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Sommaire

Assurance maladie / Health Insurance

Hamman, M. K. and K. A. Kapinos (2015). "Affordable Care Act Provision Lowered Out-Of-Pocket Cost And Increased Colonoscopy Rates Among Men In Medicare." Health Aff (Millwood) **34**(12): 2069-2076.

Colorectal cancer screening is one of the few cancer screenings with an "A" rating from the US Preventive Services Task Force, meaning that the procedure confers a substantial health benefit. However, 40 percent of people who should receive colorectal cancer screenings do not receive them. Colonoscopies are the most thorough method of screening because they allow physicians to view the entire length of the colon and remove polyps as needed. Billing methods that distinguish between screening and therapeutic procedures have kept expected colonoscopy costs high. However, the Affordable Care Act partially closed the so-called colonoscopy loophole and reduced expected out-of-pocket expenses for all Medicare beneficiaries. Using data from the Behavioral Risk Factor Surveillance System, we found that annual colonoscopy rates among men ages 66-75 increased significantly (by 4.0 percentage points) after the Affordable Care Act policy change, and we found some evidence of even larger increases among socioeconomically disadvantaged men. We found no significant increases among women, a result that may be explained by health behavior and other factors and that requires further study. Our research indicates that cost may be an important barrier to colorectal cancer screening, at least among men, and that making further policy changes to close remaining loopholes may improve screening rates.

Economie de la santé / Health Economics

Campbell, C. (2015). "Community Health Worker Home Visits for Medicaid-Enrolled Children With Asthma: Effects on Asthma Outcomes and Costs." American Journal of Public Health **105**(11) : 2366-2373.

De Oliveira, C., et al. (2016). "Patients With High Mental Health Costs Incur Over 30 Percent More Costs Than Other High-Cost Patients." Health Affairs **35**(1): 36-43.

A small proportion of health care users, called high-cost patients, account for a disproportionately large share of health care costs. Most literature on these patients has focused on the entire population. However, high-cost patients whose use of mental health care services is substantial are likely to differ from other members of the population. We defined a mental health high-cost patient as someone for whom mental health–related services accounted for at least 50 percent of total health care costs. We examined these patients' health care utilization and costs in Ontario, Canada. We found that their average cost for health care, in 2012 Canadian dollars, was $31,611. In contrast, the cost was $23,681 for other high-cost patients. Mental health high-cost patients were younger, lived in poorer neighborhoods, and had different health care utilization patterns, compared to other high-cost patients. These findings should be considered when implementing policies or interventions to address quality of care for mental health patients so as to ensure that mental health high-cost patients receive appropriate care in a cost-effective manner. Furthermore, efforts to manage mental health patients' health care use should address their complex profile through integrated multidisciplinary health care delivery.

Dunn, A., et al. (2016). "Health Care Spending Slowdown From 2000 To 2010 Was Driven By Lower Growth In Cost Per Case, According To A New Data Source." Health Affairs **35(**1): 132-140.

In 2015 the Bureau of Economic Analysis released an experimental set of measures referred to as the Health Care Satellite Account, which tracks national health care spending by medical condition. These statistics improve the understanding of the health care sector by blending medical claims data and

survey data to present measures of national spending and cost of treatment by condition. This article introduces key aspects of the new account and uses it to study the health spending slowdown that occurred in the period 2000–10. Our analysis of the account reveals that the slowdown was driven by a reduction of growth in cost per case but that spending trends varied greatly across conditions and differentially affected the slowdown. More than half of the overall slowdown was accounted for by a slowdown in spending on circulatory conditions. However, there were more dramatic slowdowns in spending on categories such as endocrine system and musculoskeletal conditions than in spending on other categories, such as cancers.

Perloff, J., et al. (2015). "Comparing the Cost of Care Provided to Medicare Beneficiaries Assigned to Primary Care Nurse Practitioners and Physicians." Health Services Research: [Ahead of print]
Objective This study is designed to assess the cost of services provided to Medicare beneficiaries by nurse practitioners (NPs) billing under their own National Provider Identification number as compared to primary care physicians (PCMDs). Data Source Medicare Part A (inpatient) and Part B (office visit) claims for 2009–2010. Study Design Retrospective cohort design using propensity score weighted regression. Data Extraction Methods Beneficiaries cared for by a random sample of NPs and primary care physicians. Principal Findings After adjusting for demographic characteristics, geography, comorbidities, and the propensity to see an NP, Medicare evaluation and management payments for beneficiaries assigned to an NP were $207, or 29 percent, less than PCMD assigned beneficiaries. The same pattern was observed for inpatient and total office visit paid amounts, with 11 and 18 percent less for NP assigned beneficiaries, respectively. Results are similar for the work component of relative value units as well. Conclusions This study provides new evidence of the lower cost of care for beneficiaries managed by NPs, as compared to those managed by PCMDs across inpatient and office-based settings. Results suggest that increasing access to NP primary care will not increase costs for the Medicare program and may be cost saving.

Etat de santé / Health Status

Byass, P. (2015). "A transition towards a healthier global population?" Lancet **386**(10009): 2121-2122.

Géographie de la santé / Geography of Health

Clarke, K. C. (2016). "A multiscale masking method for point geographic data." Int J Geogr Inf Sci **30**.

Hôpital / Hospitals

Davydow, D. S., et al. (2016). "Serious Mental Illness and Risk for Hospitalizations and Rehospitalizations for Ambulatory Care-sensitive Conditions in Denmark: A Nationwide Population-based Cohort Study." Medical Care 54(1): 90-97.
Background: Hospitalizations for ambulatory care-sensitive conditions (ACSCs) and early rehospitalizations increase health care costs. Objectives: To determine if individuals with serious mental illnesses (SMIs) (eg, schizophrenia or bipolar disorder) are at increased risk for hospitalizations for ACSCs, and rehospitalization for the same or another ACSC, within 30 days. Research Design: Population-based cohort study. Participants: A total of 5.9 million Danish persons aged 18 years and older between January 1, 1999 and December 31, 2013. Measures: The Danish Psychiatric Central

Register provided information on SMI diagnoses and the Danish National Patient Register on hospitalizations for ACSCs and 30-day rehospitalizations. Results: SMI was associated with increased risk for having any ACSC-related hospitalization after adjusting for demographics, socioeconomic factors, comorbidities, and prior primary care utilization [incidence rate ratio (IRR): 1.41; 95% confidence interval (95% CI), 1.37–1.45]. Among individual ACSCs, SMI was associated with increased risk for hospitalizations for angina (IRR: 1.14, 95% CI, 1.04–1.25), chronic obstructive pulmonary disease/asthma exacerbation (IRR: 1.87; 95% CI, 1.74–2.00), congestive heart failure exacerbation (IRR: 1.25; 95% CI, 1.16–1.35), and diabetes (IRR: 1.43; 95% CI, 1.31–1.57), appendiceal perforation (IRR: 1.49; 95% CI, 1.30–1.71), pneumonia (IRR: 1.72; 95% CI, 1.66–1.79), and urinary tract infection (IRR: 1.70; 95% CI, 1.62–1.78). SMI was also associated with increased risk for rehospitalization within 30 days for the same (IRR: 1.28; 95% CI, 1.18–1.40) or for another ACSC (IRR: 1.62; 95% CI, 1.49–1.76). Conclusion: Persons with SMI are at increased risk for hospitalizations for ACSCs, and after discharge, are at increased risk for rehospitalizations for ACSCs within 30 days.

Inégalités de santé / Health Inequalities

Christopher, A. S., et al. (2016). "Access to Care and Chronic Disease Outcomes Among Medicaid-Insured Persons Versus the Uninsured." Am J Public Health **106**(1): 63-69.

OBJECTIVES: We sought to determine the association between Medicaid coverage and the receipt of appropriate clinical care. METHODS: Using the 1999 to 2012 National Health and Nutritional Examination Surveys, we identified adults aged 18 to 64 years with incomes below the federal poverty level, and compared outpatient visit frequency, awareness, and control of chronic diseases between the uninsured (n = 2975) and those who had Medicaid (n = 1485). RESULTS: Respondents with Medicaid were more likely than the uninsured to have at least 1 outpatient physician visit annually, after we controlled for patient characteristics (odds ratio [OR] = 5.0; 95% confidence interval [CI] = 3.8, 6.6). Among poor persons with evidence of hypertension, Medicaid coverage was associated with greater awareness (OR = 1.83; 95% CI = 1.26, 2.66) and control (OR = 1.69; 95% CI = 1.32, 2.27) of their condition. Medicaid coverage was also associated with awareness of being overweight (OR = 1.30; 95% CI = 1.02, 1.67), but not with awareness or control of diabetes or hypercholesterolemia. CONCLUSIONS: Among poor adults nationally, Medicaid coverage appears to facilitate outpatient physician care and to improve blood pressure control.

Eckersley, R. (2015). "Beyond inequality: Acknowledging the complexity of social determinants of health." Social Science & Medicine **147**: 121-125.

The impact of inequality on health is gaining more attention as public and political concern grows over increasing inequality. The income inequality hypothesis, which holds that inequality is detrimental to overall population health, is especially pertinent. However the emphasis on inequality can be challenged on both empirical and theoretical grounds. Empirically, the evidence is contradictory and contested; theoretically, it is inconsistent with our understanding of human societies as complex systems. Research and discussion, both scientific and political, need to reflect better this complexity, and give greater recognition to other social determinants of health.

Fleischman, Y., et al. (2015). "Migration as a social determinant of health for irregular migrants: Israel as case study." Social Science & Medicine **147**: 89-97.

More than 150,000 irregular migrants reside in Israel, yet data regarding their utilization of and perceived barriers to health care services are limited. Drawing on semi-structured interviews conducted with 35 irregular migrant adults between January and September 2012, this article analyzes the role of migration as a social determinant of health for irregular migrants, and especially asylum seekers. We analyze two kinds of barriers faced by migrants when they attempt to access health care services: barriers resulting directly from their migration status, and barriers that are common among low-income communities but exacerbated by this status. Migration-related barriers included a lack of clear or consistent legislation; the threat of deportation; the inability to obtain work permits and

resulting poverty and harsh living and working conditions; and discrimination. Barriers exacerbated by migrant status included prohibitive cost; poor and confusing organization of services; language barriers; perceived low quality of care; and social isolation. These findings support recent arguments that migrant status itself constitutes a social determinant of health that can intersect with other determinants to adversely affect health care access and health outcomes. Findings suggest that any meaningful effort to improve migrants' health will depend on the willingness of clinicians, public health officials, and policymakers to address the complex array of upstream political and socio-economic factors that affect migrants' health rather than focusing on narrower questions of access to health care.

Jutz, R. (2015). "The role of income inequality and social policies on income-related health inequalities in Europe." International Journal for Equity in Health **14**(1): 117.
INTRODUCTION: The aim of the paper is to examine the role of income inequality and redistribution for income-related health inequalities in Europe. This paper contributes in two ways to the literature on macro determinants of socio-economic inequalities in health. First, it widens the distinctive focus of the research field on welfare state regimes to quantifiable measures such as social policy indicators. Second, looking at income differences completes studies on socio-economic health inequalities, which often analyse health inequalities based on educational differences. METHODS :Using data from the European Values Study (2008/2009), 42 European countries are available for analysis. Country characteristics are derived from SWIID, Eurostat, and ILO and include indicators for income inequality, social policies, and economic performance. The data is analysed by using a two-step hierarchical estimation approach: At the first step--the individual level--the effect of household income on self-assessed health is extracted and introduced as an indicator measuring income-related health inequalities at the second step, the country-level. RESULTS : Individual-level analyses reveal that income-related health inequalities exist all across Europe. Results from country-level analyses show that higher income inequality is significantly positively related to higher health inequalities while social policies do not show significant relations. Nevertheless, the results show the expected negative association between social policies and health inequalities. Economic performance also has a reducing influence on health inequalities. In all models, income inequality was the dominating explanatory effect for health inequalities. CONCLUSIONS :The analyses indicate that income inequality has more impact on health inequalities than social policies. On the contrary, social policies seemed to matter to all individuals regardless of socio-economic position since it is significantly positively linked to overall population health. Even though social policies are not significantly related to health inequalities, the power of public redistribution to impact health inequalities should not be downplayed. Social policies as a way of public redistribution are a possible instrument to reduce income inequalities which would in turn lead to a reduction in health inequalities.

Marques, A., et al. (2015). "Les pratiques de prescription des ordonnances de précarité à l'EPS de Ville-Évrard." Santé Publique **27**(5): 623-631.

Médicaments / Pharmaceuticals

Blain, H., et al. (2015). "[Appropriate medication prescribing in older people]." Rev Med Interne **36**(10): 677-689.
Drug-induced adverse effects are one of the main avoidable causes of hospitalization in older people. Numerous lists of potentially inappropriate medications for older people have been published, as national and international guidelines for appropriate prescribing in numerous diseases and for different age categories. The present review describes the general rules for an appropriate prescribing in older people and summarizes, for the main conditions encountered in older people, medications that are too often under-prescribed, the precautions of use of the main drugs that induce adverse effects, and drugs for which the benefit to risk ratio is unfavourable in older people. All these data are assembled in educational tables designed to be printed in a practical pocket format and used in daily practice by prescribers, whether physicians, surgeons or pharmacists.

Gidengil, C. A., et al. (2015). "The Volume-Quality Relationship in Antibiotic Prescribing: When More Isn't Better." INQUIRY: The Journal of Health Care Organization, Provision, and Financing **52**.
For many surgeries and high-risk medical conditions, higher volume providers provide higher quality care. The impact of volume on more common medical conditions such as acute respiratory infections (ARIs) has not been examined. Using electronic health record data for adult ambulatory ARI visits, we divided primary care physicians into ARI volume quintiles. We fitted a linear regression model of antibiotic prescribing rates across quintiles to assess for a significant difference in trend. Higher ARI volume physicians had lower quality across a number of domains, including higher antibiotic prescribing rates, higher broad-spectrum antibiotic prescribing, and lower guideline concordance. Physicians with a higher volume of cases manage ARI very differently and are more likely to prescribe antibiotics. When they prescribe an antibiotic for a diagnosis for which an antibiotic may be indicated, they are less likely to prescribe guideline-concordant antibiotics. Given that high-volume physicians account for the bulk of ARI visits, efforts targeting this group are likely to yield important population effects in improving quality.

Iain, M. C., et al. (2016). "Patents and the Global Diffusion of New Drugs." The American Economic Review **106**(1): 136-164.
Abstract : Analysis of the timing of launches of 642 new drugs in 76 countries during 1983–2002 shows that patent and price regulation regimes strongly affect how quickly new drugs become commercially available in different countries. Price regulation delays launch, while longer and more extensive patent rights accelerate it. Health policy institutions and economic and demographic factors that make markets more profitable also speed up diffusion. The estimated effects are generally robust to controlling for endogeneity of policy regimes with country fixed effects and instrumental variables. The results highlight the important role of policy choices in driving the diffusion of new innovations. (JEL I18, L11, L51, L65, O31, O33, O34)

Joseph, J. P., et al. (2015). "[Benefits and risks for primary prevention with statins in the elderly]." Presse Med **44**(12 Pt 1): 1219-1225.
CONTEXT: Statins in primary prevention before 75 years old reduce cardiovascular events from 20 to 30% and mortality from 10% with acceptable side effects. We investigated whether these results persisted for patients aged 75 and older taking statin. METHOD: Methodic review of large randomized clinical trials and meta-analyzes that included patients 75 years and older treated with statins in primary prevention. RESULTS: Since the 1990s, a score of randomized controlled trials studying statins versus placebo in primary prevention were published and studied in meta-analyses. Exclusion criteria, including persons older than 70 years, are often restrictive. The impact on all-cause mortality in the four main studies and meta-analyses in over 75 years has not been demonstrated. On the other hand, a recent meta-analyses of observational studies including subjects between 70 and 89 years treated with statins found that low total cholesterol was associated with a moderate decrease in cardiovascular mortality, with no decrease in all-cause mortality. Moreover, in a common context of comorbidities in this age group, statins may be responsible for many adverse effects, drug interactions and impaired quality of life. CONCLUSION: Given the lack of formal evidence of effectiveness in terms of all-cause mortality and a high level of adverse effects, the benefit/risk of primary prevention with statins is not established in the elderly. The economic weight of statin prescriptions and their possible impact on quality of life justify an economic analysis of discontinuing statin therapy for people 75 years and older.

Neumann, P. J. and J. T. Cohen (2015). "Measuring the Value of Prescription Drugs." N Engl J Med **373**(27): 2595-2597.

Méthodologie – Statistique / Methodology - Statistique

Jung, I. and H. J. Cho (2015). "A nonparametric spatial scan statistic for continuous data." International Journal of Health Geographics **14**(1): 1-6.
Spatial scan statistics are widely used for spatial cluster detection, and several parametric models exist. For continuous data, a normal-based scan statistic can be used. However, the performance of the model has not been fully evaluated for non-normal data.

Kroll, M. (2015). "A graph theoretic linkage attack on microdata in a metric space." Trans Data Priv. **8**.

Politique de santé / Health Policy

Agartan, T. I. (2015). "Health workforce policy and Turkey's health care reform." Health Policy **119**(12): 1621-1626.
The health care industry is labor intensive and depends on well-trained and appropriately deployed health professionals to deliver services. This article examines the health workforce challenges in the context of Turkey's recent health reform initiative, Health Transformation Program (HTP). Reformers identified shortages, imbalances in the skills-mix, and inequities in the geographical distribution of health professionals as among the major problems. A comprehensive set of policies was implemented within the HTP framework to address these problems. The article argues that these policies addressed some of the health workforce challenges, while on the other hand exacerbating others and hence may have resulted in increasing the burden on the workforce. So far HTP's governance reforms and health human resource policy have not encouraged meaningful participation of other key stakeholders in the governance of the health care system. Without effective participation of health professionals, the next stages of HTP implementation that focus on managerial reforms such as restructuring public hospitals, improving the primary care system and implementing new initiatives on quality improvement could be very difficult.

Belche, J. L., et al. (2015). "[From chronic disease to multimorbidity: Which impact on organization of health care]." Presse Med **44**(11): 1146-1154.
Healthcare systems are concerned with the growing prevalence of chronic diseases. Single disease approach, based on the Chronic Care Model, is known to improve specific indicators for the targeted disease. However, the co-existence of several chronic disease, or multimorbidity, within a same patient is the most frequent situation. The fragmentation of care, as consequence of the single disease approach, has negative impact on the patient and healthcare professionals. A person centred approach is a method addressing the combination of health issues of each patient. The coordination and synthesis role is key to ensure continuity of care for the patient within a network of healthcare professionals from several settings of care. This function is the main characteristic of an organized first level of care.

Campos-Matos, I. and I. Kawachi (2015). "Social mobility and health in European countries: Does welfare regime type matter?" Soc Sci Med **142**: 241-248.
Health inequalities pose an important public health challenge in European countries, for which increased social mobility has been suggested as a cause. We sought to describe how the relationship between health inequalities and social mobility varies among welfare regime types in the European region. Data from six rounds of the European Social Survey was analyzed using multilevel statistical techniques, stratified by welfare regime type, including 237,535 individuals from 136 countries. Social mobility among individuals was defined according to the discrepancy between parental and offspring educational attainment. For each welfare regime type, the association between social mobility and

self-rated health was examined using odds ratios and risk differences, controlling for parental education. Upwardly mobile individuals had between 23 and 44% lower odds of reporting bad or very bad self-rated health when compared to those who remained stable. On an absolute scale, former USSR countries showed the biggest and only significant differences for upward movement, while Scandinavian countries showed the smallest. Downward social mobility tended to be associated with worse health, but the results were less consistent. Upward social mobility is associated with worse health in all European welfare regime types. However, in Scandinavian countries the association of upward mobility was smaller, suggesting that the Nordic model is more effective in mitigating the impact of social mobility on health and/or of health on mobility.

Correia, T., et al. (2015). "The impact of the financial crisis on human resources for health policies in three southern-Europe countries." Health Policy **119**(12): 1600-1605.

The public health sector has been the target of austerity measures since the global financial crisis started in 2008, while health workforce costs have been a source of rapid savings in most European Union countries. This article aims to explore how health workforce policies have evolved in three southern European countries under external constraints imposed by emergency financial programmes agreed with the International Monetary Fund, Central European Bank and European Commission. The selected countries, Greece, Portugal and Cyprus, show similarities with regard to corporatist systems of social protection and comprehensive welfare mechanisms only recently institutionalized. Based on document analysis of the Memoranda of Understanding agreed with the Troika, our results reveal broadly similar policy responses to the crisis but also important differences. In Cyprus, General Practitioners have a key position in reducing public expenditure through gatekeeping and control of users' access, while Portugal and Greece seeks to achieve cost containment by constraining the decision-making powers of professionals. All three countries lack innovation as well as monitoring and assessment of the effects of the financial crisis in relation to the health workforce. Consequently, there is a need for health policy development to use human resources more efficiently in healthcare.

Dupin, C. M., et al. (2015). "Pistes de réflexion pour l'évaluation et le financement des interventions complexes en santé publique." Santé Publique **27**(5): 653-657.

McHugh, S. M., et al. (2015). "Health workforce planning and service expansion during an economic crisis: A case study of the national breast screening programme in Ireland." Health Policy **119**(12): 1593-1599.

This article aims to estimate the workforce and resource implications of the proposed age extension of the national breast screening programme, under the economic constraints of reduced health budgets and staffing levels in the Irish health system. Using a mixed method design, a purposive sample of 20 participants were interviewed and data were analysed thematically (June-September 2012). Quantitative data (programme-level activity data, screening activity, staffing levels and screening plans) were used to model potential workload and resource requirements. The analysis indicates that over 90% operational efficiency was achieved throughout the first six months of 2012. Accounting for maternity leave (10%) and sick leave (3.5%), 16.1 additional radiographers (whole time equivalent) would be required for the workload created by the age extension of the screening programme, at 90% operational efficiency. The results suggest that service expansion is possible with relatively minimal additional radiography resources if the efficiency of the skill mix and the use of equipment are improved. Investing in the appropriate skill mix should not be limited to clinical groups but should also include administrative staff to manage and support the service. Workload modelling may contribute to improved health workforce planning and service efficiency.

Ovseiko, P. V. and A. M. Buchan (2015). "Medical workforce education and training: A failed decentralisation attempt to reform organisation, financing, and planning in England." Health Policy **119**(12): 1545-1549.

The 2010-2015 Conservative and Liberal Democrat coalition government proposed introducing a radical decentralisation reform of the organisation, financing, and planning of medical workforce education and training in England. However, following public deliberation and parliamentary scrutiny of the government's proposals, it had to abandon and alter its original proposals to the extent that

they failed to achieve their original decentralisation objectives. This failed decentralisation attempt provides important lessons about the policy process and content of both workforce governance and health system reforms in Europe and beyond. The organisation, financing, and planning of medical workforce education is as an issue of national importance and should remain in the stewardship of the national government. Future reform efforts seeking to enhance the skills of the workforce needed to deliver high-quality care for patients in the 21st century will have a greater chance of succeeding if they are clearly articulated through engagement with stakeholders, and focus on the delivery of undergraduate and postgraduate multi-professional education and training in universities and teaching hospitals.

Vicarelli, G. and E. Pavolini (2015). "Health workforce governance in Italy." Health Policy **119**(12): 1606-1612.

More precise health workforce governance has become a prominent issue in healthcare systems. This issue is particularly important in Italy, given its strongly doctor-centered healthcare system and the dramatic aging of its physicians' labor force. Using different sources of information (statistical data, official planning documents and interviews with key informants), the article attempts to answer two questions. Why has the Italian healthcare systems found itself in the situation of a potential drastic reduction in the amount of doctors in the medium term without a rebalancing through a different mix of skills and professionals? How good is the capacity of the Italian healthcare system to plan healthcare workforce needs? The widespread presence of 'older' physicians is the result of the strong entry of doctors into the Italian healthcare system in the 1970s and 1980s. Institutional fragmentation, difficulties in drafting broad healthcare reforms, political instability and austerity measures explain why Italian health workforce forecasting and planning are still unsatisfactory, although recent developments indicate that changes are under way. In order to tackle these problems it is necessary to foster closer cooperation among a wide range of stakeholders, to move from uni-professional to multi-professional health workforce planning, and to partially re-centralise decision making.

Politique publique / Public Policy

Lang, T. (2015). "Déterminants sociaux, santé et politiques publiques? Mobiliser toutes les connaissances." Santé Publique **27**(5): 619-621.

Psychiatrie / Psychiatry

Barr, B., et al. (2015). "Trends in mental health inequalities in England during a period of recession, austerity and welfare reform 2004 to 2013." Social Science & Medicine **147**: 324-331.

Several indicators of population mental health in the UK have deteriorated since the financial crisis, during a period when a number of welfare reforms and austerity measures have been implemented. We do not know which groups have been most affected by these trends or the extent to which recent economic trends or recent policies have contributed to them. We use data from the Quarterly Labour Force Survey to investigate trends in self reported mental health problems by socioeconomic group and employment status in England between 2004 and 2013. We then use panel regression models to investigate the association between local trends in mental health problems and local trends in unemployment and wages to investigate the extent to which these explain increases in mental health problems during this time. We found that the trend in the prevalence of people reporting mental health problems increased significantly more between 2009 and 2013 compared to the previous trends. This increase was greatest amongst people with low levels of education and inequalities widened. The gap in prevalence between low and high educated groups widened by 1.29 percentage points for women (95% CI: 0.50 to 2.08) and 1.36 percentage points for men (95% CI: 0.31 to 2.42) between 2009 and 2013. Trends in unemployment and wages only partly explained these recent

increases in mental health problems. The trend in reported mental health problems across England broadly mirrored the pattern of increases in suicides and antidepressant prescribing. Welfare policies and austerity measures implemented since 2010 may have contributed to recent increases in mental health problems and widening inequalities. This has led to rising numbers of people with low levels of education out of work with mental health problems. These trends are likely to increase social exclusion as well as demand for and reliance on social welfare systems.

Ménard S. and P.ollak C. (2015/10). "L'effet d'une extension des indemnités complémentaires sur les arrêts maladie Une évaluation de l'ANI de 2008." Dossiers Solidarité et Santé (Dress)(69): 1-34.

L'accord national interprofessionnel (ANI) du 11 janvier 2008 a étendu l'accès aux indemnités journalières obligatoirement versées par les employeurs du secteur privé aux salariés de plus d'un an d'ancienneté (contre 3 ans auparavant). Cette étude évalue l'effet de l'augmentation du niveau d'indemnisation sur le recours aux arrêts maladie des salariés concernés par l'ANI. Elle mobilise des données administratives d'un échantillon représentatif d'environ 200 000 salariés suivis de 2005 à 2010. L'impact causal de la réforme est identifié par une méthode de différence de différences consistant à comparer l'évolution du recours aux arrêts maladie avant et après son entrée en vigueur entre les salariés pour lesquels les règles d'indemnisation ont été modifiées (1 à 3 ans d'ancienneté) et les autres salariés. Les résultats indiquent que l'ANI n'a pas eu d'effet sur le nombre et la durée des arrêts maladie des salariés concernés, ni en 2009, ni en 2010.

Soins de santé primaires / Primary Health Care

Barbazza, E., et al. (2015). "Health workforce governance: Processes, tools and actors towards a competent workforce for integrated health services delivery." Health Policy **119**(12): 1645-1654.

A competent health workforce is a vital resource for health services delivery, dictating the extent to which services are capable of responding to health needs. In the context of the changing health landscape, an integrated approach to service provision has taken precedence. For this, strengthening health workforce competencies is an imperative, and doing so in practice hinges on the oversight and steering function of governance. To aid health system stewards in their governing role, this review seeks to provide an overview of processes, tools and actors for strengthening health workforce competencies. It draws from a purposive and multidisciplinary review of literature, expert opinion and country initiatives across the WHO European Region's 53 Member States. Through our analysis, we observe distinct yet complementary roles can be differentiated between health services delivery and the health system. This understanding is a necessary prerequisite to gain deeper insight into the specificities for strengthening health workforce competencies in order for governance to rightly create the institutional environment called for to foster alignment. Differentiating between the contribution of health services and the health system in the strengthening of health workforce competencies is an important distinction for achieving and sustaining health improvement goals.

Barnay, T. (2015). "Health, work and working conditions: a review of the European economic literature." Eur J Health Econ. [ahead of print]

Economists have traditionally been very cautious when studying the interaction between employment and health because of the two-way causal relationship between these two variables: health status influences the probability of being employed and, at the same time, working affects the health status. Because these two variables are determined simultaneously, researchers control endogeneity skews (e.g., reverse causality, omitted variables) when conducting empirical analysis. With these caveats in mind, the literature finds that a favourable work environment and high job security lead to better health conditions. Being employed with appropriate working conditions plays a protective role on physical health and psychiatric disorders. By contrast, non-employment and retirement are generally worse for mental health than employment, and overemployment has a negative effect on health.

These findings stress the importance of employment and of adequate working conditions for the health of workers. In this context, it is a concern that a significant proportion of European workers (29 %) would like to work fewer hours because unwanted long hours are likely to signal a poor level of job satisfaction and inadequate working conditions, with detrimental effects on health. Thus, in Europe, labour-market policy has increasingly paid attention to job sustainability and job satisfaction. The literature clearly invites employers to take better account of the worker preferences when setting the number of hours worked. Overall, a specific "flexicurity" (combination of high employment protection, job satisfaction and active labour-market policies) is likely to have a positive effect on health.

Batenburg, R. (2015). "Health workforce planning in Europe: Creating learning country clusters." Health Policy **119**(12): 1537-1544.

In this article, the different dimensions and determinants of health workforce planning (HWF) are investigated to improve context-sensitivity and mutual learning among groups of countries with similar HWF characteristics. A novel approach to scoring countries according to their HFW characteristics and type of planning is introduced using data collected in 2012 by a large European Union project involving 35 European countries (the 'Matrix Study' [8]). HWF planning is measured in terms of three major dimensions: (1) data infrastructure to monitor the capacities and dynamics of health workforces, (2) the institutions involved in defining and implementing labour market regulations, and (3) the availability of models to estimate supply-demand gaps and to forecast imbalances. The result shows that the three dimensions of HWF planning are weakly interrelated, indicating that countries invest in HWF in different ways. Determinant analysis shows that countries with larger health labour markets, National Healthcare Service (NHS), mobility, and strong primary health care score higher on HWF planning dimensions than others. Consequently, the results suggest that clustering countries with similar conditions in terms of HWF planning is a way forward towards mutual and contextual learning.

Boucher, N. A., et al. (2016). "A Framework for Improving Chronic Critical Illness Care: Adapting the Medical Home's Central Tenets." Medical Care **54**(1): 5-8.

Brosig-Koch, J., et al. (2015). "The Effects of Introducing Mixed Payment Systems for Physicians: Experimental Evidence." Health Economics: [ahead of print]

Mixed payment systems have become a prominent alternative to paying physicians through fee-for-service and capitation. While theory shows mixed payment systems to be superior, causal effects on physicians' behavior when introducing mixed systems are not well understood empirically. We systematically analyze the influence of fee-for-service, capitation, and mixed payment systems on physicians' service provision. In a controlled laboratory setting, we implement an exogenous variation of the payment method. Medical and non-medical students in the role of physicians in the lab (N = 213) choose quantities of medical services affecting patients' health outside the lab. Behavioral data reveal significant overprovision of medical services under fee-for-service and significant underprovision under capitation, although less than predicted when assuming profit maximization. Introducing mixed payment systems significantly reduces deviations from patient-optimal treatment. Although medical students tend to be more patient regarding, our results hold for both medical and non-medical students. Responses to incentive systems can be explained by a behavioral model capturing individual altruism. In particular, we find support that altruism plays a role in service provision and can partially mitigate agency problems, but altruism is heterogeneous in the population. Copyright © 2015 John Wiley & Sons, Ltd.

Clanet, R., et al. (2015). "Revue systématique sur les documents de sortie d'hospitalisation et les attentes des médecins généralistes." Santé Publique **27**(5): 701-711.

Flye Sainte Marie, C., et al. (2015). "Difficultés des médecins généralistes dans la prise en charge de leurs patients précaires." Santé Publique **27**(5): 679-690.

Glinos, I. A. (2015). "Health professional mobility in the European Union: Exploring the equity and efficiency of free movement." Health Policy **119**(12): 1529-1536.

The WHO Global Code of Practice on the International Recruitment of Health Personnel is a landmark in the health workforce migration debate. Yet its principles apply only partly within the European Union (EU) where freedom of movement prevails. The purpose of this article is to explore whether free mobility of health professionals contributes to "equitably strengthen health systems" in the EU. The article proposes an analytical tool (matrix), which looks at the effects of health professional mobility in terms of efficiency and equity implications at three levels: for the EU, for destination countries and for source countries. The findings show that destinations as well as sources experience positive and negative effects, and that the effects of mobility are complex because they change, overlap and are hard to pin down. The analysis suggests that there is a risk that free health workforce mobility disproportionally benefits wealthier Member States at the expense of less advantaged EU Member States, and that mobility may feed disparities as flows redistribute resources from poorer to wealthier EU countries. The article argues that the principles put forward by the WHO Code appear to be as relevant within the EU as they are globally.

Graves, J. A., et al. (2016). "Role of Geography and Nurse Practitioner Scope-of-Practice in Efforts to Expand Primary Care System Capacity: Health Reform and the Primary Care Workforce." Medical Care **54**(1): 81-89.

Background: Little is known about the geographic distribution of the overall primary care workforce that includes both physician and non physician clinicians—particularly in areas with restrictive nurse practitioner scope-of-practice laws and where there are relatively large numbers of uninsured. Objective: We investigated whether geographic accessibility to primary care clinicians (PCCs) differed across urban and rural areas and across states with more or less restrictive scope-of-practice laws. Research Design: An observational study. Subjects: 2013 Area Health Resource File (AHRF) and US Census Bureau county travel data. Measures: The measures included percentage of the population in low-accessibility, medium-accessibility, and high-accessibility areas; number of geographically accessible primary care physicians (PCMDs), nurse practitioners (PCNPs), and physician assistants (PCPAs) per 100,000 population; and number of uninsured per PCC. Results: We found divergent patterns in the geographic accessibility of PCCs. PCMDs constituted the largest share of the workforce across all settings, but were relatively more concentrated within urban areas. Accessibility to non physicians was highest in rural areas: there were more accessible PCNPs per 100,000 population in rural areas of restricted scope-of-practice states (21.4) than in urban areas of full practice states (13.9). Despite having more accessible non physician clinicians, rural areas had the largest number of uninsured per PCC in 2012. While less restrictive scope-of-practice states had up to 40% more PCNPs in some areas, we found little evidence of differences in the share of the overall population in low-accessibility areas across scope-of-practice categorizations. Conclusions: Removing restrictive scope-of-practice laws may expand the overall capacity of the primary care workforce, but only modestly in the short run. Additional efforts are needed that recognize the locational tendencies of physicians and non physicians.

Groenewegen, P., et al. (2015). "Primary care practice composition in 34 countries." Health Policy **119**(12): 1576-1583.

Health care needs in the population change through ageing and increasing multimorbidity. Primary health care might accommodate to this through the composition of practices in terms of the professionals working in them. The aim of this article is to describe the composition of primary care practices in 34 countries and to analyse its relationship to practice circumstances and the organization of the primary care system. The data were collected through a survey among samples of general practitioners (n=7183) in 34 countries. In some countries, primary care is mainly provided in single-handed practices. Other countries which have larger practices with multiple professional groups. There is no overall relationship between the professional groups in the practice and practice location. Practices that are located further from other primary care practices have more different professions. Practices with a more than average share of socially disadvantaged people and/or ethnic minorities have more different professions. In countries with a stronger pro-primary care workforce development and more comprehensive primary care delivery the number of different professions is higher. In conclusion, primary care practice composition varies strongly. The organizational scale of primary care is largely country dependent, but this is only partly explained by system characteristics.

Levesque J. F., et al. (2015). "Barriers and Facilitators for Primary Care Reform in Canada: Results from a Deliberative Synthesis across Five Provinces." Healthcare Policy **11**(2): 44-57.
Introduction: Since 2000, primary care (PC) reforms have been implemented in various Canadian provinces. Emerging organizational models and policies are at various levels of implementation across jurisdictions. Few cross-provincial analyses of these reforms have been realized. The aim of this study is to identify the factors that have facilitated or hindered implementation of reforms in Canadian provinces between 2000 and 2010. Methods: A literature and policy scan identified evaluation studies across Canadian jurisdictions. Experts from British Columbia, Manitoba, Nova Scotia, Ontario and Quebec were asked to review the scope of published evaluations and draft provincial case descriptions. A one-day deliberative forum was held, bringing together researchers (n = 40) and decision-makers n = 20) from all the participating provinces. Results: Despite a relative lack of published evaluations, our results suggest that PC reform has varied with regard to the scope and the policy levers used to implement change. Some provinces implemented specific PC models, while other provinces designed overarching policies aiming at changing professional behaviour and practice. The main perceived barriers to reform were the lack of financial investment, resistance from professional associations, too overtly prescriptive approaches lacking adaptability and an overly centralized governance model. The main perceived facilitators were a strong financial commitment using various allocation and payment approaches, the cooperation of professional associations and an incremental emergent change philosophy based on a strong decentralization of decisions allowing adaptation to local circumstances. So far the most beneficial results of the reforms seem to be an increase in patients' affiliation with a usual source of care, improved experience of care by patients and a higher workforce satisfaction. Conclusion: PC reforms currently under consideration in other jurisdictions could learn from the factors identified as promoting or hindering change in the provinces that have been most proactive

Jennings, R. (2015). "Rather than pay GPs to reduce referrals, use the money to improve community services." BMJ **351**.

Kuhlmann, E. and C. Larsen (2015). "Why we need multi-level health workforce governance: Case studies from nursing and medicine in Germany." Health Policy **119**(12): 1636-1644.
Health workforce needs have moved up on the reform agendas, but policymaking often remains 'piece-meal work' and does not respond to the complexity of health workforce challenges. This article argues for innovation in healthcare governance as a key to greater sustainability of health human resources. The aim is to develop a multi-level approach that helps to identify gaps in governance and improve policy interventions. Pilot research into nursing and medicine in Germany, carried out between 2013 and 2015 using a qualitative methodology, serves to illustrate systems-based governance weaknesses. Three explorative cases address major responses to health workforce shortages, comprising migration/mobility of nurses, reform of nursing education, and gender-sensitive work management of hospital doctors. The findings illustrate a lack of connections between transnational/EU and organizational governance, between national and local levels, occupational and sector governance, and organizations/hospital management and professional development. Consequently, innovations in the health workforce need a multi-level governance approach to get transformative potential and help closing the existing gaps in governance.

Maier, C. B. (2015). "The role of governance in implementing task-shifting from physicians to nurses in advanced roles in Europe, U.S., Canada, New Zealand and Australia." Health Policy **119**(12): 1627-1635.
Task-shifting from physicians to nurses is increasing worldwide; however, research on how it is governed is scarce. This international study assessed task-shifting governance models and implications on practice, based on a literature scoping review; and a survey with 93 country experts in 39 countries (response rate: 85.3%). Governance was assessed by several indicators, regulation of titles, scope of practice, prescriptive authority, and registration policies. This policy analysis focused on eleven countries with task-shifting at the Advanced Practice Nursing/Nurse Practitioner (APN/NP) level. Governance models ranged from national, decentralized to no regulation, but at the discretion of employers and settings. In countries with national or decentralized regulation, restrictive scope of

practice laws were shown as barrier, up-to-date laws as enablers to advanced practice. Countries with decentralized regulation resulted in uneven levels of practice. In countries leaving governance to individual settings, practice variations existed, moreover data availability and role clarity was limited. Policy options include periodic reviews to ensure laws are up to date, minimum harmonization in decentralized contexts, harmonized educational and practice-level requirements to reduce practice variation and ensure quality. From a European Union (EU) perspective, regulation is preferred over non-regulation as a first step toward the recognition of qualifications in countries with similar levels of advanced practice. Countries early on in the process need to be aware that different governance models can influence practice.

Roland, M. (2015). "GPs should not be paid to reduce unnecessary referrals." BMJ **351**.

Financial incentives work, but not usually as well as those who introduce them hope for. Financial incentives can also have perverse or unintended consequences. Both of these are clear from extensive published research. So, when “pay for performance” is contemplated, the aim should be to design the scheme to maximise the benefits and minimise the risks. One fundamental principle in doing this is to ensure that professional and financial incentives are aligned as closely as possible. When doctors are incentivised to do things that they believe conflict with their professional duties, the risk of perverse outcomes inevitably increases. These well tested observations mean that the last thing the NHS should be doing is to pay doctors not to refer patients to hospital. If you were a patient, would you really want to visit a GP thinking that his next skiing holiday might depend on him not referring you to a specialist? If variation in GPs’ rates of referral is a problem, there are better ways of dealing with it.

Rosenthal, M. B., et al. (2015). "Pay for Performance in Medicaid: Evidence from Three Natural Experiments." Health Services Research

Objective To examine the impact of pay for performance in Medicaid on the quality and utilization of care. Data Sources Medicaid claims and encounter data in three intervention states (Pennsylvania, Minnesota, and Alabama) and three comparison states. Study Design Difference-in-difference analysis with propensity score-matched comparison group. Primary outcomes of interest were Healthcare Effectiveness Data and Information Set (HEDIS)-like process measures of quality, utilization by service category, and ambulatory care–sensitive admissions and emergency department visits. Principal Findings In Pennsylvania, there was a statistically significant reduction of 88 ambulatory visits per 1,000 enrollee months compared with Florida. In Minnesota, there was a significant decrease of 7.2 hospital admissions per thousand enrollee months compared with Wisconsin. In Alabama, where incentives were not paid out until the end of a 2-year waiver period, there was a decline of 1.6 hospital admissions per thousand member months, and an increase of 59 ambulatory visits per 1,000 enrollees compared with Georgia. No significant quality improvements in intervention relative to control states. Conclusions : Our findings are mixed, with no measurable quality improvements across the three states, but reductions in hospital admissions in two programs. As states move to value-based payment for patient-centered medical homes and Accountable Care Organizations, lessons learned from these pioneering states should inform program design.

Wong , S.T., et al.(2015). "Incorporating Group Medical Visits into Primary Healthcare: Are There Benefits?" Healthcare Policy **11**(2): 27-42.

Objective: Group medical visits (GMVs) have been touted as an innovation to effectively and efficiently provide primary healthcare (PHC) services. The purpose of this paper is to report whether GMVs have tangible benefits for providers and patients. Methods: This descriptive study included in-depth interviews with patients attending and providers facilitating GMVs and direct observation. Five primary care practices in rural towns and four First Nations communities participated. This paper reports on an analysis of interviews and observations. Results: Thirty-four providers and 29 patients were interviewed. Patient participants were an average of 62 years old, mostly female and married. The three most common chronic conditions reported by patients were diabetes (n=9), high blood pressure (n= 8) and arthritis (n= 7). Three themes illustrated how GMVs: (1) can foster access to needed health services; (2) expand opportunities for collaboration and team-based care; and (3) improve patient and provider experiences. A fourth theme captured structural challenges in delivering GMVs. Discussion: There are tangible benefits in delivering GMVs in PHC. While whole patient panels

can benefit from the integration of GMVs into practice, those who could gain the most are patients with complex medical and social needs. GMVs provide an opportunity to enhance PHC, strengthening the system particularly for patients with chronic conditions.

Schellevis, F. G. and P. P. Groenewegen (2015). "Together we change: An ambitious blueprint for primary healthcare in Flanders." Eur J Gen Pract **21**(4): 215-216.

Van Den Berg, M. J., et al. (2015). "Accessible and continuous primary care may help reduce rates of emergency department use. An international survey in 34 countries." Family Practice. [Ahead of print.]
Background. Part of the visits to emergency departments (EDs) is related to complaints that may well be treated in primary care. Objectives. (i) To investigate how the likelihood of attending an ED is related to accessibility and continuity of primary care. (ii) To investigate the reasons for patients to visit EDs in different countries. Methods. Data were collected within the EU Seventh Framework project Quality and Costs in Primary Care (QUALICOPC) in 31 European countries, Australia, New Zealand and Canada. The data were collected between 2011 and 2013 and contain survey data from 60991 patients and 7005 GPs, within 7005 general practices. Outcome measure: whether the patient visited the ED in the previous year (yes/no). Multilevel logistic regression analyses were carried out to analyse the data. Results. Some 29.4% had visited the ED in the past year. Between countries, the percentages varied between 18% and 40%. ED visits show a significant and negative relation with better accessibility of primary care. Patients with a regular doctor who knows them personally were less likely to attend EDs. Only one-third of all patients who visited an ED indicated that the main reason for this was that their complaint could not be treated by a GP. Conclusions. Good accessibility and continuity of primary care may well reduce ED use. In some countries, it may be worthwhile to invest in more continuous relationships between patients and GPs or to eliminate factors that hamper people to use primary care (e.g. for costs or travelling).

Systèmes de santé / Health Systems

Biller-Andorno, N. and T. Zeltner (2015). "Individual Responsibility and Community Solidarity--The Swiss Health Care System." N Engl J Med **373**(23): 2193-2197.

Liaropoulos, L. and I. Goranitis (2015). "Health care financing and the sustainability of health systems." International Journal for Equity in Health **14**(1): 80.
The economic crisis brought an unprecedented attention to the issue of health system sustainability in the developed world. The discussion, however, has been mainly limited to "traditional" issues of cost-effectiveness, quality of care, and, lately, patient involvement. Not enough attention has yet been paid to the issue of who pays and, more importantly, to the sustainability of financing. This fundamental concept in the economics of health policy needs to be reconsidered carefully. In a globalized economy, as the share of labor decreases relative to that of capital, wage income is increasingly insufficient to cover the rising cost of care. At the same time, as the cost of Social Health Insurance through employment contributions rises with medical costs, it imperils the competitiveness of the economy. These reasons explain why spreading health care cost to all factors of production through comprehensive National Health Insurance financed by progressive taxation of income from all sources, instead of employer-employee contributions, protects health system objectives, especially during economic recessions, and ensures health system sustainability.

Urquhart R. and Jackson L. (2015). "Health System-Level Factors Influence the Implementation of Complex Innovations in Cancer Care." Healthcare Policy **11**(2): 102-118.
Background: The movement of new knowledge and tools into healthcare settings continues to be a slow, complex and poorly understood process. In this paper, we present the system-level factors important to the implementation of synoptic reporting tools in two initiatives (or cases) in Nova

Scotia, Canada. Methods: This study used case study methodology. Data were collected through interviews with key informants, document analysis, non-participant observation and tool use/examination. Analysis involved production of case histories, analysis of each case and a cross-case analysis. Results: The healthcare system's delivery and support structure, information technology infrastructure, policy environment and history of collaboration and inter-organizational relationships influenced tool implementation in the two cases. Conclusions: The findings provide an in-depth, nuanced understanding of how healthcare system components can influence the implementation of a new tool in clinical practice.

Travail et santé : Occupational Health

Givord, P. and C. Marbot (2015). "Does the cost of child care affect female labor market participation? An evaluation of a French reform of childcare subsidies." Labour Economics **36**: 99-111.

This study evaluates the short-run impact of an increase in childcare subsidies on the use of paid childcare and the participation rate of mothers of preschool children. We use a natural experiment provided by the PAJE, a French reform in family allowances introduced in 2004. This reform temporarily creates discrepancies in the childcare subsidies received by families according to the year of birth of the children. We apply a difference-in-differences strategy on exhaustive French fiscal data that provide information on gross income as well as on the use of paid childcare services between 2005 and 2008. We use the fact that the new policy results in a significant increase in the use of paid childcare services. The effect on the labor force participation of mothers is significant but of a smaller magnitude. The highest impact is observed for mothers of large families.

Durand-Moreau, Q., and Dewitte, J.D. (2015). "[Creating a new table of occupational diseases for burnout is not a good answer to prevent it]." Presse Med **44**(12 Pt 1): 1215-1218.

Vieillissement / Ageing

Hève, D., et al. (2015). "Living Lab AVC-LR : accident vasculaire cérébral en Languedoc-Roussillon." Presse Médicale **44**(51): 537-535.

Noguès, M., et al. (2015). "Living Lab-MACVIA-LR Fragilité." Presse Médicale **44**(51): 536-546.