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Assurance maladie / Health Insurance

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Marié R. (2014/10), La généralisation du tiers payant. *Droit Social*, (10) : 847-863

Duijmelinck D.M., Van de Ven W.P. (2014). Choice of insurer for basic health insurance restricted by supplementary insurance. *Eur J Health Econ*, 15 (7) : 737-746.

Abstract: Choice of insurer is an essential precondition for efficiency in healthcare systems based on regulated competition. However, supplementary insurance (SI) may restrict choice of insurer for basic health insurance (BI) due to a joint purchase of BI and SI. Roos and Schut (*Eur J Health Econ* 13(1):51-62, 2012) found that the belief in not being accepted by another insurer for SI was an important reason for not switching insurer for BI for 4 % of the non-switching Dutch population in 2006. This increased to approximately 7 % in 2009. In this paper, we provide evidence that in 2011 and 2012 approximately 10 % of the Dutch population expected that another insurer would not accept them for SI. An additional 20 % of the consumers expected to be accepted by another insurer, but only for a higher premium than other consumers with the same SI. About one-third of the elderly (55+) consumers, and more than half of the consumers with bad or moderate health status, expected their current insurer to offer them more favourable conditions for SI, in terms of acceptance and premium, than other insurers do for similar SI. However, if dissatisfied high-risk consumers, due to a joint purchase of BI and SI, do not switch insurer for BI, the disciplining effect of 'voting with one's feet' is substantially reduced. This is a serious problem that may increase in coming years. We discuss several potential solutions. Our conclusion is that the integration of BI and SI into one basic-plus-insurance is an effective solution under current EU legislation. This conclusion may also be relevant for other countries.

McGuire T.G., Newhouse J.P., Normand S.L., Shi J., Zuvekas S. (2014). Assessing incentives for service-level selection in private health insurance exchanges. *J Health Econ*, 35 47-63.

Abstract: Even with open enrollment and mandated purchase, incentives created by adverse selection may undermine the efficiency of service offerings by plans in the new health insurance Exchanges created by the Affordable Care Act. Using data on persons likely to participate in Exchanges drawn from five waves of the Medical Expenditure Panel Survey, we measure plan incentives in two ways. First, we construct predictive ratios, improving on current methods by taking into account the role of premiums in financing plans. Second, relying on an explicit model of plan profit maximization, we measure incentives based on the predictability and predictiveness of various medical diagnoses. Among the chronic diseases studied, plans have the greatest incentive to skimp on care for cancer, and mental health and substance abuse.

Economie de la santé / Health Economics

Himmelstein D.U., Jun M., Busse R., Chevreul K., Geissler A., Jeurissen P., Thomson S., Vinet M.A., Woolhandler S. (2014). A Comparison Of Hospital Administrative Costs In Eight Nations: US Costs Exceed All Others By Far. *Health Aff.(Millwood.)*, 33 (9) : 1586-1594.

Abstract: A few studies have noted the outsize administrative costs of US hospitals, but no research has compared these costs across multiple nations with various types of health care systems. We assembled a team of international health policy experts to conduct just such a challenging analysis of hospital administrative costs across eight nations: Canada, England, Scotland, Wales, France, Germany, the Netherlands, and the United States. We found that administrative costs accounted for 25.3 percent of total US hospital expenditures—a percentage that is increasing. Next highest were the Netherlands (19.8 percent) and England (15.5 percent), both of which are transitioning to market-oriented payment systems. Scotland and Canada, whose single-payer systems pay hospitals global operating budgets, with separate grants for capital, had the lowest administrative costs. Costs were intermediate in France and Germany (which bill per patient but pay separately for capital projects) and in Wales. Reducing US per capita spending for hospital administration to Scottish or Canadian levels would have saved more than \$150 billion in 2011. This study suggests that the reduction of US administrative costs would best be accomplished through the use of a simpler and less market-oriented payment scheme.

Géographie de la santé / Geography of Health

Allan D. (2014). Catchments of general practice in different countries- a literature review. *International Journal of Health Geographics*, 13 (1) : 32.

Abstract: The purpose of this paper is to review the current research on catchment areas of private general practices in different developed countries because healthcare reform, including primary health care, has featured prominently as an important political issue in a number of developed countries. The debates around health reform have had a significant health geographic focus. Conceptually, GP catchments describe the distribution, composition and profile of patients who access a general practitioner or a general practice (i.e. a site or facility comprising one or more general practitioners). Therefore, GP catchments provide important information into the geographic variation of access rates, utilisation of services and health outcomes by all of the population or different population groups in a defined area or aggregated area. This review highlights a wide range of diversity in the literature as to how GP catchments can be described, the indicators and measures used to frame the scale of catchments. Patient access to general practice health care services should be considered from a range of locational concepts, and not necessarily constrained by their place of residence. An analysis of catchment patterns of general practitioners should be considered as dynamic and multi-perspective. Geographic information systems provide opportunities to contribute valuable methodologies to study these relationships. However, researchers acknowledge that a conceptual framework for the analysis of GP catchments requires access to real world data. Recent studies have shown promising developments in the use of real world data, especially from studies in the UK. Understanding the catchment profiles of individual GP surgeries is important if governments are serious about patient choice being a key part of proposed primary health reforms. Future health planning should incorporate models of GP catchments as planning tools, at the micro level as well as the macro level, to assist policies on the allocation of resources so that opportunities for good health outcomes for all groups within society, especially those who have been systematically denied equitable access, are maximised.

<http://www.ij-healthgeographics.com/content/13/1/32>

Livingston M., Lee D. (2014). "The Glasgow effect?"- The result of the geographical patterning of deprived areas? *Health Place*, 29 1-9.

Abstract: The aim of this research was to examine whether the excess mortality found in Glasgow, compared to other cities in the UK ("Glasgow effect"), could be attributed to patterns of the distribution of deprived neighbourhoods within the cities. Data on mortality and deprivation at a neighbourhood scale were used to examine the impact of the patterning of neighbourhood deprivation on mortality in Glasgow, Liverpool and Manchester. Analysis using a combination of GIS and statistical approaches, including a Morans I test and Conditional Auto Regressive models to capture residual spatial autocorrelation, was carried out. The pattern of deprivation was found to be more dispersed in

Glasgow compared to the other cities. The impact of surrounding deprivation at two different scales shows strong impact on neighbourhood health outcomes in Glasgow and Liverpool but not in Manchester, suggesting that patterning is not a major contribution to the excess mortality in Glasgow.

Hôpital / Hospitals

Wheeler S.B., Kuo T.M., Goyal R.K., Meyer A.M., Hassmiller L.K., Gillen E.M., Tyree S., Lewis C.L., Crutchfield T.M., Martens C.E., Tangka F., Richardson L.C., Pignone M.P. (2014). Regional variation in colorectal cancer testing and geographic availability of care in a publicly insured population. *Health Place*, 29 114-123.

Abstract: Despite its demonstrated effectiveness, colorectal cancer (CRC) testing is suboptimal, particularly in vulnerable populations such as those who are publicly insured. Prior studies provide an incomplete picture of the importance of the intersection of multilevel factors affecting CRC testing across heterogeneous geographic regions where vulnerable populations live. We examined CRC testing across regions of North Carolina by using population-based Medicare and Medicaid claims data from disabled individuals who turned 50 years of age during 2003-2008. We estimated multilevel models to examine predictors of CRC testing, including distance to the nearest endoscopy facility, county-level endoscopy procedural rates, and demographic and community contextual factors. Less than 50% of eligible individuals had evidence of CRC testing; men, African-Americans, Medicaid beneficiaries, and those living furthest away from endoscopy facilities had significantly lower odds of CRC testing, with significant regional variation. These results can help prioritize intervention strategies to improve CRC testing among publicly insured, disabled populations.

Silber J.H., Rosenbaum P.R., Ross R.N., Ludwig J.M., Wang W., Niknam B.A., Saynisch P.A., Even-Shoshan O., Kelz R.R., Fleisher L.A. (2014). A hospital-specific template for benchmarking its cost and quality. *Health Serv Res*, 49 (5) : 1475-1497.

Abstract: OBJECTIVE: Develop an improved method for auditing hospital cost and quality tailored to a specific hospital's patient population. DATA SOURCES/SETTING: Medicare claims in general, gynecologic and urologic surgery, and orthopedics from Illinois, New York, and Texas between 2004 and 2006. STUDY DESIGN: A template of 300 representative patients from a single index hospital was constructed and used to match 300 patients at 43 hospitals that had a minimum of 500 patients over a 3-year study period. DATA COLLECTION/EXTRACTION METHODS: From each of 43 hospitals we chose 300 patients most resembling the template using multivariate matching. PRINCIPAL FINDINGS: We found close matches on procedures and patient characteristics, far more balanced than would be expected in a randomized trial. There were little to no differences between the index hospital's template and the 43 hospitals on most patient characteristics yet large and significant differences in mortality, failure-to-rescue, and cost. CONCLUSION: Matching can produce fair, directly standardized audits. From the perspective of the index hospital, "hospital-specific" template matching provides the fairness of direct standardization with the specific institutional relevance of indirect standardization. Using this approach, hospitals will be better able to examine their performance, and better determine why they are achieving the results they observe.

Verhaegh K.J., MacNeil-Vroomen J.L., Eslami S., Geerlings S.E., de Rooij S.E., Buurman B.M. (2014). Transitional care interventions prevent hospital readmissions for adults with chronic illnesses. *Health Aff.(Millwood.)*, 33 (9) : 1531-1539.

Abstract: Transitional care interventions aim to improve care transitions from hospital to home and to reduce hospital readmissions for chronically ill patients. The objective of our study was to examine if these interventions were associated with a reduction of readmission rates in the short (30 days or less), intermediate (31-180 days), and long terms (181-365 days). We systematically reviewed twenty-six randomized controlled trials conducted in a variety of countries whose results were published in the period January 1, 1980-May 29, 2013. Our analysis showed that transitional care was effective in

reducing all-cause intermediate-term and long-term readmissions. Only high-intensity interventions seemed to be effective in reducing short-term readmissions. Our findings suggest that to reduce short-term readmissions, transitional care should consist of high-intensity interventions that include care coordination by a nurse, communication between the primary care provider and the hospital, and a home visit within three days after discharge.

Sabbatini A.K., Nallamotheu B.K., Kocher K.E. (2014). Reducing variation in hospital admissions from the emergency department for low-mortality conditions may produce savings. *Health Aff.(Millwood.)*, 33 (9) : 1655-1663.

Abstract: The emergency department (ED) is now the primary source for hospitalizations in the United States, and admission rates for all causes differ widely between EDs. In this study we used a national sample of ED visits to examine variation in risk-standardized hospital admission rates from EDs and the relationship of this variation to inpatient mortality for the fifteen most commonly admitted medical and surgical conditions. We then estimated the impact of variation on national health expenditures under different utilization scenarios. Risk-standardized admission rates differed substantially across EDs, ranging from 1.03-fold for sepsis to 6.55-fold for chest pain between the twenty-fifth and seventy-fifth percentiles of the visits. Conditions such as chest pain, soft tissue infection, asthma, chronic obstructive pulmonary disease, and urinary tract infection were low-mortality conditions that showed the greatest variation. This suggests that some of these admissions might not be necessary, thus representing opportunities to improve efficiency and reduce health spending. Our data indicate that there may be sizeable savings to US payers if differences in ED hospitalization practices could be narrowed among a few of these high-variation, low-mortality conditions.

Weeks W.B., Jardin M., Dufour J.C., Paraponaris A., Ventelou B. (2014). Geographic Variation in Admissions for Knee Replacement, Hip Replacement, and Hip Fracture in France: Evidence of Supplier-induced Demand in For-Profit and Not-for-Profit Hospitals. *Med Care*, 52 (10) : 909-917.

Abstract: INTRODUCTION: We sought to determine whether there was evidence of supplier-induced demand in mainland France, where health care is mainly financed by a public and compulsory health insurance and provided by both for-profit and not-for-profit hospitals. METHODS: Using a dataset of all admissions to French hospitals for 2009 and 2010, we calculated department-level age-adjusted and sex-adjusted per capita admission rates for hip replacement, knee replacement, and hip fracture for 2 age groups (45-64 and 65-99 y old), for-profit and not-for-profit hospitals. We used spatial regression analysis to examine the relationship between ecological variables, procedure rates, and supply of surgeons or sector-specific surgical beds. RESULTS: The large majority of hip and knee replacement surgeries were performed in for-profit hospitals, whereas the large majority of hip fracture admissions were in not-for-profit hospitals; nonetheless, we found approximately 2-fold variation in per capita rates of hip and knee replacement surgery in both age groups and settings. Spatial regression results showed that among younger patients, higher incomes were associated with lower admission rates; among older patients, higher levels of reliance on social benefits were associated with lower rates of elective surgery in for-profit hospitals. Although overall surgical bed supply was not associated with admission rates, for-profit-specific and not-for-profit-specific bed supply were associated with higher rates of elective procedures within a respective hospital type. DISCUSSION: We found evidence of supplier-induced demand within the French for-profit and not-for-profit hospital systems; however, these systems appear to complement one another so that there is no overall national supplier-induced effect.

Inégalités de santé / Health Inequalities

Wang L., Hu W. (2013). Immigrant health, place effect and regional disparities in Canada. *Soc Sci Med*, 98 8-17.

Abstract: The paper addresses a critically important area in Canadian immigration and health from both a social and a spatial perspective. It employs multilevel and contextual approaches to examine the social determinants of immigrant health as well as the place effects on self-reported health at a regional and neighborhood scale. The data come from the raw microdata file of the 2005-10 Canadian Community Health Survey (a random national health survey) and the publicly available Canadian Marginalization index based on the 2006 Census. Three populations are compared: Canadian-born, overall foreign-born, and Chinese immigrants. The results suggest various degrees of association between self-reported health, individual and lifestyle behavioral characteristics, and neighborhood material deprivation and ethnic concentration in census tracts. These factors contribute differently to the reported health of Chinese immigrants, Canada's largest recent immigrant group. A healthy immigrant effect is partially evident in the overall foreign-born population, but appears to be relatively weak in Chinese immigrants. For all groups, neighborhood deprivation moderately increases the likelihood of reporting poor health. Ethnic concentration negatively affects self-rated health, with the exception of the slight protective effect of Chinese-specific ethnic density in census tracts. The multilevel models reveal significant area inequalities across Census Metropolitan Areas/Census Agglomerations in risk of reporting unhealthy status, with greater magnitude in the foreign-born population. The vast regional variations in health among Chinese immigrants should be interpreted carefully due to the group's heavy concentration in large cities. The study contributes to the literature on ethnicity and health by systematically incorporating neighborhood contextual effects in modeling the social determinants of immigrant health status. It fills a gap in the literature on neighborhoods and health by focusing on ethnically disparate groups rather than on the general population. By revealing regional disparities in health, the paper adds a spatial perspective to the work on immigrant health.

Dahlin J., Harkonen J. (2013). Cross-national differences in the gender gap in subjective health in Europe: does country-level gender equality matter? *Soc Sci Med*, 98 24-28.

Abstract: Multiple studies have found that women report being in worse health despite living longer. Gender gaps vary cross-nationally, but relatively little is known about the causes of comparative differences. Existing literature is inconclusive as to whether gender gaps in health are smaller in more gender equal societies. We analyze gender gaps in self-rated health (SRH) and limiting longstanding illness (LLI) with five waves of European Social Survey data for 191,104 respondents from 28 countries. We use means, odds ratios, logistic regressions, and multilevel random slopes logistic regressions. Gender gaps in subjective health vary visibly across Europe. In many countries (especially in Eastern and Southern Europe), women report distinctly worse health, while in others (such as Estonia, Finland, and Great Britain) there are small or no differences. Logistic regressions ran separately for each country revealed that individual-level socioeconomic and demographic variables explain a majority of these gaps in some countries, but contribute little to their understanding in most countries. In yet other countries, men had worse health when these variables were controlled for. Cross-national variation in the gender gaps exists after accounting for individual-level factors. Against expectations, the remaining gaps are not systematically related to societal-level gender inequality in the multilevel analyses. Our findings stress persistent cross-national variability in gender gaps in health and call for further analysis.

Faist T (2014). On the transnational social question: How social inequalities are reproduced in Europe. *Journal of European Social Policy*, 24 (3) : 207-222.

Abstract: What are the consequences of cross-border employment and social protection practices for social inequalities in Europe? The transnational social question is a multifaceted one: it is linked not only to inequalities generated by heterogeneities such as class, gender, ethnicity, legal status and religion, but also to the perception that cross-border interdependence has grown and that transnational interactions themselves have become a criterion for differentiation. International migration is of strategic significance for an understanding of the transnational social question, because it reveals the cross-connections of the fragmented world of social protection. In particular, it provides a window into the social mechanisms that support social protection across borders and how these mitigate old and generate new social inequalities.

Shareck M., Frohlich K.L., Kestens Y. (2014). Considering daily mobility for a more comprehensive understanding of contextual effects on social inequalities in health: A conceptual proposal. *Health Place*, 29 154-160.

Abstract: Despite growing interest in integrating people's daily mobility into contextual studies of social inequalities in health, the links between daily mobility and health inequalities remain inadequately conceptualised. This conceptual proposal anchors the relationship between daily mobility and contextual influences on social inequalities in health into the concept of mobility potential, which encompasses the opportunities and places individuals can choose (or are constrained) to access. Mobility potential is realized as actual mobility through agency. Being shaped by socially-patterned personal and geographic characteristics, mobility potential is unequally distributed across social groups. Social inequalities in realized mobility may thus result. We discuss pathways by which these may contribute to contextual influences on social inequalities in health. One pathway is reflected in disadvantaged groups encountering more fast-food outlets during their daily activities, which may relate to their higher risk of unhealthy eating. This proposal lays the bases for empirical research explicitly testing hypotheses regarding the contribution of daily mobility to social inequalities in health.

Nelson J.P. (2014). Gender differences in alcohol demand: a systematic review of the role of prices and taxes. *Health Econ*, 23 (10) : 1260-1280.

Abstract: Gender differences in drinking patterns are potentially important for public policies, especially policies that rely extensively on higher alcohol taxes and prices. This paper presents a systematic review of alcohol prices and gender differences in drinking and heavy drinking by adults and young adults. Starting with a database of 578 studies of alcohol demand and other outcomes, 15 studies are reviewed of adult drinking including discussion of samples, measurement issues, econometric models, special variables, and key empirical results. A similar discussion is presented for eight studies of drinking by young adults, ages 18-26 years. Four conclusions are obtained from the review. First, adult men have less elastic demands compared with women. Second, there is little or no price response by heavy-drinking adults, regardless of gender. Third, although the sample is small, price might be important for drinking participation by young adults. Fourth, the results strongly suggest that heavy drinking by young adults, regardless of gender, is not easily dissuaded by higher prices. Policy implications, primary study limitations, and suggestions for future research are discussed.

Ludbrook A., Holmes J., Stockwell T. (2014). Gender differences in alcohol demand: a systematic review of the role of prices and taxes. Comment on conclusions by Nelson. *Health Econ*, 23 (10) : 1281-1283.

Nelson J.P. (2014). Reply to a comment by Ludbrook, Holmes, and Stockwell: gender differences in alcohol demand. *Health Econ*, 23 (10) : 1284-1286.

Berkowitz S.A., Traore C.Y., Singer D.E., Atlas S.J. (2014). Evaluating Area-Based Socioeconomic Status Indicators for Monitoring Disparities within Health Care Systems: Results from a Primary Care Network. *Health Serv Res*,

Abstract: OBJECTIVE: To determine which area-based socioeconomic status (SES) indicator is best suited to monitor health care disparities from a delivery system perspective. DATA SOURCES/STUDY SETTING: 142,659 adults seen in a primary care network from January 1, 2009 to December 31, 2011. STUDY DESIGN: Cross-sectional, comparing associations between area-based SES indicators and patient outcomes. DATA COLLECTION: Address data were geocoded to construct area-based SES indicators at block group (BG), census tract (CT), and ZIP code (ZIP) levels. Data on health outcomes were abstracted from electronic records. Relative indices of inequality (RIIs) were calculated to quantify disparities detected by area-based SES indicators and compared to RIIs from self-reported educational attainment. PRINCIPAL FINDINGS: ZIP indicators had less missing data than BG or CT indicators ($p < .0001$). Area-based SES indicators were strongly associated with self-report educational attainment ($p < .0001$). ZIP, BG, and CT indicators all detected expected SES gradients in health outcomes similarly. Single-item, cut point defined indicators performed as well as multidimensional indices and quantile indicators. CONCLUSIONS: Area-based SES indicators detected health outcome differences well and may be useful for monitoring disparities within health

care systems. Our preferred indicator was ZIP-level median household income or percent poverty, using cut points.

Razum O., Stronks K. (2014). The health of migrants and ethnic minorities in Europe: where do we go from here? *Eur J Public Health*, 24 (5) : 701-702.

Habib R.R., Hojeij S., Elzein K., Chaaban J., Seyfert K. (2014). Associations between life conditions and multi-morbidity in marginalized populations: the case of Palestinian refugees. *Eur J Public Health*, 24 (5) : 727-733.

Abstract: BACKGROUND: Evidence suggests that higher multi-morbidity rates among people with low socioeconomic status produces and maintains poverty. Our research explores the relationship between socioeconomic deprivation and multi-morbidity among Palestinian refugees in Lebanon, a marginalized and impoverished population. METHODS: A representative sample of Palestinian refugees in Lebanon was surveyed, interviewing 2501 respondents (97% response rate). Multi-morbidity was measured by mental health, chronic and acute illnesses and disability. Multinomial logistic regression models assessed the association between indicators of poverty and multi-morbidities. RESULTS: Findings showed that 14% of respondents never went to school, 41% of households reported water leakage and 10% suffered from severe food insecurity. Participants with an elementary education or less and those completing intermediate school were more than twice as likely to report two health problems than those with secondary education or more (OR: 2.60, CI: 1.73-3.91; OR: 2.47, CI: 1.62-3.77, respectively). Those living in households with water leakage were nearly twice as likely to have three or more health reports (OR = 1.88, CI = 1.45-2.44); this pattern was more pronounced for severely food insecure households (OR = 3.41, CI = 1.83-6.35). CONCLUSION: We identified a positive gradient between socioeconomic status and multi-morbidity within a refugee population. These findings reflect inequalities produced by the health and social systems in Lebanon, a problem expected to worsen following the massive influx of refugees from Syria. Ending legal discrimination and funding infrastructural, housing and health service improvements may counteract the effects of deprivation. Addressing this problem requires providing a decent livelihood for refugees in Lebanon.

Herr M., Arvieu J.J., Aegerter P., Robine J.M., Ankri J. (2014). Unmet health care needs of older people: prevalence and predictors in a French cross-sectional survey. *Eur J Public Health*, 24 (5) : 808-813.

Abstract: BACKGROUND: Unmet health care needs are associated with negative health outcomes, yet there is a paucity of data on this problem among older people. OBJECTIVE: To identify unmet health care needs and associated factors among older people in France. METHODS: This is a cross-sectional population study of people aged 70 years or older in which 2350 respondents were interviewed in 2008-10. During a standardized interview, a nurse examined health problems, functional abilities and use of health care resources. Unmet health care needs were defined as situations in which a participant needed health care and did not receive it. RESULTS: The mean age was 83.2 +/- 7.4 years. Almost all participants reporting a chronic disease (98.6%) had consulted a physician in the previous 6 months. Unmet health care needs were found in 23.0% of the sample and mainly consisted of lack of dental care (prevalence of 17.7%), followed by lack of management of visual or hearing impairments (prevalence of 4.4% and 3.1%, respectively). Age was the main factor associated with unmet health care needs [compared with people aged 70-79: odds ratio 80-89 years = 2.26 (1.70-3.03), odds ratio 90 years and over = 3.85 (2.71-5.45)]. Other associated factors were regular smoking, homebound status, poor socioeconomic conditions, depression, limitations in instrumental activities of daily living and low medical density. CONCLUSION: Unmet health care needs affect almost one-quarter of older people in France. Efforts should be made to improve oral health and develop home care, especially for the oldest-olds.

Médicaments / Pharmaceuticals

Ulucanlar S., Faulkner A., Peirce S., Elwyn G. (2013). Technology identity: the role of sociotechnical representations in the adoption of medical devices. *Soc Sci Med*, 98 95-105.

Abstract: This study explored the sociotechnical influences shaping the naturally-occurring adoption and non-adoption of device technologies in the UK's National Health Service (NHS), amid increasing policy interest in this area. The study was informed by Science and Technology Studies and structuration and Actor Network Theory perspectives, drawing attention to the performative capacities of the technology alongside human agentic forces such as agendas and expectations, in the context of structural and macro conditions. Eight technologies were studied using a comparative ethnographic case study design and purposive and snowball sampling to identify relevant NHS, academic and industry participants. Data were collected between May 2009 and February 2012, included in-depth interviews, conference observations and printed and web-based documents and were analysed using constructivist grounded theory methods. The study suggests that while adoption decisions are made within the jurisdiction of healthcare organisations, they are shaped within a dynamic and fluid 'adoption space' that transcends organisational and geographic boundaries. Diverse influences from the industry, health care organisation and practice, health technology assessment and policy interact to produce 'technology identities.' Technology identities are composite and contested attributes that encompass different aspects of the technology (novelty, effectiveness, utility, risks, requirements) and that give a distinctive character to each. We argue that it is these socially constructed and contingent heuristic identities that shape the desirability, acceptability, feasibility and adoptability of each technology, a perspective that policy must acknowledge in seeking to intervene in health care technology adoption.

O'Donoghue A.C., Williams P.A., Sullivan H.W., Boudewyns V., Squire C., Willoughby J.F. (2014). Effects of comparative claims in prescription drug direct-to-consumer advertising on consumer perceptions and recall. *Soc Sci Med*, 120C 1-11.

Abstract: Although pharmaceutical companies cannot make comparative claims in direct-to-consumer (DTC) ads for prescription drugs without substantial evidence, the U.S. Food and Drug Administration permits some comparisons based on labeled attributes of the drug, such as dosing. Researchers have examined comparative advertising for packaged goods; however, scant research has examined comparative DTC advertising. We conducted two studies to determine if comparative claims in DTC ads influence consumers' perceptions and recall of drug information. In Experiment 1, participants with osteoarthritis (n = 1934) viewed a fictitious print or video DTC ad that had no comparative claim or made an efficacy comparison to a named or unnamed competitor. Participants who viewed print (but not video) ads with named competitors had greater efficacy and lower risk perceptions than participants who viewed unnamed competitor and non-comparative ads. In Experiment 2, participants with high cholesterol or high body mass index (n = 5317) viewed a fictitious print or video DTC ad that had no comparative claim or made a comparison to a named or unnamed competitor. We varied the type of comparison (of indication, dosing, or mechanism of action) and whether the comparison was accompanied by a visual depiction. Participants who viewed print and video ads with named competitors had greater efficacy perceptions than participants who viewed unnamed competitor and non-comparative ads. Unlike Experiment 1, named competitors in print ads resulted in higher risk perceptions than unnamed competitors. In video ads, participants who saw an indication comparison had greater benefit recall than participants who saw dosing or mechanism of action comparisons. In addition, visual depictions of the comparison decreased risk recall for video ads. Overall, the results suggest that comparative claims in DTC ads could mislead consumers about a drug's efficacy and risk; therefore, caution should be used when presenting comparative claims in DTC ads.

Deb P., Trivedi P.K., Zimmer D.M. (2014). Cost-offsets of prescription drug expenditures: data analysis via a copula-based bivariate dynamic hurdle model. *Health Econ*, 23 (10) : 1242-1259.

Abstract: In this paper, we estimate a copula-based bivariate dynamic hurdle model of prescription drug and nondrug expenditures to test the cost-offset hypothesis, which posits that increased expenditures on prescription drugs are offset by reductions in other nondrug expenditures. We apply the proposed methodology to data from the Medical Expenditure Panel Survey, which have the following features: (i) the observed bivariate outcomes are a mixture of zeros and continuously measured positives; (ii) both the zero and positive outcomes show state dependence and inter-temporal interdependence; and (iii) the zeros and the positives display contemporaneous association. The point mass at zero is accommodated using a hurdle or a two-part approach. The copula-based approach to generating joint distributions is appealing because the contemporaneous association involves asymmetric dependence. The paper studies samples categorized by four health conditions: arthritis, diabetes, heart disease, and mental illness. There is evidence of greater than dollar-for-dollar cost-offsets of expenditures on prescribed drugs for relatively low levels of spending on drugs and less than dollar-for-dollar cost-offsets at higher levels of drug expenditures.

Franchetti J., Desmaizieres M., Galinski M., De S.C., Reuter P.G., Lapostolle F. (2014). [Generic drugs: What do patients really know about them?]. *Encephale*, 40 (4) : 351-352.

Babar Z.U., Kan S.W., Scahill S. (2014). Interventions promoting the acceptance and uptake of generic medicines: A narrative review of the literature. *Health Policy*, 117 (3) : 285-296.

Abstract: OBJECTIVE: The objective of this paper was to undertake a narrative review of the literature regarding strategies and interventions promoting the acceptance and uptake of generic medicines. METHOD: A literature search was performed between November 2011 and January 2012 to identify published full text original research articles documenting interventions to promote the use of generic medicines. Keywords used were: "generic medicine", "generic drug", "intervention", "promotion", "acceptance", "uptake", "generic/therapeutic substitution" and their related root words. The electronic databases comprised of Embase (1980 - present), Google, Google Scholar, Medline.

Hassali M.A., Wong Z.Y., Alrasheedy A.A., Saleem F., Mohamad Yahaya A.H., Aljadhey H. (2014). Perspectives of physicians practicing in low and middle income countries towards generic medicines: A narrative review. *Health Policy*, 117 (3) : 297-310.

Abstract: OBJECTIVES: This review was conducted to document published literature related to physicians' knowledge, attitudes, and perceptions of generic medicines in low- and middle-income countries (LMICs) and to compare the findings with high-income countries. METHODS: A systematic search of articles published in peer-reviewed journals from January 2001 to February 2013 was performed. The search comprised nine electronic databases. The search strategy involved using Boolean operators for combinations of the following terms: generic medicines, generic medications, generic drugs, generic, generic substitution, generic prescribing, international non-proprietary, prescribers, doctors, general practitioners, physicians, and specialists. RESULTS: Sixteen articles were included in this review. The majority (n=11) were from high income countries and five from LMICs. The main difference between high income countries and LMICs is that physicians from high income countries generally have positive views whereas those from LMICs tend to have mixed views regarding generic medicines. Few similarities were identified among different country income groups namely low level of physicians' knowledge of the basis of bioequivalence testing, cost of generic medicines as an encouraging factor for generic medicine prescribing, physicians' concerns towards safety and quality of generic medicines and effect of pharmaceutical sales representative on generic medicine prescribing. CONCLUSION: The present literature review revealed that physicians from LMICs tend to have mixed views regarding generic medicines. This may be due to differences in the health care system and pharmaceutical funding system, medicine policies, the level of educational interventions, and drug information sources in countries of different income levels.

Vogler S., Habimana K., Arts D. (2014). Does deregulation in community pharmacy impact accessibility of medicines, quality of pharmacy services and costs? Evidence from nine European countries. *Health Policy*, 117 (3) : 311-327.

Abstract: OBJECTIVE: To analyse the impact of deregulation in community pharmacy on accessibility of medicines, quality of pharmacy services and costs. METHODS: We analysed and compared community pharmacy systems in five rather deregulated countries (England, Ireland, the Netherlands, Norway, Sweden) and four rather regulated countries (Austria, Denmark, Finland, Spain). Data were collected by literature review, a questionnaire survey and interviews. RESULTS: Following a deregulation, several new pharmacies and dispensaries of Over-the-Counter (OTC) medicines tended to be established, predominantly in urban areas. Unless prevented by regulation, specific stakeholders, e.g. wholesalers, were seen to gain market dominance which limited envisaged competition. There were indications for an increased workload for pharmacists in some deregulated countries. Economic pressure to increase the pharmacy turnover through the sale of OTC medicines and non-pharmaceuticals was observed in deregulated and regulated countries. Prices of OTC medicines were not found to decrease after a deregulation in pharmacy. CONCLUSIONS: Access to pharmacies usually increases after a deregulation but this is likely to favour urban populations with already good accessibility. Policy-makers are recommended to take action to ensure equitable accessibility and sustainable competition in a more deregulated environment. No association between pharmaceutical expenditure and the extent of regulation/deregulation appears to exist.

Minghetti P., Pantano D., Gennari C.G., Casiraghi A. (2014). Regulatory framework of pharmaceutical compounding and actual developments of legislation in Europe. *Health Policy*, 117 (3) : 328-333.

Abstract: Pharmaceutical preparations are medicines that the pharmacist makes for the special needs of the patients that the pharmaceutical industry cannot comply for economic and logistic reasons. Pharmacy compounding is still an important component of pharmacy practice and a valuable therapeutic service that is an integrant part of the modern health care system, but its legislation is not harmonized among European and US countries. In 2011 the Committee of Ministers of the Council of Europe has adopted a Resolution on quality and safety assurance requirements for medicinal products prepared in pharmacies for the special needs of patients. Aim of this resolution is to harmonize quality assurance and standards for pharmacy-made medicinal products among European countries and to pass the gap in quality assurance and standards between preparation in pharmacies and medicines prepared by the pharmaceutical industry. This article will analyze the actual rules and technical norms that regulate compounding activity and the expectations resultants from the new European and US laws.

Van Hoof J.J., Cents M.H., Megens N.M., Van der Tang S.J. (2014). Druggists and pharmacists as gatekeepers: Sales routines and compliance with sales protocols for over-the-counter naproxen 275 mg medicines in the Netherlands. *Health Policy*, 117 (3) : 353-360.

Abstract: OBJECTIVES: Since for the sales of over-the-counter (OTC) medicines, prescribing physicians are not involved, and written instructions on/in the medicine boxes are inefficient, druggists and pharmacists are important gatekeepers in preventing customers' accidents. In this study we investigated the sales routines, and compliance with sales protocols, in order to evaluate that gatekeeper's function. METHODS: By means of the mystery shopping method, 228 pharmacies and drugstores in The Netherlands were visited and a naproxen 275mg medium-risk medicine was requested for a (fictitious) patient who was suffering from severe back pains. According to the sales protocols the vendors should never sell the requested medicine, because the mystery shoppers only gave an answer to one of the four mandatory sales protocol questions. Furthermore, the requested medicine is not the right or best choice for back pains. Four different scenarios were used in a 2x2 design (8-year-old patient vs. 25-year-old patient, and 1 box with 12 pills vs. 3 boxes with 12 pills). RESULTS: Of the drugstores and pharmacies only 16.7% complied with the sales protocols and did not sell the specific (or comparable) medicine, after asking all four mandatory questions (or already after one, two or three questions). Most vendors (83.3%) did not comply and sold the requested medicine, a comparable medicine, or even a more risky medicine after no question at all (or after asking some or even all four questions). Although both score low, pharmacists show better compliance (23.9%) than druggists (10.1%). CONCLUSIONS: When it comes to OTC medicines, druggists and pharmacists largely commit sloppy sales. The expected gatekeeping function of pharmacists and druggists is very limited, and customers might be in danger of inappropriate medicine selection,

quantity and usage. We call for thorough evaluation of the over-the-counter system, improvement of the educational programs for medicine providers, and national campaigns to inform the public.

Schwander B., Banz K., Kaier K., Walzer S. (2014). Evaluation of a possible predictor for Federal Joint Committee decisions on early benefit assessments according to the German act on the reform of the market for medicinal products. *Health Policy*, 117 (3) : 334-344.

Abstract: OBJECTIVES: As of 1st January 2011 the German drug market is regulated by the act on the reform of the market for medicinal products (AMNOG). Since then the normal procedure for reimbursement of a new pharmaceutical is a benefit assessment by the joint federal committee (G-BA) which determines one of six additional benefit levels. METHODS: In order to evaluate a possible predictor of G-BA decisions, the 'evaluation of pharmaceutical innovations (EVITA)' score was calculated for 40 out of 63 dossiers and compared with published G-BA appraisals. RESULTS: Univariate ordinary least squares ($p < 0.001$) and ordered logit regression ($p = 0.008$) analyses show statistically significant correlations between EVITA scores and the G-BA additional benefit levels. Moreover, for the prediction of an additional benefit level of at least 'minor', an EVITA score cutpoint of ≥ 3 is associated with a sensitivity of 100% and a specificity of 80%. For the prediction of an additional benefit level of at least 'considerable', an EVITA score cutpoint of ≥ 7.5 is associated with a sensitivity of 100% and a specificity of 93.1%. CONCLUSION: The present investigation indicates that the EVITA score may have some potential to act as a possible predictor of G-BA decisions related to AMNOG early benefit assessments.

Keown O.P., Parston G., Patel H., Rennie F., Saoud F., Al K.H., Darzi A. (2014). Lessons from eight countries on diffusing innovation in health care. *Health Aff. (Millwood.)*, 33 (9) : 1516-1522.

Abstract: Health care systems are under increasing pressure to cope with shifting demographics, the threat of chronic and noncommunicable disease, and rising health care costs. The uptake of innovations to meet these challenges and to advance medicine and health care delivery is not as rapid as the pace of change. Greater emphasis on the diffusion of innovation and greater understanding of the structural and organizational levers that can be used to facilitate systemwide improvement are essential. This article describes the results of a qualitative and quantitative study to assess the factors and behaviors that foster the adoption of health care innovation in eight countries: Australia, Brazil, England, India, Qatar, South Africa, Spain, and the United States. It describes the front-line cultural dynamics that must be fostered to achieve cost-effective and high-impact transformation of health care, and it argues that there is a necessity for greater focus on vital, yet currently underused, organizational action to support the adoption of innovation.

Breeze P., Brennan A. (2014). Valuing trial designs from a pharmaceutical perspective using value-based pricing. *Health Econ*, (on line)

Abstract: Our aim was to adapt the traditional framework for expected net benefit of sampling (ENBS) to be more compatible with drug development trials from the pharmaceutical perspective. We modify the traditional framework for conducting ENBS and assume that the price of the drug is conditional on the trial outcomes. We use a value-based pricing (VBP) criterion to determine price conditional on trial data using Bayesian updating of cost-effectiveness (CE) model parameters. We assume that there is a threshold price below which the company would not market the new intervention. We present a case study in which a phase III trial sample size and trial duration are varied. For each trial design, we sampled 10 000 trial outcomes and estimated VBP using a CE model. The expected commercial net benefit is calculated as the expected profits minus the trial costs. A clinical trial with shorter follow-up, and larger sample size, generated the greatest expected commercial net benefit. Increasing the duration of follow-up had a modest impact on profit forecasts. Expected net benefit of sampling can be adapted to value clinical trials in the pharmaceutical industry to optimise the expected commercial net benefit. However, the analyses can be very time consuming for complex CE models.

Méthodologie – Statistique / Methodology – Statistique

Perlberg J , Allonier C,Boisnault P,Daniel F, Le Fur P,Szidon P, et al. (2014). Faisabilité et intérêt de l'appariement des données individuelles en médecine générale et de données de remboursement appliqué au diabète et à l'hypertension artérielle. *Santé publique - Pratiques et Organisations des Soins*, 26 (3) : 355-363.

Abstract: Objectif : Le monde de la santé publique en France est soucieux d'améliorer l'utilisation des bases de données nationales. L'objectif du projet était de construire un outil de recherche en soins ambulatoires en appariant des données médicales et des données de remboursement. Méthodes : Les sources étaient la base de données du SNIIRAM et la base de données de l'Observatoire de Médecine Générale (OMG). Le SNIIRAM est une base médico-administrative nationale regroupant les données ayant servi au remboursement des soins et l'OMG est une base de données médicales en soins ambulatoires fournissant les motifs de recours aux soins appelés Résultats de Consultation (RC). À partir des données des patients ayant consulté un des 30 médecins généralistes sélectionnés en 2008, nous avons réalisé un appariement probabiliste des deux bases. Résultats : La procédure d'appariement a permis d'apparier 89 211 séances et 29 088 patients. La comparaison des affections de longue durée (ALD) et des RC a montré que 94 % des patients en ALD diabète avaient un RC diabète dans l'année. Mais seulement 65 % des patients avec un RC diabète étaient déclarés en ALD. L'appariement a permis d'identifier 12 % de patients diabétiques sans traitement antidiabétique et hors ALD qui n'étaient pas repérables dans le SNIIRAM. Conclusion : Cette étude a décrit une méthodologie novatrice d'appariement de bases de données. Elle a également montré les apports de ce modèle de données appariées pour le ciblage de populations à risque. D'autres pistes d'exploitation sur l'analyse des comorbidités, des pratiques et des parcours de soins sont encore envisageables.

Clark M.D., Determann D., Petrou S., Moro D., de Bekker-Grob E.W. (2014). Discrete choice experiments in health economics: a review of the literature. *Pharmacoeconomics*, 32 (9) : 883-902.

Abstract: BACKGROUND: Discrete choice experiments (DCEs) are increasingly used in health economics to address a wide range of health policy-related concerns. OBJECTIVE: Broadly adopting the methodology of an earlier systematic review of health-related DCEs, which covered the period 2001-2008, we report whether earlier trends continued during 2009-2012. METHODS: This paper systematically reviews health-related DCEs published between 2009 and 2012, using the same database as the earlier published review (PubMed) to obtain citations, and the same range of search terms. RESULTS: A total of 179 health-related DCEs for 2009-2012 met the inclusion criteria for the review. We found a continuing trend towards conducting DCEs across a broader range of countries. However, the trend towards including fewer attributes was reversed, whilst the trend towards interview-based DCEs reversed because of increased computer administration. The trend towards using more flexible econometric models, including mixed logit and latent class, has also continued. Reporting of monetary values has fallen compared with earlier periods, but the proportion of studies estimating trade-offs between health outcomes and experience factors, or valuing outcomes in terms of utility scores, has increased, although use of odds ratios and probabilities has declined. The reassuring trend towards the use of more flexible and appropriate DCE designs and econometric methods has been reinforced by the increased use of qualitative methods to inform DCE processes and results. However, qualitative research methods are being used less often to inform attribute selection, which may make DCEs more susceptible to omitted variable bias if the decision framework is not known prior to the research project. CONCLUSIONS: The use of DCEs in healthcare continues to grow dramatically, as does the scope of applications across an expanding range of countries. There is increasing evidence that more sophisticated approaches to DCE design and analytical techniques are improving the quality of final outputs. That said, recent evidence that the use of qualitative methods to inform attribute selection has declined is of concern.

Politique de santé / Health Policy

Marty J., Pellet R. (2014/10), Les dépassements d'honoraires, l'assurance maladie et le projet de loi relatif à la réforme de santé. *Droit Social*, (10) : 839-846

Iajya V., Lacetera N., Macis M., Slonim R. (2013). The effects of information, social and financial incentives on voluntary undirected blood donations: evidence from a field experiment in Argentina. *Soc Sci Med*, 98 214-223.

Abstract: In many low- and middle-income countries blood donations per capita are substantially lower than in advanced economies. In these countries blood supply is mostly collected through directed donations from relatives and friends to individuals needing transfusions or to replace blood used in emergencies. The World Health Organization considers this method of blood supply inefficient compared to undirected voluntary donations. To examine methods to motivate undirected voluntary donations, we ran a large-scale, natural field experiment in Argentina, testing the effectiveness of information, social and financial incentives. We find that only higher-valued financial incentives generated more donations, increasing with the value of the reward. These incentives did not create adverse selection in the safety or usability of the donated blood. We discuss the implications of our findings for researchers interested in understanding motivations for pro-social behavior and for health agencies and policymakers concerned with the current and growing shortages in blood supply in low- and middle-income countries.

Burke S., Thomas S., Barry S., Keegan C. (2014). Indicators of health system coverage and activity in Ireland during the economic crisis 2008-2. *Health Policy*, 117 (3) : 275-278.

Abstract: A new Irish government came to power in March 2011 with the most radical proposals for health system reform in the history of the state, including improving access to healthcare, free GP care for all by 2015 and the introduction of Universal Health Insurance after 2016. All this was to be achieved amidst the most severe economic crisis experienced by Ireland since the 1930s. The authors assess how well the system coped with a downsizing of resources by an analysis of coverage and health system activity indicators. These show a health system that managed 'to do more with less' from 2008 to 2012. They also demonstrate a system that was 'doing more with less' by transferring the cost of care onto people and by significant resource cuts. From 2013, the indicators show a system that has no choice but 'to do less with less' with diminishing returns from crude cuts. This is evident in declining numbers with free care, of hospital cases and home care hours, alongside increased wait-times and expensive agency staffing. The results suggest a limited window of benefit from austerity beyond which cuts and rationing prevail which is costly, in both human and financial terms.

Goranitis I., Siskou O., Liaropoulos L. (2014). Health policy making under information constraints: An evaluation of the policy responses to the economic crisis in Greece. *Health Policy*, 117 (3) : 279-284.

Abstract: INTRODUCTION: Cost consolidation in the highly fragmented and inefficient Greek health care system was necessary. However, policies introduced were partly formed in a context of insufficient information. Expenditure data from a consumption point of view were lacking and the depth of the political and structural problems was of unknown magnitude to the supervisory authorities. METHODS: Drawing upon relevant literature and evidence from the newly implemented OECD System of Health Accounts, the paper evaluates the health policy responses to the economic crisis in Greece. The discussion and recommendations are also of interest to other countries where data sources are not reliable or decisions are based on preliminary data and projections. RESULTS: Between 2009 and 2012, across-the-board cuts have resulted in a decline in public health expenditure for inpatient care by 8.6%, for pharmaceuticals by 42.3% and for outpatient care by 34.6%. Further cuts are expected from the ongoing reforms but more structural changes are needed. CONCLUSION: Cost-containment was not well targeted and expenditure cuts were not always addressed to the real reasons of the pre-crisis cost explosion. Policy responses were restricted to quick and easy fiscal adjustment, ignoring the need for substantial structural reforms or individuals' right to access health

care irrespective of their financial capacity. Developing appropriate information infrastructure, restructuring and consolidating the hospital sector and moving toward a tax-based national health insurance could offer valuable benefits to the system.

Heitmueller A., Henderson S., Warburton W., Elmagarmid A., Pentland A.S., Darzi A. (2014). Developing public policy to advance the use of big data in health care. *Health Aff.(Millwood.)*, 33 (9) : 1523-1530.

Abstract: The vast amount of health data generated and stored around the world each day offers significant opportunities for advances such as the real-time tracking of diseases, predicting disease outbreaks, and developing health care that is truly personalized. However, capturing, analyzing, and sharing health data is difficult, expensive, and controversial. This article explores four central questions that policy makers should consider when developing public policy for the use of "big data" in health care. We discuss what aspects of big data are most relevant for health care and present a taxonomy of data types and levels of access. We suggest that successful policies require clear objectives and provide examples, discuss barriers to achieving policy objectives based on a recent policy experiment in the United Kingdom, and propose levers that policy makers should consider using to advance data sharing. We argue that the case for data sharing can be won only by providing real-life examples of the ways in which it can improve health care.

Stock S., Pitcavage J.M., Simic D., Altin S., Graf C., Feng W., Graf T.R. (2014). Chronic care model strategies in the United States and Germany deliver patient-centered, high-quality diabetes care. *Health Aff.(Millwood.)*, 33 (9) : 1540-1548.

Abstract: Improving the quality of care for chronic diseases is an important issue for most health care systems in industrialized nations. One widely adopted approach is the Chronic Care Model (CCM), which was first developed in the late 1990s. In this article we present the results from two large surveys in the United States and Germany that report patients' experiences in different models of patient-centered diabetes care, compared to the experiences of patients who received routine diabetes care in the same systems. The study populations were enrolled in either Geisinger Health System in Pennsylvania or Barmer, a German sickness fund that provides medical insurance nationwide. Our findings suggest that patients with type 2 diabetes who were enrolled in the care models that exhibited key features of the CCM were more likely to receive care that was patient-centered, high quality, and collaborative, compared to patients who received routine care. This study demonstrates that quality improvement can be realized through the application of the Chronic Care Model, regardless of the setting or distinct characteristics of the program.

Hernandez-Boussard T., Burns C.S., Wang N.E., Baker L.C., Goldstein B.A. (2014). The affordable care act reduces emergency department use by young adults: evidence from three States. *Health Aff.(Millwood.)*, 33 (9) : 1648-1654.

Abstract: The Affordable Care Act (ACA) extended eligibility for health insurance for young adults ages 19-25. This extension may have affected how young adults use emergency department (ED) care and other health services. To test the impact of the ACA on how young adults used ED services, we used 2009-11 state administrative records from California, Florida, and New York to compare changes in ED use in young adults ages 19-25 before and after the ACA provision was implemented with changes in the same period for people ages 26-31 (the control group). Following implementation of the ACA provision, the younger group had a decrease of 2.7 ED visits per 1,000 people compared to the older group—a relative change of -2.1 percent. The largest relative decreases were found in women (-3.0 percent) and blacks (-3.4 percent). This relative decrease in ED use implies a total reduction of more than 60,000 visits from young adults ages 19-25 across the three states in 2011. When we compared the probability of ever using the ED before and after implementation of the ACA provision, we found a minimal decrease (-0.4 percent) among the younger group compared to the older group. This suggests that the change in the number of visits was driven by fewer visits among ED users, not by changes in the number of people who ever visited the ED.

Howard S.W., Bernell S.L., Yoon J., Luck J. (2014). Oregon's Coordinated Care Organizations: A Promising and Practical Reform Model. *J Health Polit.Policy Law*, 39 (4) : 933-940.

Abstract: Continuing its path of Medicaid program innovation, Oregon recently embarked on a major reform that gives regional coordinated care organizations (CCOs) global budgets and accountability for the physical, behavioral, and dental care of the state's Medicaid beneficiaries (Howard et al. 2014). There are some who maintain that the state's bold reform initiative is overly aggressive in scope and unrealistically optimistic in schedule and may prove to be a costly debacle to the state of Oregon. We argue that the Oregon CCO model is not only bold in its aims and timetable but also realistically achievable.

Prévention / Prevention

Savage M. (2014). Smoking outside: the effect of the Irish workplace smoking ban on smoking prevalence among the employed. *Health Econ Policy Law*, 9 (4) : 407-424.

Abstract: In March 2004, Ireland became the first country to introduce a nationwide workplace smoking ban. The primary aim of the ban was to reduce people's exposure to second-hand smoke. A 95% compliance rate among employers suggests this aim was achieved. By prohibiting smoking in the majority of indoor working places, an effect of the ban was to increase the non-monetary cost of smoking. The aim of this paper is to examine whether the extra non-monetary cost of smoking was concentrated on the employed. A difference-in-differences approach is used to measure changes in smoking behaviour among the employed relative to the non-working population following the introduction of the workplace smoking ban. The research finds that the workplace smoking ban did not induce a greater reduction in smoking prevalence among the employed population compared with the non-working population. In fact, the evidence suggests a significantly larger decrease in smoking prevalence among the non-workers relative to the employed. Changes in the real price of cigarettes and changes in attitudes to risk are discussed as possible causes for the pattern observed.

Durkin S., Bayly M., Cotter T., Mullin S., Wakefield M. (2013). Potential effectiveness of anti-smoking advertisement types in ten low and middle income countries: do demographics, smoking characteristics and cultural differences matter? *Soc Sci Med*, 98 204-213.

Abstract: Unlike high income countries, there is limited research to guide selection of anti-tobacco mass media campaigns in low and middle income countries, although some work suggests that messages emphasizing serious health harms perform better than other message types. This study aimed to determine whether certain types of anti-smoking advertisements are more likely to be accepted and perceived as effective across smokers in 10 low to middle income countries. 2399 18-34 year old smokers were recruited in Bangladesh, China, Egypt, India, Indonesia, Mexico, Philippines, Russia, Turkey and Vietnam to view and rate 10 anti-tobacco ads. Five ads were shown in all countries and five ads were chosen by country representatives, providing a total of 37 anti-smoking ads across all countries (10 graphic health effects ads, 6 simulated health effects, 8 emotional stories of health effects, 7 other health effects and 6 non-health effects). Smokers rated ads on a series of 5-point scales containing aggregated measures of Message Acceptance and Perceived Effectiveness. All ads and materials were translated into the local language of the testing regions. In multivariate analysis, graphic health effects ads were most likely to be accepted and perceived as effective, followed by simulated health effects ads, health effects stories, other health effects ads, and then non-health effects ads. Interaction analyses indicated that graphic health effects ads were less likely to differ in acceptance or perceived effectiveness across countries, gender, age, education, parental status and amount smoked, and were less likely to be affected by cultural differences between characters and contexts in ads and those within each country. Ads that did not emphasize the health effects of smoking were most prone to inconsistent impact across countries and population subgroups.

Graphic ads about the negative health effects of smoking may be most suitable for wide population broadcast in low and middle income countries.

Prévision – Evaluation

Richards M.R., Marti J. (2014). Heterogeneity in the smoking response to health shocks by out-of-pocket spending risk. *Health Econ Policy Law*, 9 (4) : 343-357.

Abstract: An existing literature demonstrates that adverse changes to health can lead to improvements in health behaviors. Although the exact explanations for these empirical findings are debated, some posit that individuals learn about their true health risks through health shocks. Updated health risk information can then induce changes in health behaviors. While we follow a learning framework, we argue that past work has neglected the role of health insurance and medically related financial risk within this decision making context. Using longitudinal data from 11 European countries, we investigate the impact of a new cardiovascular (CV) health shock on smoking decisions among older adults and examine whether personal exposure to medical spending risk influences the smoking response. We then explore two potential mechanisms for this link: larger updates to health risk beliefs and higher medical expenditures to incentivize behavior change. We find that CV shocks impact the propensity to smoke, with relatively more impact among individuals with high financial risk exposure to medical spending. We also see larger increases in out-of-pocket expenditures following a shock for this group - consistent with the latter mechanism for behavior change.

Postmus D., Tervonen T., van V.G., Hillege H.L., Buskens E. (2014). A multi-criteria decision analysis perspective on the health economic evaluation of medical interventions. *Eur J Health Econ*, 15 (7) : 709-716.

Abstract: A standard practice in health economic evaluation is to monetize health effects by assuming a certain societal willingness-to-pay per unit of health gain. Although the resulting net monetary benefit (NMB) is easy to compute, the use of a single willingness-to-pay threshold assumes expressibility of the health effects on a single non-monetary scale. To relax this assumption, this article proves that the NMB framework is a special case of the more general stochastic multi-criteria acceptability analysis (SMAA) method. Specifically, as SMAA does not restrict the number of criteria to two and also does not require the marginal rates of substitution to be constant, there are problem instances for which the use of this more general method may result in a better understanding of the trade-offs underlying the reimbursement decision-making problem. This is illustrated by applying both methods in a case study related to infertility treatment.

Psychiatrie / Psychiatry

Icick R., Kovess V., Gasquet I., Lepine J.P. (2014). [Days out of role due to common mental and physical disorders: French results from the WHO World Mental Health surveys]. *Encephale*, 40 (4) : 338-344.

Abstract: INTRODUCTION: The burden of health problems, including mental disorders, can be assessed in several ways such as through healthcare costs or loss of productivity. Their impact on daily activities as a whole has received much less attention, especially in France. Therefore, we undertook the analysis of the French general population data from the World Mental Health (WMH) surveys promoted by the World Health Organization (WHO) assessing the number of days out of role due to common mental and physical disorders. METHODS: Face-to-face interviews were carried out with 2894 respondents (45.9% pooled response rate). Presence of ten chronic physical disorders and

nine mental disorders was assessed for each respondent along with information about the number of days in the past month each respondent reported being totally unable to work or carry out their other normal daily activities because of problems with either physical or mental health. Multiple regression analysis was used to estimate associations of specific conditions and comorbidities with days out of role, after controlling for basic socio-demographics. RESULTS: One thousand four hundred and thirty-six subjects reporting at least one core-symptom of a mental disorder underwent the whole assessment. The mean annual number of days out of role was high among those with at least one mental disorder (24.2+/-8.3). The population attributable risk proportion (PARP), i.e. the proportion of days out of role that would have been avoided if the considered disorder had remitted, was also estimated. Mental disorders as a whole accounted for 49.5% of the PARP. DISCUSSION: French data on days out of role from the WHO WMH surveys showed the high burden of mental illness in the general population. These results may have been underestimated, taking into account that subjects who were hospitalized at the time of recruitment, whose disorders might also account for a high proportion of days out of role, could not be assessed with our design. CONCLUSION: Common health conditions, especially mental disorders, make up a large proportion of the number of days out of role. Such data should be considered to design more efficient public health strategies.

Karlin B.E., Karel M.J. (2014). National Integration of Mental Health Providers in VA Home-Based Primary Care: An Innovative Model for Mental Health Care Delivery With Older Adults. *Gerontologist*, 54 (5) : 868-879.

Abstract: PURPOSE OF THE STUDY: To promote mental health (MH) service access and quality for veterans with complex and chronic medical, social, and behavioral conditions, the U.S. Department of Veterans Affairs (VA) has integrated a full-time MH provider into each VA home-based primary care (HBPC) team. The goal of the current evaluation is to examine the nature and extent to which MH care processes and practices have been integrated into HBPC nationally. DESIGN AND METHODS: Separate surveys assessing the integration of a wide range of MH care practices and HBPC team processes were sent to MH providers and program directors in each HBPC program in 2010. RESULTS: A total of 132 MH providers representing 119 HBPC programs, and 112 program directors completed the surveys. The most common clinical issues addressed by MH providers were depression, coping with illness and disability, anxiety, caregiver/family stress, and cognitive evaluation. Other team members typically conducted initial MH screenings, with MH providers' time focusing on cases with identified needs. Approximately 40% of MH providers' time was devoted to direct clinical care. Significant time was also spent on team activities, driving, and charting. IMPLICATIONS: Integration of MH services into HBPC is feasible and facilitates service access for a vulnerable population. Mental health care delivery in HBPC generally involves a high degree of interdisciplinary practice. Mental health integration into HBPC may serve as a model for other systems interested in promoting MH care delivery among homebound and other older individuals.

Soins de santé primaires / Primary Health Care

Boulmier D., (2014/07). Les relations médecins-infirmiers dans la loi du 20 juillet 2011. *Droit Social*, (7) : 661-667

Duffaud S. L.S. (2014). Comment les médecins généralistes limitent-ils leurs prescriptions ? Etude qualitative par entretiens collectifs. *Santé publique - Pratiques et Organisations des Soins*, 26 (3) : 323-336.

Abstract: Objectif : Dans de nombreuses situations en médecine générale, la prescription ne fait pas consensus. Cette étude cherchait à objectiver les stratégies utilisées par les généralistes lorsqu'ils choisissent de limiter leurs prescriptions, pour en favoriser le recours. Méthodes : Un échantillon de généralistes, hétérogène en termes de caractéristiques démographiques, d'âge et de mode d'exercice, ont été interrogés grâce à la méthode des entretiens collectifs jusqu'à saturation des données. Résultats : Trois entretiens ont permis d'interroger 14 femmes et 10 hommes âgés de 32 à 64 ans. Lors de la consultation, différentes stratégies ont été identifiées : l'attitude du praticien (écoute

et valorisation des symptômes, identification précoce de la demande du patient, appui de l'examen clinique), l'emploi de ressources pertinentes (outils et référentiels, actualités) ; l'importance de la clôture de la consultation (conseils écrits ou compte rendu de consultation, relecture et réévaluation de l'ordonnance précédente) et de l'explication (informer des motivations de la limitation, rassurer, argumenter, proposer une consultation contrôle). Enfin, la limitation de prescription s'appuie sur des facteurs propres au praticien (formation initiale et continue, motivation et objectifs personnels, appartenance à un groupe de pairs) mais également sur le réseau de soins (apports de l'institution, du spécialiste). Conclusion : De nombreux éléments favorisent la limitation de prescription : formation et information des praticiens comme des patients, gestion de la consultation, communication avec le réseau de soins et les instances politiques. Les organismes de formation continue et les instances de santé pourraient favoriser ces stratégies, au bénéfice du patient.

Wammes J.J.G., Jeurissen P.P.T., Verhoef L.M., Assendelft W.J.J., Westert G.P., Faber M.J. (2014). Is the role as gatekeeper still feasible? A survey among Dutch general practitioners. *Family Practice*, 31 (5) : 538-544.

Abstract: Introduction. In the 2012 International Health Policy Survey by the Commonwealth Fund, 57% of Dutch GPs indicated that Dutch patients receive too much health care. This is an unexpected finding, given the clear gatekeeper role of Dutch GPs and recent efforts strengthening this role. Objectives. The study aims to explore where perceived overuse of care prevails and to identify factors associated with too much care at the entry point of Dutch health care. Method. An American survey exploring perceptions of the amount of care among primary care providers was modified for relevance to the Dutch health system. We further included additional factors possibly related to overuse based on 12 interviews with Dutch GPs. The survey was sent to a random sample of 600 GPs. Results. Dutch GPs (N = 157; response rate 26.2%) indicated that patients receive (much) too much care in general hospitals, primary care, GP cooperatives as well as private clinics. The Dutch responding GPs showed a relatively demand-satisfying attitude, which contributed to the delivery of too much care, often leading to deviation from guidelines and professional norms. The increasing availability of diagnostic facilities was identified as an additional factor contributing to the provision of unnecessary care. Finally, funding gaps between primary care and hospitals impede cooperation and coordination, provoking unnecessary care. Conclusion. Our results most notably regarding the demand-satisfying attitude of responding GPs-call into question the classical view of the guidance and gatekeeper role of GPs in the Dutch health care system.

<http://fampra.oxfordjournals.org/content/31/5/538.abstract>

Levitt C.A., Nair K., Dolovich L., Price D., Hilts L. (2014). Refinement of indicators and criteria in a quality tool for assessing quality in primary care in Canada: a Delphi Panel study. *Family Practice*, 31 (5) : 607-621.

Abstract: Purpose. Primary care is the cornerstone of the health care system and increasingly countries are developing indicators for assessing quality in primary care practices. The "Quality Tool", developed in Ontario, Canada, provides a framework for assessing practices and consists of indicators and criteria. The purpose of this study was to validate the indicators and simplify the Quality Tool. Methods. This study involved a systematic comparison of indicators in the Quality Tool with those in other local and international tools to determine common indicators to include as valid in the Quality Tool. A Delphi process was used to help reach consensus for inclusion of any indicators that were not included in the comparison exercise. Setting. Primary care in Ontario, Canada. Subjects. Key informants were those with known expertise and experience in quality assessment in primary care. Main outcome. Validated set of indicators for inclusion in an updated Quality Tool. Results. Twenty-three stakeholders participated in the Delphi panel. Forty-four indicators were included as valid after the systematic comparison of similar indicators in other assessment tools. Of the 63 indicators brought to the Delphi panel, 37 were included as valid, 15 were excluded and 11 became criteria for other included indicators. Conclusions. The study resulted in a set of 81 validated primary care indicators. The validation of the indicators provided a strong foundation for the next version of the Quality Tool and may be used for quality assessment in primary care.

<http://fampra.oxfordjournals.org/content/31/5/607.abstract>

Busse R., Stahl J. (2014). Integrated care experiences and outcomes in Germany, the Netherlands, and England. *Health Aff.(Millwood)*, 33 (9) : 1549-1558.

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Abstract: Care for people with chronic conditions is an issue of increasing importance in industrialized countries. This article examines three recent efforts at care coordination that have been evaluated but not yet included in systematic reviews. The first is Germany's *Gesundes Kinzigtal*, a population-based approach that organizes care across all health service sectors and indications in a targeted region. The second is a program in the Netherlands that bundles payments for patients with certain chronic conditions. The third is England's integrated care pilots, which take a variety of approaches to care integration for a range of target populations. Results have been mixed. Some intermediate clinical outcomes, process indicators, and indicators of provider satisfaction improved; patient experience improved in some cases and was unchanged or worse in others. Across the English pilots, emergency hospital admissions increased compared to controls in a difference-in-difference analysis, but planned admissions declined. Using the same methods to study all three programs, we observed savings in Germany and England. However, the disease-oriented Dutch approach resulted in significantly increased costs. The *Kinzigtal* model, including its shared-savings incentive, may well deserve more attention both in Europe and in the United States because it combines addressing a large population and different conditions with clear but simple financial incentives for providers, the management company, and the insurer.

Casalino L.P., Pesko M.F., Ryan A.M., Mendelsohn J.L., Copeland K.R., Ramsay P.P., Sun X., Rittenhouse D.R., Shortell S.M. (2014). Small primary care physician practices have low rates of preventable hospital admissions. *Health Aff.(Millwood.)*, 33 (9) : 1680-1688.

Abstract: Nearly two-thirds of US office-based physicians work in practices of fewer than seven physicians. It is often assumed that larger practices provide better care, although there is little evidence for or against this assumption. What is the relationship between practice size-and other practice characteristics, such as ownership or use of medical home processes-and the quality of care? We conducted a national survey of 1,045 primary care-based practices with nineteen or fewer physicians to determine practice characteristics. We used Medicare data to calculate practices' rate of potentially preventable hospital admissions (ambulatory care-sensitive admissions). Compared to practices with 10-19 physicians, practices with 1-2 physicians had 33 percent fewer preventable admissions, and practices with 3-9 physicians had 27 percent fewer. Physician-owned practices had fewer preventable admissions than hospital-owned practices. In an era when health care reform appears to be driving physicians into larger organizations, it is important to measure the comparative performance of practices of all sizes, to learn more about how small practices provide patient care, and to learn more about the types of organizational structures-such as independent practice associations-that may make it possible for small practices to share resources that are useful for improving the quality of care.

Christianson J.B., Carlin C.S., Warrick L.H. (2014). The dynamics of community health care consolidation: acquisition of physician practices. *Milbank Q*, 92 (3) : 542-567.

Abstract: Policy Points: In order to develop effective policies on the consolidation of community health systems, policymakers must understand both the motivations and processes for consolidation. We found that physician practice consolidation is often a strategic response by providers to public and private cost containment efforts; therefore, it will be difficult to reverse using traditional policy options. Many current health care cost containment policies incentivize continued provider consolidation, which presents a direct challenge to health care reform models that rely on competition among providers to accomplish cost control and quality improvement. CONTEXT: Health care delivery systems are becoming increasingly consolidated in urban areas of the United States. While this consolidation could increase efficiency and improve quality, it also could raise the cost of health care for payers. This article traces the consolidation trajectory in a single community, focusing on factors influencing recent acquisitions of physician practices by integrated delivery systems. METHODS: We used key informant interviews, supplemented by document analysis. FINDINGS: The acquisition of physician practices is a process that will be difficult to reverse in the current health care environment. Provider revenue uncertainty is a key factor driving consolidation, with public and private attempts to control health care costs contributing to that uncertainty. As these efforts will likely continue, and possibly intensify, community health care systems now are less consolidated than they will be in the future. Acquisitions of multispecialty and primary care practices by integrated delivery systems follow a common process, with relatively predictable issues relating to purchase agreements, employment contracts, and

compensation. Acquisitions of single-specialty practices are less common, with motivations for acquisitions likely to vary by specialty type, group size, and market structure. Total cost of care contracting could be an important catalyst for practice acquisitions in the future. **CONCLUSIONS:** In the past, market and regulatory forces aimed at controlling costs have both encouraged and rewarded the consolidation of providers, with important new developments likely to create momentum for further consolidation, including acquisitions of physician practices.

Zendjidjian X.Y., Boyer L., Magalon D., Magalon-Bingenheimer K., Griguer Y., Lancon C. (2014). [Therapeutic patient education of depressive disorder in primary care]. *Presse Med*, 43 (9) : 883-885.

Tak H.J., Hougham G.W., Ruhnke A., Ruhnke G.W. (2014). The effect of in-office waiting time on physician visit frequency among working-age adults. *Soc Sci Med*, 118 43-51.

Abstract: Disparities in unmet health care demand resulting from socioeconomic, racial, and financial factors have received a great deal of attention in the United States. However, out-of-pocket costs alone do not fully reflect the total opportunity cost that patients must consider as they seek medical attention. While there is an extensive literature on the price elasticity of demand for health care, empirical evidence regarding the effect of waiting time on utilization is sparse. Using the nationally representative 2003 Community Tracking Study Household Survey, the most recent iteration containing respondents' physician office visit frequency and estimated in-office waiting time in the United States (N = 23,484), we investigated the association between waiting time and calculated time cost with the number of physician visits among a sample of working-age adults. To avoid the bias that literature suggests would result from excluding respondents with zero physician visits, we imputed waiting time for the essential inclusion of such individuals. On average, respondents visited physician offices 3.55 times, during which time they waited 28.7 min. The estimates from a negative binomial model indicated that a doubling of waiting time was associated with a 7.7 percent decrease (p-value < 0.001) in physician visit frequency. For women and unemployed respondents, who visited physicians more frequently, the decrease was even larger, suggesting a stronger response to greater waiting times. We believe this finding reflects the discretionary nature of incremental visits in these groups, and a consequent lower perceived marginal benefit of additional visits. The results suggest that in-office waiting time may have a substantial influence on patients' propensity to seek medical attention. Although there is a belief that expansions in health insurance coverage increase health care utilization by reducing financial barriers to access, our results suggest that unintended consequences may arise if in-office waiting time increases.

Westert G.P., Jeurissen P.P., Assendelft W.J. (2014). Why Dutch general practitioners do not put the squeeze on access to hospital care? *Fam Pract*, 31 (5) : 499-501.

Van Loenen T., Van den Berg M.J., Westert G.P., Faber M.J. (2014). Organizational aspects of primary care related to avoidable hospitalization: a systematic review. *Family Practice*, 31 (5) : 502-516.

Abstract: Background. Often used indicators for the quality of primary care are hospital admissions rates for conditions which are potentially avoidable by well-functioning primary care. Such hospitalizations are frequently termed as ambulatory care sensitive conditions (ACSCs). Objective. We aim to investigate which characteristics of primary care organization influence avoidable hospitalization for chronic ACSCs. Methods. MEDLINE, Embase and SciSearch were searched for publications on avoidable hospitalization and primary care. Studies were included if peer reviewed, written in English, published between January 1997 and November 2013, conducted in high income countries, identified hospitalization for ACSC as outcome measures and researched organization characteristics of primary care. A risk of bias assessment was performed to assess the quality of the articles. Findings. A total of 1778 publications were reviewed, of which 49 met inclusion criteria. Twenty-two primary care factors were found. Factors were clustered into four primary care clusters: system-level characteristics, accessibility, structural and organizational characteristics and organization of the care process. Adequate physician supply and better longitudinal continuity of care reduced avoidable hospitalizations. Furthermore, inconsistent results were found on the effectiveness

of various disease management programs in reducing hospitalization rates. Conclusions. Available evidence suggests that strong primary care in terms of adequate primary care physician supply and long-term relationships between primary care physicians and patients reduces hospitalizations for chronic ACSCs. There is a lack of evidence for the positive effects of many other organizational primary care aspects, such as specific disease management programs.

<http://fampra.oxfordjournals.org/content/31/5/502.abstract>

Travail et santé / Occupational Health

Mastekaasa A., Melsom A.M. (2014). Occupational Segregation and Gender Differences in Sickness Absence: Evidence from 17 European Countries. *European Sociological Review*, 30 (5) : 582-594.

Abstract: Previous research indicates that women fare less well than men on a wide range of health-related measures, including sickness absence from work. Possible explanations are that women have on average less healthy jobs than men, or that they are more vulnerable to job-related stressors. We address these issues using comparative data on 17 European countries from the EU Labour Force Surveys. Employing logistic regression, we find that gender differences in sickness absence tend to increase if we control for up to 147 detailed occupational categories, thus indicating that women are, if anything, in more healthy jobs than men in most countries. We also examine to what extent the gender differences in sickness absence are systematically related to the gender mix of the occupation, e.g. whether women have particularly high sickness absence in occupations that are strongly male dominated. There is a tendency towards smaller gender differences in female-dominated occupations in a few countries, but in most cases the gender difference is of similar magnitude in female-dominated, male-dominated, and gender-balanced occupations.

<http://esr.oxfordjournals.org/content/30/5/582.abstract>

Van Leeuwen K.M., Malley J., Bosmans J.E., Jansen A.P., Ostelo R.W., Van der Horst H.E., Netten A. (2014). What can local authorities do to improve the social care-related quality of life of older adults living at home? Evidence from the Adult Social Care Survey. *Health Place*, 29 104-113.

Abstract: Local authorities spend considerable resources on social care at home for older adults. Given the expected growth in the population of older adults and budget cuts on local government, it is important to find efficient ways of maintaining and improving the quality of life of older adults. The ageing in place literature suggests that policies in other functions of local authorities may have a significant role to play. This study aims to examine the associations between social care-related quality of life (SCRQoL) in older adults and three potential policy targets for local authorities: (i) accessibility of information and advice, (ii) design of the home and (iii) accessibility of the local area. We used cross-sectional data from the English national Adult Social Care Survey (ASCS) 2010/2011 on service users aged 65 years and older and living at home (N=29,935). To examine the association between SCRQoL, as measured by the ASCOT, and three single-item questions about accessibility of information, design of the home and accessibility of the local area, we estimate linear and quantile regression models. After adjusting for physical and mental health factors and other confounders our findings indicate that SCRQoL is significantly lower for older adults who find it more difficult to find information and advice, for those who report that their home design is inappropriate for their needs and for those who find it more difficult to get around their local area. In addition, these three variables are as strongly associated with SCRQoL as physical and mental health factors. We conclude that in seeking to find ways to maintain and improve the quality of life of social care users living at home, local authorities could look more broadly across their responsibilities. Further research is required to explore the cost-effectiveness of these options compared to standard social care services.

Vieillesse / Aging

Balia S., Brau R. (2014). A country for old men? Long-term home care utilization in Europe. *Health Econ*, 23 (10) : 1185-1212.

Abstract: This paper investigates long-term home care utilization in Europe. Data from the first wave of the Survey on Health, Ageing and Retirement (SHARE) on formal (nursing care and paid domestic help) and informal care (support provided by relatives) are used to study the probability and the quantity of both types of care. The overall process is framed in a fully simultaneous equation system that takes the form of a bivariate two-part model where the reciprocal interaction between formal and informal care is estimated. Endogeneity and unobservable heterogeneity are addressed using a common latent factor approach. The analysis of the relative impact of age and disability on home care utilization is enriched by the use of a proximity to death (PtD) indicator built using the second wave of SHARE. All these indicators are important predictors of home care utilization. In particular, a strong significant effect of PtD is found in the paid domestic help and informal care models. The relationship between formal and informal care moves from substitutability to complementarity depending on the type of care considered, and the estimated effects are small in absolute size. This might call for a reconsideration of the effectiveness of incentives for informal care as instruments to reduce public expenditure for home care services.

Ruppner L., Bostean G. (2014). Who Cares? Caregiver Well-being in Europe. *European Sociological Review*, 30 (5) : 655-669.

Abstract: This paper analyzes a multi-national sample comparing self-reported well-being of those who provide dependent care with that of noncaregivers. We pair individual-level data from the 2004 European Social Survey (ESS) for respondents in 22 nations (n = 41,000+) with country-level measures of attitudinal support for coresidential familial caregiving (2007 Eurobarometer), old age and family public transfers (OECD Social Expenditures Database, 2014), and economic development (GDP). Using multi-level modeling, we examine the association between country-level coresidential familial attitudes and public spending and individual-level caregiver well-being, comparing effects by gender. We find that (i) caregiving is differentially associated with well-being for men and women; (ii) female caregivers report worse well-being than male caregivers in countries with greater attitudinal support for coresidential familial caregiving; (iii) caregivers, regardless of gender, report better well-being in countries with more generous old age transfers. These findings are important in the context of Europe's population structure and the threats to public spending for dependent populations.

<http://esr.oxfordjournals.org/content/30/5/655.abstract>