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## Assurance maladie / Health insurance

**Aviva A., Liran E., Amy F. (2013). Assurance The RAND Health Insurance Experiment, Three Decades Later.** *Journal of Economic Perspectives*, 27 (1) : 197-222.

Abstract: Between 1974 and 1981, the RAND health insurance experiment provided health insurance to more than 5,800 individuals from about 2,000 households in six different locations across the United States, a sample designed to be representative of families with adults under the age of 62. More than three decades later, the RAND results are still widely held to be the “gold standard” of evidence for predicting the likely impact of health insurance reforms on medical spending, as well as for designing actual insurance policies. On cost grounds alone, we are unlikely to see something like the RAND experiment again. In this essay, we reexamine the core findings of the RAND health insurance experiment in light of the subsequent three decades of work on the analysis of randomized experiments and the economics of moral hazard. First, we re-present the main findings of the RAND experiment in a manner more similar to the way they would be presented today. Second, we reexamine the validity of the experimental treatment effects. Finally, we reconsider the famous RAND estimate that the elasticity of medical spending with respect to its out-of pocket price is  $-0.2$ . We draw a contrast between how this elasticity was originally estimated and how it has been subsequently applied, and more generally we caution against trying to summarize the experimental treatment effects from nonlinear health insurance contracts using a single price elasticity

**Einav L., Finkelstein A., Ryan S.P., Schrimpf P., Cullen M.R. (2013). Selection on Moral Hazard in Health Insurance.** *American Economic Review*, 103 (1) : 178-219.

**Johar M., Jones G., Keane M.P., Savage E., Stavrunova O. (2013). Discrimination in a universal health system: explaining socioeconomic waiting time gaps.** *J Health Econ*, 32 (1) : 181-194.

Abstract: One of the core goals of a universal health care system is to eliminate discrimination on the basis of socioeconomic status. We test for discrimination using patient waiting times for non-emergency treatment in public hospitals. Waiting time should reflect patients' clinical need with priority given to more urgent cases. Using data from Australia, we find evidence of prioritisation of the most socioeconomically advantaged patients at all quantiles of the waiting time distribution. These patients also benefit from variation in supply endowments. These results challenge the universal health system's core principle of equitable treatment

## Economie de la santé / Health economics

**Ricci P., Mezzarobba M., Blotière P.O., Polton D. (2013). Les dépenses de soins remboursées durant la dernière année de vie, en 2008, en France.** *Revue d'Epidémiologie et de Santé Publique*, 61 (1) : 29-36.

Abstract: Position du problème : Mesurer le coût pour l'Assurance maladie de la dernière année de vie ainsi que la part que celle-ci représente dans l'ensemble des remboursements en 2008, analyser la structure des dépenses lors de la dernière année de vie et distinguer les coûts selon quelques exemples de causes de décès.

Méthodes : Les données ont été obtenues à partir du Système national d'informations interrégimes de l'assurance maladie (SNIIRAM), chaîné au PMSI MCO, HAD et SSR. Les

analyses ont porté sur le régime général hors fonctionnaires et étudiants ( $n=49$  millions). Le coût de la dernière année de vie a été calculé en population exhaustive (361 328 décédés en 2008). La cause supposée du décès a été identifiée principalement à partir du diagnostic principal du séjour au cours duquel il est survenu. Résultats : Les remboursements de la dernière année de vie s'élèvent à 22 000€ en moyenne en 2008 dont 12 500€ pour l'hôpital public. Ils diffèrent selon les causes médicales de décès : 52 300€ pour les maladies à VIH et environ 40 000€ pour les tumeurs malignes. Un effet négatif de l'âge sur les dépenses de fin de vie est observé. Les dépenses de santé augmentent à l'approche de la mort, le dernier mois de vie correspondant à 28 % des remboursements de la dernière année. Parmi l'ensemble des remboursements de l'assurance maladie en 2008, 10,5 % sont associés à la dernière année de vie. Conclusion : Cette étude retrouve des résultats proches de ceux observés dans le passé ou dans d'autres pays. Nos résultats montrent en particulier que la part des dépenses consacrée à la dernière année de vie reste stable.

**Mielck A. (2013). Social epidemiology and health economics: the need to find common grounds.** The European Journal of Public Health, 23 (1) : 2.

**Gonzalez P., Macho-Stadler I. (2013). A theoretical approach to dual practice regulations in the health sector.** J Health Econ, 32 (1) : 66-87.

Abstract: Internationally, there is wide cross-country heterogeneity in government responses to dual practice in the health sector. This paper provides a uniform theoretical framework to analyze and compare some of the most common regulations. We focus on three interventions: banning dual practice, offering rewarding contracts to public physicians, and limiting dual practice (including both limits to private earnings of dual providers and limits to involvement in private activities). An ancillary objective of the paper is to investigate whether regulations that are optimal for developed countries are adequate for developing countries as well. Our results offer theoretical support for the desirability of different regulations in different economic environments

## Etat de santé / Health status

**Alison K.C., David H.R., Julianna D., Barbara A. (2013). Education and obesity at age 40 among American adults.** Social Science & Medicine, 78 (2) : 34-41.

Abstract: Although many have studied the association between educational attainment and obesity, studies to date have not fully examined prior common causes and possible interactions by race/ethnicity or gender. It is also not clear if the relationship between actual educational attainment and obesity is independent of the role of aspired educational attainment or expected educational attainment. The authors use generalized linear log link models to examine the association between educational attainment at age 25 and obesity (BMI=30) at age 40 in the USA's National Longitudinal Survey of Youth 1979 cohort, adjusting for demographics, confounders, and mediators. Race/ethnicity but not gender interacted with educational attainment. In a complete case analysis, after adjusting for socioeconomic covariates from childhood, adolescence, and adulthood, among whites only, college graduates were less likely than high school graduates to be obese (RR = 0.69, 95%CI: 0.57, 0.83). The risk ratio remained similar in two sensitivity analyses when the authors adjusted for educational aspirations and educational expectations and analyzed a multiply imputed dataset to address missingness. This more nuanced understanding of the role of education after controlling for a thorough set of confounders and mediators helps advance the study of social determinants of health and risk factors for obesity

## Géographie de la santé / Geography of Health

**Case C., Hawthorne T.L. (2013). Served or unserved? A site suitability analysis of social services in Atlanta, Georgia using Geographic Information Systems.** Applied Geography, 38 (0) : 96-106.

Abstract: Geographers, planners and public health officials are increasingly interested in working with community partners, organizations, and residents to engage in action oriented research designed to impact positive community change. One growing area of community-based research focuses on geographic examinations of aspects of social service accessibility. In this study, we work with multiple community partners in an urban area to examine the spatial distribution of social service providers. We also identify potential new locations for social service providers that can meet the unmet demands for such services. We utilize a Public Participation GIS framework to create shared community resources and research deliverables for our community partners. The results of our work help local providers, leaders, and community residents to visualize gaps and coverage in social services across urban space; draw attention to additional forces that shape access, i.e. public transportation, walkability, and zoning codes; and confirm the anecdotal evidence of poor accessibility presented by neighborhood leaders

**Etzioni D.A., Fowl R.J., Wasif N., Donohue J.H., Cima R.R. (2013). Distance Bias and Surgical Outcomes.** Medical Care, 51 (3) :

Abstract: Background: A body of research has found that patients who travel a significant distance to obtain medical treatment experience better outcomes, a phenomenon termed distance bias. • This study uses risk-adjusted surgical outcomes data to analyze distance bias in a population of patients treated surgically at a tertiary care institution. Methods: We used risk-adjusted surgical outcomes data from the National Surgical Quality Improvement Project at the Mayo Clinic to calculate observed and expected risk of a severe complication. Operations were stratified into quintiles based on the distance traveled by the patient. Results: The average age of patients in our cohort was 56.7 years, and 59.2% were female; patients traveled an average of 226 miles for treatment. Patients living closest to the Mayo Clinic (quintile 1) had lower observed and expected risks of a severe complication relative to patients in quintiles . Patients from quintile 1 had outcomes which were better than predicted [observed:expected risk ratio of 0.82 (range, 0.63 0.99)]. Patients traveling intermediate distances (quintile 2) had outcomes which were worse than predicted [observed:expected risk ratio of 1.18 (range, 1.00.42)]. Operations performed on patients from greater distances (quintiles 3-5) had an observed risk of severe complications which was similar to expected. Discussion: The phenomenon of distance bias which has previously been documented in medical and oncologic treatment is not demonstrated in this study. An opposite phenomenon may be more pertinent, where patients who are treated locally are less likely to have a severe complication and have outcomes which are better than predicted

**Sandra J.T. (2013). Reducing Variation in Health Care: The Rhetorical Politics of a Policy Idea.** Journal of Health Politics, Policy and Law (Highwire), 38 (1) : 5-26.

Abstract: For decades, geographic variation in the use and cost of health care has captured the imagination of researchers and policy makers. As a policy problem, variation suggests its own solution — reducing variation — but the substantive weaknesses of this policy idea invite a second look at its success. This article considers the politics of policy ideas to analyze the potential rhetorical strengths of reducing variation. It finds that this idea appeals to multiple health care audiences, remains practically and politically ambiguous as to problem and solution, and resonates with long-held aspirations of policy elites, including being hopeful about solving the seemingly intractable problems of the US health care system



## Hôpital / Hospitals

**Sinha S., Peach G., Poloniecki J.D., Thompson M.M., Holt P.J. (2013). Studies using English administrative data (Hospital Episode Statistics) to assess health-care outcomes systematic review and recommendations for reporting.** The European Journal of Public Health, 23 (1) : 86-92.

**Abstract:** Background: Studies using English administrative data from the Hospital Episode Statistics (HES) are increasingly used for the assessment of health-care quality. This study aims to catalogue the published body of studies using HES data to assess health-care outcomes, to assess their methodological qualities and to determine if reporting recommendations can be formulated. Methods: Systematic searches of the EMBASE, Medline and Cochrane databases were performed using defined search terms. Included studies were those that described the use of HES data extracts to assess health-care outcomes. Results: A total of 148 studies were included. The majority of published studies were on surgical specialties (60.8%), and the most common analytic theme was of inequalities and variations in treatment or outcome (27%). The volume of published studies has increased with time as has the length of study period and the number of outcomes assessed per study. Age (80%) and gender (57.4%) were the most commonly used factors in risk adjustment, and regression modelling was used most commonly (65.2%) to adjust for confounders. Generic methodologic data were better reported than those specific to HES data extraction. For the majority of parameters, there were no improvements with time. Conclusions: Studies published using HES data to report health-care outcomes have increased in volume, scope and complexity with time. However, persisting deficiencies related to both generic and context-specific reporting have been identified. Recommendations have been made to improve these aspects as it is likely that the role of these studies in assessing health care, benchmarking practice and planning service delivery will continue to increase.

**Burnett S., Renz A., Wiig S., Fernandes A., Weggelaar A.M., Calltorp J., Anderson J.E., Robert G., Vincent C., Fulop N. (2013). Prospects for comparing European hospitals in terms of quality and safety: lessons from a comparative study in five countries.**

International Journal for Quality in Health Care, 25 (1) : 1-7.

**Abstract:** Purpose Being able to compare hospitals in terms of quality and safety between countries is important for a number of reasons. For example, the 2011 European Union directive on patients' rights to cross-border health care places a requirement on all member states to provide patients with comparable information on health-care quality, so that they can make an informed choice. Here, we report on the feasibility of using common process and outcome indicators to compare hospitals for quality and safety in five countries (England, Portugal, The Netherlands, Sweden and Norway). Main Challenges Identified The cross-country comparison identified the following seven challenges with respect to comparing the quality of hospitals across Europe: different indicators are collected in each country; different definitions of the same indicators are used; different mandatory versus voluntary data collection requirements are in place; different types of organizations oversee data collection; different levels of aggregation of data exist (country, region and hospital); different levels of public access to data exist; and finally, hospital accreditation and licensing systems differ in each country. Conclusion Our findings indicate that if patients and policymakers are to compare the quality and safety of hospitals across Europe, then further work is urgently needed to agree the way forward. Until then, patients will not be able to make informed choices about where they receive their health care in different countries, and some governments will remain in the dark about the quality and safety of care available to their citizens as compared to that available in neighbouring countries

**Austin P.C., Reeves M.J. (2013). The Relationship Between the C-Statistic of a Risk-adjustment Model and the Accuracy of Hospital Report Cards: A Monte Carlo Study.**

Medical Care, 51 (3) :

**Abstract:** Background: Hospital report cards, in which outcomes following the provision of medical or surgical care are compared across health care providers, are being published with increasing frequency. Essential to the production of these reports is risk-adjustment, which allows investigators to account for differences in the distribution of patient illness severity across different hospitals. Logistic regression models are frequently used for risk adjustment in hospital report cards. Many applied researchers use the c-statistic (equivalent to the area under the receiver operating characteristic curve) of the logistic regression model as a measure of the credibility and accuracy of hospital report cards. Objectives: To determine the relationship between the c-statistic of a risk-adjustment model and the accuracy of hospital report cards. Research Design: Monte Carlo simulations were used to examine this issue. We examined the influence of 3 factors on the accuracy of hospital report cards: the c-statistic of the logistic regression model used for risk adjustment, the number of hospitals, and the number of patients treated at each hospital. The parameters used to generate the simulated datasets came from analyses of patients hospitalized with a diagnosis of acute myocardial infarction in Ontario, Canada. Results: The c-statistic of the risk-adjustment model had, at most, a very modest impact on the accuracy of hospital report cards, whereas the number of patients treated at each hospital had a much greater impact. Conclusions: The c-statistic of a risk-adjustment model should not be used to assess the accuracy of a hospital report card.

**Federspiel J.J., Stearns S.C., D'Arcy L.P., Geissler K.H., Beadles C.A., Crespin D.J., Carey T.S., Rossi J.S., Sheridan B.C. (2013). Resource Use Trajectories for Aged Medicare Beneficiaries with Complex Coronary Conditions.** Health Services Research, 10 Fev. (ahead of print)

**Abstract:** Objective To use coronary revascularization choice to illustrate the application of a method simulating a treatment's effect on subsequent resource use. Data Sources Medicare inpatient and outpatient claims from 2002 to 2008 for patients receiving multivessel revascularization for symptomatic coronary disease in 2003 2004. Study Design This retrospective cohort study of 102,877 beneficiaries assessed survival, days in institutional settings, and Medicare payments for up to 6 years following receipt of percutaneous coronary intervention (PCI) or coronary artery bypass grafting (CABG). Methods A three-part estimator designed to provide robust estimates of a treatment's effect in the setting of mortality and censored follow-up was used. The estimator decomposes the treatment effect into effects attributable to survival differences versus treatment-related intensity of resource use. Principal Findings After adjustment, on average CABG recipients survived 23days longer, spent an 11 additional days in institutional settings, and had cumulative Medicare payments that were \$12,834 higher than PCI recipients. The majority of the differences in institutional days and payments were due to intensity rather than survival effects. Conclusions In this example, the survival benefit from CABG was modest and the resource implications were substantial, although further adjustments for treatment selection are needed.

**Lindrooth R.C., Konetzka R.T., Navathe A.S., Zhu J., Chen W., Volpp K. (2013). The Impact of Profitability of Hospital Admissions on Mortality.** Health Services Research, 10 Fev. (ahead of print)

**Abstract:** Background Fiscal constraints faced by Medicare are leading to policies designed to reduce expenditures. Evidence of the effect of reduced reimbursement on the mortality of Medicare patients discharged from all major hospital service lines is limited. Methods We modeled risk-adjusted 30-day mortality of patients discharged from 21 hospital service lines as a function of service line profitability, service line time trends, and hospital service line and

year-fixed effects. We simulated the effect of alternative revenue-neutral reimbursement policies on mortality. Our sample included all Medicare discharges from PPS-eligible hospitals (1997, 2001, and 2005). Results The results reveal a statistically significant inverse relationship between changes in profitability and mortality. A \$0.19 average reduction in profit per \$1.00 of costs led to a 0.010-0.020 percentage-point increase in mortality rates ( $p < .001$ ). Mortality in newly unprofitable service lines is significantly more sensitive to reduced payment generosity than in service lines that remain profitable. Policy simulations that target service line inequities in payment generosity result in lower mortality rates, roughly 700-13,000 fewer deaths nationally. The policy simulations raise questions about the trade-offs implicit in universal reductions in reimbursement. The effect of reduced payment generosity on mortality could be mitigated by targeting highly profitable services only for lower reimbursement

**Ghaffarzadegan N., Epstein A.J., Martin E.G. (2013). Practice Variation, Bias, and Experiential Learning in Cesarean Delivery: A Data-Based System Dynamics Approach.** Health Services Research, 10 Fev. (ahead of print)

Abstract: Objectives To simulate physician-driven dynamics of delivery mode decisions (scheduled cesarean delivery [CD] vs. vaginal delivery [VD] vs. unplanned CD after labor), and to evaluate a behavioral theory of how experiential learning leads to emerging bias toward more CD and practice variation across obstetricians. Data Sources/Study Setting Hospital discharge data on deliveries performed by 300 randomly selected obstetricians in Florida who finished obstetrics residency and started practice after 1991. Study Design We develop a system dynamics simulation model of obstetricians' delivery mode decision based on the literature of experiential learning. We calibrate the model and investigate the extent to which the model replicates the data. Principal Findings Our learning-based simulation model replicates the empirical data, showing that physicians are more likely to schedule CD as they practice longer. Variation in CD rates is related to the way that physicians learn from outcomes of past decisions and accumulate experience. Conclusions The repetitive nature of medical decision making, learning from past practice, and accumulating experience can account for increases in CD decisions and practice variation across physicians. Policies aimed at improving medical decision making should account for providers' feedback-based learning mechanisms

## Inégalités sociales de santé / Social inequalities of Health

**Jusot F., Tubeuf S., Trannoy A. (2013). Circumstances and efforts: how important is their correlation for the measurement of inequality of opportunity in health?** Health Economics, 24 Janv (ahead of print).

Abstract: The way to treat the correlation between circumstances and effort is a central, yet largely neglected issue in the applied literature on inequality of opportunity. This paper adopts three alternative normative ways of treating this correlation championed by Roemer, Barry and Swift and assesses their empirical relevance using survey data. We combine regression analysis with the natural decomposition of the variance to compare the relative contributions of circumstances and efforts to overall health inequality according to the different normative principles. Our results suggest that, in practice, the normative principle on the way to treat the correlation between circumstances and effort makes little difference on the relative contributions of circumstances and efforts to explained health inequality.

**Borrell C., Morrison J., Burstrom B., Pons-Vigues M., Hoffmann R., Gandarillas A., Martikainen P., Dominguez-Berjon M.F., Tarkiainen L., Diez E. (2013). Comparison of health policy documents of European cities: Are they oriented to reduce inequalities in**

health? *J Public Health Policy*, 34 (1) : 100-120.

Abstract: Health policies are specified in documents that contain values, objectives, strategies, and interventions to be implemented. The objective of our study was to analyse health policy documents of six European cities and one county council published around 2010 to determine (i) how cities conceptualize health inequalities, and (ii) what strategies are proposed to reduce them. We performed a qualitative document analysis. We selected Health or Health Inequalities policy documents and analysed the following aspects: general characteristics of the document, inclusion and definition of health inequalities, promotion of good governance and participation, number of objectives, and evaluation. We also described specific objectives. Rotterdam, London, and Stockholm use a conceptual framework. Two of them define health inequalities as a social gradient. Intersectoral action, participation, and evaluation are included in most documents. Interventions focus mainly on the socioeconomic context.

**Hamilton T.G., Kawachi I. (2013). Changes in income inequality and the health of immigrants.** *Social Science & Medicine*, 80 (0) : 57-66.

Abstract: Research suggests that income inequality is inversely associated with health. This association has been documented in studies that utilize variation in income inequality across countries or across time from a single country. The primary criticism of these approaches is their inability to account for potential confounders that are associated with income inequality. This paper uses variation in individual experiences of income inequality among immigrants within the United States (U.S.) to evaluate whether individuals who moved from countries with greater income inequality than the U.S. have better health than those who migrated from countries with less income inequality than the U.S. Utilizing individual-level (March Current Population Survey) and country-level data (the United Nations Human Development Reports), we show that among immigrants who have resided in the U.S. between 6 and 20 years, self-reported health is more favorable for the immigrants in the former category (i.e., greater income inequality) than those in the latter (i.e., lower income inequality). Results also show that self-reported health is better among immigrants from more developed countries and those who have more years of education, are male, and are married

**Mohnen S.M., Volker B., Flap H., Subramanian S.V., Groenewegen P.P. (2013). You have to be there to enjoy it? Neighbourhood social capital and health.** *The European Journal of Public Health*, 23 (1) : 33-39.

Abstract: Background: Several studies have shown the positive effect of neighbourhood social capital on health. Existing research, however, has hitherto not studied whether the duration and intensity of exposure to neighbourhood social capital conditions and its effect on health. The aim of this study was to examine whether neighbourhood social capital affects individual's health immediately and equally. Methods: We used two waves of the Dutch cross-sectional "Housing and Living Survey". One (from 2009) as individual data (n = 65 990), and the other (from 2006) to estimate with econometric measurements a social capital measure for 3001 Dutch neighbourhoods. We assessed by means of multilevel regression models the combined effect of exposure and amount of neighbourhood social capital on self-rated health. Results: Duration of exposure, measured by the length of stay in the same neighbourhood is not linearly associated with individual health. Health of people who live up to 6 years or >22 years in the same neighbourhood is not affected by neighbourhood social capital. People with young children in the household or elderly were assumed to be more intensively exposed. However, exposure intensity was only found to have an effect for households with young children. Conclusions: Duration and intensity of exposure to neighbourhood social capital, a social aspect of the environment, matters for people's health. Interventions focusing on the health of people with young children may want to stimulate the creation of neighbourhood social capital.

**Armstrong K., Putt M., Halbert C.H., Grande D., Schwartz J.S., Liao K., Marcus N., Demeter M.B., Shea J.A. (2013). Prior Experiences of Racial Discrimination and Racial Differences in Health Care System Distrust.** *Medical Care*, 51 (2) :

**Abstract:** Purpose: Factors contributing to racial differences in health care system distrust (HCSD) are currently unknown. Proposed potential contributing factors are prior experiences of racial discrimination and racial residential segregation. Methods: Random digit dialing survey of 762 African American and 1267 white adults living in 40 US metropolitan statistical areas. Measures included the Revised Health Care System Distrust scale, the Experiences of Discrimination scale, metrics of access to care, sociodemographic characteristics, and the level of racial residential segregation in the city (using the isolation index). Results: In unadjusted analyses, African Americans had higher levels of HCSD, particularly values distrust, and greater experiences of discrimination. Experience of discrimination was also strongly associated with HCSD. Adjusting for sociodemographic characteristics, health care access, and residential segregation had little effect on the association between African American race and overall HCSD or values distrust. In contrast, adjusting for experiences of racial discrimination reversed the association so that distrust was lower among African Americans than whites (odds ratio 0.53; 95% confidence interval, 0.33â€“0.85 for the overall measure). The Sobel test for mediation was strongly significant ( $P < 0.001$ ). Conclusions: Higher HCSD among African Americans is explained by a greater burden of experiences of racial discrimination than whites. Reasons for higher distrust among whites after adjusting for experiences of racial discrimination are not known. Efforts to eliminate racial discrimination and restore trust given prior discrimination are needed.

**Zhang X., Cook P., Lisboa P., Jarman I., Bellis M. (2013). The effects of deprivation and relative deprivation on self-reported morbidity in England: an area-level ecological study.** *International Journal of Health Geographics*, 12 (1) : 5.

**Abstract:** BACKGROUND: Socioeconomic status gradients in health outcomes are well recognised and may operate in part through the psychological effect of observing disparities in affluence. At an area-level, we explored whether the deprivation differential between neighbouring areas influenced self-reported morbidity over and above the known effect of the deprivation of the area itself. METHODS: Deprivation differentials between small areas (population size approximately 1,500) and their immediate neighbours were derived (from the Index of Multiple Deprivation (IMD)) for Lower Super Output Area (LSOA) in the whole of England ( $n=32482$ ). Outcome variables were self-reported from the 2001 UK Census: the proportion of the population suffering Limiting Long-Term Illness (LLTI) and 'not good health'. Linear regression was used to identify the effect of the deprivation differential on morbidity in different segments of the population, controlling for the absolute deprivation. The population was segmented using IMD tertiles and P2 People and Places geodemographic classification. P2 is a commercial market segmentation tool, which classifies small areas according to the characteristics of the population. The classifications range in deprivation, with the most affluent type being 'Mature Oaks' and the least being 'Urban Challenge'. RESULTS: Areas that were deprived compared to their immediate neighbours suffered higher rates of 'not good health' ( $\beta=0.312$ ,  $p < 0.001$ ) and LLTI ( $\beta=0.278$ ,  $p < 0.001$ ), after controlling for the deprivation of the area itself ('not good health'--- $Ss=0.655$ ,  $p < 0.001$ ; LLTI--- $Ss=0.548$ ,  $p < 0.001$ ). The effect of the deprivation differential relative to the effect of deprivation was strongest in least deprived segments (e.g., for 'not good health', P2 segments 'Mature Oaks'--- $\beta=0.638$ ; 'Rooted Households'--- $\beta=0.555$ ). CONCLUSIONS: Living in an area that is surrounded by areas of greater affluence has a negative impact on health in England. A possible explanation for this phenomenon is that negative social comparisons between areas cause ill-health. This 'psychosocial effect' is greater still in least deprived segments of the population, supporting the notion that psychosocial effects become more important when material (absolute) deprivation is less relevant

**Giuliana L., Michela P., Antonio A. (2013). Health care utilization by immigrants in Italy.** International Journal of Health Care Finance and Economics, 13 (1) : 1-31.

Abstract: Healthcare utilization studies show how well documented disparities between migrants and non-migrants. Reducing such disparities is a major goal in European countries. However, healthcare utilization among Italian immigrants is under-studied. The objective of this study is to explore differences in healthcare use between immigrant and native Italians. Cross-sectional study using the latest available (2004/2005) Italian Health Conditions Survey. We estimated separate hurdle binomial negative regression models for GP, specialist, and telephone consultations and a logit model for emergency room (ER) use. We used logistic regression and zero-truncated negative binomial regression to model the zero (contact decision) and count processes (frequency decisions) respectively. Adjusting for risk factors, immigrants are significantly less likely to use healthcare services with 2.4 and 2.7 % lower utilization probability for specialist and telephone consultations, respectively. First- and second-generation immigrants' probability for specialist and telephone contact is significantly lower than natives'. Immigrants, ceteris paribus, have a much higher probability of using ERs than natives (0.7 %). First-generation immigrants show a higher probability of visiting ERs (1 %). GP visits show no significant difference. In conclusion Italian immigrants are much less likely to use specialist healthcare and medical telephone consultations than natives but more likely to use ERs. Hence, we report an over-use of ERs and under-utilization of preventive care among immigrants. We recommend improved health policies for immigrants: promotion of better information dissemination among them, simplification of organizational procedures, better communications between providers and immigrants, and an increased supply of health services for the most disadvantaged populations.

Healthcare utilization studies show how well documented disparities between migrants and non-migrants. Reducing such disparities is a major goal in European countries. However, healthcare utilization among Italian immigrants is under-studied. The objective of this study is to explore differences in healthcare use between immigrant and native Italians. Cross-sectional study using the latest available (2004/2005) Italian Health Conditions Survey. We estimated separate hurdle binomial negative regression models for GP, specialist, and telephone consultations and a logit model for emergency room (ER) use. We used logistic regression and zero-truncated negative binomial regression to model the zero (contact decision) and count processes (frequency decisions) respectively. Adjusting for risk factors, immigrants are significantly less likely to use healthcare services with 2.4 and 2.7 % lower utilization probability for specialist and telephone consultations, respectively. First- and second-generation immigrants' probability for specialist and telephone contact is significantly lower than natives'. Immigrants, ceteris paribus, have a much higher probability of using ERs than natives (0.7 %). First-generation immigrants show a higher probability of visiting ERs (1 %). GP visits show no significant difference. In conclusion Italian immigrants are much less likely to use specialist healthcare and medical telephone consultations than natives but more likely to use ERs. Hence, we report an over-use of ERs and under-utilization of preventive care among immigrants. We recommend improved health policies for immigrants: promotion of better information dissemination among them, simplification of organizational procedures, better communications between providers and immigrants, and an increased supply of health services for the most disadvantaged populations

## Médicaments / Pharmaceuticals

**Epstein A.J., Busch S.H., Busch A.B., Asch D.A., Barry C.L. (2013). Does Exposure to Conflict of Interest Policies in Psychiatry Residency Affect Antidepressant Prescribing?** Medical Care, 51 (2) : 199-203

Abstract: BACKGROUND:: Academic medical institutions have instituted conflict of interest

(COI) policies in response to concerns about pharmaceutical industry influence.

**OBJECTIVE::** To determine whether exposure to COI policies during psychiatry residency training affects psychiatrists' antidepressant prescribing patterns after graduation.

**RESEARCH DESIGN:** We used 2009 physician-level national administrative prescribing data from IMS Health for 1652 psychiatrists from 162 residency programs. We used difference-in-differences estimation to compare antidepressant prescribing based on graduation before (2001) or after (2008) COI policy adoption across residency program groups with maximally, moderately, and minimally restrictive COI policies. The primary outcomes were shares of psychiatrists' prescribing of heavily promoted, brand reformulated, and brand antidepressants. **RESULTS:** Rates of prescribing heavily promoted, brand reformulated, and brand antidepressants in 2009 were lower among post-COI graduates than pre-COI graduates at all levels of COI restrictiveness. However, differences between pre-COI and post-COI graduates' prescribing of heavily promoted medications were larger for maximally restrictive programs than both minimally restrictive programs [-4.3 percentage points; 95% confidence interval (CI), -7.0, -1.6] and moderately restrictive programs (-3.6 percentage points; 95% CI, -6.2, -1.1). The difference in prescribing reformulations was larger for maximally restrictive programs than minimally restrictive programs (-3.0 percentage points; 95% CI, -5.3, -0.7). Results were consistent for prescribing of brand drugs. **CONCLUSIONS::** This study provides the first empirical evidence of the effects of COI policies. Our results suggest that COI policies can help inoculate physicians against persuasive aspects of pharmaceutical promotion. Further research should assess whether these policies affect other drug classes and physician specialties similarly.

**Godman B., Gustafsson L.L. (2013). A New Reimbursement System for Innovative Pharmaceuticals Combining Value-Based and Free Market Pricing.** Applied Health Economics and Health Policy, 11 (1) :79-82

**Persson U., Svensson J., Pettersson B. (2013). Authors' Reply to Godman and Gustafsson: "A New Reimbursement System for Innovative Pharmaceuticals Combining Value-Based and Free Market Pricing".** Applied Health Economics and Health Policy, 11 (1) : 83-84

**Sorek G. (2013). Price controls for medical innovations in a life cycle perspective.** Health Economics [ahead of print]

**Abstract:** We study the market for new medical technologies from a life cycle perspective, incorporating the fact that healthcare utilization is biased towards old age. Contrary to conventional wisdom, we find that price controls on medical innovations can expand investment in medical R&D and results in Pareto superior social outcomes, a consequence of the price controls' ability to increase saving. Importantly, this finding occurs only when the price cap regime is extensive: selective regulation on few technologies such as pharmaceuticals alone have the conventional negative effect on innovation.

## Méthodologie / Methodology

**Marti H., Chavance M. (2013). Les enquêtes cas-cohortes.** Revue d'Epidémiologie et de Santé Publique, 61 (1) : 67-74.

**Abstract:** IDans cet article, nous présentons les principaux outils pour la conception, la mise en œuvre et l'analyse des enquêtes cas-cohorte. Plus précisément, nous décrivons les estimateurs pondérés classiquement utilisés, les estimateurs pondérés proposés récemment par Breslow et al., ainsi que l'imputation multiple, une méthode alternative aux estimateurs pondérés pour l'analyse des enquêtes cas-cohorte. Les estimateurs de leurs variances sont aussi présentés. Nous évoquons les outils nécessaires pour le calcul de la taille de la sous-cohorte. Enfin, nous mentionnons les fonctions et procédures disponibles dans les logiciels

R, SAS et Stata et nous illustrons la mise en œuvre avec deux sous-cohortes simulées à partir de la cohorte PRIME

**Linden-Bostrom M., Persson C. (2013). A selective follow-up study on a public health survey.** The European Journal of Public Health, 23 (1) : 152-157.

**Abstract:** Background: The non-response rates in surveys are increasing which is problematic as it means that a progressively smaller proportion of the population represents the majority, and it is uncertain how health survey results are affected. This follow-up was performed on the non-responders to the postal questionnaire in the public health survey Life and Health, conducted in Å–rebro County Council, Sweden, where large differences in response rates had been found between different socio-demographic groups and geographical areas. The main objective was to analyse non-response bias regarding self-rated health. Methods: This follow-up study was conducted as a census to all non-responders in the area that had the lowest response rate and, in one other geographical area used as a control. It was carried out by telephone interviews, 49.3% (580 individuals) answered the follow-up. The outcome variable was self-rated health, a main variable in public health surveys. Differences in response patterns between responders and initial non-responders were approximated by prevalences with confidence intervals and adjusted odds ratios. Results: Poor health was more common in the initial non-response group than among the responders, even with consideration given to sex, age, country of birth and education. However, good health was equally common among responders and initial non-responders. Conclusions: Public health surveys can be biased due to certain groups being under-represented or not represented at all. For this reason, in repeated public health surveys, we recommend selective follow-ups of such groups at regular intervals.

### Prévention santé / Health prevention

**Parron S., Gentile S., Enel P., Benhaim L., Ferrandino J., Bentz L., Sambuc R. (2013). Éducation thérapeutique du patient : état des lieux des programmes en région Provence-Alpes-Côte d'Azur en 2008 avant la parution des textes officiels sur les autorisations de l'Agence régionale de santé.** Revue d'Epidémiologie et de Santé Publique, 61 (1) : 57-65.

**Abstract:** Position du problème. Dans le cadre du plan 2007–2011 d'amélioration de la qualité de vie des personnes atteintes de maladies chroniques et à la demande de l'Agence régionale de l'hospitalisation, cette étude a eu pour but de dresser le bilan régional des programmes d'éducation thérapeutique du patient en 2008 en région Provence-Alpes-Côte d'Azur (PACA), avant la parution des décrets relatifs à l'éducation thérapeutique et des autorisations de l'Agence régionale de santé. Méthodes : Une enquête transversale conduite dans les structures sanitaires de la région, réalisée sur les trois secteurs de prise en charge que sont les établissements de santé, les structures ambulatoires et les réseaux de santé, a permis d'identifier, dans un premier temps, les structures déclarant avoir mis en place des programmes d'éducation thérapeutique, puis de mettre en évidence, dans un second temps, les modalités de conception et de mise en œuvre des programmes préalablement identifiés. Résultats : Cette étude a permis de recenser 491 programmes qui se répartissent géographiquement de façon inégale en région PACA et ciblent essentiellement le diabète, les maladies respiratoires et les maladies cardiovasculaires. Les principaux objectifs visés par ces programmes sont la qualité de vie, l'observance thérapeutique et les comportements préventifs. Les programmes des établissements de santé ciblent préférentiellement les 36 à 60ans, alors que ceux du secteur ambulatoire et des réseaux de santé ciblent les plus de 60ans. Plus de 50 % des professionnels impliqués dans les programmes n'ont pas été formés à l'éducation thérapeutique du patient. Conclusion : Cette étude a mis en évidence de nombreux points importants qui doivent être améliorés dans l'organisation de l'éducation thérapeutique, notamment l'implication et la formation des professionnels.



**Rezayatmand R., Pavlova M., Groot W. (2013). The impact of out-of-pocket payments on prevention and health-related lifestyle: a systematic literature review.** The

European Journal of Public Health, 23 (1) : 74-79.

Abstract: Background: Out-of-pocket payments can have a large impact on the demand for healthcare. They can be essential not only to decrease unnecessary service use, but also to encourage the use of particular preventive services provided free of charge or at a lower price. Moreover, out-of-pocket payments may increase the costs of unhealthy behaviour and provide incentives for a healthier lifestyle. Method: This study systematically reviews empirical evidence on the effects of out-of-pocket payments on the use of preventive services and health-related lifestyle. All possible combinations of three key words prevention patient payment and health-related behaviour were searched in PUBMED, ECONLIT, ECONPAPER and EMBASE. In total, 47 relevant publications were identified. Results: The results suggest that out-of-pocket payments can create a financial barrier and can decrease the use of preventive services and the uptake of preventive medications. A few studies (with contradicting empirical evidence) address the impact of cost sharing and reduced insurance coverage on a healthier lifestyle. Conclusion: Although the great diversity of study designs (various indicators of out-of-pocket payments and preventive/health-related behaviour) makes it difficult to offer robust policy recommendations, our findings support calls to reconsider how preventive services should be financed. More research is needed to explore the actual impact of cost sharing on different aspects of health-related lifestyles, as well as to explain the role of other relevant determinants that could impact this relationship

**Gonzalez M., Glantz S.A. (2013). Failure of policy regarding smoke-free bars in the Netherlands.** The European Journal of Public Health, 23 (1) : 139-145.

Abstract: Background: Tobacco companies consistently work to prevent and undermine smoke-free laws. The tobacco industry and its allies have funded hospitality associations and other third parties to oppose smoke-free laws, argue that smoke-free laws will economically damage hospitality venues, promote ventilation and voluntary smoker accommodation as an alternative to smoke-free laws, and to challenge smoke-free laws in court. In 2008, the Netherlands extended its smoke-free law to hospitality venues. Methods: We triangulated news articles, government documents, scientific papers, statistical reports and interviews to construct this case study. Results: Despite widespread public support for smoke-free hospitality venues, opponents successfully represented these laws as unpopular and damaging to small bars. These challenges and related smokers rights activities resulted in non-compliance among all bars and reinstating an exemption for small, owner-run venues. This policy reversal was the result of a weak implementing media campaign (which failed to present the law as protecting nonsmokers), smoking room exemptions and reactive (vs. proactive) measures by the Ministry of Health and civil society. Conclusion: The policy failure in the Netherlands is the result of poor implementation efforts and the failure to anticipate and deal with opposition to the law. When implementing smoke-free laws it is important to anticipate opposition, used the media to target non-smokers to reinforce public support, and actively enforce the law.

**Nguyen H.V. (2013). Do smoke-free car laws work? Evidence from a quasi-experiment.** J Health Econ, 32 (1) : 138-148.

Abstract: In response to increased risks of second-hand smoke exposure for children travelling in cars and its resulting deleterious health impacts, several jurisdictions passed legislation that bans smoking in private vehicles when children are present. In this study, I exploit a unique quasi-experiment from Canada and employ the difference-in-differences and triple-differences techniques to empirically evaluate this legislation. I find that the legislation

reduces exposure to second-hand smoke inside cars for children. Further, there appears no marked increase in smoking at home after the implementation of the legislation

**Okeke E.N., Adepiti C.A., Ajenifuja K.O. (2013). What is the price of prevention? New evidence from a field experiment.** J Health Econ, 32 (1) : 207-218.

Abstract: How does increasing access to treatment affect the demand for preventive testing? In this paper we present results from a field experiment in Nigeria in which we offered cervical cancer screening to women at randomly chosen prices. To test our hypothesis, we also offered women a lottery where the payoff was a subsidy towards the cost of cervical cancer treatment (conditional upon a diagnosis of cervical cancer). We find that women randomly selected to receive the conditional cancer treatment subsidy were about 4 percentage points more likely to take up screening than those in the control group. We also show that reducing the price of screening by 10 cents increased take-up by about 1 percentage point. These results offer compelling evidence that the optimal set of subsidies to increase take-up of preventive testing in developing countries, must include subsidies towards treatment costs (in addition to price subsidies)

### Psychiatrie / Psychiatry

**Dinwiddie G.Y., Gaskin D.J., Chan K.S., Norrington J., McCleary R. (2013). Residential segregation, geographic proximity and type of services used: Evidence for racial/ethnic disparities in mental health.** Social Science & Medicine, 80 (0) : 67-75.

Abstract: Residential characteristics influence opportunities, life chances and access to health services in the United States but what role does residential segregation play in differential access and mental health service utilization? We explore this issue using secondary data from the 2006 Medical Expenditure Panel Survey, 2006 American Medical Association Area Research File and the 2000 Census. Our sample included 9737 whites, 3362 African Americans and 5053 Latinos living in Metropolitan Statistical Areas. Using logistic regression techniques, results show respondents high on Latino isolation and Latino centralization resided in psychiatrist shortage areas whereas respondents high on African American concentration had access to psychiatrists in their neighborhoods. Predominant race of neighborhood was associated with the type of mental health professional used where respondents in majority African American neighborhoods were treated by non-psychiatrists and general doctors whereas respondents in majority Latino neighborhoods saw general doctors. Respondents high on Latino Isolation and Latino Centralization were more likely to utilize non-psychiatrists. These findings suggest that living in segregated neighborhoods influence access and utilization of mental health services differently for race/ethnic groups which contradicts findings that suggest living in ethnic enclaves is beneficial to health

**Gili M., Roca M., Basu S., McKee M., Stuckler D. (2013). The mental health risks of economic crisis in Spain: evidence from primary care centres, 2006 and 2010.** The European Journal of Public Health, 23 (1) : 103-108.

Abstract: Background: Nearly all European countries have been affected by the economic crisis that began in 2007, but the consequences have been among the worst in Spain. We investigated the associations of the recession on the frequency of mood, anxiety, somatoform, alcohol-related and eating disorders among those visiting Spanish primary care settings. Methods: Primary care physicians selected randomized samples of patients attending primary care centres representing Spain's consulting populations. A total of 7940 patients in 2006-2007 and 5876 in 2010-2011 were administered the Primary Care Evaluation of Mental Disorders (PRIME-MD) instrument to diagnose mental disorders. Multivariate logistic regression models were used to quantify overall changes in the frequency of mental disorders, adjusting for potential socio-demographic differences in

consulting populations unrelated to economic factors. Results: Compared with the pre-crisis period of 2006, the 2010 survey revealed substantial and significant increases in the proportion of patients with mood (19.4% in major depression), anxiety (8.4% in generalized anxiety disorder), somatoform (7.3%) and alcohol-related disorders (4.6% in alcohol dependence). We observed a significantly elevated risk of major depression associated with mortgage repayment difficulties and evictions). About one-third of the overall risk in the consulting population's attendance with mental health disorders could be attributed to the combined risks of household unemployment and mortgage payment difficulties. Conclusion: Recession has significantly increased the frequency of mental health disorders and alcohol abuse among primary care attendees in Spain, particularly among families experiencing unemployment and mortgage payment difficulties

**Fisher C.E., Spaeth-Rublee B., Alan Pincus H., for the IIMHL Clinical Leaders Group (2013). Developing mental health-care quality indicators: toward a common framework. International Journal for Quality in Health Care, 25 (1) : 75-80.**

Abstract: Objective Inconsistent performance measurement schemes hinder attempts to make international comparisons about mental health-care quality. This report describes a project undertaken by an international collaborative group that aims to develop a common framework of measures that will allow for international comparisons of mental health system performance. Design Representatives from each country submitted reports of quality measurement initiatives in mental health. Indicators were reviewed, and all measurable indicators were compiled and organized. Sample Twenty-nine programs from 11 countries and two cross-national programs submitted reports. Methods Indicators were evaluated according to measurable inclusion criteria. Results These methods yielded 656 total measures that were organized into 17 domains and 80 subdomains. Conclusions No single program contained indicators in all domains, highlighting the need for a comprehensive, shared scheme for international measurement. By collecting and organizing measures through an inductive compilation of existing programs, the present study has generated a maximally inclusive basis for the creation of a common framework of international mental health quality indicators

**Tai-Seale M., Foo P.K., Stults C.D. (2013). Patients With Mental Health Needs Are Engaged In Asking Questions, But Physicians Responses Vary. Health Affairs, 32 (2) : 259-267.**

Abstract: Increased patient engagement is of particular interest regarding patients with mental health needs, given the high burden of mental illness in the United States and the potential for greater patient engagement to improve health outcomes. Little is known about the extent to which these patients ask questions of their physicians; how physicians respond; and what the relationship is between patients' questions and visit outcomes. We conducted in-depth mixed-method analyses of 322 audio recordings of primary care visits by people with mental health needs. We found that patients asked many questions—a median of fifteen per visit—but that they were more likely to ask about biomedical topics, such as diabetes, than about mental health topics. Patients received highly varied responses from physicians. Our findings suggest that efforts aimed at improving patient engagement should move beyond simply encouraging patients to ask questions. The goal should also be to support physicians in recognizing patients' concerns and providing the most responsive answers, as well as promoting strong relationships to undergird communication among all members of the care team.

## **Soins de santé primaires / Primary Health Care**

**Chauvel N., Le Vaillant M., Pelletier-Fleury N. (2013). Variation in HbA1c prescription for patients with diabetes in French general practice: an observational study prior to**

**the implementation of a P4P programme.** The European Journal of Public Health, 23 (1) : 61-66.

**Abstract:** Background: Prior to a large diffusion of a pay-for-performance programme (P4P) in primary care in France, it seemed of particular interest to identify, the doctors not performing optimally who could be the main target of this programme. Based on the example of HbA1c prescription for patients with diabetes, this study examined the impact of general practitioner's (GPs) characteristics on the variation of a P4P indicator for diabetes care, i.e. the percentage of patients undergoing three or four HbA1c tests during one year. Methods: We used a large database from the national health insurance fund for salaried workers in Brittany to select a cohort of patients with diabetes who had been attended to by their doctors for 1 year. In all, 2545 GPs attending to 41 453 patients with diabetes were included. A two-level hierarchical logistic model was used to analyse the data. Results: Thirty-six per cent of patients with diabetes underwent three or four HbA1c tests during the year (the target objective was 65% in a patient list). There was a large variability between GPs, even after adjusting for patient characteristics. Doctors who were female, young, working in a group practice, participating in quality-control groups, and who had a lower patient load prescribed the three or four recommended tests more often. Discussion: The results indicate a target group of doctors which require attention. There is still room to improve the quality of care for patients with diabetes in general practice, notably by encouraging doctors to train better and practice in groups

**Andreassen L., Di Tommaso M.L., Strom S. (2012). Do medical doctors respond to economic incentives?** J Health Econ, 32 (2) : 392-409.

**Abstract:** A longitudinal analysis of married physicians labor supply is carried out on Norwegian data from 1997 to 1999. The model utilized for estimation implies that physicians can choose among 10 different job packages which are a combination of part time/full time, hospital/primary care, private/public sector, and not working. Their current choice is influenced by past available options due to a habit persistence parameter in the utility function. In the estimation we take into account the budget constraint, including all features of the tax system. Our results imply that an overall wage increase or less progressive taxation moves married physicians toward full time job packages, in particular to full time jobs in the private sector. But the overall and aggregate labor supply elasticities in the population of employed doctors are rather low compared to previous estimates

**Wulff C.N., Vedsted P., Sondergaard J. (2013). A Randomized Controlled Trial of Hospital-based Case Management in Cancer Care: a General Practitioner Perspective.** Family Practice, 30 (1) : 5-13.

**Abstract:** Background. Case management (CM) models based on experienced nurses are increasingly used to improve coordination and continuity of care for patients with complex health care needs. Anyway, little is known about the effects of hospital-based CM in cancer care. Aim. To analyse the effects of hospital-based CM on (i) GPs evaluation of information from the hospital and collaboration with the hospital staff and (ii) patients contacts with GPs during daytime and out of hours. Design. A randomized controlled trial allocated 280 colorectal cancer patients 1:1 to either a control group or CM intervention. Setting. Patients were recruited at a Danish surgical department. Methods. An ad hoc piloted questionnaire was sent to all patients GPs 30 weeks after patients recruitment and the responses from the two groups of GPs were compared. Registry data on patients contacts with general practice during daytime and out of hours were collected 9 months after recruitment and the data from the two groups were compared quarterly. Results. CM was associated with an overall tendency towards more positive GP evaluations, which for 3 of 20 items reached statistical significance. Statistically significantly fewer GPs of CM patients reported contacting the hospital. CM did not affect the number of patient contacts with the GPs during the daytime, but CM patients showed a tendency towards more contacts to the out-of-hours GP services

than non-CM patients. Conclusions. CM was appreciated by the GPs and reduced their need for subsequent hospital contact. CM increased the number of patient contacts to the out-of-hours GP services

**Elovainio M., Steen N., Presseau J., Francis J., Hrisos S., Hawthorne G., Johnston M., Stamp E., Hunter M., Grimshaw J.M., Eccles M.P. (2013). Is organizational justice associated with clinical performance in the care for patients with diabetes in primary care? Evidence from the improving Quality of care in Diabetes study.** Family Practice, 30 (1) : 31-39.

Abstract: Background. Type 2 diabetes is an increasingly prevalent illness, and there is considerable variation in the quality of care provided to patients with diabetes in primary care. Objectives. The aim of this study was to explore whether organizational justice and organizational citizenship behaviour are associated with the behaviours of clinical staff when providing care for patients with diabetes. Methods. The data were from an ongoing prospective multicenter study, the improving Quality of care in Diabetes (iQuaD) study. Participants (N = 467) were clinical staff in 99 primary care practices in the UK. The outcome measures were six self-reported clinical behaviours: prescribing for glycaemic control, prescribing for blood pressure control, foot examination, giving advice about weight management, providing general education about diabetes and giving advice about self-management. Organizational justice perceptions were collected using a self-administered questionnaire. The associations between organizational justice and behavioural outcomes were tested using linear multilevel regression modelling. Results. Higher scores on the procedural component of organizational justice were associated with more frequent weight management advice, self-management advice and provision of general education for patients with diabetes. The associations between justice and clinical behaviours were not explained by individual or practice characteristics, but evidence was found for the partial mediating role of organizational citizenship behaviour. Conclusions. Quality improvement efforts aimed at increasing advice and education provision in diabetes management in primary care could target also perceptions of procedural justice.

**Mira J.J., Orozco-Beltran D., Perez-Jover V., et al. (2013). Physician patient communication failure facilitates medication errors in older polymedicated patients with multiple comorbidities.** Family Practice, 30 (1) : 56-63.

Abstract: Objective. To analyse the frequency of mistakes in communication between the physician and the patient and their incidence in errors in self-administered drugs. Methods. We undertook a descriptive, cross-sectional study based on interviews with a random sample of patients older than 65 years who were polymedicated (five or more drugs) and had multiple comorbidities. Data were analysed about the patients reports of what the physician said, medication mistakes by the patients and their consequences. Results. Responses were provided by 382 patients. A medication error in the last year was reported by 287 patients (75%), and 16 patients (4%) reported four or more errors. Most cases concerned the dosage, a similar appearance of the medication or a lack of understanding of the physician's instructions. Very severe consequences occurred in 19 cases (5%). Multiple comorbidities (P = 0.006) and a greater number of treatments (P = 0.002) were associated with making mistakes. Frequent changes in prescription (P = 0.02), not considering the prescriptions of other physicians (P = 0.01), inconsistency in the messages (P = 0.01), being treated by various different physicians at the same time (P = 0.03), a feeling of not being listened to (P < 0.001) or loss of trust in the physician (P < 0.001) were associated with making medication mistakes. Conclusions. Mistakes by polymedicated patients with multiple comorbidities represent a real risk that should be addressed by the professionals. A review should be made of the routine control questions that the physician asks the patient to identify what other drugs the patient may be taking that have been indicated by another physician

**Clerkin P., Buckley B.S., Murphy A.W., MacFarlane A.E. (2013). Patients views about the use of their personal information from general practice medical records in health research: a qualitative study in Ireland.** Family Practice, 30 (1) : 105-112.

Abstract: Background. National policies are being developed, which may limit access to patients records for health research. This could reduce the ability of health research to benefit society as a whole. It is important to develop an in-depth understanding of people's views across demographic groups to inform such policy development. Aims. To explore patients views about the use of their general practice records in health research with attention to gender and age. Design of study. Qualitative study using focus groups. Setting. Six General Practices in the west of Ireland .Method. Focus Group interviews with 35 people who were patients at the practices. Results. Overall, participants were positively inclined towards the idea of information from their records (anonymous and identifiable) being used in research for the greater good although there were some concerns about personal information being leaked. Males emphasized risks in relation to employment and finances, whereas females emphasized risks in relation to social discomfort and embarrassment. Participants were supportive of consent models that enable patients to give prior ongoing consent for specific agreed levels of data use, affording patients self-determination without the need for consent request on study-by-study basis. Conclusion. Overall male and female patients of different ages are supportive of the use of their general practice records in health research and of general practitioners as data protectors.

**Chishti T., Harris T., Conroy R., Oakeshott P., Tulloch J., Coster D., Kerry S.R., Kerry S.M. (2013). How reliable are stroke patients reports of their numbers of general practice consultations over 12 months?** Family Practice, 30 (1) : 119-122.

Abstract: Background. Data on primary health care use are frequently used in economic evaluations. However, it is unclear how patient self-reports of their number of consultations with their general practitioner (GP) relate to actual consultations in the electronic records. These data are crucial if self-reports are used to conduct economic evaluations. Objectives. To report the accuracy of stroke patients self-reports of their number of primary care consultations over a 12-month period by comparison with practice-held electronic records. We also recorded the number of contacts required to collect service use data from the practices. Methods. We contacted 65 practices requesting electronic consultation records over 12 months for 115 stroke patients who took part in a trial of home blood pressure monitoring. Consultation rates from the electronic records were compared with patients self-reported number of consultations from a questionnaire covering the same period. Results. Fifty-one practices (78%) responded. Patients questionnaires (n = 83) reported a mean of 5.7 consultations with their GP per year compared with 7.2 in the electronic records (difference 1.6, 95% confidence interval 0.5 2.7, P < 0.01). The mean time taken to obtain records from practices was 6 weeks. Conclusions. Patients modestly under-reported the number of consultations they had with a GP. Obtaining patient records from practices required more effort than obtaining information from patient questionnaires at the same time as assessing main trial outcomes. If patient self-reports of health care usage are used in economic evaluations in primary care, researchers should consider validating a sample against electronic records.

**Bernabeo E., Holmboe E.S. (2013). Patients, Providers, And Systems Need To Acquire A Specific Set Of Competencies To Achieve Truly Patient-Centered Care.** Health Affairs, 32 (2) : 250-258.

Abstract: Studies show that patients want to be more involved in their own health care. Yet insufficient attention has been paid to the specific competencies of both patients and providers that are needed to optimize such patient engagement and shared decision making. In this article we address the knowledge, skills, and attitudes that patients, physicians, and health care systems require to effectively engage patients in their health care. For example,

many patient-physician interactions still follow the traditional office visit format, in which the patient is passive, trusting, and compliant. We recommend imaginative models for redesigned office care, restructured reimbursement schemes, and increased support services for patients and professionals. We present three clinical scenarios to illustrate how these competencies must work together. We conclude that effective shared decision making takes time to deliver proficiently and that among other measures, policy makers must change payment models to focus on value and support education and discussion of competencies for a modern health care system.

**Christel E.Dijk, Bernard B., Robert A., V, Peter S., Peter P.G., Dinny H.B. (2013). Moral hazard and supplier-induced demand: empirical evidence in general practice.** Health Economics, 22 (3) : 340-352.

Abstract: Changes in cost sharing and remuneration system in the Netherlands in 2006 led to clear changes in financial incentives faced by both consumers and general practitioner (GPs). For privately insured consumers, cost sharing was abolished, whereas those socially insured never faced cost sharing. The separate remuneration systems for socially insured consumers (capitation) and privately insured consumers (fee-for-service) changed to a combined system of capitation and fee-for-service for both groups. Our first hypothesis was that privately insured consumers had a higher increase in patient-initiated GP contact rates compared with socially insured consumers. Our second hypothesis was that socially insured consumers had a higher increase in physician-initiated contact rates. Data were used from electronic medical records from 32 GP-practices and 35 336 consumers in 2005–2007. A difference-in-differences approach was applied to study the effect of changes in cost sharing and remuneration system on contact rates. Abolition of cost sharing led to a higher increase in patient-initiated utilisation for privately insured consumers in persons aged 65 and older. Introduction of fee-for-service for socially insured consumers led to a higher increase in physician-initiated utilisation. This was most apparent in persons aged 25 to 54. Differences in the trend in physician-initiated utilisation point to an effect of supplier-induced demand. Differences in patient-initiated utilisation indicate limited evidence for moral hazard.

**Green L.V., Savin S., Lu Y. (2013). Primary care physician shortages could be eliminated through use of teams, nonphysicians, and electronic communication.**

Health Aff.(Millwood.), 32 (1) : 11-19.

Abstract: Most existing estimates of the shortage of primary care physicians are based on simple ratios, such as one physician for every 2,500 patients. These estimates do not consider the impact of such ratios on patients' ability to get timely access to care. They also do not quantify the impact of changing patient demographics on the demand side and alternative methods of delivering care on the supply side. We used simulation methods to provide estimates of the number of primary care physicians needed, based on a comprehensive analysis considering access, demographics, and changing practice patterns. We show that the implementation of some increasingly popular operational changes in the ways clinicians deliver care-including the use of teams or "pods," better information technology and sharing of data, and the use of non-physicians have the potential to offset completely the increase in demand for physician services while improving access to care, thereby averting a primary care physician shortage

## Travail Santé / Health at work

**Torp S., Nielsen R.A., FossÃ S.D., Gudbergsson S.B., Dahl A.A. (2013). Change in employment status of 5-year cancer survivors.** The European Journal of Public Health, 23 (1) : 116-122.

**Abstract:** **Aims:** To follow the employment status of 5-year cancer survivors for 5 years after diagnosis with their first lifetime invasive cancer and to identify socio-demographic, work-related and cancer-related predictors of employment status after 5 years. **Methods:** This prospective registry study concerned all 3278 people in Norway (18 - 61 years old) diagnosed with their first lifetime invasive cancer in 1999 and alive in 2004 and a cancer-free control group matched by sex, age, educational level and employment status in 1998. **Results:** The employment rate among male cancer survivors declined steadily every year, from 94% the year before diagnosis (1998) to 77% 5 years after diagnosis (2004). This change did not differ significantly from that of male controls. The employment rate of female survivors also declined steadily, from 87% (1998) to 69% (2004). This decline was greater than that among female controls, and in 2004 survivors had a significantly lower employment rate. For both men and women, the significant pre-diagnosis predictors of being employed in 2004 concerned higher socio-economic position. For both sexes, lung cancer survivors had the highest decline in employment rate, and male skin cancer survivors had a lower decline in employment rate than controls. Socio-demographic and work-related factors explained more of the variance in employment status than did cancer diagnosis. **Conclusion:** The employment rate among 5-year cancer survivors did not change significantly except for female survivors. Low socio-economic position is a risk factor for decline in employment rate and should be focused on to prevent cancer-related inequity