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Economie de la santé / Health Economics

Kiil, A., Houlberg, K. (2014). How does copayment for health care services affect demand, health and redistribution? A systematic review of the empirical evidence from 1990 to 2011. *Eur J Health Econ* 15(8), 813-828.

Abstract: This article reviews the quantitative evidence on the behavioural effects of copayment within the health area across a wide range of countries. The review distinguishes itself from previous similar reviews by having a high degree of transparency for the search strategy used to identify the studies included in the review as well as the criteria for inclusion and by including the most recent literature. Empirical studies were identified by performing searches in EconLit. The literature search identified a total of 47 studies of the behavioural effects of copayment. Considering the demand effects, the majority of the reviewed studies found that copayment reduces the use of prescription medicine, consultations with general practitioners and specialists, and ambulatory care, respectively. The literature found no significant effects of copayment on the prevalence of hospitalisations. The empirical evidence on whether copayment for some services, but not for others, causes substitution from the services that are subject to copayment to the 'free' services rather than lower total use is sparse and mixed. Likewise, the health effects of copayment have only been analysed empirically in a limited number of studies, of which half did not find any significant effects in the short term. Finally, the empirical evidence on the distributional consequences of copayment indicates that individuals with low income and in particular need of care generally reduce their use relatively more than the remaining population in consequence of copayment. Hence, it is clear that copayment involves some important economic and political trade-offs.

Baji, P., Pavlova, M., Gulacsi L., Farkas, M., Groot, W. (2014). The link between past informal payments and willingness of the Hungarian population to pay formal fees for health care services: results from a contingent valuation study. *Eur J Health Econ* 15(8), 853-867.

Abstract: We examine the willingness of health care consumers to pay formal fees for health care use and how this willingness to pay is associated with past informal payments. We use data from a survey carried out in Hungary in 2010 among a representative sample of 1,037 respondents. The contingent valuation method is used to elicit the willingness to pay official charges for health care services covered by the social health insurance if certain quality attributes (regarding the health care facility, access to the services and health care personnel) are guaranteed. A bivariate probit model is applied to examine the relationship between willingness to pay and past informal payments. We find that 66 % of the respondents are willing to pay formal fees for specialist examinations and 56 % are willing to pay for planned hospitalizations if these services are provided with certain quality and access attributes. The act of making past informal payments for health care services is positively associated with the willingness to pay formal charges. The probability that a respondent is willing to pay official charges for health care services is 22 % points higher for specialist examinations and 45 % points higher for hospitalization if the respondent paid informally during the last 12 months. The introduction of formal fees should be accompanied by adequate service provision to assure acceptance of the fees. Furthermore, our results suggest that the problem of informal patient payments may remain even after the implementation of user fees.

Geue, C., Briggs, A., Lewsey, J., Lorgelly, P. (2014). Population ageing and healthcare expenditure projections: new evidence from a time to death approach. *Eur J Health Econ* 15(8), 885-896.

Abstract: BACKGROUND: Health care expenditure (HCE) is not distributed evenly over a person's life course. How much is spent on the elderly is important as they are a population group that is increasing in size. However other factors, such as death-related costs that are known to be high, need be considered as well in any expenditure projections and budget planning decisions. OBJECTIVE: This article analyses, for the first time in Scotland, how expenditure projections for acute inpatient care are influenced when applying two different analytical approaches: (1) accounting for healthcare (HC) spending at the end of life and (2) accounting for demographic changes only. The association between

socioeconomic status and HC utilisation and costs at the end of life is also estimated. METHODS: A representative, longitudinal data set is used. Survival analysis is employed to allow inclusion of surviving sample members. Cost estimates are derived from a two-part regression model. Future population estimates were obtained for both methods and multiplied separately by cost estimates. RESULTS: Time to death (TTD), age at death and the interaction between these two have a significant effect on HC costs. As individuals approach death, those living in more deprived areas are less likely to be hospitalised than those individuals living in the more affluent areas, although this does not translate into incurring statistically significant higher costs. Projected HCE for acute inpatient care for the year 2028 was approximately 7 % higher under the demographic approach as compared to a TTD approach. CONCLUSION: The analysis showed that if death is postponed into older ages, HCE (and HC budgets) would not increase to the same extent if these factors were ignored. Such factors would be ignored if the population that is in their last year(s) of life were not taken into consideration when obtaining cost estimates.

Géographie de la santé / Geography of Health

Hudebine H., Jourdain A., Munoz J.(2014). Les premières années des ARS dans le secteur médico-social. *Journal de Gestion et d'Economie Médicales* 32(3), 81-82.

Li, J., Scott, A., McGrail, M., Humphreys, J., Witt, J. (2014). Retaining rural doctors: Doctors' preferences for rural medical workforce incentives. *Soc Sci Med* 121C 56-64.

Abstract: Many governments have implemented incentive programs to improve the retention of doctors in rural areas despite a lack of evidence of their effectiveness. This study examines rural general practitioners' (GPs') preferences for different types of retention incentive policies using a discrete choice experiment (DCE). In 2009, the DCE was administered to a group of 1720 rural GPs as part of the "Medicine in Australia: Balancing Employment and Life (MABEL)" study. We estimate both a mixed logit model and a generalized multinomial logit model to account for different types of unobserved differences in GPs' preferences. Our results indicate that increased level of locum relief incentive, retention payments and rural skills loading leads to an increase in the probability of attracting GPs to stay in rural practice. The locum relief incentive is ranked as the most effective, followed by the retention payments and rural skills loading payments. These findings are important in helping to tailor retention policies to those that are most effective.

Hôpital / Hospitals

(2014). Séminaire de l'étude nationale de coût à méthodologie commune. *Journal de Gestion et d'Economie Médicales* 32(2), 105-162.

Abstract: Ce fascicule restitue les communications du Séminaire de l'étude nationale des coûts à méthodologie commune, qui ont eu lieu à Bordeaux les 7 et 8 novembre 2014.

Quan, H., Moskal, L., Forster, A.J., Brien, S., Walker R., Romano, P.S., Sundararajan, V., Burnand, B., Henriksson, G., Steinum, O., Droessler, S., Pincus, H.A., Ghali, W.A. (2014). International variation in the definition of 'main condition' in ICD-coded health data. *Int J Qual. Health Care* 26(5), 511-515.

Abstract: Hospital-based medical records are abstracted to create International Classification of Disease (ICD) coded discharge health data in many countries. The 'main condition' is not defined in a consistent manner internationally. Some countries employ a 'reason for admission' rule as the basis for the main condition, while other countries employ a 'resource use' rule. A few countries have

recently transitioned from one of these approaches to the other. The definition of 'main condition' in such ICD data matters when it is used to define a disease cohort to assign diagnosis-related groups and to perform risk adjustment. We propose a method of harmonizing the international definition to enable researchers and international organizations using ICD-coded health data to aggregate or compare hospital care and outcomes across countries in a consistent manner. Inter-observer reliability of alternative harmonization approaches should be evaluated before finalizing the definition and adopting it worldwide.

Ukawa, N., Ikai, H., Imanaka, Y. (2014). Trends in hospital performance in acute myocardial infarction care: a retrospective longitudinal study in Japan. *Int J Qual. Health Care* 26 (5), 516-523.

Abstract: OBJECTIVE: To elucidate the hospital characteristics associated with hospital performance and time trends in acute myocardial infarction (AMI) care using multilevel multivariable analysis of longitudinal data. DESIGN: Retrospective longitudinal study. SETTING: One hundred and fourteen hospitals in Japan. PARTICIPANTS: A total of 26 210 AMI patients admitted between 2008 and 2011. MAIN OUTCOME MEASURE: A composite score was calculated from five AMI process measures. Hospital performances and time trends were then investigated based on this composite score. Using generalized linear mixed models with random intercepts (indicating hospital baseline performance) and random slopes (indicating trends in improvement), we analyzed the associations between performance and the following factors: hospital ownership, AMI case volume, number of cardiovascular specialists per AMI patient and participation in a public disclosure program. RESULTS: Hospitals that demonstrated high performance in the composite score were significantly associated with high AMI case volume, municipal ownership and agreement to named disclosure of hospital performance. The following factors were significantly associated with time trends of improvement in performance: public and private ownership, AMI case volume and number of cardiovascular specialists per AMI patient. In addition, higher performances were associated with diminished improvement. CONCLUSIONS: Time trends in improvement were related to baseline performance and several hospital characteristics. Furthermore, hospitals that had agreed to named disclosure of performance were more likely to have better quality of care at the initial point of public disclosure. These findings can inform the decision-making process for quality improvement, and allow a greater understanding and interpretation of disclosed performances in quality measures.

Blecker, S., Shine, D., Park, N., Goldfeld, K., Scott, B.R., Radford, M.J., Gourevitch, M.N. (2014). Association of weekend continuity of care with hospital length of stay. *Int J Qual. Health Care* 26(5), 530-537.

Abstract: OBJECTIVE: The purpose of this study was to evaluate the association of physician continuity of care with length of stay, likelihood of weekend discharge, in-hospital mortality and 30-day readmission. DESIGN: A cohort study of hospitalized medical patients. The primary exposure was the weekend usual provider continuity (UPC) over the initial weekend of care. This metric was adapted from an outpatient continuity of care index. Regression models were developed to determine the association between UPC and outcomes. SETTING: An academic medical center. MAIN OUTCOME MEASURE: Length of stay which was calculated as the number of days from the first Saturday of the hospitalization to the day of discharge. RESULTS: Of the 3391 patients included in this study, the prevalence of low, moderate and high UPC for the initial weekend of hospitalization was 58.7, 22.3 and 19.1%, respectively. When compared with low continuity of care, both moderate and high continuity of care were associated with reduced length of stay, with adjusted rate ratios of 0.92 (95% CI 0.86-1.00) and 0.64 (95% CI 0.53-0.76), respectively. High continuity of care was associated with likelihood of weekend discharge (adjusted odds ratio 2.84, 95% CI 2.11-3.83) but was not significantly associated with mortality (adjusted odds ratio 0.72, 95% CI 0.29-1.80) or readmission (adjusted odds ratio 0.88, 95% CI 0.68-1.14) when compared with low continuity of care. CONCLUSIONS: Increased weekend continuity of care is associated with reduced length of stay. Improvement in weekend cross-coverage and patient handoffs may be useful to improve clinical outcomes.

Van De Steeg, L., Langelaan, M., Wagner, C. (2014). Can preventable adverse events be predicted among hospitalized older patients? The development and validation of a predictive model. *Int J Qual. Health Care* 26(5), 547-552.

Abstract: OBJECTIVE: To develop and validate a predictive model for preventable adverse events (AEs) in hospitalized older patients, using clinically important risk factors that are readily available on admission. DESIGN: Data from two retrospective patient record review studies on AEs were used. Risk factors included patient characteristics as well as admission and organizational characteristics. Multilevel logistical regression analysis was used to develop the model. Backward elimination was applied to identify the most parsimonious model. SETTING: Twenty-one Dutch hospitals were included in the 2004 sample and 20 Dutch hospitals in the 2008 sample. PARTICIPANTS: A total of 3977 patients aged 70 years or over who were admitted to a Dutch hospital in 2004 and 2119 patients aged 70 years or over admitted in 2008. MAIN OUTCOME MEASURES: Identified predictors of preventable AEs in older patients. RESULTS: In 2004 predictors of preventable AEs in patients aged 70 years or over were increased age (OR 1.04, confidence interval (CI) 1.01-1.06); elective admission (OR 1.65, CI 1.14-2.40) and admission to a surgical department (OR 1.53, CI 1.08-2.16). The area under the receiver operating characteristic curve for the 2004 sample was 0.60 and for 2008, 0.59. CONCLUSIONS: This study showed that several expected risk factors for preventable AEs in older patients, including comorbidity, could not predict these events. It was not possible, using in-patient data available on admission and collected during the course of two patient record review studies, to develop a satisfactory predictive model for preventable AEs in older patients.

Inégalités de santé / Health Inequalities

Siegel, M., Vogt, V., Sundmacher, L. (2014). From a conservative to a liberal welfare state: decomposing changes in income-related health inequalities in Germany, 1994-2011. *Soc Sci Med* 108 10-19.

Abstract: Individual socio-economic status and the respective socio-economic and political contexts are both important determinants of health. Welfare regimes may be linked with health and health inequalities through two potential pathways: first, they may influence the associations between socio-economic status and health. Second, they may influence the income-related distributions of socio-economic determinants of health within a society. Using the Socio-Economic Panel (SOEP) for the years 1994-2011, we analyze how income-related health inequalities evolved in the context of the transformation from a conservative to a liberal welfare system in Germany. We use the concentration index to measure health inequalities, and the annual concentration indices are decomposed to reveal how the contributions of the explanatory variables age, sex, income, education, and occupation changed over time. The changes in the contributions are further decomposed to distinguish whether changes in health inequalities stem from redistributions of the explanatory variables, from changes in their associations with health, or from changes in their means. Income-related health inequalities to the disadvantage of the economically deprived roughly doubled over time, which can largely be explained by changes in the contributions of individual characteristics representing weaker labor market positions, particularly income and unemployment. The social and labor market reforms coincide with the observed changes in the distributions of these characteristics and, to a lesser extent, with changes of their associations with health.

Allanson, P., Petrie, D. (2014). Understanding the vertical equity judgements underpinning health inequality measures. *Health Economics* 23(11), 1390-1396.

Abstract: The choice of income-related health inequality measures in comparative studies is often determined by custom and analytical concerns, without much explicit consideration of the vertical equity judgements underlying alternative measures. This note employs an inequality map to illustrate how these judgements determine the ranking of populations by health inequality. In particular, it is

shown that relative indices of inequality in health attainments and shortfalls embody distinct vertical equity judgments, where each may represent ethically defensible positions in specific contexts. Further research is needed to explore people's preferences over distributions of income and health.

Shareck, M., Kestens, Y., Frohlich, K.L. (2014). Moving beyond the residential neighborhood to explore social inequalities in exposure to area-level disadvantage: Results from the Interdisciplinary Study on Inequalities in Smoking. *Soc Sci Med* 108 106-114.

Abstract: The focus, in place and health research, on a single, residential, context overlooks the fact that individuals are mobile and experience other settings in the course of their daily activities. Socio-economic characteristics are associated with activity patterns, as well as with the quality of places where certain groups conduct activities, i.e. their non-residential activity space. Examining how measures of exposure to resources, and inequalities thereof, compare between residential and non-residential contexts is required. Baseline data from 1890 young adults (18-25 years-old) participating in the Interdisciplinary Study of Inequalities in Smoking, Montreal, Canada (2011-2012), were analyzed. Socio-demographic and activity location data were collected using a validated, self-administered questionnaire. Area-level material deprivation was measured within 500-m road-network buffer zones around participants' residential and activity locations. Deprivation scores in the residential area and non-residential activity space were compared between social groups. Multivariate linear regression was used to estimate associations between individual- and area-level characteristics and non-residential activity space deprivation, and to explore whether these characteristics attenuated the education-deprivation association. Participants in low educational categories lived and conducted activities in more disadvantaged areas than university students/graduates. Educational inequalities in exposure to area-level deprivation were larger in the non-residential activity space than in the residential area for the least educated, but smaller for the intermediate group. Adjusting for selected covariates such as transportation resources and residential deprivation did not significantly attenuate the education-deprivation associations. Results support the existence of social isolation in residential areas and activity locations, whereby less educated individuals tend to be confined to more disadvantaged areas than their more educated counterparts. They also highlight the relevance of investigating both residential and non-residential contexts when studying inequalities in health-relevant exposures.

Embrett, M.G., Randall, G.E. (2014). Social determinants of health and health equity policy research: exploring the use, misuse, and nonuse of policy analysis theory. *Soc Sci Med* 108 147-155.

Abstract: Despite a dramatic growth in SDH/HE (social determinants of health/health equity) public policy research and demonstrated government interest in promoting equity in health policies, health inequities are actually growing among some populations and there is little evidence that "healthy public policies" are being adopted and implemented. Moreover, these issues are typically failing to even reach governments' policy agendas, which is a critical step towards serious debate and the identification of policy options. This systematic review pursues three main objectives. First, is to identify barriers to SDH/HE issues reaching the government policy agenda. Second, to evaluate the characteristics of peer-reviewed research articles that utilize common policy analysis theories. And third, to determine the extent to which the SDH/HE literature utilizes common policy analysis theories. Our systematic review, conducted in June 2012, identified 6200 SDH/HE related articles in the peer-reviewed literature; however, only seven articles explicitly used a commonly recognized policy analysis theory to inform their analysis. Our analysis revealed that the SDH/HE policy literature appears to be focused on advocacy rather than analysis and that the use of policy analysis theory is extremely limited. Our results also suggest that when such theories are incorporated into an analysis they are often not comprehensively employed. We propose explanations for this non-use and misuse of policy analysis theory, and conclude that researchers may have greater influence in helping to get SDH/HE issues onto government policy agendas if they gain a greater understanding of the policy process and the value of incorporating policy analysis theories into their research. Using a policy analysis lens to help identify why healthy public policies are typically not being adopted is an important step towards moving beyond advocacy to understanding and addressing some of the political barriers to reforms.

Arber, S., Fenn, K., Meadows, R. (2014). Subjective financial well-being, income and health inequalities in mid and later life in Britain. *Soc Sci Med* 100 12-20.

Abstract: The relationship between health and income is well established, but the link between subjective financial well-being and self-reported health has been relatively ignored. This study investigates the relationship between income, subjective financial well-being and health in mid-life and later life in Britain. Analysis of the General Household Survey for 2006 examined these relationships at ages 45-64 (n = 4639) and 65 and over (n = 3104). Logistic regression analysis was used to adjust for income and other socio-economic factors associated with self-reported health. Both income and subjective financial well-being are independently associated with health in mid-life; those with lower incomes and greater subjective financial difficulties had higher risk of reporting 'less than good' health. In contrast in later life, subjective financial well-being was associated with health, but the effect of income on health was mediated entirely through subjective financial well-being. The poorer health of the divorced/separated was also entirely mediated by differences in subjective financial well-being. Research on health inequalities should pay greater attention to the link between subjective financial hardship and ill-health, especially during periods of greater economic difficulties and financial austerity.

Woodward, A., Howard, N., Wolffers, I. (2014). Health and access to care for undocumented migrants living in the European Union: a scoping review. *Health Policy Plan* 29(7), 818-830.

Abstract: BACKGROUND: Literature on health and access to care of undocumented migrants in the European Union (EU) is limited and heterogeneous in focus and quality. Authors conducted a scoping review to identify the extent, nature and distribution of existing primary research (1990-2012), thus clarifying what is known, key gaps, and potential next steps. METHODS: Authors used Arksey and O'Malley's six-stage scoping framework, with Levac, Colquhoun and O'Brien's revisions, to review identified sources. Findings were summarized thematically: (i) physical, mental and social health issues, (ii) access and barriers to care, (iii) vulnerable groups and (iv) policy and rights. RESULTS: Fifty-four sources were included of 598 identified, with 93% (50/54) published during 2005-2012. EU member states from Eastern Europe were under-represented, particularly in single-country studies. Most study designs (52%) were qualitative. Sampling descriptions were generally poor, and sampling purposeful, with only four studies using any randomization. Demographic descriptions were far from uniform and only two studies focused on undocumented children and youth. Most (80%) included findings on health-care access, with obstacles reported at primary, secondary and tertiary levels. Major access barriers included fear, lack of awareness of rights, socioeconomic. Mental disorders appeared widespread, while obstetric needs and injuries were key reasons for seeking care. Pregnant women, children and detainees appeared most vulnerable. While EU policy supports health-care access for undocumented migrants, practices remain haphazard, with studies reporting differing interpretation and implementation of rights at regional, institutional and individual levels. CONCLUSIONS: This scoping review is an initial attempt to describe available primary evidence on health and access to care for undocumented migrants in the European Union. It underlines the need for more and better-quality research, increased co-operation between gatekeepers, providers, researchers and policy makers, and reduced ambiguities in health-care rights and obligations for undocumented migrants.

Siegel, M., Mielck, A., Maier, W. (2014). Individual income, area deprivation, and health: do income-related-health inequalities vary by small area deprivation? *Health Econ.* [Epub ahead of print]

Abstract: This paper aims to explore potential associations between health inequalities related to socioeconomic deprivation at the individual and the small area level. We use German cross-sectional survey data for the years 2002 and 2006, and measure small area deprivation via the German Index of Multiple Deprivation. We test the differences between concentration indices of income-related and small area deprivation related inequalities in obesity, hypertension, and diabetes. Our results suggest that small area deprivation and individual income both yield inequalities in health favoring the better-off, where individual income-related inequalities are significantly more pronounced than those related to small area deprivation. We then apply a semiparametric extension of Wagstaff's corrected concentration index to explore how individual-level health inequalities vary with the degree of regional deprivation. We find that the concentration of obesity, hypertension, and diabetes among lower

income groups also exists at the small area level. The degree of deprivation-specific income-related inequalities in the three health outcomes exhibits only little variations across different levels of multiple deprivation for both sexes.

Helgertz, J., Persson, M.R. (2014). Early life conditions and long-term sickness absence during adulthood - A longitudinal study of 9000 siblings in Sweden. *Soc Sci Med. [Epub ahead of print]*

Abstract: This study examines the influence of health conditions experienced during the individual's first year of life on the incidence of sickness absence during adulthood. Using a sample of approximately 9000 biological siblings from 17 countries of origin and living in Sweden during the time period 1981-1991, sibling fixed effect models are estimated. This approach is combined with the use of an exogenous measurement of early life conditions, operationalized as the infant mortality rate. The link between early life conditions and later life outcomes is examined both with and without intermediary characteristics observed during the individual's childhood and adulthood, aiming for a better understanding regarding to what extent the effect of exposure to an early life insult can be mediated. The results suggest that exposure to worse health conditions during the first year of life is associated with an elevated risk of experiencing sickness absence during adulthood. An increase in infant mortality rate by ten per thousand is associated with a four percentage point higher probability of experiencing sickness absence. Despite the importance of adulthood socioeconomic status on sickness absence propensity, these factors do not mediate the influence from the health conditions experienced during the first year of life, suggesting that the association from early life conditions on sickness absence in adulthood operates as a direct mechanism. The link between early life conditions and sickness absence is only present for children to parents with primary schooling and not for individuals with more educated parents. These findings suggest that families with more abundant resources have the ability to protect their child from exposure to adverse health conditions during early life, or to cancel out the influence from an early life insult.

Krieger N. (2014). Discrimination and Health Inequities. *International Journal of Health Services* 44(4), 643-710.

Abstract: In 1999, only 20 studies in the public health literature employed instruments to measure self-reported experiences of discrimination. Fifteen years later, the number of empirical investigations on discrimination and health easily exceeds 500, with these studies increasingly global in scope and focused on major types of discrimination variously involving race/ethnicity, indigenous status, immigrant status, gender, sexuality, disability, and age, separately and in combination. And yet, as I also document, even as the number of investigations has dramatically expanded, the scope remains narrow: studies remain focused primarily on interpersonal discrimination, and scant research investigates the health impacts of structural discrimination, a gap consonant with the limited epidemiologic research on political systems and population health. Accordingly, to help advance the state of the field, this updated review article: (a) briefly reviews definitions of discrimination, illustrated with examples from the United States; (b) discusses theoretical insights useful for conceptualizing how discrimination can become embodied and produce health inequities, including via distortion of scientific knowledge; (c) concisely summarizes extant evidence both robust and inconsistent linking discrimination and health; and (d) addresses several key methodological controversies and challenges, including the need for careful attention to domains, pathways, level, and spatiotemporal scale, in historical context.

Cabieses K., Bird P. (2014). Glossary of Access to Health Care and Related Concepts for Low- and Middle-Income Countries (LMICs): A Critical Review of International Literature. *International Journal of Health Services* 44(4), 845-861.

Abstract: Access to health care is a multidimensional and complex concept. Achieving equitable access to care is an important goal for all countries, but particularly challenging in Low- and Middle-Income Countries (LMICs). Despite wide use of the concept of access, it continues to be defined and measured in very different ways. This glossary is a structured overview of key definitions for concepts related to access to health care, with special focus on the interpretation for LMICs. It aims to help people with interest in health service delivery to draw an overview and provide some pointers for further reading in both conceptual and empirical advances in access to health care in LMICs. This

document is structured in five sections. The first introduces a general description of the concept of access to health care and its relevance to LMICs, the second displays the search conducted on access to health care for LMICs and the framework used for presentation of glossary terms, the third describes theoretical models most frequently used in the past when looking at access to health care in LMICs, the fourth is the list of terms, and the final section is a discussion of the most salient aspects of this critical review.

Fusco, A., Silber, J. (2014). On social polarization and ordinal variables: the case of self-assessed health. *Eur J Health Econ* 15(8), 841-851.

Abstract: Social polarization refers to the measurement of the distance between different social groups, defined on the basis of variables such as race, religion, or ethnicity. We propose two approaches to measuring social polarization in the case where the distance between groups is based on an ordinal variable, such as self-assessed health status. The first one, the 'stratification approach', amounts to assessing the degree of non-overlapping of the distributions of the ordinal variable between the different population subgroups that are distinguished. The second one, the 'antipodal approach', considers that the social polarization of an ordinal variable will be maximal if the individuals belonging to a given population subgroup are in the same health category, this category corresponding either to the lowest or to the highest health status. An empirical illustration is provided using the 2009 cross-sectional data of the European Union Statistics on Income and Living Conditions (EU-SILC). We find that Estonia, Latvia, and Ireland have the highest degree of social polarization when the ordinal variable under scrutiny refers to self-assessed health status and the (unordered) population subgroups to the citizenship of the respondent whereas Luxembourg is the country with the lowest degree of social polarization in health.

Au, N., Johnston, D.W. (2014). Self-assessed health: What does it mean and what does it hide? *Soc Sci Med* 121C 21-28.

Abstract: Self-assessed general health (SAH) is one of the most frequently employed health measures in social science research. Its generic nature means it captures elements of health that more guided measures cannot, and its brevity makes it possible for health information to be included in crowded multifaceted surveys. However, a shortcoming of SAH is that it provides little guidance to researchers as to what individuals are thinking of when they assess their health - when a survey respondent reports that their health is "poor", is it because they are in pain, tired, depressed, unable to climb stairs, or something else entirely? This limits the possible inference from empirical research. It also means that important determinants and consequences of health can be missed if they are only weakly reflected in SAH. Given the continued use of SAH, it is important to better understand its structure. In this paper we use household panel data from Australia to answer two related questions: (i) what components of health does SAH most strongly represent? and (ii) does the use of SAH conceal important health effects? To answer the first question, we use a detailed health instrument and take a rigorous econometric approach to identify the health dimensions most strongly reflected in SAH. To answer the second question, we estimate the causal effects of income on SAH and on disaggregated health measures using instrumental-variables models. We find that some health dimensions - especially vitality - are consistently important to an individual when they assess their health, while other dimensions are inconsequential. We demonstrate that this fact provides insight in to why some studies find weak income gradients in SAH. Instrumental-variable regression results show that shocks to household income have no effect on SAH, but strongly improve several dimensions of health that are less commonly measured.

Médicaments / Pharmaceuticals

Lessing, C., Ashton, T., Davis, P. (2014). The impact on health outcomes and healthcare utilisation of switching to generic medicines consequent to reference pricing: the case of lamotrigine in New Zealand. *Appl. Health Econ Health Policy* 12(5), 537-546.

Abstract: BACKGROUND: Many countries have implemented generic reference pricing and substitution as methods of containing pharmaceutical expenditure. However, resistance to switching between medicines is apparent, especially in the case of anti-epileptic medicines. OBJECTIVES: This study sought to exploit a nation-wide policy intervention on generic reference pricing in New Zealand to evaluate the health outcomes of patients switching from originator to generic lamotrigine, an anti-epileptic medicine. METHODS: A retrospective study using the national health collections and prescription records was conducted comparing patients who switched from originator brand to generic lamotrigine with patients who remained on the originator brand. Primary outcome measures included switch behaviour, changes in utilisation of healthcare services at emergency departments, hospitalisations and use of specialist services, and mortality. RESULTS: Approximately one-quarter of all patients using the originator brand of lamotrigine switched to generic lamotrigine, half of whom made the switch within 60 days of the policy implementation. Multiple switches (three or more) between generic and brand products were evident for around 10 % of switchers. Switch-back rates of 3 % were apparent within 30 days post-switch. No difference in health outcome measures was associated with switching from originator lamotrigine to a generic equivalent and hence no increased costs could be found for switchers. CONCLUSIONS: Switching from brand to generic lamotrigine is largely devoid of adverse health outcomes; however, creating an incentive to ensure a greater proportion of patients switch to generic lamotrigine is required to achieve maximal financial savings from a policy of generic reference pricing.

Hirsch, B.R., Balu, S., Schulman, K.A. (2014). The impact of specialty pharmaceuticals as drivers of health care costs. *Health Aff. (Millwood.)* 33(10), 1714-1720.

Abstract: The pharmaceutical industry is shifting its focus from blockbuster small molecules to specialty pharmaceuticals. Specialty pharmaceuticals are novel drugs and biologic agents that require special handling and ongoing monitoring, are administered by injection or infusion, and are sold in the marketplace by a small number of distributors. They are frequently identified by having a cost to payers and patients of \$600 or more per treatment. The total costs of the new agents are likely to have a substantial impact on overall health care costs and on patients during the next decade, unless steps are taken to align competing interests. We examine the economic and policy issues related to specialty pharmaceuticals, taking care to consider the impact on patients. We assess the role of cost-sharing provisions, legislation that is promoting realignment within the market, the role of biosimilars in price competition, and the potential for novel drug development paradigms to help bend the cost curve. The economic aspects of this analysis highlight the need for a far-reaching discussion of potential novel approaches to innovation pathways in our quest for both affordability and new technology.

Chambers, J.D., Thorat, T., Pyo, J., Chenoweth, M., Neumann, P.J. (2014). Despite high costs, specialty drugs may offer value for money comparable to that of traditional drugs. *Health Aff. (Millwood.)* 33(10), 1751-1760.

Abstract: Specialty drugs are often many times more expensive than traditional drugs, which raises questions of affordability and value. We compared the value of specialty and traditional drugs approved by the Food and Drug Administration (FDA) in the period 1999-2011. To do this, we identified published estimates of additional health gains (measured in quality-adjusted life-years, or QALYs) and increased costs of drug and health care resource use that were associated with fifty-eight specialty drugs and forty-four traditional drugs, compared to preexisting care. We found that specialty drugs offered greater QALY gains (0.183 versus 0.002 QALYs) but were associated with greater additional costs (\$12,238 versus \$784), compared to traditional drugs. The two types of drugs had comparable cost-effectiveness. However, the distributions across the two types differed, with 26 percent of specialty drugs-but only 9 percent of traditional drugs-associated with incremental cost-effectiveness ratios of greater than \$150,000 per QALY. Our study suggests that although specialty drugs often have higher costs than traditional drugs, they also tend to confer greater benefits and hence may still offer reasonable value for money.

Schoenenberger, A.W., Stuck, A.E. (2014). Inappropriate drug use among older persons: is it time for action? *Age Ageing* 43(6), 737-739.

Tosato, M., Landi, F., Martone, A.M., Cherubini, A., Corsonello, A., Volpato, S., Bernabei, R., Onder, G. (2014). Potentially inappropriate drug use among hospitalised older adults: results from the CRIME study. *Age Ageing* 43(6), 767-773.

Abstract: BACKGROUND: Beers criteria and screening tool of older person's prescriptions (STOPP) criteria are widely used to assess potentially inappropriate drug use (PIDU). OBJECTIVE: the aims of the present study are (i) to assess the prevalence of PIDU based on 2012 Beers criteria and STOPP criteria and (ii) to determine the impact of PIDU, as defined by these criteria, on health outcomes among older in-hospital patients. DESIGN: prospective observational study. SETTING AND SUBJECTS: a total of 871 in-hospital patients participating to the CRIME to Assess Appropriate Medication Use among Elderly Complex Patients project. METHODS: outcome measures were (i) adverse drug reactions (ADR); (ii) decline in functional status; (iii) combined outcome (ADR or declined in functional status). RESULTS: the prevalence of PIDU was 58.4% applying Beers criteria, 50.4% applying STOPP criteria and 75.0% combining both sets of criteria. PIDU defined based on STOPP criteria was significantly associated with ADR [odds ratio (OR) 2.36; 95% confidence interval (CI) 1.10-5.06], and decline in physical function (OR: 2.00; 95% CI: 1.10-3.64), while, despite a positive trend, no significant association was observed for Beers criteria or the combination of both criteria. The combined outcome was significantly associated with PIDU defined based on Beers (OR: 1.74; 95% CI: 1.06-2.85), STOPP criteria (OR: 2.14; 95% CI: 1.32-3.47) or both (OR 2.02; 95% CI: 1.06-3.84). CONCLUSIONS: PIDU is common in hospitalised older adults and the combination of Beers and STOPP criteria might lead to the identification of a larger number of cases of PIDU than the application of a single set of criteria. STOPP criteria significantly predict all in-hospital outcomes considered, while Beers criteria were significantly associated with the combined outcome only.

Méthodologie – Statistique / Methodology – Statistics

Batinti, A. (2014). On medical progress and health care demand: a CES perspective using the Grossman model of health status. *Health Econ.*

Abstract: I propose an application of the pure-consumption version of the Grossman model of health care demand, where utility depends on consumption and health status and health status on medical care and health technology. I derive the conditions under which an improvement in health care technology leads to an increase/decrease in health care consumption. In particular, I show how the direction of the effect depends on the relationship between the constant elasticity of substitution parameters of the utility and health production functions. I find that, under the constancy assumption, the ratio of the two elasticity of substitution parameters determines the direction of a technological change on health care demand. On the other hand, the technology share parameter in the health production function contributes to the size but not to the direction of the technological effect. I finally explore how the ratio of the elasticity of substitution parameters work in measurement and practice and discuss how future research may use the theoretical insight provided here. Copyright (c) 2014 John Wiley Sons, Ltd.

Politique de santé / Health Politics

Lombrail P. Orientations du projet de loi de santé : aller plus loin pour répondre aux défis structurels du système de santé. *Santé Publique* 26(4), 475-80. 2014.

Boes, S., Marti, J., Maclean, J.C. (2014). The impact of smoking bans on smoking and consumer behavior: quasi-experimental evidence from Switzerland. *Health Econ.*

Abstract: In this paper, we exploit the progressive implementation of smoking bans in public venues at the state level in Switzerland to evaluate both the direct effects on smoking and the potential

unintended consequences of these legislations on consumer behaviors as measured by visiting restaurants/bars and discos ('going out'). Our results indicate that public venue smoking bans in Switzerland reduce smoking rates, but the findings do not emerge until 1 year following the ban. This pattern of results is consistent with delays in ban enforcement on the part of business owners, difficulties in changing addictive behaviors such as smoking, and/or learning on the part of smokers. We find evidence that smoking bans influence going-out behavior and there is substantial heterogeneity across venue and consumer characteristics.

Fierlbeck, K. (2014). The changing contours of experimental governance in European health care. *Soc Sci Med* 108 89-96.

Abstract: For over a decade, beginning in the late 1990s, discussion over softer modes of governance animated academic scholarship in the fields of law, politics, and public policy. This debate was especially pronounced in Europe. Since the late 2000s, however, discussion of this approach has declined precipitously. Is the "soft governance" model dead? Or, more precisely, has the economic crisis killed it? This article argues that, to the contrary, the EU's austerity measures have made softer governance more relevant in two quite distinct ways. Administratively, new mechanisms of health policy coordination are able to provide policy solutions in a much more effective way than could more formal and rigid forms of legal harmonisation. Politically, it establishes a normative perspective which unifies actors across a number of administrative units and challenges the dominant ideological force of the market-based principles upon which the EU's austerity policies are constructed.

Prévision – Evaluation

Hutter, M.F., Rodriguez-Ibeas, R., Antonanzas, F. (2014). Methodological reviews of economic evaluations in health care: what do they target? *Eur J Health Econ* 15(8), 829-840.

Abstract: INTRODUCTION AND OBJECTIVES: An increasing number of published studies of economic evaluations of health technologies have been reviewed and summarized with different purposes, among them to facilitate decision-making processes. These reviews have covered different aspects of economic evaluations, using a variety of methodological approaches. The aim of this study is to analyze the methodological characteristics of the reviews of economic evaluations in health care, published during the period 1990-2010, to identify their main features and the potential missing elements. This may help to develop a common procedure for elaborating these kinds of reviews. METHODS: We performed systematic searches in electronic databases (Scopus, Medline and PubMed) of methodological reviews published in English, period 1990-2010. We selected the articles whose main purpose was to review and assess the methodology applied in the economic evaluation studies. We classified the data according to the study objectives, period of the review, number of reviewed studies, methodological and non-methodological items assessed, medical specialty, type of disease and technology, databases used for the review and their main conclusions. We performed a descriptive statistical analysis and checked how generalizability issues were considered in the reviews. RESULTS: We identified 76 methodological reviews, 42 published in the period 1990-2001 and 34 during 2002-2010. The items assessed most frequently (by 70 % of the reviews) were perspective, type of economic study, uncertainty and discounting. The reviews also described the type of intervention and disease, funding sources, country in which the evaluation took place, type of journal and author's characteristics. Regarding the intertemporal comparison, higher frequencies were found in the second period for two key methodological items: the source of effectiveness data and the models used in the studies. However, the generalizability issues that apparently are creating a growing interest in the economic evaluation literature did not receive as much attention in the reviews of the second period. The remaining items showed similar frequencies in both periods. CONCLUSIONS: Increasingly more reviews of economic evaluation studies aim to analyze the application of methodological principles, and offer summaries of papers classified by either diseases or health technologies. These reviews are useful for finding literature trends, aims of studies and possible deficiencies in the implementation of methods of specific health interventions. As no significant

methodological improvement was clearly detected in the two periods analyzed, it would be convenient to pay more attention to the methodological aspects of the reviews.

Psychiatrie / Psychiatry

Green, H. (2014). Classification in psychiatry: Inevitable but not insurmountable. *Soc Theory Health* 12(4), 361-375.

Abstract: The debate about psychiatric nosology was reignited last year when the fifth edition of the Diagnostic and Statistical Manual (DSM) was published to widespread criticism. Critics cite a number of problems with /'psychiatric diagnosis/', though it is sometimes unclear which classificatory practices are included under this broad heading. Although it may be possible to avoid the problems inherent in the DSM system, other difficulties associated with classification (labelling, stigma) may prove harder to escape. The first part of this article argues that some form of psychiatric classification is made inevitable by the communicative, epistemic and ethical pressures on psychiatry. In the second half it is suggested that there are ways to think differently about our relationship to psychiatric classification, and that these could play a role in mitigating the harms outlined by diagnosis/' critics.

Soins de santé primaires / Primary Health Care

Huard P.Schaller P. Éléments pour une gestion stratégique d'une maison de santé. *Santé Publique* (4), 509-517. 2014.

Abstract: Objectif : L'article vise à souligner l'intérêt d'une approche stratégique pour aider au développement d'une maison de santé (MS). Méthodes : La méthode est adaptée de la stratégie d'entreprise : (i) Analyse de la situation de la MS et des obstacles à son développement. (ii) Sélection des relations sur lesquelles la stratégie peut être élaborée. (iii) Élaboration du système d'interventions susceptible de donner naissance à un processus cumulatif de développement. (iv) Illustration de la méthode par une application sur un cas. Résultats : L'illustration permet de préciser les principes et la méthode ; elle souligne l'importance des interprétations et des choix dans l'élaboration d'une stratégie qui est donc toujours une construction particulière. Conclusion : L'approche stratégique fournit un cadre qui (i) sert d'objet de discussion et de négociation entre les membres de la MS, (ii) renforce la cohérence des décisions structurelles, (iii) aide la MS à dépasser les blocages et à initier un processus de développement.

Brunt C., Jensen G. (2014). Payment generosity and physician acceptance of Medicare and Medicaid patients. *International Journal of Health Care Finance and Economics* 14(4), 289-310.

Abstract: Using 2008 physician survey data, we estimate the relationship between the generosity of fees paid to primary care physicians under Medicaid and Medicare and his/her willingness to accept new patients covered by Medicaid, Medicare, or both programs (i.e., dually enrolled patients). Findings reveal physicians are highly responsive to fee generosity under both programs. Also, their willingness to accept patients under either program is affected by the generosity of fees under the other program, i.e., there are significant spillover effects between Medicare and Medicare fee generosity. We also simulate how physicians in 2008 would have likely responded to Medicaid and Medicare payment reforms similar to those embodied in the 2010 Affordable Care Act, had they been permanently in place in 2008. Our findings suggest that "Medicaid Parity" for primary care physicians would have likely dramatically improved physician willingness to accept new Medicaid patients while only slightly reducing their willingness to accept new Medicare patients. Also, many more primary care physicians would have been willing to treat dually enrolled patients.

Meininger, V., Fontaine, B., Grabli, D., Basdevant, A., Clement, K., Vignot, M., Cordesse, V. (2014). [What about a new job in the health system: The coordinator of care]. *Presse Med* 43(10 Pt 1), 1031-1033.

Abimbola, S., Negin, J., Jan, S., Martiniuk, A. (2014). Towards people-centred health systems: a multi-level framework for analysing primary health care governance in low- and middle-income countries. *Health Policy Plan* 29 Suppl 2 ii29-ii39.

Abstract: Although there is evidence that non-government health system actors can individually or collectively develop practical strategies to address primary health care (PHC) challenges in the community, existing frameworks for analysing health system governance largely focus on the role of governments, and do not sufficiently account for the broad range of contribution to PHC governance. This is important because of the tendency for weak governments in low- and middle-income countries (LMICs). We present a multi-level governance framework for use as a thinking guide in analysing PHC governance in LMICs. This framework has previously been used to analyse the governance of common-pool resources such as community fisheries and irrigation systems. We apply the framework to PHC because, like common-pool resources, PHC facilities in LMICs tend to be commonly owned by the community such that individual and collective action is often required to avoid the 'tragedy of the commons'-destruction and degradation of the resource resulting from lack of concern for its continuous supply. In the multi-level framework, PHC governance is conceptualized at three levels, depending on who influences the supply and demand of PHC services in a community and how: operational governance (individuals and providers within the local health market), collective governance (community coalitions) and constitutional governance (governments at different levels and other distant but influential actors). Using the example of PHC governance in Nigeria, we illustrate how the multi-level governance framework offers a people-centred lens on the governance of PHC in LMICs, with a focus on relations among health system actors within and between levels of governance. We demonstrate the potential impact of health system actors functioning at different levels of governance on PHC delivery, and how governance failure at one level can be assuaged by governance at another level.

Martinez-Gonzalez, N.A., Berchtold, P., Ullman, K., Busato, A., Egger, M. (2014). Integrated care programmes for adults with chronic conditions: a meta-review. *Int J Qual. Health Care* 26(5), 561-570.

Abstract: OBJECTIVE: To review systematic reviews and meta-analyses of integrated care programmes in chronically ill patients, with a focus on methodological quality, elements of integration assessed and effects reported. DESIGN: Meta-review of systematic reviews and meta-analyses identified in Medline (1946-March 2012), Embase (1980-March 2012), CINHALL (1981-March 2012) and the Cochrane Library of Systematic Reviews (issue 1, 2012). MAIN OUTCOME MEASURES: Methodological quality assessed by the 11-item Assessment of Multiple Systematic Reviews (AMSTAR) checklist; elements of integration assessed using a published list of 10 key principles of integration; effects on patient-centred outcomes, process quality, use of healthcare and costs. RESULTS: Twenty-seven systematic reviews were identified; conditions included chronic heart failure (CHF; 12 reviews), diabetes mellitus (DM; seven reviews), chronic obstructive pulmonary disease (COPD; seven reviews) and asthma (five reviews). The median number of AMSTAR checklist items met was five: few reviewers searched for unpublished literature or described the primary studies and interventions in detail. Most reviews covered comprehensive services across the care continuum or standardization of care through inter-professional teams, but organizational culture, governance structure or financial management were rarely assessed. A majority of reviews found beneficial effects of integration, including reduced hospital admissions and re-admissions (in CHF and DM), improved adherence to treatment guidelines (DM, COPD and asthma) or quality of life (DM). Few reviews showed reductions in costs. CONCLUSIONS: Systematic reviews of integrated care programmes were of mixed quality, assessed only some components of integration of care, and showed consistent benefits for some outcomes but not others.

Wang, J.J., Cha, J., Sebek, K.M., McCullough, C.M., Parsons, A.S., Singer, J., Shih, S.C. (2014). Factors Related to Clinical Quality Improvement for Small Practices Using an EHR. *Health Serv Res*.

Abstract: OBJECTIVE: To analyze the impact of three primary care practice transformation program models on performance: Meaningful Use (MU), Patient-Centered Medical Home (PCMH), and a pay-for-performance program (eHearts). DATA SOURCES/STUDY SETTING: Data for seven quality measures (QM) were retrospectively collected from 192 small primary care practices between October 2009 and October 2012; practice demographics and program participation status were extracted from in-house data. STUDY DESIGN: Bivariate analyses were conducted to measure the impact of individual programs, and a Generalized Estimating Equation model was built to test the impact of each program alongside the others. DATA COLLECTION/EXTRACTION METHODS: Monthly data were extracted via a structured query data network and were compared to program participation status, adjusting for variables including practice size and patient volume. Seven QMs were analyzed related to smoking prevention, blood pressure control, BMI, diabetes, and antithrombotic therapy. PRINCIPAL FINDINGS: In bivariate analysis, MU practices tended to perform better on process measures, PCMH practices on more complex process measures, and eHearts practices on measures for which they were incentivized; in multivariate analysis, PCMH recognition was associated with better performance on more QMs than any other program. CONCLUSIONS: Results suggest each of the programs can positively impact performance. In our data, PCMH appears to have the most positive impact.

Kralewski, J., Dowd, B., Knutson, D., Tong, J., Savage, M. (2014). The Relationships of Physician Practice Characteristics to Quality of Care and Costs. *Health Serv Res.* [Epub ahead of print]

Abstract: BACKGROUND: Medical group practices are central to many of the proposals for health care reform, but little is known about the relationship between practice-level characteristics and the quality and cost of care. METHODS: Practice characteristics from a 2009 national survey of 211 group practices were linked to Medicare claims data for beneficiaries attributed to the practices. Multivariate regression was used to examine the relationship between practice characteristics and claims-computable measures of screening and monitoring, avoidable utilization, risk-adjusted per-beneficiary per-year (PBPY) costs, and the practice's net revenue. RESULTS: Several characteristics of group practices are predictive of screening and monitoring measures. Those measures, in turn, are predictive of lower values of avoidable utilization measures that contribute to higher PBPY costs. The effects of group practice characteristics on avoidable utilization, cost, and practice net revenue appear to work primarily through improved screening and monitoring. CONCLUSIONS: Practice characteristics influence costs indirectly through a set of statistically significant relationships among screening and monitoring measures and avoidable utilization. However, these relationships are not the only pathways connecting practice characteristics to cost and those additional pathways contain substantial "noise" adding uncertainty to the estimated direct effects. Some of the attributes thought to be important characteristics of accountable care organizations and medical homes appear to be associated with lower quality and no improvement in cost.

Van Dijk, C.E., Korevaar, J.C., Koopmans, B., de Jong, J.D., de Bakker, D.H. (2014). The primary-secondary care interface: Does provision of more services in primary care reduce referrals to medical specialists? *Health Policy.* [Epub ahead of print]

Abstract: Great variation in referral rates between primary care physicians has been the main reason to influence physician's referral behaviour, by for example, stimulating extra services. This study investigated the extent to which the number of therapeutic and diagnostic services performed by primary care physicians influenced referrals. Data was derived from electronic medical records of 70 general practices for the period 2006 until 2010. For the total patient population (N=651,089 patient years) and specific patients groups for whom specific services were performed mostly (28 groups; 10 services), logistic multilevel regression analyses were conducted to determine associations between the number of services performed in a practice and referrals to medical specialists. The total number of services performed in a practice was not associated with the referral rate (OR: 1.00). Only for two specific services was a significant association found: a lower referral rate for minor surgery for patient with sebaceous cysts (OR: 0.98) and a higher rate for Doppler diagnostic tests for patients with other peripheral arterial diseases (OR: 1.04). As the number of services in general practice was rarely associated with referrals, other measures might be more effective in changing referral behaviour. Another explanation for our results could be that certain preconditions have not been met.

Janus, K., Brown, L.D. (2014). Physician integration revisited-An exploratory study of monetary and professional incentives in three countries. *Health Policy*. [Epub ahead of print]

Abstract: Discussions - and definitions - of "integration" in health services and systems are abundant, but little is known about the inducements that organizational leaders use to win the support of physicians within integrated systems. This paper, drawing on a qualitative exploratory survey of sources within 151 integrated care organizations in three nations (the U.S., England, and Germany), explores the mix of monetary and professional inducements these organizations employ to attract and retain physicians. The organizations we sampled do not rely exclusively, and seldom preponderantly, on selective monetary incentives, but rather employ a composite portfolio of the two types. These inducements appear with remarkable consistency at the "micro" level of organizations in our three nations, notwithstanding the marked differences in their "macro" health systemic contexts. Since public policy sets the framework for the design of inducements and individual organizations are in charge of their implementation, our findings call for closer attention to the big motivational picture, and especially to the importance of professional considerations within it, if healthcare organizations hope to deploy effectively the whole spectrum of available incentives for physician-organization integration in the future.

Pierard, E. (2014). The effect of physician supply on health status: Canadian evidence. *Health Policy*. [Epub ahead of print]

Abstract: We estimate the relationship between per capita supply of physicians, both general practitioners and specialists, and health status of Canadians. We use data from the Canadian National Population Health Survey and the Canadian Institute for Health Information. Two measures of quality of life, self-assessed health status and the Health Utility Index, are explored. Random effects ordered probits are used to model self-assessed health status, and quantile regressions are used for the Health Utility Index. A higher supply of general practitioners is correlated with better health outcomes as measured by both measures of health status, albeit for different age groups, and it is correlated with a higher HUI for some individuals who report having a chronic condition. A higher supply of specialists is correlated with worse health outcomes for the HUI for some individuals. It is possible that a higher supply of general practitioners increases the likelihood of diagnosing and treating health conditions in a timely manner and that this in turn affects health status. Specialists, due to the nature of their expertise could affect negatively health, both through the use of riskier procedures and due to their clientele being in relatively worse health. Based on our findings, we therefore would recommend maintaining a robust supply and distribution of GPs across Canada.

Quinones, A.R., Ramsey, K., Newsom, J. T., Dorr, D.A. (2014). Racial and ethnic differences in clinical outcome trajectories for care managed patients. *Med Care* 52(11), 998-1005.

Abstract: BACKGROUND: Care management has demonstrated improvements in quality of care for patients with complex care needs. The extent to which these interventions benefit race/ethnic minority populations is unclear. OBJECTIVES: To characterize race/ethnic differences in the longitudinal control of clinical outcomes for patients with complex care needs enrolled in Care Management Plus, a health information technology-enabled care coordination intervention. RESEARCH DESIGN: Multilevel models of repeated observations from clinical encounters before and after program enrollment for 6 Oregon and California primary care clinics. SUBJECTS: A total of 18,675 clinic patients were examined. We estimated multilevel models for 1481 and 5320 care-managed individuals with repeated hemoglobin A1c and blood pressure measurements, respectively. MEASURES: Primary outcomes were changes over time for 2 clinical markers of health status for complex care patients: (1) hemoglobin A1c for patients with diabetes; and (2) mid-blood pressure (BP) (average systolic and diastolic blood pressure). RESULTS: We found significant reductions in A1c for patients with previously uncontrolled A1c (preperiod slope, $b=1.03$ [0.83, 1.24]; postperiod slope, $b=-0.63$ [-0.91, -0.35]). For mid-BP we found increasing unconditional preperiod trajectories ($b=3.52$ [2.39, 4.64]) and decreasing postperiod trajectories ($b=-5.21$ [-5.70, -4.72]). We also found the trajectories of A1c and mid-BP were not statistically different for black, Latino, and white patients. CONCLUSIONS: These analyses demonstrate some promising results for intermediate clinical outcomes for underrepresented patients with complex chronic care needs. It remains to be seen whether these health care system

delivery redesigns yield long-term benefits for patients, such as improvements in function and quality of life.

Bourke, J., Roper, S. (2014). The influence of experiential learning on medical equipment adoption in general practices. *Health Policy*. [Epub ahead of print]

Abstract: The benefits of the availability and use of medical equipment for medical outcomes are understood by physicians and policymakers alike. However, there is limited understanding of the decision-making processes involved in adopting and using new technologies in health care organisations. Our study focuses on the adoption of medical equipment in Irish general practices which are marked by considerable autonomy in terms of commercial practice and the range of medical services they provide. We examine the adoption of six items of medical equipment taking into account commercial, informational and experiential stimuli. Our analysis is based on primary survey data collected from a sample of 601 general practices in Ireland on practice characteristics and medical equipment use. We use a multivariate Probit to identify commonalities in the determinants of the adoption. Many factors, such as GP and practice characteristics, influence medical equipment adoption. In addition, we find significant and consistent evidence of the influence of learning-by-using effects on the adoption of medical equipment in a general practice setting. Knowledge generated by experiential or applied learning can have commercial, organisational and health care provision benefits in small health care organisations.

Emmert, M., Meier, F., Heider, A.K., Durr, C., Sander, U. (2014). What do patients say about their physicians? An analysis of 3 000 narrative comments posted on a German physician rating website. *Health Policy*. [Epub ahead of print]

Abstract: BACKGROUND: Physician rating websites (PRWs) could be shown to have an impact on physician choice making. However, little research has been carried out to assess the content and nature of narrative comments. OBJECTIVE: The aim of this study was to explore the concerns of patients who commented on physician care and to address and enhance patient satisfaction. METHODS: Content analysis of 3000 randomly selected narrative comments from the German PRW, jameda, from 2012. We therefore developed a theoretical categorization framework addressing physician, staff, and practice related patient concerns. FINDINGS: In total, 50 sub-categories addressing the physician (N=20), the office staff (N=13), and the practice (N=17) were derived from the content of all comments. The most frequently mentioned concerns were assessing the professional competence of the physician (63%, N=1874) and friendliness of the physician (38%, N=1148). Thereby, 80% of all comments (mean length 45.3 words +/-42.8) were classified as positive, 4% as neutral and 16% as negative. CONCLUSION: Users of the German PRW, jameda, are mostly satisfied with their physicians. However, physicians should focus on the time spent with the patients, waiting time, as well as on taking the patients more seriously.

Schmid, C. (2014). Consumer health information and the demand of physician visits. *Health Econ*. [Epub ahead of print]

Abstract: The present study empirically investigates the effect of consumer health information on the demand for physician visits. Using a direct information measure based on questions from the Swiss Health Survey, we estimate a Poisson hurdle model for office visits. We find that information has a negative effect on health care utilization, contradicting previous findings in the literature. We consider differences in the used information measures to be the most likely explanation for the different findings. However, our results suggest that increasing consumer health information has the potential to reduce health care expenditures.

Systèmes de santé / Health Care Systems

Barnes,A.J., Unruh,L., Chukmaitov,A., Van Ginneken, E. (2014). Accountable care organizations in the USA: Types, developments and challenges. *Health Policy*. [Epub ahead of print]

Abstract: A historically fragmented U.S. health care system, where care has been delivered by multiple providers with little or no coordination, has led to increasing issues with access, cost, and quality. The Affordable Care Act included provisions to use Medicare, the U.S. near universal public coverage program for older adults, to broadly implement Accountable Care Organization (ACO) models with a triple aim of improving the experience of care, the health of populations, and reducing per capita costs. Private payers in the U.S. are also embracing ACO models. Various European countries are experimenting with similar reforms, particularly those in which coordinated (or integrated) care from a network of providers is reimbursed with bundled payments and/or shared savings. The challenges for these reforms remain formidable and include: (1) overcoming incentives for ACOs to engage in rationing and denial of care and taking on too much financial risk, (2) collecting meaningful data that capture quality and enable rewarding quality improvement and not just volume reduction, (3) creating incentives for ACOs that do not accept much risk to engage in prevention and health promotion, and (4) creating effective governance and IT structures that are patient-centered and integrate care.

Hofmarcher, M.M. (2014). The Austrian health reform 2013 is promising but requires continuous political ambition. *Health Policy*[ahead of print]

Abstract: The Austrian health system is much more complex and fragmented than in other OECD countries. In 2013 legislation was adopted to enhance efficiency through better balancing care provision across providers by promoting new primary care models and better coordination of care. Reform objectives should be achieved by cooperative and unified decision making across key stakeholders and by adherence to a budget cap that prescribes fiscal containment on the order of 3.4 billion Euros until 2016. This is priced into the envisaged savings of the current consolidation program. Efforts have been made to bridge the accountability divide by establishing agreements and administrative layers to govern the health system by objectives. Yet, more could have been achieved. For example, cross-stakeholder pooling of funds for better contracting governance and effective purchasing across care settings could have been introduced. This would have required addressing overcapacity and fragmentation within social security. At the same time, legal provisions for cooperative governance between Sickness Funds and the governments on the regional level should have been stipulated. The Austrian 2013 reform is interesting to other countries as it aims to ensure better-balanced care at a sustainable path by employing a public management approach to governance relations across key payers of care.

Gebel,M., Vossemer,J. (2014). The impact of employment transitions on health in Germany. A difference-in-differences propensity score matching approach. *Soc Sci Med* 108 128-136.

Abstract: This article investigates the effects of transitions between employment and unemployment on health. It also addresses the question of whether or not the widespread use of temporary employment has altered the positive health effects of employment. Drawing on data from the German Socio-Economic Panel for the period 1995-2010, we apply difference-in-differences propensity score matching to identify the direct causal effects of unemployment and reemployment on psychological and physical health. This combination of two approaches towards causal inference controls for both unobserved fixed effects and observable differences in a flexible semi-parametric specification. Our sample includes persons between the ages of 16-54 who have at least experienced one respective employment transition (treatment groups) or are continuously employed or unemployed (control groups). The results show that only psychological but not physical health is causally affected by the respective employment transitions. Specifically, the effects of unemployment and reemployment are of similar size, highlighting the importance of reemployment in compensating unemployment's negative

impact on psychological health. In contrast, health selection and confounding seem to be important determinants of the cross-sectional association between unemployment and physical health. Carrying out separate analyses for permanent and temporary workers, we shed new light on the health effects of temporary employment. It has been argued that the rise of temporary employment has introduced a new inequality in the world of work, blurring the line between employment and unemployment. However, contrary to our expectations we find that both employment transitions have effects of a similar size for permanent and temporary workers. In sum, our results highlight two points. First, longitudinal research is needed to properly evaluate the health effects of unemployment, reemployment, and temporary employment. Second, compared to temporary employment, unemployment is still the greater threat to individuals' psychological health.

Travail et santé / Occupational Health

Bradford, W.D., Lastrapes, W.D. (2014). A prescription for unemployment? Recessions and the demand for mental health drugs. *Health Econ* 23(11), 1301-1325.

Abstract: We estimate the relationship between mental health drug prescriptions and the level of labor market activity in the USA. Based on monthly data from the National Ambulatory Medical Care Survey of physicians and aggregated by US census regions, we find that the number of mental health drug prescriptions (those aimed at alleviating depression and anxiety) rises by about 10% when employment falls by 1% and when unemployment rises by 100 basis points, but only for patients in the Northeast region. This paper is one of the first to look at compensatory health behavior in response to the business cycle.

Reeves, A., Karanikolos, M., Mackenbach, J., McKee, M., Stuckler, D. (2014). Do employment protection policies reduce the relative disadvantage in the labour market experienced by unhealthy people? A natural experiment created by the Great Recession in Europe. *Social Science & Medicine* 121(0), 98-108.

Abstract : Unhealthy persons are more likely to lose their jobs than those who are healthy but whether this is affected by recession is unclear. We asked how healthy and unhealthy persons fared in labour markets during Europe's 2008–2010 recessions and whether national differences in employment protection helped mitigate any relative disadvantage experienced by those in poor health. Two retrospective cohorts of persons employed at baseline were constructed from the European Statistics of Income and Living Conditions in 26 EU countries. The first comprised individuals followed between 2006 and 2008, $n = 46,085$ (pre-recession) and the second between 2008 and 2010, $n = 85,786$ (during recession). We used multi-level (individual- and country-fixed effects) logistic regression models to assess the relationship (overall and disaggregated by gender) between recessions, unemployment, and health status, as well as any modifying effect of OECD employment protection indices measuring the strength of policies against dismissal and redundancy. Those with chronic illnesses and health limitations were disproportionately affected by the recession, respectively with a 1.5- and 2.5-fold greater risk of unemployment than healthy people during 2008–2010. During severe recessions (>7% fall in GDP), employment protections did not mitigate the risk of job loss (OR = 1.06, 95% CI: 0.94–1.21). However, in countries experiencing milder recessions (<7% fall in GDP), each additional unit of employment protection reduced job loss risk (OR = 0.72, 95% CI: 0.58–0.90). Before the recession, women with severe health limitations especially benefited, with additional reductions of 22% for each unit of employment protection (AOR_{female} = 0.78, 95% CI: 0.62–0.97), such that at high levels the difference in the risk of job loss between healthy and unhealthy women disappeared. Employment protection policies may counteract labour market inequalities between healthy and unhealthy people, but additional programmes are likely needed to protect vulnerable groups during severe recessions.

Hammig, O., Gutzwiller, F., Kawachi, I. (2014). The contribution of lifestyle and work factors to social inequalities in self-rated health among the employed population in Switzerland. *Soc Sci Med* 121C 74-84.

Abstract: We sought to examine the joint and independent contributions of working conditions and health-related behaviours in explaining social gradients in self-rated health (SRH). Nationally representative cross-sectional data from the Swiss Health Survey of 2007 were used for this study. Bi- and multivariate statistical analyses were carried out on a sample of 6950 adult employees of working age. We examined a comprehensive set of five health behaviours and lifestyle factors as well as twelve physical and psychosocial work factors as potential mediators of the relationship between social status and SRH. Analyses were stratified by sex and performed using two measures of social status, educational level and occupational position. Strong social gradients were found for SRH, but mainly in men whereas in women the associations were either not linear (educational level) or not statistically significant (occupational position). Social gradients were also found for most lifestyle and all physical and psychosocial work factors studied. These three groups of factors equally contributed to and largely accounted for the social gradients in SRH although not all of the individual factors turned out to be independent and significant risk factors for poor SRH. Such risk factors included physical inactivity and obesity, poor posture and no or low social support at work (both sexes), heavy smoking (men) and underweight, overweight, uniform arm or hand movements at work, monotonous work and job insecurity (women). In conclusion, social inequalities (or more precisely educational and occupational status differences) in SRH were more pronounced in men and can be attributed for the most part to a sedentary lifestyle and to a physically demanding and socially unsupportive and insecure work environment. Apart from this main finding and overall pattern, sex-specific risk profiles were observed with regard to SRH and need to be taken into consideration.

Vieillessement / Ageing

Courtin, E., Jemai, N., Mossialos, E. (2014). Mapping support policies for informal carers across the European Union. *Health Policy*.

Abstract: BACKGROUND: At a time when health and social care services in European countries are under pressure to contain or cut costs, informal carers are relied upon as the main providers of long-term care. However, still little is known about the availability of direct and indirect support for informal carers across the European Union. METHODS: Primary data collection in all EU member states was supplemented with an extensive review of the available literature. RESULTS: Various forms and levels of support have been implemented across Europe to facilitate the role of informal caregivers. Financial support is the most common type of support provided, followed by respite care and training. Most countries do not have a process in place to systematically identify informal carers and to assess their needs. Policies are often at an early stage of development and the breadth of support varies significantly across the EU. CONCLUSIONS: Policy developments are uneven across the member states, with some countries having mechanisms in place to assess the needs and support informal carers while others are only starting to take an interest in developing support services. Given the unprecedented challenges posed by population ageing, further research and better data are needed to capture and monitor information on informal carers, to help design adequate support policies and eventually to evaluate their impact across the EU.

Maskileyson, D. (2014). Healthcare system and the wealth-health gradient: A comparative study of older populations in six countries. *Soc Sci Med* 119C 18-26.

Abstract: The present study provides a comparative analysis of the association between wealth and health in six healthcare systems (Sweden, the United Kingdom, Germany, the Czech Republic, Israel, the United States). National samples of individuals fifty years and over reveal considerable cross-country variations in health outcomes. In all six countries wealth and health are positively associated. The findings also show that state-based healthcare systems produce better population health outcomes than private-based healthcare systems. The results indicate that in five out of the six countries studied, the wealth-health gradients were remarkably similar, despite significant variations in healthcare system type. Only in the United States was the association between wealth and health substantially different from, and much greater than that in the other five countries. The findings suggest that private-based healthcare system in the U.S. is likely to promote stronger positive associations between wealth and health.

Turner, G., Clegg, A. (2014). Best practice guidelines for the management of frailty: a British Geriatrics Society, Age UK and Royal College of General Practitioners report. *Age Ageing* 43(6), 744-747.

Abstract: Older people are majority users of health and social care services in the UK and internationally. Many older people who access these services have frailty, which is a state of vulnerability to adverse outcomes. The existing health care response to frailty is mainly secondary care-based and reactive to the acute health crises of falls, delirium and immobility. A more proactive, integrated, person-centred and community-based response to frailty is required. The British Geriatrics Society Fit for Frailty guideline is consensus best practice guidance for the management of frailty in community and outpatient settings. RECOGNITION OF FRAILITY: The BGS recommends that all encounters between health and social care staff and older people in community and outpatient settings should include an assessment for frailty. A gait speed <0.8m/s; a timed-up-and-go test >10s; and a score of ≥ 3 on the PRISMA 7 questionnaire can indicate frailty. The common clinical presentations of frailty (falls, delirium, sudden immobility) can also be used to indicate the possible presence of frailty. MANAGEMENT OF FRAILITY: The BGS recommends an holistic medical review based on the principles of comprehensive geriatric assessment (CGA) for all older people identified with frailty. This will: diagnose medical illnesses to optimise treatment; apply evidence-based medication review checklists (e.g. STOPP/START criteria); include discussion with older people and carers to define the impact of illness; work with the older person to create an individualised care and support plan. SCREENING FOR FRAILITY: The BGS does not recommend population screening for frailty using currently available instruments.