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Sommaire

Assurance maladie / Health Insurance

Bakx, P., et al. (2015). "Can universal access and competition in long-term care insurance be combined?" International Journal of Health Economics and Management **15**(2): 185-213.

In countries with a public long-term care (LTC) insurance scheme administered by multiple non-competing insurers, these insurers typically lack incentives for purchasing cost-effective LTC because they are not at risk for LTC expenses. Plans to introduce these incentives by allowing competition among risk bearing LTC insurers are likely to jeopardize universal access. Combining universal access and competition among risk bearing LTC-insurers requires an adequate system of risk adjustment. While risk adjustment is now widely adopted in health insurance, LTC-specific features cause uncertainty about the feasibility of risk adjustment for LTC insurance. We examine the feasibility of appropriate risk adjustment in LTC insurance by using a rich set of linked nationwide Dutch administrative data. As expected, prior LTC use and demographic information are found to explain much of the variation in individual LTC expenses. However, we find that prior health care expenditures are also important in reducing predicted losses for subgroups of health care users. Nevertheless, incentives for risk selection against some easily identifiable subgroups persist. Moreover, using prior utilization and expenditure as risk adjusters reduces incentives for efficiency, creating a trade-off between equity and efficiency. To ease this trade-off, data on individuals' underlying needs for LTC are required.

MacLean, C. H., et al. (2015). "Quality Varies Across Health Insurance Marketplace Pricing Regions." Med Care **53**(7): 607-618.

BACKGROUND: Although consumers purchasing health plans in the new Health Insurance Marketplace will be provided information on the cost and quality of participating health plans, it is unclear whether the state-wide plan quality averages that will be reported will accurately represent quality at the pricing region level where care will be received. OBJECTIVES: To evaluate whether currently reported state-wide health plan quality scores accurately represent quality within pricing regions established for the Health Insurance Marketplace. RESEARCH DESIGN: Observational, historical cohort study using health plan administrative and pharmacy data. SUBJECTS: A total of 5.2 million members enrolled in the preferred provider organization health plans of 1 large commercial California insurer in 2012. MEASURES: State-wide and pricing region performance on each of the 17 Healthcare Effectiveness Data and Information Set (HEDIS) measures. RESULTS: Across the 17 measures assessed in each of the 19 pricing regions, scores were statistically different (P<0.05) than the overall plan rate for 176 (54%). Variations in scores across regions were observed for each measure ranging from 6.4-percentage points for engagement in treatment for people with dependence of alcohol or other drugs to 47.2-percentage points for appropriate testing for pharyngitis among children. CONCLUSIONS: Quality scores in California vary greatly across geographic regions. Statewide averages may misrepresent the quality of care that consumers are likely to receive within a geographic area making difficult assessments about the value of the health care.

Stone, L. C., et al. (2015). "Place as a predictor of health insurance coverage: A multivariate analysis of counties in the United States." Health Place **34**: 207-214.

This study assessed the importance of county characteristics in explaining county-level variations in health insurance coverage. Using public databases from 2008 to 2012, we studied 3112 counties in the United States. Rates of uninsurance ranged widely from 3% to

53%. Multivariate analysis suggested that poverty, unemployment, Republican voting, and percentages of Hispanic and American Indian/Alaskan Native residents in a county were significant predictors of uninsurance rates. The associations between uninsurance rates and both race/ethnicity and poverty varied significantly between metropolitan and non-metropolitan counties. Collaborative actions by the federal, tribal, state, and county governments are needed to promote coverage and access to care.

Economie de la santé / Health Economics

Seidl, H., et al. (2015). "Cost-effectiveness of nurse-based case management versus usual care for elderly patients with myocardial infarction: results from the KORINNA study." Eur J Health Econ **16**(6): 671-681.

OBJECTIVES: We assessed the cost-effectiveness of a case management intervention by trained nurses in elderly (>/=65 years) patients with myocardial infarction from a societal perspective. METHODS: The intervention and observation period spanned 1 year and 329 participants were enrolled. The intervention consisted of at least one home visit and quarterly telephone calls. Data on resource use and quality of life were collected quarterly. The primary measurements of effect were quality-adjusted life years (QALYs), based on the EuroQol five-dimensional questionnaire (EQ-5D-3L) health utilities from the German time trade-off. The secondary measurements were EQ-5D-3L utility values and patients' self-rated health states according to the visual analogue scale (VAS) among survivors. To estimate mean differences, a linear regression model was used for QALYs and a gamma model for costs. Health states among the survivors were analysed using linear mixed models. To assess the impact of different health state valuation methods, VAS-adjusted life years were constructed. RESULTS: The mean difference in QALYs was small and not significant (-0.0163; CI -0.0681-0.0354, p value: 0.536, n = 297). Among survivors, EQ-5D-3L utilities showed significant improvements within 6 months in the intervention group (0.051; CI 0.0028-0.0989; p value: 0.0379, n = 280) but returned towards baseline levels by month 12. The mean improvement in self-rated health (VAS) within 1 year was significantly larger in the intervention group (+9.2, CI 4.665-13.766, p value: <0.0001, n = 266). The overall cost difference was -<euro>17.61 (CI - <euro>2,601-<euro>2,615; p value: 0.9856, n = 297). The difference in VAS-adjusted life years was 0.0378 (CI -0.0040-0.0796, p value: 0.0759, n = 297). CONCLUSIONS: This study could not provide evidence to conclude that the case management intervention was an effective and cost-effective alternative to usual care within a time horizon of 1 year.

Shih, Y. T., et al. (2015). "Cost-Effectiveness Analysis of a Capitated Patient Navigation Program for Medicare Beneficiaries with Lung Cancer." Health Serv Res.

OBJECTIVE: To assess the cost-effectiveness of implementing a patient navigation (PN) program with capitated payment for Medicare beneficiaries diagnosed with lung cancer. DATA SOURCES/STUDY SETTING: Cost-effectiveness analysis. STUDY DESIGN: A Markov model to capture the disease progression of lung cancer and characterize clinical benefits of PN services as timeliness of treatment and care coordination. Taking a payer's perspective, we estimated the lifetime costs, life years (LYs), and quality-adjusted life years (QALYs) and addressed uncertainties in one-way and probabilistic sensitivity analyses. DATA COLLECTION/EXTRACTION METHODS: Model inputs were extracted from the literature, supplemented with data from a Centers for Medicare and Medicaid Services demonstration project. PRINCIPAL FINDINGS: Compared to usual care, PN services incurred higher costs but also yielded better outcomes. The incremental cost and effectiveness was $9,145 and 0.47 QALYs, respectively, resulting in an incremental cost-effectiveness ratio of $19,312/QALY. One-way sensitivity analysis indicated that findings were most sensitive to a parameter capturing PN survival benefit for local-stage patients. CE-acceptability curve showed the probability that the PN program was cost-effective was 0.80 and 0.91 at a societal willingness-to-pay of $50,000 and $100,000/QALY, respectively. CONCLUSION: Instituting a capitated PN program is cost-effective for lung cancer patients in Medicare. Future research should evaluate whether the same conclusion holds in other cancers.

Van Walbeek, C. (2015). "The economics of tobacco control (Part 2): evidence from the ITC Project." Tobacco Control **24**(Suppl 3): iii1-iii3.

Etat de santé / Health Status

Vos, T., et al. "Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013." The Lancet.

BackgroundUp-to-date evidence about levels and trends in disease and injury incidence, prevalence, and years lived with disability (YLDs) is an essential input into global, regional, and national health policies. In the Global Burden of Disease Study 2013 (GBD 2013), we estimated these quantities for acute and chronic diseases and injuries for 188 countries between 1990 and 2013.

Géographie de la santé / Geography of Health

Bocquier A. ; El-haïk Y. ; Jardin M., e. a. (2015). "Intérêt des données de remboursement de l'Assurance-maladie pour l'étude des disparités territoriales de la prévalence de l'asthme : une étude Provence-Alpes-Côte d'Azur. ." Revue d'Epidémiologie et de Santé Publique **63**(3): 155-162.

Caumes, E., et al. (2015). "Tintin's travel traumas: Health issues affecting the intrepid globetrotter." Presse Med **44**(6 Pt 1): e203-210.

BACKGROUND: Despite the highly hazardous life-style led by comic book characters such as Tintin, we are unaware of any previous systematic description of the challenges and health impairments faced by Tintin in the course of his adventures. METHODS: We evaluated the spectrum of health impairments (HIs) that Tintin sustained in his 23 adventures as well as their causes, consequences, and relation to travel. We diagnosed Tintin's HIs according to descriptive terms in the text. We then classified HIs as traumatic and non-traumatic, and distinguished between intentional (those perpetrated by others) and unintentional events. RESULTS: We found 236 events leading to 244 HIs, 13 kidnappings, six hospitalisations and two surgical procedures. There was a median of 8 HIs/adventure (range 1-30/adventure). The mean number of HIs per adventure was much greater before 1945 than subsequently (14.9 vs. 6.1; P=0.002), which was also true of the number of kidnappings (11 vs. 2; P=0.001). Of the 244 HIs, there were 191 cases of trauma (78.3%) and 53 non-traumatic problems (21.7%). The most common form of trauma was concussion (62%) whereas the most common forms of non-traumatic problems were sleep problems (15.1%), depression/anxiety (13%), and gas or chloroform poisoning (13%). Overall, we found 46 losses of consciousness (LoC), including 29 traumatic and 17 non-traumatic LoCs. Of the 236 events, there were 69 (29%) perpetrated by others against Tintin (including 55 homicide attempts), and 167 (71%) events that were not (including 69 events related to Tintin's actions). CONCLUSION: Tintin's almost superhuman qualities, a luxury afforded him by his fictional status, make him highly resistant to trauma. He is also not susceptible to the usual travel-related illnesses but is easily influenced by his friends and Snowy, his faithful hound.

Hôpital / Hospitals

Chevalier L.B.J. ; Marquestaut O. ; Lukacs B., e. a. (2015). "Impacts sur les pratiques professionnelles d'un protocole de soins mis en place entre l'hospitalisation avec hébergement et l'hospitalisation à domicile." Santé Publique(2): 205-211.

Gusmano, M. K. and F. J. Thompson (2015). "An Examination Of Medicaid Delivery System Reform Incentive Payment Initiatives Under Way In Six States." Health Affairs **34**(7): 1162-1169.
Medicaid waivers for Delivery System Reform Incentive Payment (DSRIP) seek to hold hospitals and other providers accountable for measureable improvements in health care delivery. We explore the policy context giving rise to these waivers in six states, with particular attention to the interplay among the financial needs of hospitals; the rise of managed care; and federal interest in replacing an “unconditional” Medicaid funding stream, the upper payment limit, with one rooted in pay-for-performance. Key characteristics of these main DSRIP waivers are compared with a particular focus on the establishment of project menus, performance metrics, and pay-for-performance processes. Concluding sections discuss the potential and limits of the waivers as vehicles for health care reform. The long-term durability and impact of DSRIP remains unclear. But federal and state officials have made considerable headway in planning and otherwise laying the groundwork for it.

Herrin, J., et al. (2015). "Assessing Community Quality of Health Care." Health Serv Res.
OBJECTIVE: To determine the agreement of measures of care in different settings-hospitals, nursing homes (NHs), and home health agencies (HHAs)-and identify communities with high-quality care in all settings. DATA SOURCES/STUDY SETTING: Publicly available quality measures for hospitals, NHs, and HHAs, linked to hospital service areas (HSAs). STUDY DESIGN: We constructed composite quality measures for hospitals, HHAs, and nursing homes. We used these measures to identify HSAs with exceptionally high- or low-quality of care across all settings, or only high hospital quality, and compared these with respect to sociodemographic and health system factors. PRINCIPAL FINDINGS: We identified three dimensions of hospital quality, four HHA dimensions, and two NH dimensions; these were poorly correlated across the three care settings. HSAs that ranked high on all dimensions had more general practitioners per capita, and fewer specialists per capita, than HSAs that ranked highly on only the hospital measures. CONCLUSION: Higher quality hospital, HHA, and NH care are not correlated at the regional level; regions where all dimensions of care are high differ systematically from regions which score well on only hospital measures and from those which score well on none.

Lamarche-Vadel, A., et al. (2015). "Hospital Comparisons Based on Mortality: Revisiting the Choice of Postadmission Timeframe and Evaluating the Contribution of Cause-of-death Data,

France, 2009." Med Care **53**(8): 736-742.
Background: In-hospital mortality is widely used to judge the quality of hospital care, but is biased by discharge patterns. Fixed-timeframe indicators have thus been recommended. However, the 30-day postadmission indicator may underestimate hospital-wide mortality, as patients dying in hospital >30 days after admission are considered as survivors. Objectives: To identify the most relevant timeframes and to assess the contribution of cause-of-death data. Methods: The 2009 French hospital discharge database was linked to vital status records and to the causes of death register for 11.5 million hospital stays by beneficiaries of French general health insurance. Correlations and agreements between the 30-day hospital standardized mortality ratio (HSMR) and the in-hospital, 60-, 90-, 180-, and 365-day postadmission HSMRs were estimated. Results: A total of 7.8%, 1.5%, and 0.5% of patients who died during their hospital stay were considered as survivors by the 30-, 60-, and 90-day HSMRs, respectively. The 30-day HSMR correlated strongly with the 60-day HSMR (Pearson coefficient=0.92), and their agreement on outlier status was excellent (κ coefficient=0.80). The association remained substantial at 90 days, but weakened at 180 days and even more so at 365 days. Regardless of the timeframe, exclusion of deaths likely due to independent causes barely modified the indicators. Conclusions: This nationwide study shows that 60- and 90-day HSMRs encompass in-hospital deaths better than the 30-day HSMR, while capturing the same interhospital variations. They should thus be preferred. The contribution of cause-of-death data to hospital-wide indicators seems negligible.

Lee, J., et al. (2015). "Return to the ED and hospitalisation following minor injuries among older persons treated in the emergency department: predictors among independent seniors within 6 months." Age and Ageing **44**(4): 624-629.
Background: minor traumatic injuries among independent older people have received little attention to date, but increasingly the impact of such injuries is being recognised.Objectives: we assessed the frequency and predictors of acute health care use, defined as return to the emergency department (ED) or hospitalisation.Study design: national multicentre prospective observational study.Setting: eight Canadian teaching EDs between April 2009 and April 2013.Participants: a total of 1,568 patients aged 65–100 years, independent in basic activities of daily living, discharged from ED following a minor traumatic injury.Methods: trained assessors measured baseline data including demographics, functional status, cognition, comorbidities, frailty and injury severity. We then conducted follow-up telephone interviews at 6 months to assess subsequent acute health care use. We used log-binomial regression analyses to identify predictors of acute health care use, and reported relative risks and 95% CIs.Results: participants' mean age was 77.0, 66.4% female, and their injuries included contusions (43.5%), lacerations (25.1%) and fractures (25.4%). The cumulative rate of acute health care use by 6 months post-injury was 21.5% (95% CI: 19.0–24.3%). The strongest predictors of acute health care use within 6 months were cognitive impairment, RR = 1.6 (95% IC: 1.2–2.1) and the mechanism of injury including pedestrian struck or recreational injuries, RR = 1.6 (95% CI 1.2–2.2).Conclusions: among independent community living older persons with a minor injury, cognitive impairment and mechanism of injury were independent risk factors for acute healthcare use. Future studies should look at whether tailored discharge planning can reduce the need for acute health care use.

Lim, E., et al. (2015). "Risk-Adjusted In-Hospital Mortality Models for Congestive Heart Failure and Acute Myocardial Infarction: Value of Clinical Laboratory Data and Race/Ethnicity." Health Serv Res.
OBJECTIVE: To examine the impact of key laboratory and race/ethnicity data on the prediction of in-hospital mortality for congestive heart failure (CHF) and acute myocardial infarction (AMI). DATA SOURCES: Hawaii adult hospitalizations database between 2009 and

2011, linked to laboratory database. STUDY DESIGN: Cross-sectional design was employed to develop risk-adjusted in-hospital mortality models among patients with CHF (n = 5,718) and AMI (n = 5,703). DATA COLLECTION/EXTRACTION METHODS: Results of 25 selected laboratory tests were requested from hospitals and laboratories across the state and mapped according to Logical Observation Identifiers Names and Codes standards. The laboratory data were linked to administrative data for each discharge of interest from an all-payer database, and a Master Patient Identifier was used to link patient-level encounter data across hospitals statewide. PRINCIPAL FINDINGS: Adding a simple three-level summary measure based on the number of abnormal laboratory data observed to hospital administrative claims data significantly improved the model prediction for inpatient mortality compared with a baseline risk model using administrative data that adjusted only for age, gender, and risk of mortality (determined using 3M's All Patient Refined Diagnosis Related Groups classification). The addition of race/ethnicity also improved the model. CONCLUSIONS: The results of this study support the incorporation of a simple summary measure of laboratory data and race/ethnicity information to improve predictions of in-hospital mortality from CHF and AMI. Laboratory data provide objective evidence of a patient's condition and therefore are accurate determinants of a patient's risk of mortality. Adding race/ethnicity information helps further explain the differences in in-hospital mortality.

Meacock, R., et al. (2015). "What are the Costs and Benefits of Providing Comprehensive Seven-day Services for Emergency Hospital Admissions?" Health Econ **24**(8): 907-912.

The English National Health Service is moving towards providing comprehensive 7-day hospital services in response to higher death rates for emergency weekend admissions. Using Hospital Episode Statistics between 1st April 2010 and 31st March 2011 linked to all-cause mortality within 30 days of admission, we estimate the number of excess deaths and the loss in quality-adjusted life years associated with emergency weekend admissions. The crude 30-day mortality rate was 3.70% for weekday admissions and 4.05% for weekend admissions. The excess weekend death rate equates to 4355 (risk adjusted 5353) additional deaths each year. The health gain of avoiding these deaths would be 29 727-36 539 quality-adjusted life years per year. The estimated cost of implementing 7-day services is pound1.07- pound1.43 bn, which exceeds by pound339- pound831 m the maximum spend based on the National Institute for Health and Care Excellence threshold of pound595 m- pound731 m. There is as yet no clear evidence that 7-day services will reduce weekend deaths or can be achieved without increasing weekday deaths. The planned cost of implementing 7-day services greatly exceeds the maximum amount that the National Health Service should spend on eradicating the weekend effect based on current evidence. Policy makers and service providers should focus on identifying specific service extensions for which cost-effectiveness can be demonstrated. Copyright (c) 2015 John Wiley & Sons, Ltd.

Silber, J. H., et al. (2015). "Examining Causes of Racial Disparities in General Surgical Mortality: Hospital Quality Versus Patient Risk." Med Care **53**(7): 619-629.

BACKGROUND: Racial disparities in general surgical outcomes are known to exist but not well understood. OBJECTIVES: To determine if black-white disparities in general surgery mortality for Medicare patients are attributable to poorer health status among blacks on admission or differences in the quality of care provided by the admitting hospitals. RESEARCH DESIGN: Matched cohort study using Tapered Multivariate Matching. SUBJECTS: All black elderly Medicare general surgical patients (N=18,861) and white-matched controls within the same 6 states or within the same 838 hospitals. MEASURES: Thirty-day mortality (primary); others include in-hospital mortality, failure-to-rescue, complications, length of stay, and readmissions. RESULTS: Matching on age, sex, year, state, and the exact same procedure, blacks had higher 30-day mortality (4.0% vs. 3.5%, P<0.01), in-hospital mortality (3.9% vs. 2.9%, P<0.0001), in-hospital complications (64.3% vs. 56.8% P<0.0001), and failure-to-rescue rates (6.1% vs. 5.1%, P<0.001), longer length of stay (7.2 vs. 5.8 d, P<0.0001), and more 30-day readmissions (15.0% vs. 12.5%, P<0.0001). Adding preoperative risk factors to the above match, there was no significant difference in mortality or failure-to-rescue, and all other outcome differences were small. Blacks matched to whites in the same hospital displayed no significant differences in mortality, failure-to-rescue, or readmissions. CONCLUSIONS: Black and white Medicare patients undergoing the same procedures with closely matched risk factors displayed similar mortality, suggesting that racial disparities in general surgical mortality are not because of differences in hospital quality. To reduce the observed disparities in surgical outcomes, the poorer health of blacks on presentation for surgery must be addressed.

Wubulihasimu, P., et al. (2015). "The Impact of Hospital Payment Schemes on Healthcare and Mortality: Evidence from Hospital Payment Reforms in OECD Countries." Health Econ.

In this study, aggregate-level panel data from 20 Organization for Economic Cooperation and Development countries over three decades (1980-2009) were used to investigate the impact of hospital payment reforms on healthcare output and mortality. Hospital payment schemes were classified as fixed-budget (i.e. not directly based on activities), fee-for-service (FFS) or patient-based payment (PBP) schemes. The data were analysed using a difference-in-difference model that allows for a structural change in outcomes due to payment reform. The results suggest that FFS schemes increase the growth rate of healthcare output, whereas PBP schemes positively affect life expectancy at age 65 years. However, these results should be interpreted with caution, as results are sensitive to model specification. Copyright (c) 2015 John Wiley & Sons, Ltd.

Inégalités de santé / Health Inequalities

Arcaya, M. C., et al. (2015). "Inequalities in health: definitions, concepts, and theories." Glob Health Action **8**: 27106.

Individuals from different backgrounds, social groups, and countries enjoy different levels of health. This article defines and distinguishes between unavoidable health inequalities and unjust and preventable health inequities. We describe the dimensions along which health inequalities are commonly examined, including across the global population, between countries or states, and within geographies, by socially relevant groupings such as race/ethnicity, gender, education, caste, income, occupation, and more. Different theories attempt to explain group-level differences in health, including psychosocial, material deprivation, health behavior, environmental, and selection explanations. Concepts of relative versus absolute; dose-response versus threshold; composition versus context; place versus space; the life course perspective on health; causal pathways to health; conditional health effects; and group-level versus individual differences are vital in understanding health inequalities. We close by reflecting on what conditions make health inequalities unjust, and to consider the merits of policies that prioritize the elimination of health disparities versus those that focus on raising the overall standard of health in a population.

Farrer, L., et al. (2015). "Advocacy for health equity: a synthesis review." Milbank Q **93**(2): 392-437.

Policy Points: Many barriers hamper advocacy for health equity, including the contemporary economic zeitgeist, the biomedical health perspective, and difficulties cooperating across policy sectors on the issue. Effective advocacy should include persistent efforts to raise awareness and understanding of the social determinants of health. Education on the social determinants as part of medical training should be encouraged, including professional training within disadvantaged communities. Advocacy organizations have a central role in advocating for health equity given the challenges bridging the worlds of civil society, research, and policy. CONTEXT: Health inequalities are systematic differences in health among social groups that are caused by unequal exposure to-and distributions of-the social determinants of health (SDH). They are persistent between and within countries despite action to reduce them. Advocacy is a means of promoting policies that improve health equity, but the literature on how to do so effectively is dispersed. The aim of this review is to synthesize the evidence in the academic and gray literature and to provide a body of knowledge for advocates to draw on to inform their efforts. METHODS: This article is a systematic review of the academic literature and a fixed-length systematic search of the gray literature. After applying our inclusion criteria, we analyzed our findings according to our predefined dimensions of advocacy for health equity. Last, we synthesized our findings and made a critical appraisal of the literature. FINDINGS: The policy world is complex, and scientific evidence is unlikely to be conclusive in making decisions. Timely qualitative, interdisciplinary, and mixed-methods research may be valuable in advocacy efforts. The potential impact of evidence can be increased by "packaging" it as part of knowledge transfer and translation. Increased contact between researchers and policymakers could improve the uptake of research in policy processes. Researchers can play a role in advocacy efforts, although health professionals and disadvantaged people, who have direct contact with or experience of hardship, can be particularly persuasive in advocacy efforts. Different types of advocacy messages can accompany evidence, but messages should be tailored to advocacy target. Several barriers hamper advocacy efforts. The most frequently cited in the academic literature are the current political and economic zeitgeist and related public opinion, which tend to blame disadvantaged people for their ill health, even though biomedical approaches to health and political short-termism also act as barriers. These barriers could be tackled through long-term actions to raise public awareness and understanding of the SDH and through training of health professionals in advocacy. Advocates need to take advantage of "windows of opportunity," which open and close quickly, and demonstrate expertise and credibility. CONCLUSIONS: This article brings together for the first time evidence from the academic and the gray literature and provides a building block for efforts to advocate for health equity. Evidence regarding many of the dimensions is scant, and additional research is merited, particularly concerning the applicability of findings outside the English-speaking world. Advocacy organizations have a central role in advocating for health equity, given the challenges bridging the worlds of civil society, research, and policy.

Fiorati, R. C. and V. M. Elui (2015). "Social determinants of health, inequality and social inclusion among people with disabilities." Rev Lat Am Enfermagem **23**(2): 329-336.

OBJECTIVE: to analyze the socio-familial and community inclusion and social participation of people with disabilities, as well as their inclusion in occupations in daily life. METHOD: qualitative study with data collected through open interviews concerning the participants' life histories and systematic observation. The sample was composed of ten individuals with acquired or congenital disabilities living in the region covered by a Family Health Center. The social conception of disability was the theoretical framework used. Data were analyzed according to an interpretative reconstructive approach based on Habermas' Theory of Communicative Action. RESULTS: the results show that the socio-familial and community inclusion of the study participants is conditioned to the social determinants of health and present high levels of social inequality expressed by difficult access to PHC and rehabilitation services, work and income, education, culture, transportation and social participation. CONCLUSION: there is a need to develop community-centered care programs in cooperation with PHC services aiming to cope with poverty and improve social inclusion.

Hwang, S. W., et al. (2015). "Accuracy of Self-Reported Health Care Use in a Population-Based Sample of Homeless Adults." Health Serv Res.
OBJECTIVE: To assess the accuracy of self-reported ambulatory care visits, emergency department (ED) encounters, and overnight hospitalizations in a population-based sample of homeless adults. DATA SOURCE: Self-report survey data and administrative health care utilization databases. STUDY DESIGN: Self-reported health care use in the past 12 months was compared to administrative encounter records among 1,163 homeless adults recruited in 2004-2005 from shelters and meal programs in Toronto, Ontario. DATA EXTRACTION METHODS: Self-reported health care use was assessed using a structured face-to-face survey. Each participant was linked to administrative databases using a unique personal health number or their first name, last name, sex, and date of birth. PRINCIPAL FINDINGS: The sensitivity of self-report for ambulatory care visits, ED encounters, and overnight hospitalizations was 89, 80, and 73 percent, respectively; specificity was 37, 83, and 91 percent. The mean difference between self-reported and documented number of encounters in the past 12 months was +1.6 for ambulatory care visits (95 percent CI = 0.4, 2.8), -0.6 for ED encounters (95 percent CI = -0.8, -0.4), and 0.0 for hospitalizations (95 percent CI = 0.0, 0.1). CONCLUSIONS: Adults experiencing homelessness are quite accurate reporters of their use of health care, especially for ED encounters and hospitalizations.

Mata, J., et al. (2015). "Higher body mass index, less exercise, but healthier eating in married adults: Nine representative surveys across Europe." Soc Sci Med **138**: 119-127.
Numerous studies show that married individuals enjoy better health than those who were never married. This representative survey examines whether they also have a healthier body mass index (BMI) and weight-related behaviors, and tests four independent explanations. Face-to-face interviews were conducted with representative samples (N = 4555) from nine European countries (Austria, France, Germany, Italy, the Netherlands, Poland, Russia, Spain, UK). On average, never married respondents had a lower BMI than married respondents (p = .048). Married individuals reported stronger preferences for organic/fair trade food and regional/unprocessed food, and paying less attention to dietary convenience or dietary fat and body weight. Importantly, married men also exercised less (all ps < .05). Despite these behavioral differences, only attention to dietary fat and body weight (p = .001) predicted BMI differently for married versus never married men. There were few country differences in the relationship between marital status and BMI. All analyses were controlled for age and socio-economic status. In conclusion, despite more favorable eating-related cognitions and behaviors, married respondents had a higher BMI than never married respondents, but differences were small. The link between marital status and BMI cannot be fully described by one single explanation. Obesity interventions may benefit from considering specific weight-related behaviors in married versus never married individuals.

Médicaments / Pharmaceuticals

Hilary Short, T. S. and M. Devidas (2015). "A National Approach to Reimbursement Decision-Making on Drugs for Rare Diseases in Canada? Insights from Across the Ponds." Healthcare Policy **10**(4): 24-46.

<p>Introduction: Regardless of the type of health system or payer, coverage decisions on drugs for rare diseases (DRDs) are challenging. While these drugs typically represent the only active treatment option for a progressive and/or life-threatening condition, evidence of clinical benefit is often limited because of small patient populations and the costs are high. Thus, decisions come with considerable uncertainty and risk. In Canada, interest in developing a pan-Canadian decision-making approach informed by international experiences exists.</p> <p>Objective: To develop an inventory of existing policies and processes for making coverage decisions on DRDs around the world.</p> <p>Methods: A systematic review of published and unpublished documents describing current policies and processes in the top 20 gross domestic product countries was conducted. Bibliographic databases, the Internet and government/health technology assessment organization websites in each country were searched. Two researchers independently extracted information and tabulated it to facilitate qualitative comparative analyses. Policy experts from each country were contacted and asked to review the information collected for accuracy and completeness.</p> <p>Results: Almost all countries have multiple mechanisms through which coverage for a DRD may be sought. However, they typically begin with a review that follows the same process as drugs for more common conditions (i.e., the centralized review process), although specific submission requirements could differ (e.g., no need to submit a cost-effectiveness analysis). When drugs fail to receive a positive recommendation/decision, they are reconsidered by "safety net"-type programs. Eligibility criteria vary across countries, as do the decision options, which may be applied to individual patients or patient groups.</p> <p>Conclusions: With few exceptions, countries have not created separate centralized review processes for DRDs. Instead, they have modified components of existing mechanisms and added safety nets.</p>

Houy, N. and I. Jelovac (2015). "Drug Launch Timing and International Reference Pricing." Health Econ **24**(8): 978-989.

This paper analyzes the timing decisions of pharmaceutical firms to launch a new drug in countries involved in international reference pricing. We show three important features of launch timing when all countries refer to the prices in all other countries and in all previous periods of time. First, there is no withdrawal of drugs in any country and in any period. Second, whenever the drug is sold in a country, it is also sold in all countries with larger willingness to pay. Third, there is no strict incentive to delay the launch of a drug in any country. We then show that the first and third results continue to hold when the countries only refer to the prices of a subset of all countries in a transitive way and in any period. We also show that the second result continues to hold when the reference is on the last period prices only. Last, we show that the seller's profits increase as the sets of reference countries decrease with respect to inclusion. Copyright (c) 2014 John Wiley & Sons, Ltd.

Jillian Kratzer, L. C. S. A. and R. L. Michael (2015). "The Impact of Private Insurance Coverage on Prescription Drug Use in Ontario, Canada." Healthcare Policy **10**(4): 62-74.

<p>Canadians obtain prescription drug coverage through a patchwork of public insurance, private benefit plans and out-of-pocket payments. Prior evidence suggests that insurance coverage, in general, leads to higher utilization rates of essential medicines; it is unclear whether individuals with private insurance have better access to medicines.</p> <p>Using data from the 2008 Canadian Community Health Survey, we identified cohorts from Ontario who reported having been diagnosed by a physician with asthma, high blood pressure or diabetes. Using propensity score stratification techniques, we compared drug utilization of individuals holding private insurance with that of individuals holding either public insurance (for those aged over 65 years) or no insurance (aged under 65 years).</p> <p>In five out of six comparisons, individuals with private insurance were more likely to take prescribed drugs

than those without. Raw differences in the percentage of patients taking medicines ranged from 0.1 to 8.1%.</p> <p>Ontarians with chronic conditions holding private drug insurance are more likely to use prescription drugs than those who do not. Whether these inequities result in health outcome differences remains unknown.</p>

Lo-Ciganic, W.-H., et al. (2015). "Using Machine Learning to Examine Medication Adherence Thresholds and Risk of Hospitalization." Med Care **53**(8): 720-728.

Background: Quality improvement efforts are frequently tied to patients achieving ≥80% medication adherence. However, there is little empirical evidence that this threshold optimally predicts important health outcomes. Objective: To apply machine learning to examine how adherence to oral hypoglycemic medications is associated with avoidance of hospitalizations, and to identify adherence thresholds for optimal discrimination of hospitalization risk. Methods: A retrospective cohort study of 33,130 non–dual-eligible Medicaid enrollees with type 2 diabetes. We randomly selected 90% of the cohort (training sample) to develop the prediction algorithm and used the remaining (testing sample) for validation. We applied random survival forests to identify predictors for hospitalization and fit survival trees to empirically derive adherence thresholds that best discriminate hospitalization risk, using the proportion of days covered (PDC). Outcomes: Time to first all-cause and diabetes-related hospitalization. Results: The training and testing samples had similar characteristics (mean age, 48 y; 67% female; mean PDC=0.65). We identified 8 important predictors of all-cause hospitalizations (rank in order): prior hospitalizations/emergency department visit, number of prescriptions, diabetes complications, insulin use, PDC, number of prescribers, Elixhauser index, and eligibility category. The adherence thresholds most discriminating for risk of all-cause hospitalization varied from 46% to 94% according to patient health and medication complexity. PDC was not predictive of hospitalizations in the healthiest or most complex patient subgroups. Conclusions: Adherence thresholds most discriminating of hospitalization risk were not uniformly 80%. Machine-learning approaches may be valuable to identify appropriate patient-specific adherence thresholds for measuring quality of care and targeting nonadherent patients for intervention.

Puig-Junoy, J., et al. (2015). "Free Medicines Thanks to Retirement: Impact of Coinsurance Exemption on Pharmaceutical Expenditures and Hospitalization Offsets in a national health service." Health Econ., Ahead of pub

This paper examines the impact of coinsurance exemption for prescription medicines applied to elderly individuals in Spain after retirement. We use a rich administrative dataset that links pharmaceutical consumption and hospital discharge records for the full population aged 58 to 65 years in January 2004 covered by the public insurer in a Spanish region, and we follow them until December 2006. We use a difference-in-differences strategy and exploit the eligibility age for Social Security to control for the endogeneity of the retirement decision. Our results show that this uniform exemption increases the consumption of prescription medicines on average by 17.5%, total pharmaceutical expenditure by 25% and the costs borne by the insurer by 60.4%, without evidence of any offset effect in the form of lower short term probability of hospitalization. The impact is concentrated among consumers of medicines for acute and other non-chronic diseases whose previous coinsurance rate was 30% to 40%. Copyright (c) 2015 John Wiley & Sons, Ltd.

Shajarizadeh, A. and A. Hollis (2015). "Price-cap Regulation, Uncertainty and the Price Evolution of New Pharmaceuticals." Health Econ **24**(8): 966-977.

This paper examines the effect of the regulations restricting price increases on the evolution of pharmaceutical prices. A novel theoretical model shows that this policy leads firms to price new drugs with uncertain demand above the expected value initially. Price decreases after drug launch are more likely, the higher the uncertainty. We empirically test the model's predictions using data from the Canadian pharmaceutical market. The level of uncertainty is shown to play a crucial role in drug pricing strategies. (c) 2014 The Authors. Health Economics Published by John Wiley & Sons Ltd.

Méthodologie – Statistique / Methodology - Statistics

Cornelius, M. E., et al. (2015). "Trends in cigarette pricing and purchasing patterns in a sample of US smokers: findings from the ITC US Surveys (2002–2011)." Tobacco Control **24**(Suppl 3): iii4-iii10.
Objective This paper examines trends in cigarette prices and corresponding purchasing patterns over a 9-year period and explores characteristics associated with the quantity and location of cigarettes purchased by adult smokers in the USA.Methods The data for this paper come from a nationally representative longitudinal survey of 6669 adult smokers (18 years and older) who were recruited and surveyed between 2002 and 2011. Telephone interviews were conducted annually, and smokers were asked a series of questions about the location, quantity (ie, single vs multiple packs or cartons) and price paid for their most recent cigarette purchase. Generalised estimating equations were used to assess trends and model characteristics associated with cigarette purchasing behaviours.Results Between 2002 and 2011, the reported purchase of cigarette cartons and the use of coupons declined while multipack purchases increased. Compared with those purchasing by single packs, those who purchased by multipacks and cartons saved an average of $0.53 and $1.63, respectively. Purchases in grocery and discount stores declined, while purchases in tobacco only outlets increased slightly. Female, older, white smokers were more likely to purchase cigarettes by the carton or in multipacks and in locations commonly associated with tax avoidance (ie, duty free shops, Indian reservations).Conclusions As cigarette prices have risen, smokers have begun purchasing via multipacks instead of cartons. As carton sales have declined, purchases from grocery and discount stores have also declined, while an increasing number of smokers report low tax sources as their usual purchase location for cigarettes.

Shang, C., et al. (2015). "The association between tax structure and cigarette price variability: findings from the ITC Project." Tobacco Control **24**(Suppl 3): iii88-iii93.
Background Recent studies have shown that more opportunities exist for tax avoidance when cigarette excise tax structure departs from a uniform specific structure. However, the association between tax structure and cigarette price variability has not been thoroughly studied in the existing literature.Objective To examine how cigarette tax structure is associated with price variability. The variability of self-reported prices is measured using the ratios of differences between higher and lower prices to the median price such as the IQR-to-median ratio.Methods We used survey data taken from the International Tobacco Control Policy Evaluation (ITC) Project in 17 countries to conduct the analysis. Cigarette prices were derived using individual purchase information and aggregated to price variability measures for each surveyed country and wave. The effect of tax structures on price variability was estimated using Generalised Estimating Equations after adjusting for year and country attributes.Findings Our study provides empirical evidence of a relationship between tax structure and cigarette price variability. We find that, compared to the specific uniform tax structure, mixed uniform and tiered (specific, ad valorem or mixed) structures are associated with greater price variability ($p \le 0.01$). Moreover, while a greater share of the specific

component in total excise taxes is associated with lower price variability (p≤0.05), a tiered tax structure is associated with greater price variability (p≤0.01). The results suggest that a uniform and specific tax structure is the most effective tax structure for reducing tobacco consumption and prevalence by limiting price variability and decreasing opportunities for tax avoidance.

Prévention / Prevention

Desveaux, L., et al. (2015). "Yoga in the Management of Chronic Disease: A Systematic Review and Meta-analysis." Med Care **53**(7): 653-661.

BACKGROUND: Heart disease, stroke, and chronic obstructive pulmonary disease (COPD) are the leading causes of death and disability worldwide. Although individuals with these conditions have been reported to benefit from yoga, its effectiveness remains unclear. OBJECTIVE: To perform a systematic review of the effectiveness of yoga on exercise capacity, health related quality of life (HRQL), and psychological well-being for individuals with chronic disease and describe the structure and delivery of programs. RESEARCH DESIGN: We performed a systematic review of randomized controlled trials examining yoga programs for individuals with heart disease, stroke, and COPD compared with usual care. Quality was assessed using the Cochrane risk of bias tool. Meta-analyses were conducted using Review Manager 5.3. The protocol was registered on PROSPERO (CRD42014014589). RESULTS: Ten studies (431 individuals, mean age 56+/-8 y) were included and were comparable in their design and components, irrespective of the chronic disease. The standardized mean difference for the mean change in exercise capacity was 2.69 (95% confidence interval, 1.39-3.99) and for HRQL it was 1.24 (95% confidence interval, -0.37 to 2.85). Symptoms of anxiety were reduced after yoga in individuals with stroke, although this was not observed in individuals with COPD. The effect of yoga on symptoms of depression varied across studies with no significant effects compared with usual care. CONCLUSIONS: Yoga programs have similar designs and components across chronic disease populations. Compared with usual care, yoga resulted in significant improvements in exercise capacity and a mean improvement in HRQL. Yoga programs may be a useful adjunct to formal rehabilitation programs.

Psychiatrie / Psychiatry

Arevalo, S. P., et al. (2015). "Beyond cultural factors to understand immigrant mental health: Neighborhood ethnic density and the moderating role of pre-migration and post-migration factors." Soc Sci Med **138**: 91-100.

Pre-migration and post-migration factors may influence the health of immigrants. Using a cross-national framework that considers the effects of the sending and receiving social contexts, we examined the extent to which pre-migration and post-migration factors, including individual and neighborhood level factors, influence depressive symptoms at a 2-year follow-up time point. Data come from the Boston Puerto Rican Health Study, a population-based prospective cohort of Puerto Ricans between the ages of 45 and 75 y. The association of neighborhood ethnic density with depressive symptomatology at follow-up was significantly modified by sex and level of language acculturation. Men, but not women, experienced protective effects of ethnic density. The interaction of neighborhood ethnic density with language acculturation had a non-linear effect on depressive symptomatology, with lowest depressive symptomatology in the second highest quartile of language acculturation, relative to the lowest and top two quartiles among residents of high ethnic density neighborhoods. Results from this study highlight the complexity, and interplay, of a number of factors that influence the health of immigrants, and emphasize the significance of moving beyond cultural variables to better understand why the health of some immigrant groups deteriorates at faster rates overtime.

Soins de santé primaires / Primary Health Care

Barham, V. and O. Milliken (2015). Payment Mechanisms and the Composition of Physician Practices: Blancing Cost-Containment, Access, and Quality of Care." Health Econ 24(7): 895-906

We take explicit account of the way in which the supply of physicians and patients in the economy affects the design of physician remuneration schemes, highlighting the three-way trade-off between quality of care, access, and cost. Both physicians and patients are heterogeneous. Physicians choose both the number of patients and the quality of care to provide to their patients. When determining physician payment rates, the principal must ensure access to care for all patients. When physicians can adjust the number of patients seen, there is no incentive to over-treat. In contrast, altruistic physicians always quality stint: they prefer to add an additional patient, rather than to increase the quality of service provided. A mixed payment mechanism does not increase the quality of service provided with respect to capitation. Offering a menu of compensation schemes may constitute a cost-effective strategy for inducing physicians to choose a given overall caseload but may also generate difficulties with access to care for frail patients. Copyright © 2014 John Wiley & Sons, Ltd.

Calitri, R., et al. (2015). "Distance from practice moderates the relationship between patient management involving nurse telephone triage consulting and patient satisfaction with care." Health Place **34**: 92-96.

The ESTEEM trial was a randomised-controlled trial of telephone triage consultations in general practice. We conducted exploratory analyses on data from 9154 patients from 42 UK general practices who returned a questionnaire containing self-reported ratings of satisfaction with care following a request for a same-day consultation. Mode of care was identified through case notes review. There were seven main types: a GP face-to-face consultation, GP or nurse telephone triage consultation with no subsequent same day care, or a GP or nurse telephone triage consultation with a subsequent face-to-face consultation with a GP or a nurse. We investigated the contribution of mode of care to patient satisfaction and distance between the patients home and the practice as a potential moderating factor. There was no overall association between patient satisfaction and distance from practice. However, patients managed by a nurse telephone consultation showed lowest levels of satisfaction, and satisfaction for this group of patients increased the further they lived from the practice. There was no association between any of the other modes of management and distance from practice.

Douven, R., et al. (2015). "The effect of physician remuneration on regional variation in hospital treatments." International Journal of Health Economics and Management **15**(2): 215-240.

We study medical practice variations for nine hospital treatments in the Netherlands. Our panel data estimations include various control factors and physician's role to explain hospital treatments in about 3,000 Dutch zip code regions over the period 2006–2009. In particular, we exploit the physicians' remuneration difference—fee-for-service (FFS) versus salary—to explain the effect of financial incentives on medical production. We find that utilization rates are higher in geographical areas where more patients are treated by physicians that are paid FFS. This effect is strong for supply sensitive treatments, such as cataracts and tonsillectomies, while we do not find an effect for non-supply sensitive treatments, such as hip fractures.

Drummond, M. (2015). "When do performance-based risk-sharing arrangements make sense?" Eur J Health Econ **16**(6): 569-571.

Holte, J. H., et al. (2015). "Modelling Nonlinearities and Reference Dependence in General ***Practitioners' Income Preferences."*** Health Econ.

This paper tests for the existence of nonlinearity and reference dependence in income preferences for general practitioners. Confirming the theory of reference dependent utility, within the context of a discrete choice experiment, we find that losses loom larger than gains in income for Norwegian general practitioners, i.e. they value losses from their current income level around three times higher than gains. Our results are validated by comparison with equivalent contingent valuation values for marginal willingness to pay and marginal willingness to accept compensation for changes in job characteristics. Physicians' income preferences determine the effectiveness of 'pay for performance' and other incentive schemes. Our results may explain the relative ineffectiveness of financial incentive schemes that rely on increasing physicians' incomes. Copyright (c) 2015 John Wiley & Sons, Ltd.

Hsieh, H.-M., et al. (2015). "Effects of Changes in Diabetes Pay-for-Performance Incentive Designs on Patient Risk Selection." Health Serv Res: n/a-n/a.

Objective Taiwan's National Health Insurance (NHI) Program implemented a Diabetes Pay-for-Performance Program (P4P) based on process-of-care measures in 2001. In late 2006, that P4P program was reformed to also include achievement of intermediate health outcomes. This study examined how the change in design affected patient risk selection. Designs/Study Populations Study populations were identified from a 2002 to 2003 period (Phase 1) and a 2007 to 2008 period (Phase 2), spanning pre- and postimplementation of reforms in the P4P incentive design. Phase 1 had 74,529 newly enrolled P4P patients and 215,572 non-P4P patients, and Phase 2 had 76,901 newly enrolled P4P patients and 299,573 non-P4P patients. Logistic regression models were used to estimate the effect of changes in design on P4P patient selection. Principal Findings Patients with greater disease severity and comorbidity were more likely to be excluded from the P4P program in both phases. Furthermore, the additional financial incentive for patients' intermediate outcomes moderately worsened patient risk selection. Conclusions Policy makers need to carefully monitor the care of the diabetes patients with more severe and complex disease statuses after the changes of P4P financial incentive design.

Jelovac, I. (2015). "Physicians' balance billing, supplemental insurance and access to health care." International Journal of Health Economics and Management **15**(2): 269-280.

Some countries allow physicians to balance bill patients, that is, to bill a fee above the one that is negotiated with, and reimbursed by the health authorities. Balance billing is known for restricting access to physicians' services while supplemental insurance against balance billing amounts is supposed to alleviate the access problem. This paper analyzes in a theoretical setting the consequences of balance billing on the fees setting and on the inequality of access among the users of physicians' services. It also shows that supplemental insurance against the expenses associated with balance billing, rather than alleviating the access problem, increases it.

Pourat, N., et al. (2015). "In California, Primary Care Continuity Was Associated With Reduced Emergency Department Use And Fewer Hospitalizations." Health Affairs **34**(7): 1113-1120.
The expansion of health insurance to millions of Americans through the Affordable Care Act has given rise to concerns about increased use of emergency department (ED) and hospital services by previously uninsured populations. Prior research has demonstrated that continuity with a regular source of primary care is associated with lower use of these services and with greater patient satisfaction. We assessed the impact of a policy to increase patients' adherence to an individual primary care provider or clinic on subsequent use of ED and hospital services in a California coverage program for previously uninsured adults called the Health Care Coverage Initiative. We found that the policy was associated with a 42 percent greater probability of adhering to primary care providers. Furthermore, patients who were always adherent had a higher probability of having no ED visits (change in probability: 2.1 percent) and no hospitalizations (change in probability: 1.7 percent), compared to those who were never adherent. Adherence to a primary care provider can reduce the use of costly care because it allows patients' care needs to be managed within the less costly primary care setting.

Scharlach, A. E., et al. (2015). "An Integrated Model of Co-ordinated Community-Based Care." The Gerontologist **55**(4): 677-687.
Purpose of the Study: Co-ordinated approaches to community-based care are a central component of current and proposed efforts to help vulnerable older adults obtain needed services and supports and reduce unnecessary use of health care resources.Design and Methods: This study examines ElderHelp Concierge Club, an integrated community-based care model that includes comprehensive personal and environmental assessment, multilevel care co-ordination, a mix of professional and volunteer service providers, and a capitated, income-adjusted fee model. Evaluation includes a retrospective study (n = 96) of service use and perceived program impact, and a prospective study (n = 21) of changes in participant physical and social well-being and health services utilization.Results: Over the period of this study, participants showed greater mobility, greater ability to meet household needs, greater access to health care, reduced social isolation, reduced home hazards, fewer falls, and greater perceived ability to obtain assistance needed to age in place.Implications: This study provides preliminary evidence that an integrated multilevel care co-ordination approach may be an effective and efficient model for serving vulnerable community-based elders, especially low and moderate-income elders who otherwise could not afford the cost of care. The findings suggest the need for multisite controlled studies to more rigorously evaluate program impacts and the optimal mix of various program components.

Vanmeerbeek, M., et al. (2015). "[Preventive health care and health promotion: Which models for supporting the evolution of clinical practice in primary health care?]." Presse Med **44**(6 Pt 1): e211-220.
OBJECTIVES: Published operating models about preventive health care and health promotion in primary care were sought with the aim of (1) compiling a functional inventory; and (2) to formulate working hypotheses for the improvement of clinical practice towards more efficiency and more equity. METHODS: Narrative literature review, using keywords related to the various prevention classes, health promotion, primary care, practice models and health care delivery. The diversity of models led to a multi-criteria analysis. RESULTS: Twelve models

were selected. Their characteristics were unevenly distributed. The models, whose authors announce that they apply to prevention, mainly describe approaches that focus on individuals within physician-patient relationship, and take into account practice organization. Some socio-ecological and systems models illustrate health promotion: educational practice, group- or population-based targets, community environment and social determinants of health. There is little room for patients in elaborating the models, as they have little role in health care systems. The definitions of prevention, health promotion and patient education greatly differ from one model to another. DISCUSSION: Little is known about practical implementation of the models; assessment data are scarce. Some elements valued by health promotion could be integrated to health care: empowerment of citizens, addressing community environment; increased involvement in local health professionals' networks; integration of individual and collective approaches within the same health care facilities to address simultaneously individual customization, efficiency and equity objectives. These developments may call for adaptation in vocational training and continuous professional development: communication skills, awareness to public health concepts, and early and longitudinal exposure to community-based learning experiences for students.

Wegman, M. P., et al. (2015). "Quality of Care for Chronic Conditions Among Disabled Medicaid Enrollees: An Evaluation of a 1915 (b) and (c) Waiver Program." Med Care **53**(7): 599-606.
IMPORTANCE: Examining the impact of Medicaid-managed care home-based and community-based service (HCBS) alternatives to institutional care is critical given the recent rapid expansion of these models nationally. OBJECTIVE: We analyzed the effects of STAR+PLUS, a Texas Medicaid-managed care HCBS waiver program for adults with disabilities on the quality of chronic disease care. DESIGN, SETTING, AND PARTICIPANTS: We compared quality before and after a mandatory transition of disabled Medicaid enrollees older than 21 years from fee-for-service (FFS) or primary care case management (PCCM) to STAR+PLUS in 28 counties, relative to enrollees in counties remaining in the FFS or PCCM models. MEASURES AND ANALYSIS: Person-level claims and encounter data for 2006-2010 were used to compute adherence to 6 quality measures. With county as the independent sampling unit, we employed a longitudinal linear mixed-model analysis accounting for administrative clustering and geographic and individual factors. RESULTS: Although quality was similar among programs at baseline, STAR+PLUS enrollees experienced large and sustained improvements in use of beta-blockers after discharge for heart attack (49% vs. 81% adherence posttransition; P<0.01) and appropriate use of systemic corticosteroids and bronchodilators after a chronic obstructive pulmonary disease event (39% vs. 68% adherence posttransition; P<0.0001) compared with FFS/PCCM enrollees. No statistically significant effects were identified for quality measures for asthma, diabetes, or cardiovascular disease. CONCLUSION: In 1 large Medicaid-managed care HCBS program, the quality of chronic disease care linked to acute events improved while that provided during routine encounters appeared unaffected.

Systèmes de santé / Health Systems

Valentine, N., et al. (2015). "Health systems' responsiveness and reporting behaviour: Multilevel analysis of the influence of individual-level factors in 64 countries." Soc Sci Med **138**: 152-160.
Health systems' responsiveness encompasses attributes of health system encounters valued by people and measured from the user's perspective in eight domains: dignity, autonomy,

confidentiality, communication, prompt attention, social support, quality of basic amenities and choice. The literature advocates for adjusting responsiveness measures for reporting behaviour heterogeneity, which refers to differential use of the response scale by survey respondents. Reporting behaviour heterogeneity between individual respondents compromises comparability between countries and population subgroups. It can be studied through analysing responses to pre-defined vignettes - hypothetical scenarios recounting a third person's experience in a health care setting. This paper describes the first comprehensive approach to studying reporting behaviour heterogeneity using vignettes. Individual-level variables affecting reporting behaviour are grouped into three categories: (1) sociodemographic, (2) health-related and (3) health value system. We use cross-sectional data from 150 000 respondents in 64 countries from the World Health Organization's World Health Survey (2002-03). Our approach classifies effect patterns for the scale as a whole, in terms of strength and in relation to the domains. For the final eight variables selected (sex; age; education; marital status; use of inpatient services; perceived health (own); caring for close family or friends with a chronic illness; the importance of responsiveness), the strongest effects were present for education, health, caring for friends or relatives with chronic health conditions, and the importance of responsiveness. Patterns of scale elongation or contraction were more common than uniform scale shifts and were usually constant for a particular factor across domains. The dependency of individual-level reporting behaviour heterogeneity on country is greatest for prompt attention, quality of basic amenities and confidentiality domains.

Technologies médicales / Medical Technologies

Radhakrishnan, K., et al. (2015). "Barriers and Facilitators for Sustainability of Tele-Homecare Programs: A Systematic Review." Health Serv Res.

OBJECTIVE: To identify the barriers and facilitators for sustainability of tele-homecare programs implemented by home health nursing agencies for chronic disease management. DATA SOURCES: English-language articles on home telehealth in the CINAHL, PubMed/MEDLINE, PsychInfo, Web of Science, and Cochrane Reviews databases published from January 1996 to December 2013. STUDY DESIGN: We performed a systematic literature review. Data extraction using PRISMA guidelines and quality appraisal using the Mixed Methods Appraisal Tool (MMAT) were conducted on relevant empirical studies. Thematic analysis across the studies and narrative summaries were used to synthesize the findings from the included studies. PRINCIPAL FINDINGS: Of the initial 3,920 citations, we identified 16 articles of moderate quality meeting our inclusion criteria. Perceptions on effectiveness of tele-homecare programs for achieving intended outcomes; tailoring of tele-homecare programs to patient characteristics and needs; relationship and communication between patient, nurse, and other health care professional users of tele-homecare; home health organizational process and culture; and technology quality, capability, and usability impacted the sustainability of tele-homecare programs. CONCLUSIONS: The findings of this systematic review provide implications for sustained usage of tele-homecare programs by home health nursing agencies and can help such programs realize their potential for chronic disease management.

Travail et santé / Occupational Health

Buffel, V., et al. (2015). "Employment status and mental health care use in times of economic contraction: a repeated cross-sectional study in Europe, using a three-level model." Int J Equity Health **14**(1): 29.

INTRODUCTION: Framed within the recent economic crisis, in this study we investigate the medical mental health care use of the unemployed compared with that of the employed in Europe, and whether the relationship between employment status and mental health care use varies across macro-economic conditions. We examine whether the macro-economic context and changes therein are related to mental health care use, via their impact on mental health, or more directly, irrespective of mental health. METHODS: We use data from three waves of the Eurobarometer (2002, 2005/2006, and 2010), which has a repeated cross-sectional and cross-national design. Linear and logistic multilevel regression analyses are performed with mental health, contacting a general practitioner, and contacting a psychiatrist for mental health problems as dependent variables. The multilevel design has three levels (the individual, the period-country, and the country), which allows us to estimate both longitudinal and cross-sectional macro-effects. The macro-economic context and changes therein are assessed using national unemployment rates and growth rates in Gross Domestic Product (GDP). RESULTS: The mean unemployment rate is negatively related to mental health, although for women, this effect only applies to the employed. Among women, no relationship is found between changes in the macro-economic context and mental health. The unemployment rate, and changes in both the unemployment rate and the real GDP growth rate, are associated with men's care use, regardless of their mental health, whereas this does not hold for women. In countries with an increase in the unemployment rate, both unemployed and employed men tend to medicalize their problems more by contacting a general practitioner, irrespective of their mental health, while the likelihood of contacting a psychiatrist is lower among employed men. CONCLUSIONS: Our findings stress the importance of taking the macro-economic context and changes therein into account when studying the mental health care use of unemployed people compared with the employed, in particular among men. Moreover, it is important to make the distinction between primary and specialized medical care use, as the impact of macro-economic conditions is dependent on the type of care, which also applies when controlling for mental health.

Catalina-Romero, C., et al. (2015). "The impact of poor psychosocial work environment on non-work-related sickness absence." Soc Sci Med **138**: 210-216.

PURPOSE: We aimed to analyse the impact of psychosocial work environment on non-work-related sickness absence (NWRSA) among a prospective cohort study, stratified using a random sampling technique. METHODS: Psychosocial variables were assessed among 15,643 healthy workers using a brief version of the Spanish adaptation of Copenhagen Psychosocial Questionnaire. A one year follow-up assessed the total count of NWRSA days. Zero-inflated negative binomial regression was used for multivariate analyses. RESULTS: After adjusting for covariates, low levels of job control and possibilities for development (Odds Ratio [OR]: 1.17; 95% CI: 1.01-1.36 [men]; OR: 1.39 95% CI: 1.09-1.77 [women]), poor social support and quality of leadership (OR: 1.29; 95% CI: 1.11-1.50 [men]; OR: 1.28; 95% CI: 1.01-1.63 [women]), and poor rewards (OR: 1.34; 95% CI: 1.14-1.57 [men]; OR: 1.30; 95% CI: 1.01-1.66 [women]) predicted a total count of sickness absence greater than zero, in both men and women. Double presence was also significantly associated with NWRSA different than 0, but only among women (OR: 1.40; 95% CI: 1.08-1.81). Analyses found no association between psychosocial risk factors at work and the total count (i.e., number of days) of sickness absences. CONCLUSIONS: The results suggest that work-related psychosocial factors may increase the likelihood of initiating an NWRSA episode, but were not associated with the length of the sickness absence episode. Among our large cohort we observed that some associations were gender-dependent, suggesting that future research should consider gender when designing psychosocial interventions aimed at decreasing sickness absences.

Lesuffleur T. ; Chastang J.F. ; Cavet M., e. a. (2015). "Facteurs psychosociaux au travail et santé perçue dans l'enquête nationale Sumer." Santé Publique(2): 177-186.

McQuoid, J., et al. (2015). "Integrating paid work and chronic illness in daily life: A space-time approach to understanding the challenges." Health Place **34**: 83-91.
The upward trend of chronic illness in working age populations calls for better understanding of the difficulties chronically ill people face with workforce participation. Existing research focuses primarily on physical limitations and employer attitudes about chronic illness. Here we use a space-time approach to illuminate the importance of negotiating logistical challenges and embodied rhythms when balancing work and chronic illness. We draw from time geography and rhythmanalysis in analysing interviews from a qualitative case study of 26 individuals living with chronic kidney disease in Australia. Difficulties with paid work arise from: (1) competition for space-time resources by employers and health services; (2) arrhythmias between the body, work and health services; and (3) the absence of workplace rhythms on which to 'hook' health activities. Implications for workplaces and health services design are discussed.

Vieillissement / Ageing

Dutta, R., et al. (2015). "Use of the MMRI-R prognostic tool for older patients discharged to nursing homes from hospital: a prospective cohort study." Age Ageing **44**(4): 673-676.
BACKGROUND: the Minimum Dataset Mortality Risk Index-Revised (MMRI-R) is a prognostic score predicting 6-month mortality in US nursing homes. It has not been validated in the UK nor at the hospital-nursing home interface. METHODS: prospective cohort study of consecutive patients discharged from hospital or intermediate care to nursing homes from January 2012 to January 2014. MMRI-R scoring was done prior to discharge and subsequent deaths were ascertained. Calibration plots, receiver operative characteristic curves with area under the curve (AUC) and an optimal cutpoint were obtained. Kaplan-Meier curves were plotted with scores stratified by the cutpoint. RESULTS: a total of 183 patients were followed up for a median of 230 days. Median age was 87 years and 55.7% were female. Median MMRI-R score was 55. By the end of follow-up, 99 patients (54.1%) were dead. The Hosmer-Lemeshow test showed P-values of 0.4406 for 3-month and 0.8904 for 6-month mortality. The AUC was 0.70 (95% CI: 0.622-0.777) for 3-month death prediction and 0.723 (95% CI: 0.649-0.797) for death at 6 months. Of patients with MMRI-R scores >48 (the cutpoint), 43.6% were dead at 3 months and 53.6% by 6 months. The corresponding figures for scores <48 were 9.6 and 16.4% ($P < 0.001$, log-rank test). CONCLUSION: the MMRI-R can be used at the acute hospital/nursing home interface, and can help predict 3-month and 6-month mortality. The finding of an MMRI-R score of >/=48 should trigger end-of-life discussions.

Eibich, P. (2015). "Understanding the effect of retirement on health: Mechanisms and heterogeneity." J Health Econ **43**: 1-12.
This paper investigates the mechanisms behind the health effects of retirement. Using a Regression Discontinuity Design to exploit financial incentives in the German pension system

for identification, I find that retirement improves subjective health status and mental health, while also reducing outpatient care utilization. I explore a wide range of health behaviors, time use, and effect heterogeneity as potential mechanisms. Relief from work-related stress and strain, increased sleep duration as well as more frequent physical exercise seem to be key mechanisms through which retirement affects health.

Finlay, J., et al. (2015). "Therapeutic landscapes and wellbeing in later life: Impacts of blue and green spaces for older adults." Health Place **34**: 97-106.

This paper extends the concept of therapeutic landscapes by investigating how green and blue spaces affect older adult health and wellbeing. We draw on interview data from participants aged 65-86 years old who described their everyday experiences with green and especially blue spaces across Metro Vancouver, Canada. Landscapes embedded with therapeutic qualities included parks, gardens, street greenery, lakes, and the ocean. Interactions with these spaces influenced participants' perceived physical, mental, and social health. Issues of safety, accessibility, and personal perception complicated this relationship. Overall, the findings indicate that nature plays a nuanced and influential role in the everyday lives of older adults. Better understanding how older adults experience health and landscape is critical towards developing everyday contact with nature that can improve quality of life for ageing populations.

Jalenques I. ; Auclair C. ; Rondepierre F., et al. (2015). "Evaluation de la qualité de vie liée à la santé de sujets âgés de 65 ans et plus vivant à domicile en région auvergne." Revue d'Epidémiologie et de Santé Publique **63**(2): 183-190.

Ranci, C. and E. Pavolini (2015). "Not all that glitters is gold: Long-term care reforms in the last two decades in Europe." Journal of European Social Policy **25**(3): 270-285.

This article explores changes that took place in long-term care (LTC) policies during the last two decades in six European welfare states. In this regard, it addresses three issues: (1) why reforms took place, (2) the main actors and coalitions driving this process and the institutional mechanisms at work and (3) the main outcomes of reform processes. In order to analyse the development of LTC policies, the article applies theoretical concepts of historical institutionalism. Our interpretation is that institutional change in LTC policy has taken place through a protracted institutional dynamic in which continuity and discontinuity are inextricably linked and where tensions and contradictions have played a crucial role. With regard to outcomes, the article analyses coverage and citizens' social rights, working conditions in the care sector and trajectories of de-/re-familization of care. The final impact is that the level of universalism has generally increased in Europe, but that in part it has adopted a new form of 'restricted universalism', characterized by universal entitlements to LTC benefits constrained by limitations in provision due to financial constraints and budget ceilings.

Rockwood, K., et al. (2015). "What are frailty instruments for?" Age and Ageing **44**(4): 545-547.

Frailty is measured to understand its nature and biology, to aid diagnosis and care planning, to measure outcomes and to stratify risk. Such goals oblige two types of frailty measures — for screening and for assessment — and recognition that not all measures will serve all purposes. When the goal is broad identification of people at risk, a dichotomised approach (frailty is present or absent) is appropriate. If, however, the degree of risk varies, strategies to test grades of frailty will be required. Frailty measures should be implemented and evaluated in relation to the goal for their use.

Vilaplana Prieto, C. and S. Jiménez-Martín (2015). "Unmet needs in formal care: kindling the spark

for caregiving behavior." International Journal of Health Economics and Management **15**(2): 153-184.

This paper studies if a situation of formal care unmet needs is a strong motivation for the onset of caregiving behavior, and if becoming caregiving is a compelling argument for leaving current job (in the presence/absence of formal care unmet needs). We use data from the Eurobarometer 67.3 for 18 European countries and estimate a three simultaneous equations model taking into account the potential endogeneity of labor participation and formal care unmet needs and assuming non-zero correlation among the error terms of the three equations. Results show that individuals who anticipate that becoming caregiver can suppose an obstacle for continuing working feel more refractory and are more prone to avoid caregiving responsibilities. Knowing someone with an unmet needs problem increases the probability of becoming caregiver by +19.23 pp (with a maximum of +39.39 pp for difficult access unmet needs) and raises the probability of leaving employment by 5.77 pp. Having to possibility of receiving economic benefits for caregivers encourage more labor market exit as compared to payment of social security contributions during care leaves.