivité des hôpitaux et leurs impacts sur les conditions de travail des personnels hospitaliers. Trois travaux de différentes natures, dont celui de la Fédération hospitalière de France sur l'évaluation de la T2A, convergent cependant sur un constat : si l'on se contente de productivités partielles, les établissements de santé publics ont vu la productivité du personnel paramédical augmenter.

**Van Kleef R.C., Van Vliet R.C., Van Rooijen E.M. (2014). Diagnoses-based cost groups in the Dutch risk-equalization model: The effects of including outpatient diagnoses.** *Health Policy*, 115 (1)

Abstract: BACKGROUND: The Dutch basic health-insurance scheme for curative care includes a risk equalization model (RE-model) to compensate competing health insurers for the predictable high costs of people in poor health. Since 2004, this RE-model includes the so-called Diagnoses-based Cost Groups (DCGs) as a risk adjuster. Until 2013, these DCGs have been mainly based on diagnoses from inpatient hospital treatment. OBJECTIVES: This paper examines (1) to what extent the Dutch RE-model can be improved by extending the inpatient DCGs with diagnoses from outpatient hospital treatment and (2) how to treat outpatient diagnoses relative to their corresponding inpatient diagnoses. METHOD: Based on individual-level administrative costs we estimate the Dutch RE-model with three different DCG modalities. Using individual-level survey information from a prior year we examine the outcomes of these modalities for different groups of people in poor health. CONCLUSIONS: We find that extending DCGs with outpatient diagnoses has hardly any effect on the R-squared of the RE-model, but reduces the undercompensation for people with a chronic condition by about 8%. With respect to incentives, it may be preferable to make no distinction between corresponding inpatient and outpatient diagnoses in the DCG-classification, although this will be at the expense of the predictive accuracy of the RE-model.

**Gao J., Moran E., Li Y.F., Almenoff P.L. (2014). Predicting Potentially Avoidable Hospitalizations.** *Medical Care*, 52 (2) :

Abstract: Background :Hospitalizations due to ambulatory care sensitive conditions (ACSCs) are widely accepted as an indicator of primary care access and effectiveness. However, broad early intervention to all patients in a health care system may be deemed infeasible due to limited resources. Objective :To develop a predictive model to identify high-risk patients for early intervention to reduce ACSC hospitalizations, and to explore the predictive power of different variables. Methods :The study population included all patients treated for ACSCs in the VA system in fiscal years (FY) 2011 and 2012 (n=2,987,052). With all predictors from FY2011, we developed a statistical model using hierarchical logistic regression with a random intercept to predict the risk of ACSC hospitalizations in the first 90 days and the full year of FY2012. In addition, we configured separate models to assess the predictive power of different variables. We used a random split-sample method to prevent overfitting. Results:For hospitalizations within the first 90 days of FY2012, the full model reached c-statistics of 0.856 (95% CI, 0.853-0.860) and 0.856 (95% CI, 0.852-0.860) for the development and validation samples, respectively. For predictive power of the variables, the model with only a random intercept yielded c-statistics of 0.587 (95% CI, 0.582-0.593) and 0.578 (95% CI, 0.573-0.583), respectively; with patient demographic and socioeconomic variables added, the c-statistics improved to 0.725 (95% CI, 0.720-0.729) and 0.721 (95% CI, 0.717-0.726), respectively; adding prior year utilization and cost raised the c-statistics to 0.826 (95% CI, 0.822-0.830) and 0.826 (95% CI, 0.822-0.830), respectively; the full model was reached with HCCs added. For the 1-year hospitalizations, only the full model was fitted, which yielded c-statistics of 0.835 (95% CI, 0.831-0.837) and 0.833 (95% CI, 0.830-0.837), respectively, for development and validation samples. Conclusions :Our analyses demonstrate that administrative data can be effective in predicting ACSC hospitalizations. With high predictive ability, the model can assist primary care providers to identify high-risk patients for early intervention to reduce ACSC hospitalizations.

**Liang L.L. (2014). Do diagnosis-related group--based payments incentivise hospitals to adjust output mix?** *Health Economics*, n/a.

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**Abstract:** This study investigates whether the diagnosis-related group (DRG)-based payment method motivates hospitals to adjust output mix in order to maximise profits. The hypothesis is that when there is an increase in profitability of a DRG, hospitals will increase the proportion of that DRG (own-price effects) and decrease those of other DRGs (cross-price effects), except in cases where there are scope economies in producing two different DRGs. This conjecture is tested in the context of the case payment scheme (CPS) under Taiwan's National Health Insurance programme over the period of July 1999 to December 2004. To tackle endogeneity of DRG profitability and treatment policy, a fixed-effects three-stage least squares method is applied. The results support the hypothesised own-price and cross-price effects, showing that DRGs which share similar resources appear to be complements rather substitutes. For-profit hospitals do not appear to be more responsive to DRG profitability, possibly because of their institutional characteristics and bonds with local communities. The key conclusion is that DRG-based payments will encourage a type of 'product-range' specialisation, which may improve hospital efficiency in the long run. However, further research is needed on how changes in output mix impact patient access and pay-outs of health insurance.

**Thomas R., Huntley A.L., Mann M., Huws D., Elwyn G., Paranjothy S., Purdy S. (2014). Pharmacist-led interventions to reduce unplanned admissions for older people: a systematic review and meta-analysis of randomised controlled trials. *Age and Ageing*, 43 (2) : 174-187.**

**Abstract:** Purpose: medication problems are thought to cause between 10 and 30% of all hospital admissions in older people. This systematic review aimed to evaluate the effectiveness of interventions led by hospital or community pharmacists in reducing unplanned hospital admissions for older people. Methods: eighteen databases were searched with a customised search strategy. Relevant websites and reference lists of included trials were checked. Randomised controlled trials were included that evaluated pharmacist-led interventions compared with usual care, with unplanned admissions or readmissions as an outcome. Two authors independently extracted data and assessed methodological quality. Results: twenty-seven randomised controlled trials (RCTs) were identified; seven trials were excluded. The 20 included trials comprised 16 for older people and 4 for older people with heart failure. Interventions led by hospital pharmacists (seven trials) or community pharmacists (nine trials) did not reduce unplanned admissions in the older population (risk ratios 0.97 95% CI: 0.88, 1.07; 1.07 95% CI: 0.96, 1.20). Three trials in older people with heart failure showed that interventions delivered by a hospital pharmacist reduced the relative risk of admissions. However, these trials were heterogeneous in intensity and duration of follow-up. One trial had a high risk of bias. Conclusions: evidence from three randomised controlled trials suggests that interventions led by hospital pharmacists reduce unplanned hospital admissions in older patients with heart failure, although these trials were heterogeneous. Data from 16 trials do not support the concept that interventions led by hospital or community pharmacists for the general older population reduces unplanned admissions.

**Dugoff E.H., Bekelman J.E., Stuart E.A., Armstrong K., Pollack C.E. (2014). Surgical Quality Is More Than Volume: The Association between Changing Urologists and Complications for Patients with Localized Prostate Cancer. *Health Serv Res*, [ahead of print]**

**Abstract:** OBJECTIVES: To examine the association of changing urologists on surgical complications in men with prostate cancer. DATA SOURCES/STUDY SETTING: Registry and administrative claims data from the Surveillance, Epidemiology, and End Results-Medicare database from 1995 to 2005. STUDY DESIGN: A cross-sectional observational study of men with prostate cancer who underwent radical prostatectomy. METHODS: Subjects were classified as having "changed urologists" if they had a different urologist who diagnosed their cancer from the one who performed their surgery. "Doubly robust" propensity score weighted multivariable logistic regression models were used to investigate the effect of changing urologists on 30-day surgical complications, late urinary complications, and long-term incontinence. PRINCIPAL FINDINGS: Men who changed urologists between diagnosis and treatment had significantly lower odds of 30-day surgical complications compared with men who did not change urologists (odds ratio: 0.82; 95 percent confidence interval: 0.76-0.89), after adjustment. Changing urologists was associated with lower risks of 30-day complications for both black and white men compared with staying with the same urologist for their diagnosis and surgical treatment. CONCLUSIONS: Urologist changing is associated with the observed variation in complications

following radical prostatectomy. This may suggest that patients are responding to aspects of surgical quality not captured in surgical volume.

**Sheaff R., Windle K., Wistow G., Ashby S., Beech R., Dickinson A., Henderson C., Knapp M. (2014). Reducing emergency bed-days for older people? Network governance lessons from the 'Improving the Future for Older People' programme. *Soc Sci Med*, 106C 59-66.**

Abstract: In 2007, the UK government set performance targets and public service agreements to control the escalation of emergency bed-days. Some years earlier, nine English local authorities had each created local networks with their health and third sector partners to tackle this increase. These networks formed the 'Improving the Future for Older People' initiative (IFOP), one strand of the national 'Innovation Forum' programme, set up in 2003. The nine sites set themselves one headline target to be achieved jointly over three years; a 20 per cent reduction in the number of emergency bed-days used by people aged 75 and over. Three ancillary targets were also monitored: emergency admissions, delayed discharges and project sustainability. Collectively the sites exceeded their headline target. Using a realistic evaluation approach, we explored which aspects of network governance appeared to have contributed to these emergency bed-day reductions. We found no simple link between network governance type and outcomes. The governance features associated with an effective IFOP network appeared to suggest that the selection and implementation of a small number of evidence-based services was central to networks' effectiveness. Each service needed to be coordinated by a network-based strategic group and hierarchically implemented at operational level by the responsible network member. Having a network-based implementation group with a 'joined-at-the-top' governance structure also appeared to promote network effectiveness. External factors, including NHS incentives, health reorganisations and financial targets similarly contributed to differences in performance. Targets and financial incentives could focus action but undermine horizontal networking. Local networks should specify which interventions network structures are intended to deliver. Effective projects are those likely to be evidence based, unique to the network and difficult to implement through vertical structures alone.

**Herwartz H., Strumann C. (2014). Hospital efficiency under prospective reimbursement schemes: an empirical assessment for the case of Germany. *Eur J Health Econ*, 15 (2) : 175-186.**

Abstract: The introduction of prospective hospital reimbursement based on diagnosis-related groups (DRG) has been a conspicuous attempt to decelerate the steady increase of hospital expenditures in the German health sector. In this work, the effect of the financial reform on hospital efficiency is subjected to empirical testing by means of two complementary testing approaches. On the one hand, we apply a two-stage procedure based on non-parametric efficiency measurement. On the other hand, a stochastic frontier model is employed that allows a one-step estimation of both production frontier parameters and inefficiency effects. To identify efficiency gains as a consequence of changes in the hospital incentive structure, we account for technological progress, spatial dependence and hospital heterogeneity. The results of both approaches do not reveal any increase in overall efficiency after the DRG reform. In contrast, a significant decline in overall hospital efficiency over time is observed.

## Inégalités de santé / Health Inequalities

**Norman P., Boyle P. (2013). Are health inequalities between differently deprived areas evident at different ages? A longitudinal study of census records in England and Wales, 1991-2001. *Health Place*, 26C 88-93.**

Abstract: The notion that mortality inequalities between differently deprived areas vary by age is logical since not all causes of death increase in risk with age and not all causes of death are related to the gradient of deprivation. In addition to the cause-age and cause-deprivation relationships, population

migration may redistribute the population such that the health-deprivation relationship varies by age. We calculate cross-sectional all cause mortality and self-reported limiting long-term illness (LLTI) rate ratios of most to least deprived areas to demonstrate inequalities at different ages. We use longitudinal data to investigate whether there are changes in the distribution of cohorts between differently deprived areas over time and whether gradients of LLTI with deprivation also change. We find similar deprivation inequalities by age for all cause mortality and self-reported health with less inequality for young adults and the elderly but the greatest inequalities during mid life. Over time there are systematic movements of cohorts between differently deprived areas and associated increases and decreases in the gradient of LLTI across deprivation. It seems likely that population migration does influence inequalities by age. Further work should investigate whether the situation exists for other morbidities and, to better inform public health policy, whether restricting summary measures of area health to ages between 30 and 60 when inequalities are greatest will highlight between area differences.

**Shaw B.A., McGeever K, Vasquez, Agahi, Fors (2014). Socioeconomic inequalities in health after age 50: Are health risk behaviors to blame?** *Social Science & Medicine*, 101 (6) : 52-60.

**Abstract:** Recent studies indicate that socioeconomic inequalities in health extend into the elderly population, even within the most highly developed welfare states. One potential explanation for socioeconomic inequalities in health focuses on the role of health behaviors, but little is known about the degree to which health behaviors account for health inequalities among older adults, in particular. Using data from the Health and Retirement Study (N=19,245), this study examined the degree to which four behavioral risk factors - smoking, obesity, physical inactivity, and heavy drinking - are associated with socioeconomic position among adults aged 51 and older, and whether these behaviors mediate socioeconomic differences in mortality, and the onset of disability among those who were disability-free at baseline, over a 10-year period from 1998 to 2008. Results indicate that the odds of both smoking and physical inactivity are higher among persons with lower wealth, with similar stratification in obesity, but primarily among women. The odds of heavy drinking decrease at lower levels of wealth. Significant socioeconomic inequalities in mortality and disability onset are apparent among older men and women; however, the role that health behaviors play in accounting for these inequalities differs by age and gender. For example, these health behaviors account for between 23 and 45% of the mortality disparities among men and middle aged women, but only about 5% of the disparities found among women over 65 years. Meanwhile, these health behaviors appear to account for about 33% of the disparities in disability onset found among women survivors, and about 9-14% among men survivors. These findings suggest that within the U.S. elderly population, behavioral risks such as smoking and physical inactivity contribute moderately to maintaining socioeconomic inequalities in health. As such, promoting healthier lifestyles among the socioeconomically disadvantaged older adults should help to reduce later life health inequalities.

**Hajizadeh M., Karen C.M., Sarma S. (2014). Socioeconomic inequalities in adult obesity risk in Canada: trends and decomposition analyses.** *Eur J Health Econ*, 15 (2) : 203-221.

**Abstract:** This study examines trends in socioeconomic-related inequalities in obesity risk among Canadian adults (aged 18-65 years) from 2000 to 2010 using five nationally representative Canadian Community Health Surveys (CCHSs). We employed the concentration index (C) to quantify the socioeconomic inequalities in obesity risk across different demographic groups and geographic regions in each survey period. A decomposition analysis of inequality is performed to determine factors that lie behind income-related inequality in obesity risk. Although declining over time, the results show that there exists income-related inequality in obesity risk in Canada. The estimated Cs for men indicate that obesity is concentrated among the rich and its trend is increasing over time. The findings, however, suggest that obesity is more prevalent among economically disadvantaged women. While we found that obesity is mainly concentrated among the poor in the Atlantic Provinces, the degree of socioeconomic related inequality in obesity risk is increasing in these provinces. The results for Alberta showed that obesity is concentrated among the better-off individuals. The decomposition analysis suggests that factors such as demographics, income, immigration, education, drinking habits, and physical activity are the key factors explaining income-related inequality in obesity risk in Canada.

Our empirical findings suggest that, in order to combat the obesity epidemic, health policies should focus on poorer females and economically well-off males.

## Médicaments / Pharmaceuticals

**(2014). La bataille des médicaments.** *Alternatives Economiques*, (Numéro Hors-Série) :

Abstract: Très favorable aux laboratoires pharmaceutiques, le fonctionnement du marché des médicaments en France doit se recentrer sur les patients. Cet article revient sur l'ensemble des étapes de la commercialisation du médicament de l'innovation à sa consommation.

**Kalo Z., Annemans L., Garrison L.P. (2013). Differential pricing of new pharmaceuticals in lower income European countries.** *Expert Review of Pharmacoeconomics & Outcomes Research*, 13 (6) : 735-741.

Abstract: Pharmaceutical companies adjust the pricing strategy of innovative medicines to the imperatives of their major markets. The ability of payers to influence the ex-factory price of new drugs depends on country population size and income per capita, among other factors. Differential pricing based on Ramsey principles is a 'second-best' solution to correct the imperfections of the global market for innovative pharmaceuticals, and it is also consistent with standard norms of equity. This analysis summarizes the boundaries of differential pharmaceutical pricing for policymakers, payers and other stakeholders in lower-income countries, with special focus on Central-Eastern Europe, and describes the feasibility and implications of potential solutions to ensure lower pharmaceutical prices as compared to higher-income countries. European stakeholders, especially in Central-Eastern Europe and at the EU level, should understand the implications of increased transparency of pricing and should develop solutions to prevent the limited accessibility of new medicines in lower-income countries.

**Gurprit K.R. (2013). Evaluating the Adoption of E-prescribing in Primary Care.** *Healthcare Quarterly*, 16 (4) : 55-60.

Abstract: The purpose of this study was to examine the adoption of e-prescribing by primary care physicians in Central Vancouver Island. To accomplish this, a multi-method study design was used to compare the ideal state of e-prescribing (desired e-prescribing features in an electronic medical record [EMR]) with the possible state (what the EMR offers) and current state (what physicians are using in practice). The authors found that recruited physicians are using most of the e-prescribing and EMR features available. However, there are several gaps between the ideal, possible and current states of e-prescribing. The authors address the identified gaps through physician-level, policy-related and technology-related recommendations to improve the adoption, design and development of e-prescribing features.

**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 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.

<http://esp.sagepub.com/content/24/1/39.abstract>

**Levaggi R. (2014). Pricing schemes for new drugs: A welfare analysis.** *Social Science & Medicine*, 202 69-73.

Abstract: Drug price regulation is acquiring increasing significance in the investment choices of the pharmaceutical sector. The overall objective is to determine an optimal trade-off between the incentives for innovation, consumer protection, and value for money. However, price regulation is itself a source of distortion. In this study, we examine the welfare properties of listing through a bargaining process and value-based pricing schemes. The latter are superior instruments to uncertain listing processes for maximising total welfare, but the distribution of the benefits between consumers and the industry depends on rate of rebate chosen by the regulator. However, through an appropriate choice, it is always possible to define a value-based pricing scheme with risk sharing, which both consumers and the industry prefer to an uncertain bargaining process.

**Viksveen P., Dymitr Z., Simoens S. (2014). Economic evaluations of homeopathy: a review.** *Eur J Health Econ*, 15 (2) : 157-174.

Abstract: CONTEXT: Economic evaluations of commonly used complementary and alternative medicine (CAM) therapies such as homeopathy are needed to contribute to the evidence base on which policy makers, clinicians, health-care payers, as well as patients base their health-care decisions in an era of constrained resources. OBJECTIVES: To review and assess existing economic evaluations of homeopathy. METHODS: Literature search was made to retrieve relevant publications using AMED, the Cochrane Library, CRD (DARE, NHS EED, HTA), EMBASE, MEDLINE, and the journal Homeopathy (former British Homoeopathic Journal). A hand search of relevant publications was carried out. Homeopathy researchers were contacted. Identified publications were independently assessed by two authors. RESULTS: Fifteen relevant articles reported on 14 economic evaluations of homeopathy. Thirteen studies reported numbers of patients: a total of 3,500 patients received homeopathic treatment (median 97, interquartile range 48-268), and 10 studies reported on control group participants (median 57, IQR 40-362). Eight out of 14 studies found improvements in patients' health together with cost savings. Four studies found that improvements in homeopathy patients were at least as good as in control group patients, at comparable costs. Two studies found improvements similar to conventional treatment, but at higher costs. Studies were highly heterogeneous and had several methodological weaknesses. CONCLUSIONS: Although the identified evidence of the costs and potential benefits of homeopathy seemed promising, studies were highly heterogeneous and had several methodological weaknesses. It is therefore not possible to draw firm conclusions based on existing economic evaluations of homeopathy. Recommendations for future research are presented.

## Méthodologie – Statistique / Methodology - Statistics

**Paddock S.M. (2014). Statistical Benchmarks for Health Care Provider Performance Assessment: A Comparison of Standard Approaches to a Hierarchical Bayesian Histogram-Based Method.** *Health Serv Res*, [ahead of print]

Abstract: OBJECTIVE: Examine how widely used statistical benchmarks of health care provider performance compare with histogram-based statistical benchmarks obtained via hierarchical Bayesian modeling. DATA SOURCES: Publicly available data from 3,240 hospitals during April 2009-March 2010 on two process-of-care measures reported on the Medicare Hospital Compare website. STUDY DESIGN: Secondary data analyses of two process-of-care measures comparing statistical benchmark estimates and threshold exceedance determinations under various combinations of hospital performance measure estimates and benchmarking approaches. PRINCIPAL FINDINGS: Statistical benchmarking approaches for determining top 10 percent performance varied with respect to which hospitals exceeded the performance benchmark; such differences were not found at the 50 percent

threshold. Benchmarks derived from the histogram of provider performance under hierarchical Bayesian modeling provide a compromise between benchmarks based on direct (raw) estimates, which are overdispersed relative to the true distribution of provider performance and prone to high variance for small providers, and posterior mean provider performance, for which over-shrinkage and under-dispersion relative to the true provider performance distribution is a concern. CONCLUSIONS: Given the rewards and penalties associated with characterizing top performance, the ability of statistical benchmarks to summarize key features of the provider performance distribution should be examined.

**Ali M.S., Groenwold R.H., Klungel O.H. (2014). Propensity Score Methods and Unobserved Covariate Imbalance: Comments on "Squeezing the Balloon".** *Health Serv Res*, [ahead of print]

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

**Bjertnaes O. (2014). Patient-reported experiences with hospitals: comparison of proxy and patient scores using propensity-score matching.** *Int J Qual. Health Care*, 26 (1) : 34-40.

Abstract: OBJECTIVE: The objective of this study was to compare patient-experience scores between patients with a proxy response and without a proxy response, using propensity-score matching to maximize the comparability between these two groups. DESIGN: Cross-sectional survey. SETTING: Hospital inpatient services in Norway. PARTICIPANTS: Patients were randomly selected from each of the 61 hospitals in Norway during spring 2011. Postal questionnaires were mailed to 23 420 patients after their discharge from hospital. INTERVENTION: No intervention. MAIN OUTCOME MEASURES: All of the patient respondents (n = 8744) and the matched cases (n = 734) were compared with patients with a proxy response (n = 734) on 12 patient-experience indicators using t-tests. RESULTS: Compared with patient respondents, patients with a proxy response had poorer health, were older and were more often discharged from the hospital to another health-care institution (P < 0.001). Patients with a proxy response yielded significantly lower patient-experience scores than those without a proxy response for 9 of the 12 indicators. Compared with the matched patient group, patients with a proxy response had significantly lower scores for 3 of the 12 indicators and a significantly higher score for one indicator. Differences in scores between patients with a proxy response and the matched patient sample were small, with the largest difference being 4 on a scale of 0-100. CONCLUSIONS: Patients with a proxy response report somewhat poorer experiences than those without a proxy response; however, proxies represent a different patient group than the patient group as a whole, and the results were very similar after controlling for these differences.

## Politique de santé / Health Policy

**Burgess T., Braunack-Mayer A., Crawford G.B., Beilby J. (2014). Australian health policy and end of life care for people with chronic disease: An analysis.** *Health Policy*, 115 (1)

Abstract: End of life care for people with advanced chronic disease is a growing international imperative, with the majority of deaths in the world now related to chronic disease. The provision of care that meets the needs of people with advanced chronic disease must be guided by appropriate

policy. The key policy areas impacting directly on end of life care are related to chronic disease, palliative care and, increasingly, aged care. This paper describes the outcomes of an audit of Australian chronic disease and end of life/palliative care policies. We identified that chronic disease health policies/strategies demonstrate a focus on prevention, early intervention and management, with scant recognition of end of life care needs. The majority assume that a referral to palliative care will address end of life care needs for people with chronic disease. By contrast, palliative care policies recognise the need for the incorporation of a palliative approach into advanced chronic disease care, but there are few connections between these two policy areas. Whilst palliative care policies intersect with carer and advance care planning policies, chronic disease policy does not. Key concerns requiring consideration when developing policy in this area are discussed and possible policy options identified.

**Jang S.I., Nam J.M., Choi J., Park E.C. (2014). Disease management index of potential years of life lost as a tool for setting priorities in national disease control using OECD health data. *Health Policy*, 115 (1)**

Abstract: Limited healthcare resources make it necessary to maximize efficiency in disease management at the country level by priority-setting according to disease burden. To make the best priority settings, it is necessary to measure health status and have standards for its judgment, as well as consider disease management trends among nations. We used 17 International Classification of Diseases (ICD) categories of potential years of life lost (YPLL) from Organization for Economic Co-operation and Development (OECD) health data for 2012, 37 disease diagnoses YPLL from OECD health data for 2009 across 22 countries and disability-adjusted life years (DALY) from the World Health Organization (WHO). We set a range of 1-1 for each YPLL per disease in a nation (position value for relative comparison, PARC). Changes over 5 years were also accounted for in this disease management index (disease management index, DMI). In terms of ICD categories, the DMI indicated specific areas for priority setting for different countries with regard to managing disease treatment and diagnosis. Our study suggests that DMI is a realistic index that reflects trend changes over the past 5 years to the present state, and PARC is an easy index for identifying relative status. Moreover, unlike existing indices, DMI and PARC make it easy to conduct multiple comparisons among countries and diseases. DMI and PARC are therefore useful tools for policy implications and for future studies incorporating them and other existing indexes.

## Soins de santé primaires / Primary Health Care

**Keriel-Gascou M., Bami J., Chaneliere M., Haeringer-Cholet A., Larrieu C., Villebrun F., Robert T., Michel P. (2014). [Which definition and taxonomy of incident to use for a French reporting system in primary care settings?]. *Rev Epidemiol Santé Publique*, 62 (1) : 41-52.**

Abstract: BACKGROUND: There is no widely accepted definition of incident for primary care doctors in France and no taxonomic classification system for epidemiological use. In preparation for a future epidemiological study on primary care incidents in France (the ESPRIT study), this work was designed to identify the definitions and taxonomic classifications used internationally along with the usual methods and results in terms of frequency in the literature. The goal was to determine a French definition and taxonomy. DESIGN: Systematic review of the literature and consensus methods. METHOD: An exhaustive search of epidemiological surveys was performed. A structured grid was used. After having identified the definitions used in the literature, a definition was chosen using the focus groups method. Taxonomies identified in the literature were classified by relationship, architecture, code number, and number of studies published. Subsequently, a consensus among experts, who independently tested these taxonomies on six incidents, was reached for choosing the most appropriate for epidemiological data collection (little information on a large number of cases). RESULTS: Twenty-four papers reporting 17 studies were selected among 139 articles. Five definitions and eight taxonomies were found. The chosen definition of incident was based on the WHO definition "A patient safety incident is an event or circumstance that could have resulted, or did result, in harm to

a patient, and whose wish it is not repeated again". The test of incidents resulted in the choice of the TAPS version of the International Taxonomy of Medical Error in Primary Care for a reproducible and internationally recognized codification and the tempos method for its current use in French general practice. DISCUSSION: The definitions, taxonomies, data collection characteristics and frequency of incidents results in the international literature on incidents in primary care are key components for the preparation of an epidemiological survey on incidents in primary care.

**Adalsteinn D.B. (2013). Public Health and Primary Care: Competition or Collaboration.** *HealthcarePapers*, 13 (3) : 4-8.

Abstract: In this commentary, the authors summarize and discuss some of the concerns presented in the papers herein, including issues of funding, skill sets and education. They present two key steps we could take across this country to ensure the long-term viability of public health within our healthcare system and ensure that public health and population goals are shared widely across our health systems.

<http://www.longwoods.com/product/23690>

**Andrew D.P. (2013). Improving Collaboration between Public Health and Primary Healthcare.** *HealthcarePapers*, 13 (3) : 41-48.

Abstract: <p>This paper responds to the ideas set forth by Millar et al. in their exploration of whether public health is ready to participate in the transformation of the healthcare system. In this commentary, the author proposes a number of novel solutions to address these challenges, categorized into four areas: experimenting with joint planning, using innovative ways to share and analyze data, employing joint training and networks and facilitating how primary healthcare engages in health promotion in the local community. The author asserts that, ultimately, no single solution will address the multiple barriers to collaboration, but the implementation of some of these ideas can move Canada forward in this area.

**Chen P.G.-C., Mehrotra A., Auerbach D.I. (2014). Do We Really Need More Physicians? Responses to Predicted Primary Care Physician Shortages.** *Medical Care*, 52 (2) :

Abstract: Predicted primary care shortages have spurred action to increase the number of primary care physicians. However, simply increasing the number of primary care providers is not the only solution to resolving the imbalance between the supply of primary care physicians and the demand for primary care services. In this point-counterpoint, we highlight the limitations of existing primary care shortage predictions and discuss strategies to deliver primary care services without necessarily increasing the number of primary care physicians for a given population. Innovative solutions can be used to reduce or even eliminate projected primary care shortages while changing the prevailing paradigm of primary care.

**Phillips R.L.J., Bazemore A.M., Peterson L.E. (2014). Effectiveness Over Efficiency: Underestimating the Primary Care Physician Shortage.** *Medical Care*, 52 (2) :

Abstract: Interest in improving health care outcomes requires increasing the effectiveness of primary care. Focus on effectiveness is leading many innovative health systems to shrink primary care patient panels to strengthen relationships, and to enhance primary care teams to increase comprehensiveness. Such strategies would make primary care shortages worse than predicted, and are compounded by substantial declines in clinicians of all types choosing primary care careers. Severe primary care shortages beg for efficiency, but emphasizing efficiency at the expense of effectiveness threatens achieving the Triple Aim for health care. We cannot avoid the hard work of repairing our clinician training pipeline for primary care.

**Friedman A., Hahn K.A., Etz R., Rehwinkel-Morfe A.M., Miller W.L., Nutting P.A., Jaén C.R., Shaw E.K., Crabtree B.F. (2014). A Typology of Primary Care Workforce Innovations in the United States Since 2000.** *Medical Care*, 52 (2) :

**Abstract:** Purpose :Innovative workforce models are being developed and implemented to meet the changing demands of primary care. A literature review was conducted to construct a typology of workforce models used by primary care practices. Methods: Ovid Medline, CINAHL, and PsycInfo were used to identify published descriptions of the primary care workforce that deviated from what would be expected in the typical practice in the year 2000. Expert consultants identified additional articles that would not show up in a regular computerized search. Full texts of relevant articles were read and matrices for sorting articles were developed. Each article was reviewed and assigned to one of 18 cells in the matrices. Articles within each cell were then read again to identify patterns and develop an understanding of the full spectrum of workforce innovation within each category. Results :This synthesis led to the development of a typology of workforce innovations represented in the literature. Many workforce innovations added personnel to existing practices, whereas others sought to retrain existing personnel or even develop roles outside the traditional practice. Most of these sought to minimize the impact on the existing practice roles and functions, particularly that of physicians. The synthesis also identified recent innovations which attempted to fundamentally transform the existing practice, with transformation being defined as a change in practice members'governing variables or values in regard to their workforce role. Conclusions: Most conceptualizations of the primary care workforce described in the literature do not reflect the level of innovation needed to meet the needs of the burgeoning numbers of patients with complex health issues, the necessity for roles and identities of physicians to change, and the call for fundamentally redesigned practices. However, we identified 5 key workforce innovation concepts that emerged from the literature: team care, population focus, additional resource support, creating workforce connections, and role change.

**Booth H.P., Prevost A.T., Gulliford M.C. (2014). Impact of body mass index on prevalence of multimorbidity in primary care: cohort study. *Fam Pract*, 31 (1) : 38-43.**

**Abstract:** BACKGROUND: Multimorbidity is the co-occurrence of long-term conditions. Obesity is associated with an increased risk of long-term conditions including type 2 diabetes and depression. OBJECTIVE: To quantify the association between body mass index (BMI) category and multimorbidity in a large cohort registered in primary care. METHODS: The sample comprised primary care electronic health records of adults aged  $\geq 30$  years, sampled from the Clinical Practice Research Datalink between 2005 and 2011. Multimorbidity was defined as the co-occurrence of  $\geq 2$  of 11 conditions affecting seven organ systems. Age- and sex-standardized prevalence of multimorbidity was estimated by BMI category. Adjusted odds ratios associating BMI with additional morbidity were estimated adjusting for socioeconomic deprivation and smoking. RESULTS: The sample comprised 300 006 adults. After excluding participants with BMI never recorded, data were analysed for 223 089 (74%) contributing 1 374 109 person-years. In normal weight men, the standardized prevalence of multimorbidity was 23%, rising to 27% in overweight, 33% in category I obesity, 38% in category II and 44% in category III obesity. In women, the corresponding values were 28%, 34%, 41%, 45% and 51%. In category III obesity, the adjusted odds, relative to normal BMI, were 2.24 (2.13-2.36) for a first condition; 2.63 (2.51-2.76) for a second condition and 3.09 (2.92-3.28) for three or more conditions. In a cross-sectional analysis, 32% of multimorbidity was attributable to overweight and obesity. CONCLUSIONS: Multiple morbidity is highly associated with increasing BMI category and obesity, highlighting the potential for targeted primary and secondary prevention interventions in primary care.

**Lin K.Y. (2014). Physicians' perceptions of autonomy across practice types: Is autonomy in solo practice a myth? *Soc Sci Med*, 100 21-29.**

**Abstract:** Physicians in the United States are now less likely to practice in smaller, more traditional, solo practices, and more likely to practice in larger group practices. Though older theory predicts conflict between bureaucracy and professional autonomy, studies have shown that professions in general, and physicians in particular, have adapted to organizational constraints. However, much work remains in clarifying the nature of this relationship and how exactly physicians have adapted to various organizational settings. To this end, the present study examines physicians' autonomy experiences in different decision types between organization sizes. Specifically, I ask: In what kinds of decisions do doctors perceive autonomous control? How does this vary by organizational size? Using stacked "spell" data constructed from the Community Tracking Study (CTS) Physician Survey (1996-2005) (n = 16,519) I examine how physicians' perceptions of autonomy vary between solo/two physician practices, small group practices with three to ten physicians, and large practices with ten or more

physicians, in two kinds of decisions: logistic-based and knowledge-based decisions. Capitalizing on the longitudinal nature of the data I estimate how changes in practice size are associated with perceptions of autonomy, accounting for previous reports of autonomy. I also test whether managed care involvement, practice ownership, and salaried employment help explain part of this relationship. I find that while physicians practicing in larger group practices reported lower levels of autonomy in logistic-based decisions, physicians in solo/two physician practices reported lower levels of autonomy in knowledge-based decisions. Managed care involvement and ownership explain some, but not all, of the associations. These findings suggest that professional adaptation to various organizational settings can lead to varying levels of perceived autonomy across different kinds of decisions.

**Moloughney B.W. (2014). Public health readiness and role in transformation to a community-based primary healthcare system. *Healthc.Pap.*, 13 (3) : 64-70.**

Abstract: Millar et al. provide a high-level vision for transforming primary care into a community-based primary healthcare system, arguing that public health involvement is critical to the success of this transformation. The authors discuss a number of approaches to mitigate challenges to public health's readiness to participate. In this commentary, the author addresses selected points encouraging the avoidance of high-level conceptual language, a focus on specific value-added linkages and addressing the complex range of critical success factors needed to effect this transformation.

## Systèmes de santé / Health Systems

**De Cos P.H., Moral-Benito E. (2014). Determinants of health-system efficiency: evidence from OECD countries. *Int J Health Care Finance Econ*, 14 (1) : 69-93.**

Abstract: This paper analyzes the most important determinants of healthcare efficiency across OECD countries. As previously documented in the literature, we first provide evidence of significant differences in the cross-country level of efficiency in healthcare provision. We then investigate how improvements in efficiency can be achieved by considering alternative efficiency indices (parametric and non-parametric) and a novel dataset with information on the characteristics of healthcare systems across OECD countries. Our empirical findings suggest a positive correlation between policies such as increasing the regulation of prices billed by providers and reducing the degree of gate keeping and the efficiency of national healthcare systems.

## Travail et santé / Occupational Health

**(2013). Do financial incentives induce disability insurance recipients to return to work? *Natl Bur.Econ Res Bull Aging Health*, (2) : 3-4.**

**Bambra C., Lunau T., Van der We K., Eikemo T., Dragano N. (2014). Work, Health, and Welfare: The Association between Working Conditions, Welfare States, and Self-Reported General Health in Europe. *International Journal of Health Services*, 44 (1) : 113-136.**

Abstract: This article is the first to examine the association between self-reported general health and a wide range of working conditions at the European level and by type of welfare state regime. Data for 21,705 men and women ages 16 to 60 from 27 European countries were obtained from the 2010 European Working Conditions Survey. The influence of individual-level sociodemographic, physical, and psychosocial working conditions and of the organization of work were assessed in multilevel logistic regression analyses, with additional stratification by welfare state regime type (Anglo-Saxon, Bismarckian, Eastern European, Scandinavian, and Southern). At the European level, we found that

"not good" general health was more likely to be reported by workers more exposed to hazardous working conditions. Most notably, tiring working positions, job strain, and temporary job contracts were strongly associated with a higher likelihood of reporting "not good" health. Analysis by welfare state regime found that only tiring or painful working conditions were consistently associated with worse self-reported health in all regimes. There was no evidence that the Scandinavian welfare regime protected against the adverse health effects of poor working conditions. The article concludes by examining the implications for comparative occupational health research.

## Vieillessement / Ageing

**Romero-Ortuno R., Fouweather T., Jagger C. (2014). Cross-national disparities in sex differences in life expectancy with and without frailty. *Age and Ageing*, 43 (2) : 222-228.**

**Abstract:** Background: with continued ageing, levels of frailty are an increasing concern. Women live longer than men, but how life expectancies (LE) with frailty differ between men and women and whether sex differences are the same for all European countries is unknown. Objective: to compare sex differences in LE in phenotypic frailty categories and disability at age  $\geq 50$  between European countries. Design: the Survey of Health, Ageing and Retirement in Europe (SHARE). Subjects: a total of 50,351 people aged  $\geq 50$  from SHARE wave 4 (included countries: Austria, Belgium, Czech Republic, Denmark, Estonia, France, Germany, Hungary, Italy, the Netherlands, Poland, Portugal, Slovenia, Spain, Sweden). Methods: the SHARE Frailty Instrument for Primary Care and the Global Activity Limitation Indicator were combined to define four phenotypic frailty and disability categories: robust, pre-frail, frail and severely limited. LEs with each state by sex and country were calculated using Sullivan's method. Results: at age 70, the LE robust ranged from 4.1 to 10.4 years (men) and 3.0 to 8.9 years (women), LE pre-frail from 0.8-3.1 years (men) and 2.2-5.5 years (women), LE frail from 0.1-1.8 years (men) and 0.4-5.5 years (women) and LE with severe activity limitation from 1.9 to 4.4 years (men) and 2.9 to 7.5 years (women). At all ages and both sexes the fewest years were spent frail. Conclusions: this study is the first to compare differences in LE in frailty categories across European countries. In most European countries, years spent robust (free of frailty or limitation) are significantly less for women than men, perhaps due to socio-economic as well as biological factors.

**Sixsmith J., Sixsmith A., Fange A.M., Naumann D., Kucsera C., Tomsone S., Haak M., Dahlin-Ivanoff S., Woolrych R. (2014). Healthy ageing and home: The perspectives of very old people in five European countries. *Soc Sci Med*, 106C 1-9.**

**Abstract:** This paper reports on in-depth research, using a grounded theory approach, to examine the ways in which very old people perceive healthy ageing in the context of living alone at home within urban settings in five European countries. This qualitative study was part of a cross-national project entitled ENABLE-AGE which examined the relationship between home and healthy ageing. Interviews explored the notion of healthy ageing, the meaning and importance of home, conceptualisations of independence and autonomy and links between healthy ageing and home. Data analysis identified five ways in which older people constructed healthy ageing: home and keeping active; managing lifestyles, health and illness; balancing social life; and balancing material and financial circumstances. Older people reflected on their everyday lives at home in terms of being engaged in purposeful, meaningful action and evaluated healthy ageing in relation to the symbolic and practical affordances of the home, contextualised within constructions of their national context. The research suggests that older people perceive healthy ageing as an active achievement, created through individual, personal effort and supported through social ties despite the health, financial and social decline associated with growing older. The physicality and spatiality of home provided the context for establishing and evaluating the notion of healthy ageing, whilst the experienced relationship between home, life history and identity created a meaningful space within which healthy ageing was negotiated.