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## Assurance maladie / Health Insurance

**Allaire, B. T., et al. (2016). "Who Wants Long-Term Care Insurance? A Stated Preference Survey of Attitudes, Beliefs, and Characteristics." *Inquiry : The Journal of Health Care Organization, Provision, and Financing* 53.**

<http://ing.sagepub.com/content/53/0046958016663728.abstract>

Approximately half of people turning 65 years between 2015 and 2019 are projected to need long-term support and services. Yet the long-term care insurance (LTCI) market is depressed, with only 7.4 million people owning policies. The objective of this study was to provide an analysis of potential LTCI purchasers. We investigate (1) who wants to purchase LTCI, (2) what are the attitudes and beliefs among those who have a preference for LTCI, and (3) who would prefer a law mandating the purchase of LTCI and how that view relates to willingness to purchase LTC. We combine a discrete choice experiment with a survey on attitudes toward LTCI. We estimate odds ratio for choosing a plan based on sociodemographic characteristics, attitudes, and beliefs. Our sample consists of a population of 12 936 people who completed an Internet panel survey. Female respondents were substantially less likely to choose an LTCI plan (OR = 0.74). Income and assets over \$100 000 were strong predictors of LTCI uptake (OR = 1.27 and OR = 1.48, respectively). Having adult children live close by was not associated with preference for LTCI. People who support almost any government intervention are more likely to purchase private insurance (OR = 1.12-1.33). Minorities expressed a preference for mandatory enrollment relative to whites. There is a relationship between attitudes toward long-term care financing reform and preference for LTCI, but it is not limited to supporters of private sector initiatives. While support for mandatory LTCI is low overall, it is strongest among racial/ethnic minorities and people with health problems, who potentially have the most to gain.

**Baird, K. (2016). "High Out-of-Pocket Medical Spending among the Poor and Elderly in Nine Developed Countries." *Health Serv Res* 51(4): 1467-1488.**

**OBJECTIVE:** The design of health insurance, and the role out-of-pocket (OOP) payments play in it, is a key policy issue as rising health costs have encouraged greater cost-sharing measures. This paper compares the percentage of Americans spending large amounts OOP to meet their health needs with percentages in eight other developed countries. By disaggregating by age and income, the paper focuses on the poor and elderly populations within each. **DATA SOURCE:** The study uses nationally representative household survey data made available through the Luxembourg Income Study. It includes nations with high, medium, and low levels of OOP spending. **STUDY DESIGN:** Households have high medical spending when their OOP expenditures exceed a threshold share of income. I calculate the share of each nation's population, as well as subpopulations within it, with high OOP expenditures. **PRINCIPAL FINDINGS:** The United States is not alone in exposing large numbers of citizens to high OOP expenses. In six of the other eight countries, one-quarter or more of low-income citizens devoted at least 5 percent of their income to OOP expenses, and in all but two countries, more than 1 in 10 elderly citizens had high medical expenses. **CONCLUSIONS:** For some populations in the sample nations, health insurance does not provide adequate financial protection and likely contributes to inequities in health care delivery and outcomes.

**Baji, P., et al. (2016). "Comparative analysis of decision maker preferences for equity/efficiency attributes in reimbursement decisions in three European countries." *Eur J Health Econ* 17(7): 791-799.**

**BACKGROUND:** 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. **OBJECTIVE:** To explore the preferences of policymakers and healthcare professionals involved in the decision-making process for different efficiency and equity attributes of interventions and to analyse cross-country differences. **METHOD:** Discrete choice experiments (DCEs) were carried out in Austria, Hungary, and Norway with

polymakers and other professionals working in the health industry (N = 153 respondents). Interventions were described in terms of different efficiency and equity attributes (severity of disease, target age of the population and willingness to subsidise others, potential number of beneficiaries, individual health benefit, and cost-effectiveness). Parameter estimates from the DCE were used to calculate the probability of choosing a healthcare intervention with different characteristics, and to rank different equity and efficiency attributes according to their importance. RESULTS: In all three countries, cost-effectiveness, individual health benefit and severity of the disease were significant and equally important determinants of decisions. All countries show preferences for interventions targeting young and middle aged populations compared to those targeting populations over 60. However, decision-makers in Austria and Hungary show preferences more oriented to efficiency than equity, while those in Norway show equal preferences for equity and efficiency attributes. CONCLUSION: We find that factors other than cost-effectiveness seem to play an equally important role in decision-making. We also find evidence of cross-country differences in the weight of efficiency and equity attributes.

**Dale, C. R., et al. (2016). "Counting Better — The Limits and Future of Quality-Based Compensation." *New England Journal of Medicine* 375(7): 609-611.**

<http://www.nejm.org/doi/full/10.1056/NEJMp1604897>

**Kisser, A., et al. (2016) "Factors influencing coverage decisions on medical devices: A retrospective analysis of 78 medical device appraisals for the Austrian hospital benefit catalogue 2008-2013;2015." *Health Policy* 120(8): 903-912.**

<http://dx.doi.org/10.1016/j.healthpol.2016.06.007>

We examined how various factors impact medical device coverage decisions in Austria. Several variables describing device characteristics and the evidence base were analysed. Evidence quality was a positive predictor for risk class II devices only. High risk device characteristics were positive predictors in the absence of RCTs' coverage possibly more likely for high risk devices combined with low evidence.

**Rosenthal, M. B., et al. (2016). "Pay for Performance in Medicaid: Evidence from Three Natural Experiments." *Health Serv Res* 51(4): 1444-1466.**

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

## E-santé / E-health

**Butler, R. J. et Johnson, W. G. (2016). "Rating the digital help: electronic medical records, software providers, and physicians." *International Journal of Health Economics and Management* 16(3): 269-283.**

<http://dx.doi.org/10.1007/s10754-016-9190-8>

To separate the effects of physicians' characteristics on the perceived productivity of EMRs from the effects of limitations on usability inherent in EMR design, a multivariate regression model is used to estimate the factors influencing physicians' rankings of five attributes of their EMRs, namely; ease of use and reliability; the EMRs effect on physician and staff productivity and the EMRs performance vs. vendor's promises. We divide the factors influencing the rankings into three groups: physician characteristics, EMR characteristics and practice characteristics (type of practice, size, and location). The data are from approximately 1800 practicing physicians in Arizona. Physician's characteristics influence perceived ease of use and physicians' productivity, but not staff productivity, reliability or vendors' promised performance. Practice type and EMR characteristics affect perceived productivity, reliability and performance versus vendors' promises. Vendor-specific effects are highly correlated across all five attributes and are always jointly significant. EMR characteristics are the most significant influence on physicians' perceptions of the EMRs effect on their productivity and that of their staff. Physicians' characteristics (particularly age) have a small but significant influence on perceived productivity.

**Fares, A. et Bernstein, D. A. (2016). "Organization of the Swiss model of primary care telemedicine. Is adoption by the French health system possible?" *Techniques Hospitalières*(758): 2 p.**

La Fédération française de télémédecine présente un extrait d'article publié dans la revue *European Research in Telemedicine*, qui pourrait intéresser les lecteurs de *Techniques hospitalières* (voir le sommaire dans la "Description" ci-dessous). L'article présenté ici a été publié dans le numéro de mars 2016 par Asma Fares et David Nathan Bernstein, qui développent le modèle suisse de télémédecine de premier recours et suggèrent son adaptabilité à la France (Fares A, Bernstein DN. Organization of the Swiss model of primary care telemedicine: Is adoption by the French health system possible? *Eur Res Telemed.* 2016 Mar;5(1) :3–8. <http://dx.doi.org/10.1016/j.eurテル.2016.01.001>).

**Cassagnes, J., C. (2016/07-08). "Cardiauvergne : service de télésurveillance et de coordination des soins des insuffisants cardiaques." *Technologies Hospitalières*(758).**

Cardiauvergne est un service de télésurveillance et de coordination des soins ouvert en décembre 2011. Deux principes : des professionnels de santé « maîtres du jeu » et une télésurveillance simple. Le dossier patient informatisé (DPI) est accessible grâce à la carte de professionnel de santé (CPS). Un système expert analyse les données et génère des alertes ou alarmes. Une évaluation après quatre ans et 1 084 patients montre un taux de décès de 12,1 % par an (versus 25 % avec prise en charge conventionnelle en Auvergne), des réhospitalisations pour nouvelle poussée d'insuffisance cardiaque réduites à 13,8 % par an (vs 21 % avant Cardiauvergne ) avec raccourcissement de la durée moyenne de séjour de 11,5 à 9,4 jours. L'économie est estimée à 5 430 €/patient/an moins le coût de Cardiauvergne qui est à 672 €/patient/an. Le taux de satisfaction est unanimement favorable. Un travail de recherche sur de nouveaux capteurs est en cours. Mots-clés : insuffisance cardiaque ; télésurveillance ; éducation thérapeutique ; réhospitalisation ; évaluation médico-économique.

## Economie de la santé / Health Economics

**Conrad, D. A., et al. (2016). "Implementing Value-Based Payment Reform: A Conceptual Framework and Case Examples." *Med Care Res Rev* 73(4): 437-457.**

This article develops a conceptual framework for implementation of value-based payment (VBP)

reform and then draws on that framework to systematically examine six distinct multi-stakeholder coalition VBP initiatives in three different regions of the United States. The VBP initiatives deploy the following payment models: reference pricing, "shadow" primary care capitation, bundled payment, pay for performance, shared savings within accountable care organizations, and global payment. The conceptual framework synthesizes prior models of VBP implementation. It describes how context, project objectives, payment and care delivery strategies, and the barriers and facilitators to translating strategy into implementation affect VBP implementation and value for patients. We next apply the framework to six case examples of implementation, and conclude by discussing the implications of the case examples and the conceptual framework for future practice and research.

**Dormont, B. et Peron, M. (2016). "Does Health Insurance Encourage the Rise in Medical Prices? A Test on Balance Billing in France." *Health Econ* 25(9): 1073-1089.**

We evaluate the causal impact of an improvement in insurance coverage on patients' decisions to consult physicians who charge more than the regulated fee. We use a French panel data set of 43,111 individuals observed from 2010 to 2012. At the beginning of the period, none of them were covered for balance billing; by the end, 3819 had switched to supplementary insurance contracts that cover balance billing. Using instrumental variables to deal with possible non-exogeneity of the decision to switch, we find evidence that better coverage increases demand for specialists who charge high fees, thereby contributing to the rise in medical prices. People whose coverage improves increased their average amount of balance billing per consultation by 32%. However, the impact of the coverage shock depends on the supply of physicians. For people residing in areas where few specialists charge the regulated fee, better coverage increases not only prices but also the number of consultations, a finding that suggests that balance billing might limit access to care. Conversely, in areas where patients have a genuine choice between specialists who balance bill and those who do not, we find no evidence of a response to better coverage. Copyright (c) 2016 John Wiley & Sons, Ltd.

**Grigorakis, N., et al. "Out of pocket payments and social health insurance for private hospital care: Evidence from Greece." *Health Policy* 120(8): 948-959.**

<http://dx.doi.org/10.1016/j.healthpol.2016.06.011>

We examine social health insurance's risk pooling mechanisms. We consider the catastrophic impact that health care OOPs may have on insured's income and well-being. Using data from Greece, we find that the OOPs for inpatient care in private hospitals have a positive relationship with SHI funding. We show that the SHI funding is inadequate to total inpatient financing.

**Hartmann, J., et al. (2016). "Analysing predictors for future high-cost patients using German SHI data to identify starting points for prevention." *The European Journal of Public Health* 26(4): 549-555.**

<http://eurpub.oxfordjournals.org/content/eurpub/26/4/549.full.pdf>

Background: Demographic change influences not only the terms of health care, but also its financing. Hence, prevention is becoming a more important key to facing upcoming challenges. Aim of this study was to identify predictors for future high-cost patients and derive implications for potential starting points for prevention. Methods: Claims data from a German statutory health insurance agency were used. High-cost patients were defined as the 10% most expensive persons to insure in 2011. The predictors stemmed from the previous year. Logistic regression with stepwise forward selection for 10 sex- and age-specific subgroups was performed. Model fit was assessed by Nagelkerke's R-squared value. Results: Model fit values indicated well-suited models that yielded better results among younger age-groups. Identified predictors can be summarized as different sets of variables that mostly pertain to diseases. Some are rather broad and include different disorders, like the set of mental/behavioural disorders including depression and schizophrenia; other sets of variables are more homogenous, such as metabolic diseases, with diabetes mellitus (DM) being the dominant member of every subgroup. Conclusion: Because diabetes was a significant predictor for future high-cost patients in all analysed subgroups, it should be considered as a potential starting point for prevention. The disease is specific enough to allow for the implementation of effective prevention strategies, and it is

possible to intervene, even in patients already affected by DM. Furthermore, the monetary savings potential is probably high because the long-term complications of DM are expensive to treat and affect a large part of the population.

**Hibbard, J. H., et al. (2016). "Improving Population Health Management Strategies: Identifying Patients Who Are More Likely to Be Users of Avoidable Costly Care and Those More Likely to Develop a New Chronic Disease." Health Serv Res.**

OBJECTIVE: To explore using the Patient Activation Measure (PAM) for identifying patients more likely to have ambulatory care-sensitive (ACS) utilization and future increases in chronic disease. DATA SOURCES: Secondary data are extracted from the electronic health record of a large accountable care organization. STUDY DESIGN: This is a retrospective cohort design. The key predictor variable, PAM score, is measured in 2011, and is used to predict outcomes in 2012-2014. Outcomes include ACS utilization and the likelihood of a new chronic disease. DATA: Our sample of 98,142 adult patients was drawn from primary care clinic users. To be included, patients had to have a PAM score in 2011 and at least one clinic visit in each of the three subsequent years. PRINCIPAL FINDINGS: PAM level is a significant predictor of ACS utilization. Less activated patients had significantly higher odds of ACS utilization compared to those with high PAM scores. Similarly, patients with low PAM scores were more likely to have a new chronic disease diagnosis over each of the years of observation. CONCLUSIONS: Assessing patient activation may help to identify patients who could benefit from greater support. Such an approach may help ACOs reach population health management goals.

**Meyer, S. (2016). "Dispensing physicians, asymmetric information supplier-induced demand: evidence from the Swiss Health Survey." International Journal of Health Economics and Management 16(3): 215-245.**

<http://dx.doi.org/10.1007/s10754-016-9187-3>

In this paper, we apply a two-part model to estimate the effect of health literacy on the demand for physician visits under different institutional settings. Using a constructed measure of health information, we find evidence for supplier-induced demand in some parts of Switzerland. While the level of health information is uncorrelated with the likelihood of visiting a physician (contact decision), the conditional number of visits (frequency decision) depends on the individual's information status and the regulation of physician drug dispensing. In cantons with a drug prescription scheme, we do not find a significant difference in the number of visits between well-informed individuals and people with relatively little health literacy. In contrast, the existence of self-dispensing general practitioner and specialists is associated with a gap in demand that is strongly related to health literacy: Compared to cantons with prescription schemes, uninformed patients exhibit a higher number of outpatient visits in the cantons that (partly) allow the dispensation of drugs by physicians. However, patients with a high level of health information seem to be rather unaffected by physician drug dispensing. As a consequence, we observe an information-related gap in the number of outpatient contacts that only prevails in areas where doctors are entitled to sell drugs themselves. These findings suggest that self-dispensing doctors succeed in inducing demand that affects the number of physician-patient contacts. Health literacy, on the other hand, tends to counter these incentives.

**Wong, C. Y., et al. (2016). "The Rise and Fall in Out-of-Pocket Costs in Australia: An Analysis of the Strengthening Medicare Reforms." Health Econ., Ahead of print.**

After a period of steady decline, out-of-pocket (OOP) costs for general practitioner (GP) consultations in Australia began increasing in the mid-1990s. Following the rising community concerns about the increasing costs, the Australian Government introduced the Strengthening Medicare reforms in 2004 and 2005, which included a targeted incentive for GPs to charge zero OOP costs for consultations provided to children and concession cardholders (older adults and the poor), as well as an increase in the reimbursement for all GP visits. This paper examines the impact of those reforms using longitudinal survey and administrative data from a large national sample of women. The findings suggest that the reforms were effective in reducing OOP costs by an average of \$A0.40 per visit.

Decreases in OOP costs, however, were not evenly distributed. Those with higher pre-reform OOP costs had the biggest reductions in OOP costs, as did those with concession cards. However, results also reveal increases in OOP costs for most people without a concession card. The analysis suggests that there has been considerable heterogeneity in GP responses to the reforms, which has led to substantial changes in the fees charged by doctors and, as a result, the OOP costs incurred by different population groups. Copyright (c) 2016 John Wiley & Sons, Ltd.

## Etat de santé / Health Status

**Bräker, A. B. et Soellner, R. (2016). "Alcohol drinking cultures of European adolescents." *The European Journal of Public Health* 26(4): 581-586.**

<http://eurpub.oxfordjournals.org/content/eurpub/26/4/581.full.pdf>

Background: Adolescent alcohol use varies across Europe. Differences in use might be due to variations in social drinking norms. These norms become apparent, e.g. in different proportions of alcohol drinking types per country. This study's purpose is to cluster European countries according to prevalence rates of alcohol drinking habits among adolescents aged 12–16. Methods: Based on results of previously done cluster analyses regarding alcohol use patterns in Europe, a second level hierarchical cluster analysis is performed. To do so, the proportions of each drinking pattern per country (non, mild, episodic, frequent and heavy episodic use) across 25 European countries (N = 48 423, M = 13.83 years, 48.5% male) are used as classifying variables. Results: Three country clusters are extracted that differentiate between eight countries with 'mainly non-using' adolescents, six countries with adolescents who use alcohol in a 'mainly mild but frequent' way and 11 countries that show the 'highest proportions of (heavy) episodic drinking adolescents'. Conclusions: When applying and developing intervention strategies, differences in adolescent alcohol drinking cultures (i.e. social drinking norms) within Europe should be focused on. Alcohol policies and prevention programs should take cultural aspects like social drinking norms into account.

**Croezen, S., et al. (2016). "Self-perceived health in older Europeans: Does the choice of survey matter?" *The European Journal of Public Health* 26(4): 686-692.**

<http://eurpub.oxfordjournals.org/content/eurpub/26/4/686.full.pdf>

Background: Cross-national comparisons of health in European countries provide crucial information to monitor health and disease within and between countries and to inform policy and research priorities. However, variations in estimates might occur when information from cross-national European surveys with different characteristics are used. We compared the prevalence of very good or good self-perceived health across 10 European countries according to three European surveys and investigated which survey characteristics contributed to differences in prevalence estimates. Methods: We used aggregate data from 2004 to 2005 of respondents aged 55–64 years from the European Union Statistics on Income and Living Conditions (EU-SILC), the Survey of Health, Ageing and Retirement in Europe (SHARE) and the European Social Survey (ESS). Across the surveys, self-perceived health was assessed by the same question with response options ranging from very good to very bad. Results: Despite a good correlation between the surveys (intraclass correlation coefficient: 0.77), significant differences were found in prevalence estimates of very good or good self-perceived health. The survey response, sample size and survey mode contributed statistically significantly to the differences between the surveys. Multilevel linear regression analyses, adjusted for survey characteristics, showed a higher prevalence for SHARE (+6.96, 95% CIs: 3.14 to 10.8) and a lower prevalence (–3.12; 95% CIs: –7.11 to 0.86) for ESS, with EU-SILC as the reference survey. Conclusion: Three important health surveys in Europe showed substantial differences for presence of very good or good self-perceived health. These differences limit the usefulness for direct comparisons across studies in health policies for Europe.

**Healey, J. S., et al. "Occurrence of death and stroke in patients in 47 countries 1 year after**

**presenting with atrial fibrillation: a cohort study."** *The Lancet*, Ahead of print.  
[http://dx.doi.org/10.1016/S0140-6736\(16\)30968-0](http://dx.doi.org/10.1016/S0140-6736(16)30968-0)

Background: Atrial fibrillation is an important cause of morbidity and mortality worldwide, but scant data are available for long-term outcomes in individuals outside North America or Europe, especially in primary care settings.

## Géographie de la santé / Geography of Health

**Brown, E. J., et al. (2016). "Racial Disparities In Geographic Access To Primary Care In Philadelphia."** *Health Affairs* **35**(8): 1374-1381.  
<http://content.healthaffairs.org/content/35/8/1374.abstract>

Primary care is often thought of as the gateway to improved health outcomes and can lead to more efficient use of health care resources. Because of primary care's cardinal importance, adequate access is an important health policy priority. In densely populated urban areas, spatial access to primary care providers across neighborhoods is poorly understood. We examined spatial variation in primary care access in Philadelphia, Pennsylvania. We calculated ratios of adults per primary care provider for each census tract and included buffer zones based on pre-specified drive times around each tract. We found that the average ratio was 1,073; the supply of primary care providers varied widely across census tracts, ranging from 105 to 10,321. We identified six areas of Philadelphia that have much lower spatial accessibility to primary care relative to the rest of the city. After adjustment for sociodemographic and insurance characteristics, the odds of being in a low-access area were twenty-eight times greater for census tracts with a high proportion of African Americans than in tracts with a low proportion of African Americans.

**Hoyez, A.-C., et al. (2016). "Parallel worlds? French and anglophone perspectives on health geography."** *Social Science & Medicine* **165**: 196-200.  
<http://www.sciencedirect.com/science/article/pii/S0277953616300302>

In this short commentary, we address the following question: setting aside the issue of translation, do health geographers in France speak the same language as their English-speaking counterparts in various parts of the world? Specifically, do they have comparable empirical, theoretical and political concerns? We briefly survey the 'states of knowledge' in both fields for points of difference and similarity. We devote particular attention to the diverse contexts in which health geography is practiced. Our overarching goal is not to oppose two 'blocks'; nor is it to produce syntheses of two bodies of work. Rather, we seek to identify the diverse contexts in which geographic knowledge of health issues is produced, and to encourage reflection on what these mean for current and future collaboration across linguistic boundaries. We contend that meaningful Anglo-French comparative work will need to be particularly attentive to takes on theory that is 'the same, but different', to alternative spatial lenses (territory vs. place), and to sometimes sharply distinct perspectives on social difference.

**Padilla, C. et al., e. (2016). "Création d'indicateurs géographiques pour caractériser les disparités territoriales de santé, Nice, France."** *Revue d'Epidémiologie et de Santé Publique* **64**(S4): PS192.

L'objectif est d'évaluer les inégalités territoriales de santé en lien avec la mortalité infantile à une échelle fine, en analysant comment les indicateurs socioéconomiques, d'accès aux soins et d'expositions environnementales interagissent et s'accumulent entre eux sur le territoire. Méthodes : À l'aide de systèmes d'informations géographiques, des indicateurs géographiques ont été créés : indicateur de défaveur, de proximité aux routes majeures, et aux espaces verts, et des indicateurs d'accessibilité et de densité des soins. Les cas ont été collectés à l'aide des certificats de décès dans les

mairies de toutes les communes de l'agglomération niçoise et géocodées à l'aide de l'adresse de résidence des parents. Une analyse en composante principale et une classification nous a permis de caractériser nos IRIS en fonction de ces critères bien différents par nature et un modèle de régression de Poisson a été réalisé pour analyser la relation avec la mortalité infantile. Résultats : Les résultats montrent que malgré l'existence d'inégalités environnementales et d'inégalités sociales de santé en lien avec la mortalité infantile, la proximité des installations de santé liées à la mère et au nouveau-né des quartiers les plus défavorisés permet de ne pas conclure d'inégalités territoriales de santé en lien avec la mortalité infantile à l'échelle de l'IRIS sur l'agglomération niçoise. Conclusion : Cette étude montre l'intérêt d'une approche locale à fine échelle caractérisée par de multiples critères afin d'étudier les inégalités territoriales de santé.

## Hôpital / Hospitals

**Pladys, A., et al. (2016). "Hémodialyse quotidienne, accès à la greffe rénale et survie des patients." *Revue d'Epidémiologie et de Santé Publique* 64(S4): PS190.**

L'hémodialyse quotidienne (HDQ) a été développée afin d'améliorer la qualité de vie des patients ainsi que l'épuration sanguine. Néanmoins, son effet sur la survie reste controversé et son lien avec l'accès à la greffe rénale n'a jamais été mesuré. Population et méthodes : Tous les patients incidents majeurs, ayant démarré une HDQ entre 2003 et 2012 en France ont été inclus. En utilisant un score de propension, chaque patient en HDQ a été apparié à trois patients en HD 3x/semaine. Les données ont été extraites du Registre épidémiologique et information en néphrologie (REIN). Les modèles de Fine & Gray et Cox ont été utilisés pour étudier le lien entre l'HDQ et l'accès à la greffe ainsi que la survie. Résultats : Nous avons inclus 575 patients en HDQ et 1696 en HD 3x/semaine. Au 31 décembre 2013, 48 % des patients en HDQ et 32,5 % des patients en HD 3x/semaine étaient décédés. Après ajustement sur l'âge, le sexe et les comorbidités, l'HDQ était associée avec un sur-risque de décès (HR=1,58 ; IC 95 % : 1,4–1,8). Après ajustement sur l'âge, le sexe et les comorbidités, l'HDQ n'était plus associée significativement avec l'inscription sur la liste d'attente. Après ajustement, les patients en HDQ avaient moins de chance d'être greffé que les patients en HD 3x/semaine (SHR=0,74 ; IC 95 % : 0,58–0,95). La probabilité d'être greffé deux ans après l'inscription était de 30 % pour les patients en HDQ et de 38 % pour ceux en HD 3x/semaine. Discussion : En France, les patients en HDQ décèdent plus et ont moins de chance d'être greffés que les patients en HD 3x/semaine. Les patients en HDQ présentent des profils très variés et malgré la prise en compte de leurs caractéristiques, notre étude n'explique pas pourquoi ce traitement, qui paraît plus proche du rôle physiologique du rein, est associé avec un sur-risque de décès.

**Vogt, V., et al. (2016). "Continuity of care in the ambulatory sector and hospital admissions among patients with heart failure in Germany." *Eur J Public Health*.**

BACKGROUND: Heart failure is one of the most cost-intensive chronic diseases and the most common cause of hospitalization. More than 60% of the treatment costs of heart failure are incurred in the inpatient sector in Germany. However, hospital admissions due to heart failure are considered to be potentially avoidable through effective and continuous ambulatory care. Our aim is to examine whether continuity in ambulatory care is associated with hospitalizations due to heart failure. METHODS: Using insurance claims data from Germany's biggest statutory health insurance company, we defined three measures of continuity of care: Continuity of Care Index (COCI), Usual Provider Index (UPC) and the Sequential Continuity Index (SECON). We analyzed whether these measures are associated with hospitalization due to heart failure using separate logistic regression models. We controlled for a wide range of covariates such as sex, age and the Charlson comorbidity index. RESULTS: Data of 382 118 heart failure patients were included in the analyses. Index values range from 0.77 to 0.89. Results of logistic regression analyses indicate that the continuity indices COCI, UPC and SECON based on visits to general practitioners (GPs), cardiologists and internists are negatively associated with the probability of hospitalization whereas of the continuity indices based on GP visits

only SECON is significantly associated with hospitalization. CONCLUSION: The results indicate that the overall continuity in the ambulatory sector is high for heart failure patients in Germany. Public policy should, nevertheless, focus on increasing sequential continuity of specialist and generalist ambulatory care as this was found to be significantly associated with a reduced likelihood of hospitalization.

## Inégalités de santé / Health Inequalities

**Chéron, A. (2016). "Dépréciation du capital humain et formation continue au cours du cycle de vie : Quelle dynamique des externalités sociales ?" *Revue d'Economie Politique* 126(3): 435-462.**

Dans cette étude, nous présentons un cadre théorique permettant d'analyser les interactions entre investissements en capital humain, turbulence économique et cycle de vie afin d'examiner la dynamique des externalités sociales liées à la formation générale. L'existence de telles externalités conduit à exclure certains travailleurs du système de formation professionnelle, à tort du point de vue de ce qui serait socialement souhaitable. Il convient donc de proposer une politique de soutien à la formation ciblée vers certains types de travailleurs. Notre principale contribution consiste à positionner cette problématique des externalités sociales de la formation continue dans la perspective du cycle de vie du travailleur, et de souligner qu'il serait nécessaire de mettre en place une politique d'incitation à la formation dépendante de l'âge. Nous montrons en effet que les employeurs tendent à accroître trop tôt dans le cycle de vie des travailleurs leur critère d'accès à la formation continue relativement à ce que suggérerait de faire la prise en compte des externalités sociales. En revanche, en toute fin de carrière (à l'approche de la retraite) le rendement social converge vers le rendement privé de la formation et tend vers zéro. Au bilan, ceci plaide donc pour une politique incitative non monotone avec l'âge, croissante jusqu'à un certain âge, puis décroissante ensuite.

**Ginsburg, C., et al. (2016). "Healthy or unhealthy migrants? Identifying internal migration effects on mortality in Africa using health and demographic surveillance systems of the INDEPTH network." *Social Science & Medicine* 164: 59-73.**

<http://www.sciencedirect.com/science/article/pii/S0277953616303252>

Migration has been hypothesised to be selective on health but this healthy migrant hypothesis has generally been tested at destinations, and for only one type of flow, from deprived to better-off areas. The circulatory nature of migration is rarely accounted for. This study examines the relationship between different types of internal migration and adult mortality in Health and Demographic Surveillance System (HDSS) populations in West, East, and Southern Africa, and asks how the processes of selection, adaptation and propagation explain the migration-mortality relationship experienced in these contexts. The paper uses longitudinal data representing approximately 900 000 adults living in nine sub-Saharan African HDSS sites of the INDEPTH Network. Event History Analysis techniques are employed to examine the relationship between all-cause mortality and migration status, over periods ranging from 3 to 14 years for a total of nearly 4.5 million person-years. The study confirms the importance of migration in explaining variation in mortality, and the diversity of the migration-mortality relationship over a range of rural and urban local areas in the three African regions. The results confirm that the pattern of migration-mortality relationship is not exclusively explained by selection but also by propagation and adaptation. Consequences for public health policy are drawn.

**Kihal, W., et al. (2016). "Inégalités sociales et insuffisance rénale chronique terminale." *Revue d'Epidémiologie et de Santé Publique* 64(S4): PS176.**

Contexte : Plusieurs études ont mis en évidence une relation entre la défaveur sociale et les différents aspects de l'insuffisance rénale chronique terminale (IRCT) : l'incidence de l'IRCT, la prise en charge tardive par un néphrologue et l'accès à la transplantation rénale. À notre connaissance, aucune étude

n'a investigué le lien entre les inégalités sociales et l'IRCT à l'échelle géographique infra-communale en France. Objectif : L'objectif de notre étude est d'examiner l'association entre les données contextuelles du lieu de résidence et l'accès à la greffe rénale (accès à la liste puis à la greffe) ainsi que la survie des patients en IRCT à partir du registre REIN. Matériel et méthode : L'adresse de 2006 cas incidents de l'IRCT ayant démarré la dialyse, entre 2004 et 2009, en Bretagne a été géocodée à l'échelle infra-communale de l'IRIS (Ilôts regroupés pour l'information statistique). Chaque IRIS a été caractérisé par le degré d'urbanisation et le niveau de défaveur socio-économique. Un modèle de Cox ajusté sur les données démographiques et bio-cliniques des patients a été mis en place pour étudier le lien entre la défaveur sociale et : i) l'accès à la liste d'attente ; ii) l'accès à la greffe, et iii) la survie des patients. Résultats/Discussion :Après l'ajustement sur l'âge et les comorbidités, le niveau de défaveur sociale et le degré d'urbanisation du lieu de résidence n'influencent pas significativement l'accès à la liste, à la greffe ou la survie. Bien que la défaveur sociale joue un rôle dans les variations spatiales de l'incidence de l'IRCT, elle ne constitue pas un frein à l'accès à la liste d'attente ou à la greffe en Bretagne. Une des hypothèses avancées est que la politique de santé en France garantit une prise en charge à 100 % des patients en IRCT quel que soit leur niveau de défaveur, contrairement aux pays anglo-saxons.

**Popescu, I., et al. (2016). "Racial/Ethnic and Socioeconomic Differences in Colorectal and Breast Cancer Treatment Quality: The Role of Physician-level Variations in Care." Medical Care 54(8): 780-788.**

[http://journals.lww.com/lww-medicalcare/Fulltext/2016/08000/Racial\\_Ethnic\\_and\\_Socioeconomic\\_Differences\\_in.8.aspx](http://journals.lww.com/lww-medicalcare/Fulltext/2016/08000/Racial_Ethnic_and_Socioeconomic_Differences_in.8.aspx)

Background: Despite a large body of research showing racial/ethnic and socioeconomic disparities in cancer treatment quality, the relative role of physician-level variations in care is unclear. Objective: To examine the effect of physicians on disparities in breast and colorectal cancer care. Subjects: Linked SEER Medicare data were used to identify Medicare beneficiaries diagnosed with colorectal and breast cancer during 1995–2007 and their treating physicians. Research Design: We identified treating physicians from Medicare claims data. We measured the use of NIH guideline–recommended therapies from SEER and Medicare claims data, and used logistic models to examine the relationship between race/ethnicity, socioeconomic status, and cancer quality of care. We used physician fixed effects to account for between-physician variations in treatment. Results: Minority and low socioeconomic status beneficiaries with breast and colorectal cancer were less likely to receive any recommended treatments as compared with whites. Overall, between-physician variation explained <20% of the total variation in quality of care. After accounting for between-physician differences, median household income explained 14.3%, 18.4%, and 13.2% of the variation in use of breast-conserving surgery, chemotherapy, and radiation for breast cancer, and 13.7%, 12.9%, and 12.6% of the within-physician variation in use of colorectal surgery, chemotherapy, and radiation for colorectal cancer, whereas race and ethnicity explained <2% of the within-physician variation in cancer care. Conclusions: Between-physician variations partially explain racial disparities in cancer care. Residual within-physician disparities may be due to differences in patient-provider communication, patient preferences and treatment adherence, or unmeasured clinical severity.

**Skogberg, N., et al. (2016). "Cardiovascular risk factors among Russian, Somali and Kurdish migrants in comparison with the general Finnish population." The European Journal of Public Health 26(4): 667-673.**

<http://eurpub.oxfordjournals.org/content/eurpub/26/4/667.full.pdf>

Background: There is limited information on cardiovascular risk among migrants. We compared cardiovascular risk factors among three major migrant groups in Finland with the general population. Methods: Cross-sectional data from 30- to 64-year-old health examination participants (n = 921) of the Migrant Health and Wellbeing Study (2010–12) were used. Data for comparison with the general Finnish population were obtained from the Health 2011 Study (n = 892). Results: Russian men had a similar risk profile to that of the reference group. Kurdish men had lower prevalence of hypertension [prevalence ratio (PR) 0.55, 95% confidence interval (CI) 0.39–0.79] but higher prevalence of

dyslipidaemia (PR: 1.12, 95% CI: 1.02–1.24) and hyperglycaemia (PR: 2.61, 95% CI: 1.88–3.64) compared with the reference group. Somali men had lower prevalence of smoking (PR: 0.18, 95% CI: 0.08–0.44), hypertension (PR: 0.55, 95% CI: 0.32–0.97) and obesity (PR: 0.35, 95% CI: 0.17–0.71) but higher prevalence of hyperglycaemia (PR: 2.59, 95% CI: 1.73–3.86) compared with the reference group. Similar patterns were observed for women, except for higher prevalence of hyperglycaemia among Russian women (PR: 1.95, 95% CI: 1.26–3.01) and obesity among Kurdish and Somali women (PR: 1.41, 95% CI: 1.15–1.72 and PR: 1.68, 95% CI: 1.40–2.03, respectively) compared with the reference group. All migrant women had significantly lower prevalence of smoking than the reference group. Conclusions: There were significant variations in cardiovascular risk profiles of Kurdish and Somali migrants compared with the general population. Differences in cardiovascular risk factors by migrant group need to be taken into account in planning and implementing health promotion strategies.

**Stipkova, M. (2016). "Immigrant disadvantage or the healthy immigrant effect? Evidence about low birth weight differences in the Czech Republic." *Eur J Public Health* 26(4): 662-666.**

BACKGROUND: Most of the research about immigrants' birth outcomes comes from countries with high numbers of immigrants. This article provides evidence from the Czech Republic, a country with a short immigration history and a small immigrant population. Two hypotheses are tested: the immigrant disadvantage hypothesis and the healthy immigrant hypothesis. METHODS: Live singleton births in 2013-14 from the national birth register are analysed. The odds of low birth weight (LBW) among the native population and five immigrant groups are compared using logistic regression. Control variables include maternal age, parity, education and marital status, paternal immigrant status, age and education. RESULTS: All immigrant groups, except for Slovaks, showed smaller odds of LBW than native mothers. Adjusted odds ratios for non-Slovak immigrants range between 0.52 and 0.65. Furthermore, maternal immigrant status interacts with education. There is a wide educational gradient in LBW among Czech and Slovak mothers with low education representing a large disadvantage. Such pattern is not present among other ethnic groups. This makes the outcomes of Czech and Slovak mothers less favourable. Native mothers and immigrants with higher level of education show more similar outcomes. Paternal immigrant status does not have a net effect on LBW when maternal ethnicity is taken into account. CONCLUSIONS: Results provide evidence for the healthy immigrant effect. The favourable outcomes of non-Slovak immigrants seem to result from a combination of two factors, health selection of immigrants and relatively high prevalence of LBW in the native population caused by adverse outcomes of mothers with low education.

**Tunstall, H. V. Z., et al. (2016). "Are migration patterns and mortality related among European regions?" *The European Journal of Public Health* 26(4): 724-726.**

<http://eurpub.oxfordjournals.org/content/eurpub/26/4/724.full.pdf>

Geographical inequalities in mortality across Europe may be influenced by migration between regions. The relationship between age- and sex-standardised death rates, 2008–2010, and population change resulting from migration 2000–2010, was analysed in 250 'Nomenclature of Statistical Territorial Units' (NUTS) level 2 regions in 26 European countries. Across Europe death rates were significantly higher in regions experiencing population loss. This association continued after adjustment for 2005 household income among all regions and Western regions but not among Eastern areas. This analysis suggests migration could contribute to Europe's persistent inequalities in mortality, and highlights the problems of Eastern regions with the highest death rates, lowest incomes and declining populations.

## Médicaments / Pharmaceuticals

**Bergman, M. A., et al. (2016). "Reforming the Swedish pharmaceuticals market: consequences for costs per defined daily dose." *International Journal of Health Economics and Management* 16(3):**

201-214.

<http://dx.doi.org/10.1007/s10754-016-9186-4>

In 2009 and 2010, the Swedish pharmaceuticals market was reformed. One of the stated policy goals was to achieve low costs for pharmaceutical products dispensed in Sweden. We use price and sales data for off-patent brand-name and generic pharmaceuticals to estimate a log-linear regression model, allowing us to assess how the policy changes affected the cost per defined daily dose. The estimated effect is an 18 % cost reduction per defined daily dose at the retail level and a 34 % reduction in the prices at the wholesale level (pharmacies' purchase prices). The empirical results suggest that the cost reductions were caused by the introduction of a price cap, an obligation to dispense the lowest-cost generic substitute available in the whole Swedish market, and the introduction of well-defined exchange groups. The reforms thus reduced the cost per defined daily dose for consumers while being advantageous also for the pharmacies, who saw their retail margins increase. However, pharmaceutical firms supplying off-patent pharmaceuticals experienced a clear reduction in the price received for their products.

**Lichtenberg, F. R. (2016). "The impact of pharmaceutical innovation on premature cancer mortality in Switzerland, 1995-2012." *Eur J Health Econ* 17(7): 833-854.**

The premature cancer mortality rate has been declining in Switzerland, but there has been considerable variation in the rate of decline across cancer sites (e.g., breast or digestive organs). I analyze the effect that pharmaceutical innovation had on premature cancer mortality in Switzerland during the period 1995-2012 by investigating whether the cancer sites that experienced more pharmaceutical innovation had larger declines in premature mortality, controlling for the number of people diagnosed and mean age at diagnosis. Premature cancer mortality before ages 75 and 65 is significantly inversely related to the cumulative number of drugs registered 5, 10, and 15 years earlier. The number of drugs registered during 1980-1997 explains 63 % of the variation across cancer sites in the 1995-2012 log change in the premature (before age 75) mortality rate. Controlling for the cumulative number of drugs, the cumulative number of chemical subgroups does not have a statistically significant effect on premature mortality. This suggests that drugs (chemical substances) within the same class (chemical subgroup) are not "therapeutically equivalent". Over 17,000 life-years before age 75 were gained in 2012 due to drugs registered during 1990-2007. The number of life-years before age 75 gained in 2012 from drugs registered during two earlier periods (1985-2002 and 1980-1997) were more than twice as great. Since mean utilization of new drugs is much lower than mean utilization of older drugs, more recent drug registrations may have a smaller effect on premature mortality than earlier drug registrations even if the average quality of newer drugs is higher. Estimates of the cost per life-year gained before ages 75 and 65 in 2012 from drugs registered during 1990-2007 are \$21,228 and \$28,673, respectively. These figures are below even the lowest estimates from the value-of-life literature of the value of a quality-adjusted life-year. The estimates indicate that the cost per life-year before age 75 gained from drugs registered during earlier periods (1985-2002 and 1980-1997) were considerably lower: \$5299 and \$3218, respectively. The largest reductions in premature mortality occur at least a decade after drugs are registered, when their utilization increases significantly. This suggests that if Switzerland is to obtain substantial additional reductions in premature cancer mortality in the future (a decade or more from now) at a modest cost, pharmaceutical innovation (registration of new drugs) is needed today.

**Mueller, T. et Östergren, P.-O. "The correlation between regulatory conditions and antibiotic consumption within the WHO European Region." *Health Policy* 120(8): 882-889.**

<http://dx.doi.org/10.1016/j.healthpol.2016.07.004>

The correlation between regulatory conditions and antibiotic consumption throughout the WHO Europe region was studied. Countries with high levels of regulation observe less consumption of antibiotics. Associations between specific regulatory aspects and antibiotic consumption differ between countries, possibly due to contextual aspects.

**Pilorge, C. "Monopole officinal et concurrence en prix pour la délivrance des médicaments non**

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**remboursables : l'exemple français." *Revue Economique* 67(5): 1057-1084.**

Cette étude analyse l'existence d'une concurrence en prix sur le marché des médicaments non remboursables, dans un cadre de monopole officinal en France. À partir de données de prix mensuelles pour trente médicaments pour un échantillon de 4 700 pharmacies, entre 2006 et 2008, le niveau des prix est comparé selon le degré de concurrence dans l'environnement proche de la pharmacie, mesurée à partir d'un indicateur fin de densité communale. Les résultats indiquent que la concurrence s'exerce très peu sur ce segment de marché. Alors que le degré de concurrence est très variable entre les pharmacies, la plupart d'entre elles vendent au même prix. Ces résultats interrogent sur les effets d'une ouverture de ce marché à de nouveaux entrants, au regard des expériences étrangères.

**Zhang, W., et al. (2016). "The Impact of Price-cap Regulations on Exit by Generic Pharmaceutical Firms." *Medical Care* 54(9): 884-890.**

[http://journals.lww.com/lww-medicalcare/Fulltext/2016/09000/The\\_Impact\\_of\\_Price\\_cap\\_Regulations\\_on\\_Exit\\_by.10.aspx](http://journals.lww.com/lww-medicalcare/Fulltext/2016/09000/The_Impact_of_Price_cap_Regulations_on_Exit_by.10.aspx)

Background: In 1998, the Province of Ontario in Canada adopted price-cap "70/90" regulations whereby the first generic entrant was required to be priced at  $\leq 70\%$  of the associated brand-name product and subsequent generics were priced at  $\leq 90\%$  of the first generic price. The price-caps were further lowered to 50% in 2006 and 25% in 2010. This study assessed the impact of such price-cap regulations on exit by generic drug firms. Methods: Formulary (2003–2012) listings of prescription drugs covered under the Ontario Drug Benefit program were used. The formulary tracks the "status" (on formulary, discontinued by manufacturer, and delisted for other reasons) for each drug. Markets were defined based on unique active ingredient and form within Ontario. Firm exit occurred when a manufacturer discontinued all its generic drugs within a market. The exit rate was defined as the number of generic firm-market exits divided by total generic firm-market follow-up years. Poisson regression was used to compare the exit rates during the 3 policy periods ("25," "50," and "70/90"). Results: A total of 1126 generic manufacturers paired with 290 markets were identified. The exit rate ratio during the 25% price-cap period compared with the 70%/90% period was 2.42 (95% confidence interval, 1.56–3.77). A small manufacturer or a manufacturer in a market with  $\geq 3$  competitors or in an older market was more likely to exit. Conclusions: Lowering the price-cap level is associated with a higher incidence of generic firm exit from markets. Continuously reducing price-caps may have the unintended consequence of forcing generic firms to exit.

## Méthodologie – Statistique / Methodology - Statistics

**Morrissey, K., et al. (2016). "Web based health surveys: Using a Two Step Heckman model to examine their potential for population health analysis." *Social Science & Medicine* 163: 45-53.**

<http://www.sciencedirect.com/science/article/pii/S0277953616303434>

In June 2011 the BBC Lab UK carried out a web-based survey on the causes of mental distress. The 'Stress Test' was launched on 'All in the Mind' a BBC Radio 4 programme and the test's URL was publicised on radio and TV broadcasts, and made available via BBC web pages and social media. Given the large amount of data created, over 32,800 participants, with corresponding diagnosis, demographic and socioeconomic characteristics; the dataset are potentially an important source of data for population based research on depression and anxiety. However, as respondents self-selected to participate in the online survey, the survey may comprise a non-random sample. It may be only individuals that listen to BBC Radio 4 and/or use their website that participated in the survey. In this instance using the Stress Test data for wider population based research may create sample selection bias. Focusing on the depression component of the Stress Test, this paper presents an easy-to-use method, the Two Step Probit Selection Model, to detect and statistically correct selection bias in the Stress Test. Using a Two Step Probit Selection Model; this paper did not find a statistically significant

selection on unobserved factors for participants of the Stress Test. That is, survey participants who accessed and completed an online survey are not systematically different from non-participants on the variables of substantive interest.

## Politique de santé / Health Policy

**Storm, I., et al. (2016). "How to improve collaboration between the public health sector and other policy sectors to reduce health inequalities? – A study in sixteen municipalities in the Netherlands." *International Journal for Equity in Health* 15(1): 1-14.**

<http://dx.doi.org/10.1186/s12939-016-0384-y>

The causes of health inequalities are complex. For the reduction of health inequalities, intersectoral collaboration between the public health sector and both social policy sectors (e.g. youth affairs, education) and physical policy sectors (e.g. housing, spatial planning) is essential, but in local practice difficult to realize. The aim of this study was to examine the collaboration between the sectors in question more closely and to identify opportunities for improvement.

**Thornton, R. L. J., et al. (2016). "Evaluating Strategies For Reducing Health Disparities By Addressing The Social Determinants Of Health." *Health Affairs* 35(8): 1416-1423.**

<http://content.healthaffairs.org/content/35/8/1416.abstract>

The opportunities for healthy choices in homes, neighborhoods, schools, and workplaces can have decisive impacts on health. We review scientific evidence from promising interventions focused on the social determinants of health and discuss how such interventions can improve population health and reduce health disparities. We found sufficient evidence of successful outcomes to support disparity-reducing policy interventions targeted at education and early childhood; urban planning and community development; housing; income enhancements and supplements; and employment. Cost-effectiveness evaluations show that these interventions lead to long-term societal savings, but the interventions require more routine attention to cost considerations. We discuss challenges to implementation, including the need for long-term financing to scale up effective interventions for implementation at the local, state, and national levels.

## Prévention / Prevention

**(2016). "Activités physiques et santé." *Santé Publique* 28(1 - Supplément 2016): 189p.**

**Contandriopoulos, D., Hanusaik N. Maximova K., et al. (2016). " Mapping Collaborative Relations among Canada's Chronic Disease Prevention Organizations." *Healthcare Policy* 12(1): 101-115.**

<http://www.longwoods.com/publications/healthcare-policy/24636>

In the field of chronic disease prevention (CDP), collaborations between organizations provide a vital framework for intersectoral engagement and exchanges of knowledge, expertise and resources. However, little is known about how the structures of preventive health systems actually articulate with CDP capacity and outcomes. Drawing upon data from the Public Health Organizational Capacity Study; a repeat census of all public health organizations in Canada; we used social network analysis to map and examine interorganizational collaborative relationships in the Canadian preventive health system. The network of relationships obtained through our study shows that provincial boundaries remain a major factor influencing collaborative patterns. Not only are collaborations scarce on the interprovincial level but they are also mostly limited to links with federal and multi-provincial

organizations. Given this finding, federal or multi-provincial organizations that occupy central bridging positions in the Canadian CDP collaborative structure should serve as key players for shaping CDP practices in the country.

## Prévision – Evaluation / Prevision - Evaluation

Herida, M., et al. (2016). "Economic Evaluations of Public Health Surveillance Systems: a Systematic Review." *Eur J Public Health* **26**(4): 674-680.

## Psychiatrie / Psychiatry

Korkeila, J., et al. (2003). "Establishing a set of mental health indicators for Europe." *Scand J Public Health* **31**(6): 451-459.

AIMS: This review presents the background work for developing a set of mental health indicators as part of a comprehensive health monitoring system in the European Union. The review focuses on the appraisal of mental health at population level with special emphasis on assessments that could be useful for mental health promotion. METHODS: A functional model of mental health is used to delineate variables important for a set of mental health indicators. Variables that are not possible to monitor at population level are not discussed here. Literature searches were conducted through the MEDLINE, PSYCHLIT, and SOCIOLOGICAL ABSTRACTS databases and available textbooks. RESULTS: The review presents findings from research seeking associations between mental health and ill health and different individual, social, economic, ecological, and service-related characteristics. Specific domains as key starting points in establishing a set of mental health indicators are outlined according to the research findings. CONCLUSION: A set of mental health indicators can enhance the visibility of mental health issues in the European context. Ultimately the indicators could be used in estimating how the targets set for health policies are met, and whether there has been a measurable decrease in disability, suffering, and disease.

Raitakari, S., et al. (2016). "Tackling community integration in mental health home visit integration in Finland." *Health & Social Care in the Community* **24**(5): e53-e62.

<http://www.ingentaconnect.com/content/bsc/hsc/2016/0000024/0000005/art00006>

<http://dx.doi.org/10.1111/hsc.12246>

Integration and its synonym inclusion is emphasised in the western welfare states and in the European Union in particular. Integration is also a central topic in the social sciences and in current mental health and homelessness research and practice. As mental healthcare has shifted from psychiatric hospitals to the community, it has inevitably become involved with housing and integration issues. This article explores how community integration is understood and tackled in mental health floating support services (FSSs) and, more precisely, in service user-practitioner home visit interaction. The aim, through shedding light on how the idea of integration is present and discussed in front line mental health practices, is to offer a template on how we might, in a systematic and reflective way, develop community integration research and practice. The analysis is based on ethno-methodological and micro-sociological interaction research. The research settings are two FSSs located in a large Finnish city. The data contain 24 audio-recorded and transcribed home visits conducted in 2011 and 2012 with 16 different service users. The study shows how the participants in service user-practitioner interaction give meaning to community integration and make decisions about how it should (or should not) be enhanced in each individual case. This activity is called community integration work in action. Community integration work in action is based on various dimensions of integration: getting out of the house, participating in group activities and getting along with those involved in one's life and working life. Additionally, the analysis demonstrates how community integration work is

accomplished by discursive devices (resistance, positioning, excuses and justifications, delicacy and advice-giving). The article concludes that community integration is about interaction: it is not only service users' individual challenge but also a social challenge, our challenge.

## Soins de santé primaires / Primary Health Care

**Pendrith C., Thind A., Sisira, S. (2016). " Financial Incentives and Cervical Cancer Screening Participation in Ontario's Primary Care Practice Models." *Healthcare Policy* 12(1): 116-128.**  
<http://www.longwoods.com/publications/healthcare-policy/24636>

**Objectives:** The primary objective of this paper is to compare cervical cancer screening rates of family physicians in Ontario's two dominant reformed practice models, Family Health Group (FHG) and Family Health Organization (FHO), and traditional fee-for-service (FFS) model. Both reformed models formally enrol patients and offer extensive pay-for-performance incentives; however, they differ by remuneration for core services (FHG is FFS; FHO is capitated). The secondary objective is to estimate the average and marginal costs of screening in each model. **Methods:** Using administrative data on 7,298 family physicians and their 2,083,633 female patients aged 35; 69 eligible for cervical cancer screening in 2011, we assessed screening rates after adjusting for patient and physician characteristics. Predicted screening rates, fees and bonus payments were used to estimate the average and marginal costs of cervical cancer screening. **Results:** Adjusted screening rates were highest in the FHG (81.9%), followed by the FHO (79.6%), and then the traditional FFS model (74.2%). The cost of a cervical cancer screening was \$18.30 in the FFS model. The estimated average cost of screening in the FHGs and FHOs were \$29.71 and \$35.02, respectively, while the corresponding marginal costs were \$33.05 and \$39.06. **Discussion:** We found significant differences in cervical cancer screening rates across Ontario's primary care practice models. Cervical screening rates were significantly higher in practice models eligible for incentives (FHGs and FHOs) than the traditional FFS model. However, the average and marginal cost of screening were lowest in the traditional FFS model and highest in the FHOs.

**Iacobucci, G. (2016). "GP appointments should be 15 minutes long, says BMA." *Bmj* 354: i4709.**

**Iversen, T. et Mokienko, A. (2016). "Supplementing gatekeeping with a revenue scheme for secondary care providers." *International Journal of Health Economics and Management* 16(3): 247-267.**  
<http://dx.doi.org/10.1007/s10754-016-9188-2>

We study implications of a change in the payment scheme for radiology providers in Norway that was implemented in 2008. The change implies reduced fee-for-service and increased fixed budget for a contracted volume of services. A consequence of the change is that private providers have less incentive to conduct examinations beyond the contracted volume. Different from the situation observed before the change in 2008, the volume is no longer determined by the demand side, and a rationing of the supply occurs. We employ data on radiological examinations initiated by GPs' referrals. We apply monthly data at the physician-practice level for 2007–2010. The data set is unique because it includes information about all GPs in the Norwegian patient-list system. The results indicate that private providers conducted fewer examinations in 2008–2010 compared with previous periods and that public hospitals did either the same volume or more. We find that GPs who operate in a more competitive environment experienced a greater reduction in magnetic resonance imaging, both performed by private providers and in total for their patients. We argue that this result supports a hypothesis that patients with lower expected benefits are rationed. Hence, rationing from the supply side might supplement GP gatekeeping.

**Lionis, C., et al. (2016). "Engaging migrants and other stakeholders to improve communication in**

**cross-cultural consultation in primary care: a theoretically informed participatory study."**

BMJ Open 6(7).

<http://bmjopen.bmj.com/content/6/7/e010822.abstract>

Objectives Guidelines and training initiatives (G/TIs) are available to support communication in cross-cultural consultations but are rarely implemented in routine practice in primary care. As part of the European Union RESTORE project, our objective was to explore whether the available G/TIs make sense to migrants and other key stakeholders and whether they could collectively choose G/TIs and engage in their implementation in primary care settings. Setting As part of a comparative analysis of 5 linked qualitative case studies, we used purposeful and snowball sampling to recruit migrants and other key stakeholders in primary care settings in Austria, England, Greece, Ireland and the Netherlands. Participants A total of 78 stakeholders participated in the study (Austria 15, England 9, Ireland 11, Greece 16, Netherlands 27), covering a range of groups (migrants, general practitioners, nurses, administrative staff, interpreters, health service planners). Primary and secondary outcome measures We combined Normalisation Process Theory (NPT) and Participatory Learning and Action (PLA) research to conduct a series of PLA style focus groups. Using a standardised protocol, stakeholders' discussions about a set of G/TIs were recorded on PLA commentary charts and their selection process was recorded through a PLA direct-ranking technique. We performed inductive and deductive thematic analysis to investigate sense-making and engagement with the G/TIs. Results The need for new ways of working was strongly endorsed by most stakeholders. Stakeholders considered that they were the right people to drive the work forward and were keen to enrol others to support the implementation work. This was evidenced by the democratic selection by stakeholders in each setting of one G/ TI as a local implementation project. Conclusions This theoretically informed participatory approach used across 5 countries with diverse healthcare systems could be used in other settings to establish positive conditions for the start of implementation journeys for G/TIs to improve healthcare for migrants.

**Martsof, G. R., et al. (2016). "Creating Unidimensional Global Measures of Physician Practice Quality Based on Health Insurance Claims Data." *Health Serv Res.* [Epub ahead of print]**

OBJECTIVE: To explore the extent to which commonly used claims-based process quality indicators can be used to create an internally valid global composite measure of physician practice quality. DATA SOURCES: Health insurance claims data (October 2007-May 2010) from 134 physician practices in Seattle, WA. STUDY DESIGN: We use confirmatory and exploratory factor analysis to develop theory- and empirically driven internally valid composite measures based on 19 quality indicators. DATA COLLECTION METHODS: Health insurance claims data from nine insurance companies and self-funded employers were collected and aggregated by third-party organization. PRINCIPAL FINDINGS: Our results did not support a single global measure using the entire set of quality indicators. We did identify an acceptable multidimensional model (RMSEA = 0.059; CFI = 0.934; TLI = 0.910). The four dimensions in our data were diabetes, depression, preventive care, and generic drug prescribing. CONCLUSIONS: Our study demonstrates that commonly used process indicators can be used to create a small set of useful composite measures. However, the lack of an internally valid single unidimensional global measure has important implications for policy approaches meant to improve quality by rewarding "high-quality physicians."

**Nolte, E., et al. (2016). "Implementing integrated care: A synthesis of experiences in three European countries." *International Journal of Care Coordination.***<http://icp.sagepub.com/content/early/2016/06/29/2053434516655626.abstract>

Many countries are experimenting with new models to better integrate care; yet, innovative care models are often implemented as time-limited, localised projects with limited impact on service delivery more broadly. This paper seeks to understand the processes behind successful projects that achieved some form of 'routinisation' and informed system-wide integrated care strategies. It draws on detailed case studies of three integrated care experiments: the 'Integrated effort for people living with chronic diseases' project in Denmark; the *Gesundes Kinzigtal* network in Germany; and *Zio*, a care group in the Maastricht region in the Netherlands. It explores how they were developed, implemented

and sustained, and how they impacted the wider system context. All three models implicitly or explicitly adopted processes shown to be conducive to the dissemination of innovations, including dedicated time and resources, support and advocacy, leadership and management, stakeholder involvement, communication and networks, adaptation to local context and feedback. Each showed robust evidence of improvements on a number of service and patient outcomes and these findings were central to their wider impacts, shaping country-wide integrated care policies. However, the wider dissemination of projects occurred in an incremental and somewhat haphazard way. To further redesign health and social care a more formal strategy, alongside resources, may thus be needed to provide funders and providers with genuine incentives to invest in new business models of care. There remains a crucial need for better understanding of specific local conditions that influence implementation and sustainability to enable translation to other contexts and settings.

**Wilk, A. S. et Platt, J. E. (2016). "Measuring physicians' trust: A scoping review with implications for public policy." *Social Science & Medicine* 165: 75-81.**

<http://www.sciencedirect.com/science/article/pii/S0277953616304002>

Increasingly, physicians are expected to work in productive, trusting relationships with other health system stakeholders to improve patient and system outcomes. A better understanding of physicians' trust is greatly needed. This study assesses the state of the literature on physicians' trust in patients, other health care providers, institutions, and data systems or technology, and identifies key themes, dimensions of trust considered, quantitative measures used, and opportunities for further development via a scoping review. Peer-reviewed, English-language research articles were identified for inclusion in this study based on systematic searches of the Ovid/Medline, Pubmed, Proquest, Scopus, Elsevier, and Web of Science databases. Search terms included "trust" along with "physician," "doctor," "primary care provider," "family practitioner," "family practice," "generalist," "general practitioner," "general practice," "internist," "internal medicine," or "health professional," and plausible variants. Among the relevant articles identified (n = 446), the vast majority focused on patient trust in physicians (81.2%). Among articles examining physicians' trust, rigorous investigations of trust are rare, narrowly focused, and imprecise in their discussion of trust. Robust investigations of the effects of trust or distrust—as opposed to trust's determinants—and studies using validated quantitative trust measures are particularly rare. Studies typically measured trust using the language of confidence, effective communication, or cooperation, rarely or never capturing other important dimensions of trust, such as fidelity, the trustee's reputation, social capital, vulnerability, and acceptance. Research employing new, validated measures of physicians' trust, especially trust in institutions, may be highly informative to health system leaders and policymakers seeking to hone and enhance tools for improving the effectiveness and efficiency of the health care system.

**Yasaitis, L. C., et al. (2016). "Physicians' Participation In ACOs Is Lower In Places With Vulnerable Populations Than In More Affluent Communities." *Health Aff (Millwood)* 35(8): 1382-1390.**

Early evidence suggested that accountable care organizations (ACOs) could improve health care quality while constraining costs, and ACOs are expanding throughout the United States. However, if disadvantaged patients have unequal access to physicians who participate in ACOs, that expansion may exacerbate health care disparities. We examined the relationship between physicians' participation in both Medicare and commercial ACOs across the country and the sociodemographic characteristics of their likely patient populations. Physicians' participation in ACOs varied widely across hospital referral regions, from nearly 0 percent to over 85 percent. After we adjusted for individual physician and practice characteristics, we found that physicians who practiced in ZIP Code Tabulation Areas where a higher percentage of the population was black, living in poverty, uninsured, or disabled or had less than a high school education—compared to other areas—had significantly lower rates of ACO participation than other physicians. Our findings suggest that vulnerable populations' access to physicians participating in ACOs may not be as great as access for other groups, which could exacerbate existing disparities in health care quality.

## Systèmes de santé / Health Systems

**Obama, B. (2016). "United States Health Care Reform: Progress to Date and Next Steps." *Jama* 316(5): 525-532.**

**IMPORTANCE:** The Affordable Care Act is the most important health care legislation enacted in the United States since the creation of Medicare and Medicaid in 1965. The law implemented comprehensive reforms designed to improve the accessibility, affordability, and quality of health care. **OBJECTIVES:** To review the factors influencing the decision to pursue health reform, summarize evidence on the effects of the law to date, recommend actions that could improve the health care system, and identify general lessons for public policy from the Affordable Care Act. **EVIDENCE:** Analysis of publicly available data, data obtained from government agencies, and published research findings. The period examined extends from 1963 to early 2016. **FINDINGS:** The Affordable Care Act has made significant progress toward solving long-standing challenges facing the US health care system related to access, affordability, and quality of care. Since the Affordable Care Act became law, the uninsured rate has declined by 43%, from 16.0% in 2010 to 9.1% in 2015, primarily because of the law's reforms. Research has documented accompanying improvements in access to care (for example, an estimated reduction in the share of nonelderly adults unable to afford care of 5.5 percentage points), financial security (for example, an estimated reduction in debts sent to collection of \$600-\$1000 per person gaining Medicaid coverage), and health (for example, an estimated reduction in the share of nonelderly adults reporting fair or poor health of 3.4 percentage points). The law has also begun the process of transforming health care payment systems, with an estimated 30% of traditional Medicare payments now flowing through alternative payment models like bundled payments or accountable care organizations. These and related reforms have contributed to a sustained period of slow growth in per-enrollee health care spending and improvements in health care quality. Despite this progress, major opportunities to improve the health care system remain. **CONCLUSIONS AND RELEVANCE:** Policy makers should build on progress made by the Affordable Care Act by continuing to implement the Health Insurance Marketplaces and delivery system reform, increasing federal financial assistance for Marketplace enrollees, introducing a public plan option in areas lacking individual market competition, and taking actions to reduce prescription drug costs. Although partisanship and special interest opposition remain, experience with the Affordable Care Act demonstrates that positive change is achievable on some of the nation's most complex challenges.

**Oberlander, J. (2016). "Implementing the Affordable Care Act: The Promise and Limits of Health Care Reform." *J Health Polit Policy Law* 41(4): 803-826.**

The Obama administration has confronted a formidable array of obstacles in implementing the Affordable Care Act (ACA). The ACA has overcome those obstacles to substantially expand access to health insurance, though significant problems with its approach have emerged. What does the ACA's performance to date tell us about the possibilities and limits of health care reform in the United States? I identify key challenges in ACA implementation—the inherently disruptive nature of reform, partisan polarization, the limits of "near universal" coverage, complexity, and divided public opinion—and analyze how these issues have shaped its evolution. The article concludes by exploring the political and policy challenges that lie ahead for the ACA.

**Smith, N., et al. (2016). "High performance in healthcare priority setting and resource allocation: A literature- and case study-based framework in the Canadian context." *Social Science & Medicine* 162: 185-192.**

<http://www.sciencedirect.com/science/article/pii/S0277953616303112>

Priority setting and resource allocation, or PSRA, are key functions of executive teams in healthcare organizations. Yet decision-makers often base their choices on historical patterns of resource distribution or political pressures. Our aim was to provide leaders with guidance on how to improve PSRA practice, by creating organizational contexts which enable high performance. We carried out in-depth case studies of six Canadian healthcare organizations to obtain from healthcare leaders their

understanding of the concept of high performance in PSRA and the factors which contribute to its achievement. Individual and group interviews were carried out (n = 62) with senior managers, middle managers and Board members. Site observations and document review were used to assist researchers in interpreting the interview data. Qualitative data were analyzed iteratively with the literature on empirical examples of PSRA practice, in order to develop a framework of high performance in PSRA. The framework consists of four domains - structures, processes, attitudes and behaviours, and outcomes - within which are 19 specific elements. The emergent themes derive from case studies in different kinds of health organizations (urban/rural, small/large) across Canada. The elements can serve as a checklist for 'high performance' in PSRA. This framework provides a means by which decision-makers in healthcare might assess their practice and identify key areas for improvement. The findings are likely generalizable, certainly within Canada but also across countries. This work constitutes, to our knowledge, the first attempt to present a full package of elements comprising high performance in health care PSRA.

**Vargas, R. (2016). "How health navigators legitimize the Affordable Care Act to the uninsured poor." *Social Science & Medicine* 165: 263-270.**

<http://www.sciencedirect.com/science/article/pii/S0277953616300120>

Health navigators are a new health care workforce created by the Affordable Care Act (ACA) to assist low-income minority populations with acquiring health insurance. Given the high levels of distrust among the poor toward government and the medical profession, this article asks: How do health navigators build the legitimacy necessary to persuade low-income uninsured clients to enroll in health insurance? Through ethnography of face-to-face interaction between navigators and the uninsured poor in Chicago, this study shows that successful navigators deployed a combination of cultural repertoires for building trust and legitimacy. These repertoires included ceding control of the conversation, creating ethnic solidarity, and disassociating themselves from government bureaucrats or self-serving insurance employees. These findings demonstrate the usefulness of cultural sociology for understanding health insurance provision to the poor, ACA outreach efforts, and the more general study of how occupations legitimize themselves to clients.

## Travail et santé / Occupational Health

**Curnock, E., et al. (2016). "The impact on health of employment and welfare transitions for those receiving out-of-work disability benefits in the UK." *Social Science & Medicine* 162: 1-10.**

<http://www.sciencedirect.com/science/article/pii/S0277953616302702>

Employment status has a dynamic relationship with health and disability. There has been a striking increase in the working age population receiving out-of-work disability benefits in many countries, including the UK. In response, recent UK welfare reforms have tightened eligibility criteria and introduced new conditions for benefit receipt linked to participation in return-to-work activities. Positive and negative impacts have been suggested but there is a lack of high quality evidence of the health impact when those receiving disability benefits move towards labour market participation. Using four waves of the UK's Understanding Society panel survey (2009–2013) three different types of employment and welfare transition were analysed in order to identify their impact on health. A difference-in-difference approach was used to compare change between treatment and control groups in mental and physical health using the SF-12. To strengthen causal inference, sensitivity checks for common trends used pre-baseline data and propensity score matching. Transitions from disability benefits to employment (n = 124) were associated on average with an improvement in the SF12 mental health score of 5.94 points (95% CI = 3.52–8.36), and an improvement in the physical health score of 2.83 points (95% CI = 0.85–4.81) compared with those remaining on disability benefits (n = 1545). Transitions to unemployed status (n = 153) were associated with a significant improvement in mental health (3.14, 95% CI = 1.17–5.11) but not physical health. No health differences were detected for those who moved on to the new out-of-work disability benefit. It remains rare for

disability benefit recipients to return to the labour market, but our results indicate that for those that do, such transitions may improve health, particularly mental health. Understanding the mechanisms behind this relationship will be important for informing policies to ensure both work and welfare are 'good for health' for this group.

## Vieillesse / Ageing

**Allen, J. O. (2016). "Ageism as a Risk Factor for Chronic Disease." *The Gerontologist* 56(4): 610-614.**  
<http://gerontologist.oxfordjournals.org/content/56/4/610.abstract>

Ageism is one of the most socially condoned and institutionalized forms of prejudice in the United States. Older adults are discriminated against in employment, health care, and other domains. Exposure to unfavorable stereotypes adversely affects the attitudes, cognitions, and behavior of older adults. Recurrent experiences with negative stereotypes combined with discrimination may make ageism a chronic stressor in the lives of older adults. The way stress influences physical health is gaining increasing support. The weathering hypothesis (Geronimus, A. T. (1992). The weathering hypothesis and the health of African-American women and infants: Evidence and speculations. *Ethnicity and Disease*, 2, 207–221) posits that the cumulative effects of chronic objective and subjective stressors and high-effort coping cause deterioration of the body, premature aging, and associated health problems such as chronic diseases. Researchers have found empirical support for the weathering hypothesis as well as its theorized contribution to racial and ethnic health disparities. Although ageism is not experienced over the entire life course, as racism typically is, repeated exposure to chronic stressors associated with age stereotypes and discrimination may increase the risk of chronic disease, mortality, and other adverse health outcomes. I conclude with implications for practice in the helping professions and recommendations for future research. Ageism warrants greater recognition, social condemnation, and scientific study as a possible social determinant of chronic disease.

**Mair, C. A., et al. (2016). "Care Preferences Among Middle-Aged and Older Adults With Chronic Disease in Europe: Individual Health Care Needs and National Health Care Infrastructure." *The Gerontologist* 56(4): 687-701.**  
<http://gerontologist.oxfordjournals.org/content/56/4/687.abstract>

**Purpose of the Study:** The purpose of this study is to expand knowledge of care options for aging populations cross-nationally by examining key individual-level and nation-level predictors of European middle-aged and older adults' preferences for care. **Design and Methods:** Drawing on data from the Survey of Health, Ageing and Retirement in Europe and the Organisation for Economic Co-operation and Development, we analyze old age care preferences of a sample of 6,469 adults aged 50 and older with chronic disease in 14 nations. Using multilevel modeling, we analyze associations between individual-level health care needs and nation-level health care infrastructure and preference for family-based (vs. state-based) personal care. **Results:** We find that middle-aged and older adults with chronic disease whose health limits their ability to perform paid work, who did not receive personal care from informal sources, and who live in nations with generous long-term care funding are less likely to prefer family-based care and more likely to prefer state-based care. **Implications:** We discuss these findings in light of financial risks in later life and the future role of specialized health support programs, such as long-term care.

**Perrine, A. L., et al. (2016). "Pré-fragilité, fragilité et multimorbidité en France : prévalences et déterminants ." *Revue d'Epidémiologie et de Santé Publique* 64(S4): PS206.**

Les concepts de pré-fragilité/fragilité et de multimorbidité sont utilisés pour identifier les personnes âgées en amont de la dépendance. L'objectif de cette étude était d'estimer les prévalences de pré-fragilité, fragilité et multimorbidité en France et de comparer les caractéristiques des sujets identifiés.

Méthode : Les données des enquêtes santé et protection sociale (ESPS2012) et Handicap-Santé-Ménages (HSM2008) ont été analysées. Les sujets âgés de plus de 55ans et ne présentant pas d'atteinte aux activités de la vie quotidienne ont été sélectionnés. Les indicateurs de pré-fragilité/fragilité étaient définis à partir des critères de Fried (fatigabilité, marche lente, faiblesse musculaire, manque d'activité physique et perte de poids non intentionnelle). La multimorbidité était définie par la présence de maladies appartenant à au moins deux des groupes suivants : maladies cardio-cérébro-vasculaires, diabète, maladies respiratoires chroniques et arthralgies. Les déterminants indépendants de chacun des indicateurs ont été estimés à partir de régressions logistiques multivariées. Résultats : Les prévalences de la pré-fragilité, de la fragilité et de la multimorbidité étaient de 48 %, 11 % et 15 % dans ESPS2012 et de 39 %, 12 % et 17 % dans HSM2008. Multimorbidité ou fragilité concernaient 22 % de la population dans ESPS et 24 % dans HSM. Parmi les personnes multimorbides 27 % (ESPS) et 29 % (HSM) étaient fragiles. Parmi les fragiles, 37 % (ESPS) et 39 % (HSM) étaient multimorbides. L'âge, le déclin fonctionnel et la mauvaise santé mentale étaient significativement associés à la présence des trois indicateurs. Le tabac était associé à la multimorbidité ; la non-participation à la vie associative était associée à la fragilité et de faibles revenus à la pré-fragilité. Conclusion Cette analyse renseigne sur les prévalences de la fragilité et de la multimorbidité en France et souligne l'hétérogénéité du concept de pré-fragilité. Elle permet également de caractériser les spécificités des sujets multimorbides et des sujets fragiles afin de mieux orienter les actions de prévention.