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3 octobre 2014 / October the 3rd, 2014

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Economie de la santé / Health Economics

Tambor M., Pavlova M., Rechel B., Golinowska S., Sowada C., Groot W. (2014). Willingness to pay for publicly financed health care services in Central and Eastern Europe: Evidence from six countries based on a contingent valuation method. *Soc Sci Med*, 116C 193-201.

Abstract: The increased interest in patient cost-sharing as a measure for sustainable health care financing calls for evidence to support the development of effective patient payment policies. In this paper, we present an application of a stated willingness-to-pay technique, i.e. contingent valuation method, to investigate the consumer's willingness and ability to pay for publicly financed health care services, specifically hospitalisations and consultations with specialists. Contingent valuation data were collected in nationally representative population-based surveys conducted in 2010 in six Central and Eastern European (CEE) countries (Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine) using an identical survey methodology. The results indicate that the majority of health care consumers in the six CEE countries are willing to pay an official fee for publicly financed health care services that are of good quality and quick access. The consumers' willingness to pay is limited by the lack of financial ability to pay for services, and to a lesser extent by objection to pay. Significant differences across the six countries are observed, though. The results illustrate that the contingent valuation method can provide decision-makers with a broad range of information to facilitate cost-sharing policies. Nevertheless, the intrinsic limitations of the method (i.e. its hypothetical nature) and the context of CEE countries call for caution when applying its results.

Ehlert A., Oberschachtsiek D. (2014). Does managed care reduce health care expenditure? Evidence from spatial panel data. *Int J Health Care Finance Econ*, 14 (3) : 207-227.

Abstract: Similar to, for example, the US, Switzerland or Great Britain the German health care sector has recently undergone a series of reforms towards managed care. These measures are intended to yield both a higher quality of care and cost containment. In our study we ask whether managed care reduces health care expenditure at the market level. We apply a macroeconomic evaluation approach based on a regional panel data set which is as yet unique in the context of managed care. Econometrically, we account for both unobserved heterogeneity and spatial dependence, i.e. regional interrelations in health care. We discuss alternative model specifications and include a range of sensitivity analyses. Our results suggest that in contrast to public perception the share of managed care contracts has a positive impact on pharmaceutical spending, in particular through regional spillover effects.

Villaverde J., Maza A., Hierro M. (2014). Health care expenditure disparities in the European Union and underlying factors: a distribution dynamics approach. *Int J Health Care Finance Econ*, 14 (3) : 251-268.

Abstract: This paper examines health care expenditure (HCE) disparities between the European Union countries over the period 1995-2010. By means of using a continuous version of the distribution dynamics approach, the key conclusions are that the reduction in disparities is very weak and, therefore, persistence is the main characteristic of the HCE distribution. In view of these findings, a preliminary attempt is made to add some insights into potentially main factors behind the HCE distribution. The results indicate that whereas per capita income is by far the main determinant, the dependency ratio and female labour participation do not play any role in explaining the HCE distribution; as for the rest of the factors studied (life expectancy, infant mortality, R&D expenditure and public HCE expenditure share), we find that their role falls somewhat in between.

Riley G.F., Rupp K. (2014). Cumulative Expenditures under the DI, SSI, Medicare, and Medicaid Programs for a Cohort of Disabled Working-Age Adults. *Health Serv Res*, [Epub ahead of print]

Abstract: OBJECTIVE: To estimate cumulative DI, SSI, Medicare, and Medicaid expenditures from initial disability benefit award to death or age 65. DATA SOURCES: Administrative records for a cohort of new CY2000 DI and SSI awardees aged 18-64. STUDY DESIGN: Actual expenditures were obtained for 2000-2006/7. Subsequent expenditures were simulated using a regression-adjusted Markov process to assign individuals to annual disability benefit coverage states. Program expenditures were simulated conditional on assigned benefit coverage status. Estimates reflect present value of expenditures at initial award in 2000 and are expressed in constant 2012 dollars. Expenditure estimates were also updated to reflect benefit levels and characteristics of new awardees in 2012. DATA COLLECTION: We matched records for a 10 percent nationally representative sample. PRINCIPAL FINDINGS: Overall average cumulative expenditures are \$292,401 through death or age 65, with 51.4 percent for cash benefits and 48.6 percent for health care. Expenditures are about twice the average for individuals first awarded benefits at age 18-30. Overall average expenditures increased by 10 percent when updated for a simulated 2012 cohort. CONCLUSIONS: Data on cumulative expenditures, especially combined across programs, are useful for evaluating the long-term payoff of investments designed to modify entry to and exit from the disability rolls.

Horner-Johnson W., Dobbertin K., Lee J.C., Andresen E.M. (2014). Disparities in Health Care Access and Receipt of Preventive Services by Disability Type: Analysis of the Medical Expenditure Panel Survey. Health Serv Res, [Epub ahead of print]

Abstract: OBJECTIVE: To examine differences in access to health care and receipt of clinical preventive services by type of disability among working-age adults with disabilities. DATA SOURCE: Secondary analysis of Medical Expenditure Panel Survey (MEPS) data from 2002 to 2008. STUDY DESIGN: We conducted cross-sectional logistic regression analyses comparing people with different types of disabilities on health insurance status and type; presence of a usual source of health care; delayed or forgone care; and receipt of dental checkups and cancer screening. DATA COLLECTION: We pooled annualized MEPS data files across years. Our analytic sample consisted of adults (18-64 years) with physical, sensory, or cognitive disabilities and nonmissing data for all variables of interest. PRINCIPAL FINDINGS: Individuals with hearing impairment had better health care access and receipt than people with other disability types. People with multiple types of limitations were especially likely to have health care access problems and unmet health care needs. CONCLUSIONS: There are differences in health care access and receipt of preventive care depending on what type of disability people have. More in-depth research is needed to identify specific causes of these disparities and assess interventions to address health care barriers for particular disability groups.

Etat de santé / Health Status

Frenk J., Gomez-Dantes O. (2014). Designing a framework for the concept of health. *J Public Health Policy*, 35 (3) : 401-406.

Abstract: We discuss a set of ideas related to defining health - using the World Health Organization definition, several debates in the academic literature, and the Meikirch Model of Health. Given the complex and dynamic nature of health, we cannot aim to generate a once-and-for-all agreement on its precise meaning. Instead, let us work to develop a general framework to guide further explorations to identify and measure the complex components and determinants of that elusive aspiration we call health.

Meier-Abt P.J. (2014). The Meikirch Model of Health fits well into the concept of 'personalized health'. *J Public Health Policy*, 35 (3) : 420-421.

Abstract: The Meikirch Model of Health is compatible with the ongoing development of individualized medicine. It facilitates the conceptualization and implementation of personalized health.

Géographie de la santé / Geography of Health

Castelli A., Jacobs R., Goddard M., Smith P.C. (2013). Health, policy and geography: insights from a multi-level modelling approach. Soc Sci Med, 92 61-73.

Abstract: Improving the health and wellbeing of citizens ranks highly on the agenda of most governments. Policy action to enhance health and wellbeing can be targeted at a range of geographical levels and in England the focus has tended to shift away from the national level to smaller areas, such as communities and neighbourhoods. Our focus is to identify the potential for targeting policy interventions at the most appropriate geographical levels in order to enhance health and wellbeing. The rationale is that where variations in health and wellbeing indicators are larger, there may be greater potential for policy intervention targeted at that geographical level to have an impact on the outcomes of interest, compared with a strategy of targeting policy at those levels where relative variations are smaller. We use a multi-level regression approach to identify the degree of variation that exists in a set of health indicators at each level, taking account of the geographical hierarchical organisation of public sector organisations. We find that for each indicator, the proportion of total residual variance is greatest at smaller geographical areas. We also explore the variations in health indicators within a hierarchical level, but across the geographical areas for which public sector organisations are responsible. We show that it is feasible to identify a sub-set of organisations for which unexplained variation in health indicators is significantly greater relative to their counterparts. We demonstrate that adopting a geographical perspective to analyse the variation in indicators of health at different levels offers a potentially powerful analytical tool to signal where public sector organisations, faced increasingly with many competing demands, should target their policy efforts. This is relevant not only to the English context but also to other countries where responsibilities for health and wellbeing are being devolved to localities and communities.

Belasco E.J., Gong G., Pence B., Wilkes E. (2014). The impact of rural health care accessibility on cancer-related behaviors and outcomes. Appl.Health Econ Health Policy, 12 (4) : 461-470.

Abstract: BACKGROUND: This research seeks to identify the relationship between economic factors related to the ability to receive and pay for health services and adverse cancer outcomes, as well as preventative screening and behavioral factors that influence the risk of cancer. We focus on the Northern High Plains region, where we are able to compare regions with extremely low access to health services with those with relatively high levels of access. OBJECTIVE: This study aims to identify health disparities in rural communities, particularly among Native American populations, and, thereby, begin to determine the most effective means by which to deliver health services to areas where geography, economics, and culture might prevent traditional models of health delivery from providing sufficient incentives for the prevention of adverse cancer-related outcomes. METHODS: The Health Care Accessibility Index (HCAI) is computed through the use of principal component analysis and includes economic variables as well as variables concerning institutional and geographic access to health care. Index values are then regressed onto cancer outcomes, cancer-prevention outcomes, and cancer-related risk, using weighted least squares and quantile regressions. RESULTS: Counties with relatively poor access to health care (low HCAI) also have statistically (1) lower breast cancer screening rates, (2) higher smoking prevalence, (3) higher obesity prevalence, and (4) higher cancer-related mortality rates. Breast cancer screening is found to be especially sensitive to areas of low health accessibility. CONCLUSIONS: Empirical results provide support for policy efforts to increase the accessibility of health care services that are targeted to areas with low mammography screening rates, high obesity rates, high smoking prevalence, as well as areas near Native American reservation territories.

Minton J. (2014). Real geographies and virtual landscapes: Exploring the influence on place and space on mortality Lexis surfaces using shaded contour maps. *Spat.Spatiotemporal.Epidemiol*, 10 49-66.

Abstract: This paper describes how shaded contour plots, applied to mortality data from the Human Mortality Database, can be used to compare between nations, and start to tease out some of the ways that place and space matters. A number of shaded contour plots are presented, in order to describe the age, period and cohort effects which are apparent within them. They show variations between different subpopulations within the same nation, over time, and between nations. In illustrating these intra- and international variations in the patterns, we hope to encourage the development of hypotheses about the influence of such factors on mortality rates. We conclude with a brief discussion about how such hypotheses might be developed into statistical models, allowing for more rigorous testing of hypotheses and projection across time, place and space.

Maheswaran R., Strong M. (2014). GEOMED 2. *Spat.Spatiotemporal.Epidemiol*, (10): 27-28.

Hôpital / Hospitals

Januleviciute J., Askildsen J.E., Kaarboe O., Holmas T.H., Sutton M. (2013). The impact of different prioritisation policies on waiting times: case studies of Norway and Scotland. *Soc Sci Med*, 97 1-6.

Abstract: We investigate the distributional consequences of two different waiting times initiatives, one in Norway, and one in Scotland. The primary focus of Scotland's recent waiting time reforms, introduced in 2003, and modified in 2005 and 2007, has been on reducing maximum waiting times through the imposition of high profile national targets accompanied by increases in resources. In Norway, the focus of the reform introduced in September 2004, has been on assigning patients referred to hospital a maximum waiting time based on disease severity, the expected benefit and the cost-effectiveness of the treatment. We use large, national administrative datasets from before and after each of these reforms and assign priority groups based on the maximum waiting times stipulated in medical guidelines. The analysis shows that the lowest priority patients benefited most from both reforms. This was at the cost of longer waiting times for patients that should have been given higher priority in Norway, while Scotland's high priority patients remained unaffected.

Martelli N., Van den Brink H. (2014). Special funding schemes for innovative medical devices in French hospitals: the pros and cons of two different approaches. *Health Policy*, 117 (1) : 1-5.

Abstract: Financing innovative medical devices is an important challenge for national health policy makers, and a crucial issue for hospitals. However, when innovative medical devices are launched on the European market there is generally little clinical evidence regarding both efficacy and safety, both because of the flaws in the European system for regulating such devices, and because they are at an early stage of development. To manage the uncertainty surrounding the reimbursement of innovation, several European countries have set up temporary funding schemes to generate evidence about the effectiveness of devices. This article explores two different French approaches to funding innovative in-hospital devices and collecting supplementary data: the coverage with evidence development (CED) scheme introduced under Article L. 165-1-1 of the French Social Security Code; and national programs for hospital-based research. We discuss pros and cons of both approaches in the light of CED policies in Germany and the UK. The CED policies for devices share common limitations. Thus, transparency of CED processes should be enhanced and decisions need to be made in a timely way. Finally, we think that closer collaboration between manufacturers, health authorities and hospitals is essential to make CED policies more operational.

Clemens T., Michelsen K., Commers M., Garel P., Dowdeswell B., Brand H. (2014). European hospital reforms in times of crisis: aligning cost containment needs with plans for structural redesign? *Health Policy*, 117 (1) : 6-14.

Abstract: Hospitals have become a focal point for health care reform strategies in many European countries during the current financial crisis. It has been called for both, short-term reforms to reduce costs and long-term changes to improve the performance in the long run. On the basis of a literature and document analysis this study analyses how EU member states align short-term and long-term pressures for hospital reforms in times of the financial crisis and assesses the EU's influence on the national reform agenda. The results reveal that there has been an emphasis on cost containment measures rather than embarking on structural redesign of the hospital sector and its position within the broader health care system. The EU influences hospital reform efforts through its enhanced economic framework governance which determines key aspects of the financial context for hospitals in some countries. In addition, the EU health policy agenda which increasingly addresses health system questions stimulates the process of structural hospital reforms by knowledge generation, policy advice and financial incentives. We conclude that successful reforms in such a period would arguably need to address both the organisational and financing sides to hospital care. Moreover, critical to structural reform is a widely held acknowledgement of shortfalls in the current system and belief that new models of hospital care can deliver solutions to overcome these deficits. Advancing the structural redesign of the hospital sector while pressured to contain cost in the short-term is not an easy task and only slowly emerging in Europe.

Hakkinen U., Rosenqvist G., Peltola M., Kapiainen S., Ratto H., Cots F., Geissler A., Or Z., Serden L., Sund R. (2014). Quality, cost, and their trade-off in treating AMI and stroke patients in European hospitals. *Health Policy*, 117 (1) : 15-27.

Abstract: OBJECTIVES: This study compared the cost and in-hospital mortality of hospital care for two major diseases, acute myocardial infarction (AMI) and stroke, by pooling patient-level data from five European countries (Finland, France, Germany, Spain, and Sweden). We examined whether a cost-quality trade-off existed in these countries by comparing hospital-level costs and survival rates, and whether hospitals which performed well in terms of cost or quality in treating one patient group (AMI) performed well also in treating the other patient group (stroke). METHODS: A fixed-effect probit regression model for survival and the linear model for log costs were used to calculate indicators for hospital quality and cost, which were plotted against each other. FINDINGS: Both with AMI and stroke there were remarkable differences between hospitals and countries in (both crude and adjusted) rates of patients discharged alive. Swedish and French hospitals had lower mortality than hospitals in Germany, Finland and Spain in the care of AMI patients. However, a longer length of stay in Spanish and German hospitals may bias the results in the two countries. The Finnish hospitals seemed to have lower mortality than the other countries' hospitals in the care of stroke patients. There was no correlation at either the national or hospital level in the quality of treatment of these two diseases. We did not find a clear cost-quality trade-off. The only notable exception was Sweden, where the costs for AMI patients were higher in hospitals with the highest quality of care. CONCLUSIONS: Countries should identify the best performing hospitals both in terms of cost and quality in order to learn from hospitals that demonstrate better practice. It is equally important to better understand the reasons behind the observed differences between hospitals in costs and quality.

Doiron D., Fiebig D.G., Suziedelyte A. (2014). Hips and hearts: The variation in incentive effects of insurance across hospital procedures. *J Health Econ*, 37 81-97.

Abstract: The separate identification of effects due to incentives, selection and preference heterogeneity in insurance markets is the topic of much debate. In this paper, we investigate the presence and variation in moral hazard across health care procedures. The key motivating hypothesis is the expectation of larger causal effects in the case of more discretionary procedures. The empirical approach relies on an extremely rich and extensive dataset constructed by linking survey data to

administrative data for hospital medical records. Using this approach we are able to provide credible evidence of large moral hazard effects but for elective surgeries only.

Kristensen S.R., Meacock R., Turner A.J., Boaden R., McDonald R., Roland M., Sutton M. (2014). Long-term effect of hospital pay for performance on mortality in England. *N Engl J Med*, 371 (6) : 540-548.

Abstract: BACKGROUND: A pay-for-performance program based on the Hospital Quality Incentive Demonstration was introduced in all hospitals in the northwest region of England in 2008 and was associated with a short-term (18-month) reduction in mortality. We analyzed the long-term effects of this program, called Advancing Quality. METHODS: We analyzed 30-day in-hospital mortality among 1,825,518 hospital admissions for eight conditions, three of which were covered by the financial-incentive program. The hospitals studied included the 24 hospitals in the northwest region that were participating in the program and 137 elsewhere in England that were not participating. We used difference-in-differences regression analysis to compare risk-adjusted mortality for an 18-month period before the program was introduced with subsequent mortality in the short term (the first 18 months of the program) and the longer term (the next 24 months). RESULTS: Throughout the short-term and the long-term periods, the performance of hospitals in the incentive program continued to improve and mortality for the three conditions covered by the program continued to fall. However, the reduction in mortality among patients with these conditions was greater in the control hospitals (those not participating in the program) than in the hospitals that were participating in the program (by 0.7 percentage points; 95% confidence interval [CI], 0.3 to 1.2). By the end of the 42-month follow-up period, the reduced mortality in the participating hospitals was no longer significant (-0.1 percentage points; 95% CI, -0.6 to 0.3). From the short term to the longer term, the mortality for conditions not covered by the program fell more in the participating hospitals than in the control hospitals (by 1.2 percentage points; 95% CI, 0.4 to 2.0), raising the possibility of a positive spillover effect on care for conditions not covered by the program. CONCLUSIONS: Short-term relative reductions in mortality for conditions linked to financial incentives in hospitals participating in a pay-for-performance program in England were not maintained.

Burns M.E., Galbraith A.A., Ross-Degnan D., Balaban R.B. (2014). Feasibility and evaluation of a pilot community health worker intervention to reduce hospital readmissions. *Int J Qual. Health Care*, 26 (4) : 358-365.

Abstract: OBJECTIVE: To pilot-test the feasibility and preliminary effect of a community health worker (CHW) intervention to reduce hospital readmissions. DESIGN: Patient-level randomized quality improvement intervention. SETTING: An academic medical center serving a predominantly low-income population in the Boston, Massachusetts area and 10 affiliated primary care practices. PARTICIPANTS: Medical service patients with an in-network primary care physician who were discharged to home (n = 423) and had one of five risk factors for readmission within 30 days. INTERVENTION: Inpatient introductory visit and weekly post-discharge telephonic support for 4 weeks to assist patient in coordinating medical visits, obtaining and using medications, and in self-management. MAIN OUTCOME MEASURES: Number of completed CHW contacts; CHW-reported barriers and facilitators to assisting patients; primary care, emergency department and inpatient care use. RESULTS: Roughly 70% of patients received at least one post-discharge CHW call; only 38% of patients received at least four calls as intended. Hospital readmission rates were lower among CHW patients (15.4%) compared with usual care (17.9%); the difference was not statistically significant. CONCLUSION: Under performance-based payment systems, identifying cost-effective solutions for reducing hospital readmissions will be crucial to the economic survival of all hospitals, especially safety-net systems. This pilot study suggests that with appropriate supportive infrastructure, hospital-based CHWs may represent a feasible strategy for improving transitional care among vulnerable populations. An ongoing, randomized, controlled trial of a CHW intervention, developed according to the lessons of this pilot, will provide further insight into the utility of this approach to reducing readmissions.

Johnson E.C., Horwood J., Gooberman-Hill R. (2014). Conceptualising time before surgery: The experience of patients waiting for hip replacement. *Soc Sci Med*, 116 126-133.

Abstract: Interpretations of time underlie patients' experiences of illness and the way in which the

National Health Service (NHS) is organised. In the NHS, achieving short waiting times for treatment is seen as important, and this is particularly evident in relation to chronic conditions where the time waiting in care from onset of symptoms to successful management can last months and years. One example of a chronic condition with high prevalence is osteoarthritis, estimated to affect 10% of people aged over 55 years in the UK. Osteoarthritis of the hip is particularly common, and treatments include exercise and medication. If these options do not provide enough relief from pain and functional difficulties, then joint replacement may be considered. With over 70,000 such operations conducted every year in England and Wales, processes relating to waiting times impact on many patients. This article explores how 24 patients with osteoarthritis experience time during the lead up to hip replacement surgery. We draw on data collected during longitudinal in-depth interviews with patients a median of 9.5 days before surgery and at two to four weeks post-operatively. Transcripts of audio-recorded interviews were imported into Atlas.ti((R)) and inductive thematic analysis undertaken. Increasing pain and deterioration in function altered the experience of time during the journey towards hip replacement. Patients made essential changes to how they filled their days. They experienced lost and wasted time and faced disruption to the temporal order of their lives. A surgical date marked in the calendar became their focus. However, this date was not static, moving because of changing perceptions of duration and real-time alterations by the healthcare system. Findings highlight that patients' experience of time is complex and multi-dimensional and does not reflect the linear,

Inégalités de santé / Health Inequalities

Maki N., Martikainen P., Eikemo T., Menvielle G., Lundberg O., Ostergren O., Jasilionis D., Mackenbach J.P. (2013). Educational differences in disability-free life expectancy: a comparative study of long-standing activity limitation in eight European countries. *Soc Sci Med*, 94 1-8.

Abstract: Healthy life expectancy is a composite measure of length and quality of life and an important indicator of health in aging populations. There are few cross-country comparisons of socioeconomic differences in healthy life expectancy. Most of the existing comparisons focus on Western Europe and the United States, often relying on older data. To address these deficiencies, we estimated educational differences in disability-free life expectancy for eight countries from all parts of Europe in the early 2000s. Long-standing severe disability was measured as a Global Activity Limitation Indicator (GALI) derived from the European Union Statistics on Income and Living Conditions (EU-SILC) survey. Census-linked mortality data were collected by a recent project comparing health inequalities between European countries (the EURO-GBD-SE project). We calculated sex-specific educational differences in disability-free life expectancy between the ages of 30 and 79 years using the Sullivan method. The lowest disability-free life expectancy was found among Lithuanian men and women (33.1 and 39.1 years, respectively) and the highest among Italian men and women (42.8 and 44.4 years, respectively). Life expectancy and disability-free life expectancy were directly related to the level of education, but the educational differences were much greater in the latter in all countries. The difference in the disability-free life expectancy between those with a primary or lower secondary education and those with a tertiary education was over 10 years for males in Lithuania and approximately 7 years for males in Austria, Finland and France, as well as for females in Lithuania. The difference was smallest in Italy (4 and 2 years among men and women, respectively). Highly educated Europeans can expect to live longer and spend more years in better health than those with lower education. The size of the educational difference in disability-free life expectancy varies significantly between countries. The smallest and largest differences appear to be in Southern Europe and in Eastern and Northern Europe, respectively.

Hudson D.L., Puterman E., Bibbins-Domingo K., Matthews K.A., Adler N.E. (2013). Race, life course socioeconomic position, racial discrimination, depressive symptoms and self-rated health. *Soc Sci Med*, 97 7-14.

Abstract: Greater levels of socioeconomic position (SEP) are generally associated with better health. However results from previous studies vary across race/ethnicity and health outcomes. Further, the majority of previous studies do not account for the effects of life course SEP on health nor the effects of racial discrimination, which could moderate the effects of SEP on health. Using data from the Coronary Artery Risk Development in Young Adults (CARDIA) study, we examined the relationship between a life course SEP measure on depressive symptoms and self-rated health. A life course SEP was constructed for each participant, using a framework that included parental education and occupation along with respondents' highest level of education and occupation. Interaction terms were created between life course SEP and racial discrimination to determine whether the association between SEP and health was moderated by experiences of racial discrimination. Analyses revealed that higher levels of life course SEP were inversely related to depressive symptoms. Greater life course SEP was positively associated with favorable self-rated health. Racial discrimination was associated with more depressive symptoms and poorer self-rated health. Analyses indicated a significant interaction between life course SEP and racial discrimination on depressive symptoms in the full sample. This suggested that for respondents with greater levels of SEP, racial discrimination was associated with reports of more depressive symptoms. Future research efforts should be made to examine whether individuals' perceptions and experiences of racial discrimination at the interpersonal and structural levels limits their ability to acquire human capital as well as their advancement in education and occupational status.

Adena M., Myck M. (2014). Poverty and transitions in health in later life. *Soc Sci Med*, 116C 202-210.

Abstract: Using a sample of Europeans aged 50+ from 12 countries in the Survey of Health, Ageing and Retirement in Europe (SHARE), we analyse the role of poor material conditions as a determinant of changes in health over a four- to five-year period. We find that poverty defined with respect to relative income has no effect on changes in health. However, broader measures of poor material conditions, such as subjective poverty or low wealth, significantly increase the probability of transition to poor health among the healthy and reduce the chance of recovery from poor health over the time interval analysed. In addition to this, the subjective measure of poverty has a significant effect on mortality, increasing it by 65% among men and by 68% among those aged 50-64. Material conditions affect health among older people. We suggest that if attempts to reduce poverty in later life and corresponding policy targets are to focus on the relevant measures, they should take into account broader definitions of poverty than those based only on relative incomes.

Carpiano R.M., Fitterer L.M. (2014). Questions of trust in health research on social capital: What aspects of personal network social capital do they measure? *Soc Sci Med*, 116C 225-234.

Abstract: Health research on personal social capital has often utilized measures of respondents' perceived trust of others as either a proxy for one's social capital in the absence of more focused measures or as a subjective component of social capital. Little empirical work has evaluated the validity of such practices. We test the construct validity of two trust measures used commonly in health research on social capital-generalized trust and trust of neighbors-with respect to measures of people's general network-, organization-, family-, friend-, and neighborhood-based social capital and the extent to which these two trust measures are associated with self-rated general health and mental health when social capital measures are included in the same models. Analyses of 2008 Canadian General Social Survey data (response rate 57.3%) indicate that generalized trust and trust of neighbors are both positively-yet modestly-associated with measures of several domains of network-based social capital. Both trust measures are positively associated with general and mental health, but these associations remain robust after adjusting for social capital measures. Our findings suggest that (a) trust is conceptually distinct from social capital, (b) trust measures are inadequate proxies for actual personal social networks, and (c) trust measures may only be capturing psychological aspects relevant to-but not indicative of-social capital. Though links between perceived trust and health deserve study, health research on social capital needs to utilize measures of respondents' actual social networks and their inherent resources.

Kassar H., Dourgnon P. (2014). The big crossing: illegal boat migrants in the Mediterranean. *Eur J Public Health*, 24 Suppl 1 11-15.

Abstract: This article explores illegal migration routes and groups across North Africa to Europe. We describe sub-Saharan and cross-Mediterranean routes, and how they changed during the years. We propose an analytical framework for the main factors for these migrations, from local to international and regulatory context. We then describe sea-migrants' nationalities and socio-economic and demographic characteristics, from studies undertaken in Tunisia and Morocco. While boat migration represents only a fraction of illegal migration to Europe, it raises humanitarian as well as ethical issues for European and North African (NA) countries, as a non-negligible amount of them end up in death tolls of shipwrecks in the Mediterranean Sea. Moreover, existing statistics show that illegal trans-Mediterranean migration is growing exponentially. Ongoing crises in Africa and the Middle East are likely to prompt even larger outflows of refugees in the near future. This should induce NA countries to share closer public policy concerns with European countries.

Moullan Y., Jusot F. (2014). Why is the 'healthy immigrant effect' different between European countries? *Eur J Public Health*, 24 Suppl 1 80-86.

Abstract: BACKGROUND: : Even if health status of immigrants constitutes an important public health issue, the literature provides contradictory results on the existence of a 'healthy migrant' effect in Europe. This study proposes to explore the heterogeneity of the health gap between migrants and natives across four European countries. DATA AND METHODS: : Based on several harmonized national health interview surveys, the association between migratory status and self-assessed health was firstly explored separately in Belgium, France, Spain and Italy. To explore whether differences in health gap between countries reflect differences in health status of immigrants between host countries or whether they are because of differences in health status of natives between host countries, the association between the host country and health was secondly analysed separately among a pooled sample of immigrants and one of natives, controlling for socio-economic status and country of origin. RESULTS: : After controlling for socio-economic status, immigrants report a poorer health status than natives in France, Belgium and Spain, whereas they report a better health status than natives in Italy, among both women and men. A North-South gradient in immigrants' health status appears: their health status is better in Italy and in Spain than in France and Belgium. Conversely, health status of natives is poorer in Italy and in Belgium than in France and in Spain. CONCLUSION: : Differences in health gap reflect differences in health status of both natives and immigrants between host countries. This suggests differences in health selection at migration and in immigrants' integration between European countries.

Dourgnon P., Kassar H. (2014). Refugees in and out North Africa: a study of the Choucha refugee camp in Tunisia. *Eur J Public Health*, 24 Suppl 1 6-10.

Abstract: In recent years, North African (NA) countries ceased to be emigration-only countries and are now on the verge of becoming immigration as well as transit countries for economic migrants and refugees. Contextual as well as structural long-term factors are driving these changes. The ongoing crises in Africa and the Middle East are prompting strong outflows of refugees, which are likely to induce NA countries to share some common public policy and public health concerns with European countries in a near future. This article highlights some aspects of these changes, from the study of the consequences of the 2011 Libyan crisis in Tunisia. It addresses individual trajectories and health concerns of refugees in and out North Africa from a study of the Choucha camp in Tunisia. The camp opened to immigrants from Libya during the 2011 crisis and accommodated the bulk of the refugees flow to Tunisia until July 2012. The study includes a monographic approach and a qualitative survey in the Choucha camp refugees. We describe the crisis history and the health response with a focus on the camp. We then address refugees' trajectories, and health needs and concerns from the interviews we collected in the camp in April 2012.

Foubert J., Levecque K., Van R.R., Romagnoli A. (2014). Do welfare regimes influence the association between disability and self-perceived health? A multilevel analysis of 57 countries. *Soc Sci Med*, 117 10-17.

Abstract: Disability is usually associated with poorer self-rated health. However, as many people with disabilities do not consider themselves unhealthy, the association may not be as straightforward as it appears. This study examines whether the relationship between disability and self-rated health is dependent on a country's welfare regime. Welfare regimes can play a significant role in securing the

needs of disabled people and lessening their social exclusion. However, welfare regimes also label disabled people accordingly, before they become entitled to specific provisions and services. Being given a low status label and being dependent on welfare provisions might trigger a negative self-evaluation of health. Using data from 57 countries of the World Health Survey of 2002-2004, the multilevel regression analyses show that people with a disability tend to rate their health worse than people without any disability. Moreover, the strength of this negative association varies significantly across countries and is affected by a country's welfare regime. The association is the strongest in the various Welfare State regimes (mostly European countries) and the weakest in Informal-Security regimes (Latin-American and Asian countries) and in Insecurity regimes (African countries). Disabled people living in Welfare States regimes tend to rate their health worse than people in other regimes. These findings confirm that welfare regimes play a role in shaping the health perception of disabled people and that processes of labeling may result in unintended and negative consequences of welfare programs. Research on the nexus between disability and self-rated health that neglects this macro-social context of welfare regimes may lead to undifferentiated and even incorrect conclusions.

Palencia L., Malmusi D., De M.D., Artazcoz L., Backhans M., Vanroelen C., Borrell C. (2014). The influence of gender equality policies on gender inequalities in health in Europe. *Soc Sci Med*, 117 25-33.

Abstract: Few studies have addressed the effect of gender policies on women's health and gender inequalities in health. This study aims to analyse the relationship between the orientation of public gender equality policies and gender inequalities in health in European countries, and whether this relationship is mediated by gender equality at country level or by other individual social determinants of health. A multilevel cross-sectional study was performed using individual-level data extracted from the European Social Survey 2010. The study sample consisted of 23,782 men and 28,655 women from 26 European countries. The dependent variable was self-perceived health. Individual independent variables were gender, age, immigrant status, educational level, partner status and employment status. The main contextual independent variable was a modification of Korpi's typology of family policy models (Dual-earner, Traditional-Central, Traditional-Southern, Market-oriented and Contradictory). Other contextual variables were the Gender Empowerment Measure (GEM), to measure country-level gender equality, and the Gross Domestic Product (GDP). For each country and country typology the prevalence of fair/poor health by gender was calculated and prevalence ratios (PR, women compared to men) and 95% confidence intervals (CI) were computed. Multilevel robust Poisson regression models were fitted. Women had poorer self-perceived health than men in countries with traditional family policies (PR = 1.13, 95%CI: 1.07-1.21 in Traditional-Central and PR = 1.27, 95%CI: 1.19-1.35 in Traditional-Southern) and in Contradictory countries (PR = 1.08, 95%CI: 1.05-1.11). In multilevel models, only gender inequalities in Traditional-Southern countries were significantly higher than those in Dual-earner countries. Gender inequalities in self-perceived health were higher, women reporting worse self-perceived health than men, in countries with family policies that were less oriented to gender equality (especially in the Traditional-Southern country-group). This was partially explained by gender inequalities in the individual social determinants of health but not by GEM or GDP.

Edge S., Newbold K.B., McKeary M. (2014). Exploring socio-cultural factors that mediate, facilitate, & constrain the health and empowerment of refugee youth. *Soc Sci Med*, 117 34-41.

Abstract: Studies on youth health and well-being are predominantly quantitative and expert-driven with less attention given to how youth understand what it means to be healthy themselves and the role of socio-cultural factors in shaping this. Knowledge on the perceptions and experiences of refugee youth is particularly lacking and notable given their unique stressors related to migratory, settlement and integration experiences. We contribute a better understanding of how refugee youth themselves define and contextualize health, with particular emphasis given to socio-cultural factors that enable or constrain health promotion efforts and individual health agency. This research was undertaken at a downtown drop-in centre in Hamilton, Ontario, Canada that provided settlement and integration services to newcomer youth. We employ a grounded theory approach and draw upon participant observation, focus groups and in-depth interviews. Twenty-six youth (age 18-25 years), representing

12 different countries of origin participated. The youth defined health very broadly touching upon many typical determinants of health (e.g. education, income, etc.). Yet factors of most importance (as demonstrated by the frequency and urgency in which they were discussed by youth) included a sense of belonging, positive self-identity, emotional well-being, and sense of agency or self-determination. We conceptualize these as "mediating" factors given the youth argued they enabled or constrained their ability to cope with adversities related to other health determinant categories. The youth also discussed what we interpret as "facilitators" that encourage mediating factors to manifest positively (e.g. informal, non-biomedical settings and programs that nurture trust, break down access barriers, and promote a sense of community amongst peers, mentors, and health professionals). When creating health promotion strategies for refugee youth (and perhaps youth more generally) it is important to understand the factors that may mediate the magnitude of effects from various risks/stressors, in addition to those which facilitate health agency.

Kulhanova I., Hoffmann R., Judge K., Looman C.W., Eikemo T.A., Bopp M., Deboosere P., Leinsalu M., Martikainen P., Rychtarikova J., Wojtyniak B., Menvielle G., Mackenbach J.P. (2014). Assessing the potential impact of increased participation in higher education on mortality: Evidence from 21 European populations. *Soc Sci Med*, 117 142-149.

Abstract: Although higher education has been associated with lower mortality rates in many studies, the effect of potential improvements in educational distribution on future mortality levels is unknown. We therefore estimated the impact of projected increases in higher education on mortality in European populations. We used mortality and population data according to educational level from 21 European populations and developed counterfactual scenarios. The first scenario represented the improvement in the future distribution of educational attainment as expected on the basis of an assumption of cohort replacement. We estimated the effect of this counterfactual scenario on mortality with a 10-15-year time horizon among men and women aged 30-79 years using a specially developed tool based on population attributable fractions (PAF). We compared this with a second, upward levelling scenario in which everyone has obtained tertiary education. The reduction of mortality in the cohort replacement scenario ranged from 1.9 to 10.1% for men and from 1.7 to 9.0% for women. The reduction of mortality in the upward levelling scenario ranged from 22.0 to 57.0% for men and from 9.6 to 50.0% for women. The cohort replacement scenario was estimated to achieve only part (4-25% (men) and 10-31% (women)) of the potential mortality decrease seen in the upward levelling scenario. We concluded that the effect of on-going improvements in educational attainment on average mortality in the population differs across Europe, and can be substantial. Further investments in education may have important positive side-effects on population health.

Marmot M., Allen J.J. (2014). Social determinants of health equity. *Am J Public Health*, 104 Suppl 4 S517-S519.

Moullan Y., Jusot F. (2014). Why is the 'healthy immigrant effect' different between European countries? *The European Journal of Public Health*, 24 (suppl 1) : 80-86.

Abstract: Background: Even if health status of immigrants constitutes an important public health issue, the literature provides contradictory results on the existence of a healthy migrant effect in Europe. This study proposes to explore the heterogeneity of the health gap between migrants and natives across four European countries. Data and methods: Based on several harmonized national health interview surveys, the association between migratory status and self-assessed health was firstly explored separately in Belgium, France, Spain and Italy. To explore whether differences in health gap between countries reflect differences in health status of immigrants between host countries or whether they are because of differences in health status of natives between host countries, the association between the host country and health was secondly analysed separately among a pooled sample of immigrants and one of natives, controlling for socio-economic status and country of origin. Results: After controlling for socio-economic status, immigrants report a poorer health status than natives in France, Belgium and Spain, whereas they report a better health status than natives in Italy, among both women and men. A North - South gradient in immigrants' health status appears: their health status is better in Italy and in Spain than in France and Belgium. Conversely, health status of natives is poorer in Italy and in Belgium than in France and in Spain. Conclusion : Differences in health gap reflect differences in

health status of both natives and immigrants between host countries. This suggests differences in health selection at migration and in immigrants' integration between European countries.

http://eurpub.oxfordjournals.org/content/24/suppl_1/80.abstract

Médicaments / Pharmaceuticals

Chapman A.M., Taylor C.A., Girling A.J. (2014). Are the UK Systems of Innovation and Evaluation of Medical Devices Compatible? The Role of NICE's Medical Technologies Evaluation Programme (MTEP). *Appl.Health Econ Health Policy*, 12 (4) : 347-357.

Abstract: The economic evaluation of medical products and services is increasingly prioritised by healthcare decision makers and plays a key role in informing funding allocation decisions. It is well known that there are a number of methodological difficulties in the health technology assessment of medical devices, particularly in the provision of efficacy evidence. By contrasting devices with pharmaceuticals, the way in which the differing systems of innovation mould the UK's industry landscape is described and substantiated with market statistics. In recognition of the challenges faced by industry, as well as the growing need for cost-effective allocation of National Health Service (NHS) resources, the National Institute for Health and Care Excellence (NICE) led the development of the Medical Technologies Evaluation Programme (MTEP), which launched in 2009/2010. The review of the UK's medical devices market supports the programme's three principal aims: to simplify access to evaluation, speed up the process, and increase evaluative capacity for devices within NICE. However, an analysis of the output of MTEP's first 3 years suggests that it has some way to go to meet each of these aims.

Pringle J.L., Boyer A., Conklin M.H., McCullough J.W., Aldridge A. (2014). The Pennsylvania project: pharmacist intervention improved medication adherence and reduced health care costs. *Health Aff.(Millwood.)*, 33 (8) : 1444-1452.

Abstract: Improving medication adherence across the health care system is an ingredient that is vital to improving patient outcomes and reducing downstream health care costs. The Pennsylvania Project, a large-scale community pharmacy demonstration study, evaluated the impact of a pharmacy-based intervention on adherence to five chronic medication classes. To implement the study, 283 pharmacists from a national community pharmacy chain were assigned to the intervention group. Collectively, they screened 29,042 patients for poor adherence risk and provided brief interventions to people with an elevated risk. Compared to a control group of 295 pharmacists who screened 30,454 patients, the intervention significantly improved adherence for all medication classes, from 4.8 percent for oral diabetes medications to 3.1 percent for beta-blockers. Additionally, there was a significant reduction in per patient annual health care spending for patients taking statins (\$241) and oral diabetes medications (\$341). This study demonstrated that pharmacist-provided intervention is a cost-effective tool that may be applied in community pharmacies and health care sites across the country.

Rischatsch M. (2014). Lead me not into temptation: drug price regulation and dispensing physicians in Switzerland. *Eur J Health Econ*, 15 (7) : 697-708.

Abstract: While most countries separate drug prescription and dispensation to ensure independent drug choice, some allow this combination to increase pharmaceutical access in rural areas or to increase the utilization of pharmacist skills. A drawback of this approach is that dispensing physicians or prescribing pharmacists may be incentivized to increase their own profits through the prescription of cost-inefficient drug packages, leading to an increase in pharmaceutical spending. Switzerland constitutes an interesting example of where dispensing and non-dispensing physicians coexist,

permitting a comparison of their prescribing behavior. The present study shows that drug margin optimization is possible under the current drug price regulation scheme in Switzerland. Using drug claims data, empirical findings indicate a 5-10 % higher margin per dose for dispensing physicians compared to pharmacists. Cost per dose is 3-5 % higher when dispensed by physicians instead of pharmacists.

Méthodologie – Statistique / Methodology – Statistics

Taylor J., Twigg L., Moon G. (2014). The convergent validity of three surveys as alternative sources of health information to the 2011 UK census. *Soc Sci Med*, 116C 187-192.

Abstract: Censuses have traditionally been a key source of localised information on the state of a nation's health. Many countries are now adopting alternative approaches to the traditional census, placing such information at risk. The purpose of this paper is to inform debate about whether existing social surveys could provide an adequate 'base' for alternative model-based small area estimates of health data in a post traditional census era. Using a case study of 2011 UK Census questions on self-assessed health and limiting long term illness, we examine the extent to which the results from three large-scale surveys - the Health Survey for England, the Crime Survey for England and Wales and the Integrated Household Survey - conform to census output. Particularly in the case of limiting long term illness, the question wording renders comparisons difficult. However, with the exception of the general health question from the Health Survey for England all three surveys meet tests for convergent validity.

Gannon B., Harris D., Harris M. (2014). Threshold effects in nonlinear models with an application to the social capital-retirement-health relationship. *Health Econ*, 23 (9) : 1072-1083.

Abstract: This paper considers the relationship between social capital and health in the years before, at and after retirement. This adds to the current literature that only investigates this relationship in either the population as a whole or two subpopulations, pre-retirement and post-retirement. We now investigate if there are further additional subpopulations in the years to and from retirement. We take an information criteria approach to select the optimal model of subpopulations from a full range of potential models. This approach is similar to that proposed for linear models. Our contribution is to show how this may also be applied to nonlinear models and without the need for estimating subsequent subpopulations conditional on previous fixed subpopulations. Our main finding is that the association of social capital with health diminishes at retirement, and this decreases further 10 years after retirement. We find a strong positive significant association of social capital with health, although this turns negative after 20 years, indicating potential unobserved heterogeneity. The types of social capital may differ in later years (e.g. less volunteering) and hence overall social capital may have less of an influence on health in later years.

Seghieri C., Mengoni A., Nuti S. (2014). Applying discrete choice modelling in a priority setting: an investigation of public preferences for primary care models. *Eur J Health Econ*, 15 (7) : 773-785.

Abstract: OBJECTIVES: The shift toward more innovative and sustainable primary care models in Italy leads policy makers and clinicians to face difficult decisions between options that are all regarded as potentially beneficial. In this study, patient preferences for different primary care models in the Tuscany region of Italy were elicited. The relative importance of different attributes to the surveyed respondents was then examined, as well as the rate at which individuals trade between attributes and the relative value of different service configurations. METHODS: A discrete choice experiment survey explored the following attributes in a stratified random sample of 6,970 adults: primary care provider, diagnostic facilities and waiting time for the visit. RESULTS: Respondents (3,263) were likely to prefer

a consultation by their own general practitioner (GP) and a practice with many diagnostic facilities. The predicted utilities of different service configurations have shown that a "primary care centre" with many diagnostic facilities was preferable to a "solo GP" model or a "group general practice". CONCLUSIONS: The study demonstrated how a patient choice model could be used by decision makers for developing successful policies that takes into account different healthcare needs, balancing responsiveness with care continuity, equity and appropriateness. Considering that a primary care centre would perform better than a "solo GP", especially for younger respondents and for those with minor healthcare needs, for a more rapid diffusion of this model policymakers and managers could direct the care of primary care centres towards these targeted subgroups, at least in the first phase.

Politique de santé / Health Policy

Stafinski T., Menon D. (2014). Transparency in Reimbursement Decisions: In Whose Best Interest? *PharmacoEconomics*, 32 (8) : 725-727.

Abstract: According to the Oxford English Dictionary, 'transparency' is defined as "Easily seen through or understood; easily discerned; obvious; (of a person, statement, etc.) frank, open, ingenuous" [1]. In the context of decision-making, 'transparency' comprises a key condition of procedural justice. Procedural justice concerns the fairness of processes by which decisions are made [2]. For the past decade, 'procedural justice' has, implicitly or explicitly, served as a guiding principle for many healthcare decision-making bodies, particularly those tasked with determining which services to provide and under what conditions. This has, in part, been attributed to increased awareness of recent scholarly frameworks for making healthcare funding decisions (e.g., accountability for reasonableness [3]). These frameworks embrace Rawlsian notions of 'pure procedural justice,' which state that there is no criterion for what constitutes a 'just' outcome other than the procedure itself [2].

<http://dx.doi.org/10.1007/s40273-014-0176-4>

Prévision – Evaluation / Prevision – Evaluation

Marchal B., Westhorp G., Wong G., Van B.S., Greenhalgh T., Kegels G., Pawson R. (2013). Realist RCTs of complex interventions - an oxymoron. *Soc Sci Med*, 94 124-128.

Abstract: Bonell et al. discuss the challenges of carrying out randomised controlled trials (RCTs) to evaluate complex interventions in public health, and consider the role of realist evaluation in enhancing this design (Bonell, Fletcher, Morton, Lorenc, & Moore, 2012). They argue for a "synergistic, rather than oppositional relationship between realist and randomised evaluation" and that "it is possible to benefit from the insights provided by realist evaluation without relinquishing the RCT as the best means of examining intervention causality." We present counter-arguments to their analysis of realist evaluation and their recommendations for realist RCTs. Bonell et al. are right to question whether and how (quasi-)experimental designs can be improved to better evaluate complex public health interventions. However, the paper does not explain how a research design that is fundamentally built upon a positivist ontological and epistemological position can be meaningfully adapted to allow it to be used from within a realist paradigm. The recommendations for "realist RCTs" do not sufficiently take into account important elements of complexity that pose major challenges for the RCT design. They also ignore key tenets of the realist evaluation approach. We propose that the adjective 'realist' should continue to be used only for studies based on a realist philosophy and whose analytic approach follows the established principles of realist analysis. It seems more correct to call the approach proposed by Bonell and colleagues 'theory informed RCT', which indeed can help in enhancing RCTs.

Ryen L., Svensson M. (2014). The willingness to pay for a quality adjusted life year: a review of the empirical literature. *Health Economics, (Ahead of pub)* : n/a.

Abstract: There has been a rapid increase in the use of cost-effectiveness analysis, with quality adjusted life years (QALYs) as an outcome measure, in evaluating both medical technologies and public health interventions. Alongside, there is a growing literature on the monetary value of a QALY based on estimates of the willingness to pay (WTP). This paper conducts a review of the literature on the WTP for a QALY. In total, 24 studies containing 383 unique estimates of the WTP for a QALY are identified. Trimmed mean and median estimates amount to 74,159 and 24,226 Euros (2010 price level), respectively. In regression analyses, the results indicate that the WTP for a QALY is significantly higher if the QALY gain comes from life extension rather than quality of life improvements. The results also show that the WTP for a QALY is dependent on the size of the QALY gain valued. <http://dx.doi.org/10.1002/hec.3085>

Mohiuddin S. (2014). A systematic and critical review of model-based economic evaluations of pharmacotherapeutics in patients with bipolar disorder. *Appl. Health Econ Health Policy*, 12 (4) : 359-372.

Abstract: BACKGROUND: Bipolar disorder (BD) is a chronic and relapsing mental illness with a considerable health-related and economic burden. The primary goal of pharmacotherapeutics for BD is to improve patients' well-being. The use of decision-analytic models is key in assessing the added value of the pharmacotherapeutics aimed at treating the illness, but concerns have been expressed about the appropriateness of different modelling techniques and about the transparency in the reporting of economic evaluations. OBJECTIVES: This paper aimed to identify and critically appraise published model-based economic evaluations of pharmacotherapeutics in BD patients. METHODS: A systematic review combining common terms for BD and economic evaluation was conducted in MEDLINE, EMBASE, PSYCINFO and ECONLIT. Studies identified were summarised and critically appraised in terms of the use of modelling technique, model structure and data sources. Considering the prognosis and management of BD, the possible benefits and limitations of each modelling technique are discussed. RESULTS: Fourteen studies were identified using model-based economic evaluations of pharmacotherapeutics in BD patients. Of these 14 studies, nine used Markov, three used discrete-event simulation (DES) and two used decision-tree models. Most of the studies (n = 11) did not include the rationale for the choice of modelling technique undertaken. Half of the studies did not include the risk of mortality. Surprisingly, no study considered the risk of having a mixed bipolar episode. CONCLUSIONS: This review identified various modelling issues that could potentially reduce the comparability of one pharmacotherapeutic intervention with another. Better use and reporting of the modelling techniques in the future studies are essential. DES modelling appears to be a flexible and comprehensive technique for evaluating the comparability of BD treatment options because of its greater flexibility of depicting the disease progression over time. However, depending on the research question, modelling techniques other than DES might also be appropriate in some cases.

Psychiatrie / Psychiatry

Fernandez F., Leze S. (2014). The psychiatric report as moral tool: A case study in a French district court. *Soc Sci Med*, 116C 41-48.

Abstract: Mental health evaluation within a legal setting is widely seen as a power to judge. The aim of this paper is to challenge this current thesis, which was popularised by Michel Foucault, who encapsulated the notion in a brief sentence: "The sordid business of punishing is thus converted into the fine profession of curing" (Foucault, 2003: 23). On the basis of an ethnography of a French district court (between September 2008 and May 2009, n = 60 trials) including interviews with judges (n = 10) and psychiatrists (n = 10), we study the everyday penal treatment of sexual offenders using psychiatric reports. Our findings show how (i.) the expectations of the judges select the psychiatrists' skills (based on the following criteria for their reports: accessibility of knowledge, singularization and individualization of content) and (ii.) reframe the psychiatric report as a moral tool. The clinical reasoning of forensic psychiatrists in their reports offer moral affordances due to their clinical caution

regarding the risk of recidivism (therapeutic and criminological reversal, moral prevention). Both the judges' evaluation and the psychiatrists' clinical authority are shaped by a moral economy of dangerousness, which eclipses the idea of lack of criminal responsibility. In conclusion, we show that these unintended effects are necessarily of interest to most clinical practitioners engaged in work as expert witnesses.

Soins de santé primaires / Primary Health Care

Wilensky G.R., Berwick D.M. (2014). Reforming the Financing and Governance of GME. *N Engl J Med*, 371:792-793

Abstract: Several recent reports have highlighted the mismatch between the health needs of the U.S. population and the specialty distribution of newly trained physicians, the continuing geographic maldistribution of physicians within the country, inadequate diversity among physicians, gaps in physicians' skills for practicing in the new health care delivery context, and the lack of fiscal transparency in the graduate medical education (GME) system. As a direct follow-on to two Macy Foundation reports on these issues,^{1,2} the Institute of Medicine (IOM) convened a Committee on the Governance and Financing of GME. That committee, which we cochaired, issued its own report on July 29.

<http://www.nejm.org/doi/full/10.1056/NEJMp1406174>

Richards M.R., Saloner B., Kenney G.M., Rhodes K., Polsky D. (2014). Access Points for the Underserved: Primary Care Appointment Availability at Federally Qualified Health Centers in 10 States. *Medical Care*, 52 (9) :

Abstract: Background:Federally Qualified Health Centers (FQHCs) are a vital source of primary care for underserved populations, such as Medicaid enrollees and the uninsured. Their role in delivering care may increase through new funding allocations in the Affordable Care Act and expanded Medicaid programs across many states. Objective:Examine differences in appointment availability and wait-times for new patient visits between FQHCs and other providers. Research Design:We use experimental data from a simulated patient study to compare new patient appointment rates across FQHC and non-FQHC practices for 3 insurance types (private, Medicaid, and self-pay). Trained auditors, posing as patients requesting the first available new patient appointment, were randomized to call primary care providers in 10 states in late 2012 and early 2013. Multivariate regression models adjust for caller-level, clinic-level, and area-level variables. Study Setting:The sample comprises 10,904 calls, including 544 calls to FQHCs. Results:FQHCs grant new patient appointments at high rates, irrespective of patient insurance status. Adjusting for caller, clinic, and area variables, the Medicaid appointment rate at FQHCs is 22 percentage points higher than other primary care practices. Although the appointment rate difference between FQHCs and non-FQHCs is somewhat smaller for the self-pay group, FQHCs are much more likely to provide a lower-cost visit to these patients. Conditional on receiving an appointment, wait-times at FQHCs are comparable with other providers. Conclusion:FQHCsGCÖ greater willingness to accept new underserved patients before 2014 underscores their potential key roles as health reform proceeds.

[http://journals.lww.com/lww-](http://journals.lww.com/lww-medicalcare/Fulltext/2014/09000/Access_Points_for_the_Underserved_Primary_Care.9.aspx)

[medicalcare/Fulltext/2014/09000/Access_Points_for_the_Underserved_Primary_Care.9.aspx](http://journals.lww.com/lww-medicalcare/Fulltext/2014/09000/Access_Points_for_the_Underserved_Primary_Care.9.aspx)

Poulsen C.A. (2014). Introducing out-of-pocket payment for general practice in Denmark: feasibility and support. *Health Policy*, 117 (1) : 64-71.

Abstract: AIMS: The financing of General Practice (GP) is a much-debated topic. In spite of out-of-pocket (OOP) payment for other primary health care provided by self-employed professionals, there is no OOP payment for the use of GP in Denmark. This article aims to explore the arguments, the actors and the decision-making context. METHODS AND MATERIALS: An analysis of the healthcare-policy debate in Parliament and the media from 1990 until September 2012. The materials are parliamentary hearings/discussions and newspaper articles. Kingdon's model on Policy Windows and the Advocacy Pôle documentation de l'Irdes / Irdes Documentation centre - Safon M.-O., Suhard V.

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www.irdes.fr/documentation/actualites.html

www.irdes.fr/documentation/veille-bibliographique-en-economie-de-la-sante.html

www.irdes.fr/english/documentation/watch-on-health-economics-literature.html

Coalition framework by Sabatier and Jenkins are used to investigate explanations. RESULTS: The arguments from the proponents are: that OOP payment for GP will reduce pressure on the primary sector; that the current allocation of OOP payment in the sector is historically conditioned; and that resistance towards OOP payment is based on emotions. The main argument from the opponents is that OOP payment will increase social inequality in health. CONCLUSIONS: There is little connection between the attitudes and ideological backgrounds of the political parties. Despite factors such as perceived expert/scientific evidence for OOP payment, changes of government, financial crisis and a market-based reform wave, no government has introduced OOP payment for GP. This article suggests that governmental positions, public- and especially health-professional support are important factors in the decision-making context.

Hong C.S., Abrams M.K., Ferris T.G. (2014). Toward increased adoption of complex care management. *N Engl J Med*, 371 (6) : 491-493.
PM:25099573

Knight A.W., Szucs C., Dhillon M., Lembke T., Mitchell C. (2014). The eCollaborative: using a quality improvement collaborative to implement the National eHealth Record System in Australian primary care practices. *Int J Qual. Health Care*, 26 (4) : 411-417.

Abstract: QUALITY PROBLEM: The new national patient-controlled electronic health record is an important quality improvement, and there was a pressing need to pilot its use in Australian primary care practices. Implementation of electronic health records in other countries has met with mixed success. INITIAL ASSESSMENT: New work was required in general practices participating in the national electronic health record. National implementers needed to engage with small private general practices to test the changes before general introduction. CHOICE OF SOLUTION: The National E-health Transition Authority contracted the Improvement Foundation Australia to conduct a quality improvement collaborative based on 9 years of experience with the Australian Primary Care Collaborative Program. IMPLEMENTATION: Aims, measures and change ideas were addressed in a collaborative programme of workshops and supported activity periods. Data quality measures and numbers of health summaries uploaded were collected monthly. Challenges such as the delay in implementation of the electronic health summary were met. EVALUATION: Fifty-six practices participated. Nine hundred and twenty-nine patients registered to participate, and 650 shared health summaries were uploaded. Five hundred and nineteen patient views occurred. Four hundred and twenty-one plan/do/study/act cycles were submitted by participating practices. LESSONS LEARNED: The collaborative methodology was adapted for implementing innovation and proved useful for engaging with multiple small practices, facilitating low-risk testing of processes, sharing ideas among participants, development of clinical champions and development of resources to support wider use. Email discussion between participants and system designers facilitated improvements. Data quality was a key challenge for this innovation, and quality measures chosen require development. Patient participants were partners in improvement.

McRae I., Butler J.R. (2014). Supply and demand in physician markets: a panel data analysis of GP services in Australia. *Int J Health Care Finance Econ*, 14 (3) : 269-287.

Abstract: To understand the trends in any physician services market it is necessary to understand the nature of both supply and demand, but few studies have jointly examined supply and demand in these markets. This study uses aggregate panel data on general practitioner (GP) services at the Statistical Local Area level in Australia spanning eight years to estimate supply and demand equations for GP services. The structural equations of the model are estimated separately using population-weighted fixed effects panel modelling with the two stage least squares formulation of the generalised method of moments approach (GMM (2SLS)). The estimated price elasticity of demand of [Formula: see text] is comparable with other studies. The direct impact of GP density on demand, while significant, proves almost immaterial in the context of near vertical supply curves. Supply changes are therefore due to shifts in the position of the curves, partly determined by a time trend. The model is validated by comparing post-panel model predictions with actual market outcomes over a period of three years and is found to provide surprisingly accurate projections over a period of significant policy change. The study confirms the need to jointly consider supply and demand in exploring the behaviour of physician services markets.

Johar M., Jones G., Savage E. (2014). What explains the quality and price of gp services? An investigation using linked survey and administrative data. *Health Econ*, 23 (9) : 1115-1133.

Abstract: We examine patient socioeconomic status, the strength of the patient-doctor relationship and local area competition as determinants of the quality and price of GP services. We exploit a large-sample patient data set in Australia and its linkage to administrative databases. The sample contains over 260 000 patients and over 12 600 GPs, observed between 2005 and 2010. Controlling for GP fixed effects and patient health, we find no strong evidence that quality differs by patient age, gender, country of origin, health concession card status and income, but quality is increased by stronger patient-doctor relationship. Using a competition measure that is defined at the individual GP level and not restricted to a local market, we find that competition lowers quality. Price is increasing in patient income, whereas competition has a small impact on price.

Systèmes de santé / Health Care Systems

Macinati M.S., Anessi-Pessina E. (2014). Management accounting use and financial performance in public health-care organisations: evidence from the Italian National Health Service. *Health Policy*, 117 (1) : 98-111.

Abstract: Reforms of the public health-care sector have emphasised the role of management accounting (MA). However, there is little systematic evidence on its use and benefits. To fill this gap, we propose a contingency-based model which addresses three related issues, that is, whether: (i) MA use is influenced by contextual variables and MA design; (ii) top-management satisfaction with MA mediates the relationship between MA design and MA use; and (iii) financial performance is influenced by MA use. A questionnaire was mailed out to all Italian public health-care organisations. Structural equation modelling was performed to validate the research hypotheses. The response rate was 49%. Our findings suggest that: (i) cost-containment strategies encourage more sophisticated MA designs; (ii) MA use is directly and indirectly influenced by contingency, organisational, and behavioural variables; (iii) a weakly significant positive relationship exists between MA use and financial performance. These findings are relevant from the viewpoint of both top managers and policymakers. The former must make sure that MA is not only technically advanced, but also properly understood and appreciated by users. The latter need to be aware that MA may improve performance in ways and along dimensions that may not fully translate into better financial results.

Howard L.L. (2014). Do the Medicaid and Medicare programs compete for access to health care services? A longitudinal analysis of physician fees, 1998-2004. *Int J Health Care Finance Econ*, 14 (3) : 229-250.

Abstract: As the demand for publicly funded health care continues to rise in the U.S., there is increasing pressure on state governments to ensure patient access through adjustments in provider compensation policies. This paper longitudinally examines the fees that states paid physicians for services covered by the Medicaid program over the period 1998-2004. Controlling for an extensive set of economic and health care industry characteristics, the elasticity of states' Medicaid fees, with respect to Medicare fees, is estimated to be in the range of 0.2-0.7 depending on the type of physician service examined. The findings indicate a significant degree of price competition between the Medicaid and Medicare programs for physician services that is more pronounced for cardiology and critical care, but not hospital care. The results also suggest several policy levers that work to either increase patient access or reduce total program costs through changes in fees.

Travail et santé / Occupational Health

Dollard M.F., Nesar D.Y. (2013). Worker health is good for the economy: union density and psychosocial safety climate as determinants of country differences in worker health and productivity in 31 European countries. *Soc Sci Med*, 92 114-123.

Abstract: Work stress is recognized globally as a social determinant of worker health. Therefore we explored whether work stress related factors explained national differences in health and productivity (gross domestic product (GDP)). We proposed a national worker health productivity model whereby macro market power factors (i.e. union density), influence national worker health and GDP via work psychosocial factors and income inequality. We combined five different data sets canvassing 31 wealthy European countries. Aggregated worker self-reported health accounted for 13 per cent of the variance in national life expectancy and in national gross domestic product (GDP). The most important factors explaining worker self-reported health and GDP between nations were two levels of labor protection, macro-level (union density), and organizational-level (psychosocial safety climate, PSC, i.e. the extent of management concern for worker psychological health). The majority of countries with the highest levels of union density and PSC (i.e., workplace protections) were Social Democratic in nature (i.e., Sweden, Finland, Denmark, Norway). Results support a type of society explanation that social and economic factors (e.g., welfare regimes, work related policies) in concert with political power agents at a national level explain in part national differences in workplace protection (PSC) that are important for worker health and productivity. Attention should be given across all countries, to national policies to improve worker health, by bolstering national and local democratic processes and representation to address and implement policies for psychosocial risk factors for work stress, bullying and violence. Results suggest worker health is good for the economy, and should be considered in national health and productivity accounting. Eroding unionism may not be good for worker health or the economy either.

Frijters P., Johnston D.W., Shields M.A. (2014). The effect of mental health on employment: evidence from Australia 2014. *Health Economics*, (Ahead of pub) : n/a.

Abstract: To what extent does poor mental health affect employment outcomes? Answering this question involves multiple technical difficulties: two-way causality between health and work, unobservable confounding factors and measurement error in survey measures of mental health. We attempt to overcome these difficulties by combining 10 waves of high-quality panel data with an instrumental variable model that allows for individual-level fixed effects. We focus on the extensive margin of employment, and we find evidence that a one-standard-deviation decline in mental health reduces employment by 30 percentage points. Further investigations suggest that this effect is predominantly a supply rather than a demand-side response and is larger for older than young workers.

<http://dx.doi.org/10.1002/hec.3083>

Duguet E., Le Clainche C. (2014). The Effect of Non-Work Related Health Events on Career Outcomes: An Evaluation in the French Labor Market. *Revue d'Economie Politique*, 124 (3) : 437-465.

Abstract: L'effet des événements de santé non reliés au travail sur les carrières professionnelles: une évaluation sur le marché du travail français Cet article analyse l'effet d'une maladie chronique et des accidents sur les performances sur le marché du travail. Nous utilisons l'enquête « Santé Itinéraires professionnels (SIP) réalisée en 2006-2007. Nous évaluons l'impact des maladies chroniques et des accidents en utilisant la méthode du score de propension et trouvons que ces événements de santé affectent négativement la carrière professionnelle, les femmes se trouvant plus souvent bénéficiaires du RMI. Par ailleurs, si le premier choc de santé a des effets de long terme en général, il est différencié par genre et par la nature du choc de santé: les effets pour les hommes montrent une domination des effets de court terme s'agissant des accidents tandis qu'à long terme ce sont les effets des maladies chroniques qui dominent. Nous ne trouvons pas de résultats similaires pour les femmes, les accidents ayant aussi des effets de long terme.

Lundborg P., Nilsson A., Rooth D.O. (2014). Adolescent health and adult labor market outcomes. *J Health Econ*, 37 25-40.

Abstract: Whereas a large literature has shown the importance of early life health for adult socioeconomic outcomes, there is little evidence on the importance of adolescent health. We contribute to the literature by studying the impact of adolescent health status on adult labor market outcomes using a unique and large-scale dataset covering almost the entire population of Swedish males. We show that most types of major conditions have long-run effects on future outcomes, and that the strongest effects result from mental conditions. Including sibling fixed effects or twin pair fixed effects reduces the magnitudes of the estimates, but they remain substantial.

Frijters P., Johnston D.W., Shields M.A. (2014). The effect of mental health on employment: evidence from Australian panel data. *Health Econ*, 23 (9) : 1058-1071.

Abstract: To what extent does poor mental health affect employment outcomes? Answering this question involves multiple technical difficulties: two-way causality between health and work, unobservable confounding factors and measurement error in survey measures of mental health. We attempt to overcome these difficulties by combining 10 waves of high-quality panel data with an instrumental variable model that allows for individual-level fixed effects. We focus on the extensive margin of employment, and we find evidence that a one-standard-deviation decline in mental health reduces employment by 30 percentage points. Further investigations suggest that this effect is predominantly a supply rather than a demand-side response and is larger for older than young workers.

Vieillessement / Ageing

Ichida Y., Hirai H., Kondo K., Kawachi I., Takeda T., Endo H. (2013). Does social participation improve self-rated health in the older population? A quasi-experimental intervention study. *Soc Sci Med*, 94 83-90.

Abstract: Social participation has been linked to healthy aging and the maintenance of functional independence in older individuals. However, causality remains tenuous because of the strong possibility of reverse causation (healthy individuals selectively participate in social activities). We describe a quasi-experimental intervention in one municipality of Japan designed to boost social participation as a way of preventing long-term disability in senior citizens through the creation of 'salons' (or community centers). In this quasi-experimental intervention study, we compared 158 participants with 1391 non-participants in salon programs, and examined the effect of participation in the salon programs on self-rated health. We conducted surveys of community residents both before (in 2006) and after (in 2008) the opening of the salons. Even with a pre/post survey design, our study could be subject to reverse causation and confounding bias. We therefore utilized an instrumental variable estimation strategy, using the inverse of the distance between each resident's dwelling and the nearest salon as the instrument. After controlling for self-rated health, age, sex, equivalized income in 2006, and reverse causation, we observed significant correlations between participation in the salon programs and self-rated health in 2008. Our analyses suggest that participation in the newly-opened community salon was associated with a significant improvement in self-rated health over time. The odds ratio of participation in the salon programs for reporting excellent or good self-rated health in 2008 was 2.52 (95% CI 2.27-2.79). Our study provides novel empirical support for the notion that investing in community infrastructure to boost the social participation of communities may help promote healthy aging.

Moore H., Gillespie A. (2014). The caregiving bind: Concealing the demands of informal care can undermine the caregiving identity. *Soc Sci Med*, 116C 102-109.

Abstract: Disagreements and misunderstandings between informal caregivers and care-receivers have been widely reported, but the causes are unclear. The present article compares the views of people with acquired brain injury and their main informal caregivers (28 dyads, n = 56). First, we report a quantitative analysis finding that the majority of disagreements were about caregivers' identity. Caregivers saw themselves as less confident, less intelligent, more embarrassed, more independent and more overprotective than care-receivers rated them to be. Caregivers understood the care-receivers' ratings but disagreed with them' Second, we report a qualitative analysis focussing on how caregivers felt themselves to be perceived by significant others. Caregivers felt that the care-receiver, family members, the general public, health services and even friends often have negative views of them. The 'caregiving bind' is proposed as a cause of caregivers' negative identity. It arises when caregivers try to protect the care-receiver's identity by concealing the extent of informal care provision, with the unintended consequence of undermining the prospects of the caregiver receiving positive social recognition for the challenging work of caregiving. The caregiving bind has implications for therapy and points to the potential of friends and health services to provide caregivers with positive social recognition.

Ilinca S., Calciolari S. (2014). The Patterns of Health Care Utilization by Elderly Europeans: Frailty and Its Implications for Health Systems. *Health Serv Res*,

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

Fairhall N., Sherrington C., Lord S.R., Kurrle S.E., Langron C., Lockwood K., Monaghan N., Aggar C., Cameron I.D. (2014). Effect of a multifactorial, interdisciplinary intervention on risk factors for falls and fall rate in frail older people: a randomised controlled trial. *Age Ageing*, 43 (5) : 616-622.

Abstract: BACKGROUND: frail older people have a high risk of falling. OBJECTIVE: assess the effect of a frailty intervention on risk factors for falls and fall rates in frail older people. DESIGN: randomised controlled trial. PARTICIPANTS: 241 community-dwelling people aged 70+ without severe cognitive impairment who met the Cardiovascular Health Study frailty definition. INTERVENTION: multifactorial, interdisciplinary intervention targeting frailty characteristics with an individualised home exercise programme prescribed in 10 home visits from a physiotherapist and interdisciplinary management of medical, psychological and social problems. MEASUREMENTS: risk factors for falls were measured using the Physiological Profile Assessment (PPA) and mobility measures at 12 months by a blinded assessor. Falls were monitored with calendars. RESULTS: participants had a mean (SD) age of 83.3 (5.9) years, 68% were women and 216 (90%) completed the study. After 12 months the intervention group had significantly better performance than the control group, after controlling for baseline values, in the PPA components of quadriceps strength (between-group difference 1.84 kg, 95% CI 0.17-3.51, P = 0.03) and body sway (-90.63 mm, 95% CI -168.6 to -12.6, P = 0.02), short physical performance battery (1.58, 95% CI 1.02-2.14, P <= 0.001) and 4 m walk (0.06 m/s 95% CI 0.01-0.10, P = 0.02) with a trend toward a better total PPA score (-0.40, 95% CI -0.83-0.04, P = 0.07) but no difference in fall rates (incidence rate ratio 1.12, 95% CI 0.78-1.63, P = 0.53). CONCLUSION: the intervention improved performance on risk factors for falls but did not reduce the rate of falls. TRIAL REGISTRATION: ACTRN12608000250336.

Patterson L. (2014). Making our health and care systems fit for an ageing population: David Oliver, Catherine Foot, Richard Humphries. King's Fund March 2014. *Age Ageing*, 43 (5) : 731.

Ellis G. (2014). Timely care for frail older people: the next battleground. *Age Ageing*, 43 (5) : 732.