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24 avril 2015 / April The 24th, 2015

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Contacts

Espace documentation : documentation@irdes.fr

Marie-Odile Safon : safon@irdes.fr

Véronique Suhard : suhard@irdes.fr

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Assurance maladie / Health Insurance

Buttorff, C., et al. (2015). "Comparing employer-sponsored and federal exchange plans: wide variations in cost sharing for prescription drugs." *Health Aff (Millwood)* 34(3): 467-476.

Just under seven million Americans acquired private insurance through the new health insurance exchanges, or Marketplaces, in 2014. The exchange plans are required to cover essential health benefits, including prescription drugs. However, the generosity of prescription drug coverage in the plans has not been well described. Our primary objective was to examine the variability in drug coverage in the exchanges across plan types (health maintenance organization or preferred provider organization) and metal tiers (bronze, silver, gold, and platinum). Our secondary objective was to compare the exchange coverage to employer-sponsored coverage. Analyzing prescription drug benefit design data for the federally facilitated exchanges, we found wide variation in enrollees' out-of-pocket costs for generic, preferred brand-name, nonpreferred brand-name, and specialty drugs, not only across metal tiers but also within those tiers across plan types. Compared to employer-sponsored plans, exchange plans generally had lower premiums but provided less generous drug coverage. However, for low-income enrollees who are eligible for cost-sharing subsidies, the exchange plans may be more comparable to employer-based coverage. Policies and programs to assist consumers in matching their prescription drug needs with a plan's benefit design may improve the financial protection for the newly insured.

Economie de la santé / Health Economics

Specchia, M. L., et al. (2015). "Economic impact of adult obesity on health systems: a systematic review." *Eur J Public Health* 25(2): 255-262.

BACKGROUND: Obesity represents an important public health issue. An assessment of its costs would be useful to provide recommendations for policy and decision-making strategies. The aims of our study were to carry out a systematic review to assess the economic burden of adult obesity in terms of direct and indirect costs and to perform a quality appraisal of the analysed studies. **METHODS:** A literature search was carried out on PubMed, Scopus and Cochrane Library to retrieve cost-of-illness (COI) analyses focused on adult (aged 18 years or more) overweight or obese people and published up to 2013. COI analyses that considered direct and indirect costs were included. Each included manuscript was independently appraised by three groups of researchers on the basis of the British Medical Journal Drummond's checklist. **RESULTS:** Approximately 2044 articles were initially retrieved, and 17 were included in the current review. The included studies showed a medium-high-quality level. The available studies seemed to be heterogeneous both in terms of methodology and results reporting. However, as many studies have been conducted from the payer perspective, just direct medical costs can be considered exhaustive. As only three studies included considered also indirect costs, there is no strong evidence to give a comprehensive picture of this phenomenon also from the societal perspective. **CONCLUSION:** The review confirmed that obesity absorbs a huge amount of health-care resources. Further research is therefore needed to better understand the economic impact and to identify and promote public health strategies to tackle obesity.

Géographie de la santé / Geography of Health

Fernandez, J. L. and J. Forder (2015). "Local variability in long-term care services: local autonomy, exogenous influences and policy spillovers." *Health Econ* 24 Suppl 1: 146-157.

In many countries, public responsibility over the funding and provision of long-term care services is held at the local level. In such systems, long-term care provision is often characterised by significant local variability. Using a panel dataset of local authorities over the period 2002-2012, the paper investigates the underlying causes of variation in gross social care expenditure for older people in England. The analysis distinguishes between factors outside the direct control of policy makers, local preferences and local policy spillovers. The results indicate that local demand and supply factors, and to a much lesser extent local political preferences and spatial policy spillovers, explain a large majority of the observed variation in expenditure. Copyright (c) 2015 John Wiley & Sons, Ltd.

Hôpital / Hospitals

Gaughan, J., et al. (2015). "Testing the bed-blocking hypothesis: does nursing and care home supply reduce delayed hospital discharges?" *Health Econ* 24 Suppl 1: 32-44.

Hospital bed-blocking occurs when hospital patients are ready to be discharged to a nursing home, but no place is available, so that hospital care acts as a more costly substitute for long-term care. We investigate the extent to which greater supply of nursing home beds or lower prices can reduce hospital bed-blocking using a new Local Authority (LA) level administrative data from England on hospital delayed discharges in 2009-2013. The results suggest that delayed discharges respond to the availability of care home beds, but the effect is modest: an increase in care home beds by 10% (250 additional beds per LA) would reduce social care delayed discharges by about 6-9%. We also find strong evidence of spillover effects across LAs: more care home beds or fewer patients aged over 65 years in nearby LAs are associated with fewer delayed discharges. (c) 2015 The Authors. Health Economics Published by John Wiley & Sons Ltd.

Kim, H. and E. C. Norton (2015). "Practice Patterns among Entrants and Incumbents in the Home Health Market after the Prospective Payment System was Implemented." *Health Econ* 24 Suppl 1: 118-131.

Home health care expenditures were the fastest growing part of Medicare from 2001-2009, despite the implementation of prospective payment. Prior research has shown that home health agencies adopted two specific strategies to take advantage of Medicare policies: provide at least 10 therapy visits to get an enormous marginal payment and recertify patients for additional episodes. We study whether there is heterogeneity in the adoption of those strategic behaviors between home health agency entrants and incumbents and find that entrants were more likely to adopt strategic practice patterns than were incumbents. We also find that for-profit incumbents mimicked one of the practice patterns following entrants in the same market. Our findings suggest that it is important to understand the heterogeneity in providers' behavior and how firms interact with each other in the same market. These findings help explain the rapid rise in expenditures in the home health care market. Copyright (c) 2015 John Wiley & Sons, Ltd.

Li-Lin, L. (2015). "Do Diagnosis-Related Group-Based Payments Incentivise Hospitals to Adjust

Output Mix?" *Health Economics* **24**(4): 454-469.

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. Copyright © 2014 John Wiley & Sons, Ltd.

Lu, M., et al. (2015). "Systematic Review of Risk Adjustment Models of Hospital Length of Stay (LOS)." Med Care **53**(4): 355-365.

BACKGROUND: Policy decisions in health care, such as hospital performance evaluation and performance-based budgeting, require an accurate prediction of hospital length of stay (LOS). This paper provides a systematic review of risk adjustment models for hospital LOS, and focuses primarily on studies that use administrative data. METHODS: MEDLINE, EMBASE, Cochrane, PubMed, and EconLit were searched for studies that tested the performance of risk adjustment models in predicting hospital LOS. We included studies that tested models developed for the general inpatient population, and excluded those that analyzed risk factors only correlated with LOS, impact analyses, or those that used disease-specific scales and indexes to predict LOS. RESULTS: Our search yielded 3973 abstracts, of which 37 were included. These studies used various disease groupers and severity/morbidity indexes to predict LOS. Few models were developed specifically for explaining hospital LOS; most focused primarily on explaining resource spending and the costs associated with hospital LOS, and applied these models to hospital LOS. We found a large variation in predictive power across different LOS predictive models. The best model performance for most studies fell in the range of 0.30-0.60, approximately. CONCLUSIONS: The current risk adjustment methodologies for predicting LOS are still limited in terms of models, predictors, and predictive power. One possible approach to improving the performance of LOS risk adjustment models is to include more disease-specific variables, such as disease-specific or condition-specific measures, and functional measures. For this approach, however, more comprehensive and standardized data are urgently needed. In addition, statistical methods and evaluation tools more appropriate to LOS should be tested and adopted.

Meyer, S. (2015). "Payment schemes and cost efficiency: evidence from Swiss public hospitals." International Journal of Health Economics and Management **15**(1): 73-97.***Scott, A. and J. Yong (2015). "Do new workforce roles reduce waiting times in ED? A difference-in-difference evaluation using hospital administrative data." Health Policy*** **119**(4): 488-493.

This paper evaluates the effect of introducing two new workforce roles under a pilot program conducted in Victoria, Australia. The trial took place at a regional hospital's emergency department (ED) between 1 July 2008 and 30 June 2009. The evaluation is based on three outcome measures: waiting time (in minutes) at ED before treatment; proportion of

presentations with waiting time on target; and length of stay (in days), for ED presentations that led to in-patient admissions. The technique of difference-in-differences analysis is used. A total of 142,980 patient records from the pilot hospital and three comparison hospitals were extracted from the Victorian Emergency Minimum Dataset (VEMD). Further, 21,925 records of patients whose ED presentations led to in-patient admissions were extracted from the Victorian Admitted Episodes Dataset (VAED). The evaluation finds the piloted roles have lowered waiting time and raised the proportion of on-target presentations. These effects were found to be the strongest for less urgent triage categories. However, the evidence on in-patient length of stay was mixed. The results provide positive evidence that new workforce roles can be effective in improving the efficiency of emergency care delivery.

Sorenson, C., et al. (2015). "The role of hospital payments in the adoption of new medical technologies: an international survey of current practice." *Health Econ Policy Law* 10(2): 133-159.

This study examined the role of prospective payment systems in the adoption of new medical technologies across different countries. A literature review was conducted to provide background for the study and guide development of a survey instrument. The survey was disseminated to hospital payment systems experts in 15 jurisdictions. Fifty-one surveys were disseminated, with 34 returned. The surveys returned covered 14 of the 15 jurisdictions invited to participate. The majority (71%) of countries update the patient classification system and/or payment tariffs on an annual basis to try to account for new technologies. Use of short-term separate or supplementary payments for new technologies occurs in 79% of countries to ensure adequate funding and facilitate adoption. A minority (43%) of countries use evidence of therapeutic benefit and/or costs to determine or update payment tariffs, although it is somewhat more common in establishing short-term payments. The main barrier to using evidence is uncertain or unavailable clinical evidence. Almost three-fourths of respondents believed diagnosis-related group systems incentivize or deter technology adoption, depending on the particular circumstances. Improvements are needed, such as enhanced strategies for evidence generation and linking evidence of value to payments, national and international collaboration and training to improve existing practice, and flexible timelines for short-term payments. Importantly, additional research is needed to understand how different payment policies impact technology uptake as well as quality of care and costs.

Inégalités de santé / Health Inequalities

Bélanger, D., et al. (2015). "Neighbourhood and dwelling characteristics associated with the self-reported adverse health effects of heat in most deprived urban areas: A cross-sectional study in 9 cities." *Health & Place* 32(0): 8-18.

Dwelling and neighbourhood characteristics associated with the prevalence of self-reported heat-induced adverse health effects are not well known. We interviewed 3485 people in the most disadvantaged neighbourhoods of the nine largest cities in Québec, Canada. The prevalence of heat-induced adverse health effects was 46%, out of which one fourth led to medical consultation. Multivariate analyses showed that dissatisfaction with the summer dwelling temperature, which refers to home heat exposure, and perception that the neighbourhood is polluted due to traffic, were determinant, even after adjusting for current health status. These risk indicators can be used to identify subgroups at high risk and as priority-setting criteria for urban renewal programs for the hotter climate to come.

Brooks, F., et al. (2015). "Trends in adolescents' perceived parental communication across 32 countries in Europe and North America from 2002 to 2010." *Eur J Public Health* 25 Suppl 2: 46-50.

BACKGROUND: The quality of communication with parents is a determinant of health and well-being during adolescence, being predictive of self-esteem, self-rated health and the ability to navigate health risk behaviours. **METHODS:** This article describes trends in adolescent's (aged 11, 13 and 15 years) perception of communication with mothers and fathers by gender across 32 European and North American countries from 2002 to 2010. Analyses were performed on 425 699 records employing a General Linear Model (MANOVA). **RESULTS:** In most countries, significant increases in the prevalence of ease of communication with both mothers and fathers were observed, with the greatest positive changes over time in Estonia, Denmark and Wales. In some countries, the opposite trend was found with the greatest negative changes occurring in France, Slovenia and Poland. Across the pooled dataset, a significant positive trend was observed for ease of communication with father, for both boys and girls and for ease of communication with mother for boys only. **CONCLUSION:** The temporal trends demonstrated an increase in a positive health asset for many young people, that of family communication. Positive trends may be a feature of the economic boom over the past decade coupled with cultural changes in attitudes to parenting, especially fathering.

Cabrera-Barona, P., et al. (2015). "A multi-criteria spatial deprivation index to support health inequality analyses." *International Journal of Health Geographics* 14(1): 11.

BACKGROUND: Deprivation indices are useful measures to analyze health inequalities. There are several methods to construct these indices, however, few studies have used Geographic Information Systems (GIS) and Multi-Criteria methods to construct a deprivation index. Therefore, this study applies Multi-Criteria Evaluation to calculate weights for the indicators that make up the deprivation index and a GIS-based fuzzy approach to create different scenarios of this index is also implemented. **METHODS:** The Analytical Hierarchy Process (AHP) is used to obtain the weights for the indicators of the index. The Ordered Weighted Averaging (OWA) method using linguistic quantifiers is applied in order to create different deprivation scenarios. Geographically Weighted Regression (GWR) and a Moran's I analysis are employed to explore spatial relationships between the different deprivation measures and two health factors: the distance to health services and the percentage of people that have never had a live birth. This last indicator was considered as the dependent variable in the GWR. The case study is Quito City, in Ecuador. **RESULTS:** The AHP-based deprivation index show medium and high levels of deprivation (0,511 to 1,000) in specific zones of the study area, even though most of the study area has low values of deprivation. OWA results show deprivation scenarios that can be evaluated considering the different attitudes of decision makers. GWR results indicate that the deprivation index and its OWA scenarios can be considered as local estimators for health related phenomena. Moran's I calculations demonstrate that several deprivation scenarios, in combination with the 'distance to health services' factor, could be explanatory variables to predict the percentage of people that have never had a live birth. **CONCLUSIONS:** The AHP-based deprivation index and the OWA deprivation scenarios developed in this study are Multi-Criteria instruments that can support the identification of highly deprived zones and can support health inequalities analysis in combination with different health factors. The methodology described in this study can be applied in other regions of the world to develop spatial deprivation indices based on Multi-Criteria analysis.

Cavallo, F., et al. (2015). "Trends in self-rated health in European and North-American adolescents

from 2002 to 2010 in 32 countries. *Eur J Public Health* **25 Suppl 2**: 13-15.

BACKGROUND: Self-rated health (SRH) in adolescence is known to be associated with health outcomes in later life. We carried out a trend analysis on data coming from three waves of data collected in 32 countries (mostly European) from 2002 to 2010 coming from the Health Behaviour in School-Aged Children surveys. METHODS: SRH in adolescents was assessed using a Likert scale (excellent, good, fair and poor). Responses were dichotomized into 'excellent' vs. 'rest'. Country, age and gender groups were compared based on the odds ratio of declaring excellent SRH in 2010 with respect to 2002 and 2006. RESULTS: The trend for European adolescents indicates an improvement over the last decade, although, in the majority of countries, a higher proportion of adolescents rate their health as excellent during the period 2002-06 with respect to the second half of the decade (2006-10). Girls were found to constantly rate their health as poorer, compared to their male peers, in all countries. Age has also a very stable trend towards a decreasing rating of health with increasing age. CONCLUSION: Decreased rating of health in the period 2006-10 may be a signal of the socio-economic difficulties of Europe in the last part of this decade.

Mackenbach, J. P. (2015). "Should we aim to reduce relative or absolute inequalities in mortality?" *Eur J Public Health* **25(2)**: 185.

Malmusi, D. (2015). "Immigrants' health and health inequality by type of integration policies in European countries." *Eur J Public Health* **25(2)**: 293-299.

BACKGROUND: Recent efforts to characterize integration policy towards immigrants and to compare immigrants' health across countries have rarely been combined so far. This study explores the relationship of country-level integration policy with immigrants' health status in Europe. METHODS: Cross-sectional study with data from the 2011 European Union Survey on Income and Living Conditions. Fourteen countries were grouped according to a typology of integration policies based on the Migrant Integration Policy Index: 'multicultural' (highest scores: UK, Italy, Spain, Netherlands, Sweden, Belgium, Portugal, Norway, Finland), 'exclusionist' (lowest scores: Austria, Denmark) and 'assimilationist' (high or low depending on the dimension: France, Switzerland, Luxembourg). People born in the country (natives, n = 177 300) or outside the European Union with >10 years of residence (immigrants, n = 7088) were included. Prevalence ratios (PR) of fair/poor self-rated health between immigrants in each country cluster, and for immigrants versus natives within each, were computed adjusting by age, education, occupation and socio-economic conditions. RESULTS: Compared with multicultural countries, immigrants report worse health in exclusionist countries (age-adjusted PR, 95% CI: men 1.78, 1.49-2.12; women 1.58, 1.37-1.82; fully adjusted, men 1.78, 1.50-2.11; women 1.47, 1.26-1.70) and assimilationist countries (age-adjusted, men 1.21, 1.03-1.41; women 1.21, 1.06-1.39; fully adjusted, men 1.19, 1.02-1.40; women 1.22, 1.07-1.40). Health inequalities between immigrants and natives were also highest in exclusionist countries, where they persisted even after adjusting for differences in socio-economic situation. CONCLUSION: Immigrants in 'exclusionist' countries experience poorer socio-economic and health outcomes. Future studies should confirm whether and how integration policy models could make a difference on migrants' health.

Shankardass, K., et al. (2015). "Strengthening the implementation of Health in All Policies: a methodology for realist explanatory case studies." *Health Policy and Planning* **30(4)**: 462-473.

To address macro-social and economic determinants of health and equity, there has been growing use of intersectoral action by governments around the world. Health in All Policies (HiAP) initiatives are a special case where governments use cross-sectoral structures and relationships to systematically address health in policymaking by targeting broad health

determinants rather than health services alone. Although many examples of HiAP have emerged in recent decades, the reasons for their successful implementation—and for implementation failures—have not been systematically studied. Consequently, rigorous evidence based on systematic research of the social mechanisms that have regularly enabled or hindered implementation in different jurisdictions is sparse. We describe a novel methodology for explanatory case studies that use a scientific realist perspective to study the implementation of HiAP. Our methodology begins with the formulation of a conceptual framework to describe contexts, social mechanisms and outcomes of relevance to the sustainable implementation of HiAP. We then describe the process of systematically explaining phenomena of interest using evidence from literature and key informant interviews, and looking for patterns and themes. Finally, we present a comparative example of how Health Impact Assessment tools have been utilized in Sweden and Quebec to illustrate how this methodology uses evidence to first describe successful practices for implementation of HiAP and then refine the initial framework. The methodology that we describe helps researchers to identify and triangulate rich evidence describing social mechanisms and salient contextual factors that characterize successful practices in implementing HiAP in specific jurisdictions. This methodology can be applied to study the implementation of HiAP and other forms of intersectoral action to reduce health inequities involving multiple geographic levels of government in diverse settings.

Médicaments / Pharmaceuticals

Anderson, T. S., et al. (2015). "Antipsychotic prescribing: do conflict of interest policies make a difference?" *Med Care* 53(4): 338-345.

BACKGROUND: Academic medical centers (AMCs) have increasingly adopted conflict of interest policies governing physician-industry relationships; it is unclear how policies impact prescribing. **OBJECTIVES:** To determine whether 9 American Association of Medical Colleges (AAMC)-recommended policies influence psychiatrists' antipsychotic prescribing and compare prescribing between academic and nonacademic psychiatrists. **RESEARCH DESIGN:** We measured number of prescriptions for 10 heavily promoted and 9 newly introduced/reformulated antipsychotics between 2008 and 2011 among 2464 academic psychiatrists at 101 AMCs and 11,201 nonacademic psychiatrists. We measured AMC compliance with 9 AAMC recommendations. Difference-in-difference analyses compared changes in antipsychotic prescribing between 2008 and 2011 among psychiatrists in AMCs compliant with $\geq 7/9$ recommendations, those whose institutions had lesser compliance, and nonacademic psychiatrists. **RESULTS:** Ten centers were AAMC compliant in 2008, 30 attained compliance by 2011, and 61 were never compliant. Share of prescriptions for heavily promoted antipsychotics was stable and comparable between academic and nonacademic psychiatrists (63.0%-65.8% in 2008 and 62.7%-64.4% in 2011). Psychiatrists in AAMC-compliant centers were slightly less likely to prescribe these antipsychotics compared with those in never-compliant centers (relative odds ratio, 0.95; 95% CI, 0.94-0.97; $P < 0.0001$). Share of prescriptions for new/reformulated antipsychotics grew from 5.3% in 2008 to 11.1% in 2011. Psychiatrists in AAMC-compliant centers actually increased prescribing of new/reformulated antipsychotics relative to those in never-compliant centers (relative odds ratio, 1.39; 95% CI, 1.35-1.44; $P < 0.0001$), a relative increase of 1.1% in probability. **CONCLUSIONS:** Psychiatrists exposed to strict conflict of interest policies prescribed heavily promoted antipsychotics at rates similar to academic psychiatrists and nonacademic psychiatrists exposed to less strict or no policies.

Baxerres C., (2015). "Le discours sur les faux médicaments : maintenir la domination du marché pharmaceutique au temps de la libéralisation de la distribution." Sciences Sociales et Santé 33(1): 117-125.

Etienne, C. and C. Pulcini (2015). "[Prospective cross-sectional study of antibiotic prescriptions in a sample of French general practitioners]." Presse Med 44(3): e59-66.

OBJECTIVES: The aim of our study was to assess the quality of antibiotic prescriptions in a sample of general practitioners (GPs) receiving junior doctors in training, whatever the motive of the prescription. METHODS: We performed a prospective observational study of all antibiotics prescribed in October 2012 by 21 GPs working in southeastern France. Two specialists (general medicine and infectious diseases) independently assessed the compliance with recommendations of antibiotic prescriptions using a validated algorithm. RESULTS: Two hundred and thirty-two antibiotic courses were prescribed, mainly for low respiratory tract infections (30%), ENT (26%), urinary tract (22%) or skin (13%) infections. Forty prescriptions were considered as appropriate (17%), 77 as inappropriate (33%; mainly due to a non-recommended molecule choice [77%] or a too long treatment duration [44%]) and 115 prescriptions were unnecessary (50%), due to diagnostic issues. There were wide variations between GPs. An essential laboratory or imaging investigation was missing for 36% of prescriptions: chest X-ray for pneumonia (80% were missing), rapid antigen diagnostic test for acute pharyngitis (23% missing) and urine dipstick for urinary tract infections (80% missing). Fluoroquinolones and macrolides/synergistins accounted for 31% of the prescriptions, and were associated with a lower prevalence of appropriate prescriptions (7% and 2% respectively, $P < 0.001$). There was a co-prescription of anti-inflammatory drugs in 15% of the cases. CONCLUSION: The misuse of antibiotics was frequent in this study. Improving the diagnostic workout is of paramount importance. Urgent actions are needed to improve antibiotic use in general practice.

Quet M. (2015). "Sécurisation pharmaceutique et économies du médicament : controverses globales autour des politiques anti-contrefaçon." Sciences Sociales et Santé 33(1): 91-116.

Rutkow, L., et al. (2015). "Most primary care physicians are aware of prescription drug monitoring programs, but many find the data difficult to access." Health Aff (Millwood) 34(3): 484-492.

State prescription drug monitoring programs are common tools intended to reduce prescription drug abuse and diversion, or the nonmedical use of a prescribed drug. The success of these programs depends largely upon physicians' awareness and use of them. We conducted a nationally representative mail survey of 1,000 practicing primary care physicians in 2014 to characterize their attitudes toward and awareness and use of prescription drug monitoring programs. A total of 420 eligible physicians (adjusted response rate: 58 percent) returned completed surveys. Among all physicians surveyed, 72 percent were aware of their state's prescription drug monitoring program, and 53 percent reported using one of the programs. We identified several barriers that may prevent greater use of the programs, including the time-consuming nature of information retrieval and the lack of an intuitive format for data provided by the programs. These results suggest that the majority of US primary care physicians are aware of and use prescription drug monitoring programs at least on occasion, although many did not access these programs routinely. To increase the use of the programs in clinical practice, states should consider implementing legal mandates, investing in prescriber education and outreach, and taking measures to enhance ease of access to and use of the programs.

Skipper, N. and R. Vejlín (2015). "Determinants of generic vs. brand drug choice: Evidence from

population-wide Danish data. *Soc Sci Med* **130**: 204-215.

We investigate if demand for branded prescription medications in post-patent markets is patient- or doctor driven. When drugs go off-patent the brand medication often maintains non-negligible market shares. We use population-wide Danish data including all prescriptions for seven blockbuster drugs from 1998 to 2008, which amounts to 13,415,012 prescriptions. At the outset, descriptive statistics suggest large variation in drug choice over doctors. Nonetheless, using a two-way fixed effects model we find that the primary determinants of brand drug use are unobserved patient characteristics and price effects.

Méthodologie –Statistique / Methodology - Statistics

Valentine, M. A., et al. (2015). "Measuring teamwork in health care settings: a review of survey instruments." *Med Care* **53**(4): e16-30.

BACKGROUND: Teamwork in health care settings is widely recognized as an important factor in providing high-quality patient care. However, the behaviors that comprise effective teamwork, the organizational factors that support teamwork, and the relationship between teamwork and patient outcomes remain empirical questions in need of rigorous study. **OBJECTIVE:** To identify and review survey instruments used to assess dimensions of teamwork so as to facilitate high-quality research on this topic. **RESEARCH DESIGN:** We conducted a systematic review of articles published before September 2012 to identify survey instruments used to measure teamwork and to assess their conceptual content, psychometric validity, and relationships to outcomes of interest. We searched the ISI Web of Knowledge database, and identified relevant articles using the search terms team, teamwork, or collaboration in combination with survey, scale, measure, or questionnaire. **RESULTS:** We found 39 surveys that measured teamwork. Surveys assessed different dimensions of teamwork. The most commonly assessed dimensions were communication, coordination, and respect. Of the 39 surveys, 10 met all of the criteria for psychometric validity, and 14 showed significant relationships to nonself-report outcomes. **CONCLUSIONS:** Evidence of psychometric validity is lacking for many teamwork survey instruments. However, several psychometrically valid instruments are available. Researchers aiming to advance research on teamwork in health care should consider using or adapting one of these instruments before creating a new one. Because instruments vary considerably in the behavioral processes and emergent states of teamwork that they capture, researchers must carefully evaluate the conceptual consistency between instrument, research question, and context.

Eeren, H. V., et al. (2015). "Estimating subgroup effects using the propensity score method: a practical application in outcomes research." *Med Care* **53**(4): 366-373.

OBJECTIVE: Our aim was to demonstrate the feasibility of the univariate and generalized propensity score (PS) method in subgroup analysis of outcomes research. **METHODS:** First, to estimate subgroup effects, we tested the performance of 2 different PS methods, using Monte Carlo simulations: (1) the univariate PS with additional adjustment on the subgroup; and (2) the generalized PS, estimated by crossing the treatment options with a subgroup variable. The subgroup effects were estimated in a linear regression model using the 2 PS adjustments. We further explored whether the subgroup variable should be included in the univariate PS. Second, the 2 methods were compared using data from a large effectiveness study on psychotherapy in personality disorders. Using these data we tested the differences between short-term and long-term treatment, with the severity of patients' problems

defining the subgroups of interest. RESULTS: The Monte Carlo simulations showed minor differences between both PS methods, with the bias and mean squared error overall marginally lower for the generalized PS. When considering the univariate PS, the subgroup variable can be excluded from the PS estimation and only adjusted for in the outcome equation. When applied to the psychotherapy data, the univariate and generalized PS estimations gave similar results. CONCLUSION: The results support the use of the generalized PS as a feasible method, compared with the univariate PS, to find certain subgroup effects in nonrandomized outcomes research.

Fransen, K., et al. (2015). "A commuter-based two-step floating catchment area method for measuring spatial accessibility of daycare centers." *Health & Place* 32(0): 65-73.

This paper puts forward a commuter-based version of the two-step floating catchment area (2SFCA) method, which has gained acceptance in studies on spatial health care accessibility. Current implementations of the 2SFCA method are static in that they consider centroid-based night-time representations of the population. The proposed enhancement to the 2SFCA approach addresses this limitation by accounting for trip-chaining behavior. The presented method is illustrated in a case study of accessibility of daycare centers in the province East Flanders in Belgium. The results show significant spatial differences in accessibility between the original and commuter-based version of the 2SFCA (CB2SFCA). They highlight the importance of giving heed to more complex travel behavior in cases where the need for detailed accessibility calculations is apparent.

Rockers, P. C., et al. (2015). "Inclusion of quasi-experimental studies in systematic reviews of health systems research." *Health Policy* 119(4): 511-521.

Systematic reviews of health systems research commonly limit studies for evidence synthesis to randomized controlled trials. However, well-conducted quasi-experimental studies can provide strong evidence for causal inference. With this article, we aim to stimulate and inform discussions on including quasi-experiments in systematic reviews of health systems research. We define quasi-experimental studies as those that estimate causal effect sizes using exogenous variation in the exposure of interest that is not directly controlled by the researcher. We incorporate this definition into a non-hierarchical three-class taxonomy of study designs - experiments, quasi-experiments, and non-experiments. Based on a review of practice in three disciplines related to health systems research (epidemiology, economics, and political science), we discuss five commonly used study designs that fit our definition of quasi-experiments: natural experiments, instrumental variable analyses, regression discontinuity analyses, interrupted times series studies, and difference studies including controlled before-and-after designs, difference-in-difference designs and fixed effects analyses of panel data. We further review current practices regarding quasi-experimental studies in three non-health fields that utilize systematic reviews (education, development, and environment studies) to inform the design of approaches for synthesizing quasi-experimental evidence in health systems research. Ultimately, the aim of any review is practical: to provide useful information for policymakers, practitioners, and researchers. Future work should focus on building a consensus among users and producers of systematic reviews regarding the inclusion of quasi-experiments.

Savall H., F. D. (2015). "Etude comparative de méthodologies de recherche en médecine et en gestion : cas de la recherche-intervention socio-économique d'ordre qualimétrique." *Journal de Gestion et d'Economie Médicales* 32(5-6): 355-370.

Xiu-Xia, L., et al. (2015). "The reporting characteristics and methodological quality of Cochrane reviews about health policy research." *Health Policy* 119(4): 503-510.

The systematic review has increasingly become a popular tool for researching health policy. However, due to the complexity and diversity in the health policy research, it has also encountered more challenges. We set out the Cochrane reviews on health policy research as a representative to provide the first examination of epidemiological and descriptive characteristics as well as the compliance of methodological quality with the AMSTAR. 99 reviews were included by inclusion criteria, 73% of which were Implementation Strategies, 15% were Financial Arrangements and 12% were Governance Arrangements; involved Public Health (34%), Theoretical Exploration (18%), Hospital Management (17%), Medical Insurance (12%), Pharmaceutical Policy (9%), Community Health (7%) and Rural Health (2%). Only 39% conducted meta-analysis, and 49% reported being updates, and none was rated low methodological quality. Our research reveals that the quantity and quality of the evidence should be improved, especially Financial Arrangements and Governance Arrangements involved Rural Health, Health Care Reform and Health Equity, etc. And the reliability of AMSTAR needs to be tested in larger range in this field.

Politique de santé / Health Policy

(2015). "Maladies chroniques et innovations : numéro spécial " *Santé Publique* **27**(1 - Supplément 2015): 225p.

Carinci, F. (2015). "Essential levels of health information in Europe: An action plan for a coherent and sustainable infrastructure." *Health Policy* **119**(4): 530-538.

The European Union needs a common health information infrastructure to support policy and governance on a routine basis. A stream of initiatives conducted in Europe during the last decade resulted into several success stories, but did not specify a unified framework that could be broadly implemented on a continental level. The recent debate raised a potential controversy on the different roles and responsibilities of policy makers vs the public health community in the construction of such a pan-European health information system. While institutional bodies shall clarify the statutory conditions under which such an endeavour is to be carried out, researchers should define a common framework for optimal cross-border information exchange. This paper conceptualizes a general solution emerging from past experiences, introducing a governance structure and overarching framework that can be realized through four main action lines, underpinned by the key principle of "Essential Levels of Health Information" for Europe. The proposed information model is amenable to be applied in a consistent manner at both national and EU level. If realized, the four action lines outlined here will allow developing a EU health information infrastructure that would effectively integrate best practices emerging from EU public health initiatives, including projects and joint actions carried out during the last ten years. The proposed approach adds new content to the ongoing debate on the future activity of the European Commission in the area of health information.

Soins de santé primaires / Primary Health Care

Le Chaffotec A. (2015). "Trajectoires de soins et facteurs sociodémographiques : l'exemple des maladies rares en France." *Journal de Gestion et d'Economie Médicales* **32**(5-6): 389-409.

Pham, M. and I. McRae "Who provides GP after-hours care?" *Health Policy* 119(4): 447-455.

Female, older, and urban GPs are less likely to work outside of normal hours? Employee GPs are less likely to take the work compared with principals or partners of a practice, although the latter group, like GPs in solo practice, is likely take a heavier workload if they do work outside normal hours? The role of GP wages and family income does not seem to be compelling in GP after-hours care provision in Australia.

Buja, A., et al. (2015). "Out-of-hours primary care services: Demands and patient referral patterns in a Veneto region (Italy) Local Health Authority." *Health Policy* 119(4): 437-446.

PURPOSE: The aim of this study was to describe the characteristics of patients admitted to an out-of-hours (OOH) service and to analyze the related outputs. SETTING: A retrospective population-based cohort study was conducted by analyzing an electronic database recording 23,980 OOH service contacts in 2011 at a Local Health Authority in the Veneto Region (North-East Italy). METHOD: A multinomial logistic regression was used to compare the characteristics of contacts handled by the OOH physicians with cases referred to other services. RESULTS: OOH service contact rates were higher for the oldest and youngest age groups and for females rather than males. More than half of the contacts concerned patients who were seen by a OOH physician. More than one in three contacts related problems managed over the phone; only approximately 10% of the patients were referred to other services. Many factors, including demographic variables, process-logistic variables and clinical characteristics of the contact, were associated with the decision to visit the patient's home (rather than provide telephone advice alone), or to refer patients to an ED or to a specialist. Our study demonstrated, even after adjusting, certain OOH physicians were more likely than their colleagues to refer a patient to an ED. CONCLUSION: Our study shows that OOH services meet composite and variously expressed demands. The determining factors associated with cases referred to other health care services should be considered when designing clinical pathways in order to ensure a continuity of care. The unwarranted variability in OOH physicians' performance needs to be addressed.

David, G., et al. (2015). "Do Patient-Centered Medical Homes Reduce Emergency Department Visits?" *Health Services Research* 50(2): 418-439.

Objective : To assess whether adoption of the patient-centered medical home (PCMH) reduces emergency department (ED) utilization among patients with and without chronic illness. Data Sources Data from approximately 460,000 Independence Blue Cross patients enrolled in 280 primary care practices, all converting to PCMH status between 2008 and 2012. Research Design : We estimate the effect of a practice becoming PCMH-certified on ED visits and costs using a difference-in-differences approach which exploits variation in the timing of PCMH certification, employing either practice or patient fixed effects. We analyzed patients with and without chronic illness across six chronic illness categories. Principal Findings Among chronically ill patients, transition to PCMH status was associated with 5–8 percent reductions in ED utilization. This finding was robust to a number of specifications, including analyzing avoidable and weekend ED visits alone. The largest reductions in ED visits are concentrated among chronic patients with diabetes and hypertension. Conclusions : Adoption of the PCMH model was associated with lower ED utilization for chronically ill patients, but not for those without chronic illness. The effectiveness of the PCMH model varies by chronic condition. Analysis of weekend and avoidable ED visits suggests that reductions in ED utilization stem from better management of chronic illness rather than expanding access to primary care clinics.

Lagarde, M., et al. (2015). "Determinants of the choice of GP practice registration in England:

Evidence from a discrete choice experiment. Health Policy **119**(4): 427-436.

There have been growing concerns that general practitioner (GP) services in England, which are based on registration with a single practice located near the patient's home, are not sufficiently convenient for patients. To inform the decision as to whether to change registration rules allowing patients to register 'out-of-area' and to estimate the demand for this wider choice, we undertook a discrete choice experiment with 1706 respondents. Latent class models were used to analyse preferences for GP practice registration comparing preferences for neighbourhood and non-neighbourhood practices. We find that there is some appetite for registering outside the neighbourhood, but this preference is not uniformly shared across the population. Specifically individuals who are less mobile (e.g. older people and those with caring responsibilities), or satisfied with their local practice are less likely to be interested in registering at a practice outside their neighbourhood. Overall, people feel most strongly about obtaining an appointment with a GP as quickly as possible. Respondents regarded weekend opening as less important than other factors, and particularly less important than extended practice opening hours from Monday to Friday. Assuming a constant demand for GP services, a policy encouraging GP practices to extend their opening hours during the week is likely to decrease the average patient waiting time for an appointment and is likely to be preferred by patients.

Marshall, M. (2015). "A Precious Jewel — The Role of General Practice in the English NHS." New England Journal of Medicine **372**(10): 893-897.

Pollack, C. E., et al. (2015). "Patient sharing and quality of care: measuring outcomes of care coordination using claims data." Med Care **53**(4): 317-323.

Background: With the goal of improving clinical efficiency and effectiveness, programs to enhance care coordination are a major focus of health care reform. Objective: To examine whether "care density"-a claims-based measure of patient sharing by office-based physicians-is associated with measures of quality. Care density is a proxy measure that may reflect how frequently a patient's doctors collaborate. Research design: Cohort study using administrative databases from 3 large commercial insurance plans. Subjects: A total of 1.7 million adult patients; 31,675 with congestive heart failure, 78,530 with chronic obstructive pulmonary disease, and 240,378 with diabetes. Measures: Care density was assessed in 2008. Prevention Quality Indicators (PQIs), 30-day readmissions, and Healthcare Effectiveness Data and Information Set quality indicators were measured in the following year. Results: Among all patients, we found that patients with the highest care density density-indicating high levels of patient sharing among their office-based physicians-had significantly lower rates of adverse events measured as PQIs compared with patients with low-care density (odds ratio=0.88; 95% confidence interval, 0.85-0.92). A significant association between care density and PQIs was also observed for patients with diabetes mellitus but not congestive heart failure or chronic obstructive pulmonary disease. Diabetic patients with higher care density scores had significantly lower odds of 30-day readmissions (odds ratio=0.68, 95% confidence interval, 0.48-0.97). Significant associations were observed between care density and Healthcare Effectiveness Data and Information Set measures although not always in the expected direction. Conclusion: In some settings, patients whose doctors share more patients had lower odds of adverse events and 30-day readmissions.

Saint-Lary, O. and J. Sicsic (2015). "Impact of a pay for performance programme on French GPs' consultation length." Health Policy **119**(4): 417-426.

Background: In 2009, a voluntary-based pay for performance scheme targeting general practitioners (GPs) was introduced in France through the 'Contract for Improving Individual Practices' (CAPI). Objective: To study the impact of the CAPI on French GPs' consultation

length. Methods: Univariate analysis, and multilevel regression analyses were performed to disentangle the different sources of the consultation length variability (intra and inter physician). The dependant variable was the logarithm of the consultation length. Independent variables included patient's sociodemographics as well as the characteristics of GPs and their medical activity. RESULTS: Between November 2011 and April 2012, 128 physicians were recruited throughout France and generated 20,779 consultations timed by residents. The average consultation length in the sample was 16.8min. After adjusting for patients' characteristics only, the consultation length of CAPI signatories was 14.1% lower than that observed for non signatories ($p < 0.001$). After adjusting for GPs' characteristics and the case mix, the CAPI was no longer a significant predictor of the consultation length. The results did not change significantly from one type of consultation to another. Conclusion: Although the CAPI was extended to all GPs in 2012, our results provide a cautionary message to regulators about its ability to generate higher quality of care.

Scherrer, J. F., et al. (2015). "Depression leads to incident vascular disease: evidence for the relevance to primary care." *Family Practice* 32(2): 147-151.

Background. Depression is a known risk factor for vascular disease in community cohorts and in large, system-wide, health care databases. It is not known if the association between depression and incident vascular disease exists when patient data is restricted to depression presenting in primary care. Methods. Data were from a medical record registry capturing all primary care encounters at a large academic medical practice from 2008 to 2013. From 27225 registry patients, we identified 7383 patients free of vascular disease for 18 months prior to baseline. ICD-9-CM codes were used to define depression and vascular disease. Volume of health care use, demographics and comorbid diagnoses were obtained from the patient data registry. Cox proportional hazard models with time dependent covariates were computed to measure the association between depression and incident vascular disease before and after adjusting for covariates. Results. Of the 7383 patients initially free of vascular disease, 14% were diagnosed with depression and 8.6% developed vascular disease. Incident vascular disease was significantly ($P < 0.01$) higher among patients with depression (12.7%) compared to those without depression (7.9%). In the unadjusted model, depression was associated with a 49% increased risk of developing vascular disease (odds ratio [OR] = 1.49; 95% confidence interval [CI]: 1.19–1.86) and this association remained significant after adjusting for all potential confounders (OR = 1.28; 95% CI: 1.02–1.62). Conclusions. The association between depression and incident vascular disease is observed in patients diagnosed and managed by primary care physicians. Primary care physicians have an opportunity to impact this association. Guidelines for primary care providers are needed to prompt aggressive depression treatment and vascular disease screening.

Systemes de santé / Health Systems

Burwell, S. M. (2015). "Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care." *New England Journal of Medicine* 372(10): 897-899.

Joynt, K. E., et al. (2015). "The impact of massachusetts health care reform on access, quality, and costs of care for the already-insured." *Health Serv Res* 50(2): 599-613.

Objective: To assess the impact of Massachusetts Health Reform (MHR) on access, quality, and costs of outpatient care for the already-insured. Data sources/Study setting: Medicare data from before (2006) and after (2009) MHR implementation. Study Design: We performed

a retrospective difference-in-differences analysis of quantity of outpatient visits, proportion of outpatient quality metrics met, and costs of care for Medicare patients with ≥ 1 chronic disease in 2006 versus 2009. We used the remaining states in New England as controls. Data collection/Extraction methods: We used existing Medicare claims data provided by the Centers for Medicare and Medicaid Services. Principal Findings: MHR was not associated with a decrease in outpatient visits per year compared to controls (9.4 prereform to 9.6 postreform in MA vs. 9.4-9.5 in controls, $p = .32$). Quality of care in MA improved more than controls for hemoglobin A1c monitoring, mammography, and influenza vaccination, and similarly to controls for diabetic eye examination, colon cancer screening, and pneumococcal vaccination. Average costs for patients in Massachusetts increased from \$9,389 to \$10,668, versus \$8,375 to \$9,114 in control states ($p < .001$). Conclusions: MHR was not associated with worsening in access or quality of outpatient care for the already-insured, and it had modest effects on costs. This has implications for other states expanding insurance coverage under the Affordable Care Act.

Landwehr, C. and D. Klinnert (2015). "Value congruence in health care priority setting: social values, institutions and decisions in three countries." *Health Econ Policy Law* 10(2): 113-132. Most developed democracies have faced the challenge of priority setting in health care by setting up specialized agencies to take decisions on which medical services to include in public health baskets. Under the influence of Daniels and Sabin's seminal work on the topic, agencies increasingly aim to fulfil criteria of procedural justice, such as accountability and transparency. We assume, however, that the institutional design of agencies also and necessarily reflects substantial value judgments on the respective weight of distributive principles such as efficiency, need and equality. The public acceptance of prioritization decisions, and eventually of the health care system at large, will ultimately depend not only on considerations of procedural fairness, but also on the congruence between a society's values and its institutions. We study social values, institutions and decisions in three countries (France, Germany and the United Kingdom) in order to assess such congruence and formulate expectations on its effects.

Travail et santé / Occupational Health

Maruthappu, M., et al. (2015). "Unemployment, public-sector health-care spending and breast cancer mortality in the European Union: 1990-2009." *Eur J Public Health* 25(2): 330-335. Background: The global economic crisis has been associated with increased unemployment, reduced health-care spending and adverse health outcomes. Insights into the impact of economic variations on cancer mortality, however, remain limited. METHODS: We used multivariate regression analysis to assess how changes in unemployment and public-sector expenditure on health care (PSEH) varied with female breast cancer mortality in the 27 European Union member states from 1990 to 2009. We then determined how the association with unemployment was modified by PSEH. Country-specific differences in infrastructure and demographic structure were controlled for, and 1-, 3-, 5- and 10-year lag analyses were conducted. Several robustness checks were also implemented. Results: Unemployment was associated with an increase in breast cancer mortality [$P < 0.0001$, coefficient (R) = 0.1829, 95% confidence interval (CI) 0.0978-0.2680]. Lag analysis showed a continued increase in breast cancer mortality at 1, 3, 5 and 10 years after unemployment rises ($P < 0.05$). Controlling for PSEH removed this association ($P = 0.063$, R = 0.080, 95% CI - 0.004 to 0.163). PSEH increases were associated with significant decreases in breast cancer

mortality ($P < 0.0001$, $R = -1.28$, 95% CI -1.67 to -0.877). The association between unemployment and breast cancer mortality remained in all robustness checks. Conclusion: Rises in unemployment are associated with significant short- and long-term increases in breast cancer mortality, while increases in PSEH are associated with reductions in breast cancer mortality. Initiatives that bolster employment and maintain total health-care expenditure may help minimize increases in breast cancer mortality during economic crises.

Ganem V. (2015). "Origines des nouvelles pathologies liées au travail et possibilités de prévention." *Journal de Gestion et d'Economie Médicales* 32(5-6): 411-417.

Vieillesse / Ageing

Costa-Font, J. and C. Courbage (2015). "Crowding out of long-term care insurance: evidence from European expectations data." *Health Econ* 24 Suppl 1: 74-88.

Long-term care (LTC) is the largest insurable risk that old-age individuals face in most western societies. However, the demand for LTC insurance is still ostensibly small in comparison with the financial risk. One explanation that has received limited support is that expectations of either 'public sector funding' and 'family support' crowd out individual incentives to seek insurance. This paper aims to investigate further the aforementioned motivational crowding-out hypothesis by developing a theoretical model and by drawing on an innovative empirical analysis of representative European survey data containing records on individual expectations of LTC funding sources (including private insurance, social insurance, and the family). The theoretical model predicts that, when informal care is treated as exogenously determined, expectations of both state support and informal care can potentially crowd out LTC insurance expectations, while this is not necessarily the case when informal care is endogenous to insurance, as happens when intra-family moral hazard is integrated in the insurance decision. We find evidence consistent with the presence of family crowding out but no robust evidence of public sector crowding out. Copyright (c) 2015 John Wiley & Sons, Ltd.

Costa-Font, J., et al. (2015). "Transitioning between 'the old' and 'the new' long-term care systems." *Health Econ* 24 Suppl 1: 1-3.

Guo, J., et al. (2015). "The causal effects of home care use on institutional long-term care utilization and expenditures." *Health Econ* 24 Suppl 1: 4-17.

Limited evidence exists on whether expanding home care saves money overall or how much institutional long-term care can be reduced. This paper estimates the causal effect of Medicaid-financed home care services on the costs and utilization of institutional long-term care using Medicaid claims data. A unique instrumental variable was applied to address the potential bias caused by omitted variables or reverse effect of institutional care use. We find that the use of Medicaid-financed home care services significantly reduced but only partially offset utilization and Medicaid expenditures on nursing facility services. A \$1000 increase in Medicaid home care expenditures avoided 2.75 days in nursing facilities and reduced annual Medicaid nursing facility costs by \$351 among people over age 65 when selection bias is addressed. Failure to address selection biases would misestimate the substitution and offset effects. Copyright (c) 2015 John Wiley & Sons, Ltd.

Jimenez-Martin, S. and C. Vilaplana Prieto (2015). "Informal care motivations and

intergenerational transfers in European countries. " Health Econ **24 Suppl 1**: 89-103.

This work sets out to analyze the motivations adult children may have to provide informal care, considering the monetary transfers they receive from their parents. Traditional motivations, such as altruism and exchange, are matched against more recent social bond theories. Our findings indicate that informal caregivers receive less frequent and less generous transfers than non-caregivers; that is, caregivers are more prone to suppress their self-interested motivations in order to prioritize the well-being of another person. Additionally, long-term public care benefits increase both the probability of receiving a transfer and its amount, with this effect being more intense for both the poorest and richest households. Our findings suggest that if long-term care benefits are intended to increase the recipients' welfare and represent a higher fraction of total income for the poorest households, the effectiveness of these long-term care policies may be diluted. Copyright (c) 2015 John Wiley & Sons, Ltd.