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## Sommaire

### Assurance maladie / Health Insurance ..... 6

- Li Q., Trivedi P.K. (2014). Adverse and advantageous selection in the Medicare supplemental market: a Bayesian analysis of prescription drug expenditures ..... 6
- Haeder S.F. (2014). Balancing adequacy and affordability?: Essential Health Benefits under the Affordable Care Act ..... 6
- McCue M.J., Hall M. (2015). Health Insurers' Financial Performance and Quality Improvement Expenditures in the Affordable Care Act's Second Year..... 6
- Franc C., Pierre A. (2015). Compulsory private complementary health insurance offered by employers in France: Implications and current debate. .... 7

### Economie de la santé / Health Economics ..... 7

- Cunningham P.J. (2015). The share of people with high medical costs increased prior to implementation of the affordable care act..... 7

### Géographie de la santé / Geography of Health ..... 8

- Barba-Vasseur M., Desmarests M., Cao M.M.et al. (2014). Démographie des psychiatres et facteurs d'attractivité : l'exemple de la Franche-Comté ..... 8
- Mennicken R., Kolodziej I.W., Augurzky B., Kreienberg R. (2014). Concentration of gynaecology and obstetrics in Germany: Is comprehensive access at stake? ..... 8
- Holte J.H., Kjaer T., Abelsen B., Olsen J.A. (2014). The impact of pecuniary and non-pecuniary incentives for attracting young doctors to rural general practice. .... 9

### Hôpital / Hospitals ..... 9

- Ho K., Pakes A. (2014). Hospital Choices, Hospital Prices, and Financial Incentives to Physicians. 9
- Besstremyannaya G. (2014). Differential effects of declining rates in a per diem payment system ..... 9
- Cassel C.K., Conway P.H., Delbanco S.F., Jha A.K., Saunders R.S., Lee T.H. (2014). Getting more performance from performance measurement..... 10
- Siciliani L., Moran V., Borowitz M. (2014). Measuring and comparing health care waiting times in OECD countries..... 10
- Raulinajtys-Grzybek M. (2014). Cost accounting models used for price-setting of health services: An international review..... 10
- Emmert M., Hessemer S., Meszmer N., Sander U. (2014). Do German hospital report cards have the potential to improve the quality of care?..... 10

Lee K.S., Kwak J.M. (2014). Effect of patient risk on the volume-outcome relationship in obstetric delivery services. ....	11
Ohta Y., Sakuma M., Koike K., Bates D.W., Morimoto T. (2014). Influence of adverse drug events on morbidity and mortality in intensive care units: the JADE study .....	11
Nuttall D., Parkin D., Devlin N. (2015). Inter-provider comparison of patient-reported outcomes: developing an adjustment to account for differences in patient case mix.....	12
Whittaker A., Chee H.L. (2015). Perceptions of an 'international hospital' in Thailand by medical travel patients: Cross-cultural tensions in a transnational space .....	12
Dor A., Encinosa W.E., Carey K. (2015). Medicare's Hospital Compare Quality Reports Appear To Have Slowed Price Increases For Two Major Procedures .....	12
<b>Inégalités de santé / Health Inequalities .....</b>	<b>13</b>
Coruble G., Sauze L.Riff H. (2014). Quelle stratégie peut développer une Agence régionale de santé pour réduire les inégalités sociales de santé ? .....	13
Mehdipanah R., Manzano A., Borrell C., Malmusi D., Rodriguez-Sanz M., Greenhalgh J., Muntaner C., Pawson R. (2015). Exploring complex causal pathways between urban renewal, health and health inequality using a theory-driven realist approach.....	13
<b>Médicaments / Pharmaceuticals .....</b>	<b>14</b>
Costa-Font J., McGuire A., Varol N. (2014). Price regulation and relative delays in generic drug adoption .....	14
Richardson K., Bennett K., Kenny R.A. (2015). Polypharmacy including falls risk-increasing medications and subsequent falls in community-dwelling middle-aged and older adults .....	14
Ferrario A., Kanavos P. (2015). Dealing with uncertainty and high prices of new medicines: A comparative analysis of the use of managed entry agreements in Belgium, England, the Netherlands and Sweden .....	14
<b>Méthodologie – Statistique / Methodology – Statistics.....</b>	<b>15</b>
Zaugg V., Savoldelli V., Sabatier P., Durieux B. (2014). Améliorer les pratiques et l'organisation des soins : méthodologie des revues systématiques .....	15
Ryan A.M., Burgess J.F., Jr., Dimick J.B. (2014). Why We Should Not Be Indifferent to Specification Choices for Difference-in-Differences .....	15
Bilger M., Manning W.G. (2015). Measuring overfitting in nonlinear models: a new method and an application to health expenditures .....	16
Bihmann K., Ersboll A.K. (2015). Estimating range of influence in case of missing spatial data: a simulation study on binary data.....	16
Davis R.H., Valadez J.J. (2014). Improving the collection of knowledge, attitude and practice data with community surveys: a comparison of two second-stage sampling methods .....	16

**Politique de santé / Health Policy ..... 17**

Ogden J., Morrison K., Hardee K. (2014). Social capital to strengthen health policy and health systems..... 17

Anell A. (2015). The public-private pendulum--patient choice and equity in Sweden. .... 17

Féry-Lemonnier E., Monnet E., Prisse N. (2014). Parcours de santé : enjeux et perspectives. Dossier ..... 17

Bouvet S., Daurès J.P., Landais P., Castelli C. (2015). Valorisation d'un parcours de soins : entre difficultés et alternatives..... 17

**Soins de santé primaires / Primary Health Care ..... 18**

Peek M.E., Drum M., Cooper L.A. (2014). The Association of Patient Chronic Disease Burden and Self-Management Requirements With Shared Decision Making in Primary Care Visits..... 18

Mays N., Tan S., Eastmure E., Erens B., Lagarde M., Wright M. (2014). Potential impact of removing general practice boundaries in England: A policy analysis ..... 18

Tan S., Mays N. (2014). Impact of initiatives to improve access to, and choice of, primary and urgent care in the England: A systematic review ..... 19

Chokshi D.A., Ruge J., Shah N.R. (2014). Redesigning the regulatory framework for ambulatory care services in New York..... 19

Kash B.A., Zhang Y., Cline K.M., Menser T., Miller T.R. (2014). The Perioperative Surgical Home (PSH): A Comprehensive Review of US and Non-US Studies Shows Predominantly Positive Quality and Cost Outcomes..... 20

Ward B.M., Buykx P.F., Tham R., Kinsman L., Humphreys J.S. (2014). Investing in longitudinal studies of primary healthcare: what can we learn about service performance, sustainability and quality? ..... 21

Zhao Y., Thomas S.L., Guthridge S.L., Wakerman J. (2014). Better health outcomes at lower costs: the benefits of primary care utilisation for chronic disease management in remote Indigenous communities in Australia's Northern Territory ..... 21

Mace S, Wolff F.C. (2015). Les médecins grands et beaux sont-ils plus souvent perçus comme de "grands médecins" ?..... 21

Rudoler D., Laporte A., Barnsley J., Glazier R.H., Deber R.B. (2015). Paying for primary care: A cross-sectional analysis of cost and morbidity distributions across primary care payment models in Ontario Canada..... 21

Janssen B.M., Snoeren M.W., Van R.T., Abma T.A. (2015). Working towards integrated community care for older people: Empowering organisational features from a professional perspective. .... 22

Wiley J.A., Rittenhouse D.R., Shortell S.M., Casalino L.P., Ramsay P.P., Bibi S., Ryan A.M., Copeland K.R., Alexander J.A. (2015). Managing chronic illness: physician practices increased the use of care management and medical home processes ..... 22

Damberg C.L., Elliott M.N., Ewing B.A. (2015). Pay-for-performance schemes that use patient and provider categories would reduce payment disparities..... 22

Hoffman G. (2015). Cost-sharing, physician utilization, and adverse selection among medicare beneficiaries with chronic health conditions. .... 23

Trybou J., De R.M., Gemmel P., Duyck P., Annemans L. (2014). Effects of physician-owned specialized facilities in health care: A systematic review..... 23

**Systèmes de santé / Health Care Systems ..... 24**

McClellan M., Kent J., Beales S.J., Cohen S.I., Macdonnell M., Thoumi A., Abdulmalik M., Darzi A. (2014). Accountable care around the world: a framework to guide reform strategies ..... 24

Torbica A., Calciolari S., Fattore G. (2015). Does informal care impact utilization of healthcare services? Evidence from a longitudinal study of stroke patients..... 24

Cervero-Liceras F., McKee M., Legido-Quigley H. (2015). The effects of the financial crisis and austerity measures on the Spanish health care system: A qualitative analysis of health professionals' perceptions in the region of Valencia ..... 24

**Vieillessement / Ageing ..... 25**

Khaskhoussi T., Langot F. (2015). Réformer le système de retraite pour accroître l'emploi et la productivité des seniors. .... 25

Osborn R., Moulds D., Squires D., Doty M.M., Anderson C. (2014). International survey of older adults finds shortcomings in access, coordination, and patient-centered care ..... 25

Callan A., O'Shea E. (2015). Willingness to pay for telecare programmes to support independent living: Results from a contingent valuation study..... 26

Kalousova L., Mendes de L.C. (2015). Increase in frailty of older workers and retirees predicted by negative psychosocial working conditions on the job..... 26

Cornwell B., Laumann E.O. (2015). The health benefits of network growth: New evidence from a national survey of older adults..... 26

Ellwardt L., Van Tilburg T.G., Aartsen M.J. (2015). The mix matters: Complex personal networks relate to higher cognitive functioning in old age. .... 27

Bindels J., Cox K., Abma T.A., van Schayck O.C., Widdershoven G. (2015). Implementing care programmes for frail older people: A project management perspective. .... 27

Schipper L., Luijkx K., Meijboom B., Schols J. (2015). The 3 A's of the access process to long-term care for elderly: Providers experiences in a multiple case study in the Netherlands..... 28

Philp I. (2015). The contribution of geriatric medicine to integrated care for older people ..... 28

## Assurance maladie / Health Insurance

**Li Q., Trivedi P.K. (2014). Adverse and advantageous selection in the Medicare supplemental market: a Bayesian analysis of prescription drug expenditures.** *Health Economics*, ahead of pub.

Abstract: This paper develops an extended specification of the two-part model, which controls for unobservable self-selection and heterogeneity of health insurance, and analyzes the impact of Medicare supplemental plans on the prescription drug expenditure of the elderly, using a linked data set based on the Medicare Current Beneficiary Survey data for 2003-2004. The econometric analysis is conducted using a Bayesian econometric framework. We estimate the treatment effects for different counterfactuals and find significant evidence of endogeneity in plan choice and the presence of both adverse and advantageous selections in the supplemental insurance market. The average incentive effect is estimated to be \$757 (2004 value) or 41% increase per person per year for the elderly enrolled in supplemental plans with drug coverage against the Medicare fee-for-service counterfactual and is \$350 or 21% against the supplemental plans without drug coverage counterfactual. The incentive effect varies by different sources of drug coverage: highest for employer-sponsored insurance plans, followed by Medigap and managed Medicare plans. Copyright - © 2014 John Wiley & Sons, Ltd.

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**Haeder S.F. (2014). Balancing adequacy and affordability?: Essential Health Benefits under the Affordable Care Act.** *Health Policy*, 118 (3) : 285-291.

Abstract: The Essential Health Benefits provisions under the Affordable Care Act require that eligible plans provide coverage for certain broadly defined service categories, limit consumer cost-sharing, and meet certain actuarial value requirements. Although the Department of Health and Human Services (HHS) was tasked with the regulatory development of these EHB under the ACA, the department quickly devolved this task to the states. Not surprisingly, states fully exploited the leeway provided by HHS, and state decision processes and outcomes differed widely. However, none of the states took advantage of the opportunity to restructure fundamentally their health insurance markets, and only a very limited number of states actually included sophisticated policy expertise in their decisionmaking processes. As a result, and despite a major expansion of coverage, the status quo ex ante in state insurance markets was largely perpetuated. Decisionmaking for the 2016 revisions should be transparent, included a wide variety of stakeholders and policy experts, and focus on balancing adequacy and affordability. However, the 2016 revisions provide an opportunity to address these previous shortcomings.

**McCue M.J., Hall M. (2015). Health Insurers' Financial Performance and Quality Improvement Expenditures in the Affordable Care Act's Second Year.** *Med Care Res Rev*, 72 (1) : 113-122.

Abstract: The Affordable Care Act requires health insurers to rebate any amounts less than 80%-85% of their premiums that they fail to spend on medical claims or quality improvement. This study uses the new comprehensive reporting under this law to examine changes in insurers' financial performance and differences in their quality improvement expenditures. In the ACA's second year

(2012), insurers' median medical loss ratios continued to increase and their median administrative cost ratios dropped, producing moderate operating margins in the group markets but a small operating loss in the individual market, at the median. For-profit insurers showed larger changes, in general, than did nonprofits. For quality improvement, insurers reported spending a significantly greater amount per member in their government plans than they did on their self-insured members, with spending on commercial insurance being in between these two extremes. The magnitude and source of these differences varied by corporate ownership.

**Franc C., Pierre A. (2015). Compulsory private complementary health insurance offered by employers in France: Implications and current debate.** In : *Health Policy*, Ahead of pub

Abstract: In January 2013, within the framework of a National Inter-professional Agreement (NIA), the French government required all employers (irrespective of the size of their business) to offer private complementary health insurance to their employees from January 2016. The generalization of group complementary health insurance to all employees will directly affect insurers, employers and employees, as well as individuals not directly concerned (students, retirees, unemployed and civil servants). In this paper, we present the issues raised by this regulation, the expected consequences and the current debate around this reform. In particular, we argue that this reform may have adverse effects on equity of access to complementary health insurance in France, since the risk structure of the market for individual health insurance will change, potentially increasing inequalities between wage-earners and others. Moreover, tax exemptions given to group contracts are problematic because public funds used to support these contracts can be higher at individual level for high-salary individuals than those allocated to improve access for the poorest. In response to the criticism and with the aim of ensuring equity in the system, the government decided to reconsider some of the fiscal advantages given to group contracts, to enhance programs and aids dedicated to the poorest and to redefine an overall context of incentives. In January 2013, within the framework of a National Inter-professional Agreement (NIA), the French government required all employers (irrespective of the size of their business) to offer private complementary health insurance to their employees from January 2016. The generalization of group complementary health insurance to all employees will directly affect insurers, employers and employees, as well as individuals not directly concerned (students, retirees, unemployed and civil servants). In this paper, we present the issues raised by this regulation, the expected consequences and the current debate around this reform. In particular, we argue that this reform may have adverse effects on equity of access to complementary health insurance in France, since the risk structure of the market for individual health insurance will change, potentially increasing inequalities between wage-earners and others. Moreover, tax exemptions given to group contracts are problematic because public funds used to support these contracts can be higher at individual level for high-salary individuals than those allocated to improve access for the poorest. In response to the criticism and with the aim of ensuring equity in the system, the government decided to reconsider some of the fiscal advantages given to group contracts, to enhance programs and aids dedicated to the poorest and to redefine an overall context of incentives.

[http://www.healthpolicyjrn.com/article/S0168-8510\(14\)00348-0/abstract](http://www.healthpolicyjrn.com/article/S0168-8510(14)00348-0/abstract)

## Economie de la santé / Health Economics

**Cunningham P.J. (2015). The share of people with high medical costs increased prior to implementation of the affordable care act.** *Health Aff.(Millwood.)*, 34 (1) : 117-124.

Abstract: The percentage of Americans with high medical cost burdens—those who spend more than 10 percent of their family income on out-of-pocket expenses for health care—increased to 19.2 percent in 2011, after having stabilized at 18.2 percent during the Great Recession of 2007–09. The increase was driven primarily by growth in premium expenses in 2009–11 for people with employer-sponsored coverage. Out-of-pocket spending on health services, especially for prescription drugs, continued to decrease between 2007–09 and 2011. Medical cost burdens were highest for income groups most likely to benefit from the Affordable Care Act's coverage expansions, including people with private insurance coverage. Those who purchased nongroup coverage before the implementation of the health insurance Marketplaces in 2014 spent an especially high proportion of their income on health care, and over half of these people will qualify for premium subsidies in the Marketplaces. Federal subsidies will substantially reduce medical cost burdens for many people who do not obtain health insurance through their employers.

## Géographie de la santé / Geography of Health

**Barba-Vasseur M., Desmarets M., Cao M.M. et al. (2014). Démographie des psychiatres et facteurs d'attractivité : l'exemple de la Franche-Comté. *Santé Publique*, 26 (5) : 639-645.**

Abstract: Introduction : En France, l'augmentation de la demande faite à la psychiatrie s'ajoute aux difficultés de renouvellement des générations de psychiatres, menaçant l'accessibilité aux soins, en particulier dans les secteurs ruraux et semi-ruraux. Cette étude avait pour objectif de décrire le lieu d'exercice des psychiatres formés en Franche-Comté et d'analyser les facteurs associés à leur installation dans cette région, notamment au sein des zones les plus déficitaires. Méthodes : Il s'agit d'une étude épidémiologique observationnelle rétrospective associée à une enquête qualitative réalisée au moyen d'entretiens semi-directifs auprès d'internes en poste. Résultats : Entre 1994 et 2013, 160 internes sont entrés en formation de psychiatrie en Franche-Comté. En octobre 2013, 87 exerçaient en tant que psychiatres dont 57 % en Franche-Comté. La région d'exercice apparaissait significativement liée au lieu de naissance ( $p = 0,03$ ). Les 18 entretiens réalisés ont montré qu'au-delà des facteurs familiaux et de qualité de vie (opportunités professionnelles du conjoint, proximité familiale, vivre en ville), les possibilités de travailler en équipe, la mise en place de projets novateurs et les valeurs défendues par l'établissement pouvaient constituer des facteurs d'attractivité pour les jeunes psychiatres. Conclusion : Si l'augmentation des effectifs annuels d'internes semble pouvoir répondre, à long terme, aux problèmes démographiques rencontrés en Franche-Comté, des mesures urgentes, structurelles et organisationnelles paraissent nécessaires. La création de postes à temps partagé, la facilitation d'installation des psychiatres au sein de maisons de santé pluridisciplinaires, les délégations de tâches et la télémédecine pourraient, entre autres, permettre une amélioration de l'offre de soins psychiatriques en Franche-Comté.

**Mennicken R., Kolodziej I.W., Augurzky B., Kreienberg R. (2014). Concentration of gynaecology and obstetrics in Germany: Is comprehensive access at stake? *Health Policy*, 118 (3) : 396-406.**

Abstract: Financial soundness will become more and more difficult in the future for all types of hospitals. This is particularly relevant for gynaecology and obstetrics departments: while some disciplines can expect higher demand due to demographic changes and progress in medicine and medical technology, the inpatient sector for gynaecology and obstetrics is likely to lose patients in line with these trends. In this paper we estimate future demand for gynaecology and obstetrics in Germany and develop a cost model to calculate the average profitability in this discipline. The number of inpatient cases in gynaecology and obstetrics can be expected to decrease by 3.62%



between 2007 and 2020 due to the demographic change and a potential shift from inpatient to outpatient services. Small departments within the fields of gynaecology and obstetrics are already incurring heavy losses, and the anticipated decline in cases should increase this financial distress even more. As such, the further centralisation of services is indicated. We calculate travel times for gynaecology and obstetrics patients and estimate the anticipated changes in travel times by simulating different scenarios for this centralisation process. Our results show that the centralisation of hospital services in gynaecology and obstetrics may be possible without compromising comprehensive access as measured by travel times.

**Holte J.H., Kjaer T., Abelsen B., Olsen J.A. (2014). The impact of pecuniary and non-pecuniary incentives for attracting young doctors to rural general practice. *Soc Sci Med*, 128C 1-9.**

Abstract: Shortages of GPs in rural areas constitute a profound health policy issue worldwide. The evidence for the effectiveness of various incentives schemes, which can be specifically implemented to boost recruitment to rural general practice, is generally considered to be poor. This paper investigates young doctors' preferences for key job attributes in general practice (GP), particularly concerning location and income, using a discrete choice experiment (DCE). The subjects were all final year medical students and interns in Norway (N = 1562), of which 831 (53%) agreed to participate in the DCE. Data was collected in November-December 2010. Policy simulations were conducted to assess the potential impact of various initiatives that can be used to attract young doctors to rural areas. Most interestingly, the simulations highlight the need to consider joint policy programs containing several incentives if the policies are to have a sufficient impact on the motivation and likelihood to work in rural areas. Furthermore, we find that increased income seem to have less impact as compared to improvements in the non-pecuniary attributes. Our results should be of interest to policy makers in countries with publicly financed GP systems that may struggle with the recruitment of GPs in rural areas.

## Hôpital / Hospitals

**Ho K., Pakes A. (2014). Hospital Choices, Hospital Prices, and Financial Incentives to Physicians. *American Economic Review*, 104 (12) : 3841-3884.**

Abstract: We estimate an insurer-specific preference function which rationalizes hospital referrals for privately insured births in California. The function is additively separable in: a hospital price paid by the insurer, the distance traveled, and plan- and severity-specific hospital fixed effects (capturing hospital quality). We use an inequality estimator that allows for errors in price and detailed hospital-severity interactions and obtain markedly different results than those from a logit. The estimates indicate that insurers with more capitated physicians are more responsive to price. Capitated plans send patients further to utilize similar quality, lower-priced hospitals; but the cost-quality trade-off does not vary with capitation rates.

**Besstremyannaya G. (2014). Differential effects of declining rates in a per diem payment system. *Health Economics*, n/a.**

Abstract: The paper demonstrates differential effects of a prospective payment system with declining per diem rates, dependent on the percentiles of length of stay. The analysis uses dynamic panel data estimates and a recent nationwide administrative database for major diagnostic categories in 1068 Japanese hospitals in 2006-2012 to show that average length of stay significantly increases for

hospitals in percentiles 0-25 of the pre-reform length of stay and significantly decreases for hospitals in percentiles 51-100. The decline of the average length of stay is larger for hospitals in higher percentiles of the length of stay. Hospitals in percentiles 51-100 significantly increase their rate of nonemergency/unanticipated readmissions within 42-days after discharge. The decline in the length of total episode of treatment is smaller for hospitals in percentiles 0-25. The findings are robust in terms of the choice of a cohort of hospitals joining the reform. The paper discusses applicability of best practice rate-setting to help improve the performance of hospitals in the lowest quartile of average length of stay. Copyright © 2014 John Wiley & Sons, Ltd.

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**Cassel C.K., Conway P.H., Delbanco S.F., Jha A.K., Saunders R.S., Lee T.H. (2014). Getting more performance from performance measurement.** *N Engl J Med*, 371 (23) : 2145-2147.

**Siciliani L., Moran V., Borowitz M. (2014). Measuring and comparing health care waiting times in OECD countries.** *Health Policy*, 118 (3) : 292-303.

Abstract: Waiting times for elective treatments are a key health-policy concern in several OECD countries. This study describes common measures of waiting times from administrative data across OECD countries. It focuses on common elective procedures, such as hip and knee replacement, and cataract surgery, where waiting times are notoriously long. It provides comparative data on waiting times across 12 OECD countries and presents trends in waiting times over the last decade. Waiting times appear to be low in the Netherlands and Denmark. In the last decade the United Kingdom (in particular England), Finland and the Netherlands have witnessed large reductions in waiting times which can be attributed to a range of policy initiatives, including higher spending, waiting-times target schemes and incentive mechanisms, which reward higher levels of activity. The negative trend in these countries has, however, halted or reversed in recent years. The analysis also emphasizes systematic differences across different waiting-time measures, in particular between the distribution of waiting times of patients treated versus that of patients on the list. Mean waiting times are systematically higher than median waiting times and the difference can be quantitatively large.

**Raulinajtyś-Grzybek M. (2014). Cost accounting models used for price-setting of health services: An international review.** *Health Policy*, 118 (3) : 341-353.

Abstract: The aim of the article was to present and compare cost accounting models which are used in the area of healthcare for pricing purposes in different countries. Cost information generated by hospitals is further used by regulatory bodies for setting or updating prices of public health services. The article presents a set of examples from different countries of the European Union, Australia and the United States and concentrates on DRG-based payment systems as they primarily use cost information for pricing. Differences between countries concern the methodology used, as well as the data collection process and the scope of the regulations on cost accounting. The article indicates that the accuracy of the calculation is only one of the factors that determine the choice of the cost accounting methodology. Important aspects are also the selection of the reference hospitals, precise and detailed regulations and the existence of complex healthcare information systems in hospitals.

**Emmert M., Hessemer S., Meszmer N., Sander U. (2014). Do German hospital report cards have the potential to improve the quality of care?** *Health Policy*, 118 (3) : 386-395.

Abstract: BACKGROUND: Hospitals report cards have been put in place within the past few years to increase the amount of publicly reported quality information in Germany. OBJECTIVE: The aim of this study was to assess the potential of German hospital report cards to improve quality of care. METHODS: First, a systematic Internet search aimed at identifying available report cards was conducted. Second, cross-sectional data (August/September 2013) were analyzed with respect to

awareness, comprehension, and impact of report cards by using descriptive analysis and binary multivariate logistic regression models. RESULTS: Hospital report cards (N=62) have become broadly available. However, awareness remains low, about one third (35.6%) of all respondents (N=2027) were aware of German hospital report card. Regarding comprehensibility, in 60.7% of all experiments (N=6081), respondents selected the hospital with the lowest risk-adjusted mortality; significant differences could be determined between the report cards ( $p < .001$ ) with scores ranging from 27.5% to 77.2%. Binary multivariate logistic regression analysis revealed different significant respondent-related predictors on each report card. Finally, an impact on hospital choice making was determined. CONCLUSIONS: To increase the potential of hospital report cards, health policy makers should promote the availability of report cards. In addition, the comprehensibility of German hospital report cards cannot be regarded as satisfying and should be enhanced in the future.

**Lee K.S., Kwak J.M. (2014). Effect of patient risk on the volume-outcome relationship in obstetric delivery services. *Health Policy*, 118 (3) : 407-412.**

Abstract: Health care organizations that offer more delivery services are assumed to provide better quality of care, and a higher rate of cesarean section (CS) is generally assumed to be an indicator of poor quality of care. This study analyzed whether the volume-outcome relationship in delivery services, measured by the rate of CS, differed depending on the risk status of delivery patients. Delivery claims were identified in the National Patient Sample (NPS) for 2009. The study hospitals were categorized into low and high delivery-volume groups, and patients were categorized into three risk groups (below average, medium, and high) based on their risk status. Risk factors were included in the adjustment model to identify differences among patients and produce risk-adjusted CS rates. Risk-adjusted CS rates did not differ significantly between patients in low- and high-volume hospitals when the sample was not divided according to risk status. However, when the sample was divided according to patient risk status, significant differences in risk-adjusted CS rates in the below-average- and medium-risk groups were revealed between low- and high-volume hospitals. No such significant difference was observed for the high-risk group. The largest difference in CS rates between low- and high-volume hospitals was observed in the medium-risk group, and the high-risk group showed the smallest difference between the two volume groups. The high-risk group had the highest CS rates, and the below-average-risk group had the lowest CS rates. Although we found the traditional volume-outcome relationship in delivery patients, the data also revealed that patient risk status influenced this relationship. Policies and interventions based on volume-outcome theory should differ according to patient risk status.

**Ohta Y., Sakuma M., Koike K., Bates D.W., Morimoto T. (2014). Influence of adverse drug events on morbidity and mortality in intensive care units: the JADE study. *Int J Qual. Health Care*, 26 (6) : 573-578.**

Abstract: OBJECTIVE: To identify the influence of adverse drug events (ADEs) on morbidity and mortality in intensive care units (ICUs). DESIGN: A prospective cohort study. SETTING: ICU setting at three acute care hospitals in Japan. PARTICIPANTS: All patients aged  $\geq 15$  years were admitted to all ICUs during a 6-month study period. INTERVENTION: No intervention. MAIN OUTCOME MEASURES: Mortality in the ICUs and the length of the ICU stay. RESULTS: We included 459 patients with a total of 3231 patient-days. Ninety-nine ADEs occurred in 70 patients (15%), so that the incidence of ADEs was 30.6 per 1000 patient-days and 21.6 ADEs per 100 admissions. Seventy-three patients (16%) died during their ICU stay. Excluding 38 deaths within 3 days after admission, 12 patients (17%) died among the 70 patients who had at least one ADE during their ICU stay and 23 (7%) died among 351 without an ADE ( $P = 0.003$ ). The median ICU length of stay was 3 days. Excluding 73 patients who died during their ICU stay, the median ICU stay of patients with at least one ADE was 13 days, while it was only 2 days in the remainder ( $P < 0.0001$ ). ADEs were associated with longer length of ICU stay but not with mortality even after adjusting for patients' severity of illness. CONCLUSIONS: ADEs were

common in ICUs and significantly associated with longer length of ICU stay but did not influence on mortality.

**Nuttall D., Parkin D., Devlin N. (2015). Inter-provider comparison of patient-reported outcomes: developing an adjustment to account for differences in patient case mix. *Health Econ*, 24 (1) : 41-54.**

Abstract: This paper describes the development of a methodology for the case-mix adjustment of patient-reported outcome measures (PROMs) data permitting the comparison of outcomes between providers on a like-for-like basis. Statistical models that take account of provider-specific effects form the basis of the proposed case-mix adjustment methodology. Indirect standardisation provides a transparent means of case mix adjusting the PROMs data, which are updated on a monthly basis. Recently published PROMs data for patients undergoing unilateral knee replacement are used to estimate empirical models and to demonstrate the application of the proposed case-mix adjustment methodology in practice. The results are illustrative and are used to highlight a number of theoretical and empirical issues that warrant further exploration. For example, because of differences between PROMs instruments, case-mix adjustment methodologies may require instrument-specific approaches. A number of key assumptions are made in estimating the empirical models, which could be open to challenge. The covariates of post-operative health status could be expanded, and alternative econometric methods could be employed. (c) 2013 Crown copyright.

**Whittaker A., Chee H.L. (2015). Perceptions of an 'international hospital' in Thailand by medical travel patients: Cross-cultural tensions in a transnational space. *Soc Sci Med*, 124 290-297.**

Abstract: The growing trade in patients seeking health care in other countries, or medical travel, is changing the forms and experiences of health care seeking and producing changes to hospitals in terms of their design, organization and spaces. What is termed in marketing parlance in Thailand as an 'international hospital' oriented to attracting foreign patients, is a hotel-hospital hybrid that is locally produced through the inflexion of local practices to make a therapeutic space for international patients. The paper reports on work undertaken within a Thai hospital in 2012 which included observations and interviews with thirty foreign in-patients and nine informal interviews with hospital staff. Although theorized as a culturally neutral transnational 'space of connectivity', we show how cross-cultural tensions affect the experience of the hospital with implications for the organization of the hospital and notions of 'cultural competence' in care. There is no single universal experience of this space, instead, there are multiple experiences of the 'international hospital', depending on who patients are, where they are from, their expectations and relationships. Such hospitals straddle the expectations of both local patients and international clientele and present highly complex cross-cultural interactions between staff and patients but also between patients and other patients. Spatial organisation within such settings may either highlight cultural difference or help create culturally safe spaces.

**Dor A., Encinosa W.E., Carey K. (2015). Medicare's Hospital Compare Quality Reports Appear To Have Slowed Price Increases For Two Major Procedures. *Health Aff.(Millwood.)*, 34 (1) : 71-77.**

Abstract: Previous research has found that Hospital Compare, Medicare's public reporting initiative, has had little impact on patient outcomes. However, little is known about the initiative's impact on hospital prices, which may be significant because private insurers are generally well positioned to respond to quality information when negotiating prices with hospitals. We estimated difference-in-differences models of the effects of Hospital Compare quality reporting on transaction prices for two major cardiac procedures, coronary artery bypass graft (CABG) and percutaneous coronary intervention (PCI). States that had mandated their own public reporting systems before the implementation of Hospital Compare formed the control group. We found that prices for these procedures continued to increase overall after the initiation of Hospital Compare quality scores, but

the rate of increase was significantly lower in states with no quality reporting metrics of their own before Hospital Compare, when compared to the control states (annual rates of increase of 4.4 percent versus 8.7 percent for PCI, and 3.9 percent versus 10.6 percent for CABG, adjusted for overall inflation). This finding implies that Hospital Compare provided leverage to purchasers in moderating price increases, while adding competitive pressures on hospitals. Providing accurate quality information on both hospitals and health plans could benefit consumers.

## Inégalités de santé / Health Inequalities

**Coruble G., Sauze L., Riff H. (2014). Quelle stratégie peut développer une Agence régionale de santé pour réduire les inégalités sociales de santé ? *Santé Publique*, 26 (5) : 621-625.**

Abstract: La réduction des inégalités sociales de santé (ISS) est une priorité majeure pour l'Agence régionale de santé Provence Alpes Côte d'Azur (ARS Paca). Les actions et objectifs définis dans le projet régional de santé ont été répartis dans un tableau à double entrée (déterminants/politiques selon la population visée) afin de vérifier la cohérence et l'étendue de ces mesures. S'il apparaît ainsi que l'ARS est bien en mesure d'agir, seule ou en partenariat sur les déterminants des ISS et sur leurs effets, c'est sur trois niveaux d'intervention distincts : dans le champ de sa compétence propre, comme ressource pour d'autres acteurs, notamment en soutenant des recherches actions et enfin dans le cadre de démarches partenariales. Elle s'est ainsi notamment dotée d'outils de mesure et de suivi disponibles à une échelle fine et a soutenu l'élaboration d'un programme de formation continue adaptée, développée en e-learning avec ses partenaires en Paca et au Québec. Mais des efforts restent toujours nécessaires pour développer les actions sur les déterminants fondamentaux, notamment environnementaux et mieux implanter cette politique. Les objectifs de certains programmes territoriaux de santé qui visent à confier à des dispositifs locaux de soins primaires une responsabilité vis-à-vis de la population desservie sont très prometteurs.

**Mehdipanah R., Manzano A., Borrell C., Malmusi D., Rodriguez-Sanz M., Greenhalgh J., Muntaner C., Pawson R. (2015). Exploring complex causal pathways between urban renewal, health and health inequality using a theory-driven realist approach. *Soc Sci Med*, 124 266-274.**

Abstract: INTRODUCTION: Urban populations are growing and to accommodate these numbers, cities are becoming more involved in urban renewal programs to improve the physical, social and economic conditions in different areas. This paper explores some of the complexities surrounding the link between urban renewal, health and health inequalities using a theory-driven approach. METHODS: We focus on an urban renewal initiative implemented in Barcelona, the Neighbourhoods Law, targeting Barcelona's (Spain) most deprived neighbourhoods. We present evidence from two studies on the health evaluation of the Neighbourhoods Law, while drawing from recent urban renewal literature, to follow a four-step process to develop a program theory. We then use two specific urban renewal interventions, the construction of a large central plaza and the repair of streets and sidewalks, to further examine this link. DISCUSSION: In order for urban renewal programs to affect health and health inequality, neighbours must use and adapt to the changes produced by the intervention. However, there exist barriers that can result in negative outcomes including factors such as accessibility, safety and security. CONCLUSION: This paper provides a different perspective to the field that is largely dominated by traditional quantitative studies that are not always able to address the complexities such interventions provide. Furthermore, the framework and discussions serve as a guide for future research, policy development and evaluation.

## Médicaments / Pharmaceuticals

**Costa-Font J., McGuire A., Varol N. (2014). Price regulation and relative delays in generic drug adoption. *J Health Econ*, 38 1-9.**

Abstract: Increasing the adoption of generic drugs has the potential to improve static efficiency in a health system without harming pharmaceutical innovation. However, very little is known about the timing of generic adoption and diffusion. No prior study has empirically examined the differential launch times of generics across a comprehensive set of markets, or more specifically the delays in country specific adoption of generics relative to the first country of (generic) adoption. Drawing on data containing significant country and product variation across a lengthy time period (1999-2008), we use duration analysis to examine relative delays, across countries, in the adoption of generic drugs. Our results suggest that price regulation has a significant effect on reducing the time to launch of generics, with faster adoption in higher priced markets. The latter result is dependent on the degree of competition and the expected market size.

**Richardson K., Bennett K., Kenny R.A. (2015). Polypharmacy including falls risk-increasing medications and subsequent falls in community-dwelling middle-aged and older adults. *Age and Ageing*, 44 (1) : 90-96.**

Abstract: Background: polypharmacy is an important risk factor for falls, but recent studies suggest only when including medications associated with increasing the risk of falls. Design: a prospective, population-based cohort study. Subjects: 6,666 adults aged  $\geq 50$  years from The Irish Longitudinal study on Ageing. Methods: participants reported regular medication use at baseline. Any subsequent falls, any injurious falls and the number of falls were reported 2 years later. The association between polypharmacy ( $>4$  medications) or fall risk-increasing medications and subsequent falls or injurious falls was assessed using modified Poisson regression. The association with the number of falls was assessed using negative binomial regression. Results: during follow-up, 231 falls per 1,000 person-years were reported. Polypharmacy including antidepressants was associated with a greater risk of any fall (adjusted relative risk (aRR) 1.28, 95% CI 1.06-1.54), of injurious falls (aRR 1.51, 95% CI 1.10-2.07) and a greater number of falls (adjusted incident rate ratio (aIRR) 1.60, 95% CI 1.19-2.15), but antidepressant use without polypharmacy and polypharmacy without antidepressants were not. The use of benzodiazepines was associated with injurious falls when coupled with polypharmacy (aRR 1.40, 95% CI 1.04-1.87), but was associated with a greater number of falls (aIRR 1.32, 95% CI 1.05-1.65), independent of polypharmacy. Other medications assessed, including antihypertensives, diuretics and antipsychotics, were not associated with outcomes. Conclusion: in middle-aged and older adults, polypharmacy, including antidepressant or benzodiazepine use, was associated with injurious falls and a greater number of falls.

<http://ageing.oxfordjournals.org/content/44/1/90.abstract>

**Ferrario A., Kanavos P. (2015). Dealing with uncertainty and high prices of new medicines: A comparative analysis of the use of managed entry agreements in Belgium, England, the Netherlands and Sweden. *Soc Sci Med*, 124 39-47.**

Abstract: Managed entry agreements are a set of instruments used to reduce the impact of uncertainty and high prices when introducing new medicines. This study develops a conceptual framework for these agreements and tests it by exploring variations in their implementation in Belgium, England, the Netherlands and Sweden and over time as well as their governance structures. Using publicly available data from HTA agencies and survey data from the European Medicines Information Network, a database of agreements implemented between 2003 and 2012 was

developed. A review of governance structures was also undertaken. In December 2012 there were 133 active MEAs for different medicine-indications across the four countries. These corresponded to 110 unique medicine-indications. Over time there has been a steady growth in the number of agreements implemented, with the highest number in the Netherlands in 2012. The number of new agreements introduced each year followed a different pattern. In Belgium and England it increased over time, while it decreased in the Netherlands and fluctuated in Sweden. Only 18 (16%) of the unique medicine-indication pairs identified were part of an agreement in two or more countries. England uses mainly discounts and free doses to influence prices. The Netherlands and Sweden have focused more on addressing uncertainties through coverage with evidence development and, in Sweden, on monitoring use and compliance with restrictions through registries. Belgium uses a combination of the above. Despite similar reasons being cited for managed entry agreements implementation, only in a minority of cases have countries implemented an agreement for the same medicine-indication; when they do, a different agreement type is often implemented. Differences in governance across countries partly explain such variations. However, more research is needed to understand whether e.g. risk-perception and/or notion of what constitutes a high price differ between these countries.

## Méthodologie – Statistique / Methodology – Statistics

**Zaugg V., Savoldelli V., Sabatier P., Durieux B. (2014). Améliorer les pratiques et l'organisation des soins : méthodologie des revues systématiques. *Santé Publique*, 26 (5) : 655-667.**

Abstract: Le nombre d'études d'interventions visant à améliorer la qualité des soins est en constante augmentation, si bien qu'il est difficile d'accéder à toute l'information disponible sur un sujet. La revue systématique est un outil permettant de fournir rapidement une information exhaustive et objective aux professionnels de la santé. Cet article a pour objectif de détailler les étapes de la réalisation d'une revue systématique : définition de la question de recherche, recherche et sélection des études, extraction et analyse des données, évaluation de la qualité méthodologique des études, synthèse des résultats. Les interventions destinées à améliorer les pratiques et l'organisation des soins présentent certaines spécificités qui conditionnent la méthodologie de la revue systématique. Il faut par exemple prendre en compte la variabilité importante qui existe souvent entre les populations, les organisations et les interventions d'une étude à l'autre, ce qui rend difficile la synthèse des résultats sous forme de métaanalyse. La connaissance des particularités des revues systématiques d'interventions est indispensable, que ce soit pour réaliser une synthèse de la littérature de qualité, ou pour évaluer le niveau de preuve d'une revue systématique publiée.

**Ryan A.M., Burgess J.F., Jr., Dimick J.B. (2014). Why We Should Not Be Indifferent to Specification Choices for Difference-in-Differences. *Health Serv Res*, [Epub ahead of print]**

Abstract: OBJECTIVE: To evaluate the effects of specification choices on the accuracy of estimates in difference-in-differences (DID) models. DATA SOURCES: Process-of-care quality data from Hospital Compare between 2003 and 2009. STUDY DESIGN: We performed a Monte Carlo simulation experiment to estimate the effect of an imaginary policy on quality. The experiment was performed for three different scenarios in which the probability of treatment was (1) unrelated to pre-intervention performance; (2) positively correlated with pre-intervention levels of performance; and (3) positively correlated with pre-intervention trends in performance. We estimated alternative DID models that varied with respect to the choice of data intervals, the comparison group, and the method of obtaining inference. We assessed estimator bias as the mean absolute deviation between

estimated program effects and their true value. We evaluated the accuracy of inferences through statistical power and rates of false rejection of the null hypothesis. **PRINCIPAL FINDINGS:** Performance of alternative specifications varied dramatically when the probability of treatment was correlated with pre-intervention levels or trends. In these cases, propensity score matching resulted in much more accurate point estimates. The use of permutation tests resulted in lower false rejection rates for the highly biased estimators, but the use of clustered standard errors resulted in slightly lower false rejection rates for the matching estimators. **CONCLUSIONS:** When treatment and comparison groups differed on pre-intervention levels or trends, our results supported specifications for DID models that include matching for more accurate point estimates and models using clustered standard errors or permutation tests for better inference. Based on our findings, we propose a checklist for DID analysis

**Bilger M., Manning W.G. (2015). Measuring overfitting in nonlinear models: a new method and an application to health expenditures. *Health Econ*, 24 (1) : 75-85.**

**Abstract:** When fitting an econometric model, it is well known that we pick up part of the idiosyncratic characteristics of the data along with the systematic relationship between dependent and explanatory variables. This phenomenon is known as overfitting and generally occurs when a model is excessively complex relative to the amount of data available. Overfitting is a major threat to regression analysis in terms of both inference and prediction. We start by showing that the Copas measure becomes confounded by shrinkage or expansion arising from in-sample bias when applied to the untransformed scale of nonlinear models, which is typically the scale of interest when assessing behaviors or analyzing policies. We then propose a new measure of overfitting that is both expressed on the scale of interest and immune to this problem. We also show how to measure the respective contributions of in-sample bias and overfitting to the overall predictive bias when applying an estimated model to new data. We finally illustrate the properties of our new measure through both a simulation study and a real-data illustration based on inpatient healthcare expenditure data, which shows that the distinctions can be important. Copyright (c) 2013 John Wiley & Sons, Ltd.

**Bihrmann K., Ersboll A.K. (2015). Estimating range of influence in case of missing spatial data: a simulation study on binary data. *Int J Health Geogr.*, 14 (1) : 1.**

**Abstract:** **BACKGROUND:** The range of influence refers to the average distance between locations at which the observed outcome is no longer correlated. In many studies, missing data occur and a popular tool for handling missing data is multiple imputation. The objective of this study was to investigate how the estimated range of influence is affected when 1) the outcome is only observed at some of a given set of locations, and multiple imputation is used to impute the outcome at the non-observed locations. **METHODS:** The study was based on the simulation of missing outcomes in a complete data set. The range of influence was estimated from a logistic regression model with a spatially structured random effect, modelled by a Gaussian field. Results were evaluated by comparing estimates obtained from complete, missing, and imputed data. **RESULTS:** In most simulation scenarios, the range estimates were consistent with inverted question mark 25% missing data. In some scenarios, however, the range estimate was affected by even a moderate number of missing observations. Multiple imputation provided a potential improvement in the range estimate with inverted question mark 50% missing data, but also increased the uncertainty of the estimate. **CONCLUSIONS:** The effect of missing observations on the estimated range of influence depended to some extent on the missing data mechanism. In general, the overall effect of missing observations was small compared to the uncertainty of the range estimate.

**Davis R.H., Valadez J.J. (2014). Improving the collection of knowledge, attitude and practice data with community surveys: a comparison of two second-stage sampling methods. *Health Policy Plan*, 29 (8) : 1054-1060.**



**Abstract:** BACKGROUND: Second-stage sampling techniques, including spatial segmentation, are widely used in community health surveys when reliable household sampling frames are not available. In India, an unresearched technique for household selection is used in eight states, which samples the house with the last marriage or birth as the starting point. Users question whether this last-birth or last-marriage (LBLM) approach introduces bias affecting survey results. METHODS: We conducted two simultaneous population-based surveys. One used segmentation sampling; the other used LBLM. LBLM sampling required modification before assessment was possible and a more systematic approach was tested using last birth only. We compared coverage proportions produced by the two independent samples for six malaria indicators and demographic variables (education, wealth and caste). We then measured the level of agreement between the caste of the selected participant and the caste of the health worker making the selection. RESULTS: No significant difference between methods was found for the point estimates of six malaria indicators, education, caste or wealth of the survey participants (range of P: 0.06 to >0.99). A poor level of agreement occurred between the caste of the health worker used in household selection and the caste of the final participant, (Kappa = 0.185), revealing little association between the two, and thereby indicating that caste was not a source of bias. CONCLUSIONS: Although LBLM was not testable, a systematic last-birth approach was tested. If documented concerns of last-birth sampling are addressed, this new method could offer an acceptable alternative to segmentation in India. However, inter-state caste variation could affect this result. Therefore, additional assessment of last birth is required before wider implementation is recommended.

## Politique de santé / Health Policy

**Ogden J., Morrison K., Hardee K. (2014). Social capital to strengthen health policy and health systems. *Health Policy Plan*, 29 (8) : 1075-1085.**

**Abstract:** This article recounts the development of a model for social capital building developed over the course of interventions focused on HIV-related stigma and discrimination, safe motherhood and reproductive health. Through further engagement with relevant literature, it explores the nature of social capital and suggests why undertaking such a process can enhance health policy and programmes, advocacy and governance for improved health systems strengthening (HSS) outcomes. The social capital process proposed facilitates the systematic and effective inclusion of community voices in the health policy process-strengthening programme effectiveness as well as health system accountability and governance. Because social capital building facilitates communication and the uptake of new ideas, norms and standards within and between professional communities of practice, it can provide an important mechanism for integration both within and between sectors-a process long considered a 'wicked problem' for health policy-makers. The article argues that the systematic application of social capital building, from bonding through bridging into linking social capital, can greatly enhance the ability of governments and their partners to achieve their HSS goals.

**Anell A. (2015). The public-private pendulum--patient choice and equity in Sweden. *N Engl J Med*, 372 (1) : 1-4.**

**Féry-Lemonnier E., Monnet E., Prisse N. (2014). Parcours de santé : enjeux et perspectives. Dossier. *Actualité et Dossier en Santé Publique*, (88) : 11-56.**

**Bouvet S., Daurès J.P., Landais P., Castelli C. (2015). Valorisation d'un parcours de soins : entre difficultés et alternatives. *Journal de Gestion et d'Economie Médicales*, 32 (4) : 280-290.**

Abstract: L'évolution démographique, les maladies chroniques en constante augmentation, l'organisation sous-optimale de la prise en charge des patients ont conduit à une hausse substantielle des dépenses de santé. Le système de santé doit nécessairement s'adapter pour prendre en compte ces évolutions dans un contexte de budget contraint. Une des réformes consiste en la nécessité de mettre en place un parcours de soins organisé et coordonné autour du médecin traitant qui orientera le patient vers un parcours efficient, limitant ainsi la surconsommation de soins inutiles. Le sujet fait débat sur son périmètre, son contenu et ses modalités organisationnelles. L'objectif de ce travail est de proposer une méthodologie permettant de définir une tarification par parcours comme outil de régulation. Pour cela, en introduction nous revenons sur le contexte français et international du parcours de soins. Une réflexion autour du périmètre et du contenu de celui-ci est ensuite proposée afin d'en estimer le coût puis d'établir une tarification par parcours. Un exemple de modélisation du parcours de soins dans le cas du diagnostic du cancer de la prostate est présenté à titre illustratif.

## Soins de santé primaires / Primary Health Care

**Peek M.E., Drum M., Cooper L.A. (2014). The Association of Patient Chronic Disease Burden and Self-Management Requirements With Shared Decision Making in Primary Care Visits. *Health Services Research and Managerial Epidemiology*, 1**

Abstract: Background: Shared decision making (SDM) is associated with positive health outcomes and may be particularly relevant for patients with chronic disease. Objectives: To investigate whether (1) patients with chronic diseases, particularly those requiring self-management, are more likely to engage in SDM behaviors than patients without chronic diseases and (2) patients with chronic diseases are more likely to have their physicians engage them in SDM. Design: A cross-sectional study of patients who were enrolled in a randomized controlled trial to improve patient-physician communication. Participants: Adult patients with hypertension at community health clinics in Baltimore, Maryland. Approach: We used multivariable regression models to examine the associations of the following predictor variables: (1) chronic disease burden and (2) diseases requiring self-management with the following outcome variables measuring SDM components: (1) patient information sharing, (2) patient decision making, and (3) physician SDM facilitation. Key Results: Patients with greater chronic disease burden and more diseases requiring self-management reported more information sharing ( $\beta = .07$ ,  $P = .03$  and  $\beta = .12$ ,  $P = .046$ , respectively) and decision making ( $\beta = .06$ ,  $P = .02$  and  $\beta = .21$ ,  $P < .001$ ) as did patients who reported poor general health. Physician facilitation of SDM was not associated with chronic disease burden or with diseases requiring self-management but was associated with higher patient income. Conclusions: Patients with chronic diseases, particularly those requiring self-management, may be more likely to engage in SDM behaviors, but physicians may not be more likely to engage such patients in SDM. Targeting patients with chronic disease for SDM may improve health outcomes among the chronically ill, particularly among vulnerable patients (eg, minorities, low-income patients) who suffer disproportionately from such conditions.

<http://hme.sagepub.com/content/1/2333392814538775.abstract>

**Mays N., Tan S., Eastmure E., Erens B., Lagarde M., Wright M. (2014). Potential impact of removing general practice boundaries in England: A policy analysis. *Health Policy*, 118 (3) : 273-278.**

Abstract: In 2015, the UK government plans to widen patient choice of general practitioner (GP) to improve access through the voluntary removal of practice boundaries in the English NHS. This follows

a 12-month pilot in four areas where volunteer GP practices accepted patients from outside their boundaries. Using evidence from the pilot evaluation, we discuss the likely impact of this policy change on patient experience, responsiveness and equity of access. Patients reported positive experiences but in a brief pilot in four areas, it was not possible to assess potential demand, the impact on quality of care or health outcomes. In the rollout, policymakers and commissioners will need to balance the access needs of local residents against the demands of those coming into the area. The rollout should include full information for prospective patients; monitoring and understanding patterns of patient movement between practices and impact on practice capacity; and ensuring the timely transfer of clinical information between providers. This policy has the potential to improve choice and convenience for a sub-group of the population at lower marginal costs than new provision. However, there are simpler, less costly, ways of improving convenience, such as extending opening hours or offering alternatives to face-to-face consultation.

**Tan S., Mays N. (2014). Impact of initiatives to improve access to, and choice of, primary and urgent care in the England: A systematic review.** *Health Policy*, 118 (3) : 304-315.

Abstract: BACKGROUND: There were ten initiatives in the primary and urgent care system in the English NHS during the New Labour government, 1997-2010, aimed at delivering higher quality, more accessible and responsive care by expanding access, increasing convenience and introducing greater patient choice of provider. We examine their impact on demand, equity, patient satisfaction, referrals, and costs. METHODS: Studies were systematically identified through electronic databases and reference lists of publications. Studies of all designs were included if published between 1997 and 2013, and with empirical data on the impacts above. RESULTS: Nineteen studies of ten initiatives were included. Innovations often overlapped, complicating care. There was some demand for new provision on grounds of convenience, but little evidence of substitution between services. Patient satisfaction varied across schemes. There was little evidence on the costs and benefits of new versus existing provision. CONCLUSION: New services generated a more complex system where new and existing providers delivered overlapping services. The new provision did not induce substitution and was likely to have increased overall demand. Initiatives to improve access to existing provision may have greater potential to improve access and convenience at lower marginal costs than developing new forms of provision.

**Chokshi D.A., Rugge J., Shah N.R. (2014). Redesigning the regulatory framework for ambulatory care services in New York.** *Milbank Q*, 92 (4) : 776-795.

Abstract: Policy Points: The landscape of ambulatory care services in the United States is rapidly changing on account of payment reform, primary care transformation, and the rise of convenient care options such as retail clinics. New York State has undertaken a redesign of regulatory policy for ambulatory care rooted in the Triple Aim (better health, higher-quality care, lower costs)-with a particular emphasis on continuity of care for patients. Key tenets of the regulatory approach include defining and tracking the taxonomy of ambulatory care services as well as ensuring that convenient care options do not erode continuity of care for patients. CONTEXT: While hospitals remain important centers of gravity in the health system, services are increasingly being delivered through ambulatory care. This shift to ambulatory care is giving rise to new delivery structures, such as retail clinics and urgent care centers, as well as reinventing existing ambulatory care capacity, as seen with the patient-centered medical home model and the movement toward team-based care. To protect the public's interests, oversight of ambulatory care services must keep pace with these rapid changes. With this purpose, in January 2013 the New York Public Health and Health Planning Council undertook a redesign of the regulatory framework for the state's ambulatory care services. This article describes the principles undergirding the framework as well as the regulatory recommendations themselves. METHODS: We explored and analyzed the regulation of ambulatory

care services in New York in accordance with the available gray and peer-reviewed literature and legislative documents. The deliberations of the Public Health and Health Planning Council informed our review. FINDINGS: The vision of high-performing ambulatory care should be rooted in the Triple Aim (better health, higher-quality care, lower costs), with a particular emphasis on continuity of care for patients. There is a pressing need to better define the taxonomy of ambulatory care services. From the state government's perspective, this clarification requires better reporting from new health care entities (eg, retail clinics), connections with regional and state health information technology hubs, and coordination among state agencies. A uniform nomenclature also would improve consumers' understanding of rights and responsibilities. Finally, the regulatory mechanisms employed—from mandatory reporting to licensure to regional planning to the certificate of need—should remain flexible and match the degree of consensus regarding the appropriate regulatory path. CONCLUSIONS: Few other states have embarked on a wide-ranging assessment of their regulation of ambulatory care services. By moving toward adopting the regulatory approach described here, New York aims to balance sound oversight with pluralism and innovation in health care delivery.

**Kash B.A., Zhang Y., Cline K.M., Menser T., Miller T.R. (2014). The Perioperative Surgical Home (PSH): A Comprehensive Review of US and Non-US Studies Shows Predominantly Positive Quality and Cost Outcomes. *Milbank Q*, 92 (4) : 796-821.**

Abstract: Policy Points: The perioperative surgical home (PSH) is complementary to the patient-centered medical home (PCMH) and defines methods for improving the patient experience and clinical outcomes, and controlling costs for the care of surgical patients. The PSH is a physician-led care delivery model that includes multi-specialty care teams and cost-efficient use of resources at all levels through a patient-centered, continuity of care delivery model with shared decision making. The PSH emphasizes "prehabilitation" of the patient before surgery, intraoperative optimization, improved return to function through follow-up, and effective transitions to home or post-acute care to reduce complications and readmissions. CONTEXT: The evolving concept of more rigorously coordinated and integrated perioperative management, often referred to as the perioperative surgical home (PSH), parallels the well-known concept of a patient-centered medical home (PCMH), as they share a vision of improved clinical outcomes and reductions in cost of care through patient engagement and care coordination. Elements of the PSH and similar surgical care coordination models have been studied in the United States and other countries. METHODS: This comprehensive review of peer-reviewed literature investigates the history and evolution of PSH and PSH-like models and summarizes the results of studies of PSH elements in the United States and in other countries. We reviewed more than 250 potentially relevant studies. At the conclusion of the selection process, our search had yielded a total of 152 peer-reviewed articles published between 1980 and 2013. FINDINGS: The literature reports consistent and significant positive findings related to PSH initiatives. Both US and non-US studies stress the role of anesthesiologists in perioperative patient management. The PSH may have the greatest impact on preparing patients for surgery and ensuring their safe and effective transition to home or other postoperative rehabilitation. There appear to be some subtle differences between US and non-US research on the PSH. The literature in non-US settings seems to focus strictly on the comparison of outcomes from changing policies or practices, whereas US research seems to be more focused on the discovery of innovative practice models and other less direct changes, for example, information technology, that may be contributing to the evolution toward the PSH model. CONCLUSIONS: The PSH model may have significant implications for policymakers, payers, administrators, clinicians, and patients. The potential for policy-relevant cost savings and quality improvement is apparent across the perioperative continuum of care, especially for integrated care organizations, bundled payment, and value-based purchasing.

**Ward B.M., Buykx P.F., Tham R., Kinsman L., Humphreys J.S. (2014). Investing in longitudinal studies of primary healthcare: what can we learn about service performance, sustainability and quality? *Rural Remote Health*, 14 (4) : 3059.**

**Zhao Y., Thomas S.L., Guthridge S.L., Wakerman J. (2014). Better health outcomes at lower costs: the benefits of primary care utilisation for chronic disease management in remote Indigenous communities in Australia's Northern Territory. *BMC Health Serv Res*, 14 463.**

Abstract: BACKGROUND: Indigenous residents living in remote communities in Australia's Northern Territory experience higher rates of preventable chronic disease and have poorer access to appropriate health services compared to other Australians. This study compared health outcomes and costs at different levels of primary care utilisation to determine if primary care represents an efficient use of resources for Indigenous patients with common chronic diseases namely hypertension, diabetes, ischaemic heart disease, chronic obstructive pulmonary disease and renal disease. METHODS: This was an historical cohort study involving a total of 14,184 Indigenous residents, aged 15 years and over, who lived in remote communities and used a remote clinic or public hospital from 2002 to 2011. Individual level demographic and clinical data were drawn from primary care and hospital care information systems using a unique patient identifier. A propensity score was used to improve comparability between high, medium and low primary care utilisation groups. Incremental cost-effectiveness ratios and acceptability curves were used to analyse four health outcome measures: total and, avoidable hospital admissions, deaths and years of life lost. RESULTS: Compared to the low utilisation group, medium and high levels of primary care utilisation were associated with decreases in total and avoidable hospitalisations, deaths and years of life lost. Higher levels of primary care utilisation for renal disease reduced avoidable hospitalisations by 82-85%, deaths 72-75%, and years of life lost 78-81%. For patients with ischaemic heart disease, the reduction in avoidable hospitalisations was 63-78%, deaths 63-66% and years of life lost 69-73%. In terms of cost-effectiveness, primary care for renal disease and diabetes ranked as more cost-effective, followed by hypertension and ischaemic heart disease. Primary care for chronic obstructive pulmonary disease was the least cost-effective of the five conditions. CONCLUSION: Primary care in remote Indigenous communities was shown to be associated with cost-savings to public hospitals and health benefits to individual patients. Investing \$1 in primary care in remote Indigenous communities could save \$3.95-\$11.75 in hospital costs, in addition to health benefits for individual patients. These findings may have wider applicability in strengthening primary care in the face of high chronic disease prevalence globally.

**Mace S, Wolff F.C. (2015). Les médecins grands et beaux sont-ils plus souvent perçus comme de "grands médecins" ? *Journal de Gestion et d'Economie Médicales*, 32 (4) : 245-262.**

Abstract: Objectif : Examiner dans quelle mesure les caractéristiques physiques telles que la taille, la corpulence et l'apparence physique des médecins traitants sont corrélées à la confiance que leur portent leurs patients, le degré auquel ils suivent leur prescription et l'évaluation qu'ils font de leur compétence. Méthode : Enquête par questionnaire auprès de 1161 jeunes adultes (âge moyen = 20,1 ans). Résultats : La confiance des patients, le degré auquel ils suivent leurs prescriptions et la compétence qu'ils attribuent à leur médecin traitant sont corrélés positivement avec sa taille et sa beauté physique, mais négativement avec son âge et sa corpulence. Le sexe du médecin n'a pas d'incidence sur le jugement.

**Rudoler D., Laporte A., Barnsley J., Glazier R.H., Deber R.B. (2015). Paying for primary care: A cross-sectional analysis of cost and morbidity distributions across primary care payment models in Ontario Canada. *Soc Sci Med*, 124 18-28.**

Abstract: Policy-makers desire an optimal balance of financial incentives to improve productivity and encourage improved quality in primary care, while also avoiding issues of risk-selection inherent to capitation-based payment. In this paper we analyze risk-selection in capitation-based payment by using administrative data for patients (n = 11,600,911) who were rostered (i.e., signed an enrollment form, or received a majority of care) with a primary care physician (n = 8621) in Ontario, Canada in 2010/11. We analyze this data using a relative distribution approach and compare distributions of patient costs and morbidity across primary care payment models. Our results suggest a relationship between being in a capitation-based payment scheme and having low cost patients (and presumably healthy patients) compared to fee-for-service physicians. However, we do not have evidence that physicians in capitation-based models are reducing the care they provide to sick and high cost patients. These findings suggest there is a relationship between payment type and risk-selection, particularly for low-cost and healthy patients.

**Janssen B.M., Snoeren M.W., Van R.T., Abma T.A. (2015). Working towards integrated community care for older people: Empowering organisational features from a professional perspective. *Health Policy*, 119 (1) : 1-8.**

Abstract: Although multi-disciplinary cooperation between professionals is a prerequisite to provide integrated care in the community, this seems hard to realise in practice. Yet, little is known about the experiences of professionals who implement it nor about the organisational features professionals identify as empowering during this cooperation process. Therefore, a case study of a multi-disciplinary geriatric team was performed. The data-collection included observations of meetings, in-depth interviews and focus groups with professionals (N=12). Data were analysed inductively and related to the three organisational levels within the model of organisational empowerment of Peterson and Zimmerman. Signs of empowering organisational features on the intraorganisational level were mutual trust and clear working routines. On the interorganisational level important features included improved linkages between participating organisations and increased insight into each other's tasks. Tensions occurred relating to the inter- and the extraorganisational level. Professionals felt that the commitment of the management of involved organisations should be improved just as the capacity of the team to influence (local) policy. It is recommended that policymakers should not determine the nature of professional cooperation in advance, but to leave that to the local context as well as to the judgement of involved professionals.

**Wiley J.A., Rittenhouse D.R., Shortell S.M., Casalino L.P., Ramsay P.P., Bibi S., Ryan A.M., Copeland K.R., Alexander J.A. (2015). Managing chronic illness: physician practices increased the use of care management and medical home processes. *Health Aff.(Millwood.)*, 34 (1) : 78-86.**

Abstract: The effective management of patients with chronic illnesses is critical to bending the curve of health care spending in the United States and is a crucial test for health care reform. In this article we used data from three national surveys of physician practices between 2006 and 2013 to determine the extent to which practices of all sizes have increased their use of evidence-based care management processes associated with patient-centered medical homes for patients with asthma, congestive heart failure, depression, and diabetes. We found relatively large increases over time in the overall use of these processes for small and medium-size practices as well as for large practices. However, the large practices used fewer than half of the recommended processes, on average. We also identified the individual processes whose use increased the most and show that greater use of care management processes is positively associated with public reporting of patient experience and clinical quality and with pay-for-performance.

**Damberg C.L., Elliott M.N., Ewing B.A. (2015). Pay-for-performance schemes that use patient and provider categories would reduce payment disparities. *Health Aff.(Millwood.)*, 34 (1) : 134-142.**

Abstract: Providers that care for disproportionate numbers of disadvantaged patients tend to perform less well than other providers on quality measures commonly used in pay-for-performance programs. This can lead to the undesired effect of redistributing resources away from providers that most need them to improve care. We present a new pay-for-performance scheme that retains the motivational aspects of standard incentive designs while avoiding undesired effects. We tested an alternative incentive payment approach that started with a standard incentive payment allocation but then "post-adjusted" provider payments using predefined patient or provider characteristics. We evaluated whether such an approach would mitigate the negative effects of redistributions of payments across provider organizations in California with disparate patient populations. The post-adjustment approach nearly doubled payments to disadvantaged provider organizations and greatly reduced payment differentials across provider organizations according to patients' income, race/ethnicity, and region. The post-adjustment of payments could be a useful supplement to paying for improvement, aligning the goals of disparity reduction and quality improvement.

**Hoffman G. (2015). Cost-sharing, physician utilization, and adverse selection among medicare beneficiaries with chronic health conditions. *Med Care Res Rev*, 72 (1) : 49-70.**

Abstract: Pooled data from the 2007, 2009, and 2011/2012 California Health Interview Surveys were used to compare the number of self-reported annual physician visits among 36,808 Medicare beneficiaries  $\geq 65$  in insurance groups with differential cost-sharing. Adjusted for adverse selection and a set of health covariates, Medicare fee-for-service (FFS) only beneficiaries had similar physician utilization compared with HMO enrollees but fewer visits compared with those with supplemental (1.04,  $p = .001$ ) and Medicaid (1.55,  $p = .003$ ) coverage. FFS only beneficiaries in very good or excellent health had fewer visits compared with those of similar health status with supplemental (1.30,  $p = .001$ ) or Medicaid coverage (2.15,  $p = .002$ ). For subpopulations with several chronic conditions, FFS only beneficiaries also had fewer visits compared with beneficiaries with supplemental or Medicaid coverage. Observed differences in utilization may reflect efficient and necessary physician utilization among those with chronic health needs.

**Trybou J., De R.M., Gemmel P., Duyck P., Annemans L. (2014). Effects of physician-owned specialized facilities in health care: A systematic review. *Health Policy*, 118 (3) : 316-340.**

Abstract: BACKGROUND: Multiple studies have investigated physician-owned specialized facilities (specialized hospitals and ambulatory surgery centres). However, the evidence is fragmented and the literature lacks cohesion. OBJECTIVES: To provide a comprehensive overview of the effects of physician-owned specialized facilities by synthesizing the findings of published empirical studies. METHODS: Two reviewers independently researched relevant studies using a standardized search strategy. The Institute of Medicine's quality framework (safe, effective, equitable, efficient, patient-centred, and accessible care) was applied in order to evaluate the performance of such facilities. In addition, the impact on the performance of full-service general hospitals was assessed. RESULTS: Forty-six studies were included in the systematic review. Overall, the quality of the included studies was satisfactory. Our results show that little evidence exists to confirm the advantages attributed to physician-owned specialized facilities, and their impact on full-service general hospitals remains limited. CONCLUSION: Although data is available on a wide variety of effects, the evidence base is surprisingly thin. There is no compelling evidence available demonstrating the added value of physician-owned specialized facilities in terms of quality or cost of the delivered care. More research is necessary on the relative merits of physician-owned specialized facilities. In addition, their corresponding impact on full-service general hospitals remains unclear. The development of physician-owned specialized facilities should thus be monitored carefully.

## Systemes de santé / Health Care Systems

**McClellan M., Kent J., Beales S.J., Cohen S.I., Macdonnell M., Thoumi A., Abdulmalik M., Darzi A. (2014). Accountable care around the world: a framework to guide reform strategies. *Health Aff.(Millwood.)*, 33 (9) : 1507-1515.**

Abstract: Accountable care--a way to align health care payments with patient-focused reform goals-- is currently being pursued in the United States, but its principles are also being applied in many other countries. In this article we review experiences with such reforms to offer a globally applicable definition of an accountable care system and propose a conceptual framework for characterizing and assessing accountable care reforms. The framework consists of five components: population, outcomes, metrics and learning, payments and incentives, and coordinated delivery. We describe how the framework applies to accountable care reforms that are already being implemented in Spain and Singapore. We also describe how it can be used to map progress through increasingly sophisticated levels of reforms. We recommend that policy makers pursuing accountable care reforms emphasize the following steps: highlight population health and wellness instead of just treating illness; pay for outcomes instead of activities; create a more favorable environment for collaboration and coordinated care; and promote interoperable data systems.

**Torbica A., Calciolari S., Fattore G. (2015). Does informal care impact utilization of healthcare services? Evidence from a longitudinal study of stroke patients. *Soc Sci Med*, 124 29-38.**

Abstract: Understanding the interplay between informal care and formal healthcare is important because it sheds light on the financial implications of such interactions and may result in different policies. On the basis of a major database on 532 Italian stroke patients enrolled in the period 2007-2008, we investigate whether the presence of a potential caregiver and the amount of informal care provided influences the use and the costs of healthcare services, and in particular rehabilitation, in the post-acute phase. Primary caregivers of stroke patients were interviewed at 3, 6 and 12 months after the acute event and use of healthcare and informal care were documented. The panel dataset included socio-demographic, clinical and economic data on patients and caregivers. A longitudinal log-linear model was applied to test the impact of informal care on total healthcare costs in the observation period. A double hurdle model was used to investigate the impact of informal care on rehabilitation costs. A total of 476 of stroke survivors in 44 hospitals were enrolled in the study and presence of informal caregiver was reported in approximately 50% of the sample (range 48.2-52.5% across the three periods). Healthcare costs at 12 months after the acute event are euro5825 per patient, with rehabilitation costs amounting to euro3985 (68.4%). Healthcare costs are significantly different between the patients with and without caregiver in all three periods. The presence of the caregiver is associated with 54.7% increase in direct healthcare costs ( $p < 0.01$ ). Instead, the amount of informal care provided does not influence significantly direct healthcare costs. The presence of caregiver significantly increases the probability of access to rehabilitation services ( $\beta = 0.648$ ,  $p = 0.039$ ) while, once the decision on access is made, it doesn't influence the amount of services used. Our results suggest that informal caregivers facilitate or even promote the access to healthcare services.

**Cervero-Liceras F., McKee M., Legido-Quigley H. (2015). The effects of the financial crisis and austerity measures on the Spanish health care system: A qualitative analysis of health professionals' perceptions in the region of Valencia. *Health Policy*, 119 (1) : 100-106.**



Abstract: The recent financial crisis has seen severe austerity measures imposed on the Spanish health care system. However, the impacts are not yet well documented. We describe the findings from a qualitative study that explored health care professionals' perception of the effects of austerity measures in the Spanish Autonomous Community of Valencia. A total of 21 semi-structured interviews were conducted with health professionals, recorded and fully transcribed. We coded all interviews using an inductive approach, drawing on techniques used in the constant comparative method. Health professionals reported increases in mental health conditions and malnutrition linked to a loss of income from employment and cuts to social support services. Health care professionals perceived that the quality of health care had become worse and health outcomes had deteriorated as a result of austerity measures. Interviewees also suggested that increased copayments meant that a growing number of patients could not afford necessary medication. While a few supported reforms and policies, such as the increase in copayments for pharmaceuticals, most opposed the privatization of health care facilities, and the newly introduced Royal Decree-law 16/2012, particularly the exclusion of non-residents from the health care system. The prevailing perception is that austerity measures are having negative effects on the quality of the health care system and population health. In light of this evidence there is an urgent need to evaluate the austerity measures recently introduced and to consider alternatives such as the derogation of the Royal Decree-law 16/2012.

## Vieillesse / Ageing

**Khaskhoussi T., Langot F. (2015). Réformer le système de retraite pour accroître l'emploi et la productivité des seniors. *Revue d'Economie Politique*, 124 (5) : 155-188.**

Abstract: Dans cet article, nous montrons qu'une courte distance à l'âge du taux plein est un facteur explicatif non seulement du faible retour en emploi des seniors mais également de leur faible investissement en formation. Ce point donne un nouveau rendement aux politiques incitatives de recul de l'âge de retraite : allonger l'horizon d'activité incite à mieux se former et cette revalorisation du travail accroît les gains de la reprise d'emploi. Un modèle de recherche d'emploi endogénéisant simultanément l'âge de départ à la retraite et les efforts d'investissement en capital humain donne des fondements théoriques à ces mécanismes alors que sa simulation, basée sur un étalonnage du cas français, montre que la contribution des plus de 55 ans dans la production totale passerait de 9,5 % à 16 %, avec une progression de plus de 10 % de la productivité individuelle sur ces tranches d'âge.

**Osborn R., Moulds D., Squires D., Doty M.M., Anderson C. (2014). International survey of older adults finds shortcomings in access, coordination, and patient-centered care. *Health Aff. (Millwood.)*, 33 (12) : 2247-2255.**

Abstract: Industrialized nations face the common challenge of caring for aging populations, with rising rates of chronic disease and disability. Our 2014 computer-assisted telephone survey of the health and care experiences among 15,617 adults age sixty-five or older in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States has found that US older adults were sicker than their counterparts abroad. Out-of-pocket expenses posed greater problems in the United States than elsewhere. Accessing primary care and avoiding the emergency department tended to be more difficult in the United States, Canada, and Sweden than in other surveyed countries. One-fifth or more of older adults reported receiving uncoordinated care in all countries except France. US respondents were among the most likely to have discussed health-promoting behaviors with a clinician, to have a chronic care plan

tailored to their daily life, and to have engaged in end-of-life care planning. Finally, in half of the countries, one-fifth or more of chronically ill adults were caregivers themselves.

**Callan A., O'Shea E. (2015). Willingness to pay for telecare programmes to support independent living: Results from a contingent valuation study. *Soc Sci Med*, 124 : 94-102.**

Abstract: An ageing population provokes an economic interest in the resource allocation questions posed by long-term care and critically, the development of sustainable community-based health and social care models that support independent living. This paper explores Irish citizens preferences and willingness to pay (WTP) for a range of community-based care programmes, including different telecare programmes that support older people to continue living at home. The paper reports on a cross-sectional multi-good contingent valuation survey conducted between April and September 2009 with three representative samples of the Irish population (N = 1214) to identify rankings and preferences for different community care programmes including: family care programme, a state-provided care programme and three different telecare programmes. The survey design permits the identification of strength, direction and relative preferences of different forms of community care provision. We also investigate convergent validity between ranking and willingness to pay results. We find that while people place significant value on formal state care provision and on telecare programmes, willingness to pay (WTP) estimates continue to highlight the importance of family care, which remains the strongest preference of the Irish population for the provision of community-based care for older people in the country. Respondents weakened their ranking preferences in the WTP exercise. However, both the direction of ranking and WTP estimates confirm the importance of family care. While all telecare programmes generated some economic value, telecare associated with social connection had much stronger support than telecare used to support physical or cognitive care needs. This paper offers unique information on societal values for different forms of community care provision, and in particular, the direction of preferences for technology-based approaches.

**Kalousova L., Mendes de L.C. (2015). Increase in frailty of older workers and retirees predicted by negative psychosocial working conditions on the job. *Soc Sci Med*, 124 : 275-283.**

Abstract: Well-established evidence has shown that negative psychosocial working conditions adversely affect the health and well-being of prime-age workers, yet little is known about the consequences on the health of older workers. Our article examines the associations between declines in health in later life, measured as frailty, and negative psychosocial working conditions, and considers the role of retirement. We use longitudinal cross-national data collected by SHARE I and SHARE IV and focus on the respondents who were working at baseline. We find that low reward, high effort, effort to reward ratio, and effort to control ratio were all predictors of increasing frailty. The association between low reward and change in frailty was modified by retirement status at follow-up, with nonretired respondents in low-reward jobs experiencing the largest increases in frailty at follow-up. These results suggest that the effect of psychosocial working conditions on physical health may extend well past the prime working age, and retirement may have a protective effect on the health of older workers in low reward jobs.

**Cornwell B., Laumann E.O. (2015). The health benefits of network growth: New evidence from a national survey of older adults. *Soc Sci Med*, 125: 94-106.**

Abstract: Scholars who study how social networks affect older adults' health are often concerned with the prospect of declining social connectedness in late life. This paper shifts the focus to older adults' tendencies to cultivate new social ties. This process of network growth can improve access to social resources, boost self-esteem, reduce loneliness, and increase physical activity. We therefore examine the link between tie cultivation and health using new longitudinal data from the National Social Life, Health, and Aging Project (NSHAP), which recorded changes in older adults' confidant

network rosters over a period of about five years. Most respondents (81.8%) added at least one new network member during the study period, and most (59.4%) cultivated multiple new confidant relationships. Longitudinal analyses suggest that the addition of new confidants is associated with improvements in functional, self-rated, and psychological health, net of baseline connectedness as well as any network losses that occurred during the same period. Network losses were associated with physical but not psychological well-being. These findings underscore the importance of distinguishing between concurrent processes that underlie social network change in later life, and highlight the need for additional research on the mechanisms by which network change may improve health.

**Ellwardt L., Van Tilburg T.G., Aartsen M.J. (2015). The mix matters: Complex personal networks relate to higher cognitive functioning in old age. *Soc Sci Med*, 125 107-115.**

Abstract: Stronger engagement of older adults in social activities and greater embeddedness in networks is often argued to buffer cognitive decline and lower risks of dementia. One of the explanations is that interaction with other people trains the brain, thereby enhancing cognitive functioning. However, research on the relationship between personal networks and cognitive functioning is not yet conclusive. While previous studies have focused on the size of personal networks as a proxy of cognitive stimulation, little attention has been paid to the complexity of the personal network. Adults embedded in a broad range of network relationships (i.e., various relationship types) are likely to be exposed to a wider range of stimuli than adults embedded in a homogeneous network including similar relationship types. We expect that higher numbers of personal relationship types rather than a higher number of similar contacts relate to higher levels of cognitive functioning and slower cognitive decline. Data are from the Longitudinal Aging Study Amsterdam (LASA) and include 2959 Dutch participants aged 54 to 85 at baseline in 1992 and six follow-ups covering a time span of twenty years. Cognitive functioning is assessed with the Mini-Mental State Examination (MMSE), and for network complexity we use the Social Network Index. We test our expectations using fixed-effects regression models. The results reveal that a reduction in network complexity is associated with a reduction in cognitive functioning, which is neither explained by size of the network nor by presence of specific relationship types. However, enhanced complexity has only a marginal buffering effect on decline in cognitive functioning. We conclude that network characteristics and cognitive functioning are intertwined and that their association is mostly cross-sectional in nature.

**Bindels J., Cox K., Abma T.A., van Schayck O.C., Widdershoven G. (2015). Implementing care programmes for frail older people: A project management perspective. *Health Policy*, 119 (1) : 9-6.**

Abstract: OBJECTIVE: To examine the issues that influenced the implementation of programmes designed to identify and support frail older people in the community in the Netherlands. METHODS: Qualitative research methods were used to investigate the perspectives of project leaders, project members and members of the steering committee responsible for the implementation of the programmes. Interviews were conducted in 2009 (n=10) and in 2012 (n=13) and a focus group was organised in 2012 (n=5). MAIN FINDINGS: The interviews revealed that the implementation was influenced by the extent and quality of collaboration between organisations, adaptation to existing structures, future funding for the programmes and project leadership. A good relationship between participating organisations and professionals is required for successful implementation. A lack of clear project leadership and structural funding hampers the implementation of complex programmes in primary care settings. IMPLICATIONS FOR PRACTICE: The findings of this study are useful for organisations and professionals who are planning to implement complex programmes. Identifying barriers concerning institutional collaboration, adaptation to existing structures, leadership and

continuation of financial support at an early stage of the implementation process can support practitioners in overcoming them.

**Schipper L., Luijkx K., Meijboom B., Schols J. (2015). The 3 A's of the access process to long-term care for elderly: Providers experiences in a multiple case study in the Netherlands.** *Health Policy*, 119 (1) : 17-25.

Abstract: The access process is an important step in the care provision to independently living elderly. Still, little attention has been given to the process of access to long-term care for older clients. Access can be described by three dimensions: availability, affordability and acceptability (three A's). In this paper we address the following question: How do care providers take the three dimensions of access into account for the access process to their care and related service provision to independently living elderly? To answer this question we performed a qualitative study. We used data gathered in a multiple case study in the Netherlands. This study provides insight in the way long-term care organizations organize their access process. Not all dimensions were equally present or acknowledged by the case organizations. The dimension acceptability seems an important dimension in the access process, as shown by the efforts done in building a relationship with their clients, mainly through a strong personal relationship between client and care advisor. In that respect it is remarkable that the case organizations do not structurally evaluate their access process. Availability is compromised by practical issues and organizational choices. Affordability hardly seems an issue. Further research can reveal the underlying factors that influence the three A dimensions.

**Philp I. (2015). The contribution of geriatric medicine to integrated care for older people.** *Age and Ageing*, 44 (1) : 11-15.

Abstract: Aims: to describe contribution of geriatric medicine to the development of integrated care for older people and to suggest future directions for the further development of integrated care for older people. Methods: literature review and case studies. Results: geriatricians have made a significant contribution to the development of integrated care for older people. The feasibility of this approach has been shown in demonstration projects. Although there is only limited evidence from randomised controlled trials, integrated care seems likely to be beneficial. There is an opportunity to develop new approaches to integrated care for older people in prevention and provision of community alternatives to hospital care. Conclusion: the principles and practice of geriatric medicine have been shown to underpin the successful development of integrated care for older people and should continue to do so as new challenges emerge.

<http://ageing.oxfordjournals.org/content/44/1/11.abstract>