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Veille bibliographique en économie de la santé / Watch on Health Economics Literature

28 juin 2013 / June 28, 2013

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Assurance Maladie / Health Insurance

(2013). Europe : renforcer la viabilité des régimes de sécurité sociale.

Abstract: Ce rapport recense, résume et analyse les développements et tendances les plus récents dans le domaine de la sécurité sociale en Europe dans la sécurité sociale. Les administrations de la sécurité sociale de la région se caractérisent par leur dynamisme et leur capacité à proposer des réponses efficaces et encourageantes pour résoudre les difficultés qu'elles rencontrent.

Cote Irdes : En ligne

<http://www.issa.int/fre/Ressources/Publications-de-l-AISS/Europe-renforcer-la-viabilite-des-regimes-de-securite-sociale>

Crepin C., Belorgey J.M., Barbier J.C. (2013). Protection sociale française et Europe.

Informations Sociales, (175) : -156p.

Abstract: Cette synthèse met l'accent sur les défis et les enjeux de la protection sociale en Europe. Quelles influences l'eupéanisation de la protection sociale entraîne-t-elle sur le système français, et réciproquement ? Quels sont les traits d'inflexion de la France sur les orientations européennes en la matière ? Il s'agit ainsi de contribuer au débat prospectif sur l'avenir de la protection sociale française tout en tenant compte du contexte européen.

Cote Irdes : c, En ligne

<http://www.cairn.info/revue-informations-sociales-2013-1.htm>

Fronstin P. (2013). Trends in Health Coverage for Part-Time Workers. *Ebri Notes*, 34 (5) : 2-8, fig.

Abstract: This paper reviews recent trends in coverage for workers by hours worked and firm size. It examines data from the U.S. Census Bureau's most recent Current Population Survey. The Patient Protection and Affordable Care Act of 2010 (PPACA) requires that employers with 50 or more full-time workers pay a penalty if they fail to provide health coverage to full-time workers in 2014. While many employers already offer health coverage, there are other provisions of PPACA that are expected to increase the cost of coverage. As a result, there is concern that employers may respond by cutting back on health coverage for part-time workers or by increasing the proportion of part-time workers employed. The recent recession has already resulted in an increased use of part-time workers. The percentage of workers employed part-time has been rising since 2007, increasing from 16.7 percent to 22.2 percent in 2011. While employers with fewer than 50 workers are not subject to the penalty if they do not provide health coverage, they may also drop coverage for part-time workers as a way to compensate for any cost increases so that they can continue offering it to full-time workers. Part-time workers have experienced a much larger decline in coverage than full-time workers. Between 2007 and 2011, full-time workers experienced a 2.8 percent reduction in the likelihood of having coverage from their own jobs, while part-time workers experienced a 15.7 percent decline.

Cote Irdes : En ligne

http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2209914

Grunow M., Nuscheler R. (2013). Public and private Health insurance in Germany. The ignored risk of selection problem. *Health Economics*, n/a.

Abstract: We investigate risk selection between public and private health insurance in Germany. With risk-rated premiums in the private system and community-rated premiums in the public system, advantageous selection in favor of private insurers is expected. Using 2000 to 2007 data from the German Socio-Economic Panel Study (SOEP), we find such selection. While private insurers are unable to select the healthy upon enrollment, they profit from an increase in the probability to switch

from private to public health insurance of those individuals who have experienced a negative health shock. To avoid distorted competition between the two branches of health care financing, risk-adjusted transfers from private to public insurers should be instituted.

Economie de la santé / Health Economics

(2013). Effets redistributifs du financement public des soins de santé au Canada : analyse sur une durée de vie : Ottawa : C.I.H.I.

Abstract: Cette analyse évalue dans quelle mesure les dépenses publiques consacrées aux soins de santé et les paiements d'impôts et de taxes varient d'un groupe de revenu à l'autre. Nous avons estimé la répartition des revenus en tenant compte de la valeur des avantages tirés du système public de santé sous forme de médicaments, de soins hospitaliers et de services de médecins. Cette analyse est inédite puisqu'elle traite de la répartition des dépenses de santé et des paiements d'impôts et de taxes sur toute la durée de vie des Canadiens, et compare ses résultats avec ceux obtenus au moyen d'une approche plus courante qui consiste à observer la répartition sur un an seulement.

L'observation de la répartition sur une durée de vie prend en considération que les personnes des groupes à revenu élevé ont tendance à vivre plus longtemps, et profitent donc plus longtemps des services de santé publics.

Cote Irdes : En ligne

https://secure.cihi.ca/free_products/Lifetime_Distributional_Effects_AiB_FR.pdf

Druet C., Bourdel-Marchasson I., Weill A., Eschwege E., Penfornis A., Fosse S., Fournier C., Chantry M., Attali C., Lecomte P., Simon D., Poutignat N., Gautier A., Risse M., Fagot-Campagna A. (2013). [Type 2 diabetes in France: Epidemiology, trends of medical care, social and economic burden]. *Presse Med*, 42 (5) : 830-838.

Abstract: Between 2001 and 2007, treatments for type 2 diabetes have increased and therapeutic choices have improved. However glycemic control remains insufficient. Cardiovascular risk control has widely increased. Statins, hypertensive and antithrombotic treatments are more often prescribed. Blood pressure and LDL cholesterol levels have decreased whatever age. However, progress remains possible, especially regarding blood pressure control. Obesity has increased between 2001 and 2007 to reach 41% whereas the frequency of dietetic visits has decreased. Insulin therapy (more than obesity) determines the frequency of dietetic visits: dietetic care happens too late. Important improvements of the quality of follow-up are observed. However, fundus exams and more specifically albuminuria measurement remain insufficiently performed and their progression is too slow, as well as the podiatric examination. Only 10% of people with type 2 diabetes have an endocrinology visit, which has been stable between 2001 and 2007. Information expectations of people with type 2 diabetes are strong, especially for diet. Education demand is lower but more important for people who have already benefited. This improvement of medical care leads to an increase in the cost of reimbursements. The consequences of diabetes, more than the disease itself, alter the quality of life.

Holahan J., Mcmorrow S. (2013). What Drove the Recent Slowdown in Health Spending Growth and Can It Continue? Washington : Urban Institute.

Abstract: National health expenditures have grown at record-low rates for the past three years. The recession has been cited as an important driver of recent trends leading many to wonder if slower spending growth will continue as the economy recovers. We review the trends in health spending growth over the last decade and show that growth began to slow well before the most recent recession. We also consider trends in incomes and insurance coverage and suggest that declines in real incomes and a shift towards less generous insurance arrangements have slowed the growth in provider revenues and forced cost containment efforts. The question remains, however, as to whether

the changes that slowed health spending growth over the last decade will be maintained or extended as the economy recovers and the Affordable Care Act expands health insurance coverage.

Cote Irdes : En ligne

<http://www.urban.org/UploadedPDF/412814-What-Drove-the-Recent-Slowdown-in-Health-Spending-Growth.pdf>

Yocom C.L. (2013). Medicaid :Alternative Measures Could Be Used to Allocate Funding More Equitably : Washington : GAO

Abstract: Medicaid is the largest federal program assisting states in financing medical and health-related services for certain low-income individuals. States and the federal government share in the financing of the Medicaid program, with the federal government matching most state expenditures for Medicaid services on the basis of a statutory formula known as the FMAP, which is based solely on state PCI in relation to national PCI. Prior GAO work has raised concerns about the FMAP, noting that PCI does not accurately represent states' populations in need of Medicaid services or states' ability to finance services, and does not account for geographic cost differences among states. GAO was asked to examine ways to improve the allocation of Medicaid funding.

Cote Irdes : En ligne

<http://www.gao.gov/assets/660/654477.pdf>

Gyrd-Hansen D., Jensen M.L., Kjaer T. (2013). Framing the willingness-to-pay question: impact on response patterns and mean willingness-to-pay. *Health Economics*, n/a.

Abstract: In this study, respondents were randomly allocated to three variants of the payment card format and an open-ended format in order to test for convergent validity. The aim was to test whether preferences (as measured by willingness to pay additional tax) would be affected by framing the willingness-to-pay question differently. Results demonstrated that valuations were highly sensitive to whether respondents were asked to express their maximum willingness to pay per month or per year. Another important finding is that the introduction of a binary response filter prior to the payment card follow-up tends to eliminate the positive aspects of introducing a payment card and produces response patterns that are much in line with those of the open-ended contingent valuation format. However, although a filter will impact on the distribution of willingness-to-pay bids and on the rate of zero and protest bids, the overall impact on the welfare estimate is minor. The outcomes of this study indicate that valuations in the stated preference literature may be, at least in part, a function of the instrument designed to obtain the valuations.

Charrier N., Chevreur K., Durand-Zaleski I. (2013). [The cost of schizophrenia: A literature review]. *Encéphale*, 39 Suppl 1 S49-S56.

Abstract: INTRODUCTION: Schizophrenia represents a major burden for patients, their families, healthcare systems and societies. The objective of this literature review is to document the economic burden of schizophrenia. METHOD: The literature search was performed using the MEDLINE-PUBMED database and the following keywords: schizophrenia and cost, burden of disease, qaly or price. The grey literature search was performed using several databases (e.g. Banque de Données en Santé Publique) and the Google Scholar((R)) web search engine. The studies that met the following criteria were included: published since 1998, written in English or French, studied OECD countries and presented costs data that were given in monetary terms. The costs data identified in the literature were classified into the following five main categories: cost for healthcare system, cost for social and medico-social system (medico-social system is a French specificity), cost for prison and legal systems, cost of informal care given by family, and cost associated with productivity losses. To improve comparability, costs were reported as a percentage of health care expenditures and as a per-ten-thousand of GDP (gross domestic product). RESULTS: Among the 201 articles identified as potentially relevant to the topic, nine were included in the literature review. Schizophrenia health care costs ranged from four (Ireland) to 140000 of GDP (Spain). Hospital care was the main health care cost

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driver but ranged from 19 (USA) to 92% (Belgium) demonstrating a great variability in treatment patterns. The costs for social and medico-social system ranged from 1.3 (Korea) to 13.80000 of GDP (USA) and the costs of informal caregivers ranged from 1.2 (Australia) to 12.70000 of GDP (Spain). The productivity losses associated with unemployment ranged from 6.2 (Australia) to 21.30000 of GDP (USA). The productivity losses associated with premature mortality ranged from less than 0.01 (Canada) to 3.850000 (Ireland). Among others factors, such as targeted population, the choice of valuation method between "Friction costs" and "Human Capital" could account for the heterogeneity of estimates. DISCUSSION: Median health care costs of schizophrenia represented 1.1% of total national health care expenditures. Productivity losses associated with morbidity constituted the major cost burden of schizophrenia. Valuation method, costs items, target populations and prevalence rates differed widely from study to study. Furthermore, the burden attributable to loss of quality of life was not estimated in the studies. CONCLUSION: Cost-of-illness studies of schizophrenia provide information about its burden on society. The external validity of such studies however is poor and justifies country-specific data collection.

Ginsburg P.B. (2013). Achieving health care cost containment through provider payment reform that engages patients and providers. *Health Aff.(Millwood.)*, 32 (5) : 929-934.

Abstract: The best opportunity to pursue cost containment in the next five to ten years is through reforming provider payment to gradually diminish the role of fee-for-service reimbursement. Public and private payers have launched many promising payment reform pilots aimed at blending fee-for-service with payment approaches based on broader units of care, such as an episode or patients' total needs over a period of time, a crucial first step. But meaningful cost containment from payment reform will not be achieved until Medicare and Medicaid establish stronger incentives for providers to contract in this way, with discouragement of nonparticipation increasing over time. In addition, the models need to evolve to engage beneficiaries, perhaps through incentives for patients to enroll in an accountable care organization and to seek care within that organization's network of providers.

Rosen A.B., Aizcorbe A., Ryu A.J., Nestoriak N., Cutler D.M., Chernew M.E. (2013). Policy makers will need a way to update bundled payments that reflects highly skewed spending growth of various care episodes. *Health Aff.(Millwood.)*, 32 (5) : 944-951.

Abstract: Bundled payment entails paying a single price for all services delivered as part of an episode of care for a specific condition. It is seen as a promising way to slow the growth of health care spending while maintaining or improving the quality of care. To implement bundled payment, policy makers must set base payment rates for episodes of care and update the rates over time to reflect changes in the costs of delivering care and the components of care. Adopting the fee-for-service paradigm of adjusting payments with uniform update rates would be fair and accurate if costs increased at a uniform rate across episodes. But our analysis of 2003 and 2007 US commercial claims data showed spending growth to be highly skewed across episodes: 10 percent of episodes accounted for 82.5 percent of spending growth, and within-episode spending growth ranged from a decline of 75 percent to an increase of 323 percent. Given that spending growth was much faster for some episodes than for others, a situation known as skewness, policy makers should not update episode payments using uniform update rates. Rather, they should explore ways to address variations in spending growth, such as updating episode payments one by one, at least at the outset.

Etat de santé / Health Status

(2013). European Perinatal Health Report. The health and care of pregnant women and babies in Europe in 2010 : Europeristat.

Abstract: Le nouveau rapport EURO-PERISTAT présente les données de la santé périnatale en 2010 pour 26 pays membres de l'Union Européenne, plus l'Islande, la Norvège et la Suisse. EURO-PERISTAT est financé par la Commission européenne (Programme de santé de l'UE, DG Santé et Consommateurs) et coordonné par l'Inserm. Ce rapport réunit les caractéristiques des femmes enceintes et des nouveau-nés, leur santé, et les pratiques médicales pendant la grossesse, l'accouchement et le post-partum en 2010. Il comprend également les données de deux autres projets européens en lien avec la santé périnatale sur la paralysie cérébrale (SCPE) et les anomalies congénitales (EUROCAT). Le rapport permet de situer la France par rapport aux autres pays européens et d'apprécier ses points forts et ses points faibles, en matière de système d'information (recueil des données concernant la mère et l'enfant) et d'indicateurs sur la santé et les pratiques médicales.

Cote Irdes : En ligne

http://www.europeristat.com/images/European%20Perinatal%20Health%20Report_2010.pdf

Amiet C., Arnaud C., Bachoud-Lévi A.-C., et al. (2013). Handicaps rares, contextes, enjeux et perspectives. Synthèse et recommandations. Expertise collective. Paris : INSERM.

Abstract: Le terme de « handicaps rares » a été introduit dans la législation française pour prendre en compte, dans l'organisation du secteur médico-social, la situation des personnes (enfants ou adultes) atteintes de deux déficiences ou plus et dont la prise en charge requiert le recours à des compétences très spécialisées. Les textes réglementaires définissent les handicaps rares par une faible prévalence (inférieure à 1 cas pour 10 000 habitants), une combinaison de déficiences et de limitations nécessitant une prise en charge complexe pour laquelle il existe peu d'expertise d'intervention (au niveau de la détection, de l'évaluation fonctionnelle et de l'accompagnement). La démarche proposée au groupe d'experts sollicité par l'Inserm, a été d'aborder, sous un angle à la fois clinique et scientifique, plusieurs configurations illustratives (surdicécité, maladie de Huntington, association d'épilepsie et d'autisme, polyhandicaps sévères) pouvant servir de modèles et aider à conceptualiser une problématique de prise en charge des handicaps rares. Il a été également recherché les spécificités et points communs aux différentes situations de handicaps rares : (historique de la notion, référence aux classifications internationales) ; données de prévalence ; stratégies d'intervention (éducation et scolarité, accompagnement des familles, communication et langage, coût des prises en charge...)

Cote Irdes : En ligne

<http://www.inserm.fr/thematiques/sante-publique/expertises-collectives>

Binder M., Coad A. (2013). "I'm afraid I have bad news for you..." Estimating the impact of different health impairments on subjective well-being. *Soc Sci Med*, 87 155-167.

Abstract: Bad health decreases individuals' happiness, but few studies measure the impact of specific illnesses. We apply matching estimators to examine how changes in different (objective) conditions of bad health affect subjective well-being for a sample of 100,265 observations from the British Household Panel Survey (BHPS) database (1996-2006). The strongest effect is for alcohol and drug abuse, followed by anxiety, depression and other mental illnesses, stroke and cancer. Adaptation to health impairments varies across health impairments. There is also a puzzling asymmetry: strong adverse reactions to deteriorations in health appear alongside weak increases in well-being after health improvements. In conclusion, our analysis offers a more detailed account of how bad health influences happiness than accounts focusing on how bad self-assessed health affects individual well-being.

Géographie de la santé / Geography of Health

(2013). Accès aux soins : en finir avec la fracture territoriale : Paris : Institut Montaigne.

Abstract: Très onéreux, d'une grande complexité institutionnelle et administrative, le système de soins français pêche également par l'archaïsme de son organisation, caractérisé par de forts cloisonnements entre ville et hôpital comme entre professionnels de santé. Au-delà des problèmes – évidents – de répartition sur le territoire des professionnels de santé, la question est sans doute plutôt celle du modèle d'organisation des soins en France, qui ne correspond plus aux exigences sociales, démographiques et technologiques de notre pays. Face à ces défis et dans un contexte de finances publiques contraint, comment adapter notre système de santé ? C'est vers une organisation décloisonnée, régionalisée, construite autour des besoins des patients qu'il faut s'orienter. Le système de santé doit également s'adapter aux exigences des nouvelles générations de professionnels de santé et leur offrir les moyens d'exercer leur métier de façon regroupée, en bénéficiant de l'apport des nouvelles technologies.

Cote Irdes : En ligne

<http://www.institutmontaigne.org/fr/publications/acces-aux-soins-en-finir-avec-la-fracture-territoriale>

Febvre D. (2013). Collectivités territoriales et santé : dossier. *Actualité et Dossier en Santé Publique*, (82) : 13-67.

Cote Irdes : P49

Lucas-Gabrielli V., Coldefy M. (2013). Le territoire comme élément structurant de l'organisation des soins. *Actualité et Dossier en Santé Publique*, (82) : 32-34.

Cote Irdes : P49

Yasaitis L.C., Bynum J.P.W., Skinner J.S. (2013). Association Between Physician Supply, Local Practice Norms, and Outpatient Visit Rates. *Medical Care*, 51 (6) : 524-531

Abstract: Background: There is considerable regional variation in Medicare outpatient visit rates; such variations may be the consequence of patient health, race/ethnicity differences, patient preferences, or physician supply and beliefs about the efficacy of frequently scheduled visits. Objective: The objective of the study was to test associations between varying regional Medicare outpatient visit rates and beneficiaries' health, race/ethnicity, preferences, and physician practice norms and supply. Methods: We used Medicare claims from 2006 and 2007 and data from national surveys of 3 different groups in 2005—Medicare beneficiaries, cardiologists, and primary care physicians. Regression analysis tested explanations for outpatient visit rates: patient health (self-reported and hierarchical condition category score), self-reported race/ethnicity, preferences for care, and local physician practice norms and supply in beneficiaries' Hospital Referral Regions (HRRs) of residence. Results: Beneficiaries in the highest quintile of the hierarchical condition category scores experienced 4.99 more visits than those in the lowest. Beneficiaries who were black experienced 2.14 fewer visits than others with similar health and preferences. Higher care-seeking preferences were marginally significantly associated with more visits, whereas education and poverty were insignificant. HRRs with high physician supply and high-frequency practice norms were associated with 2.04 additional visits per year, whereas HRRs with high supply but low-frequency norms were associated with 1.45 additional visits. Adjusting for all individual beneficiary covariates explained <20% of the original associations between visit rates and physician supply and practice norms. Conclusions: Medicare beneficiaries' health status, race, and preferences help explain individual office visit frequency; in particular, African-American patients appear to experience lower access to care. Yet, these factors explain a small fraction of the observed regional differences associated with physician supply and beliefs about the appropriate frequency of office visits.

Hôpital / Hospital

Baicker K., Chernew M., Robbins J. (2013). The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization : Cambridge : NBER

Abstract: More than a quarter of Medicare beneficiaries are enrolled in Medicare Advantage, which was created in large part to improve the efficiency of health care delivery by promoting competition among private managed care plans. This paper explores the spillover effects of the Medicare Advantage program on the traditional Medicare program and other patients, taking advantage of changes in Medicare Advantage payment policy to isolate exogenous increases in Medicare Advantage enrollment and trace out the effects of greater managed care penetration on hospital utilization and spending throughout the health care system. We find that when more seniors enroll in Medicare managed care, hospital costs decline for all seniors and for commercially insured younger populations. Greater managed care penetration is not associated with fewer hospitalizations, but is associated with lower costs and shorter stays per hospitalization. These spillovers are substantial – offsetting more than 10% of increased payments to Medicare Advantage plans.

Cote Irdes : En ligne

<http://www.nber.org/papers/w19070>

Levit K.R., Friedman B., Wong H.S. (2013). Estimating Inpatient Hospital Prices from State Administrative Data and Hospital Financial Reports. *Health Services Research*, n/a.

Abstract: Objective To develop a tool for estimating hospital-specific inpatient prices for major payers. Data Sources AHRQ Healthcare Cost and Utilization Project State Inpatient Databases and complete hospital financial reporting of revenues mandated in 10 states for 2006. Study Design Hospital discharge records and hospital financial information were merged to estimate revenue per stay by payer. Estimated prices were validated against other data sources. Principal Findings Hospital prices can be reasonably estimated for 10 geographically diverse states. All-payer price-to-charge ratios, an intermediate step in estimating prices, compare favorably to cost-to-charge ratios. Estimated prices also compare well with Medicare, MarketScan private insurance, and the Medical Expenditure Panel Survey prices for major payers, given limitations of each dataset. Conclusions Public reporting of prices is a consumer resource in making decisions about health care treatment; for self-pay patients, they can provide leverage in negotiating discounts off of charges. Researchers can also use prices to increase understanding of the level and causes of price differentials among geographic areas. Prices by payer expand investigational tools available to study the interaction of inpatient hospital price setting among public and private payers' an important asset as the payer mix changes with the implementation of the Affordable Care Act.

Coevoet V., Fresson J., Vieux R., Jay N. (2013). Socioeconomic Deprivation and Hospital Length of Stay: A New Approach Using Area-based Socioeconomic Indicators in Multilevel Models. *Medical Care*, 51 (6) : 548-54

Abstract: Background: Socioeconomic deprivation is not easily measurable in hospital information systems. However, its identification is essential, as it is associated with morbidity and hospital length of stay (LOS). We aimed at studying the feasibility of using routinely recorded individual and area-based socioeconomic indicators, and assessing their relation with LOS. Methods: In a cross-sectional

study we collected area-based socioeconomic deprivation indicators from French census databases and individual ones from the 2009 medical and administrative databases of a French referral maternity hospital. The principal outcome was the LOS for delivery. Individual level socioeconomic deprivation indicators included preferential insurance scheme (health insurance allocated to poor persons). Nine area-based socioeconomic deprivation indicators were aggregated at the census tract and commune levels. The relation between socioeconomic deprivation and LOS was studied using multilevel models. The well-documented relation between socioeconomic deprivation and preterm delivery was firstly studied in these models as a validation step. Results: The linkage between aggregated and individual data was possible for the 3471 women included. The median LOS was 5 days. In multivariable analysis adjusted for age ($P=0.02$), twinning ($P=0.0001$), delivery mode ($P<0.0001$), drug addiction ($P<0.0001$), diagnosis-related group severity level ($P<0.0001$), and unemployment rate ($P=0.002$) were associated with an increased LOS. Conclusions: Identifying deprived patients in hospital databases using routinely collected area-based indicators is feasible. The relation of these latter with LOS is consistent with previous studies. Further multicenter investigations are needed to confirm the interest of using such indicators for cost and morbidity predictions.

Keyhani S., Falk R., Howell E.A., Bishop T., Korenstein D. (2013). Overuse and Systems of Care: A Systematic Review. *Medical Care*, 51 (6) : 503-508

Abstract: Background: Current health care reform efforts are focused on reorganizing health care systems to reduce waste in the US health care system. Objective: To compare rates of overuse in different health care systems and examine whether certain systems of care or insurers have lower rates of overuse of health care services. Data Sources: Articles published in MEDLINE between 1978, the year of publication of the first framework to measure quality, and June 21, 2012. Study Selection: Included studies compared rates of overuse of procedures, diagnostic tests, or medications in at least 2 systems of care. Data Extraction: Four reviewers screened titles; 2 reviewers screened abstracts and full articles and extracted data. Results: We identified 7 studies which compared rates of overuse of 5 services across multiple different health care settings. National rates of inappropriate coronary angiography were similar in Medicare HMOs and Medicare FFS (13% vs. 13%, $P=0.33$) and in a state-based study comparing 15 hospitals in New York and 4 hospitals in a Massachusetts-managed care plan (4% vs. 6%, $P>0.1$). Rates of carotid endarterectomy in New York State were similar in Medicare HMOs and Medicare FFS plans (8.4% vs. 8.6%, $P=0.55$) but non recommended use of antibiotics for the treatment of upper respiratory infection was higher in a managed care organization than a FFS private plan (31% vs. 21%, $P=0.02$). Rates of inappropriate myocardial perfusion imaging were similar in VA and private settings (22% vs. 16.6%, $P=0.24$), but rates of inappropriate surveillance endoscopy in the management of gastric ulcers were higher in the VA compared with private settings (37.4% vs. 20.4%-23.3%, $P<0.0001$). Conclusions: The available evidence is limited but there is no consistent evidence that any 1 system of care has been more effective at minimizing the overuse of health care services. More research is necessary to inform current health care reform efforts directed at reducing overuse.

Jung K., Polsky D. (2013). Competition and quality in home health care markets. *Health Economics*, n/a.

Abstract: Market-based solutions are often proposed to improve health care quality; yet evidence on the role of competition in quality in non-hospital settings is sparse. We examine the relationship between competition and quality in home health care. This market is different from other markets in that service delivery takes place in patients' homes, which implies low costs of market entry and exit for agencies. We use 6 years of panel data for Medicare beneficiaries during the early 2000s. We identify the competition effect from within-market variation in competition over time. We analyze three quality measures: functional improvements, the number of home health visits, and discharges without hospitalization. We find that the relationship between competition and home health quality is nonlinear and its pattern differs by quality measure. Competition has positive effects on functional improvements and the number of visits in most ranges, but in the most competitive markets, functional outcomes and the number of visits slightly drop. Competition has a negative effect on discharges without hospitalization that is strongest in the most competitive markets. This finding is different from prior research on hospital markets and suggests that market-specific environments should be considered in developing policies to promote competition.

Murphy M. (2013). Use of hospital and long-term institutional care services in relation to proximity to death among older people in Finland. *Social Science & Medicine*, 88 (7) : 39-47.

Abstract: Using nationally-representative register data for older people in Finland in period 1998–2003 we study how the number of days in acute hospital and long term institutional care services varies by age and proximity to death and how these use patterns change as mortality improves. Acute health care use depends more on proximity to death than on age, a finding often interpreted as showing that the need for care services among older people will be substantially less than would be expected based on the likely increase in population numbers. We show that this assumption is too optimistic for three reasons: (1) the increase in population numbers will be concentrated mainly among the “old old” where use of services is substantial; (2) earlier findings of much lower use of acute care services by older than younger people who are close to death are not observed; and (3) any savings in acute care are more than offset by greater use of residential long-term care (LTC). The main consequences of improving mortality are: (1) to postpone rather than to reduce overall demand for health care; (2) to shift the balance of care from acute to long-term care services; and (3) to increase considerably the average age of time spent in care. We further construct a new indicator “care-free life expectancy” based on number of days in hospital and long-term care to summarise care use patterns for cohorts under a range of plausible mortality assumptions. As mortality improves, lifetime use of acute hospital and long-term care after age 65 and the proportion of life spent in LTC increases for later cohorts, but the proportion spent in acute care decreases slightly.

He D., Mellor J.M. (2013). Do Changes in Hospital Outpatient Payments Affect the Setting of Care? *Health Services Research*, n/a.

Abstract: Objective To examine whether decreases in Medicare outpatient payment rates under the Outpatient Prospective Payment System (OPPS) caused outpatient care to shift toward the inpatient setting. Data Sources/Study Setting Hospital inpatient and outpatient discharge files from the Florida Agency for Health Care Administration from 1997 through 2008. Study Design This study focuses on inguinal hernia repair surgery, one of the most commonly performed surgical procedures in the United States. We estimate multivariate regressions of inguinal hernia surgery counts in the outpatient setting and in the inpatient setting. The key explanatory variable is the time-varying Medicare payment rate specific to the procedure and hospital. Control variables include time-varying hospital and county characteristics and hospital and year-fixed effects. Principal Findings Outpatient hernia surgeries fell in response to OPPS-induced rate cuts. The volume of inpatient hernia repair surgeries did not increase in response to reductions in the outpatient reimbursement rate. Conclusions Potential substitution from the outpatient setting to the inpatient setting does not pose a serious threat to Medicare's efforts to contain hospital outpatient costs.

Huntley A.L., Thomas R., Mann M., Huws D., Elwyn G., Paranjothy S., Purdy S. (2013). Is case management effective in reducing the risk of unplanned hospital admissions for older people? A systematic review and meta-analysis. *Fam Pract*, 30 (3) : 266-275.

Abstract: BACKGROUND: Case management is a collaborative practice involving coordination of care by a range of health professionals, both within the community and at the interface of primary and secondary care. It has been promoted as a way of reducing unplanned admissions in older people. OBJECTIVE: The objective was to systematically review evidence from randomized controlled trials regarding the effectiveness of case management in reducing the risk of unplanned hospital admissions in older people. METHODS: Eighteen databases were searched from inception to June 2010. Relevant websites were searched with key words and reference lists of included studies

checked. A risk-of-bias tool was used to assess included studies and data extraction performed using customized tables. The primary outcome of interest was enumeration of unplanned hospital admission or readmissions. RESULTS: Eleven trials of case management in the older population were included. Risk of bias was generally low. Six were trials of hospital-initiated case management. Three were suitable for meta-analysis, of which two showed a reduction in unplanned admissions. Overall, there was no statistically significant reduction in unplanned admissions [relative rate: 0.71 (95% confidence interval, CI: 0.49 to 1.03)]. Three trials reported reduced length of stay. Five trials were of community-initiated case management. None showed a reduction in unplanned admissions. Three were suitable for meta-analysis [mean difference in unplanned admissions: 0.05 (95% CI: -0.04 to 0.15)]. CONCLUSIONS: The identified trials included a range of case management interventions. Nine of the 11 trials showed no reduction of unplanned hospital admissions with case management compared with the same with usual care.

Inégalités de santé / Health Inequalities

Campion C.L. (2013). Réussir 2015. Accessibilité des personnes handicapées au logement, aux établissements recevant du public, aux transports, à la voirie et aux espaces publics : Paris : Sénat.

Abstract: A l'approche de 2015, ce rapport fait le point sur l'état d'avancement de l'accessibilité des personnes en situation de handicap en France et de rechercher, dans la concertation, les solutions qui permettront à notre pays de répondre le mieux possible aux attentes légitimes suscitées par la loi de 2005. Quatre champs d'investigation ont été examinés : le logement, les établissements recevant du public, les transports ainsi que la voirie et les espaces publics.

Cote Irdes : C, En ligne

<http://www.gouvernement.fr/presse/synthese-du-rapport-de-claire-lise-campion-sur-l-accessibilite-des-personnes-en-situation-de->

(2013). Santé précaire des personnes étrangères placées en rétention administrative.

Revue Prescrire, (356) : 465.

Cote Irdes : P80

Chauvin P., Parizot I., Valle, . (2013). Les inégalités sociales et territoriales de santé en milieu urbain : enseignements de la cohorte SIRS. *Actualité et Dossier en Santé Publique*, (82) : 29-32.

Cote Irdes : P49

Freedman R.A., He Y., Winer E.P., Keating N.L. (2013). Racial/Ethnic Differences in Receipt of Timely Adjuvant Therapy for Older Women with Breast Cancer: Are Delays Influenced by the Hospitals Where Patients Obtain Surgical Care? *Health Services Research*, n/a.

Abstract : We examined delays in adjuvant chemotherapy or radiation for women diagnosed with stage I-III breast cancer during 1992-2007. We used multivariable logistic regression to assess the probability of delay by race/ethnicity and included hospital fixed effects to assess whether hospitals explained disparities. Among 54,592 women, black (11.9 percent) and Hispanic (9.9 percent) women had more delays than whites (7.8 percent, $p < .0001$). After adjustment, black (vs. white) women had higher odds of delay (odds ratio = 1.25, 95 percent confidence interval = 1.10-1.42), attenuated somewhat by including hospital fixed effects (OR = 1.17, 95 percent CI = 1.02-1.33). Hospitals are the important contributors to racial disparities in treatment delay.

Furtado D., Theodoropoulos N. (2013). SSI for Disabled Immigrants: Why Do Ethnic Networks Matter. *The American Economic Review*, 103 (3) : 462-466.

Abstract: Immigrants residing among many coethnics are especially likely to receive SSI for a disability when they belong to high SSI take-up immigrant groups. After showing that this relationship cannot be fully explained by differences in health, we consider the likely sources of these network effects by separately examining their role in the decision to apply for SSI and, conditional on applying, their role in determining who ultimately receives benefits. Our results suggest that networks may increase the probability of applying for SSI despite minor disabilities, but it is unlikely that network effects are driven by egregious lies on applications.

Médicaments / Pharmaceuticals

(2013). Medicam 2008- 2012 : Paris : Cnamts.

Abstract: Medic'AM présente des informations détaillées sur les médicaments remboursés au cours des années 2008 à 2012 (Régime Général - Hors Sections Locales Mutualistes - Métropole). Ce tableau présente pour chaque médicament, par code CIP, les données suivantes : la base de remboursement ; le montant remboursé ; le dénombrement (nombre de boîtes remboursées) ; la base de remboursement des prescripteurs de ville ; la base de remboursement des autres prescripteurs

Cote Irdes : c, en ligne

<http://www.ameli.fr/l-assurance-maladie/statistiques-et-publications/donnees-statistiques/medicament/medic-am-2008-2012.php>

(2013). Retroced'am 2010-2012 : Paris : Cnamts.

Abstract: Rétrocéd'AM présente des informations détaillées sur les médicaments remboursés dans le cadre de la rétrocession hospitalière (Régime Général - y compris Sections Locales Mutualistes - Métropole). Ce tableau présente par code UCD : la base de remboursement ; la marge de rétrocession (montants inclus dans la base de remboursement présentée) ; le montant remboursé ; le nombre d'unités remboursées. La base de remboursement et le montant remboursé sont présentés par code nature prestation pour les prestations ne donnant pas lieu à la remontée d'informations par code UCD

Cote Irdes : C, en ligne

<http://www.ameli.fr/l-assurance-maladie/statistiques-et-publications/donnees-statistiques/medicament/retroced-am-2010-2012.php>

Biosse Duplan A. (2013). Liens économiques entre industries de santé et associations de patients : bilan de trois ans de transparence. *Actualité et Dossier en Santé Publique*, (82) : 9-11.

Cote Irdes : P49

Lobo F., Feldman R. (2013). Generic drug names and social welfare. *J Health Polit. Policy Law*, 38 (3) : 573-597.

Abstract: This article studies how well International Nonproprietary Names (INNs), the "generic" names for pharmaceuticals, address the problems of imperfect information. Left in private hands, the identification of medicines leads to confusion and errors. Developed in the 1950s by the World Health Organization, INNs are a common, global, scientific nomenclature designed to overcome this failure. Taking stock after sixty years, we argue that the contribution of INNs to social welfare is paramount. They enhance public health by reducing errors and improving patient safety. They also contribute to

economic efficiency by creating transparency as the foundation of competitive generic drug markets, reducing transaction costs, and favoring trade. The law in most countries requires manufacturers to designate pharmaceuticals with INNs in labeling and advertising. Generic substitution is also permitted or mandatory in many countries. But not all the benefits of INNs are fully realized because prescribers may not use them. We advocate strong incentives or even legally binding provisions to extend the use of INNs by prescribing physicians and dispensing pharmacists, but we do not recommend replacing brand names entirely with INNs. Instead, we propose dual use of brand names and INNs in prescribing, as in drug labeling.

Rischatsch M., Trottmann M., Zweifel P. (2013). Generic substitution, financial interests, and imperfect agency. *Int J Health Care Finance Econ*, 13 (2) : 115-138.

Abstract: Policy makers around the world seek to encourage generic substitution. In this paper, the importance of prescribing physicians' imperfect agency is tested using the fact that some Swiss jurisdictions allow physicians to dispense drugs on their own account (physician dispensing, PD) while others disallow it. We estimate a model of physician drug choice with the help of drug claim data, finding a significant positive association between PD and the use of generics. While this points to imperfect agency, generics are prescribed more often to patients with high copayments or low incomes.

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Klemenc-Ketis Z., Kersnik J. (2013). The assessment of pharmaceutical sales representatives by family physicians--does it affect the prescribing index? *Fam Pract*, 30 (3) : 320-324.

Abstract: Background: Physicians' prescribing patterns depend on fixed and influence-sensitive factors. The latter include the influence of interactions with the pharmaceutical industry. Objective: To determine whether the assessment of pharmaceutical sales representatives (PSRs) by family physicians was associated with their actual prescribing index. Methods: Cross-sectional anonymous postal study. We included all family physicians working in practice settings in Slovenia in 2011. Settings: Slovenian family physicians' surgeries. Main outcome measure: Prescribing index of Slovenian family physicians. Results: We received 247 responses (27.6% response rate). A prescribing index >100% was present in 57 (23.1%) of the respondents. Multivariate analysis revealed that working in regions of Slovenia other than the central region might be associated with a prescribing

index >100%. Assessment of PSRs by family physicians was not significantly associated with a prescribing index >100%. Conclusion: The assessment of PSRs by family physicians does not have any substantial correlations with their prescribing index.

Méthodologie – Statistique / Methodology – Statistics

De Riccardis N. (2013). Traitements de la non-réponse et calages pour l'enquête santé et itinéraire professionnel de 2010. *Document de travail. Série Sources et Méthodes*, (36) : 73p.

Abstract: Ce document de travail décrit la mise en place des deux jeux de pondérations construits pour l'enquête Santé et itinéraire professionnel (SIP) : un premier permettant une exploitation en panel (rassemblant les personnes répondantes aux deux vagues 2006 et 2010) et un second destiné à des analyses transversales sur les facteurs de risques psychosociaux au travail pour la seconde vague de l'enquête (2010). Ces jeux de pondérations sont construits à la suite des processus de traitement de la non-réponse et de calage.

Cote Irdes : S35/4

<http://www.drees.sante.gouv.fr/traitements-de-la-non-reponse-et-calages-pour-l-enquete,11027.html>

Mermillod C. (2013). L'impact de la mise en place d'un suivi d'adresse entre les deux vagues de l'enquête santé et itinéraire professionnel (SIP). *Document de travail. Série Sources et Méthodes*, (37) : 26p.

Abstract: L'enquête Santé et itinéraire professionnel (SIP) a pour objet les interactions entre le travail, l'emploi et la construction ou l'altération de la santé, en prenant en compte les décalages temporels. La seconde vague de l'enquête, réalisée en 2010, reposait sur la ré-interrogation des 14 000 personnes interrogées en 2006. Le suivi d'adresse mis en place avait pour vocation de limiter l'attrition entre les deux vagues. Le document décrit le protocole, Il rend compte des étapes du suivi et analyse les résultats de collecte de la 2nde vague au regard de ce bilan intermédiaire.

Cote Irdes : S35/4

<http://www.drees.sante.gouv.fr/l-impact-de-la-mise-en-place-d-un-suivi-d-adresse-entre-les,11028.html>

Jonker M.F., Congdon P.D., van Lenthe F.J., Donkers B., Burdorf A., Mackenbach J.P. (2013). Small-area health comparisons using health-adjusted life expectancies: A Bayesian random-effects approach. *Health & Place*, (Ahead of pub) :

Abstract: Health-adjusted life expectancy (HALE) is one of the most attractive summary measures of population health. It provides balanced attention to fatal as well as non-fatal health outcomes, is sensitive to the severity of morbidity within the population, and can be readily compared between areas with very different population age structures. HALE, however, cannot be calculated at the small-area level using traditional life table methodology. Hence we propose a Bayesian random-effects modeling approach that recognizes correlations and pools strength between genders, age-groups, geographical areas, and health outcomes. This approach allows for the calculation of HALE for areas as small as 2,000 person years at risk and with relatively modest health state survey sample sizes. The feasibility of the Bayesian approach is illustrated in a real-life example, which also shows how differences in areas' health performances can be adequately quantified. Such information can be invaluable for the appropriate targeting and subsequent evaluation of urban regeneration, neighborhood renewal, and community-based initiatives aimed at improving health and reducing health inequalities.

Baker R., Wildman J., Mason H., Donaldson C. (2013). Q-ing for health - a new approach to eliciting the public's view on health care resource allocation. *Health Economics*, (Ahead of pub)

Abstract: The elicitation of societal views about healthcare priority setting is an important, contemporary research area, and there are a number of studies that apply either qualitative techniques or quantitative preference elicitation methods. However, there are methodological challenges in connecting qualitative information (what perspectives exist about a subject) with quantitative questions (to what extent are those perspectives 'supported' in a wider population). In this paper, we present an integrated, mixed-methods approach to the elicitation of public perspectives in two linked studies applying Q methodology. In the first study, we identify three broad viewpoints on the subject of health priorities. In the second study, using Q-survey methods, we describe and illustrate methods to investigate the distribution of those views in the wider population. The findings of the second study suggest that no single viewpoint dominates and none of the three views represents a 'minority perspective'. We demonstrate the potential of Q methodology as a methodological framework that can be used to link qualitative and quantitative questions and suggest some advantages of this over other approaches. However, as this represents the first applied study of this kind, there are methodological questions that require further exploration and development.

Chesher A., Rosen A.M. (2013). What Do Instrumental Variable Models Deliver with Discrete Dependent Variables. *The American Economic Review*, 103 (3) : 557-562.

Abstract: We compare nonparametric instrumental variables (IV) models with linear models and 2SLS methods when dependent variables are discrete. A 2SLS method can deliver a consistent estimator of a Local Average Treatment Effect but is not informative about other treatment effect parameters. The IV models set identify a range of interesting structural and treatment effect parameters. We give set identification results for a counterfactual probability and an Average Treatment Effect in a IV binary threshold crossing model. We illustrate using data on female employment and family size (employed by Joshua Angrist and William Evans (1998)) and compare with their LATE estimates.

Watkins S., Jonsson-Funk M., Brookhart M.A., Rosenberg S.A., O'Shea T.M., Daniels J. (2013). An Empirical Comparison of Tree-Based Methods for Propensity Score Estimation. *Health Services Research*, (Ahead of pub).

Abstract: Objective To illustrate the use of ensemble tree-based methods (random forest classification [RFC] and bagging) for propensity score estimation and to compare these methods with logistic regression, in the context of evaluating the effect of physical and occupational therapy on preschool motor ability among very low birth weight (VLBW) children. Data Source We used secondary data from the Early Childhood Longitudinal Study Birth Cohort (ECLS-B) between 2001 and 2006. Study Design We estimated the predicted probability of treatment using tree-based methods and logistic regression (LR). We then modeled the exposure-outcome relation using weighted LR models while considering covariate balance and precision for each propensity score estimation method. Principal Findings Among approximately 500 VLBW children, therapy receipt was associated with moderately improved preschool motor ability. Overall, ensemble methods produced the best covariate balance (Mean Squared Difference: 0.03±0.07) and the most precise effect estimates compared to LR (Mean Squared Difference: 0.11). The overall magnitude of the effect estimates was similar between RFC and LR estimation methods. Conclusion Propensity score estimation using RFC and bagging

produced better covariate balance with increased precision compared to LR. Ensemble methods are a useful alternative to logistic regression to control confounding in observational studies.

Politique de santé / Health Policy

(2013). Health in all policies : Seizing opportunities, implementing policies : Bruxelles : Observatoire Européen des Systèmes et Politiques de Santé.

Abstract: Health in All Policies (HiAP) is an approach to policies that systematically takes into account the health and health-system implications of decisions- , seeks synergies, and avoids harmful health impacts to improve population health and health equity. It is founded on health-related rights and obligations and has great potential to improve population health and equity. However, incorporating health into policies across sectors is often challenging and even when decisions are made, implementation may only be partial or unsustainable. This volume published in collaboration with the National Institute for Health and Welfare of Finland (THL), the European Observatory on Health Systems and Policies, and the UN Research Institute for Social Development aims to improve our understanding of the dynamics of HiAP policy-making and implementation processes. Drawing on experience from all regions, and from countries at various levels of economic development, it demonstrates that HiAP is feasible in different contexts, and provides fresh insight into how to seize opportunities to promote HiAP and how to implement policies for health across sectors. Part I sets the scene with five chapters on the concept and history of HiAP, links between socioeconomic development and health, the social determinants of health, and the importance of preserving national policy space for health in a globalizing world. Part II assesses progress in eight policy areas including early childhood development, work and health, mental health promotion, agriculture, food and nutrition, tobacco, alcohol, environment and development assistance. Part III draws together lessons for the health sector, as well as for politicians, policy-makers, researchers and civil society advocates

Cote Irdes : En ligne

http://www.euro.who.int/data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf

Cohen J., Van Landeghem P., Carpentier N., Deliens L. (2013). Different trends in euthanasia acceptance across Europe. A study of 13 western and 10 central and eastern European countries, 1981 - 2008. *The European Journal of Public Health*, 23 (3) : 378-380.

Abstract: We examined how acceptance of euthanasia among the general public has changed between 1981 and 2008 in western and central and eastern European (CEE) countries using data of the European Values Surveys. Data were collected in 1981, 1990, 1999 and 2008 for 13 western European countries and in 1990, 1999 and 2008 for 10 CEE countries. Euthanasia acceptance increased each decade up until 2008 in 11 of 13 western European countries; in CEE countries, it decreased or did not increase between 1999-2008 in 8 of 10 countries. A number of explanations for and implications of this apparent east-west polarization are suggested.

Prévention santé / Health Prevention

Lamothe L. (2013). L'utilisation des télésoins à domicile pour un meilleur suivi des maladies chroniques. *Santé Publique*, (2) : 203-211.

Abstract: Objectifs : cette étude vise à comprendre comment les technologies de télésoins à domicile peuvent concourir à une amélioration des services offerts aux personnes atteintes de maladies chroniques. Méthodes : une technologie de télésoins à domicile a été utilisée par des personnes âgées canadiennes ayant au moins une des maladies chroniques ciblées (maladie pulmonaire obstructive chronique, insuffisance cardiaque, hypertension artérielle, diabète). Des observations participatives, une analyse documentaire et des entrevues ont permis de recueillir les données nécessaires à l'analyse du processus d'implantation et au monitoring des résultats. Résultats : l'utilisation de cette technologie génère plusieurs conséquences positives pour les patients, notamment en termes d'accès aux services. Les patients estiment que l'information sur leur état de santé qu'elle leur procure contribue, avec l'enseignement offert, à améliorer leur capacité d'autogestion. Cette technologie encourage l'émergence d'une pratique interprofessionnelle en facilitant l'accès aux informations et à l'expertise nécessaires ; cela a un impact positif sur la prise de décision clinique. La technologie a un effet structurant sur le mode de fonctionnement et oblige à une adaptation organisationnelle, dont la forme varie selon les contextes cliniques et organisationnels locaux. Conclusion : l'utilisation de cette technologie permet de mettre en place plusieurs conditions auxquelles l'organisation des services doit répondre pour améliorer l'offre de services aux personnes atteintes de maladies chroniques, notamment en termes de collaboration interprofessionnelle, d'accès des professionnels à l'information et à l'expertise nécessaires ou de participation active du patient. Le succès de son implantation dépend toutefois d'une analyse détaillée du contexte local dans lequel elle est introduite.

Cote Irdes : P143

Meillet L., Combes J., Penfornis A. (2013). [Management of type 2 diabetes: Patient education]. *Presse Med*, 42 (5) : 880-885.

Abstract: Patient education emerged initially as an essential component of the management of type 1 diabetes. Patient education has also been for long an integral part of the recommendations for managing type 2 diabetes. Studies about patient education and type 2 diabetes have demonstrated the effectiveness of patient education by studying the evolution of biochemical markers including HbA1c. However, if we return to the foundations of patient education definition, we cannot summarize the effectiveness of patient education on the only decrease of HbA1c. So, if the aim of patient education is to support patients to take better care of themselves, it might be interesting to use other types of evaluation methodology, including qualitative studies, to reflect the different dimensions of patient education, especially psychosocial.

Imbeau D., Chiasson M.A., Jallonet R. (2013). Interventions pour la prévention des TMS. Mesure de l'exposition aux facteurs de risque et aspects économiques : Montréal : IRSST.

Abstract: Les troubles musculo-squelettiques (TMS) au dos et aux membres supérieurs constituent un problème majeur ayant des retombées au point de vue humain, social et économique. Ainsi, au cours des dernières années, plusieurs méthodes d'évaluation de l'exposition aux facteurs de risque (MÉEFR) de TMS ont été proposées par la communauté scientifique afin de soutenir les efforts de prévention. Toutefois, relativement peu d'information existe sur l'utilisation pratique de ces différentes méthodes en milieu de travail. Celles-ci sont nombreuses, ce qui complique pour le praticien le choix d'une méthode appropriée au contexte de l'intervention. Aussi, l'évaluation économique d'une intervention en SST est un aspect jugé stratégique par les intervenants pour encourager les entreprises à prévenir des problèmes de SST, dont les TMS. Pourtant, les méthodes existantes ne sont pas ou peu utilisées dans les entreprises pour procéder à une telle évaluation.

Cote Irdes : En ligne

<http://www.irsst.qc.ca/media/documents/PubIRSST/R-780.pdf>

Brunet S. (2013). La prévention des risques psychosociaux. Avis du Conseil Economique Social et Environnemental. Paris : CESE.

Abstract: La prévention des risques psychosociaux est une priorité du gouvernement, qui a instauré, en 2009, un plan d'urgence sur la prévention du stress en France. Le Conseil Economique, Social et Environnemental (CESE) publie son avis sur la question de la prévention des risques psychosociaux dans le contexte de la crise économique. Rapporté par Sylvie Brunet, l'avis indique que les risques psychosociaux sont mal identifiés et pourtant, bien présents, et que leurs causes sont à rechercher, notamment, dans l'évolution du monde du travail. Pour faire face à cette situation, il existe un arsenal juridique dense, mais encore évolutif et peu stabilisé. La reconnaissance des risques psychosociaux s'est améliorée, avec la mobilisation des pouvoirs publics et des partenaires sociaux, la prise de conscience des employeurs, et l'action des acteurs de la prévention. Cependant, le rapport relève une prise en charge des victimes encore insuffisante. Un ensemble de recommandations conclut le document. Le CESE propose, notamment, d'améliorer la connaissance et l'évaluation des risques psychosociaux, de stabiliser et de clarifier le cadre juridique, ou encore, de mieux former et mobiliser les acteurs de la prévention.

Cote Irdes : En ligne, P111/2

http://www.lecese.fr/sites/default/files/pdf/Avis/2013/2013_12_prevention_risques_psycho.pdf

Prévision – Evaluation / Prevision - Evaluation

Ozawa S., Sripad P. (2013). How do you measure trust in the health system? A systematic review of the literature. *Social Science & Medicine*, 91 (0) : 10-14.

Abstract: Abstract People's trust in the health system plays a role in explaining one's access to and utilization of medical care, adherence to medications, continuity of care, and even self-reported health status. Yet it is not easy to find trust measures and understand what they are measuring. A systematic review of scales and indices identified 45 measures of trust within the health system with an average of 12 questions each, which quantified levels of trust among various relationships across the health system. Existing evidence was narrow in scope, where half examined the relationship between doctors/nurses and patients, and the majority were designed, tested and validated in the United States. We developed a health systems trust content area framework, where we identified that honesty, communication, confidence and competence were captured frequently in these measures, with less focus on concepts such as fidelity, system trust, confidentiality and fairness. Half of the measures employed a qualitative method in the design of these measures and 33% were pilot tested. Reporting of test - retest reliability and inter-rater reliability were less common. This review identifies a need to develop measurements of trust beyond doctor - patient relationships and outside of U.S. contexts, and strengthen the rigor of existing trust measures. Greater development and use of trust measures in the health system could improve monitoring and evaluation efforts, which may in turn result in better health outcomes.

Psychiatrie / Psychiatry

Cabassa L.J., Humensky J., Druss B., Lewis-Fernández R., Gomes A.P., Wang S., Blanco C. (2013). Do Race, Ethnicity, and Psychiatric Diagnoses Matter in the Prevalence of Multiple Chronic Medical Conditions? *Medical Care*, 51 (6) :

Abstract: Background: The proportion of people in the United States with multiple chronic medical

conditions (MCMC) is increasing. Yet, little is known about the relationship that race, ethnicity, and psychiatric disorders have on the prevalence of MCMCs in the general population. Methods: This study used data from wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions (N=33,107). Multinomial logistic regression models adjusting for sociodemographic variables, body mass index, and quality of life were used to examine differences in the 12-month prevalence of MCMC by race/ethnicity, psychiatric diagnosis, and the interactions between race/ethnicity and psychiatric diagnosis. Results: Compared to non-Hispanic Whites, Hispanics reported lower odds of MCMC and African Americans reported higher odds of MCMC after adjusting for covariates. People with psychiatric disorders reported higher odds of MCMC compared with people without psychiatric disorders. There were significant interactions between race and psychiatric diagnosis associated with rates of MCMC. In the presence of certain psychiatric disorders, the odds of MCMC were higher among African Americans with psychiatric disorders compared to non-Hispanic Whites with similar psychiatric disorders. Conclusions: Our study results indicate that race, ethnicity, and psychiatric disorders are associated with the prevalence of MCMC. As the rates of MCMC rise, it is critical to identify which populations are at increased risk and how to best direct services to address their health care needs.

Paananen R., Santalahti P.Ä., Merikukka M., Rämö A., Wahlbeck K., Gissler M. (2013). Socioeconomic and regional aspects in the use of specialized psychiatric care - a Finnish nationwide follow-up study. *The European Journal of Public Health*, 23 (3) : 372-377.

Abstract: Background: Mental health problems in childhood and adolescence are an important public health concern. The general aim of Finnish health policy is to offer equal services for all inhabitants according to need, irrespective of socio-economic background or place of residence. Here, we assess equity in access to psychiatric care in a long-term nationwide follow-up study from birth to early adulthood. Methods: All 60 069 children born in Finland in 1987 were followed up through health registers from 1987 to 2008. The cohort members' use of specialized psychiatric outpatient and inpatient care was assessed and linked to their socio-economic status and residential area. Results: Altogether, 14.4% of the cohort members had received specialized psychiatric care during the follow-up. Females used significantly more specialized psychiatric outpatient care than males. In addition, the use of specialized psychiatric care was more common among young people with a poor socio-economic background and those living in urban areas. Conclusions: A notable number of the young adults born in Finland in 1987 used specialized psychiatric care during their childhood and adolescence. Use was clearly defined by sex and residential area, as well as by parental socio-economic status and education. The data indicate that equity in access to mental health services should be highlighted in health policies, as contemporary outpatient mental health care has not been equally available for people living within and outside urban areas.

Soins de santé primaires / Primary Health Care

(2013). Rémunération sur résultats : objectifs de soins et de coûts (n° 14 à 24). *Revue Prescrire*, (356) : 456-463.
Cote Irdes : P80

Perrin F., Le Mab G. (2013). Fonction et rôle des médecins territoriaux : les enjeux de santé publique. *Actualité et Dossier en Santé Publique*, (82) : 23-25.
Cote Irdes : P49

N'Sonde V. (2013). Halte à la flambée des dépassements d'honoraires ! 60 Millions de Consommateurs, (483) : 14-17.

Cote Irdes : c, Dossier de presse : Médecins/Actes médicaux

Wong S.T., Haggerty J. (2013). Measuring Patient Experiences in Primary Health Care: A review and classification of items and scales used in publicly-available questionnaires : Vancouver : Centre for Health Services and Policy Research.

Abstract: Cette étude identifie les éléments et les indicateurs qui pourraient être utilisés dans la conception d'un sondage de base sur l'expérience des patients au Canada. La revue offre un aperçu de 17 instruments disponibles publiquement pour mesurer l'expérience des patients en matière de soins de santé primaires.

Cote Irdes : En ligne

http://chspr.ubc.ca/sites/default/files/publication_files/Patient%20experiences%20in%20PHC%202013.pdf

Rosano A., Loha C.A., Falvo R., van der Zee J., Ricciardi W., Guasticchi G., de Belvis A.G. (2013). The relationship between avoidable hospitalization and accessibility to primary care: a systematic review. *The European Journal of Public Health*, 23 (3) : 356-360.

Abstract: Background: Avoidable hospitalization (AH) has been widely studied as a possible measure of the performance of primary health care (PHC). However, studies examining the relationship between the efficiency and quality of PHC and AH have found mixed results. Our study aims at highlighting those factors related to the relationship between AH and accessibility to PHC in different countries. Methods: We conducted a systematic search for peer-reviewed studies published between 1990 and October 2010 in English, German, French, Italian or Spanish and indexed primary electronic databases. Results: The final analysis was conducted on the basis of 51 papers. Of them, 72.5% revealed a significant inverse association between the indicator of PHC accessibility and rates of AH. Indicators of PHC calculated at individual level are more likely to reveal contradictory aspects of the relationship between rates of AH and indicators of quality and PHC accessibility. Conclusions: Most studies confirmed the expected relationship between indicators of PHC accessibility and hospitalization for ambulatory care sensitive conditions (ACSCs), showing lower hospitalization rates for ACSC in areas with greater access to PHC. The findings support the use of ACSC hospitalization as an indicator of primary care quality, with the precaution of applying appropriate adjustment factors.

Mühlbacher A., Juhnke C. (2013). Patient Preferences Versus Physicians' Judgement: Does it Make a Difference in Healthcare Decision Making? *Applied Health Economics and Health Policy*, 11 (3) : 163-180.

Abstract: Clinicians and public health experts make evidence-based decisions for individual patients, patient groups and even whole populations. In addition to the principles of internal and external validity (evidence), patient preferences must also influence decision making. Great Britain, Australia and Germany are currently discussing methods and procedures for valuing patient preferences in regulatory (authorization and pricing) and in health policy decision making. However, many questions remain on how to best balance patient and public preferences with physicians' judgement in healthcare and health policy decision making. For example, how to define evaluation criteria regarding the perceived value from a patient's perspective? How do physicians' fact-based opinions also reflect patients' preferences based on personal values? Can empirically grounded theories explain differences between patients and experts—and, if so, how? This article aims to identify and compare studies that used different preference elicitation methods and to highlight differences between patient and physician preferences. Therefore, studies comparing patient preferences and physician judgements were analysed in a review. This review shows a limited amount of literature analysing and comparing patient and physician preferences for healthcare interventions and outcomes. Moreover, it shows that methodology used to compare preferences is diverse. A total of 46 studies used the

following methods—discrete-choice experiments, conjoint analyses, standard gamble, time trade-offs and paired comparisons—to compare patient preferences with doctor judgements. All studies were published between 1985 and 2011. Most studies reveal a disparity between the preferences of actual patients and those of physicians. For most conditions, physicians underestimated the impact of intervention characteristics on patients' decision making. Differentiated perceptions may reflect ineffective communication between the provider and the patient. This in turn may keep physicians from fully appreciating the impact of certain medical conditions on patient preferences. Because differences exist between physicians' judgement and patient preferences, it is important to incorporate the needs and wants of the patient into treatment decisions. Clinicians and public health experts make evidence-based decisions for individual patients, patient groups and even whole populations. In addition to the principles of internal and external validity (evidence), patient preferences must also influence decision making. Great Britain, Australia and Germany are currently discussing methods and procedures for valuing patient preferences in regulatory (authorization and pricing) and in health policy decision making. However, many questions remain on how to best balance patient and public preferences with physicians' judgement in healthcare and health policy decision making. For example, how to define evaluation criteria regarding the perceived value from a patient's perspective? How do physicians' fact-based opinions also reflect patients' preferences based on personal values? Can empirically grounded theories explain differences between patients and experts—and, if so, how? This article aims to identify and compare studies that used different preference elicitation methods and to highlight differences between patient and physician preferences. Therefore, studies comparing patient preferences and physician judgements were analysed in a review. This review shows a limited amount of literature analysing and comparing patient and physician preferences for healthcare interventions and outcomes. Moreover, it shows that methodology used to compare preferences is diverse. A total of 46 studies used the following methods—discrete-choice experiments, conjoint analyses, standard gamble, time trade-offs and paired comparisons—to compare patient preferences with doctor judgements. All studies were published between 1985 and 2011. Most studies reveal a disparity between the preferences of actual patients and those of physicians. For most conditions, physicians underestimated the impact of intervention characteristics on patients' decision making. Differentiated perceptions may reflect ineffective communication between the provider and the patient. This in turn may keep physicians from fully appreciating the impact of certain medical conditions on patient preferences. Because differences exist between physicians' judgement and patient preferences, it is important to incorporate the needs and wants of the patient into treatment decisions.

Van den Dungen C., Hoeymans N., Schellevis F.G., Van Oers H.J. (2013). Quality aspects of Dutch general practice-based data: a conceptual approach. *Fam Pract*, 30 (3) : 355-361.

Abstract: BACKGROUND: General practice-based data, collected within general practice registration networks (GPRNs), are widely used in research. The quality of the data is important but the recording criteria about what type of information is collected and how this information should be recorded differ between GPRNs. OBJECTIVE: We aim to identify aspects that describe the quality of general practice-based data in the Netherlands. METHODS: To investigate the quality aspects, we used the method of concept mapping, a structured conceptualization process for a complex multi-dimensional topic. We explored the ideas of representatives from 10 Dutch GPRNs on the quality of general practice-based data in five steps: preparation, generation of statements, structuring, representation and interpretation. In a brainstorm session, 10 experts generated statements about good data quality from general practice, which we completed with information from the literature. In total, 18 experts participated in the ranking and clustering of the statements. These results were analysed using ARIADNE software, using a combination of principal component analysis and cluster analysis techniques. Finally, the clusters were labelled based on their content. RESULTS: A total of 72 statements were analysed, which resulted in a two-dimensional picture with six clusters, 'complete health record', 'coding of information', 'episode oriented recording', 'diagnostic validity', 'recording agreements' and 'residual category'. CONCLUSIONS: The quality of general practice-based data can be considered on five content-based aspects. These aspects determine the quality of recording.

Systèmes de santé / Health Care Systems

Marqué G. (2013). Le système de soins local, régional et national : élaborer un outil de régulation équitable. *Gestions Hospitalières*, (526) : 304-309.
Cote Irdes : P67

Basson M. Hirsch.E. (2013). Droits des malades et qualité du système de santé : dix ans après. *Actualité et Dossier en Santé Publique*, (82) : 58
Cote Irdes : P49

(2013). Service public et santé : Actes du colloque : Paris : Editions de Santé ; Les Presses de SciencesPo

Abstract: Le concept de service public qui a, pendant longtemps, constitué le socle du développement des interventions de la puissance publique, paraît aujourd'hui malmené par les transformations de l'action publique, les tensions macroéconomiques et les exigences du droit européen. Sur le champ de la santé, le service public n'a trouvé ses marques que tardivement. Au-delà des missions traditionnelles de police sanitaire, les services publics de prévention n'ont été développés qu'avec parcimonie et le service public hospitalier ne s'est constitué qu'à partir de 1958, avant d'être consacré par la loi Boulin de 1970. Quant à l'assurance maladie, elle s'est inscrite, dès son origine, dans le contexte singulier de la démocratie sociale. Les évolutions législatives et économiques de la dernière décennie ont remis en cause la conception et l'organisation des services publics de santé. Les contributions réunies dans cet ouvrage, à l'occasion du colloque organisé par la chaire Santé de Sciences Po et l'Institut Droit et santé de l'Université Paris Descartes en juin 2012, permettent de s'interroger sur la pertinence et la portée, en 2012, des principes du service public en matière de santé et d'analyser les mutations de la gestion des services publics de soins. Elles invitent ensuite à examiner les conséquences de la tourmente dans laquelle se trouvent actuellement les services publics de santé et à approfondir la réflexion sur leur avenir (4e de couverture)

Cote Irdes : A4458

Chernichovsky D. (2013). Reforms Are Needed To Increase Public Funding And Curb Demand For Private Care In Israel's Health System. *Health Affairs*, 32 (4) : 724-733.

Abstract: Historically, the Israeli health care system has been considered a high-performance system, providing universal, affordable, high-quality care to all residents. However, a decline in the ratio of physicians to population that reached a modern low in 2006, an approximate ten percentage-point decline in the share of publicly financed health care between 1995 and 2009, and legislative mandates that favored private insurance have altered Israel's health care system for the worse. Many Israelis now purchase private health insurance to supplement the state sponsored universal care coverage, and they end up spending more out of pocket even for services covered by the entitlement. Additionally, many publicly paid physicians moonlight at private facilities to earn more money. In this article I recommend that Israel increase public funding for health care and adopt reforms to address the rising demand for privately funded care and the problem of publicly paid physicians who moonlight at private facilities.

Cote Irdes : c, En ligne

Gaiamo S. (2013). Behind the Scenes of the Patient Protection and Affordable Care Act: The Making of a Health Care Co-op. *J Health Polit.Policy Law*, 38 (3) : 599-610.

Abstract: A primary goal of the Patient Protection and Affordable Care Act (PPACA) is to reduce the number of uninsured by making health insurance more affordable for small businesses and individuals. Toward

that end, the PPACA encourages the creation of nonprofit, member-owned health insurance cooperatives to operate inside each state exchange. Co-ops face significant challenges in entering mature insurance markets, but they also possess unique characteristics that may help them survive and thrive. Using Common Ground Healthcare Cooperative in Wisconsin as a case study, this article traces the origins of co-ops in health care reform at national and state levels and analyzes the political and technical challenges and opportunities facing these organizations.

Travail et santé / Occupational Health

Elovainio M., Linna A., Virtanen M., Oksanen T., Kivimäki M., Pentti J., Vahtera J. (2013). Perceived organizational justice as a predictor of long-term sickness absence due to diagnosed mental disorders: Results from the prospective longitudinal Finnish Public Sector Study. *Social Science & Medicine*, 91 (0) : 39-47.

Abstract: Abstract Organizational justice perceptions have been suggested to be associated with symptoms of mental health but the nature of the association is unknown due to reporting bias (measurement error related to response style and reversed causality). In this study, we used prospective design and long-term (>9 days) sickness absence with psychiatric diagnosis as the outcome measure. Participants were 21 221 Finnish public sector employees (the participation rate at baseline in 2000-2002 68%), who responded to repeated surveys of procedural and interactional justice in 2000-2004 along with register data on sickness absence with a diagnosis of depression or anxiety disorders (822 cases). Results from logistic regression analyses showed that a one-unit increase in self-reported and work-unit level co-worker assessed interactional justice was associated with a 25-32% lower odds of sickness absence due to anxiety disorders. These associations were robust to adjustments for a variety of potential individual-level confounders including chronic disease (adjusted OR for self-reported interactional justice 0.77, 95% CI 0.65-0.91) and were replicated using co-worker assessed justice. Only weak evidence of reversed causality was found. The results suggest that low organizational justice is a risk factor for sickness absence due to anxiety disorders.

Jones M.K., Latreille P.L., Sloane P.J., Staneva A.V. (2013). Work-related health risks in Europe: Are older workers more vulnerable? *Social Science & Medicine*, 88 (7) : 18-29.

Abstract: Recent policy reforms in a number of countries are extending working lives and deferring the statutory retirement age. Yet such changes may have profound implications for the well-being of older workers if such individuals are more likely to suffer work-related health problems. Using international data from the European Working Conditions Survey for 2005, we test whether older workers (aged 55–65 years) differ significantly from younger workers across a range of self-reported job-related indicators including health risk perception, mental and physical health, sickness absence, injury and fatigue. We estimate discrete choice (probit) models of the outcomes above for a sample comprising 17,459 individuals in 23 countries, and control for personal, job and work characteristics including exposure to physical, ergonomic and psychosocial risk factors. Our results show that failure to account for both endogeneity and the 'healthy worker effect' (sample selection) can lead to misleading inferences. The latter is especially important: only after controlling for selection bias (using a re-weighting approach) do we find older workers are more 'vulnerable' than their younger counterparts in the sense of being significantly more likely to perceive each of the various adverse health outcomes above, with the exception of injury. For the remaining indicators, our estimates suggest the magnitude of this difference is substantial: between 5 and 11 percentage points compared with prime age workers, and 8 and 14 points relative to workers aged 15–35, depending on the measure under consideration.

Vieillesse / Ageing

Laun T., Wallenius J. (2013). Social Insurance and Retirement: A Cross-Country Perspective

Uppsala : Department of Economics of Uppsala University

Abstract: This paper studies the role of social insurance, namely old-age pensions, disability insurance and healthcare, in accounting for the differing labor supply patterns of older individuals across OECD countries. To this end, it develops a life cycle model of labor supply and health with heterogeneous agents. The key features of the framework are: (1) people choose when to stop working, and when/if to apply for disability and pension benefits, (2) the awarding of disability insurance benefits is imperfectly correlated with health, and (3) people can partially insure against health shocks by investing in health, the cost of which is dependent on health insurance coverage. It finds that the incentives faced by older workers differ hugely across countries. In fact, based solely on differences in social insurance programs, the model predicts even more cross-country variation in the employment rates of people aged 55-64 than we observe in the data.

Cote Irdes : En ligne

<http://www.nek.uu.se/Pdf/20136ucfs.pdf>

Alessie R., Angelini V., Van S.P. (2013). Pension Wealth and Household Savings in Europe: Evidence from SHARELIFE

Stockholm : Sveriges Riksbank and Netspar.

Abstract: We use recently collected retrospective survey data to estimate the displacement effect of pension wealth on household savings. The third wave of the Survey of Health, Ageing and Retirement in Europe, SHARELIFE, collects information on the entire job history of the respondent, a feature missing in most previous studies. We show that addressing measurement error problems is crucial to estimate the displacement effect when using survey data. We find that each euro of pension wealth is associated with a 47 (61) cent decline in non-pension wealth using robust (median) regression. In the presence of biases from measurement errors and omitted (unobserved) variables, we estimate a lower bound to the true offset between 17% and 30%, significantly different from zero. Instrumental variables regression estimates, although less precise, suggest full displacement.

Cote Irdes : En ligne

http://www.riksbank.se/Documents/Rapporter/Working_papers/2013/rap_wp265_130424.pdf

Ichida Y., Hirai H., Kondo K., Kawachi I., Takeda T., Endo H. (2013). Does social participation improve self-rated health in the older population? A quasi-experimental intervention study. *Social Science & Medicine*, (Ahead of pub)

Abstract: Abstract Social participation has been linked to healthy aging and the maintenance of functional independence in older individuals. However, causality remains tenuous because of the strong possibility of reverse causation (healthy individuals selectively participate in social activities). We describe a quasi-experimental intervention in one municipality of Japan designed to boost social participation as a way of preventing long-term disability in senior citizens through the creation of "salons" (or community centers). In this quasi-experimental intervention study, we compared 158 participants with 1,391 non-participants in salon programs, and examined the effect of participation in the salon programs on self-rated health. We conducted surveys of community residents both before (in 2006) and after (in 2008) the opening of the salons. Even with a pre/post survey design, our study could be subject to reverse causation and confounding bias. We therefore utilized an instrumental variable estimation strategy, using the inverse of the distance between each resident's dwelling and the nearest salon as the instrument. After controlling for self-rated health, age, sex, equivalized income in 2006, and reverse causation, we observed significant correlations between participation in the salon programs and self-rated health in 2008. Our analyses suggest that participation in the newly-opened community salon was associated with a significant improvement in self-rated health over time.

The odds ratio of participation in the salon programs for reporting excellent or good self-rated health in 2008 was 2.52 (95% CI 2.27 to 2.79). Our study provides novel empirical support for the notion that investing in community infrastructure to boost the social participation of communities may help promote healthy aging.

Ducey A. (2013). Caring for America: home health workers in the shadow of the welfare state. *J Health Polit.Policy Law*, 38 (3) : 614-619.