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Sommaire

Assurance maladie / Health Insurance

French, M. T., et al. (2016). "Key Provisions of the Patient Protection and Affordable Care Act (ACA): A Systematic Review and Presentation of Early Research Findings." Health Serv Res **51**(5): 1735-1771.

OBJECTIVES: To conduct a systematic literature review of selected major provisions of the Affordable Care Act (ACA) pertaining to expanded health insurance coverage. We present and synthesize research findings from the last 5 years regarding both the immediate and long-term effects of the ACA. We conclude with a summary and offer a research agenda for future studies. STUDY DESIGN: We identified relevant articles from peer-reviewed scholarly journals by performing a comprehensive search of major electronic databases. We also identified reports in the "gray literature" disseminated by government agencies and other organizations. PRINCIPAL FINDINGS: Overall, research shows that the ACA has substantially decreased the number of uninsured individuals through the dependent coverage provision, Medicaid expansion, health insurance exchanges, availability of subsidies, and other policy changes. Affordability of health insurance continues to be a concern for many people and disparities persist by geography, race/ethnicity, and income. Early evidence also indicates improvements in access to and affordability of health care. All of these changes are certain to ultimately impact state and federal budgets. CONCLUSIONS: The ACA will either directly or indirectly affect almost all Americans. As new and comprehensive data become available, more rigorous evaluations will provide further insights as to whether the ACA has been successful in achieving its goals.

Mulcahy, A. W., et al. (2016). "Gaining Coverage Through Medicaid Or Private Insurance Increased Prescription Use And Lowered Out-Of-Pocket Spending." Health Affairs **35**(9): 1725-1733. http://content.healthaffairs.org/content/35/9/1725.abstract

A growing body of literature describes how the Affordable Care Act (ACA) has expanded health insurance coverage. What is less well known is how these coverage gains have affected populations that are at risk for high health spending. To investigate this issue, we used prescription transaction data for a panel of 6.7 million prescription drug users to compare changes in coverage, prescription fills, plan spending, and out-of-pocket spending before and after the implementation of the ACA's coverage expansion. We found a 30 percent reduction in the proportion of this population that was uninsured in 2014 compared to 2013. Uninsured people who gained private coverage filled, on average, 28 percent more prescriptions and had 29 percent less out-of-pocket spending per prescription in 2014 compared to 2013. Those who gained Medicaid coverage had larger increases in fill rates (79 percent) and reductions in out-of-pocket spending per prescription (58 percent). People who gained coverage who had at least one of the chronic conditions detailed in our study saw larger decreases in out-of-pocket spending compared to those who did not have at least one condition. These results demonstrate that by reducing financial barriers to care, the ACA has increased treatment rates while reducing out-of-pocket spending, particularly for people with chronic conditions.

Economie de la santé / Health Economics

Baltagi, B. H., et al. (2016). "Health Care Expenditure and Income: A Global Perspective." Health Econ.

This paper investigates the long-run economic relationship between healthcare expenditure and income in the world using data on 167 countries over the period 1995-2012, collected from the World Bank data set. The analysis is carried using panel data methods that allow one to account for unobserved heterogeneity, temporal persistence, and cross-section dependence in the form of either a common factor model or a spatial process. We estimate a global measure of income elasticity using all countries in the sample, and for sub-groups of countries, depending on their geo-political area and

income. Our findings suggest that at the global level, health care is a necessity rather than a luxury. However, results vary greatly depending on the sub-sample analysed. Our findings seem to suggest that size of income elasticity depends on the position of different countries in the global income distribution, with poorer countries showing higher elasticity. Copyright (c) 2016 John Wiley & Sons, Ltd.

De la Maisonneuve, C., et al. (2016). "The Role of Policy and Institutions on Health Spending." Health Econ.

This paper investigates the impact of policies and institutions on health expenditures for a large panel of Organisation for Economic Co-operation and Development countries for the period of 2000-2010. A set of 20 policy and institutional indicators developed by the Organisation for Economic Co-operation and Development are integrated into a theoretically motivated econometric framework, alongside control variables related to demographic (dependency ratio) and non-demographic (income, prices and technology) drivers of health expenditures per capita. Although a large share of cross-country differences in public health expenditures can be explained by demographic and economic factors (around 71%), cross-country variations in policies and institutions also have a significant influence, explaining most of the remaining difference in public health spending (23%). Copyright (c) 2016 John Wiley & Sons, Ltd.

Epstein, D., et al. (2016). "Modeling the costs and long-term health benefits of screening the general population for risks of cardiovascular disease: a review of methods used in the literature." Eur J Health Econ **17**(8): 1041-1053.

BACKGROUND: Strategies for screening and intervening to reduce the risk of cardiovascular disease (CVD) in primary care settings need to be assessed in terms of both their costs and long-term health effects. We undertook a literature review to investigate the methodologies used. METHODS: In a framework of developing a new health-economic model for evaluating different screening strategies for primary prevention of CVD in Europe (EPIC-CVD project), we identified seven key modeling issues and reviewed papers published between 2000 and 2013 to assess how they were addressed. RESULTS: We found 13 relevant health-economic modeling studies of screening to prevent CVD in primary care. The models varied in their degree of complexity, with between two and 33 health states. Programmes that screen the whole population by a fixed cut-off (e.g., predicted 10-year CVD risk >20 %) identify predominantly elderly people, who may not be those most likely to benefit from long-term treatment. Uncertainty and model validation were generally poorly addressed. Few studies considered the disutility of taking drugs in otherwise healthy individuals or the budget impact of the programme. CONCLUSIONS: Model validation, incorporation of parameter uncertainty, and sensitivity analyses for assumptions made are all important components of model building and reporting, and deserve more attention. Complex models may not necessarily give more accurate predictions. Availability of a large enough source dataset to reliably estimate all relevant input parameters is crucial for achieving credible results. Decision criteria should consider budget impact and the medicalization of the population as well as cost-effectiveness thresholds.

Getzen, T. E. et Okunade, A. A. (2016). "Symposium Introduction: Papers on 'Modeling National Health Expenditures'." Health Econ.

Significant contributions have been made since the World Health Organization published Brian Abel-Smith's pioneering comparative study of national health expenditures more than 50 years ago. There have been major advances in theories, model specifications, methodological approaches, and data structures. This introductory essay provides a historical context for this line of work, highlights four newly published studies that move health economics research forward, and indicates several important areas of challenging but potentially fruitful research to strengthen future contributions to the literature and make empirical findings more useful for evaluating health policy decisions. Copyright (c) 2016 John Wiley & Sons, Ltd.

Jakovljevic, M., et al. (2016). "Evolving Health Expenditure Landscape of the BRICS Nations and Projections to 2025." Health Econ.

Global health spending share of low/middle income countries continues its long-term growth. BRICS nations remain to be major drivers of such change since 1990s. Governmental, private and out-of-pocket health expenditures were analyzed based on WHO sources. Medium-term projections of national health spending to 2025 were provided based on macroeconomic budgetary excess growth model. In terms of per capita spending Russia was highest in 2013. India's health expenditure did not match overall economic growth and fell to slightly less than 4% of GDP. Up to 2025 China will achieve highest excess growth rate of 2% and increase its GDP% spent on health care from 5.4% in 2012 to 6.6% in 2025. Russia's spending will remain highest among BRICS in absolute per capita terms reaching net gain from $1523 PPP in 2012 to $2214 PPP in 2025. In spite of BRICS' diversity, all countries were able to significantly increase their investments in health care. The major setback was bold rise in out-of-pocket spending. Most of BRICS' growing share of global medical spending was heavily attributable to the overachievement of People's Republic of China. Such trend is highly likely to continue beyond 2025. Copyright (c) 2016 John Wiley & Sons, Ltd.

Kumara, A. S. et Samaratunge, R. (2016). "Patterns and determinants of out-of-pocket health care expenditure in Sri Lanka: evidence from household surveys." Health Policy and Planning **31**(8): 970-983.
http://heapol.oxfordjournals.org/content/31/8/970.abstract

This article examines patterns and determinants of the likelihood and financial burden of encountering out-of-pocket healthcare expenses in Sri Lankan households as, on average, more than 60% of households incur such costs. This percentage varies substantially across household categories in demographic properties, sectors and ability-to-pay. Households comprising more than one elderly person, pre-school children, members with chronic illnesses, and literate household heads are at significant risk of incurring out-of-pocket payments and bearing a higher financial burden. Rural and estate sector households are more likely to bear a higher burden. The marginal effects of household income show that the burden of private healthcare is less sensitive towards changes in household income and that households' burden in private healthcare was regressive in 2006/2007. Hence results imply that low-income households need to be protected. Analysis of supply side factors shows that availability of closer government hospitals, bed numbers and dentists in government hospitals reduce the burden of out-of-pocket expenses. However, more government doctors lead to higher likelihood and burden of incurring such healthcare expenses and create a government-doctor-induced cost. Therefore, the results show a convincing need for the expansion of healthcare infrastructure by government and a policy framework for its doctors that will lessen the financial burden in Sri Lankan households, particularly the poor.

Mata-Cases, M., et al. (2016). "Direct medical costs attributable to type 2 diabetes mellitus: a population-based study in Catalonia, Spain." Eur J Health Econ **17**(8): 1001-1010.

We estimated healthcare costs associated with patients with type 2 diabetes compared with non-diabetic subjects in a population-based primary care database through a retrospective analysis of economic impact during 2011, including 126,811 patients with type 2 diabetes in Catalonia, Spain. Total annual costs included primary care visits, hospitalizations, referrals, diagnostic tests, self-monitoring test strips, medication, and dialysis. For each patient, one control matched for age, gender and managing physician was randomly selected from a population database. The annual average cost per patient was euro 3110.1 and euro1803.6 for diabetic and non-diabetic subjects, respectively (difference euro 1306.6; i.e., 72.4 % increased cost). The costs of hospitalizations were euro 1303.1 and euro 801.6 (62.0 % increase), and medication costs were euro 925.0 and euro 489.2 (89.1 % increase) in diabetic and non-diabetic subjects, respectively. In type 2 diabetic patients, hospitalizations and medications had the greatest impact on the overall cost (41.9 and 29.7 %, respectively), generating approximately 70 % of the difference between diabetic and non-diabetic subjects. Patients with poor glycaemic control (glycated haemoglobin >7 %; >53 mmol/mol) had average costs of euro3296.5 versus euro2848.5 for patients with good control. In the absence of

macrovascular complications, average costs were euro 3008.1 for diabetic and euro 1612.4 for non-diabetic subjects, while its presence increased costs to euro 4814.6 and euro 3306.8, respectively. In conclusion, the estimated higher costs for type 2 diabetes patients compared with non-diabetic subjects are due mainly to hospitalizations and medications, and are higher among diabetic patients with poor glycaemic control and macrovascular complications.

Mattingly, T. J., et al. (2016). "Publication of Cost-of-Illness Studies: Does Methodological Complexity Matter?" PharmacoEconomics **34**(10): 1067-1070.
http://dx.doi.org/10.1007/s40273-016-0438-4

Saporito, A., et al. (2016). "A cost analysis of orthopedic foot surgery: can outpatient continuous regional analgesia provide the same standard of care for postoperative pain control at home without shifting costs?" Eur J Health Econ **17**(8): 951-961.

BACKGROUND AND OBJECTIVES: Same-day surgery is common for foot surgery. Continuous regional anesthesia for outpatients has been shown effective but the economic impact on the perioperative process-related healthcare costs remains unclear. METHODS: One hundred twenty consecutive patients were included in this assessor-blinded, prospective cohort study and allocated according to inclusion criteria in the day-care or in the in-patient group. Standardized continuous popliteal sciatic nerve block was performed in both groups for 48 h using an elastomeric pump delivering ropivacaine 0.2 % at a rate of 5 ml/h with an additional 5 ml bolus every 60 min. Outpatients were discharged the day of surgery and followed with standardized telephone interviews. The total direct health costs of both groups were compared. Moreover, the difference in treatment costs and the difference in terms of quality of care and effectiveness between the groups were compared. RESULTS: Total management costs were significantly reduced in the day-care group. There was no difference between the groups regarding pain at rest and with motion, persistent pain after catheter removal and the incidence of PONV. Persistent motor block and catheter inflammation/infection were comparable in both groups. There was neither a difference in the number of unscheduled ambulatory visits nor in the number of readmissions. CONCLUSIONS: Day-care continuous regional analgesia leads to an overall positive impact on costs by decreasing the incidence of unplanned ambulatory visits and unscheduled readmissions, without compromising on the quality of analgesia, patients' satisfaction, and safety.

Trish, E., et al. (2016). "Medicare Beneficiaries Face Growing Out-Of-Pocket Burden For Specialty Drugs While In Catastrophic Coverage Phase." Health Affairs **35**(9): 1564-1571.
http://content.healthaffairs.org/content/35/9/1564.abstract

The Affordable Care Act (ACA) includes provisions to reduce Medicare beneficiaries' out-of-pocket spending for prescription drugs by gradually closing the coverage gap between the initial coverage limit and the catastrophic coverage threshold (known as the doughnut hole) beginning in 2011. However, Medicare beneficiaries who take specialty pharmaceuticals could still face a large out-of-pocket burden because of uncapped cost sharing in the catastrophic coverage phase. Using 2008–12 pharmacy claims data from a 20 percent sample of Medicare beneficiaries, we analyzed trends in total and out-of-pocket spending among Medicare beneficiaries who take at least one high-cost specialty drug from the top eight specialty drug classes in terms of spending. Annual total drug spending per specialty drug user studied increased considerably during the study period, from $18,335 to $33,301, and the proportion of expenditures incurred while in the catastrophic coverage phase increased from 70 percent to 80 percent. We observed a 26 percent decrease in mean annual out-of-pocket expenditures incurred below the catastrophic coverage threshold, likely attributable to the ACA's doughnut hole cost-sharing reductions, but increases in mean annual out-of-pocket expenditures incurred while in the catastrophic coverage phase offset these reductions almost entirely. Policy makers should consider implementing limits on patients' out-of-pocket burden.

You, X. et Okunade, A. A. (2016). "Income and Technology as Drivers of Australian Healthcare Expenditures." Health Econ.

The roles of income and technology as the major determinants of aggregate healthcare expenditure (HEXP) continue to interest economists and health policy researchers. Concepts and measures of medical technologies remain complex; however, income (on the demand side) and technology (on the supply side) are important drivers of HEXP. This paper presents analysis of Australia's HEXP, using time-series econometrics modeling techniques applied to 1971-2011 annual aggregate data. Our work fills two important gaps in the literature. First, we model the determinants of Australia's HEXP using the latest and longest available data series. Second, this novel study investigates several alternative technology proxies (input and output measures), including economy-wide research and development expenditures, hospital research expenditures, mortality rate, and two technology indexes based on medical devices. We then apply the residual component method and the technology proxy approach to quantify the technology effects on HEXP. Our empirical results suggest that Australian aggregate healthcare is a normal good and a technical necessity with the income elasticity estimates ranging from 0.51 to 0.97, depending on the model. The estimated technology effects on HEXP falling in the 0.30-0.35 range and mimicking those in the literature using the US data, reinforce the global spread of healthcare technology.

Géographie de la santé / Geography of Health

Kopetsch, T. et Maier, W. (2016). "[Analysis of the Association between Regional Deprivation and Utilization: An Assessment of Need for Physicians in Germany]." Gesundheitswesen.

Background: A new strategy for planning outpatient medical care needs to be developed. The social and morbidity structure of the population should be considered in the planning of needs-based provision of medical care. This paper aims to examine the extent to which the degree of regional deprivation can be incorporated in the calculation of the regional requirements for specialists in Germany. Methods: To measure regional deprivation status at district level, we used the "German Index of Multiple Deprivation" (GIMD) developed in the Helmholtz Zentrum Munchen - German Research Center for Environmental Health. Scores were calculated for the deprivation status of each rural and urban district in Germany. The methods used to compute the deprivation-adjusted medical need are linear regression analyses. The analyses were based on regionalized data for the number of office-based physicians and their billing data. The analyses were carried out with the SPSS software package, version 20. Results: The analyses showed a clear positive correlation between regional deprivation and the utilisation of medical services both for outpatients and in-patients, on the one hand, and mortality and morbidity, as measured by the risk adjustment factor (RSA), on the other. At the district level, the analyses also revealed varying associations between the degree of deprivation and the utilisation of the 12 groups of specialists included in the needs assessment. On this basis, an algorithm was developed by which deprivation at district level can be used to calculate an increase or a decrease in the relative number of specialists needed. Discussion and conclusion: Using the GIMD and various determinants of medical utilisation, the model showed that medical need increased with the level of regional deprivation. However, regarding SHI medical specialist groups, the associations found in this analysis were statistically (R2) insufficient to suggest a needs assessment planning system based only on the factors analysed, thereby restricting physicians' constitutional right of professional freedom. In particular cases, i. e. licenses to meet special needs, the developed instruments may be suitable for indicating a greater or lesser need for doctors at a regional level due to their relative ease of use and practicability.

Hôpital / Hospitals

Baker, L. C., et al. (2016). "The effect of hospital/physician integration on hospital choice." J Health Econ **50**: 1-8.

In this paper, we estimate how hospital ownership of physicians' practices affects their patients' hospital choices. We match data on the hospital admissions of Medicare beneficiaries, including the identity of their physician, with data on the identity of the owner of their physician's practice. We find that a hospital's ownership of a physician dramatically increases the probability that the physician's patients will choose the owning hospital. We also find that patients are more likely to choose a high-cost, low-quality hospital when their physician is owned by that hospital.

Ellimoottil, C., et al. (2016). "Medicare's New Bundled Payment For Joint Replacement May Penalize Hospitals That Treat Medically Complex Patients." Health Affairs **35**(9): 1651-1657.
http://content.healthaffairs.org/content/35/9/1651.abstract

In an effort to reduce episode payment variation for joint replacement at US hospitals, the Centers for Medicare and Medicaid Services (CMS) recently implemented the Comprehensive Care for Joint Replacement bundled payment program. Some stakeholders are concerned that the program may unintentionally penalize hospitals because it lacks a mechanism (such as risk adjustment) to sufficiently account for patients' medical complexity. Using Medicare claims for patients in Michigan who underwent lower extremity joint replacement in the period 2011–13, we applied payment methods analogous to those CMS intends to use in determining annual bonuses or penalties (reconciliation payments) to hospitals. We calculated the net difference in reconciliation payments with and without risk adjustment. We found that reconciliation payments were reduced by $827 per episode for each standard-deviation increase in a hospital's patient complexity. Moreover, we found that risk adjustment could increase reconciliation payments to some hospitals by as much as $114,184 annually. Our findings suggest that CMS should include risk adjustment in the Comprehensive Care for Joint Replacement program and in future bundled payment programs.

Tedesco, D., et al. (2016). "Evaluating patient safety indicators in orthopedic surgery between Italy and the USA." International Journal for Quality in Health Care **28**(4): 486-491.
http://intqhc.oxfordjournals.org/content/intqhc/28/4/486.full.pdf

Objective : To compare patient safety in major orthopedic procedures between an orthopedic hospital in Italy, and 26 US hospitals of similar size. Design Retrospective analysis of administrative data from hospital discharge records in Italy and Florida, USA, 2011–13. Patient Safety Indicators (PSIs) developed by the Agency for Healthcare Quality and Research were used to identify inpatient adverse events (AEs). We examined the factors associated with the development of each different PSI, taking into account known confounders, using logistic regression. Setting : One Italian orthopedic hospital and 26 hospitals in Florida with ≥ 1000 major orthopedic procedures per year. Participants Patients ≥ 18 years who underwent 1 of the 17 major orthopedic procedures, and with a length of stay (LOS) > 1 day. Intervention Patient Safety management between Italy and the USA. Main Outcome Measure Patient Safety Indicators. Results : A total of 14 393 patients in Italy (mean age = 59.8 years) and 131 371 in the USA (mean age = 65.4 years) were included. US patients had lower adjusted odds of developing a PSI compared to Italy for pressure ulcers (odds ratio [OR]: 0.21; 95% confidence interval [CI]: 0.10–0.45), hemorrhage or hematoma (OR: 0.42; CI 0.23–0.78), physiologic and metabolic derangement (OR: 0.08; CI 0.02–0.37). Italian patients had lower odds of pulmonary embolism/deep vein thrombosis (OR: 3.17; CI 2.16–4.67) compared to US patients. Conclusions : Important differences in patient safety events were identified across countries using US developed PSIs. Though caution about potential coding differences is wise when comparing PSIs internationally, other differences may explain AEs, and offer opportunities for cross-country learning about safe practices

Inégalités de santé / Health Inequalities

Choi, S. (2016). "Experiencing Unmet Medical Needs or Delayed Care Because of Cost: Foreign-Born Adults in the U.S. by Region of Birth." Int J Health Serv **46**(4): 693-711.

Healthy People 2020 in the United States highlights timely access to necessary health care as a major factor that can reduce health-related disparities. This study examined the prevalence of delaying/missing necessary health care because of cost among foreign-born adults (26+ years old) in the United States by their region of origin, after controlling for geographic clustering at the county and state levels. METHODS: Using the pooled 2007-2011 National Health Interview Survey and linked state/county-level data, this study analyzed data on 61,732 foreign-born adults from nine regions of birth. Three-level multilevel modeling (state > county > individual) was conducted. The age-adjusted percentages of foreign-born adults who delayed/missed necessary health care because of cost varied by region of birth, ranging from 7.0% (Southeast Asia) and 11.9% (Europe) to 15.5% (Mexico/Central America/Caribbean) and 16.7% (the Middle East). However, after controlling for geographic clustering and other individual-level covariates (e.g., insurance), adults from Mexico/Central America/Caribbean were less likely to delay or not receive necessary care compared to their counterparts from all other parts of the world except for those from Asian regions. This study implies that disparities can be reduced if some known risk factors (e.g., insurance) are improved among foreign-born adults.

Droomers, M., et al. (2016). "Is it better to invest in place or people to maximize population health? Evaluation of the general health impact of urban regeneration in Dutch deprived neighbourhoods." Health & Place **41**: 50-57.

http://www.sciencedirect.com/science/article/pii/S1353829216300788

Abstract : To study the general health impact of urban regeneration programmes in deprived Dutch districts. We compared initiatives that focused on the improvement of place with initiatives that mainly invested in people. Method A quasi-experimental design compared the trend in good perceived general health in the target districts with comparison districts. Generalized general mixed models assessed the rate of change in prevalence of good health per half year during a prolonged period before and after the start of the interventions. Results Neither the target districts that invested mainly in place nor the ones with interventions focused on people showed trends in general health different than comparison districts ($p<0.05$). However, only districts with interventions focused on place showed no deterioration in general health during the intervention period. The trend change in these districts differed significantly from the change in the districts that invested mainly in people ($p>0.05$). Conclusion Urban regeneration programmes that focus on place may be effective in promoting general health.

Médicaments / Pharmaceuticals

Armeni, P., et al. (2016). "The simultaneous effects of pharmaceutical policies from payers' and patients' perspectives: Italy as a case study." Eur J Health Econ **17**(8): 963-977.

OBJECTIVES: This paper aims at covering a literature gap on the effects of copayments, prescription quotas and therapeutic reference pricing on public and private expenditures and volumes (1) When these policies are implemented in different areas at different times, (2) estimating their impact in the short and long run, (3) assessing the extent to which these impacts are interdependent, (4) scrutinising the extent to which the effects are mediated by prescribers' and patients' behaviours. METHODS: Monthly regional data on pharmaceutical expenditures, volumes and policies in Italy from 2000 to 2014 are analysed using a difference-in-differences model enriched to capture short- versus long-term effects and simultaneous and interactive effects. Sobel-Goodman test and bootstrap analyses were used to test for mediation. RESULTS: The three policies have different short- and long-run effects. Interactions support the hypothesis of reinforcing effects. Behavioural reactions to policies such as

reducing the demand or total per capita expenditures mediate the impact of policies, thus explaining the different effects between the short and long term. CONCLUSIONS: Evidence on the impact over time of regional policies diversely introduced in different times have important policy implications. First, pharmaceutical policies interact with each other, and the combined effect may be different from what we would expect from the sum of each single policy. Hence, policymakers should be very careful in designing mixed policies for their unexpected combined effects. Second, the impact of policies tends to reduce over time. If longer-term impact is desired, it would be appropriate to introduce some adjustments over time. Third, policies have multiple effects, and this should be considered when they are designed. Finally, pharmaceutical policies may have an unintended impact on health and health care.

Fischer, K. E. et Stargardt, T. (2016). "The diffusion of generics after patent expiry in Germany." Eur J Health Econ **17**(8): 1027-1040.

To identify the influences on the diffusion of generics after patent expiry, we analyzed 65 generic entries using prescription data of a large German sickness fund between 2007 and 2012 in a sales model. According to theory, several elements are responsible for technology diffusion: (1) time reflecting the rate of adaption within the social system, (2) communication channels, and (3) the degree of incremental innovation, e.g., the modifications of existing active ingredient's strength. We investigated diffusion in two ways: (1) generic market share (percentage of generic prescriptions of all prescriptions of a substance) and, (2) generic sales quantity (number of units sold) over time. We specified mixed regression models. Generic diffusion takes considerable time. An average generic market share of about 75 % was achieved not until 48 months. There was a positive effect of time since generic entry on generic market share ($p < 0.001$) and sales ($p < 0.001$). Variables describing the communication channels and the degree of innovation influenced generic market share (mostly $p < 0.001$), but not generic sales quantity. Market structure, e.g., the number of generic manufacturers ($p < 0.001$) and prices influenced both generic market share and sales. Imperfections in generic uptake through informational cascades seem to be largely present. Third-party payers could enhance means to promote generic diffusion to amplify savings through generic entry.

Gandjour, A. (2016). "Limiting Free Pricing of New Innovative Drugs After Launch: A Necessity for Payers?" Appl Health Econ Health Policy **14**(5): 507-509.

Weil, A. R. (2016). **"Payment Reforms, Prescription Drugs, And More."** Health Affairs **35**(9): 1555. http://content.healthaffairs.org/content/35/9/1555.short

Méthodologie – Statistique / Methodology - Statistics

Ferdynus, C. et Hulard, L. (2016). "Optimisation de la constitution de cohortes issues de bases de données médico-administratives : mise à disposition d'un algorithme pour l'intégration et la normalisation des données adapté au Système national d'information inter-régimes de l'assurance maladie (SNIIRAM). Technical improvement of cohort constitution in administrative health databases: Providing a tool for integration and standardization of data applicable in the French National Health Insurance Database (SNIIRAM)." Revue d'Epidémiologie et de Santé Publique **64**(4): 263-269.
http://www.em-consulte.com/article/1080254/alerteM

Position du problème : Les bases médico-administratives telles que le SNIIRAM sont des sources de données incontournables pour répondre à de nombreuses questions de recherche en santé publique. L'exploitation des données contenues dans ces bases pour constituer des cohortes nécessite des traitements complexes et chronophages. L'objectif de notre travail était de développer et de mettre à disposition un outil permettant d'optimiser la constitution de cohortes issues de bases médico-administratives. Méthodes : Nous avons développé un algorithme pour extraire, transformer et intégrer différentes sources de données hétérogènes dans un entrepôt de données normalisé. Cet entrepôt est architecturé selon un schéma en étoile correspondant au modèle i2b2. Nous avons ensuite évalué les performances de cet algorithme dans le cadre d'un projet de recherche en pharmaco-épidémiologie utilisant les bases de données du SNIIRAM. Résultats : L'algorithme développé comprend un ensemble de fonctionnalités permettant la création de scripts SAS. Il permet d'intégrer des données dans un entrepôt normalisé. Dans le cadre de l'évaluation des performances de cet algorithme, nous avons pu intégrer plus de 900 000 000 de lignes provenant du SNIIRAM en moins de 3heures à l'aide d'un ordinateur de bureau. Nous avons ensuite pu sélectionner les patients de l'entrepôt ainsi obtenu avec des requêtes n'excédant pas quelques secondes. Conclusion : L'algorithme présenté dans cet article permet de disposer d'un outil performant et compatible avec l'ensemble des bases de données médico-administratives, sans avoir recours à des serveurs de bases de données complexes. Cet outil permet ensuite de simplifier la constitution de cohortes issues de ces bases et, en raison de la normalisation de l'entrepôt de données, facilite le travail collaboratif entre équipes.

Fullerton, B., et al. (2016). "The Comparison of Matching Methods Using Different Measures of Balance: Benefits and Risks Exemplified within a Study to Evaluate the Effects of German Disease Management Programs on Long-Term Outcomes of Patients with Type 2 Diabetes." Health Serv Res **51**(5): 1960-1980.

OBJECTIVE: To present a case study on how to compare various matching methods applying different measures of balance and to point out some pitfalls involved in relying on such measures. DATA SOURCES: Administrative claims data from a German statutory health insurance fund covering the years 2004-2008. STUDY DESIGN: We applied three different covariance balance diagnostics to a choice of 12 different matching methods used to evaluate the effectiveness of the German disease management program for type 2 diabetes (DMPDM2). We further compared the effect estimates resulting from applying these different matching techniques in the evaluation of the DMPDM2. PRINCIPAL FINDINGS: The choice of balance measure leads to different results on the performance of the applied matching methods. Exact matching methods performed well across all measures of balance, but resulted in the exclusion of many observations, leading to a change of the baseline characteristics of the study sample and also the effect estimate of the DMPDM2. All PS-based methods showed similar effect estimates. Applying a higher matching ratio and using a larger variable set generally resulted in better balance. Using a generalized boosted instead of a logistic regression model showed slightly better performance for balance diagnostics taking into account imbalances at higher moments. CONCLUSION: Best practice should include the application of several matching methods and thorough balance diagnostics. Applying matching techniques can provide a useful preprocessing step to reveal areas of the data that lack common support. The use of different balance

diagnostics can be helpful for the interpretation of different effect estimates found with different matching methods.

Goldberg, M., et al. (2016). "[The opening of the French national health database: Opportunities and difficulties. The experience of the Gazel and Constances cohorts]." Rev Epidemiol Santé Publique **64**(4): 313-320.

BACKGROUND: In France, the national health database (SNIIRAM) is an administrative health database that collects data on hospitalizations and healthcare consumption for more than 60 million people. Although it does not record behavioral and environmental data, these data have a major interest for epidemiology, surveillance and public health. One of the most interesting uses of SNIIRAM is its linkage with surveys collecting data directly from persons. Access to the SNIIRAM data is currently relatively limited, but in the near future changes in regulations will largely facilitate open access. However, it is a huge and complex database and there are some important methodological and technical difficulties for using it due to its volume and architecture. METHODS: We are developing tools for facilitating the linkage of the Gazel and Constances cohorts to the SNIIRAM: interactive documentation on the SNIIRAM database, software for the verification of the completeness and validity of the data received from the SNIIRAM, methods for constructing indicators from the raw data in order to flag the presence of certain events (specific diagnosis, procedure, drug...), standard queries for producing a set of variables on a specific area (drugs, diagnoses during a hospital stay...). Moreover, the REDSIAM network recently set up aims to develop, evaluate and make available algorithms to identify pathologies in SNIIRAM. CONCLUSION: In order to fully benefit from the exceptional potential of the SNIIRAM database, it is essential to develop tools to facilitate its use.

Politique de santé / Health Policy

Baji, P., et al. (2016). "Comparative analysis of decision maker preferences for equity/efficiency attributes in reimbursement decisions in three European countries." The European Journal of Health Economics **17**(7): 791-799.
http://dx.doi.org/10.1007/s10198-015-0721-x

In addition to cost-effectiveness, national guidelines often include other factors in reimbursement decisions. However, weights attached to these are rarely quantified, thus decisions can depend strongly on decision-maker preferences.

Oberlander, J. "From Obamacare to Hillarycare — Democrats' Health Care Reform Agenda." New England Journal of Medicine **0**(0): null.
http://www.nejm.org/doi/full/10.1056/NEJMp1610712

Prévention / Prevention

Golder, S., et al. (2016). "Reporting of Adverse Events in Published and Unpublished Studies of Health Care Interventions: A Systematic Review." PLoS Med **13**(9): e1002127.
https://www.ncbi.nlm.nih.gov/pubmed/27649528

BACKGROUND: We performed a systematic review to assess whether we can quantify the underreporting of adverse events (AEs) in the published medical literature documenting the results of clinical trials as compared with other nonpublished sources, and whether we can measure the impact this underreporting has on systematic reviews of adverse events. METHODS AND FINDINGS: Studies were identified from 15 databases (including MEDLINE and Embase) and by hand searching, reference checking, internet searches, and contacting experts. The last database searches were conducted in July 2016. There were 28 methodological evaluations that met the inclusion criteria. Of these, 9

studies compared the proportion of trials reporting adverse events by publication status. The median percentage of published documents with adverse events information was 46% compared to 95% in the corresponding unpublished documents. There was a similar pattern with unmatched studies, for which 43% of published studies contained adverse events information compared to 83% of unpublished studies. A total of 11 studies compared the numbers of adverse events in matched published and unpublished documents. The percentage of adverse events that would have been missed had each analysis relied only on the published versions varied between 43% and 100%, with a median of 64%. Within these 11 studies, 24 comparisons of named adverse events such as death, suicide, or respiratory adverse events were undertaken. In 18 of the 24 comparisons, the number of named adverse events was higher in unpublished than published documents. Additionally, 2 other studies demonstrated that there are substantially more types of adverse events reported in matched unpublished than published documents. There were 20 meta-analyses that reported the odds ratios (ORs) and/or risk ratios (RRs) for adverse events with and without unpublished data. Inclusion of unpublished data increased the precision of the pooled estimates (narrower 95% confidence intervals) in 15 of the 20 pooled analyses, but did not markedly change the direction or statistical significance of the risk in most cases. The main limitations of this review are that the included case examples represent only a small number amongst thousands of meta-analyses of harms and that the included studies may suffer from publication bias, whereby substantial differences between published and unpublished data are more likely to be published. CONCLUSIONS: There is strong evidence that much of the information on adverse events remains unpublished and that the number and range of adverse events is higher in unpublished than in published versions of the same study. The inclusion of unpublished data can also reduce the imprecision of pooled effect estimates during meta-analysis of adverse events.

Psychiatrie / Psychiatry

Zhu, J. M., et al. (2016). "Emergency Department Length-Of-Stay For Psychiatric Visits Was Significantly Longer Than For Nonpsychiatric Visits, 2002–11." Health Affairs **35**(9): 1698-1706. http://content.healthaffairs.org/content/35/9/1698.abstract

Despite increases in the use of emergency department (EDs) for mental health care, there are limited data on whether psychiatric patients disproportionately contribute to ED crowding. We conducted a retrospective analysis using a national database of ED visits in the period 2002–11 to describe trends in median and ninetieth-percentile length-of-stay for patients with psychiatric versus nonpsychiatric primary diagnoses. Psychiatric patients who visited the ED were transferred to another facility at six times the rate of nonpsychiatric patients. Median lengths-of-stay were similar for psychiatric and nonpsychiatric patients among those who were admitted to the hospital (264 versus 269 minutes) but significantly different for those who were admitted for observation (355 versus 279 minutes), transferred (312 versus 195 minutes), or discharged (189 versus 144 minutes). Overall, differences in ED length-of-stay between psychiatric and nonpsychiatric patients did not narrow over time. These findings suggest deficiencies in ED capacity for psychiatric care, which may necessitate improvements in both throughput and alternative models of care.

Soins de santé primaires / Primary Health Care

Benzer, J. K., et al. (2016). "Team Process Variation Across Diabetes Quality of Care Trajectories." Med Care Res Rev **73**(5): 565-589.

Conceptual frameworks in health care do not address mechanisms whereby teamwork processes affect quality of care. We seek to fill this gap by applying a framework of teamwork processes to compare different patterns of primary care performance over time. We thematically analyzed 114 primary care staff interviews across 17 primary care clinics. We purposefully selected clinics using diabetes quality of care over 3 years using four categories: consistently high, improving, worsening,

and consistently low. Analyses compared participant responses within and between performance categories. Differences were observed among performance categories for action processes (monitoring progress and coordination), transition processes (goal specification and strategy formulation), and interpersonal processes (conflict management and affect management). Analyses also revealed emergent concepts related to psychological and organizational context that were reported to affect team processes. This study is a first step toward a comprehensive model of how teamwork processes might affect quality of care.

Chicoulaa, B., et al. (2016). "French general practitioners' sense of isolation in the management of elderly cancer patients." Family Practice **33**(5): 551-556.
http://fampra.oxfordjournals.org/content/33/5/551.abstract

Background. Cancer care in people over 75 years of age is particularly complex and requires collaboration between oncologists, geriatricians, GPs and other professional and family carers. To improve the care pathways for elderly people living with cancer, the French health authorities have created a network of oncologists and geriatricians; however, GPs experience difficulties in establishing their place in this network. Objective. This study aimed to analyse the impressions of French GPs involved in the care of elderly patients with cancer, including their feelings regarding their relationships with their oncologist and geriatrician colleagues. Methods. A qualitative approach using focus groups was employed. The proceedings of these focus groups were recorded, retranscribed and subjected to thematic analysis. Results. Although heavily involved in the care of their elderly patients living with cancer, the GPs who participated reported feeling isolated in their role at each step during the course of the disease. The principal themes addressed were screening and diagnosis, therapeutic decisions, multidisciplinary consultation meetings, the announcement of the diagnosis and monitoring at home. Their relationships with their oncologist colleagues showed much room for improvement, and they were unaware of the oncogeriatric network. Conclusions. Improving the communication between GPs, oncologists and geriatric medicine seems to be one response to the isolation that GPs feel when caring for older people with cancer. At the primary care level, integration of GPs into the oncogeriatric network and the creation of a cancer care communication system in collaboration with the relevant hospital teams may be effective solutions.

Cho, K. H., et al. (2016). "Impact of continuity of care on preventable hospitalization of patients with type 2 diabetes: a nationwide Korean cohort study, 2002–10." International Journal for Quality in Health Care **28**(4): 478-485.
http://intqhc.oxfordjournals.org/content/intqhc/28/4/478.full.pdf

Objective : To determine whether patients with greater continuity of care (COC) have fewer preventable hospitalizations. Design : We conducted a cohort study using a stratified random sample of Korean National Health Insurance enrollees from 2002 to 2010. The COC index was calculated for each year post-diagnosis based on ambulatory care visits. We performed a recurrent event survival analysis via Cox proportional hazard regression analysis of preventable hospitalizations. Study participants A total of 5163 patients newly diagnosed with type 2 diabetes mellitus in 2003–6 and receiving oral hypoglycemic medication. Main outcome measure Preventable hospitalization. Results : Of 5163 eligible participants, 6.4% (n = 328) experienced a preventable hospitalization during the study period. The adjusted hazard ratio (HR) was 8.69 (95% CI, 2.62–28.83) for subjects with a COC score of 0.00–0.19, 7.03 (95% CI, 4.50–10.96) for those with a score of 0.20–0.39, 3.01 (95% CI, 2.06–4.40) for those with a score of 0.40–059, 4.42 (95% CI, 3.04–6.42) for those with a score of 0.60–0.79 and 5.82 (95% CI, 3.87–8.75) for those with a score of 0.80–0.99. The difference in cumulative incidence of preventable hospitalizations in patients with COC scores of 0.00–0.19 relative to those with COC scores of 1.00 was the greatest, at 0.97% points. Conclusions Greater COC was associated with fewer preventable hospitalizations in subjects with type 2 diabetes.

Jakobsson, N. et Svensson, M. "Copayments and physicians visits: A panel data study of Swedish regions 2003-2012." Health Policy **120**(9): 1095-1099.
http://dx.doi.org/10.1016/j.healthpol.2016.07.010

The copayment for physician visits has no effect of significance on visits. We estimate the "zero effect" of copayments with very high precision. The effect of copayments seems to be vary by health care system and context.

Kane, E. P., et al. (2016). "Improving diabetes care and outcomes with community health workers." Family Practice **33**(5): 523-528.
http://fampra.oxfordjournals.org/content/33/5/523.abstract

Background. Type II diabetes continues to be a major health problem in USA, particularly in minority populations. The Diabetes Equity Project (DEP), a clinic-based diabetes self-management and education program led by community health workers (CHWs), was designed to reduce observed disparities in diabetes care and outcomes in medically underserved, predominantly Hispanic communities. Objective. The purpose of this study was to evaluate the impact of the DEP on patients' clinical outcomes, diabetes knowledge, self-management skills, and quality of life. Methods. The DEP was implemented in five community clinics from 2009 to 2013 and 885 patients completed at least two visits with the CHW. Student's paired t-tests were used to compare baseline clinical indicators with indicators obtained from patients' last recorded visit with the CHW and to assess differences in diabetes knowledge, perceived competence in managing diabetes, and quality of life. A mixed-effects model for repeated measures was used to examine the effect of DEP visits on blood glucose (HbA1c), controlling for patient demographics, clinic and enrolment date. Results. DEP patients experienced significant ($P < 0.0001$) improvements in HbA1c control, blood pressure, diabetes knowledge, perceived competence in managing diabetes, and quality of life. Mean HbA1c for all DEP patients decreased from 8.3% to 7.4%.Conclusion. Given the increasing prevalence of diabetes in USA and documented disparities in diabetes care and outcomes for minorities, particularly Hispanic patients, new models of care such as the DEP are needed to expand access to and improve the delivery of diabetes care and help patients achieve improved outcomes.

Lam, C. L. K. (2016). "The role of the family doctor in the era of multi-disciplinary primary care." Family Practice **33**(5): 447-448.
http://fampra.oxfordjournals.org/content/33/5/447.short

Muhlestein, D. B. et Smith, N. J. (2016). "Physician Consolidation: Rapid Movement From Small To Large Group Practices, 2013–15." Health Affairs **35**(9): 1638-1642.
http://content.healthaffairs.org/content/35/9/1638.abstract

In the past few decades there has been a trend of physicians moving from smaller to larger group practices. We found that this trend continued in the period 2013–15. Primary care physicians have made this change at a much faster pace than specialists have.

Orton, P. K. et Pereira Gray, D. (2016). "Factors influencing consultation length in general/family practice." Family Practice **33**(5): 529-534.
http://fampra.oxfordjournals.org/content/33/5/529.abstract

Background. The length of consultations is an important factor affecting the quality of care in general practice. It is however difficult to study as many factors are simultaneously involved. Much that is known is about patient factors as so far, doctor factors have been neglected. Objective. To investigate multiple factors affecting consultation length, how they interact and the association between consultation length and patient-centredness. Methods. Previously collected observational data from 38 National Health Service NHS GPs in England stratified according to doctor's gender, experience and degree of emotional exhaustion were used. Multiple regression analyses were applied to 822 audio-recorded and timed consultations. Each consultation was analysed for the doctor's gender, patient's gender, experience, level of emotional exhaustion and patient-centredness. Results. We previously reported that 261/564 (46%) of GPs in Essex England were emotionally exhausted. Here, we found that male and female doctors respond differently to both experience and emotional exhaustion, which

are associated with differences in their consultation length. The effect of experience on consultation length is only observed in male doctors: the more experienced, the shorter their consultation. Emotional exhaustion affected consultation length in opposite ways for females and male GPs: exhausted female GPs had shorter consultations, while exhausted male doctors had longer ones. Longer consultations were significantly more patient-centred and were associated with female patients. Conclusions. We found five factors affecting consultation length significantly. Moreover, these factors can predict the consultation length.

Paul, S., et al. (2014). "Results from using a new dyadic-dependence model to analyze sociocentric physician networks." Soc Sci Med **117**: 67-75.
https://www.ncbi.nlm.nih.gov/pubmed/25047711

Professional physician networks can potentially influence clinical practices and quality of care. With the current focus on coordinated care, discerning influences of naturally occurring clusters and other forms of dependence among physicians' relationships based on their attributes and care patterns is an important area of research. In this paper, two directed physician networks: a physician influential conversation network (N = 33) and a physician network obtained from patient visit data (N = 135) are analyzed using a new model that accounts for effect modification of the within-dyad effect of reciprocity and inter-dyad effects involving three (or more) actors. The results from this model include more nuanced effects involving reciprocity and triadic dependence than under incumbent models and more flexible control for these effects in the extraction of other network phenomena, including the relationship between similarity of individuals' attributes (e.g., same-gender, same residency location) and tie-status. In both cases we find extensive evidence of clustering and triadic dependence that if not accounted for confounds the effect of reciprocity and attribute homophily. Findings from our analysis suggest alternative conclusions to those from incumbent models.

Roland, M. et Olesen, F. (2016). "Can pay for performance improve the quality of primary care?" Bmj **354**: i4058.

Russo, G., et al. "A tale of loss of privilege, resilience and change: the impact of the economic crisis on physicians and medical services in Portugal." Health Policy **120**(9): 1079-1086.
http://dx.doi.org/10.1016/j.healthpol.2016.07.015

We explored physicians' perceptions of the impact of economic crisis and austerity measures in Portugal. Few physicians considered leaving the public sector and the country despite the loss of privileges. Diverse coping strategies are emerging depending on employment institutions and seniority. The crisis may have consolidated the private sector by shifting demand from public to the private. Physicians' responses and resilience need better understanding before designing policies to retain them.

Scapinello, M. P., et al. "Predictors of emergency department referral in patients using out-of-hours primary care services." Health Policy **120**(9): 1001-1007.
http://dx.doi.org/10.1016/j.healthpol.2016.07.018

Overcrowding the emergency department (ED) for non-urgent patients is a common problem, but strategies to decrease it are poorly studied. Our study suggests that out-of-hours (OOH) service could be a filter to decrease ED access. Our study shows some relevant conditions that increase the probability of being referred to ED from OOH primary care service.

Syed-Abdul, S., et al. (2016). "Impact of continuity of care on preventable hospitalization and evaluating patient safety indicators between Italy and the USA." International Journal for Quality in Health Care **28**(4): 425-425.
http://intqhc.oxfordjournals.org/content/intqhc/28/4/425.full.pdf

Wise, J. (2016). "Extending primary care hours cuts emergency department visits." Bmj **354**: i4818.

Wise, J. (2016). "Having a named accountable GP does not improve continuity of care, study finds." Bmj **354**: i5048.

Systèmes de santé / Health Systems

Fradgley, E. A., et al. (2016). "Getting right to the point: identifying Australian outpatients' priorities and preferences for patient-centred quality improvement in chronic disease care." International Journal for Quality in Health Care **28**(4): 470-477.
http://intqhc.oxfordjournals.org/content/intqhc/28/4/470.full.pdf

Objectives : To identify specific actions for patient-centred quality improvement in chronic disease outpatient settings, this study identified patients' general and specific preferences among a comprehensive suite of initiatives for change. Design and setting : A cross-sectional survey was conducted in three hospital-based clinics specializing in oncology, neurology and cardiology care located in New South Wales, Australia. Participants and measures Adult English-speaking outpatients completed the touch-screen Consumer Preferences Survey in waiting rooms or treatment areas. Participants selected up to 23 general initiatives that would improve their experience. Using adaptive branching, participants could select an additional 110 detailed initiatives and complete a relative prioritization exercise. Results : A total of 541 individuals completed the survey (71.1% consent, 73.1% completion). Commonly selected general initiatives, presented in order of decreasing priority (along with sample proportion), included: improved parking (60.3%), up-to-date information provision (15.0%), ease of clinic contact (12.9%), access to information at home (12.8%), convenient appointment scheduling (14.2%), reduced wait-times (19.8%) and information on medical emergencies (11.1%). To address these general initiatives, 40 detailed initiatives were selected by respondents. Conclusions Initiatives targeting service accessibility and information provision, such as parking and up-to-date information on patient prognoses and progress, were commonly selected and perceived to be of relatively greater priority. Specific preferences included the need for clinics to provide patient-designated parking in close proximity to the clinic, information on treatment progress and test results (potentially in the form of designated brief appointments or via telehealth) and comprehensive and trustworthy lists of information sources to access at home.

Mancuso, P. et Valdmanis, V. G. (2016). "Care Appropriateness and Health Productivity Evolution: A Non-Parametric Analysis of the Italian Regional Health Systems." Appl Health Econ Health Policy **14**(5): 595-607.

BACKGROUND: There has been increasing interest in measuring the productive performance of healthcare services since the mid-1980s. OBJECTIVE: By applying bootstrapped data envelopment analysis across the 20 Italian Regional Health Systems (RHSs) for the period 2008-2012, we employed a two-stage procedure to investigate the relationship between care appropriateness and productivity evolution in public hospital services. METHODS: In the first stage, we estimated the Malmquist index and decomposed this overall measure of productivity into efficiency and technological change. In the second stage, the two components of the Malmquist index were regressed on a set of variables measuring per capita health expenditure, care appropriateness, and clinical appropriateness. RESULTS: Malmquist analysis shows that no gains in productivity in the health industry have been achieved in Italy despite the sequence of reforms that took place during the 1990s, which were devoted to increasing efficiency and reducing costs. Analysis of the efficiency change index clearly indicates that the source of productivity gain relies on a rationalization of the employed inputs in the Italian RHSs. At the same time, the trend of the technological change index reveals that the health systems in the three macro-areas (North, Central, and South) are characterized by technological regress. CONCLUSION: Overall, our results suggest that productivity increases could be achieved in the Italian health system by reducing the level of inputs, improving care and clinical appropriateness, and by counteracting the 'DRG (diagnosis-related group) creep' phenomenon.

Technologies et informatique médicales / Medical and Information Technologies

Radhakrishnan, K., et al. (2016). "Unsustainable Home Telehealth: A Texas Qualitative Study." The Gerontologist **56**(5): 830-840.
http://gerontologist.oxfordjournals.org/content/56/5/830.abstract

Purpose: Telehealth has emerged as an innovative approach to aid older individuals in managing chronic diseases in their homes and avoid hospitalizations and institutionalization. However, the sustainability of home telehealth programs remains a major challenge. This qualitative study explored the reasons for the initial adoption and the eventual decline of a decade-long home telehealth program at a Texas home health agency (HHA). Barriers to and facilitators for sustaining home telehealth programs were also explored. Design and Methods: Semi-structured interviews of 13 HHA nursing staff and administrators, 1 physician, and 9 patients aged >55 years and their informal caregivers who used telehealth were conducted in summer 2013. Interview transcripts were analyzed using conventional content analysis. Results: Data analysis generated 5 themes representing the decline of the Texas home telehealth program: its impact on patient-centered outcomes, its cost-effectiveness, patient–clinician and interprofessional communication, technology usability, and home health management culture. Lack of significant impact on patient outcomes, in addition to financial, technical, management, and communication-related challenges, adversely affected the sustainability of this home telehealth program. Implications: A home telehealth program that attains patient-centered outcomes, improves cost-effectiveness of managing chronic diseases, improves quality of communication among patients and clinicians, is user-friendly for older adults, and involves end users in decision making is likely to be sustainable.

Travail et santé / Occupational Health

Aaviksoo, E. et Kiivet, R. A. "Influence of the sickness benefit reform on sickness absence." Health Policy **120**(9): 1070-1078.
http://dx.doi.org/10.1016/j.healthpol.2016.07.014

In Estonia, the sick-pay cut policy was implemented on July 1, 2009. The sick-pay cut has led to a considerable decrease in sick-days and sick-leave episodes. The duration of sick-leave episodes increased, the number of recurrent sick-leaves decreased. The number of sick-leaves shorter than three weeks decreased by half whereas the number of longer absences did not change.

Toge, A. G. (2016). "Health Effects of Unemployment in Europe During the Great Recession: The Impact of Unemployment Generosity." Int J Health Serv **46**(4): 614-641.

Social and economic security could be particularly important for health among the unemployed. Nevertheless, knowledge is still lacking as to whether and how different policy contexts affect health when people move into unemployment. This article investigates whether and to what degree the unemployment generosity explains why individual health effects of unemployment vary across Europe. The 2008-2011 longitudinal panel of the European Union statistics on income and living conditions (EU-SILC) and fixed-effects models are used to estimate the individual effects of unemployment on self-rated health (SRH). Social spending on unemployment is used as a proxy for unemployment generosity. The results show that unemployment generosity is associated with reduced negative effects of unemployment on SRH. For every increase in adjusted purchasing power standard spending, the negative effect of unemployment on SRH is reduced by 0.003 (SE = 0.001) and the change in SRH is improved by 0.002 (SE = 0.001) for each year following the transition, after controlling for time-variant confounders at the individual level and unemployment rate at the macro

level. The association between spending on unemployment and cross-national differences in individual health changes that occur as people enter unemployment provides a robust indication of the mitigating health effects of unemployment generosity.

Vieillissement / Ageing

Foureur, N. (2016). "Plus de place au principe d'autonomie pour plus de respect des personnes âgées." Gérontologie et société **vol. 38 / 150**(2): 141-154.
http://www.cairn.info/revue-gerontologie-et-societe-2016-2-page-141.htm

Cet article traite de l'intervention médico-sociale auprès des personnes âgées hospitalisées ou institutionnalisées. À partir de cas et de résultats d'études qualitatives d'éthique clinique à propos des prises de décisions médicales en gériatrie, il semble que les arguments qui priment pour décider sont l'intérêt de la médicalisation, en termes curatifs ou de meilleure qualité de vie, le meilleur intérêt des proches, les questions logistiques, institutionnelles ou administratives, et également toutes les subjectivités et représentations individuelles des équipes soignantes ou encore l'égalité de l'accès aux soins. Ces arguments relèvent des principes bioéthiques de bienfaisance/non-malfaisance et de justice. Le principe du respect de l'autonomie de la personne est souvent disqualifié. Autrement dit, les « volontés » du patient semblent peser moins dans les décisions que les autres arguments. Bien que l'autonomie de la personne âgée puisse être moins accessible que chez les patients plus jeunes, elle peut se décliner à travers différentes formes. L'objectif est ici de montrer que les arguments relevant de l'autonomie permettent d'enrichir la discussion éthique préalable à la décision médicale afin d'être plus respectueux de la personne âgée.

Hoogendijk, E. O. (2016). "How effective is integrated care for community-dwelling frail older people? The case of the Netherlands." Age and Ageing **45**(5): 585-588.
http://ageing.oxfordjournals.org/content/45/5/585.abstract

Integrated care programs have been developed to enhance the quality care for older adults in primary care. These programs usually consist of a multidisciplinary approach, with personalised care based on comprehensive geriatric assessments. However, there is limited evidence for the effectiveness of these programs in frail older people. In this article, we review the results of three recent intervention studies carried out as part of the Dutch National Care for the Elderly Programme. The results illustrate how difficult it is to improve outcomes in community-dwelling frail older adults by means of integrated care. Furthermore, we discuss the implications of these studies for future research into frailty interventions.

Szanton, S. L., et al. (2016). "Home-Based Care Program Reduces Disability And Promotes Aging In Place." Health Affairs **35**(9): 1558-1563.
http://content.healthaffairs.org/content/35/9/1558.abstract

The Community Aging in Place, Advancing Better Living for Elders (CAPABLE) program, funded by the Center for Medicare and Medicaid Innovation, aims to reduce the impact of disability among low-income older adults by addressing individual capacities and the home environment. The program, described in this innovation profile, uses an interprofessional team (an occupational therapist, a registered nurse, and a handyman) to help participants achieve goals they set. For example, it provides assistive devices and makes home repairs and modifications that enable participants to navigate their homes more easily and safely. In the period 2012–15, a demonstration project enrolled 281 adults ages sixty-five and older who were dually eligible for Medicare and Medicaid and who had difficulty performing activities of daily living (ADLs). After completing the five-month program, 75 percent of participants had improved their performance of ADLs. Participants had difficulty with an average of 3.9 out of 8.0 ADLs at baseline, compared to 2.0 after five months. Symptoms of depression and the ability to perform instrumental ADLs such as shopping and managing medications also improved.

Health systems are testing CAPABLE on a larger scale. The program has the potential to improve older adults' ability to age in place.