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## Assurance maladie / Health Insurance

**Choudhry N.K., Fischer M.A., Benjamin B.F. (2014). Five Features Of Value-Based Insurance Design Plans Were Associated With Higher Rates Of Medication Adherence.** *Health Affairs*, 33 (3) : 493-501.

**Abstract:** Value-based insurance design (VBID) plans selectively lower cost sharing to increase medication adherence. Existing plans have been structured in a variety of ways, and these variations could influence the effectiveness of VBID plans. We evaluated seventy-six plans introduced by a large pharmacy benefit manager during 2007-2010. We found that after we adjusted for the other features and baseline trends, VBID plans that were more generous, targeted high-risk patients, offered wellness programs, did not offer disease management programs, and made the benefit available only for medication ordered by mail had a significantly greater impact on adherence than plans without these features. The effects were as large as 4.5 percentage points. These findings can provide guidance for the structure of future VBID plans.

**Abraham J.M. (2014). How Might the Affordable Care Act's Coverage Expansion Provisions Influence Demand for Medical Care?** *Milbank Q*, 92 (1) : 63-87.

**Abstract:** CONTEXT: The Affordable Care Act (ACA) is predicted to expand health insurance to 25 million individuals. Since insurance reduces the price of medical care, the quantity of services demanded by these newly covered individuals is expected to rise. In this article I provide a comprehensive picture of the demographics, health status, and medical care utilization of the population targeted for the ACA's expansion of coverage, contrasted with that of other nonelderly, insured populations. In addition, I synthesize the current evidence regarding the causal impact of insurance on medical care demand, drawing heavily on recent evidence from Massachusetts and Oregon. METHODS: Using the 2008 to 2010 Medical Expenditure Panel Survey, I conducted bivariate and multivariate analyses to examine differences between the ACA target population and other insured groups. I used the results from the descriptive analysis and quasi-experimental literature to generate "back of the envelope" estimates of the potential impact of the coverage expansion on total medical care utilization by the non institutionalized US population. FINDINGS: Comparisons of the potential ACA target population with the privately and publicly insured reveal that the former is younger and more likely to be male. The ACA target population, and particularly the uninsured with incomes under 200% of the federal poverty line, reports lower rates of several medical conditions relative to those of the privately and publicly insured. Future changes in rates of inpatient hospitalization and ED use among the newly insured could vary widely, based on descriptive findings and inferences from the quasi-experimental literature. Results also suggest moderate increases in ambulatory care. Total increases in overall demand for medical care by the newly insured comprise a modest proportion of the aggregate utilization. CONCLUSIONS: With the expected increases in utilization resulting from the coverage expansion, stakeholders will need to monitor local health care delivery system capacity and respond where needed with policy- and/or market-based innovations.

## Economie de la santé / Health Economics

**Wijeyesundera H.C., Austin P.C., Wang X., Bennell M.C., Abrahamyan L., Ko D.T., Tu J.V., Krahn M. (2014). The Effect of Multidisciplinary Heart Failure Clinic Characteristics on 1-Year Postdischarge Health Care Costs: A Population-based Study.** *Medical Care*, 52 (3)

**Abstract:** Background: Although multidisciplinary heart failure (HF) clinics are efficacious, it is not known how patient factors or HF clinic structural indicators and process measures have an impact on the cumulative health care costs. Research Design: In this retrospective cohort study using



administrative databases in Ontario, Canada, we identified 1216 HF patients discharged alive after an acute care hospitalization in 2006 and treated at a HF clinic. The primary outcome was the cumulative 1-year health care costs. A hierarchical generalized linear model with a logarithmic link and gamma distribution was developed to determine patient-level and clinic-level predictors of cost. Results: The mean 1-year cost was \$27,809 (range, \$69 to \$343,743). There was a 7-fold variation in the mean costs by clinic, from \$14,670 to \$96,524. Delays in being seen at a HF clinic were a significant patient-level predictor of costs (rate ratio 1.0015 per day;  $P < 0.001$ ). Being treated at a clinic with  $> 3$  physicians was associated with lower costs (rate ratio 0.78;  $P = 0.035$ ). Unmeasured patient-level differences accounted for 97.4% of the between-patient variations in cost. The between-clinic variation in costs decreased by 16.3% when patient-level factors were accounted for; it decreased by a further 49.8% when clinic-level factors were added. Conclusions: From a policy perspective, the wide spectrum of HF clinic structure translates to inefficient care. Greater guidance as to the type of patient seen at a HF clinic, the timeliness of the initial visit, and the most appropriate structure of the HF clinics may potentially result in more cost-effective care.

**Blumberg L.J., Waidmann T.A., Blavin F., Roth J. (2014). Trends in health care financial burdens, 2001 to 2009. *Milbank Q*, 92 (1) : 88-113.**

**Abstract:** CONTEXT: Over the past decade, health care spending increased faster than GDP and income, and decreasing affordability is cited as contributing to personal bankruptcies and as a reason that some of the nonelderly population is uninsured. We examined the trends in health care affordability over the past decade, measuring the financial burdens associated with health insurance premiums and out-of-pocket costs and highlighting implications of the Affordable Care Act for the future financial burdens of particular populations. METHODS: We used cross sections of the Medical Expenditure Panel Survey Household Component (MEPS-HC) from 2001 to 2009. We defined financial burden at the health insurance unit (HIU) level and calculated it as the ratio of expenditures on health care-employer-sponsored insurance coverage (ESI) and private nongroup premiums and out-of-pocket payments to modified adjusted gross income. FINDINGS: The median health care financial burden grew on average by 2.7% annually and by 21.9% over the period. Using a range of definitions, the fraction of households facing high financial burdens increased significantly. For example, the share of HIUs with health care expenses exceeding 10% of income increased from 35.9% to 44.8%, a 24.8% relative increase. The share of the population in HIUs with health care financial burdens between 2% and 10% fell, and the share with burdens between 10% and 44% rose. CONCLUSIONS: We found a clear trend over the past decade toward an increasing share of household income devoted to health care. The ACA will affect health care spending for subgroups of the population differently. Several groups' burdens will likely decrease, including those becoming eligible for Medicaid or subsidized private insurance and those with expensive medical conditions. Those newly obtaining coverage might increase their health spending relative to income, but they will gain access to care and the ability to spread their expenditures over time, both of which have demonstrable economic value.

**Kalseth J., Halvorsen T., Kalseth B., Sarheim A.K., Peltola M., Kautiainen K., Hakkinen U., Medin E., Lundgren J., Rehnberg C., Masdottir B.B., Heimisdottir M., Bjarnadottir H.H., Kotlum J.E., Kilsmark J., Halsteinli V. (2014). Cross-country comparisons of health-care costs: The case of cancer treatment in the Nordic countries. *Health Policy*, 115 (2-3) : 172-179.**

**Abstract:** The objective of this study is to perform a cross-country comparison of cancer treatment costs in the Nordic countries, and to demonstrate the added value of decomposing documented costs in interpreting national differences. The study is based on individual-level data from national patient and prescription drug registers, and data on cancer prevalence from the NORDCAN database. Hospital costs were estimated on the basis of information on diagnosis-related groups (DRG) cost weights and national unit costs. Differences in per capita costs were decomposed into two stages: stage one separated the price and volume components, and stage two decomposed the volume component, relating the level of activity to service needs and availability. Differences in the per capita costs of cancer treatment between the Nordic countries may be as much as 30 per cent. National differences in the costs of treatment mirror observed differences in total health care costs. Differences in health care costs between countries may relate to different sources of variation with different policy implications. Comparisons of per capita spending alone can be misleading if the purpose is to



evaluate, for example, differences in service provision and utilisation. The decomposition analysis helps to identify the relative influence of differences in the prevalence of cancer, service utilisation and productivity.

## Etat de santé / Health Economics

### **Desveaux L., Beauchamp M., Goldstein R., Brooks D. (2014). Community-based Exercise Programs as a Strategy to Optimize Function in Chronic Disease: A Systematic Review. *Medical Care*, 52 (3) :**

**Abstract:** Background:Chronic diseases are the leading cause of death and disability worldwide. Preliminary evidence suggests that community-based exercise (CBE) improves functional capacity (FC) and health-related quality of life (HRQL). Objective :To describe the structure and delivery of CBE programs for chronic disease populations and compare their impact on FC and HRQL to standard care. Research Design: Randomized trials examining CBE programs for individuals with stroke, chronic obstructive pulmonary disease, osteoarthritis, diabetes, and cardiovascular disease were identified. Quality was assessed using the Cochrane risk of bias tool. Meta-analyses were conducted using Review Manager 5.1. The protocol was registered on PROSPERO (CRD42012002786). Results: Sixteen studies (2198 individuals, mean age 66.8-74.9 y) were included to describe program structures, which were comparable in their design and components, irrespective of the chronic disease. Aerobic exercise and resistance training were the primary interventions in 85% of studies. Nine studies were included in the meta-analysis. The weighted mean difference for FC, evaluated using the 6-minute walk test, was 41.7 m (95% confidence interval [CI], 20.5-62.8). The standardized mean difference for all FC measures was 0.18 (95% CI, 0.05-0.3). The standardized mean difference for the physical component of HRQL measures was 0.21 (95% CI, 0.05-0.4) and 0.38 (95% CI, 0.04-0.7) for the total score. Conclusions: CBE programs across chronic disease populations have similar structures. These programs appear superior to standard care with respect to optimizing FC and HRQL in individuals with osteoarthritis; however, the effect beyond this population is unknown. Long-term sustainability of these programs remains to be established.

### **Verguet S., Jamison D.T. (2014). Estimates of performance in the rate of decline of under-five mortality for 113 low- and middle-income countries, 1970-2010. *Health Policy Plan*, 29 (2) : 151-163.**

**Abstract:** BACKGROUND Measuring country performance in health has focused on assessing predicted vs observed levels of outcomes, an indicator that varies slowly over time. An alternative is to measure performance in terms of the rate of change in how a selected outcome compares to what would be expected given contextual determinants. Rates of change in health indicators can prove more sensitive than levels to changes in social, intersectoral or health policy context. It is thus similar to the growth rate of gross domestic product in the economic context. We assess performance in the rate of change (decline) of under-five mortality for 113 low- and middle-income countries. METHODS For 1970-2010, we study the evolution in rates of decline of under-five mortality. For each decade, we define performance as the average of the difference between the observed rate of decline and a rate of decline predicted by a model controlling for the contextual factors of income, female education levels, decade and geographical location. RESULTS In the 1970s, the top performer in the rate of decline of under-five mortality was Costa Rica. In the 2000s, the top performer was Turkey. Overall, performance in rates of decline correlated little with performance in levels of under-five mortality. A major transition in performance between decades suggests a change in underlying determinants and we report the magnitude of these transitions. For example, heavily AIDS impacted countries, such as Botswana, experienced major drops in performance between the 1980s and the 1990s and some, including Botswana, experienced major compensatory improvements between the 1990s and the 2000s. CONCLUSIONS Rate-based measures of country performance in health provide a starting point for assessments of the importance of health system, social and intersectoral determinants of performance.

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## Géographie de la santé / Geography of Health

**Combiere E, Charreire H, Le Vaillant M., et al. (2013). Temps d'accès aux maternités bourguignonnes et indicateurs de santé périnatale.** *Journal de Gestion et d'Economie médicales*, 31 (6) : 348-368.

**Nakamura D. (2014). Social participation and social capital with equity and efficiency: An approach from central-place theory.** *Applied Geography*, 49 54-57.

Abstract: A great deal of attention has been paid to the efficiency of the analysis of sustainable urban and regional growth. This includes social participation and social capital, which require a consideration of equity. In this paper, an approach from central-place theory for sustainable urban and regional growth is examined, taking into consideration relevant variables such as ageing, social interaction and accessibility. A lack of consideration of equity could cause several social exclusion problems, and these problems could develop into spatial consumer exclusion. Solutions for these problems would not only improve equity but also efficiency, and the outcome would address the necessity of an alternative spatial formation based on a wider-regional rural central-place system according to given economic, social and spatial configurations.

## Hôpital / Hospitals

**McCrum M.L., Lipsitz S.R., Berry W.R., Jha A.K., Gawande A.A. (2014). Beyond Volume: Does Hospital Complexity Matter?: An Analysis of Inpatient Surgical Mortality in the United States.** *Medical Care*, 52 (3) :

Abstract: Background: Hospitals show wide variation in outcomes and systems of care. It is unclear whether hospital complexity—the range of services and technologies provided— affects outcomes and in what direction. We sought to determine whether complexity was associated with inpatient surgical mortality. Methods :Using national Medicare data, we identified all fee-for-service inpatients who underwent 1 of 5 common high-risk surgical procedures in 2008–2009 and measured complexity by the number of unique primary diagnoses admitted to each hospital over the 2-year period. We calculated 30-day postoperative mortality rates, adjusting for patient and hospital characteristics, and used multivariable Poisson regression models to test for an association between hospital complexity and mortality rates. We then used this model to generate predicted mortality rates for low-volume and high-volume hospitals across the spectrum of hospital complexity. Results: A total of 2691 hospitals were analyzed, representing a total of 382,372 admissions. After adjusting for hospital characteristics, including hospital volume, increasing hospital complexity was associated with lower surgical mortality rates. Patients receiving care at the hospitals in the lowest quintile of unique diagnoses had a 27% higher risk of death than those at the highest quintile. The effect of complexity was largest for low-volume hospitals, which were capable of achieving mortality rates similar to high-volume hospitals when in the most complex quintile. Conclusions: Hospital complexity matters and is associated with lower surgical mortality rates, independent of hospital volume. The effect of complexity on outcomes for nonsurgical services warrants investigation.

**Chou S., Deily M.E., Li S. (2014). Travel Distance and Health Outcomes for Scheduled Surgery.** *Medical Care*, 52 (3) :

Abstract: Background :Changes in the location and availability of surgical services change the distances that patients must travel for surgery. Identifying health effects related to travel distance is therefore crucial to evaluating policies that affect the geographic distribution of these services. We examine the health outcomes of coronary artery bypass graft (CABG) patients in Pennsylvania for evidence that traveling further to a hospital for a one-time, scheduled surgical procedure causes harm.

Methods: We perform instrumental-variable regressions to test for the effect of distance to the admitting hospital on the in-hospital mortality and readmission rates of 102,858 CABG patients in Pennsylvania during 1995-2005, where the instrumental variables are constructed based on the quality of and distance to nearby CABG hospitals. Results: We found that patients living near a CABG hospital with acceptable quality traveled significantly less and if they were high-risk, had lower in-hospital mortality rates. Readmission rates in general are not affected by patients' travel distance. Discussion: The positive correlation between travel distance and health outcomes observed by previous studies may reflect the confounding effects of behavioral factors and patient health risks. We found instead that living further from the admitting hospital increases in-hospital mortality for high-risk CABG patients. More research on the possible causes of these effects is necessary to identify optimal policy responses.

**Huckfeldt P.J., Sood N., Escarce J.J., Grabowski D.C., Newhouse J.P. (2014). Effects of Medicare payment reform: Evidence from the home health interim and prospective payment systems. *J Health Econ*, 34 1-18.**

Abstract: Medicare continues to implement payment reforms that shift reimbursement from fee-for-service toward episode-based payment, affecting average and marginal payment. We contrast the effects of two reforms for home health agencies. The home health interim payment system in 1997 lowered both types of payment; our conceptual model predicts a decline in the likelihood of use and costs, both of which we find. The home health prospective payment system in 2000 raised average but lowered marginal payment with theoretically ambiguous effects; we find a modest increase in use and costs. We find little substantive effect of either policy on readmissions or mortality.

**Bontemps G. (2014). [Development of day surgery in France: More constraints for more performance?]. *Presse Med*, 43 (3) : 275-277.**

**Vons C. (2014). [Ambulatory surgery: An evolution of both the surgical technics and the way of care. To excellence in surgery]. *Presse Med*, 43 (3) : 278-282.**

Abstract: Day-case surgery has been made possible thanks to the development of surgical techniques such as video-assisted surgery. Mini-invasive surgery reduces the incisional size, decreases postoperative pain, and the duration of postoperative rehabilitation. Robot-assisted surgery is a new technical improvement which increases safety and accuracy of surgical procedures. Laser surgery decreases the risk of postoperative bleeding allowing day-case ablation of the prostate to be performed. Improvement in surgical management is related to: Day-case surgery is demanding, leading to surgeons, anaesthetists and all health care providers to better control patients' management, in order to improve health care quality and safety.

**Cuisinier A., Albaladejo P. (2014). [Management of comorbidity and preoperative treatment in ambulatory surgery?]. *Presse Med*, 43 (3) : 283-290.**

Abstract: Prevention of postoperative exacerbation of chronic medical disease requires high standard of safety and quality of care in ambulatory surgery and anesthesia. Age is not a major criterion for selection for ambulatory surgery. Ambulatory surgery may be considered for patients with ASA score I, II or III with stable medical conditions. Preoperative medical condition is not a contra-indication to ambulatory surgery, (except severe or end stage) as long as perioperative organization and patient compliance to perioperative instructions are controlled. In patients with major comorbidity, ambulatory surgery should be considered instead of conventional hospitalization. Preop treatment must be maintained during the perioperative period. Their interruption does not provide any benefit and could exacerbate an otherwise stable chronic disease.

**Triboulet J.P. (2014). [Ambulatory emergency surgery]. *Presse Med*, 43 (3) : 301-304.**

Abstract: Development of outpatient cases in emergency is still a controversy. Ambulatory surgery is possible in ambulatory surgical unit (ASU), or in emergency surgical units (ESU). Quality of care and safety need to be associated to patients' ambulatory management without impairment of ASU and

ESU organization. Patient eligibility concerns not only traumatic hand surgery but also general or visceral surgery.

**Beaussier M., Vons C. (2014). [Post-hospital home care after ambulatory surgery].** *Presse Med*, 43 (3) : 305-308.

Abstract: Ambulatory surgery should correspond to mastered acts performed on selected patients. This makes home care unnecessary in the vast majority of the cases. The development of outpatient surgery toward more complex procedures on more vulnerable patients would justify a specific home care in some circumstances. Justification of an overnight hospitalization only because the need for the patient to be reassured on experienced symptoms, supervision of analgesic device, wound incision overseeing or drains removal appears questionable. Home care after ambulatory surgery may be considered as several different modalities. The involvement of general practitioners, home nurses and telemedicine have to be explored for several procedures. Evolutions of surgical and anesthetic practices toward less invasive procedures, as well as improvement in patient's information, are the major challenges for the future of outpatient surgery.

**Quantin C., Benzerine B., Hagi M. (2014). Evaluation du PMSI comme moyen d'identification des cas incidents de cancer colorectal.** *Santé Publique*, (1) : 55-63.

**Wysocki A., Kane R.L., Golberstein E., Dowd B., Lum T., Shippee T. (2014). The Association between Long-Term Care Setting and Potentially Preventable Hospitalizations among Older Dual Eligibles.** *Health Services Research*, n/a.

Abstract: Objective To compare the probability of experiencing a potentially preventable hospitalization (PPH) between older dual eligible Medicaid home and community-based service (HCBS) users and nursing home residents. Data Sources Three years of Medicaid and Medicare claims data (2003-2005) from seven states, linked to area characteristics from the Area Resource File. Study Design A primary diagnosis of an ambulatory care sensitive condition on the inpatient hospital claim was used to identify PPHs. We used inverse probability of treatment weighting to mitigate the potential selection of HCBS versus nursing home use. Principal Findings The most frequent conditions accounting for PPHs were the same among the HCBS users and nursing home residents and included congestive heart failure, pneumonia, chronic obstructive pulmonary disease, urinary tract infection, and dehydration. Compared to nursing home residents, elderly HCBS users had an increased probability of experiencing both a PPH and a non-PPH. Conclusions HCBS users increased probability for potentially and non-PPHs suggests a need for more proactive integration of medical and long-term care.

**Safavi K.C., Dai F., Gilbertsen T.A., Schonberger R.B. (2014). Variation in Surgical Quality Measure Adherence within Hospital Referral Regions: Do Publicly Reported Surgical Quality Measures Distinguish among Hospitals That Patients Are Likely to Compare?** *Health Services Research*, ahead of pub.

Abstract: Objective To determine whether surgical quality measures that Medicare publicly reports provide a basis for patients to choose a hospital from within their geographic region. Data Source The Department of Health and Human Services' public reporting website, <http://www.medicare.gov/hospitalcompare>. Study Design We identified hospitals (n=2,953) reporting adherence rates to the quality measures intended to reduce surgical site infections (Surgical Care Improvement Project, 1-3) in 2012. We defined regions within which patients were likely to compare hospitals using the hospital referral regions (HRRs) from the Dartmouth Atlas of Health Care Project. We described distributions of reported SCIP adherence within each HRR, including medians, interquartile ranges (IQRs), skewness, and outliers. Principal Findings Ninety-seven percent of HRRs had median SCIP-1 scores  $\geq$  95 percent. In 93 percent of HRRs, half of the hospitals in the HRR were within 5 percent of the median hospital's score. In 62 percent of HRRs, hospitals were skewed toward the higher rates (negative skewness). Seven percent of HRRs demonstrated positive skewness. Only 1 percent had a positive outlier. SCIP-2 and SCIP-3 demonstrated similar distributions. Conclusions Publicly reported quality measures for surgical site infection prevention do not distinguish the majority



of hospitals that patients are likely to choose from when selecting a surgical provider. More studies are needed to improve public reporting's ability to positively impact patient decision making.

**Sheaff R., Windle K., Wistow G., Ashby S., Beech R., Dickinson A., Henderson C., Knapp M. (2014). Reducing emergency bed-days for older people? Network governance lessons from the 'Improving the Future for Older People' programme. *Soc Sci Med*, 106 59-66.**

**Abstract:** In 2007, the UK government set performance targets and public service agreements to control the escalation of emergency bed-days. Some years earlier, nine English local authorities had each created local networks with their health and third sector partners to tackle this increase. These networks formed the 'Improving the Future for Older People' initiative (IFOP), one strand of the national 'Innovation Forum' programme, set up in 2003. The nine sites set themselves one headline target to be achieved jointly over three years; a 20 per cent reduction in the number of emergency bed-days used by people aged 75 and over. Three ancillary targets were also monitored: emergency admissions, delayed discharges and project sustainability. Collectively the sites exceeded their headline target. Using a realistic evaluation approach, we explored which aspects of network governance appeared to have contributed to these emergency bed-day reductions. We found no simple link between network governance type and outcomes. The governance features associated with an effective IFOP network appeared to suggest that the selection and implementation of a small number of evidence-based services was central to networks' effectiveness. Each service needed to be coordinated by a network-based strategic group and hierarchically implemented at operational level by the responsible network member. Having a network-based implementation group with a 'joined-at-the-top' governance structure also appeared to promote network effectiveness. External factors, including NHS incentives, health reorganisations and financial targets similarly contributed to differences in performance. Targets and financial incentives could focus action but undermine horizontal networking. Local networks should specify which interventions network structures are intended to deliver. Effective projects are those likely to be evidence based, unique to the network and difficult to implement through vertical structures alone.

**Vogl M. (2014). Hospital financing: Calculating inpatient capital costs in Germany with a comparative view on operating costs and the English costing scheme. *Health Policy*, 115 (2-3) : 141-151.**

**Abstract:** OBJECTIVES: The paper analyzes the German inpatient capital costing scheme by assessing its cost module calculation. The costing scheme represents the first separated national calculation of performance-oriented capital cost lump sums per DRG. METHODS: The three steps in the costing scheme are reviewed and assessed: (1) accrual of capital costs; (2) cost-center and cost category accounting; (3) data processing for capital cost modules. The assessment of each step is based on its level of transparency and efficiency. A comparative view on operating costing and the English costing scheme is given. RESULTS: Advantages of the scheme are low participation hurdles, low calculation effort for G-DRG calculation participants, highly differentiated cost-center/cost category separation, and advanced patient-based resource allocation. The exclusion of relevant capital costs, nontransparent resource allocation, and unclear capital cost modules, limit the managerial relevance and transparency of the capital costing scheme. CONCLUSIONS: The scheme generates the technical premises for a change from dual financing by insurances (operating costs) and state (capital costs) to a single financing source. The new capital costing scheme will intensify the discussion on how to solve the current investment backlog in Germany and can assist regulators in other countries with the introduction of accurate capital costing.

**Endrei D., Zemplyeni A., Molics B., Agoston I., Boncz I. (2014). The effect of performance-volume limit on the DRG based acute care hospital financing in Hungary. *Health Policy*, 115 (2-3) : 152-156.**

**Abstract:** OBJECTIVES: The aim of our paper is to analyse the effect of the so-called performance volume limit (PVL) financing method on acute hospital care. DATA AND METHODS: The data were derived from the nationwide administrative dataset of the National Health Insurance Fund Administration (OEP) covering the period 2003-2008. We analysed the trends in the DRG cost-weights, number of cases, case-mix, and average length of stay. We calculated the average annual

reimbursement rate per DRG cost-weight with and without the application of PVL degression according to the hospital type and medical professions. RESULTS: Our results showed that although the national case mix (i.e., the sum of all of the DRG cost-weights produced in one year) did not change between 2003-2006, the trend of the annual number of cases increased, and the average length of stay decreased. During 2007-2008, a significant decline was found in each indicator. The introduction of the PVL resulted in a health insurance budget saving of 1.9% in 2004, 2.6% in 2005, 3.4% in 2006, 5.6% in 2007, and 3.2% in 2008. We found the lowest reimbursement rate per DRG cost-weight at the university medical schools (HUF 138,200 or euro 550) and children's hospitals (HUF 132,547 or euro 528), whereas the highest was at the county hospitals (HUF 143,451 or euro 571) and city hospitals (HUF 142, 082 or euro 565). CONCLUSIONS: The implementation of the PVL reduced the acute care hospital activity and reimbursement. The effect of the PVL was different on the different types of hospitals, and it had a serious disadvantageous effect on the university medical schools and children's hospitals.

**Kato N., Kondo M., Okubo I., Hasegawa T. (2014). Length of hospital stay in Japan 1971-2008: Hospital ownership and cost-containment policies. *Health Policy*, 115 (2-3) : 180-188.**

Abstract: The average length of stay (LOS) is considered one of the most significant indicators of hospital management. The steep decline in the average LOS among Japanese hospitals since the 1980s is considered to be due to cost-containment policies directed at reducing LOS. Japan's hospital sector is characterised by a diversity of ownership types. We took advantage of this context to examine different hospital behaviours associated with ownerships types. Analysing government data published from 1971 to 2008 for the effect of a series of cost-containment policies aimed at reducing LOS revealed distinctly different paths behind the declines in LOS between privately owned and publicly owned hospitals. In the earlier years, private hospitals focused on providing long-term care to the elderly, while in the later years, they made a choice between providing long-term care and providing acute care with reduced LOS and bonus payments. By contrast, the majority of public hospitals opted to provide acute care with reduced LOS in line with public targets.

## Inégalités de santé / Health Inequalities

**Chen D., Yang T.C. (2014). The pathways from perceived discrimination to self-rated health: An investigation of the roles of distrust, social capital, and health behaviors. *Soc Sci Med*, 104 64-73.**

Abstract: Although there has been extensive research on the adverse impacts of perceived discrimination on health, it remains unclear how perceived discrimination gets under the skin. This paper develops a comprehensive structural equation model (SEM) by incorporating both the direct effects of perceived discrimination on self-rated health (SRH), a powerful predictor for many health outcomes, and the indirect effects of perceived discrimination on SRH through health care system distrust, neighborhood social capital, and health behaviors and health conditions. Applying SEM to 9880 adults (aged between 18 and 100) in the 2008 Southeastern Pennsylvania Household Health Survey, we not only confirmed the positive and direct association between discrimination and poor or fair SRH, but also verified two underlying mechanisms: 1) perceived discrimination is associated with lower neighborhood social capital, which further contributes to poor or fair SRH; and 2) perceived discrimination is related to risky behaviors (e.g., reduced physical activity and sleep quality, and intensified smoking) that lead to worse health conditions, and then result in poor or fair SRH. Moreover, we found that perceived discrimination is negatively associated with health care system distrust, but did not find a significant relationship between distrust and poor or fair SRH.

**Beck A.N., Finch B.K., Lin S.F., Hummer R.A., Masters R.K. (2014). Racial disparities in self-rated health: Trends, explanatory factors, and the changing role of socio-demographics.** *Soc Sci Med*, 104 163-177.

Abstract: This paper uses data from the U.S. National Health Interview Surveys (N = 1,513,097) to describe and explain temporal patterns in black-white health disparities with models that simultaneously consider the unique effects of age, period, and cohort. First, we employ cross-classified random effects age-period-cohort (APC) models to document black-white disparities in self-rated health across temporal dimensions. Second, we use decomposition techniques to shed light on the extent to which socio-economic shifts in cohort composition explain the age and period adjusted racial health disparities across successive birth cohorts. Third, we examine the extent to which exogenous conditions at the time of birth help explain the racial disparities across successive cohorts. Results show that black-white disparities are wider among the pre-1935 cohorts for women, falling thereafter; disparities for men exhibit a similar pattern but exhibit narrowing among cohorts born earlier in the century. Differences in socioeconomic composition consistently contribute to racial health disparities across cohorts; notably, marital status differences by race emerge as an increasingly important explanatory factor in more recent cohorts for women whereas employment differences by race emerge as increasingly salient in more recent cohorts for men. Finally, our cohort characteristics models suggest that cohort economic conditions at the time of birth (percent large family, farm or Southern birth) help explain racial disparities in health for both men and women.

**Makdissi P., Yazbeck M. (2014). Measuring socioeconomic health inequalities in presence of multiple categorical information.** *J Health Econ*, 34 84-95.

Abstract: While many of the measurement approaches in health inequality measurement assume the existence of a ratio-scale variable, most of the health information available in population surveys is given in the form of categorical variables. Therefore, the well-known inequality indices may not always be readily applicable to measure health inequality as it may result in the arbitrariness of the health concentration index's value. In this paper, we address this problem by changing the dimension in which the categorical information is used. We therefore exploit the multi-dimensionality of this information, define a new ratio-scale health status variable and develop positional stochastic dominance conditions that can be implemented in a context of categorical variables. We also propose a parametric class of population health and socioeconomic health inequality indices. Finally we provide a twofold empirical illustration using the Joint Canada/United States Surveys of Health 2004 and the National Health Interview Survey 2010.

**Mocan N., Altindag D.T. (2014). Education, cognition, health knowledge, and health behavior.** *Eur J Health Econ*, 15 (3) : 265-279.

Abstract: Using data from NLSY97, we analyze the impact of education on health behavior. Controlling for health knowledge does not influence the impact of education on health behavior, supporting the productive efficiency hypothesis. Accounting for cognitive ability does not significantly alter the relationship between education and health behavior. Similarly, the impact of education on health behavior is the same between those with and without a learning disability, suggesting that cognition is not likely to be a significant factor in explaining the impact of education on health behavior.

**Burgard S.A., Chen P.V. (2014). Challenges of health measurement in studies of health disparities.** *Soc Sci Med*, 106C 143-150.

Abstract: Health disparities are increasingly studied in and across a growing array of societies. While novel contexts and comparisons are a promising development, this commentary highlights four challenges to finding appropriate and adequate health measures when making comparisons across groups within a society or across distinctive societies. These challenges affect the accuracy with which we characterize the degree of inequality, limiting possibilities for effectively targeting resources to improve health and reduce disparities. First, comparisons may be challenged by different distributions of disease and second, by variation in the availability and quality of vital events and census data often used to measure health. Third, the comparability of self-reported information about specific health conditions may vary across social groups or societies because of diagnosis bias or diagnosis



avoidance. Fourth, self-reported overall health measures or measures of specific symptoms may not be comparable across groups if they use different reference groups or interpret questions or concepts differently. We explain specific issues that make up each type of challenge and show how they may lead to underestimates or inflation of estimated health disparities. We also discuss approaches that have been used to address them in prior research, note where further innovation is needed to solve lingering problems, and make recommendations for improving future research. Many of our examples are drawn from South Africa or the United States, societies characterized by substantial socioeconomic inequality across ethnic groups and wide disparities in many health outcomes, but the issues explored throughout apply to a wide variety of contexts and inquiries.

**Pega F., Valentine N.B., Matheson D., Rasanathan K. (2014). Public social monitoring reports and their effect on a policy programme aimed at addressing the social determinants of health to improve health equity in New Zealand. *Soc Sci Med*, 101 61-69.**

**Abstract:** The important role that monitoring plays in advancing global health is well established. However, the role of social monitoring as a tool for addressing social determinants of health (SDH) and health equity-focused policies remains under-researched. This paper assesses the extent and ways in which New Zealand's (NZ) Social Reports (SRs) supported a SDH- and health equity-oriented policy programme nationally over the 2000-2008 period by documenting the SRs' history and assessing its impact on policies across sectors in government and civil society. We conducted key-informant interviews with five senior policy-makers and an e-mail survey with 24 government and civil society representatives on SRs' history and policy impact. We identified common themes across these data and classified them accordingly to assess the intensity of the reports' use and their impact on SDH- and health equity-focused policies. Bibliometric analyses of government publications and media items were undertaken to empirically assess SRs' impact on government and civil society. SRs in NZ arose out of the role played by government as the "benevolent social welfare planner" and an understanding of the necessity of economic and social security for "progress". The SRs were linked to establishing a government-wide programme aimed at reducing inequalities. They have been used moderately to highly in central and local government and in civil society, both within and outside the health sector, but have neither entered public treasury and economic development departments nor the commercial sector. The SRs have not reached the more universal status of economic indicators. However, they have had some success at raising awareness of, and have stimulated isolated action on, SDH. The NZ case suggests that national-level social monitoring provides a valuable tool for raising awareness of SDH across government and civil society. A number of strategies could improve social reports' effectiveness in stimulating action on SDH.

## Médicaments / Pharmaceuticals

**Farfan-Portet M.I., Gerkens S., Lepage-Nefkens I., Vinck I., Hulstaert F. (2014). Are biosimilars the next tool to guarantee cost-containment for pharmaceutical expenditures? *Eur J Health Econ*, 15 (3) : 223-228.**

PM:24271016

## Méthodologie – Statistique / Methodology – Statistics

**Gariépy J, Lebreton E. (2013). Recueil PMSI diagnostic amélioré par le codage partagé. *Journal de Gestion et d'Economie médicales*, 31 (6) : 388-397.**

## Politique de santé / Health Policy

### **Abasolo I., Tsuchiya A. (2013). Blood donation as a public good: an empirical investigation of the free rider problem. *Eur J Health Econ*,**

**Abstract:** A voluntary blood donation system can be seen as a public good. People can take advantage without contributing and have a free ride. We empirically analyse the extent of free riding and its determinants. Interviews of the general public in Spain (n = 1,211) were used to ask whether respondents were (or have been) regular blood donors and, if not, the reason. Free riders are defined as those who are medically capable to donate blood but do not. In addition, we distinguish four different types of free riding depending on the reason given for not donating. Binomial and multinomial logit models estimate the effect of individual characteristics on the propensity to free ride and the likelihood of the free rider types. Amongst those who are able to donate, there is a 67 % probability of being a free rider. The most likely free rider is female, single, with low/no education and abstained from voting in a recent national election. Gender, age, religious practice, political participation and regional income explain the type of free rider.

### **Sorenson C., Drummond M. (2014). Improving medical device regulation: the United States and Europe in perspective. *Milbank Q*, 92 (1) : 114-150.**

**Abstract:** CONTEXT: Recent debates and events have brought into question the effectiveness of existing regulatory frameworks for medical devices in the United States and Europe to ensure their performance, safety, and quality. This article provides a comparative analysis of medical device regulation in the two jurisdictions, explores current reforms to improve the existing systems, and discusses additional actions that should be considered to fully meet this aim. Medical device regulation must be improved to safeguard public health and ensure that high-quality and effective technologies reach patients. METHODS: We explored and analyzed medical device regulatory systems in the United States and Europe in accordance with the available gray and peer-reviewed literature and legislative documents. FINDINGS: The two regulatory systems differ in their mandate and orientation, organization, pre- and postmarket evidence requirements, and transparency of process. Despite these differences, both jurisdictions face similar challenges for ensuring that only safe and effective devices reach the market, monitoring real-world use, and exchanging pertinent information on devices with key users such as clinicians and patients. To address these issues, reforms have recently been introduced or debated in the United States and Europe that are principally focused on strengthening regulatory processes, enhancing postmarket regulation through more robust surveillance systems, and improving the traceability and monitoring of devices. Some changes in premarket requirements for devices are being considered. CONCLUSIONS: Although the current reforms address some of the outstanding challenges in device regulation, additional steps are needed to improve existing policy. We examine a number of actions to be considered, such as requiring high-quality evidence of benefit for medium- and high-risk devices; moving toward greater centralization and coordination of regulatory approval in Europe; creating links between device identifier systems and existing data collection tools, such as electronic health records; and fostering increased and more effective use of registries to ensure safe postmarket use of new and existing devices.

### **Fox D.M., Zuckerman D.M. (2014). Regulatory reticence and medical devices. *Milbank Q*, 92 (1) : 151-159.**

### **Van Dalen H.P., Henkens K. (2014). Comparing the effects of defaults in organ donation systems. *Soc Sci Med*, 106 137-142.**

**Abstract:** The ability of patients in many parts of the world to benefit from transplantation is limited by growing shortages of transplantable organs. The choice architecture of donation systems is said to play a pivotal role in explaining this gap. In this paper we examine the question how different defaults affect the decision to register as organ donor. Three defaults in organ donation systems are compared: mandated choice, presumed consent and explicit consent. Hypothetical choices from a national survey of 2069 respondents in May 2011 in the Netherlands - a country with an explicit Pôle documentation de l'Irdes / Irdes Documentation centre - Safon M.-O., Suhard V.

consent system - suggests that mandated choice and presumed consent are more effective at generating registered donors than explicit consent.

## Prevision – Evaluation / Prevision – Evaluation

**Hays R.D., Martino S., Brown J.A., Cui M., Cleary P., Gaillot S., Elliott M. (2014). Evaluation of a Care Coordination Measure for the Consumer Assessment of Healthcare Providers and Systems (CAHPS(R)) Medicare Survey. *Med Care Res Rev*, 71 (2) : 192-202.**

**Abstract:** There is widespread interest in assessing care coordination to improve overall care quality. We evaluated a five-item measure of care coordination included in the 2012 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Medicare survey (n = 326,194 respondents, 46% response rate). This measure includes patient reports of whether their personal doctor discusses their medicines, has medical records and other relevant information, and is informed about care from specialists, and whether the patient gets help in managing care and timely follow-up on test results. A one-factor categorical confirmatory factor analytic model indicated that five items constituted a coherent scale. Estimated health-plan-level reliability was 0.70 at about 102 responses per plan. The composite had a strong unique association with the CAHPS global rating of health care, controlling for the CAHPS core composite scores. This measure can be used to evaluate relative plan performance and characteristics associated with better care coordination.

**Cramm J.M., Nieboer A.P. (2014). Short and long term improvements in quality of chronic care delivery predict program sustainability. *Soc Sci Med*, 101 148-154.**

**Abstract:** Empirical evidence on sustainability of programs that improve the quality of care delivery over time is lacking. Therefore, this study aims to identify the predictive role of short and long term improvements in quality of chronic care delivery on program sustainability. In this longitudinal study, professionals [2010 (T0): n=218, 55% response rate; 2011 (T1): n=300, 68% response rate; 2012 (T2): n=265, 63% response rate] from 22 Dutch disease-management programs completed surveys assessing quality of care and program sustainability. Our study findings indicated that quality of chronic care delivery improved significantly in the first 2 years after implementation of the disease-management programs. At T1, overall quality, self-management support, delivery system design, and integration of chronic care components, as well as health care delivery and clinical information systems and decision support, had improved. At T2, overall quality again improved significantly, as did community linkages, delivery system design, clinical information systems, decision support and integration of chronic care components, and self-management support. Multilevel regression analysis revealed that quality of chronic care delivery at T0 (p<0.001) and quality changes in the first (p<0.001) and second (p<0.01) years predicted program sustainability. In conclusion this study showed that disease-management programs based on the chronic care model improved the quality of chronic care delivery over time and that short and long term changes in the quality of chronic care delivery predicted the sustainability of the projects.

## Psychiatrie / Psychiatry

**Dervaux A., Falissard B., Grohens M., Limosin F., Mercuel A., Triantafyllou M., Vidon G., Mallet L., Plaze M., Laqueille X., Bocher R. (2014). [Psychiatry in 2030?]. *Presse Med*,**

43 (3) : 237-239.

**Nicaise P., Dubois V., Lorant V. (2014). Mental health care delivery system reform in Belgium: The challenge of achieving deinstitutionalisation whilst addressing fragmentation of care at the same time. *Health Policy*, 115 (2-3) : 120-127.**

Abstract: Most mental health care delivery systems in welfare states currently face two major issues: deinstitutionalisation and fragmentation of care. Belgium is in the process of reforming its mental health care delivery system with the aim of simultaneously strengthening community care and improving integration of care. The new policy model attempts to strike a balance between hospitals and community services, and is based on networks of services. We carried out a content analysis of the policy blueprint for the reform and performed an ex-ante evaluation of its plan of operation, based on the current knowledge of mental health service networks. When we examined the policy's multiple aims, intermediate goals, suggested tools, and their articulation, we found that it was unclear how the new policy could achieve its goals. Indeed, deinstitutionalisation and integration of care require different network structures, and different modes of governance. Furthermore, most of the mechanisms contained within the new policy were not sufficiently detailed. Consequently, three major threats to the effectiveness of the reform were identified. These were: issues concerning the relationship between network structure and purpose, the continued influence of hospitals despite the goal of deinstitutionalisation, and the heterogeneity in the actual implementation of the new policy.

## Soins de santé primaires / Primary Health Care

**Lezzi E., Lippi B.M., Ugolini C. (2014). The role of GP's compensation schemes in diabetes care: Evidence from panel data. *J Health Econ*, 34 104-120.**

Abstract: We investigate the impact of the implementation of Diabetes Management Programs with financial incentives in the Italian Region Emilia-Romagna between 2003 and 2005. We focus on avoidable hospitalisations for diabetic patients for whom GPs receive additional payments exceeding capitation. We estimate a panel count data model to test the hypothesis that those patients under the responsibility of GPs receiving a higher share of their income through ad-hoc payments, are less likely to experience avoidable hospitalisations. Our findings indicate that financial transfers may help improve the quality of care, even when they are not based on the ex-post verification of performance. The estimated effect indicates that, at sample averages, an increase of 100 Euros of the financial incentives paid to GPs (around 17% of the yearly payment received by GPs for diabetes programmes) is expected to reduce the number of diabetic ACSCs by 1%, around 100 cases when projected on the entire region

**Haibach J.P., Beehler G.P., Dollar K.M., Finnell D.S. (2014). Moving Toward Integrated Behavioral Intervention for Treating Multimorbidity Among Chronic Pain, Depression, and Substance-use Disorders in Primary Care. *Medical Care*, 52 (4) :**

Abstract: Introduction: The importance of using integrated treatment for multimorbidity has been increasingly recognized. One prevalent cluster of health conditions is multimorbidity of chronic pain, depression, and substance-use disorders, a common triad of illnesses among primary care patients. This brief report brings attention to an emerging treatment method of an integrated behavioral approach to improve health outcomes for individuals with these 3 conditions in the outpatient setting, particularly primary care. Methods: A multidatabase search was conducted to identify studies of behavioral interventions targeting co-occurrence or multimorbidity among the 3 health conditions in the adult outpatient setting. An independent screening of the articles was accomplished by all authors with consensus on the final inclusion for review. Results: Three studies met formal inclusion criteria for this review. The included studies evaluated cognitive behavioral therapy or combined motivational interviewing with cognitive behavioral therapy. Key findings from other reviews and additional studies

are also included in this review to further inform the development of a common approach for treating this triad of conditions in primary care. Conclusions: Although there has been increased recognition for more effective and practical behavioral treatments for patients with multiple chronic health conditions, the evidence-base to inform practice remains limited. The findings from this review suggest that a common approach, rather than a distinct intervention for chronic pain, depression, or substance-use disorders, is indicated and that best care can be provided within the context of a coordinated, interdisciplinary, and patient-centered primary care team.

**Cordero Ferrera J.M., Cebada E.C., Murillo Zamorano L.R. (2014). The effect of quality and socio-demographic variables on efficiency measures in primary health care. *Eur J Health Econ*, 15 (3) : 289-302.**

Abstract: This paper aims to extend the literature on measuring efficiency in primary health care by considering the influence of quality indicators and environmental variables conjointly in a case study. In particular, environmental variables are represented by patients' characteristics and quality indicators are based on technical aspects. In order to deal with both aspects, different extensions of data envelopment analysis (DEA) methodology are applied. Specifically, we use weight restrictions to ensure that the efficiency scores assigned to the evaluated units take quality data into account, and a four-stage model to identify which exogenous variables have impact on performance as well as to compute efficiency scores that incorporate this information explicitly. The results provide evidence in support of the importance of including information about both aspects in the analysis so that the efficiency measures obtained can be interpreted as an accurate reflection of performance.

**Bentler S.E., Morgan R.O., Virnig B.A., Wolinsky F.D. (2014). Do claims-based continuity of care measures reflect the patient perspective? *Med Care Res Rev*, 71 (2) : 156-173.**

Abstract: Continuity of care (CoC) is a cornerstone of the patient-centered medical home (PCMH) and one of the primary means for achieving health care quality. Despite decades of study, however, CoC remains difficult to define and quantify. To incorporate patient experiences into health reform evaluations, it is critical to determine if and how well CoC measures traditionally derived from administrative claims capture patient experiences. In this study, we used claims data and self-reported continuity experiences of 2,620 Medicare beneficiaries who completed the National Health and Health Services Use Questionnaire to compare 16 claims-based CoC indices to a multidimensional patient-reported CoC measure. Our results show that most claims-based CoC measures do not reflect older adults' perceptions of continuous patient-provider relationships, indicating that claims-based assessments should be used in tandem with patient reports for defining, quantifying, and evaluating CoC in health care delivery model.

**Kantarevic J., Kralj B. (2014). Risk selection and cost shifting in a prospective physician payment system: Evidence from Ontario. *Health Policy*, 115 (2-3) : 249-257.**

Abstract: We study the risk-selection and cost-shifting behavior of physicians in a unique capitation payment model in Ontario, using the incentive to enroll and care for complex and vulnerable patients as a case study. This incentive, which is incremental to the regular capitation payment, ceases after the first year of patient enrollment and may therefore impact on the physician's decision to continue to enroll the patient. Furthermore, because the enrolled patients in Ontario can seek care from any provider, the enrolling physician may shift some treatment costs to other providers. Using longitudinal administrative data and a control group of physicians in the fee-for-service model who were eligible for the same incentive, we find no evidence of either patient 'dumping' or cost shifting. These results highlight the need to re-examine the conventional wisdom about risk selection for physician payment models that significantly deviate from the stylized capitation model.

## Systèmes de santé / Health Systems



**Yardim M.S., Cilingiroglu N., Yardim N. (2014). Financial protection in health in Turkey: the effects of the Health Transformation Programme. *Health Policy Plan*, 29 (2) : 177-192.**

Abstract: Financial protection should be the principal objective of any health system. Commonly used indicators for financial protection are out-of-pocket (OOP) payments as a share of total health expenditure and the amount of households driven into poverty by catastrophic health expenditures (CHEs). In the last decade, OOP health payments consisted of approximately one-fifth of the health finance resources in Turkey. Until the year 2008, Turkish health system covered different public and private financing programmes as well as different types of service provision. After 2008, universal financial coverage became a part of the Health Transformation Programme (HTP). This study aimed to evaluate the financial protection in health in the era of health reforms in Turkey between 2003 and 2009. Household expenditures were derived from nationally representative Turkish Household Budget Surveys (HBSs), 2003, 2006 and 2009. Proportion of households facing CHE and impoverishment are calculated by using the methodology proposed by Ke Xu. Probability of incurring and volume of OOP spending were assessed across the health insurance groups by two-part model approach using logistic and OLS regression methods. Our findings showed that the probability of incurring and volume of OOP spending increased gradually in publicly insured households between 2003 and 2009. However, there was a diminishing trend in CHE in Turkey during the period under consideration. The official data showing an approximately 3-fold increase in per capita health care use since 2003 and our study findings on decreasing CHE in this period can be interpreted as positive impact of HTP. On the other hand, increased household consumption as a share of OOP health payment and the deterioration in the progressivity of OOP spending in this period should be monitored closely. PM:23411120

**Abasolo I., Negrin-Hernandez M.A., Pinilla J. (2014). Equity in specialist waiting times by socioeconomic groups: evidence from Spain. *Eur J Health Econ*, 15 (3) : 323-334.**

Abstract: In countries with publicly financed health care systems, waiting time-rather than price-is the rationing mechanism for access to health care services. The normative statement underlying such a rationing device is that patients should wait according to need and irrespective of socioeconomic status or other non-need characteristics. The aim of this paper is to test empirically that waiting times for publicly funded specialist care do not depend on patients' socioeconomic status. Waiting times for specialist care can vary according to the type of medical specialty, type of consultation (review or diagnosis) and the region where patients' reside. In order to take into account such variability, we use Bayesian random parameter models to explain waiting times for specialist care in terms of need and non-need variables. We find that individuals with lower education and income levels wait significantly more time than their counterparts.

**Nyweide D.J. (2014). Concordance between continuity of care reported by patients and measured from administrative data. *Med Care Res Rev*, 71 (2) : 138-155.**

Abstract: Continuity of care can be measured using patient survey or administrative data, though the degree of concordance between continuity of care reported by patients and measured from their actual utilization is not well understood. A cross-sectional analysis of the 2010 Medicare Current Beneficiary Survey and linked 2009-2010 Medicare Carrier and outpatient claims data measured the concentration of ambulatory care visit patterns according to two commonly used metrics of continuity of care. Continuity of care measured from claims data did not align with patient reports of having a usual care provider. However, high levels of continuity for patients with a usual care provider were associated with a longer patient-provider relationship, greater patient-perceived provider knowledge of the patient's medical condition and history, and more confidence in the provider. Inferences about a patient's continuity of care must be placed in the context of the data source with which continuity is measured.

**Garcia-Subirats I., Vargas I., Mogollon-Perez A.S., De Paepe P., da Silva M.R., Unger J.P., Vazquez M.L. (2014). Barriers in access to healthcare in countries with different health systems. A cross-sectional study in municipalities of central Colombia and north-eastern Brazil. *Soc Sci Med*, 106 204-213.**

Abstract: There are few comprehensive studies available on barriers encountered from the initial seeking of healthcare through to the resolution of the health problem; in other words, on access in its broad domain. For Colombia and Brazil, countries with different healthcare systems but common stated principles, there have been no such analyses to date. This paper compares factors that influence access in its broad domain in two municipalities of each country, by means of a cross-sectional study based on a survey of a multistage probability sample of people who had had at least one health problem within the last three months (2163 in Colombia and 2155 in Brazil). The results reveal important barriers to healthcare access in both samples, with notable differences between and within countries, once differences in sociodemographic characteristics and health needs are accounted for. In the Colombian study areas, the greatest barriers were encountered in initial access to healthcare and in resolving the problem, and similarly when entering the health service in the Brazilian study areas. Differences can also be detected in the use of services: in Colombia greater geographical and economic barriers and the need for authorization from insurers are more relevant, whereas in Brazil, it is the limited availability of health centres, doctors and drugs that leads to longer waiting times. There are also differences according to enrolment status and insurance scheme in Colombia, and between areas in Brazil. The barriers appear to be related to the Colombian system's segmented, non-universal nature, and to the involvement of insurance companies, and to chronic underfunding of the public system in Brazil. Further research is required, but the results obtained reveal critical points to be tackled by health policies in both countries.

## Technologies médicales / Medical Technologies

**Velasco E., Agheneza T., Denecke K., Kirchner G., Eckmanns T. (2014). Social media and internet-based data in global systems for public health surveillance: a systematic review. *Milbank Q*, 92 (1) : 7-33.**

Abstract: CONTEXT: The exchange of health information on the Internet has been heralded as an opportunity to improve public health surveillance. In a field that has traditionally relied on an established system of mandatory and voluntary reporting of known infectious diseases by doctors and laboratories to governmental agencies, innovations in social media and so-called user-generated information could lead to faster recognition of cases of infectious disease. More direct access to such data could enable surveillance epidemiologists to detect potential public health threats such as rare, new diseases or early-level warnings for epidemics. But how useful are data from social media and the Internet, and what is the potential to enhance surveillance? The challenges of using these emerging surveillance systems for infectious disease epidemiology, including the specific resources needed, technical requirements, and acceptability to public health practitioners and policymakers, have wide-reaching implications for public health surveillance in the 21st century. METHODS: This article divides public health surveillance into indicator-based surveillance and event-based surveillance and provides an overview of each. We did an exhaustive review of published articles indexed in the databases PubMed, Scopus, and Scirus between 1990 and 2011 covering contemporary event-based systems for infectious disease surveillance. FINDINGS: Our literature review uncovered no event-based surveillance systems currently used in national surveillance programs. While much has been done to develop event-based surveillance, the existing systems have limitations. Accordingly, there is a need for further development of automated technologies that monitor health-related information on the Internet, especially to handle large amounts of data and to prevent information overload. The dissemination to health authorities of new information about health events is not always efficient and could be improved. No comprehensive evaluations show whether event-based surveillance systems have been integrated into actual epidemiological work during real-time health events. CONCLUSIONS: The acceptability of data from the Internet and social media as a regular part of public health surveillance programs varies and is related to a circular challenge: the willingness to integrate is rooted in a lack of effectiveness studies, yet such effectiveness can be proved only through a structured evaluation of integrated systems. Issues related to changing technical and social paradigms in both individual perceptions of and interactions with personal health data, as well as social media and other data from the Internet, must be further addressed before such information can be integrated into official surveillance systems.



## Travail et santé / Occupational Health

**Gebel M., Vossemer J. (2014). The impact of employment transitions on health in Germany. A difference-in-differences propensity score matching approach. *Social Science & Medicine*, (Ahead of pub)**

**Abstract:** This article investigates the effects of transitions between employment and unemployment on health. It also addresses the question of whether or not the widespread use of temporary employment has altered the positive health effects of employment. Drawing on data from the German Socio-Economic Panel for the period 1995-2010, we apply difference-in-differences propensity score matching to identify the direct causal effects of unemployment and reemployment on psychological and physical health. This combination of two approaches towards causal inference controls for both unobserved fixed effects and observable differences in a flexible semi-parametric specification. Our sample includes persons between the ages of 16-54 who have at least experienced one respective employment transition (treatment groups) or are continuously employed or unemployed (control groups). The results show that only psychological but not physical health is causally affected by the respective employment transitions. Specifically, the effects of unemployment and reemployment are of similar size, highlighting the importance of reemployment in compensating unemployment's negative impact on psychological health. In contrast, health selection and confounding seem to be important determinants of the cross-sectional association between unemployment and physical health. Carrying out separate analyses for permanent and temporary workers, we shed new light on the health effects of temporary employment. It has been argued that the rise of temporary employment has introduced a new inequality in the world of work, blurring the line between employment and unemployment. However, contrary to our expectations we find that both employment transitions have effects of a similar size for permanent and temporary workers. In sum, our results highlight two points. First, longitudinal research is needed to properly evaluate the health effects of unemployment, reemployment, and temporary employment. Second, compared to temporary employment, unemployment is still the greater threat to individuals' psychological health.

**Serazin C., Ha C., Bidron P. et al. (2014). Les difficultés d'un suivi épidémiologique longitudinal dans les services de la santé au travail. *Santé Publique*, (1) : 33-43.**

## Vieillesse / Ageing

**(2013). Politique de l'âge et santé : dossier. *Actualité et Dossier en Santé Publique*, (85) : 10-53.**

**Sermet C. (2013). L'état de santé des personnes âgées. In : Politique de l'âge et santé. *Actualité et Dossier en Santé Publique*, (85) : 20-26.**

**Naiditch M. (2013). La politique d'aide aux aidants. In : Politique de l'âge et santé. *Actualité et Dossier en Santé Publique*, (85) : 38-41.**

**Sixsmith J., Sixsmith A., Fange A.M., Naumann D., Kucsera C., Tomsone S., Haak M., Dahlin-Ivanoff S., Woolrych R. (2014). Healthy ageing and home: The perspectives of very old people in five European countries. *Soc Sci Med*, 106 1-9.**

Abstract: This paper reports on in-depth research, using a grounded theory approach, to examine the ways in which very old people perceive healthy ageing in the context of living alone at home within urban settings in five European countries. This qualitative study was part of a cross-national project entitled ENABLE-AGE which examined the relationship between home and healthy ageing. Interviews explored the notion of healthy ageing, the meaning and importance of home, conceptualisations of independence and autonomy and links between healthy ageing and home. Data analysis identified five ways in which older people constructed healthy ageing: home and keeping active; managing lifestyles, health and illness; balancing social life; and balancing material and financial circumstances. Older people reflected on their everyday lives at home in terms of being engaged in purposeful, meaningful action and evaluated healthy ageing in relation to the symbolic and practical affordances of the home, contextualised within constructions of their national context. The research suggests that older people perceive healthy ageing as an active achievement, created through individual, personal effort and supported through social ties despite the health, financial and social decline associated with growing older. The physicality and spatiality of home provided the context for establishing and evaluating the notion of healthy ageing, whilst the experienced relationship between home, life history and identity created a meaningful space within which healthy ageing was negotiated.