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## DOC VEILLE

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## Assurance maladie / Health Insurance

**Cawley, J., et al. (2015). "The impact of the macroeconomy on health insurance coverage: evidence from the great recession." Health Econ 24(2): 206-223.**

This paper investigates the impact of the macroeconomy on the health insurance coverage of Americans using panel data from the Survey of Income and Program Participation for 2004-2010, a period that includes the Great Recession of 2007-2009. We find that a one percentage point increase in the state unemployment rate is associated with a 1.67 percentage point (2.12%) reduction in the probability that men have health insurance; this effect is strongest among college-educated, white, and older (50-64 years old) men. For women and children, health insurance coverage is not significantly correlated with the unemployment rate, which may be the result of public health insurance acting as a social safety net. Compared with the previous recession, the health insurance coverage of men is more sensitive to the unemployment rate, which may be due to the nature of the Great Recession. Copyright (c) 2013 John Wiley & Sons, Ltd.

**Depew, B. et al. (2015). "Did the Affordable Care Act's dependent coverage mandate increase premiums?" J Health Econ 41c: 1-14.**

We investigate the impact of the Affordable Care Act's dependent coverage mandate on insurance premiums. The expansion of dependent coverage under the ACA allows young adults to remain on their parent's private health insurance plans until the age of 26. We find that the mandate has led to a 2.5-2.8 percent increase in premiums for health insurance plans that cover children, relative to single-coverage plans. We are able to conclude that employers did not pass on the entire premium increase to employees through higher required plan contributions.

## Economie de la santé / Health Economics

**Breyer, F., et al. (2015). "Health care expenditures and longevity: is there a Eubie Blake effect?" Eur J Health Econ 16(1): 95-112.**

It is still an open question whether increasing life expectancy as such causes higher health care expenditures (HCE) in a population. According to the "red herring" hypothesis, the positive correlation between age and HCE is exclusively due to the fact that mortality rises with age and a large share of HCE is caused by proximity to death. As a consequence, rising longevity-through falling mortality rates-may even reduce HCE. However, a weakness of many previous empirical studies is that they use cross-sectional evidence to make inferences on a development over time. In this paper, we analyse the impact of rising longevity on the trend of HCE over time by using data from a pseudo-panel of German sickness fund members over the period 1997-2009. Using (dynamic) panel data models, we find that age, mortality and 5-year survival rates each have a positive impact on per-capita HCE. Our explanation for the last finding is that physicians treat patients more aggressively if the results of these treatments pay off over a longer time span, which we call "Eubie Blake effect". A simulation on the basis of an official population forecast for Germany is used to isolate the effect of demographic ageing on real per-capita HCE over the coming decades. We find that, while falling mortality rates as such lower HCE, this effect is more than compensated by an increase in remaining life expectancy so that the net effect of ageing on HCE over time is

clearly positive.

## Etat de santé / Health Status

**Smits, F. and T. Huijts (2015). "Treatment for depression in 63 countries worldwide: Describing and explaining cross-national differences." *Health Place* 31: 1-9.**

This study describes differences between 63 countries in treatment for depression and explores explanations for these differences. Treatment for depression is measured as the overall chance that an individual receives treatment, plus as the chance to receive treatment given the presence of depressive symptoms. Using the World Health Survey (2002-2004, N=249,116), we find strong cross-national variation in the chance to receive treatment for depression. Additionally, multilevel regression analyses reveal that urbanization, employment status, marital status, level of education, gender, age, and national wealth all partly explain cross-national differences in the chance to receive treatment for depression.

**Wouters, S., et al. (2015). "Do people desire to be healthier than other people? A short note on positional concerns for health." *Eur J Health Econ* 16(1): 47-54.**

Contrary to traditional economic postulates, people do not only care about their absolute position but also about their relative position. However, empirical evidence on positional concerns in the context of health is scarce, despite its relevance for health care policy. This paper presents a first explorative study on positional concerns in the context of health. Using a 'two-world' survey method, a convenience sample of 143 people chose between two options (having more in absolute terms or having more in relative terms) in several health and non-health domains. Our results for the non-health domains compare reasonably well to previous studies, with 22-47 % of respondents preferring the positional option. In the health domain, these percentages were significantly lower, indicating a stronger focus on absolute positions. The finding that positional concerns are less prominent in the health domain has important implications for health policy, for instance in balancing reduction of socio-economic inequalities and absolute health improvements.

## Géographie de la santé / Geography of Health

**Brondeel, R., et al. (2014). "Use of healthcare services in the residence and workplace neighbourhood: the effect of spatial accessibility to healthcare services." *Health Place* 30: 127-133.**

This study investigated the effect of spatial accessibility to healthcare services (HS) in residential and workplace neighbourhoods on the use of HS. Questionnaire data from the RECORD Study (2007-2008) were merged with administrative healthcare and geographic data. A novel method was developed to assess clustering of visits to HS around the residence/workplace. We found clustered use of HS around the workplace for few participants (11%). Commuting from suburbs to Paris and commuting distance were associated with a higher use of HS around the workplace. No associations were found between the spatial accessibility to and the use of HS.

**Dejardin, O., et al. (2014). "The influence of geographical access to health care and material deprivation on colorectal cancer survival: evidence from France and England." *Health Place* 30: 36-44.**

This article investigates the influence of distance to health care and material deprivation on cancer survival for patients diagnosed with a colorectal cancer between 1997 and 2004 in France and England. This population-based study included all cases of colorectal cancer diagnosed between 1997 and 2004 in 3 cancer registries in France and 1 cancer registry in England (N=40,613). After adjustment for material deprivation, travel times in England were no longer significantly associated with survival. In France patients living between 20 and 90min from the nearest cancer unit tended to have a poorer survival, although this was not statistically significant. In England, the better prognosis observed for remote patients can be explained by associations with material deprivation; distance to health services alone did not affect survival whilst material deprivation level had a major influence, with lower survival for patients living in deprived areas. Increases in travel times to health services in France were associated with poorer survival rates. The pattern of this influence seems to follow an inverse U distribution, i.e. maximal for average travel times.

**Roudot, A. (2014). "Intégration territoriale et fractures sanitaires à Mayotte : états de santé du 101e département français." *Revue Française des Affaires Sociales* 4(4): 72-89.**

Mayotte, territoire français de l'archipel des Comores, est devenue le 101e département français en 2011. Le processus de départementalisation initié dans les années 1990 s'est traduit par d'importants efforts en termes d'infrastructures, de santé ou d'enseignement, puis par l'alignement institutionnel de l'île sur la métropole, et la transformation des piliers économiques, sociaux, politiques et culturels du territoire mahorais. La rapidité et la brutalité des transformations de la société mahoraise et des conditions de vie des populations placent la santé au cœur des conflits qui sous-tendent l'ouverture du territoire à son nouveau statut. Les résultats d'une étude en géographie sociale réalisée à Mayotte en 2010 permettent de comprendre les principales modalités de l'intégration territoriale de Mayotte à la France, et d'analyser les liens entre les évolutions du statut politique de Mayotte et la mise en place de l'organisation actuelle du système de santé dans l'île. Il s'agit également d'appréhender les répercussions du processus de départementalisation sur l'accès et l'accessibilité des populations au système sanitaire. Ces résultats illustrent enfin les corollaires sanitaires des dynamiques de restructurations territoriales passées et présentes à Mayotte à travers son profil épidémiologique.

## Hôpital / Hospitals

**Hernandez, J., et al. (2015). "US Hospital Payment Adjustments For Innovative Technology Lag Behind Those In Germany, France, And Japan." *Health Aff (Millwood)* 34(2): 261-270.**

Medicare pioneered add-on payments to facilitate the adoption of innovative technologies under its hospital prospective payment system. US policy makers are now experimenting with broader value-based payment initiatives, but these have not been adjusted for innovation. This article examines the structure, processes, and experience with Medicare's hospital new technology add-on payment program since its inception in 2001 and compares it with analogous payment systems in Germany, France, and Japan. Between 2001 and 2015 CMS approved nineteen of fifty-three applications for the new technology add-on payment program. We found that the program resulted in \$201.7 million in Medicare payments in fiscal years 2002-13-less than half the level anticipated by Congress and only 34 percent of the amount projected by CMS. The US program approved considerably fewer innovative technologies, compared to analogous technology payment mechanisms in Germany, France and Japan. We conclude that it is important to adjust payments for new medical innovations within prospective and value-based payment systems explicitly as well as implicitly. The most

straightforward method to use in adjusting value-based payments is for the insurer to retrospectively adjust spending targets to account for the cost of new technologies. If CMS made such retrospective adjustments, it would not financially penalize hospitals for adopting beneficial innovations.

**Herrin, J., et al. (2015). "Community factors and hospital readmission rates." *Health Serv Res* 50(1): 20-39.**

**OBJECTIVE:** To examine the relationship between community factors and hospital readmission rates. **DATA SOURCES/STUDY SETTING:** We examined all hospitals with publicly reported 30-day readmission rates for patients discharged during July 1, 2007, to June 30, 2010, with acute myocardial infarction (AMI), heart failure (HF), or pneumonia (PN). We linked these to publicly available county data from the Area Resource File, the Census, Nursing Home Compare, and the Neilsen PopFacts datasets. **STUDY DESIGN:** We used hierarchical linear models to assess the effect of county demographic, access to care, and nursing home quality characteristics on the pooled 30-day risk-standardized readmission rate. **DATA COLLECTION/EXTRACTION METHODS:** Not applicable. **PRINCIPAL FINDINGS:** The study sample included 4,073 hospitals. Fifty-eight percent of national variation in hospital readmission rates was explained by the county in which the hospital was located. In multivariable analysis, a number of county characteristics were found to be independently associated with higher readmission rates, the strongest associations being for measures of access to care. These county characteristics explained almost half of the total variation across counties. **CONCLUSIONS:** Community factors, as measured by county characteristics, explain a substantial amount of variation in hospital readmission rates.

**O'Brien, W. J., et al. (2015). "What Is the Value of Adding Medicare Data in Estimating VA Hospital Readmission Rates?" *Health Serv Res* 50(1): 40-57.**

**OBJECTIVE:** To determine the effects of including diagnostic and utilization data from a secondary payer on readmission rates and hospital profiles. **DATA SOURCES/STUDY SETTING:** Veterans Health Administration (VA) and Medicare inpatient and outpatient administrative data for veterans discharged from 153 VA hospitals during FY 2008-2010 with a principal diagnosis of acute myocardial infarction, heart failure, or pneumonia. **STUDY DESIGN:** We estimated hospital-level risk-standardized readmission rates derived using VA data only. We then used data from both VA and Medicare to reestimate readmission rates and compared hospital profiles using two methods: Hospital Compare and the CMS implementation of the Hospital Readmissions Reduction Program (HRRP). **DATA COLLECTION/EXTRACTION METHODS:** Retrospective data analysis using VA hospital discharge and outpatient data matched with Medicare fee-for-service claims by scrambled Social Security numbers. **PRINCIPAL FINDINGS:** Less than 2 percent of hospitals in any cohort were classified discordantly by the Hospital Compare method when using VA-only compared with VA/Medicare data. In contrast, using the HRRP method, 13 percent of hospitals had differences in whether they were flagged as having excessive readmission rates in at least one cohort. **CONCLUSIONS:** Inclusion of secondary payer data may cause changes in hospital profiles, depending on the methodology used. An assessment of readmission rates should include, to the extent possible, all available information about patients' utilization of care.

**Ryan, A. M., et al. (2015). "The Early Effects of Medicare's Mandatory Hospital Pay-for-Performance Program." *Health Serv Res* 50(1): 81-97.**

**OBJECTIVE:** To evaluate the impact of hospital value-based purchasing (HVBP) on clinical quality and patient experience during its initial implementation period (July 2011-March 2012). **DATA SOURCES:** Hospital-level clinical quality and patient experience data from Hospital Compare from up to 5 years before and three quarters after HVBP was initiated.

STUDY DESIGN: Acute care hospitals were exposed to HVBP by mandate while critical access hospitals and hospitals located in Maryland were not exposed. We performed a difference-in-differences analysis, comparing performance on 12 incentivized clinical process and 8 incentivized patient experience measures between hospitals exposed to the program and a matched comparison group of nonexposed hospitals. We also evaluated whether hospitals that were ultimately exposed to HVBP may have anticipated the program by improving quality in advance of its introduction. PRINCIPAL FINDINGS: Difference-in-differences estimates indicated that hospitals that were exposed to HVBP did not show greater improvement for either the clinical process or patient experience measures during the program's first implementation period. Estimates from our preferred specification showed that HVBP was associated with a 0.51 percentage point reduction in composite quality for the clinical process measures ( $p > .10$ , 95 percent CI: -1.37, 0.34) and a 0.30 percentage point reduction in composite quality for the patient experience measures ( $p > .10$ , 95 percent CI: -0.79, 0.19). We found some evidence that hospitals improved performance on clinical process measures prior to the start of HVBP, but no evidence of this phenomenon for the patient experience measures. CONCLUSIONS: The timing of the financial incentives in HVBP was not associated with improved quality of care. It is unclear whether improvement for the clinical process measures prior to the start of HVBP was driven by the expectation of the program or was the result of other factors.

## Inégalités de santé / Health Inequalities

**Agampodi, T. C., et al. (2015). "Measurement of social capital in relation to health in low and middle income countries (LMIC): A systematic review." *Soc Sci Med* 128c: 95-104.**

Social capital is a neglected determinant of health in low and middle income countries. To date, majority of evidence syntheses on social capital and health are based upon high income countries. We conducted this systematic review to identify the methods used to measure social capital in low and middle-income countries and to evaluate their relative strengths and weaknesses. An electronic search was conducted using Pubmed, Science citation index expanded, Social science citation index expanded, Web of knowledge, Cochrane, Trip, Google scholar and selected grey literature sources. We aimed to include all studies conducted in low and middle-income countries, published in English that have measured any aspect of social capital in relation to health in the study, from 1980 to January 2013. We extracted data using a data extraction form and performed narrative synthesis as the measures were heterogeneous. Of the 472 articles retrieved, 46 articles were selected for the review. The review included 32 studies from middle income countries and seven studies from low income countries. Seven were cross national studies. Most studies were descriptive cross sectional in design ( $n = 39$ ). Only two randomized controlled trials were included. Among the studies conducted using primary data ( $n = 32$ ), we identified 18 purposely built tools that measured various dimensions of social capital. Validity ( $n = 11$ ) and reliability ( $n = 8$ ) of the tools were assessed only in very few studies. Cognitive constructs of social capital, namely trust, social cohesion and sense of belonging had a positive association towards measured health outcome in majority of the studies. While most studies measured social capital at individual/micro level ( $n = 32$ ), group level measurements were obtained by aggregation of individual measures. As many tools originate in high income contexts, cultural adaptation, validation and reliability assessment is mandatory in adapting the tool to the study setting. Evidence on causality and assessing predictive validity is a problem due to the scarcity of prospective study designs. We recommend Harpham et al. s' Adapted Social Capital Assessment Tool (A-SCAT), Hurtado et al. s' six item tool and Elgar et al. s' World Value

Survey Social Capital Scale for assessment of social capital in low and middle income countries.

**Campo P, et al. (2015). "The Neighbourhood Effects on Health and Well-being (NEHW) study."**

Health Place **31c**: 65-74.

Many cross-sectional studies of neighbourhood effects on health do not employ strong study design elements. The Neighbourhood Effects on Health and Well-being (NEHW) study, a random sample of 2412 English-speaking Toronto residents (age 25-64), utilises strong design features for sampling neighbourhoods and individuals, characterising neighbourhoods using a variety of data sources, measuring a wide range of health outcomes, and for analysing cross-level interactions. We describe here methodological issues that shaped the design and analysis features of the NEHW study to ensure that, while a cross-sectional sample, it will advance the quality of evidence emerging from observational studies.

**Devaux, M. (2015). "Income-related inequalities and inequities in health care services utilisation in 18 selected OECD countries."** Eur J Health Econ **16**(1): 21-33.

A key policy objective in OECD countries is to achieve adequate access to health care for all people on the basis of need. Previous studies have shown that there are inequities in health care services utilisation (HCSU) in the OECD area. In recent years, measures have been taken to enhance health care access. This paper re-examines income-related inequities in doctor visits among 18 selected OECD countries, updating previous results for 12 countries with 2006-2009 data, and including six new countries. Inequalities in preventive care services are also considered for the first time. The indirect standardisation procedure is used to estimate the need-adjusted HCSU and concentration indexes are derived to gauge inequalities and inequities. Overall, inequities in HCSU remain present in OECD countries. In most countries, for the same health care needs, people with higher incomes are more likely to consult a doctor than those with lower incomes. Pro-rich inequalities in dental visits and cancer screening uptake are also found in nearly all countries, although the magnitude of these varies among countries. These findings suggest that further monitoring of inequalities is essential in order to assess whether country policy objectives are achieved on a regular basis.

**Gahagan, J., et al. (2015). "Sex and gender matter in health research: addressing health inequities in health research reporting."** International Journal for Equity in Health **14**(1): 12.

Attention to the concepts of "sex" and "gender" is increasingly being recognized as contributing to better science through an augmented understanding of how these factors impact on health inequities and related health outcomes. However, the ongoing lack of conceptual clarity in how sex and gender constructs are used in both the design and reporting of health research studies remains problematic. Conceptual clarity among members of the health research community is central to ensuring the appropriate use of these concepts in a manner that can advance our understanding of the sex- and gender-based health implications of our research findings. During the past twenty-five years much progress has been made in reducing both sex and gender disparities in clinical research and, to a significant albeit lesser extent, in basic science research. Why, then, does there remain a lack of uptake of sex- and gender-specific reporting of health research findings in many health research journals? This question, we argue, has significant health equity implications across all pillars of health research, from biomedical and clinical research, through to health systems and population health

**Mithen, J., et al. (2015). "Inequalities in social capital and health between people with and without disabilities."** Soc Sci Med **126**: 26-35.

The poor mental and physical health of people with disabilities has been well documented

and there is evidence to suggest that inequalities in health between people with and without disabilities may be at least partly explained by the socioeconomic disadvantage (e.g. low education, unemployment) experienced by people with disabilities. Although there are fewer studies documenting inequalities in social capital, the evidence suggests that people with disabilities are also disadvantaged in this regard. We drew on Bourdieu's conceptualisation of social capital as the resources that flow to individuals from their membership of social networks. Using data from the General Social Survey 2010 of 15,028 adults living in private dwellings across non-remote areas of Australia, we measured social capital across three domains: informal networks (contact with family and friends); formal networks (group membership and contacts in influential organisations) and social support (financial, practical and emotional). We compared levels of social capital and self-rated health for people with and without disabilities and for people with different types of impairments (sensory and speech, physical, psychological and intellectual). Further, we assessed whether differences in levels of social capital contributed to inequalities in health between people with and without disabilities. We found that people with disabilities were worse off than people without disabilities in regard to informal and formal networks, social support and self-rated health status, and that inequalities were greatest for people with intellectual and psychological impairments. Differences in social capital did not explain the association between disability and health. These findings underscore the importance of developing social policies which promote the inclusion of people with disabilities, according to the varying needs of people with different impairments types. Given the changing policy environment, ongoing monitoring of the living circumstances of people with disabilities, including disaggregation of data by impairment type, is critical.

**Roinsard, N. (2014). "Conditions de vie, pauvreté et protection sociale à Mayotte : une approche pluridimensionnelle des inégalités." *Revue française des affaires sociales* 4(4): 28-49.**

En mars 2011, Mayotte devient le 5e département français d'outre-mer. Compte tenu de la structure de l'économie locale, l'île devient en même temps le département le plus pauvre, et le plus inégalitaire, au niveau national. Le principe de l'« Égalité » sociale et de l'introduction du droit commun dans ce nouveau département reste timide à ce jour, laissant de fait aux solidarités privées un rôle primordial d'amortisseur social. Cet article se propose de décrire les effets et les enjeux de la départementalisation sur la production et la régulation des inégalités, approchées ici de manière pluridimensionnelle : à la fois celles qui structurent la société mahoraise dans son ensemble (inégalités ethniques et de nationalité, de genre, de génération et de classe), et celles qui situent Mayotte dans son environnement régional et politique, en qualité de carrefour migratoire révélateur des inégalités de régime de protection sociale d'un territoire à l'autre.

**Terraneo, M. (2015). "Inequities in health care utilization by people aged 50+: Evidence from 12 European countries." *Soc Sci Med* 126: 154-163.**

The aim of this study is to describe the magnitude of educational inequities in the use of health care services, by people aged 50+, in 12 European countries, controlling for country-level heterogeneity. We consider four services: having seen or talked to 1) a general practitioner (GP) or 2) specialist, 3) having been hospitalized, and 4) having visited a dentist (only for prevention). Data derived from the SHARE (Survey of Health, Ageing and Retirement in Europe) project, a cross-national panel that collects information from individuals aged 50 and over. A Fixed Effects approach is applied, which is a valuable alternative to the application of conventional multilevel models in country-comparative analysis. The main findings of this study confirm that there is substantial educational inequity in the use of health care, although relevant differences arise between services. A clear pro-educated gradient is found for specialists and dentist visits, whereas no evidence of educational

disparities was found for GP use. On the other hand, less clear results emerge regarding hospitalizations. However, the analysis shows that micro-level dimensions, i.e. individual needs and predisposing and enabling population characteristics, and macro level factors, i.e. health care system and welfare regime, interact to determine people's use of health services. It can be concluded that people with more education level have more resources (cognitive, communicative, relational) that allow them to make more informed choices and take more effective actions for their health goals, however, the institutional context may modify this relationship.

## Médicaments / Pharmaceuticals

**Badoum, G., et al. (2015). "[Attitude of private pharmacists in the dispensation of asthma drugs]."** *Rev Mal Respir* **32**(1): 18-23.

**INTRODUCTION:** Despite recommendations, asthma remains poorly controlled in many countries. Asthmatic patients see pharmacy staff regularly to obtain medications. The aim of this study was to evaluate the attitude of pharmacists in Burkina Faso about dispensing asthma drugs. **METHOD:** A self-administered anonymous questionnaire was used to collect data in a descriptive cross-sectional study related to pharmacists' attitudes in the management of asthma in the city of Ouagadougou (November 2010-June 2011). **RESULTS:** The rate of participation of pharmacists in the study was 82.4%. Of the pharmacists surveyed, 70.1% reported having received asthma patients both during acute asthma exacerbations and when stable. Only 9% of pharmacists insisted on a prescription when asthma patients came to the pharmacy without one. A total of 73.6% of pharmacists explained and demonstrated how to use the spray to the patients. Among pharmacists who demonstrated how to use devices, only 6.7% actually checked patients' technique. Inhaler technique demonstration was done verbally in 68.8% of case. Among pharmacists, 34.5% reported a good mastery of inhaler techniques. **CONCLUSION:** The techniques for dispensing asthma drugs are not well established among pharmacists and therefore the provision of continuous medical education to pharmacists is important.

**Berndt, E. R., et al. (2015). "Decline in economic returns from new drugs raises questions about sustaining innovations."** *Health Aff (Millwood)* **34**(2): 245-252.

The sales and financial returns realized by pharmaceutical companies are a frequent topic of discussion and debate. In this study we analyzed the economic returns for four cohorts of new prescription drugs launched in the United States (in 1991-94, 1995-99, 2000-04, and 2005-09) and compared fluctuations in revenues with changing average research and development (R&D) and other costs to determine patterns in rewards for pharmaceutical innovation. We found that the average present values of lifetime net economic returns were positive and reached a peak with the 1995-99 and 2000-04 new drug cohorts. However, returns have fallen sharply since then, with those for the 2005-09 cohort being very slightly negative and, on average, failing to recoup research and development and other costs. If this level of diminished returns persists, we believe that the rewards for innovation will not be sufficient for pharmaceutical manufacturers to maintain the historical rates of investments needed to sustain biomedical innovation.

**Danzon, P., et al. (2015). "Value-based differential pricing: efficient prices for drugs in a global context."** *Health Econ* **24**(3): 294-301.

This paper analyzes pharmaceutical pricing between and within countries to achieve second-best static and dynamic efficiency. We distinguish countries with and without universal

insurance, because insurance undermines patients' price sensitivity, potentially leading to prices above second-best efficient levels. In countries with universal insurance, if each payer unilaterally sets an incremental cost-effectiveness ratio (ICER) threshold based on its citizens' willingness-to-pay for health; manufacturers price to that ICER threshold; and payers limit reimbursement to patients for whom a drug is cost-effective at that price and ICER, then the resulting price levels and use within each country and price differentials across countries are roughly consistent with second-best static and dynamic efficiency. These value-based prices are expected to differ cross-nationally with per capita income and be broadly consistent with Ramsey optimal prices. Countries without comprehensive insurance avoid its distorting effects on prices but also lack financial protection and affordability for the poor. Improving pricing efficiency in these self-pay countries includes improving regulation and consumer information about product quality and enabling firms to price discriminate within and between countries. (c) 2013 The Authors. Health Economics published by John Wiley & Sons Ltd.

**Danzon, P., et al. (2015). "Pharmaceutical Pricing in Emerging Markets: Effects of Income, Competition, and Procurement." *Health Econ* 24(2): 238-252.**

This paper analyzes determinants of ex-manufacturer prices for originator and generic drugs across countries. We focus on drugs to treat HIV/AIDS, TB, and malaria in middle and low-income countries (MLICs), with robustness checks to other therapeutic categories and the full income range of countries. We examine the effects of per capita income, income dispersion, competition from originator and generic substitutes, and whether the drugs are sold to retail pharmacies versus tendered procurement by non-government organizations. The cross-national income elasticity of prices is 0.27 across the full income range of countries but is 0.0-0.10 between MLICs, implying that drugs are least affordable relative to income in the lowest income countries. Within-country income inequality contributes to relatively high prices in MLICs. Although generics are priced roughly 30% lower than originators on average, the variance is large. Additional generic competitors only weakly affect prices, plausibly because generic quality uncertainty leads to competition on brand rather than price. Tendered procurement that imposes quality standards attracts multinational generic suppliers and significantly reduces prices of originator and generic drugs, compared with their respective prices to retail pharmacies. -©2013 The Authors. Health Economics Published by John Wiley & Sons Ltd

**Falit, B. P., et al. (2015). "Biosimilar competition in the United States: statutory incentives, payers, and pharmacy benefit managers." *Health Aff (Millwood)* 34(2): 294-301.**

Widespread adoption of generic medications, made possible by the Hatch-Waxman Act of 1984, has contained the cost of small-molecule drugs in the United States. Biologics, however, have yet to face competition from follow-on products and represent the fastest-growing sector of the US pharmaceutical market. We compare the legislative framework governing small-molecule generics to that which regulates follow-on biologics, and we examine management tools that are likely to be most successful in promoting biosimilars' adoption. The Biologics Price Competition and Innovation Act established an abbreviated pathway for follow-on biologics, but weak statutory incentives create barriers to entry. Many authors have raised concerns that competition under the biologics act may be weaker than that posed by small-molecule generics under Hatch-Waxman, in part because of legislative choices such as the absence of market exclusivity for the first biosimilar approved and a requirement that follow-on manufacturers disclose their manufacturing processes to the manufacturer of the reference product. Provider skepticism and limited competition from biosimilars will challenge payers and pharmacy benefit managers to reduce prices and maximize uptake of follow-on biologics. Successful payers and pharmacy benefit managers

will employ various strategies, including tiered formularies and innovative fee schedules, that can control spending by promoting uptake of biosimilars across both the pharmacy and medical benefits.

**Garattini, L., et al. (2015). "Italian risk-sharing agreements on drugs: are they worthwhile?" Eur J Health Econ 16(1): 1-3.**

**Launois, R., et al. (2014). "Paiement à la performance et fixation conditionnelle du prix du médicament." Revue française des affaires sociales 4(4): 156-178.**

L'effet d'un médicament peut être différent en pratique quotidienne de ce qu'il était au cours de la recherche clinique ou au moment de la négociation de son prix avant sa mise sur le marché des médicaments remboursables. Les contrats conditionnels, fondés sur les résultats de santé, ont été créés pour se prémunir contre ce risque. Moyennant un accord rapide sur le prix, le laboratoire pharmaceutique prend l'engagement de rembourser en partie ou en totalité la valeur qui a été négociée si les résultats du traitement ne sont pas à la hauteur des espoirs suscités. Ces contrats d'accès au marché des médicaments remboursables sont étudiés ici à la lumière des schémas d'études qui président à leur mise en œuvre. Ils reposent pour l'essentiel sur des études descriptives ou normatives sans groupe témoin, études qui ne permettent pas de mesurer l'impact du médicament sur la santé. La fixation du prix du médicament sur de telles bases risque d'être fragilisée par la modeste qualité des preuves avancées pour en justifier l'octroi. Pour remédier à cette situation, nous proposons la mise en place d'études observationnelles comparatives, dont les populations devront être rendues comparables par la mise en œuvre des techniques micro-économétriques appropriées.

**Li, S. et al. (2015). "Are Physicians' Prescribing Decisions Sensitive to Drug Prices? Evidence from a Free-antibiotics Program." Health Econ 24(2): 158-174.**

This paper investigates whether patient-level factors, in particular cost considerations, affect the physicians' prescribing decisions. In the context of a natural experiment, we examine the effect of the first US commercial free-antibiotics program on retail antibiotic sales. We find an overall increase in antibiotic prescriptions under the program and substitutions to covered antibiotics from not-covered antibiotics. The shift away from not-covered antibiotics, particularly from those without covered equivalents, indicates a change in the physicians' prescribing decisions. We locate stronger program effects in low-income areas. Our findings, robust to a variety of specifications, are in contrast with previous literature. Copyright (c) 2013 John Wiley & Sons, Ltd.

**Prémont M.C., et al. (2014). "Trois types de stratégies des fabricants pour la fidélisation aux médicaments de marque." Healthcare Policy 10(2): 79-89.**

La restructuration de l'industrie pharmaceutique a mené au développement de trois nouveaux types de stratégies commerciales pour la fidélisation de différentes cohortes de patients à des médicaments: la fidélisation par le rabais, par l'accompagnement et par la compassion. La fidélisation par le rabais vise à maintenir les traitements au produit de marque et décourager la substitution au produit générique. La fidélisation par l'accompagnement est basée sur une offre des services de suivi et d'accompagnement à domicile et par téléphone afin d'encourager les patients à adopter un traitement puis d'en améliorer l'observance. Enfin, l'industrie offre des programmes de compassion où les patients peuvent recevoir des traitements avant même que le médicament ne soit généralement disponible ou remboursé par son assureur. Dès que le médicament (le plus souvent très dispendieux) est inscrit à la liste des médicaments remboursés, le manufacturier met fin au programme de compassion et bénéficie d'une importante cohorte de patients déjà

sous traitement. L'impact de ces programmes sur les politiques publiques et les droits des patients soulève de nombreuses préoccupations, au nombre desquelles figurent au premier plan l'accès direct du fabricant au patient et ses données de santé et la pression à la hausse sur les coûts de l'assurance-médicaments.

**Mennini, F. S., et al. (2015). "Cost of poor adherence to anti-hypertensive therapy in five European countries." *Eur J Health Econ* 16(1): 65-72.**

The financial burden for EU health systems associated with cardiovascular disease (CV) has been estimated to be nearly <euro>110 billion in 2006, corresponding to 10 % of total healthcare expenditure across EU or a mean <euro>223 annual cost per capita. The main purpose of this study is to estimate the costs related to hypertension and the economic impact of increasing adherence to anti-hypertensive therapy in five European countries (Italy, Germany, France, Spain and England). A probabilistic prevalence-based decision tree model was developed to estimate the direct costs of CV related to hypertension (CV defined as: stroke, heart attack, heart failure) in five European countries. Our model considered adherence to hypertension treatment as a main driver of blood pressure (BP) control (BP < 140/90 mmHg). Relative risk of CV, based on controlled or uncontrolled BP group, was estimated from the Framingham Heart Study and national review data. Prevalence and cost data were estimated from national literature reviews. A national payer (NP) perspective for 10 years was considered. Probabilistic sensitivity analysis was performed in order to evaluate uncertainty around the results (given as 95 % confidence intervals). The model estimated a total of 8.6 million (1.4 in Italy, 3.3 in Germany, 1.2 in Spain, 1.8 in France and 0.9 in England) CV events related to hypertension over the 10-year time horizon. Increasing the adherence rate to anti-hypertensive therapy to 70 % (baseline value is different for each country) would lead to 82,235 fewer CV events (24,058 in Italy, 7,870 in Germany, 18,870 in Spain, 24,855 in France and 6,553 in England). From the NP perspective, the direct cost associated with hypertension was estimated to be <euro>51.3 billion (8.1 in Italy, 17.1 in Germany, 12.2 in Spain, 8.8 in France and 5.0 in England). Increasing adherence to anti-hypertensive therapy to 70 % would save a total of <euro>332 million (CI 95 %: <euro>319-346 million) from the NPs perspective. This study is the first attempt to estimate the economic impact of non-adherence amongst patients with diagnosed hypertension in Europe, using data from five European countries (Italy, France, Germany, Spain and England).

**Mueller, M. T. and A. Frenzel (2015). "Competitive pricing within pharmaceutical classes: evidence on "follow-on" drugs in Germany 1993-2008." *Eur J Health Econ* 16(1): 73-82.**

OBJECTIVES: Competition from "follow-on" drugs has been a highly controversial issue. Manufacturers launching new molecules in existing drug classes have often been criticized for inflating health systems' expenses, but it has been argued that such drugs increase therapeutic options. Economic theory suggests that follow-on drugs induce price competition. We contribute to this discussion by addressing the topic of pricing at market entry and price development in the German market. METHODS: We measure determinants of price strategies of follow-on drugs using regression analyses, considering all new molecules launched in the German market from 1993 to 2008. Prices of products are standardized on defined daily dosages controlling for sales volumes based on data from the IMS Health DPM database and for the therapeutic quality of a new product using ratings by Fricke/Klaus as a proxy for innovation. RESULTS: We identify prices correlating with therapeutic value at market entry. While the first two molecules engage in quality competition, price discounts below the market price can be observed from the third entrant on. Price discounts are even more distinct in development races with several drugs entering the market within 2 years and in classes with a low degree of therapeutic differentiation. Prices remain relatively constant over time. CONCLUSION: This study contributes to

assessments of competition in pharmaceutical markets focusing on price strategies of new market entrants. After an initial phase of market building, further follow-on products induce price competition. Largely unchanged prices after 4 years may be interpreted as quality competition and can be attributed to prices in Germany being anchor points for international price referencing.

**Outterson, K., et al. (2015). "Repairing the broken market for antibiotic innovation." Health Aff (Millwood) 34(2): 277-285.**

Multidrug-resistant bacterial diseases pose serious and growing threats to human health. While innovation is important to all areas of health research, it is uniquely important in antibiotics. Resistance destroys the fruit of prior research, making it necessary to constantly innovate to avoid falling back into a pre-antibiotic era. But investment is declining in antibiotics, driven by competition from older antibiotics, the cost and uncertainty of the development process, and limited reimbursement incentives. Good public health practices curb inappropriate antibiotic use, making return on investment challenging in payment systems based on sales volume. We assess the impact of recent initiatives to improve antibiotic innovation, reflecting experience with all sixty-seven new molecular entity antibiotics approved by the Food and Drug Administration since 1980. Our analysis incorporates data and insights derived from several multistakeholder initiatives under way involving governments and the private sector on both sides of the Atlantic. We propose three specific reforms that could revitalize innovations that protect public health, while promoting long-term sustainability: increased incentives for antibiotic research and development, surveillance, and stewardship; greater targeting of incentives to high-priority public health needs, including reimbursement that is delinked from volume of drug use; and enhanced global collaboration, including a global treaty.

**Stavropoulou, C. and T. Valletti (2015). "Compulsory licensing and access to drugs." Eur J Health Econ 16(1): 83-94.**

Compulsory licensing allows the use of a patented invention without the owner's consent, with the aim of improving access to essential drugs. The pharmaceutical sector argues that, if broadly used, it can be detrimental to innovation. We model the interaction between a company in the North that holds the patent for a certain drug and a government in the South that needs to purchase it. We show that both access to drugs and pharmaceutical innovation depend largely on the Southern country's ability to manufacture a generic version. If the manufacturing cost is too high, compulsory licensing is not exercised. As the cost decreases, it becomes a credible threat forcing prices down, but reducing both access and innovation. When the cost is low enough, the South produces its own generic version and access reaches its highest value, despite a reduction in innovation. The global welfare analysis shows that the overall impact of compulsory licensing can be positive, even when accounting for its impact on innovation. We also consider the interaction between compulsory licensing and the strength of intellectual property rights, which can have global repercussions in other markets beyond the South.

## Méthodologie – Statistique / Methodology - Statistics

**Almeida, A. S. and J. F. Cima (2015). "Demand uncertainty and hospital costs: an application to Portuguese public hospitals." Eur J Health Econ 16(1): 35-45.**

In this paper, we evaluate the effect of demand uncertainty on hospital costs. Since hospital managers want to minimize the probability of not having enough capacity to satisfy demand,

and since demand is uncertain, hospitals have to build excess capacity and incur the associated costs. Using panel data comprising information for 43 Portuguese public hospitals for the period 2007-2009, we estimate a translog cost function that relates total variable costs to the usual variables (outputs, the price of inputs, some of the hospitals' organizational characteristics) and an additional term measuring the excess capacity related to the uncertainty of demand. Demand uncertainty is measured as the difference between actual and projected demand for emergency services. Our results indicate that the cost function term associated with the uncertainty of demand is significant, which means that cost functions that do not include this type of term may be misspecified. For most of our sample, hospitals that face higher demand uncertainty have higher excess capacity and higher costs. Furthermore, we identify economies of scale in hospital costs, at least for smaller hospitals, suggesting that a policy of merging smaller hospitals would contribute to reducing hospital costs

**Christensen, A. I., et al. (2015). "The effect of multiple reminders on response patterns in a Danish health survey." *Eur J Public Health* 25(1): 156-161.**

**BACKGROUND:** Reminders are routinely applied in surveys to increase response rates and reduce the possibility of bias. This study examines the effect of multiple reminders on the response rate, non-response bias, prevalence estimates and exposure-outcome relations in a national self-administered health survey. **METHODS:** Data derive from the Danish National Health Survey 2010, in which 298 550 individuals (16 years of age or older) were invited to participate in a cross-sectional survey using a mixed-mode approach (paper and web questionnaires). At least two reminders were sent to non-respondents, and 177 639 individuals completed the questionnaire (59.5%). Response patterns were compared between four groups of individuals (first mailing respondents, second mailing respondents, third mailing respondents and non-respondents). **RESULTS:** Multiple reminders led to an increase in response rate from 36.7 to 59.5%; however, the inclusion of second and third mailing respondents did not change the overall characteristics of respondents compared with non-respondents. Furthermore, only small changes in prevalence estimates and exposure-outcome relationships were observed when including second and third mailing respondents compared with only first mailing respondents. **CONCLUSIONS:** Multiple reminders were an effective way to increase the response rate in a national Danish health survey. However, when differences do exist between respondents and non-respondents, the results suggest that second and third mailings are unlikely to eliminate these differences. Overall, multiple reminders seemed to have only minor effect on response patterns and study conclusions in the present study.

**Verdot, C., et al. (2015). "Monitoring systems and national surveys on prison health in France and abroad." *Eur J Public Health* 25(1): 167-172.**

**BACKGROUND:** The implementation of a national monitoring system of prisoners' health is under consideration in France. As information available on this topic is quite scarce, particularly in Europe, a study was performed to identify and describe various prison health monitoring approaches implemented worldwide. **METHODS:** Data were collected for 15 countries in Oceania, North America and western and northern Europe via official state websites, bibliographical searches and interviews with international prison health representatives. **RESULTS:** The means and methods implemented to monitor prisoners' health in the studied countries are heterogeneous. Although all countries systematically record mortality data, only four have a monitoring system that covers a wide array of health data: Canada and Belgium routinely collect health data using a systematic, standardized and computerized approach, while the USA and Australia have developed regular repeated nationwide surveys. Some countries have set up monitoring systems restricted to specific

health problems, such as infectious diseases (e.g. the UK, Switzerland and Canada) and mental health (e.g. New Zealand and the Netherlands). In other countries, including France, prisoners' health monitoring systems are limited to occasional epidemiological studies covering specific topics, for example, psychiatric disorders, addiction or infectious diseases. However, their one-off nature prevents regular assessment of health prevalence and trends. CONCLUSIONS: This study highlights the diversity of approaches and methods developed to monitor prison health in high-income countries. Analysis of these different situations provides an insight into the feasibility of and requirements for the development of an efficient prison health surveillance system.

## Politique de santé / Health Policy

**Anell, A. (2014). "The Public - Private Pendulum - Patient Choice and Equity in Sweden." New England Journal of Medicine **372**(1): 1-4.**

**Van Exel, J., et al. (2015). "Public views on principles for health care priority setting: Findings of a European cross-country study using Q methodology." Soc Sci Med **126**: 128-137.**

Resources available to the health care sector are finite and typically insufficient to fulfil all the demands for health care in the population. Decisions must be made about which treatments to provide. Relatively little is known about the views of the general public regarding the principles that should guide such decisions. We present the findings of a Q methodology study designed to elicit the shared views in the general public across ten countries regarding the appropriate principles for prioritising health care resources. In 2010, 294 respondents rank ordered a set of cards and the results of these were subject to by-person factor analysis to identify common patterns in sorting. Five distinct viewpoints were identified, (I) "Egalitarianism, entitlement and equality of access"; (II) "Severity and the magnitude of health gains"; (III) "Fair innings, young people and maximising health benefits"; (IV) "The intrinsic value of life and healthy living"; (V) "Quality of life is more important than simply staying alive". Given the plurality of views on the principles for health care priority setting, no single equity principle can be used to underpin health care priority setting. Hence, the process of decision making becomes more important, in which, arguably, these multiple perspectives in society should be somehow reflected.

## Prévention / Prevention

**Fonte D, et al. (2014). "Compétences psychosociales et éducation thérapeutique du patient diabétique de type 1 : une revue de littérature." Santé Publique(9): 763-777.**

Introduction : En éducation thérapeutique, il est établi que les compétences psychosociales doivent être renforcées chez les patients pour les aider à mieux gérer leur maladie et les traitements associés. Actuellement, ce travail est difficilement réalisable en raison de questions conceptuelles, méthodologiques et opérationnelles qui restent en suspens. En particulier, se posent celles de l'identification et de l'évaluation des compétences psychosociales pertinentes à développer. Objectifs : Il s'agissait de réaliser un inventaire des compétences psychosociales ciblées par les interventions d'éducation et d'identifier les critères utilisés pour objectiver l'acquisition de ces compétences. Méthode : Une revue de la littérature a été réalisée à partir de 60 articles portant sur l'évaluation d'une intervention d'éducation de patients diabétiques. Résultats : Les compétences ont été identifiées dans le quart des articles. Elles renvoyaient à la communication et aux relations interpersonnelles, à

la prise de décision et à l'esprit critique, et à la gestion de soi. Les articles utilisent davantage de critères d'évaluation de nature médicale que de nature psychosociale. Discussion : Les compétences psychosociales sont peu explicites et peu évaluées. Souvent pensées à travers une approche biomédicale, les interventions se focalisent davantage sur les compétences d'autosoins. L'article conclut sur l'intérêt de développer une approche psychosociale pour une meilleure conceptualisation de la notion de compétence sociale.

## Soins de santé primaires Primary Health Care

**Diaz, E., et al. (2015). "How do immigrants use primary health care services? A register-based study in Norway." *Eur J Public Health* 25(1): 72-78.**

BACKGROUND: Immigrant's use of primary health care (PHC) services differs from that of native's, but studies are non-consistent, and the importance of individual explaining variables like socio-economic status, morbidity burden and length of stay in the host country is uncertain. METHODS: Registry-based study using merged data from the National Population Register and the Norwegian Health Economics Administration Database for all immigrants and natives  $\geq 15$  years registered in Norway in 2008 (3 739 244 persons), applying the Johns Hopkins ACG(R) Case-Mix System. Using multivariate binary logistic and negative binomial regression analyses, respectively, we compared overall use of PHC and number of visits to PHC between immigrants and natives, and investigated the significance of socio-economic, immigration and morbidity variables. RESULTS: A significantly lower percentage of immigrants used the general practitioner (GP) compared with natives. Among GP users, however, most immigrants used the GP at a 2-15% significantly higher rate compared with natives. Older immigrants used their GP less and at lower rates than younger immigrants. A significantly lower percentage of immigrants from high-income countries, but a higher percentage of all other immigrants used emergency services compared with natives, with no differences in use rates. Morbidity burden and length of stay were essential explaining variables. CONCLUSION: Lower use of PHC among immigrants could be due to better health or to access barriers, and should be further studied, especially for the oldest immigrants. Adjusted high frequency of use may be appropriate, but it might also be a signal of non-effective contacts.

**Diaz, E. and B. N. Kumar (2014). "Differential utilization of primary health care services among older immigrants and Norwegians: a register-based comparative study in Norway." *BMC Health Serv Res* 14: 623.**

BACKGROUND: Aging in an unfamiliar landscape can pose health challenges for the growing numbers of immigrants and their health care providers. Therefore, better understanding of how different immigrant groups use Primary Health Care (PHC), and the underlying factors that explain utilization is needed to provide adequate and appropriate public health responses. Our aim is to describe and compare the use of PHC between elderly immigrants and Norwegians. METHODS: Registry-based study using merged data from the National Population Register and the Norwegian Health Economics Administration database. All 50 year old or older Norwegians with both parents from Norway (1,516,012) and immigrants with both parents from abroad (89,861) registered in Norway in 2008 were included. Descriptive analyses were carried out. Immigrants were categorised according to country of origin, reason for migration and length of stay in Norway. Binary logistic regression analyses were conducted to study the utilization of PHC comparing Norwegians and immigrants, and to assess associations between utilization and both length of stay and reason for immigration, adjusting for other socioeconomic variables. RESULTS: A higher proportion of

Norwegians used PHC services compared to immigrants. While immigrants from high-income countries used PHC less than Norwegians disregarding age (OR from 0.65 to 0.92 depending on age group), they had similar number of diagnoses when in contact with PHC. Among immigrants from other countries, however, those 50 to 65 years old used PHC services more often (OR 1.22) than Norwegians and had higher comorbidity levels, but this pattern was reversed for older adults (OR 0.56 to 0.47 for 66-80 and 80+ years respectively). For all immigrants, utilization of PHC increased with longer stay in Norway and was higher for refugees (1.67 to 1.90) but lower for labour immigrants (0.33 to 0.45) compared to immigrants for family reunification. However, adjustment for education and income levels reduced most differences between groups. CONCLUSIONS: Immigrants' lower utilization of PHC services might reflect better health among immigrants, but it could also be due to barriers to access that pose public health challenges. The heterogeneity of life courses and migration trajectories should be taken into account when developing public policies.

**Dusheiko, M., et al. (2015). "Quality of Disease Management and Risk of Mortality in English Primary Care Practices." Health Serv Res Ahead of pub.**

Objective : To investigate whether better management of chronic conditions by family practices reduces mortality risk. Data Two random samples of 5- million patients registered with over 8,000 English family practices followed up for 4- years (2004/5â€“2007/8). Measures of the quality of disease management for 10 conditions were constructed for each family practice for each year. The outcome measure was an indicator taking the value 1 if the patient died during a specified year, 0 otherwise. Study Design Cross-section and multilevel panel data multiple logistic regressions were estimated. Covariates included age, gender, morbidity, hospitalizations, attributed socio-economic characteristics, and local health care supply measures. Principal Findings Although a composite measure of the quality of disease management for all 10 conditions was significantly associated with lower mortality, only the quality of stroke care was significant when all 10 quality measures were entered in the regression. Conclusions The panel data results suggest that a 1 percent improvement in the quality of stroke care could reduce the annual number of deaths in England by 782 [95 percent CI: 423, 1140]. A longer study period may be necessary to detect any mortality impact of better management of other conditions

**Howard, M. and S. Danho (2015). "Primary care practice transformation: start with roles and relationships." Family Practice 32(1): 1-2.**

**Ricci-Cabello, I., et al. (2015). "Measuring experiences and outcomes of patient safety in primary care: a systematic review of available instruments." Family Practice 32(1): 106-119.**

Background. Despite the enormous potential for adverse events in primary care, the knowledge base about patient safety in this context is still sparse. The lack of appropriate measurement methods is a key factor limiting the development of research in this field. Objective. To identify and characterize available patient reported instruments to measure patient safety in primary care. Methods. We conducted a systematic literature review. We searched in bibliographic sources for empirical studies describing the development, evaluation or use of patient reported instruments assessing patient safety in primary care. Study selection and data extraction were independently conducted by two researchers. Results. We identified 28 studies reporting on 23 different instruments. Fifteen instruments were designed for paper-based self-administration, six for phone interview and two consisted in electronic reporting systems. Most instruments focused on specific aspects of patient safety, most commonly on experiences of adverse drug reactions. Face validity was assessed for 10 instruments (43%), three reported construct validity (13%) and three

described reliability (13%). Responsiveness was not ascertained. Conclusions. Although there is evidence of good psychometric properties for a reduced number of patient reported instruments, currently available instruments do not offer a comprehensive set of resources to measure the effects of interventions to improve patient safety in primary care from a patient perspective. Future research in the field should prioritize (i) the evaluation of the performance of already available instruments and (ii) the development of new instruments that enable an comprehensive assessment of patient safety at general practices

**Tarrant, C., et al. (2015). "Falling through gaps' primary care patients'accounts of breakdowns in experienced continuity of care." *Family Practice* 32(1): 82-87.**

**Background.** Experienced continuity is important for good quality primary care but may be challenging to achieve. Little is known about how discontinuities or gaps in care may arise, how they impact on patients' experiences and how best to understand them so that they can be avoided or managed. **Objectives.** Using the theoretical framework of candidacy, we aim to explore patients' experiences of discontinuities in care and to gain insight into how gaps come to be bridged and why they might remain unresolved. **Methods.** A secondary analysis was undertaken of interview data from a large study into continuity in primary care, involving a diverse sample of 50 patients, recruited from 15 general practices, one walk-in centre and community settings in Leicestershire, UK. Analysis was conducted using a constant comparative approach. **Results.** Experiences of gaps in care were common, arising from failures in communication and coordination of care. Although some gaps were easily bridged, many patients described "falling through gaps" because of difficulties establishing their candidacy for ongoing care when gaps occurred. These patients commonly had complex, chronic conditions and multi-morbidity. Bridging gaps required resources; relationship continuity was a valuable resource for preventing and repairing gaps in care. When gaps were not bridged, distress and dysfunctional use of health services followed. **Conclusion.** This study demonstrates that some patients with complex chronic conditions and multi-morbidity may be unable to get the continuity they need and highlights the potential for relationship continuity to help prevent vulnerable patients falling through gaps in care

**Tinelli, M., et al. (2015). "Decision-making criteria among European patients: exploring patient preferences for primary care services." *Eur J Public Health* 25(1): 3-9.**

**BACKGROUND:** Health economics preference-based techniques, such as discrete choice experiments (DCEs), are often used to inform public health policy on patients' priorities when choosing health care. Although there is general evidence about patients' satisfaction with general-practice (GP) care in Europe, to our knowledge no comparisons are available that measure patients' preferences in different European countries, and use patients' priorities to propose policy changes. **METHODS:** A DCE was designed and used to capture patients' preferences for GP care in Germany, England and Slovenia. In the three countries, 841 eligible patients were identified across nine GP practices. The DCE questions compared multiple health-care practices (including their 'current GP practice'), described by the following attributes: 'information' received from the GP, 'booking time', 'waiting time' in the GP practice, 'listened to', as well as being able to receive the 'best care' available for their condition. Results were compared across countries looking at the attributes' importance and rankings, patients' willingness-to-wait for unit changes to the attributes' levels and changes in policy. **RESULTS:** A total of 692 respondents (75% response rate) returned questionnaires suitable for analysis. In England and Slovenia, patients were satisfied with their 'current practice', but they valued changes to alternative practices. All attributes influenced decision-making, and 'best care' or 'information' were more valued than others. In Germany, almost all respondents constantly preferred their 'current practice', and other factors did not change their preference. **CONCLUSION:** European patients have strong preference for their 'status

quo', but alternative GP practices could compensate for it and offer more valued care.

**van Hasselt, M., et al. (2015). "Total Cost of Care Lower among Medicare Fee-for-Service Beneficiaries Receiving Care from Patient-Centered Medical Homes." *Health Serv Res* 50(1): 253-272.**

**OBJECTIVE:** To compare health care utilization and payments between NCQA-recognized patient-centered medical home (PCMH) practices and practices without such recognition. **DATA SOURCES:** Medicare Part A and B claims files from July 1, 2007 to June 30, 2010, 2009 Census, 2007 Health Resources and Services Administration and CMS Utilization file, Medicare's Enrollment Data Base, and the 2005 American Medical Association Physician Workforce file. **STUDY DESIGN:** This study used a longitudinal, nonexperimental design. Three annual observations (July 1, 2008-June 30, 2010) were available for each practice. We compared selected outcomes between practices with and those without NCQA PCMH recognition. **DATA COLLECTION METHODS:** Individual Medicare fee-for-service (FFS) beneficiaries and their claims and utilization data were assigned to PCMH or comparison practices based on where they received the plurality of evaluation and management services between July 1, 2007 and June 30, 2008. **PRINCIPAL FINDINGS:** Relative to the comparison group, total Medicare payments, acute care payments, and the number of emergency room visits declined after practices received NCQA PCMH recognition. The decline was larger for practices with sicker than average patients, primary care practices, and solo practices. **CONCLUSIONS:** This study provides additional evidence about the potential of the PCMH model for reducing health care utilization and the cost of care.

**Wheat, H. C., et al. (2015). "Practices used for recommending sickness certification by general practitioners: A conversation analytic study of UK primary care consultations." *Soc Sci Med* 126: 48-58.**

Existing research indicates that many patients and doctors find the process of negotiating sickness certification for time off work to be a difficult one. This study examined how patients and general practitioners (GPs) managed these negotiations in a sample of UK primary care consultations. The study made use of an existing dataset of audio-recorded consultations between 13 GPs and 506 unselected adult patients in five general practices in London. Forty-nine consultations included discussions for both initial and repeat sickness certification across a wide range of conditions. Here we report our findings on doctor practices for recommending, as opposed to patient practices for advocating for, sickness certification (n = 26 cases). All cases were transcribed in detail and analysed using conversation analytic methods. Four main communication practices were observed: (1) declarative statements of need for sickness certification; (2) 'do you need' offers for sickness certification; (3) 'do you want' offers for sickness certification; and (4) conditional 'If X, Y' offers for sickness certification. These different communication practices indexed doctor agency, doctor endorsement and patient entitlement to varying degrees. In the main, recommendations to patients presenting with biomedical problems or a repeat occurrence of a psychosocial problem displayed stronger doctor endorsement and patient entitlement. Contrastingly, recommendations to patients presenting with new psychosocial and biopsychosocial problems, displayed weaker endorsement and patient entitlement. This study offers new evidence to support the Parsonian argument that becoming sick involves entering a social role with special rights and obligations. Through documenting doctors' orientations to their gatekeeping role as well as patients' orientations to differential rights vis a vis legitimacy, we demonstrate the contrasting stances of doctors in situ when giving sick notes for biomedical problems as opposed to difficulties of a more psychosocial nature.

**White, F. (2015). "Primary Health Care and Public Health: Foundations of Universal Health**

### **Systems." Med Princ Pract.**

The aim of this review is to advocate for more integrated and universally accessible health systems, built on a foundation of primary health care and public health. The perspective outlined identified health systems as the frame of reference, clarified terminology and examined complementary perspectives on health. It explored the prospects for universal and integrated health systems from a global perspective, the role of healthy public policy in achieving population health and the value of the social-ecological model in guiding how best to align the components of an integrated health service. The importance of an ethical private sector in partnership with the public sector is recognized. Most health systems around the world, still heavily focused on illness, are doing relatively little to optimize health and minimize illness burdens, especially for vulnerable groups. This failure to improve the underlying conditions for health is compounded by insufficient allocation of resources to address priority needs with equity (universality, accessibility and affordability). Finally, public health and primary health care are the cornerstones of sustainable health systems, and this should be reflected in the health policies and professional education systems of all nations wishing to achieve a health system that is effective, equitable, efficient and affordable. (c) 2015 S. Karger AG, Basel.

## **Systèmes de santé / Health Systems**

**Nassery, N., et al. (2015). "Systematic overuse of healthcare services: a conceptual model." Appl Health Econ Health Policy **13**(1): 1-6.**

A perfect storm of factors influences the overuse of healthcare services in the USA. Considerable attention has been placed on geographic variation in utilization; however, empiric data has shown that geographic variation in utilization is not associated with overuse. While there has been renewed interest in overuse in recent years, much of the focus has been on the overuse of individual procedures. In this paper we argue that overuse should be thought of as a widespread and pervasive phenomenon that we coin as systematic overuse. While not directly observable (i.e., a latent phenomenon), we suggest that systematic overuse could be identified by tracking a portfolio of overused procedures. Such a portfolio would reflect systematic overuse if it is associated with higher healthcare costs and no health benefit (including worse health outcomes) across a healthcare system. In this report we define and conceptualize systematic overuse and illustrate how it can be identified and validated via a simple empirical example using several Choosing Wisely indicators. The concept of systematic overuse requires further development and empirical verification, and this paper provides an important first step, a conceptual framework, to that end.

## **Travail et santé / Occupational Health**

**Clemens, T., et al. (2015). "What is the effect of unemployment on all-cause mortality? A cohort study using propensity score matching." Eur J Public Health **25**(1): 115-121.**

BACKGROUND: There is a strong association between unemployment and mortality, but whether this relationship is causal remains debated. This study utilizes population-level administrative data from Scotland within a propensity score framework to explore whether the association between unemployment and mortality may be causal. METHODS: The study examined a sample of working men and women aged 25-54 in 1991. Subsequent employment status in 2001 was observed (in work or unemployed) and the relative all-cause mortality risk of unemployment between 2001 and 2010 was estimated. To account for

potential selection into unemployment of those in poor health, a propensity score matching approach was used. Matching variables were observed prior to unemployment and included health status up to the year of unemployment (hospital admissions and self-reported limiting long-term illness), as well as measures of socioeconomic position. RESULTS: Unemployment was associated with a significant all-cause mortality risk relative to employment for men (hazard ratio [HR] 1.85; 95% confidence interval [CI] 1.33-2.55). This effect was robust to controlling for prior health and sociodemographic characteristics. Effects for women were smaller and statistically insignificant (HR 1.51; 95% CI 0.68-3.37). CONCLUSION: For men, the findings support the notion that the often-observed association between unemployment and mortality may contain a significant causal component; although for women, there is less support for this conclusion. However, female employment status, as recorded in the census, is more complex than for men and may have served to underestimate any mortality effect of unemployment. Future work should examine this issue further.

**Ten Have, M., et al. (2015). "Associations of work and health-related characteristics with intention to continue working after the age of 65 years." *Eur J Public Health* 25(1): 122-124.**

This study examines the association of work and health-related characteristics with the intention to continue working after the age of 65 years. Data were from the Netherlands Mental Health Survey and Incidence Study-2 (NEMESIS-2), a nationally representative population survey, including 1854 employees aged 45-64 years; 29.0% reported the intention to continue working after 65 years. Lower education, more adverse psychosocial working conditions and any physical disorder were negatively associated with this intention. Mental disorders were not associated. These findings highlight the importance of favourable working conditions and good physical health in relation to employees' intention to continue working after 65 years.

## Vieillesse / Ageing)

**Ilinca, S. and S. Calciolari (2015). "The patterns of health care utilization by elderly europeans: frailty and its implications for health systems." *Health Serv Res* 50(1): 305-320.**

OBJECTIVE: To examine the patterns of health care utilization by the elderly and test the influence of functional decline. DATA SOURCE AND STUDY DESIGN: We used the three regular waves of the SHARE survey to estimate the influence of frailty on health care utilization in 10 European countries. We controlled for the main correlates of frailty and unobserved individual effects. RESULTS: The frail elderly increase their primary and hospital care utilization before the onset of disability. Multimorbidity moderates the effect of frailty on care utilization. CONCLUSIONS: The prevalence of frailty is high in most countries and is expected to increase. This renders frailty prevention and remediation efforts imperative for two complementary reasons: to promote healthier aging and to reduce the burden on health systems.

**Do, Y. K., et al. (2015). "Informal Care and Caregiver's Health." *Health Econ* 24(2): 224-237.**

This study aims to measure the causal effect of informal caregiving on the health and health care use of women who are caregivers, using instrumental variables. We use data from South Korea, where daughters and daughters-in-law are the prevalent source of caregivers for frail elderly parents and parents-in-law. A key insight of our instrumental variable approach is that having a parent-in-law with functional limitations increases the probability of providing informal care to that parent-in-law, but a parent-in-law's functional limitation does not directly affect the daughter-in-law's health. We compare results for the daughter-in-law and

daughter samples to check the assumption of the excludability of the instruments for the daughter sample. Our results show that providing informal care has significant adverse effects along multiple dimensions of health for daughter-in-law and daughter caregivers in South Korea. Copyright -© 2013 John Wiley & Sons, Ltd

**Martin, P., et al. (2015). "Defining Successful Aging: A Tangible or Elusive Concept?" The Gerontologist 55(1): 14-25.**

Purpose of the Study: Everyone wants to age successfully; however, the definition and criteria of successful aging remain vague for laypersons, researchers, and policymakers in spite of decades of research on the topic. This paper highlights work of scholars who made significant theoretical contributions to the topic. Design and Methods: A thorough review and evaluation of the literature on successful aging was undertaken. Results: Our review includes early gerontological definitions of successful aging and related concepts. Historical perspectives reach back to philosophical and religious texts, and more recent approaches have focused on both process- and outcome-oriented models of successful aging. We elaborate on Baltes and Baltes' theory of selective optimization with compensation [Baltes, P. B., & Baltes, M. M. (1990a). Psychological perspectives on successful aging: The model of selective optimization with compensation. In P. B. Baltes & M. M. Baltes (Eds.), *Successful aging: Perspectives from the behavioral sciences* (pp. 1-34). United Kingdom: Cambridge University Press], Kahana and Kahana's preventive and corrective proactivity model [Kahana, E., & Kahana, B. (1996). Conceptual and empirical advances in understanding aging well through proactive adaptation. In V. Bengtson (Ed.), *Adulthood and aging: Research on continuities and discontinuities* (pp. 18-40). New York: Springer], and Rowe and Kahn's model of successful aging [Rowe, J. W., & Kahn, R. L. (1998). *Successful aging*. New York: Pantheon Books], outlining their commonalities and differences. Additional views on successful aging emphasize subjective versus objective perceptions of successful aging and relate successful aging to studies on healthy and exceptional longevity. Implications: Additional theoretical work is needed to better understand successful aging, including the way it can encompass disability and death and dying. The extent of rapid social and technological change influencing views on successful aging also deserves more consideration

**Martinson, M. and C. Berridge (2015). "Successful Aging and Its Discontents: A Systematic Review of the Social Gerontology Literature." The Gerontologist 55(1): 58-69.**

Purpose of the Study: The purpose of this study was to analyze the range of critiques of successful aging models and the suggestions for improvement as expressed in the social gerontology literature. Design and Methods: We conducted a systematic literature review using the following criteria: journal articles retrieved in the Abstracts in Social Gerontology, published 1987-2013, successful aging/ageing in the title or text (n = 453), a critique of successful aging models as a key component of the article. Sixty-seven articles met the criteria. Qualitative methods were used to identify key themes and inductively configure meanings across the range of critiques. Results: The critiques and remedies fell into 4 categories. The Add and Stir group suggested a multidimensional expansion of successful aging criteria and offered an array of additions. The Missing Voices group advocated for adding older adults' subjective meanings of successful aging to established objective measures. The Hard Hitting Critiques group called for more just and inclusive frameworks that embrace diversity, avoid stigma and discrimination, and intervene at structural contexts of aging. The New Frames and Names group presented alternative ideal models often grounded in Eastern philosophies. Implications: The vast array of criteria that gerontologists collectively offered to expand Rowe and Kahn's original successful model is symptomatic of the problem that a normative model is by definition exclusionary. Greater reflexivity about gerontology's use of "successful aging" and other normative models is needed

**Scott, P. A., et al. (2003). "Autonomy, privacy and informed consent 3: elderly care perspective." *Br J Nurs* 12(3): 158-168.**

Despite the growing interest in clinical healthcare ethics, there is a dearth of empirical studies investigating the ethical elements of day-to-day clinical practice from the perspective of either patients or staff. This article, the third in a four-part series, reports the results of a Scottish Study that formed part of a multi-site comparative study funded by the European Commission. It explores patient autonomy, privacy and informed consent in the care of elderly people in long-stay care facilities (i.e. nursing homes and continuing care units). A convenience sample of 101 elderly residents and their nurses (n = 160) participated in the study. Data were collected by means of a self-completion questionnaire for staff and a structured interview schedule for elderly residents. Results indicate marked differences between staff's and residents' responses on three of the four dimensions explored: information-giving, and opportunity to participate in decision-making about care and consent. There was much closer agreement between staff's and residents' responses regarding protection of patient privacy. From the results of this study there is indication of a clear need for further empirical studies exploring issues of patient autonomy, privacy and informed consent in the day-to-day nursing care of older people. Findings to date suggest there is still a significant need to educate staff concerning ethical awareness and sensitivity to the dignity and rights of patients.