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1er novembre 2013 / November the 1st, 2013

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Economie de la santé / Health Economics

Temple N.J. (2012). Why prevention can increase health-care spending. *Eur J Public Health*, 22 (5) : 618-619.
Abstract: This article examines the impact of disease prevention on health-care spending. The relationship between these two variables is more complex than what, at first glance, appears to be the case. Health-care spending would be reduced if more effective means could be found to prevent health problems that are expensive to treat but are generally not fatal, such as dementia, infectious diseases and accidents. The major focus here is on interventions designed to persuade people to quit smoking. Savings on health-care spending in early years after people stop smoking are counter-balanced (often exceeded) by higher spending at a later time. In addition, when people stop smoking there is a significant negative impact on government finances from the double effect of lost tax revenues combined with increased spending on pension payments. Arguments in favour of policies designed to prevent fatal disease, such as by reducing the prevalence of smoking, should be based on improvements to population health rather than on misleading claims that this will reduce spending on health care.

Fox M., Mugford M., Voordouw J., Cornelisse-Vermaat J., et al.(2013). Health sector costs of self-reported food allergy in Europe: a patient-based cost of illness study. The *European Journal of Public Health,* 23 (5) : 757-762.
Abstract: Introduction: Food allergy is a recognized health problem, but little has been reported on its cost for health services. The EuroPrevall project was a European study investigating the patterns, prevalence and socio-economic cost of food allergy. Aims: To investigate the health service cost for food-allergic Europeans and the relationship between severity and cost of illness. Methods: Participants recruited through EuroPrevall studies in a case-control study in four countries, and cases only in five countries, completed a validated economics questionnaire. Individuals with possible food allergy were identified by clinical history, and those with food-specific immunoglobulin E were defined as having probable allergy. Data on resource use were used to estimate total health care costs of illness. Mean costs were compared in the case's control cohorts. Regression analysis was conducted on cases from all 9 countries to assess impact of country, severity and age group. Results: Food-allergic individuals had higher health care costs than controls. The mean annual cost of health care was international dollars (I$)2016 for food-allergic adults and I$1089 for controls, a difference of I$927 (95% confidence interval I$324-I$1530). A similar result was found for adults in each country, and for children, and was not sensitive to baseline demographic differences. Cost was significantly related to severity of illness in cases in nine countries. Conclusions: Food allergy is associated with higher health care costs. Severity of allergic symptoms is a key explanatory factor.
http://eurpub.oxfordjournals.org/content/23/5/757.abstract

Etat de santé / Health Status

Kilpelainen K., Tuomi-Nikula A., Thelen J., Gissler M., Sihvonen A.P., Kramers P., Aromaa A. (2012). Health indicators in Europe: availability and data needs. Eur J Public Health, 22 (5) : 716-721.
Abstract: BACKGROUND: The European Union (EU) lacks adequate capacity for public health monitoring. The creation of a stable European Health Information System would help Member States to carry out evidence-based health policy. Such a system would also benefit EU health priorities by providing European wide comparable information. This study is the first comprehensive assessment of the availability of general health data in Europe. METHODS: The main aim was to assess the availability of the European Community Health Indicators (ECHI) in each EU Member State. This was done by means of a review of international health databases, an online survey and face-to-face discussions with experts in 31 European countries. RESULTS: The European average availability score for all ECHI indicators was 74% ranging from 56% to 84%. In most countries, about half of the ECHI indicators can be derived from routinely collected health information. This is true for demographic information, mortality and hospital discharge-based morbidity. However, many important ECHI indicators are lacking in most European countries. These include population representative data for health determinants, the provision and use of health care services, injuries, the quality of health care and health promotion. CONCLUSION: Valid health information is essential for improving people's health across Europe. There is an urgent need to develop harmonized methods for gathering and

disseminating representative health data. These methods should be developed jointly by DG Health and Consumers, Eurostat and EU Member States.

Allebeck P. (2013). Health effects of the crisis: challenges for science and policy. *The European Journal of Public Health,* 23 (5) : 721.

Vandoros S., Hessel P., Leone T., Avendano M. (2013). Have health trends worsened in Greece as a result of the financial crisis? A quasi-experimental approach. *The European Journal of Public Health,* 23 (5) : 727-731.
Abstract: Background: Health in Greece deteriorated after the recent financial crisis, but whether this decline was caused by the recent financial crisis has not been established. This article uses a quasi-experimental approach to examine the impact of the recent financial crisis on health in Greece. Methods: Data came from the European Union Statistics on Income and Living Conditions survey for the years 2006-09. We applied a difference-in-differences approach that compares health trends before and after the financial crisis in Greece with trends in a control population (Poland) that did not experience a recession and had health trends comparable with Greece before the crisis. We used logistic regression to model the impact of the financial crisis on poor self-rated health, controlling for demographic confounders. Results: Results provide strong evidence of a statistically significant negative effect of the financial crisis on health trends. Relative to the control population, Greece experienced a significantly larger increase in the odds of reporting poor health after the crisis (odds ratio, 1.16; 95% confidence interval, 1.04-1.29). There was no difference in health trends between Poland and Greece before the financial crisis, supporting a causal interpretation of health declines in Greece as a result of the financial crisis. Conclusion: Results provide evidence that trends in self-rated health in Greece worsened as a result of the recent financial crisis. Findings stress the need for urgent health policy responses to the recent economic collapse in Greece as the full impact of austerity measures unfolds in the coming years.

Lopez Bernal J.A., Gasparrini A., Artundo C.M., McKee M. (2013). The effect of the late 2000s financial crisis on suicides in Spain: an interrupted time-series analysis. *The European Journal of Public Health,* 23 (5) : 732-736.
Abstract: Background: The current financial crisis is having a major impact on European economies, especially that of Spain. Past evidence suggests that adverse macro-economic conditions exacerbate mental illness, but evidence from the current crisis is limited. This study analyses the association between the financial crisis and suicide rates in Spain. Methods: An interrupted time-series analysis of national suicides data between 2005 and 2010 was used to establish whether there has been any deviation in the underlying trend in suicide rates associated with the financial crisis. Segmented regression with a seasonally adjusted quasi-Poisson model was used for the analysis. Stratified analyses were performed to establish whether the effect of the crisis on suicides varied by region, sex and age group. Results: The mean monthly suicide rate in Spain during the study period was 0.61 per 100 000 with an underlying trend of a 0.3% decrease per month. We found an 8.0% increase in the suicide rate above this underlying trend since the financial crisis (95% CI: 1.009-1.156; P = 0.03); this was robust to sensitivity analysis. A control analysis showed no change in deaths from accidental falls associated with the crisis. Stratified analyses suggested that the association between the crisis and suicide rates is greatest in the Mediterranean and Northern areas, in males and amongst those of working age. Conclusions: The financial crisis in Spain has been associated with a relative increase in suicides. Males and those of working age may be at particular risk of suicide associated with the crisis and may benefit from targeted interventions.

Vetrano D.L., Martone A.M., Mastropaolo S., Tosato M., Colloca G., Marzetti E., Onder G., Bernabei R., Landi F. (2013). Prevalence of the seven cardiovascular health metrics in a Mediterranean country: results from a cross-sectional study. *The European Journal of Public Health,* 23 (5) : 858-862.
Abstract: Aim: Primordial prevention is essential for reaching cardiovascular (CV) health. This is defined by seven health metrics identified by the American Heart Association. Aim of the present study was to assess prevalence and distribution of these seven CV health metrics within an unselected population. Methods: All the 1110 consecutive individuals (mean age 56 -¦ 13 years; 56% women) who agreed to be screened within the context of a national campaign of CV prevention were included. The following findings have been considered as ideal: never/former smoker, regular participation in physical activity, body mass index lower than 25.0, healthy diet, cholesterol lower than 200 mg/dl,

diabetes absence and a blood pressure lower than 120/80 mmHg. Results: Participants presented, on average, 4.1 -¦ 1.2 ideal CV health metrics, with a decreasing number across age-groups. Only 10.4% covered more than five ideal CV health metrics and 8.3% covered less than three ideal health metrics. Only 1.9% of the study population met all the seven ideal metrics. In particular, only 34% (379 subjects) in our population presented an ideal level of cholesterol. The higher prevalence was observed in younger subjects (45%) and the lower (28%) in people older than 62 years (P < 0.001). Conclusion: Prevalence of the seven CV health metrics was low in our population and just 1 in 10 met more than five ideal CV health metrics. Social initiatives and awareness policies from governments are mandatory to promote CV health. Further studies should address the impact of such CV metrics on several outcomes in European countries.

Bechtold P., Ranzi A., Gambini M., Capelli O., Magrini N., Cavallini R., Gallo L., Casale G., De Togni A., Cavagni G., Lauriola P. (2013). Assessing Paediatric Asthma Occurrence through Dispensed Prescription Data and Questionnaires. *The European Journal of Public Health,* 23 (5) : 873-878.
Abstract: Background: The prevalence of asthma, a common disorder in childhood, is often estimated by cross-sectional studies based on questionnaires, with the drawback that estimates are limited to certain age groups and areas. The use of electronic health data is increasingly allowing researchers to overcome these limitations. This study is aimed at assessing asthma occurrence of a school-aged population in Northeast Italy using two different data sources. Methods: In 2004, a population-based survey using a standardized questionnaire was conducted to estimate asthma occurrence among a resident population of children aged 6-7 years and adolescents aged 13 years. A selection of dispensed asthma medications was extracted from electronic databases for a 4-year period prior to questionnaire completion (2000-03). Asthma prevalence was estimated by commonly used questionnaire classifications and compared with use of inhaled bronchodilators (alone or in combination) in various time periods. Correlations between the two approaches were calculated. Results: A total of 10 252 subjects were eligible for analysis (85% of the resident population). A total of 4747 subjects (38% of the resident population) were registered in the drug database during 2000–03. Asthma prevalence was higher in males and in children. Congruence between the two enquiry methods varied according to criteria applied and improved with the protraction of the observation period. Conclusion: A longer period for the capture of medication data yielded higher congruence. A degree of mismatch was observed between the two methods most likely related to factors of drug use and questionnaire reliability. Nonetheless, the benefits of using easily accessible population data prevail, and further studies are warranted.

Zavras D., Tsiantou V., Pavi E., Mylona K., Kyriopoulos J. (2013). Impact of economic crisis and other demographic and socio-economic factors on self-rated health in Greece. *Eur J Public Health,* 23 (2) : 206-210.
Abstract: BACKGROUND: Financial crisis and worsened socio-economic conditions are associated with greater morbidity, less utilization of health services and deteriorated population's health status. The aim of the present study was to investigate the determinants of self-rated health in Greece. METHODS: Two national cross-sectional surveys conducted in 2006 and 2011 were combined, and their data were pooled giving information for 10 572 individuals. The sample in both studies was random and stratified by gender, age, degree of urbanization and geographic region. Logistic regression analysis was used to determine the impact of several factors on self-rated health. RESULTS: Poor self-rated health was most common in older people, unemployed, pensioners, housewives and those suffering from chronic disease. Men, individuals with higher education and those with higher income have higher probability to report better self-rated health. Furthermore, the probability of reporting poor self-rated health is higher at times of economic crisis. CONCLUSION: Our findings confirm the association of self-rated health with economic crisis and certain demographic and socio-economic factors. Given that the economic recession in Greece deepens, immediate and effective actions targeting health inequalities and improvements in health status are deemed necessary.

Géographie de la santé / Geography of Health

Rolland C., Pierru F. (2013). Les agences régionales de santé deux ans après : une autonomie de façade. *Santé publique,* (4) : 411-419.

Touati N, Turgeon J. (2013). Répartition géographique des médecins de famille : quelles solutions à un problème complexe ? *Santé publique,* (4) : 465473.

Ghosn W., Kassi D., Jougla E., Salem G., Rey G., Rican S. (2013). Trends in geographic mortality inequalities and their association with population changes in France, 1975 to 2006. *The European Journal of Public Health,* 23 (5) : 834-840.
Abstract: Background: Although some studies have reported that population change is associated with spatial mortality inequalities, few of them have tried to take a dynamic approach to the association. The aim of this study was to explore and interpret the ecological association between the change in cause-specific mortality inequalities and population change over a 30-year period in areas exhibiting different deprivation and urbanization levels in France. Methods: The French communes were classified by category of demographic change during the period 1962-2006. The changes in standardized mortality ratios were analysed by category over 5 inter-censal periods, taking into account degree of urbanization and deprivation quintile. The magnitude and significance of the associations for various causes of death were estimated using a Generalised Estimating Equation Poisson model. Results: Overall, the change in relative mortality was negatively associated with population growth. For a compound annual population growth rate of 1% in 1990ΓÇô99, the standardized mortality ratios decreased, on average, by 2.1% (95% confidence interval: –.45 to -2.72). The association was stronger in urban areas, and reversed in the least deprived areas. The association was stronger and more significant for men, subjects aged less than 65 years and alcohol-related and violent deaths. Conclusion: This study highlights the significance of dynamic approaches. Population growth was associated with a decrease in relative mortality level; the direction and strength of the association varied depending on the socio-territorial characteristics. As is the case for English-speaking countries, in France, population growth may be considered a component of current social dynamics that are not measured by usual indicators.

Combier E., Charreire H., Vaillant M.L., Michaut F., Ferdynus C., Amat-Roze J.M., Gouyon J.B., Quantin C., Zeitlin J. (2013). Perinatal health inequalities and accessibility of maternity services in a rural French region: Closing maternity units in Burgundy. *Health & Place,* (Ahead of pub) :
Abstract: Abstract Maternity unit closures in France have increased travel time for pregnant women in rural areas. We assessed the impact of travel time to the closest unit on perinatal outcomes and care in Burgundy using multilevel analyses of data on deliveries from 2000 to 2009. A travel time of 30 minutes or more increased risks of fetal heart rate anomalies, meconium-stained amniotic fluid, out-of-hospital births, and pregnancy hospitalizations; a positive but non-significant gradient existed between travel time and perinatal mortality. The effects of long travel distances on perinatal outcomes and care should be factored into closure decisions.

Chen Y.T., Rabilloud M., Thiolet J.M., Coignard B., Metzger M.H. (2013). Benchmarking French regions according to their prevalence of healthcare-associated infections. *Int J Qual.Health Care,* 25 (5) : 555-563.
Abstract: OBJECTIVE: To propose an original method of benchmarking regions based on their prevalence of healthcare-associated infections (HAIs) and to identify regions with unusual results. DESIGN: To study between-region variability with a three-level hierarchical logistic regression model and a Bayesian non-parametric method. SETTING: French 2006 national HAIs point prevalence survey. PARTICIPANTS: A total of 336 858 patients from 2289 healthcare facilities in 27 regions. Patients with an imported HAI (1% of the data, 20.7% of infected patients), facilities with <5 patients and patients who had at least one missing value for the variables taken into account were excluded (5.0% of patients). MAIN OUTCOME MEASURE: Binary outcome variable indicates whether a given patient was infected. RESULTS: Two clusters of regions were identified: one cluster of five regions had a lower adjusted prevalence than the other one of 22 regions, while no region with unusually high prevalence could be identified. Nevertheless, the degree of heterogeneity of odds ratios between facilities for facility-specific effects of use of invasive devices was more important in some regions than in others. CONCLUSIONS: The adjusted regional prevalence of HAIs can serve as an adequate

benchmark to identify regions with concerning results. Although no outlier regions were identified, the proposed approach could be applied to the data of the 2012 national survey to benchmark regional healthcare policies. The estimation of facility-specific effects of use of invasive devices may orient future regional action plans.

Reschovsky J.D., Hadley J., Romano P.S. (2013). Geographic Variation in Fee-for-Service Medicare Beneficiaries' Medical Costs Is Largely Explained by Disease Burden. *Med Care Res Rev,* 70 (5) : 542-563.
Abstract: Control for area differences in population health (casemix adjustment) is necessary to measure geographic variations in medical spending. Studies use various casemix adjustment methods, resulting in very different geographic variation estimates. We study casemix adjustment methodological issues and evaluate alternative approaches using claims from 1.6 million Medicare beneficiaries in 60 representative communities. Two key casemix adjustment methods-controlling for patient conditions obtained from diagnoses on claims and expenditures of those at the end of life-were evaluated. We failed to find evidence of bias in the former approach attributable to area differences in physician diagnostic patterns, as others have found, and found that the assumption underpinning the latter approach-that persons close to death are equally sick across areas-cannot be supported. Diagnosis-based approaches are more appropriate when current rather than prior year diagnoses are used. Population health likely explains more than 75% to 85% of cost variations across fixed sets of areas

Hôpital / hospital

Moisdon J.C. (2013). Une histoire de la T2A. *Journal de gestion et d'économie médicale,* 31 (2-3) : 107-120.

Chièze F., Diederichs O., Verhnes M., Fournalès R. (2013). Rapport sur l'admission au séjour des étrangers malades. Rapport IGAS/IGA ; 2013 041. Paris : La documentation française
Abstract: L'inspection générale des affaires sociales et l'inspection générale de l'administration ont été conjointement chargées d'une mission sur "l'admission au séjour des étrangers malades - évaluation de l'application de l'article L. 313-11 du code de l'entrée et du séjour des étrangers". Cette demande portait essentiellement sur l'élaboration d'un bilan de la loi du 16 juin 2011, tant en matière d'organisation administrative que d'efficience de la prise en charge sanitaire des intéressés, en dégageant, le cas échéant, des voies d'amélioration. Elle mettait notamment l'accent sur la diversité d'interprétation de la condition relative à l'accès au traitement dans le pays d'origine, sur les conditions dans lesquelles les médecins des agences régionales de santé émettent leur avis, l'existence de facteurs de fraude, les risques d'utilisation purement dilatoire de la procédure et enfin la validité de la notion de circonstances humanitaires exceptionnelles (article L 313-11 et L 511-4,10° et L 521-3,5° du CESEDA). La mission devait également analyser la situation de personnes en rétention ou en détention au regard de la protection contre l'éloignement découlant du recours à la procédure "Etrangers Malades" pendant leur rétention ou leur détention. D'un point de vue plus général, la mission était enfin invitée à faciliter, grâce à ses travaux, l'établissement ultérieur d'un "diagnostic partagé" entre le ministère des affaires sociales et de la santé et le ministère de l'intérieur.
http://www.ladocumentationfrancaise.fr/rapports-publics/134000201/index.shtml

(2013). L'analyse de l'activité hospitalière 2012 : Paris : ATIH
Abstract: Le recueil de l'information des établissements de santé, cœur de métier de l'Agence technique de l'information sur l'hospitalisation (ATIH), donne lieu à différentes formes de restitution comme cette analyse de l'activité hospitalière. Réalisée chaque année, elle vise à éclairer les acteurs de santé en offrant une vision globale des financements des établissements et de leur activité comparée à celle des années précédentes. L'étude commence par le suivi des financements par l'assurance maladie de 2012 des établissements de santé, d'un montant d'environ 74 milliards d'euros annuels. Les évolutions annuelles des masses financières en jeu sont présentées en distinguant le secteur public et privé à but non lucratif et le secteur privé commercial. Au-delà des dépenses, l'intérêt est de définir la nature des activités et sa traduction en profils de patients, pathologies, modes prise en charge, niveau de sévérité... Au vu de ces éléments, les singularités des établissements publics et privés peuvent être décelées. Les activités sont détaillées par champ hospitalier : court-séjour en

médecine, chirurgie, obstétrique (MCO), hospitalisation à domicile (HAD), soins de suite et réadaptation (SSR) et psychiatrie. Les informations sont présentées sous forme de fiches selon le type d'hospitalisation, les diagnostics, l'âge des patients, la région, etc. Ce rapport propose une photographie de l'activité des établissements de santé en 2012 et la compare avec celle des années passées. Ainsi, les tendances confirment notamment le développement de la chirurgie ambulatoire, le dynamisme des établissements spécialisés en HAD et en SSR (résumé de l'éditeur).
http://www.atih.sante.fr/index.php?id=000040000BFF

(2013). Tarification de la chirurgie ambulatoire en France et à l'étranger : Etat des lieux et perspectives. 2 volumes : Rapport d'orientation ; synthèse et recommandations :
Paris : Haute Autorité de Santé.
Abstract: La chirurgie ambulatoire permet au patient de rejoindre son domicile le jour même de son intervention. Alors qu'elle s'est fortement développée dans de nombreux pays européens pour devenir très largement majoritaire, cette pratique ne représente en France qu'environ 40% du total des interventions chirurgicales. Pour favoriser le développement de cette activité, une tarification identique a été instaurée par les pouvoirs publics à partir de 2009 entre la chirurgie ambulatoire et la chirurgie conventionnelle de niveau de sévérité 1. Initialement destinée à 18 procédures chirurgicales, son champ s'est progressivement étendu jusqu'à s'appliquer à 47 procédures en 2013. La HAS a constaté que la tarification identique avait contribué au développement de la chirurgie ambulatoire, mais que la part attribuable aux incitations tarifaires était difficilement mesurable. Elle a mis par ailleurs en évidence plusieurs limites. La HAS a ensuite réalisé une revue de la littérature des différentes innovations mises en place à l'étranger au niveau tarifaire et organisationnel : tarification forfaitaire à l'épisode de soins (bundled payment) expérimentée aux États-Unis ; tarif à la meilleure pratique (best practice tariff) basé sur le coût de la pratique la plus efficiente en Grande-Bretagne ; recours à des établissements sans hébergement totalement dédiés à la chirurgie ambulatoire (ambulatory surgery centers) et autonomes sur le plan juridique et administratif aux Etats-Unis. La HAS a identifié onze thématiques et a élaboré 25 recommandations présentées dans des fiches synthétiques ; elle propose les pistes d'amélioration suivantes : l'accompagnement des mesures tarifaires par d'autres types de mesures incitatives (plan d'investissement, de formation par exemple), dont la cohérence doit être assurée, aussi bien au niveau national que local ; le rétablissement du principe de la neutralité tarifaire au niveau global ; l'amélioration de la lisibilité des incitations tarifaires, tout en précisant les objectifs du régulateur ; la déclinaison du taux national cible de 50% de chirurgie ambulatoire à l'horizon 2016 en un taux par procédure, tout en favorisant les prises en charge les plus efficientes ; la HAS recommande également de s'inspirer des modèles tarifaires du Royaume Uni et des États-Unis, afin de proposer en France une tarification adaptée à l'objectif poursuivi, et d'améliorer l'efficience de la prise en charge en chirurgie.
http://www.has-sante.fr/portail/upload/docs/application/pdf/2013-09/rapport_dorientation_-_tarification_de_la_chirurgie_ambulatoire_en_france_et_a_letranger.pdf
http://www.has-sante.fr/portail/upload/docs/application/pdf/2013-08/synthese_et_recommandations_tarification_de_la_chirurgie_ambulatoire_en_france_et_a_letranger.pdf

Uddin S., Hossain L., Kelaher M. (2012). Effect of physician collaboration network on hospitalization cost and readmission rate. *Eur J Public Health,* 22 (5) : 629-633.
Abstract: BACKGROUND: Previous studies have documented the effect of collaboration among physicians on the effectiveness in delivering health services and in producing better patient outcomes. However, there is no systematic empirical study suggesting the underlying relationship between the collaboration network of physicians and its effect on hospitalization cost and readmission rate. In this study, we explore the effect of different attributes (i.e. degree centrality, betweenness centrality, network density and network distance) of physician collaboration network (PCN) on hospitalization cost and readmission rate. METHOD: We analyse health insurance claim data set of total hip replacement (THR) patients to construct PCN and to test the effect of its network attributes on hospitalization cost and readmission rate. We consider patient age as moderating factor, which could affect the relation of the PCN attributes with hospitalization cost and readmission rate. RESULTS: We find that degree centrality (i.e. level of involvement) and network density (i.e. level of connectedness) of PCN are negatively correlated with hospitalization cost and readmission rate. In contrast, betweenness centrality (i.e. capacity to control the flow of information) is found positively correlated with hospitalization cost and readmission rate. Distance (i.e. embeddedness of actors in a network) is found positively correlated with hospitalization cost but negatively correlated with readmission rate. We

do not notice any significant impact of patient age on the relation of PCN attributes with hospitalization cost and readmission rate. CONCLUSION: The results show that the structure of PCNs is related to indicators of hospital costs and quality (readmission). In their respective hospitals, health-care managers or administrators may follow our research findings to reduce cost and improve quality.

He D., Mellor J.M. (2013). Do changes in hospital outpatient payments affect the setting of care? *Health Services Research,* 48 (5) : 1593-1616.
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.

Long S.J., Brown K.F., Ames D., Vincent C. (2013). What is known about adverse events in older medical hospital inpatients? A systematic review of the literature. *Int J Qual.Health Care,* 25 (5) : 542-554.
Abstract: PURPOSE: Large international studies have shown that older hospital inpatients are at particular risk of adverse events. The purpose of this review was to synthesize data from studies designed to assess the scale and nature of this harm, with the ultimate aim of informing the development of new safety and quality measurement tools to facilitate improved hospital care for these vulnerable patients. DATA SOURCES: STUDY SELECTION: and data extraction. A systematic search using Ovid SP and other sources was carried out, rigorous inclusion and exclusion criteria were applied and quality assessment of included studies was conducted. Data were synthesized to give a picture of the incidence, types, causes, preventability and outcomes of adverse events in older medical inpatients. RESULTS OF DATA SYNTHESIS: Nine relevant studies were identified. A wide range of adverse event incidences were reported, from 5.29 to 6.2% in re-analyses of large adverse event studies, to 60% in studies in which the development of 'geriatric syndromes' (e.g. falls, delirium, incontinence) was also considered to be adverse events. Important causative factors other than age included clinical complexity, co-morbidity, illness severity, reduced functional ability and lower quality of care. Adverse events in older people lead to unnecessary interventions with resultant complications and increased length of stay. CONCLUSION: More work is needed to understand the complex nature of adverse events in older inpatients. We must tailor safety measurement and improvement strategies to address challenges presented by the complexity of the geriatric syndromes and the processes of care encountered by older inpatients.

Braitman A., Dauriac-Le Masson V., Beghelli F., Gallois E., Guillibert E., Hoang C., Kahvedjian A., Lana P., Guedj M.J. (2013). [Decision of emergency involuntary hospitalization: Categorical or dimensional approach?]. *Encéphale,*
Abstract: BACKGROUND: In 2005, in its recommendations on the modalities of decision making for compulsory hospitalization, the French Health High Authority (HAS) had already stressed the need for rapid implementation of studies and epidemiological analyses on the subject to compensate the lack of adequate data in France. The new French law of July 5, 2011, on the rights and protection of persons under psychiatric care, establishes a judicial review of decisions for compulsory hospitalization. Therefore, healthcare professionals need to better define and characterize the criteria for such decisions, especially in their relation to psychopathology. The concept of capacity to consent to treatment includes the ability to understand (to receive information about the disease), the ability to appreciate (to weigh the risks and benefits of treatment), the ability to reason (determining the best choice rationally) and the ability to freely express a decision. However, assessment tools of capacity to consent to treatment seem to fail to predict the modality of hospitalization. OBJECTIVE: This study examined the impact of clinical and contextual characteristics on the decision in emergency services to admit patients to compulsory inpatient psychiatric units. METHOD: Data was collected from 442

successive patients admitted to hospital for care from five psychiatric emergency facilities in Paris and covered sociodemographic information, previous hospitalizations, recent course of care, clinical diagnosis, Global Assessment of Functioning scale (GAF) and Insight measured by the Q8 Bourgeois questionnaire. Patients were also assessed based on criteria established by the HAS for the severity of mental disorders and the necessity of emergency care. RESULTS: Multivariable logistic regression shows that diagnosis does not affect the decision of hospitalization. Agitation, aggressiveness toward others, being married as well as being referred by a doctor or family are all factors that increase the risk of involuntary hospitalization. Last, low Q8 and GAF scores are strong predictors for compulsory admission. CONCLUSION: Our study shows a dimensional rather than categorical assessment of patients by clinicians. Assessment of insight is the main operational criterion used by clinicians in our study. This supports using insight and GAF evaluation in clinical practice to clarify assessment and decision-making in an emergency setting regarding compulsory hospitalization.

Inégalités de santé / Health inequalities

Archimbaud A. (2013). L'accès aux soins des plus démunis : Paris : Premier Ministre.
Abstract: Ce rapport réalisé par la sénatrice Aline Archambaud rassemble 40 propositions pour améliorer l'accès des personnes les plus démunies en France. Parmi ces propositions, l'application des textes existants, en particulier sur les dépassements d'honoraires, la préconisation de sanctions pour ceux qui ne les respectent pas car le refus de soins est devenu un «phénomène massif», l'autorisation du "testing" qui permettrait d'identifier les professionnels qui y recourent. La sénatrice appelle à une extension du « choc de simplification » aux procédures administratives qui concernent les personnes les plus en difficulté, à des changements dans les cultures et les pratiques professionnelles, à la limitation des effets de seuil par l'élargissement de certains droits. Elle propose aussi d'élargir le champ de la CMU-C aux bénéficiaires de l'Allocation de solidarité aux personnes âgées (Aspa) et de l'Allocation aux adultes handicapés (AAH) et de remanier profondément le système de l'aide à l'acquisition d'une complémentaire santé. Elle demande que soient levés les obstacles financiers les plus lourds à l'accès aux soins et que soient renforcées les structures accueillant des précaires comme les centres de santé, maisons de santé, permanences d'accès aux soins (Pass). Pour faire des économies, elle suggère de mettre en place des dispositifs de prévention facilement accessibles, d'aider à l'essaimage des innovations, et enfin d'améliorer la gouvernance du secteur. Les propositions ne sont malheureusement pas chiffrées en particulier les nouveaux droits.
http://www.gouvernement.fr/sites/default/files/fichiers_joints/rapport_officiel-aline_archimbaud.pdf

Malmusi D., Artazcoz L., Benach J., Borrell C. (2012). Perception or real illness? How chronic conditions contribute to gender inequalities in self-rated health. *Eur J Public Health,* 22 (6) : 781-786.
Abstract: BACKGROUND: In Spain, as in many countries, women report poorer general health and more daily activity limitations due to health reasons when compared with men. This study aims to examine whether these poorer indicators are due to a greater prevalence of health problems and to identify the types of problems that contribute most to gender inequalities. METHODS: Cross-sectional study on the population aged >15 years and residing in Spain, with data from the 2006 National Health Survey (n = 29139). The sex prevalence ratios (PR) of poor self-rated health and chronic limitation of activity are sequentially adjusted by age and the presence of 27 chronic conditions by means of robust Poisson regression. RESULTS: At equal number of disorders, women reported equal or even better health than men. The excess of poor health in women (age-adjusted PR and 95% CI: self-rated health = 1.36, 1.29-1.41; chronic limitation = 1.25, 1.18-1.32) disappeared when adjusting for the number of chronic diseases (self-rated health = 1.00, 0.96-1.04; chronic limitation = 0.90, 0.85-0.96). Musculoskeletal, mental and other pain disorders accounted for most of the association. The results were consistent in different strata of age, social class, and type of country of birth. CONCLUSION: These results suggest that the poorer self-rated health of women is a reflection of the higher burden of disease they suffer. A health system responsive to gender inequalities should increase its efforts in addressing and resolving musculoskeletal, mental and other pain disorders, usually less considered in favour of disorders with greater impact on mortality.

Gotsens M., Dell'Olmo M., Perez K. (2013). Socioeconomic inequalities in injury mortality in small areas of 15 European cities. *Health & Place,* (Ahead of pub) :
Abstract: Abstract This study analysed socioeconomic inequalities in mortality due to injuries in small

areas of 15 European cities, by sex, at the beginning of this century. A cross-sectional ecological study with units of analysis being small areas within 15 European cities was conducted. Relative risks of injury mortality associated with the socioeconomic deprivation index were estimated using hierarchical Bayesian model. The number of small areas varies from 17 in Bratislava to 2666 in Turin. The median population per small area varies by city (e.g. Turin had 274 inhabitants per area while Budapest had 76,970). Socioeconomic inequalities in all injury mortality are observed in the majority of cities and are more pronounced in men. In the cities of northern and western Europe, socioeconomic inequalities in injury mortality are found for most types of injuries. These inequalities are not significant in the majority of cities in southern Europe among women and in the majority of central eastern European cities for both sexes. The results confirm the existence of socioeconomic inequalities in injury related mortality, and reveal variations in their magnitude between different European cities.

Frederiksen H.W., Kamper-Jorgensen Z., Agyemang C., Krasnik A., Norredam M. (2013). Health-reception of newly arrived documented migrants in Europe. Why, whom, what and how? *The European Journal of Public Health,* 23 (5) : 725-726.

Grittner U., Kuntsche S., Gmel G., Bloomfield K. (2013). Alcohol consumption and social inequality at the individual and country levels--results from an international study. *Eur J Public Health,* 23 (2): 332-339.
Abstract: BACKGROUND: International comparisons of social inequalities in alcohol use have not been extensively investigated. The purpose of this study was to examine the relationship of country-level characteristics and individual socio-economic status (SES) on individual alcohol consumption in 33 countries. METHODS: Data on 101,525 men and women collected by cross-sectional surveys in 33 countries of the GENACIS study were used. Individual SES was measured by highest attained educational level. Alcohol use measures included drinking status and monthly risky single occasion drinking (RSOD). The relationship between individuals' education and drinking indicators was examined by meta-analysis. In a second step the individual level data and country data were combined and tested in multilevel models. As country level indicators we used the Purchasing Power Parity of the gross national income, the Gini coefficient and the Gender Gap Index. RESULTS: For both genders and all countries higher individual SES was positively associated with drinking status. Also higher country level SES was associated with higher proportions of drinkers. Lower SES was associated with RSOD among men. Women of higher SES in low income countries were more often RSO drinkers than women of lower SES. The opposite was true in higher income countries. CONCLUSION: For the most part, findings regarding SES and drinking in higher income countries were as expected. However, women of higher SES in low and middle income countries appear at higher risk of engaging in RSOD. This finding should be kept in mind when developing new policy and prevention initiatives.

Informatique médicale / Medical informatics

2013). Socio-economic impact of mHealth. An assessment report for the European Union : Neuilly-sur-Seine : PricewaterhouseCoopers
Abstract: Selon cette étude prospective, le déploiement de la technologie mobile dans le domaine de la santé, ou m-Santé, permettrait d’augmenter le PIB de l’Union européenne de 93 milliards d’euros en 2017 grâce à l’amélioration de l’état de santé qui réduirait la perte de jours de travail et les retraites anticipées. Les économies réalisées faciliteraient l'accès aux soins de 24,5 millions patients supplémentaires. Une généralisation de l’utilisation des solutions mobiles contribuerait à une gestion optimisée des maladies chroniques et des conséquences liées au vieillissement de la population, deux des priorités de l’Union européenne. Selon PwC, l’atteinte de ces effets positifs suppose néanmoins l’intégration rapide de la m-Santé dans la stratégie de santé publique de l’Union européenne. Pour ce faire, les états membres doivent lever de nombreux freins d’ordre réglementaire, économique, structurel et technologique, qui limitent actuellement son développement.
http://www.pwc.fr//assets/files/pdf/2013/09/pwc_etude_socio_economic_impac_of_mhealth_the_european_union.pdf

Kim S.E., Michalopoulos C., Kwong R.M., Warren A., Manno M.S. (2013). Telephone Care Management's Effectiveness in Coordinating Care for Medicaid Beneficiaries in Managed Care: A Randomized Controlled Study. *Health Services Research,* 48 (5) : 1730-1749.
Abstract: OBJECTIVE: To test the effectiveness of a telephone care management intervention to increase the use of primary and preventive care, reduce hospital admissions, and reduce emergency department visits for Medicaid beneficiaries with disabilities in a managed care setting. DATA SOURCE: Four years (2007-2011) of Medicaid claims data on blind and/or disabled beneficiaries, aged 20-64. STUDY DESIGN: Randomized control trial with an intervention group (n = 3,540) that was enrolled in managed care with telephone care management and a control group (n = 1,524) who remained in fee-for-service system without care management services. Multi-disciplinary care coordination teams provided telephone services to the intervention group to address patients' medical and social needs. DATA COLLECTION/EXTRACTION: Medicaid claims and encounter data for all participants were obtained from the state and the managed care organization. PRINCIPAL FINDINGS: There was no significant difference in use of primary care, specialist visits, hospital admissions, and emergency department between the intervention and the control group. Care managers experienced challenges in keeping members engaged in the intervention and maintaining contact by telephone. CONCLUSIONS: The lack of success for Medicaid beneficiaries, along with other recent studies, suggests that more intensive and more targeted interventions may be more effective for the high-needs population.

Médicaments / Pharmaceuticals

Duraffourg M., Vanacker.S., Baulinet.C. (2012). La fiscalité spécifique applicable aux produits de santé et à l'industrie qui les fabrique. Rapport IGAS ; 2012 132. Paris : La Documentation française
Abstract : Le présent rapport fait suite à la 5ème réunion du Conseil stratégique des industries de santé (CSIS), tenue le 25 janvier 2012. Au cours de cette rencontre, le CSIS a adopté un certain nombre de mesures, dont la mesure n° 7 qui prévoyait la réalisation d'un "audit de l'environnement fiscal des entreprises des produits de santé en France et en Europe". Par un courrier du 4 avril 2012, les ministres de l'économie, des finances et de l'industrie ; du travail, de l'emploi et de la santé ; du budget, des comptes publics et de la réforme de l'Etat, ont chargé conjointement l'inspection générale des affaires sociales (IGAS) et l'inspection générale des finances (IGF) d'une mission relative à la fiscalité des produits de santé et à l'industrie qui les fabrique. La mission était plus particulièrement chargée de réaliser un état des lieux de la fiscalité spécifique applicable sur le territoire français, de procéder à des comparaisons avec la situation d'autres pays européens, et enfin d'identifier des pistes d'amélioration de la fiscalité ainsi que les moyens de leur mise en ouvre. A cet égard, les propositions d'évolution devaient être guidées par l'objectif d'une plus grande efficience d'ensemble du dispositif de taxation, à rendements constants pour la puissance publique.
http://www.ladocumentationfrancaise.fr/rapports-publics/134000194/index.shtml

Begaud B. (2013). Rapport sur la surveillance et la promotion du bon usage du médicament en France : Paris : Ministère chargé de la santé
Abstract: Ce rapport décrit l'exception française en matière de surconsommation médicamenteuse et d'absence de suivi du mésusage du médicament. Il constitue la synthèse du travail mené dans le cadre d'une mission sur la « pharmacosurveillance » confiée par Marisol Touraine le 26 février 2013. Les constats sont sévères. Par une carence surprenante au vu de l'enjeu, aucune étude ou programme n'a depuis plus de 20 ans permis d'estimer la proportion ou le nombre des prescriptions non conformes et l'ampleur de leurs conséquences néfastes, tant au plan clinique, sanitaire et économique. Ce qui n'empêche pas la Mission d'avancer que la France est l'un des pays développés dans lequel les prescriptions non conformes (qu'il s'agisse des recommandations de AMM autorisations de mise sur le marché ou des données actualisées de la science) semblent les plus fréquentes, si ce n'est banalisées. Les conséquences de cette situation sont considérables, avec des surcoûts induits qui se chiffrent en milliards d'euros par an et se cumulent depuis de nombreuses années. Parmi les recommandations, les auteurs du rapport préconisent, dans un premier temps,

d'agir sur deux leviers qui constituent des préalables essentiels : la création, indispensable, d'une structure organisant et facilitant l'accès, pour les autorités sanitaires et les chercheurs (dont le rôle d'appui méthodologique et de lanceurs d'alerte est essentiel), aux différentes sources de données en santé pertinentes en ce domaine, et une meilleure formation et information des professionnels de santé et du grand public, bien mal préparés en France aux principes de base de la bonne prescription et du bon usage des produits de santé.
http://www.social-sante.gouv.fr/IMG/pdf/Rapport_Begaud_Costagliola.pdf

(2013). Les médicaments biosimilaires. Un état des lieux : St Denis : ANSM
Abstract: Ce rapport sur les médicaments biosimilaires partage les données disponibles sur ces médicaments innovants dont elle assure un suivi attentif. Un médicament biosimilaire est similaire à un médicament biologique (produit à partir d'une cellule ou d'un organisme vivant ou dérivé de ceux-ci) de référence qui a déjà été autorisé en Europe et dont le brevet est tombé dans le domaine public. Il illustre l'évolution rapide du marché des médicaments biosimilaires en France. Il propose un point sur les aspects réglementaires de l'AMM qui est délivrée au niveau européen dans le cadre de la procédure centralisée. Le rapport aborde également la question du bon usage des médicaments biosimilaires dont les indications peuvent être moindres que celles du médicament de référence et dont le suivi des effets indésirables doit être spécifique à chaque produit, compte tenu notamment de leur apparition récente sur le marché. Le rapport dresse encore un état du marché des produits biosimilaires (60 millions d'euros en 2012) dont les ventes ont été multipliées par onze entre 2008 et 2012. Ces produits sont 20 à 30% moins chers que les produits de référence, mais ils représentent à l'heure actuelle moins de 10% des prescriptions. L'arrivée prochaine de nouveaux produits biosimilaires devrait provoquer une augmentation du marché des biosimilaires et une baisse du prix des produits biologiques de référence.
http://ansm.sante.fr/content/download/53857/694269/version/1/file/Rapport_Biosimilaires_26092013.pdf

Daudigny Y. (2013). Les médicaments génériques : des médicaments comme les autres. Rapport d'information : Paris : Sénat
Abstract: Les médicaments génériques font l'objet, en France, de polémiques récurrentes, d'amalgames ou de faux débats qui sont inconnus à l'étranger. Qu'est-ce qu'un médicament générique ? Pourquoi les Français sont-ils méfiants ? Comment expliquer un développement qui reste nettement inférieur en France ? Pour répondre à ces interrogations, la mission d'évaluation et de contrôle de la sécurité sociale du Sénat a organisé, le 19 juin 2013, deux tables rondes réunissant de nombreux acteurs concernés : la première pour répondre effectivement à la question lancinante de l'équivalence entre le médicament d'origine et ses génériques ; la seconde pour évaluer la politique publique poursuivie depuis quelques années en la matière. Le présent rapport retrace ces débats et présente des propositions à même de restaurer la confiance des Français dans les médicaments génériques qui constituent bien, comme l'ont montré les interventions de la première table ronde, des médicaments comme les autres.
http://www.senat.fr/rap/r12-864/r12-8641.pdf

Pulcini C., Lions C., Ventelou B., Verger P. (2013). Drug-specific quality indicators assessing outpatient antibiotic use among French general practitioners. *Eur J Public Health,* 23 (2) : 262-264.
Abstract: Quality indicators assessing the use of antibiotics among general practitioners (GPs) would be useful to target antibiotic stewardship interventions. We adapted to an individual GP level a set of 12 drug-specific quality indicators of outpatient antibiotic use in Europe developed by the European surveillance of antimicrobial consumption project. We performed a cross-sectional study analysing reimbursement data on outpatient antibiotic prescriptions in adults in south-eastern France in 2009. Substantial heterogeneity in antibiotic prescribing among French GPs was observed, and opportunity to improve antibiotic prescribing can be identified.

Tomlin Z., Faulkner A., Peirce S., Elwyn G. (2013). Technology identity: the role of sociotechnical representations in the adoption of medical devices. *Social Science & Medicine,* (Ahead of pub)

Mahmoudi E., Jensen G.A. (2013). Has Medicare Part D Reduced Racial/Ethnic Disparities in Prescription Drug Use and Spending? *Health Services Research,* (Ahead of

pub) : n/a.
Abstract: Objective To evaluate whether Medicare Part D has reduced racial/ethnic disparities in prescription drug utilization and spending. Data Nationally representative data on white, African American, and Hispanic Medicare seniors from the 2002-2009 Medical Expenditure Panel Survey are analyzed. Five measures are examined: filling any prescriptions during the year, the number of prescriptions filled, total annual prescription spending, annual out-of-pocket prescription spending, and average copay level. Study Design We apply the Institute of Medicine's definition of a racial/ethnic disparity and adopt a difference-in-difference-in-differences (DDD) estimator using a multivariate regression framework. The treatment group consists of Medicare seniors, the comparison group, adults without Medicare aged 55-63 years. Principal Findings Difference-in-difference-in-differences estimates suggest that for African Americans Part D increased the disparity in annual spending on prescription drugs by $258 (p=-.011), yet had no effect on other measures of prescription drug disparities. For Hispanics, DDD estimates suggest that the program reduced the disparities in annual number of prescriptions filled, annual total and out-of-pocket spending on prescription drugs by 2.9 (p-=-.077), $282 (p=-.019) and $143 (p<-.001), respectively. Conclusion Medicare Part D had mixed effects. Although it reduced Hispanic/white disparities related to prescription drugs among seniors, it increased the African American/white disparity in total annual spending on prescription drugs.

Gridchyna I., Baumevieille M., Aulois-Griot M., Begaud B. (2013). [Exception drugs status: Specific characteristics and the role in the proper use of drugs.]. *Rev Epidemiol Santé Publique,*
Abstract: BACKGROUND: In 1994, the French health care system established a special status for certain costly drugs reimbursed for ambulatory use: exception drugs. Drugs with this status are reimbursed only when prescribed for specified indications. The purpose of this study was to identify the specific characteristics of drugs with the exception status, and to understand the role of this status in proper use of drugs. METHODS: Drugs included in the study were analyzed using three types of data: administrative, clinical and economic. RESULTS: For most of the drugs, prescription was restrictive. For five of them, the sickness fund accepted reimbursements for fewer indications than mentioned in the marketing authorisation. For the majority, reimbursement was 100%. The exception drugs were indicated for the treatment of 15 diseases. Eighty percent of expenditures for exception drugs concerned ten drugs. CONCLUSION: The characteristics considered in the study did not enable a specific description of the inherent features of exception drugs. This special status was established for the purpose of economic efficiency. Currently, its role in ensuring proper use of drugs is questionable.

Fagnani F., Vespignani H., Kusnik-Joinville O., Bertrand M., Murat C., Levy-Bachelot L., Kahane P. (2013). [Use of drug reimbursement as markers of disease for epidemiological and cost analysis: The case of severe epilepsy in France]. *Presse Med,* 42 (9 Pt 1) : e285-e292.
Abstract: OBJECTIVES: Population characteristics of epileptic patients remain poorly documented in France. Health Insurance claims database may be useful to perform cost and epidemiological studies provided that patients' diagnosis could be identified especially through drugs used as markers. This study explored the possibility to use the French Sickness Fund (FSF) database to determine the prevalence and direct cost of epilepsy. METHOD: The "FSF" reimbursement database is a 1/97 representative sample of the population covered under the French General Scheme. Only the fraction of patients fully covered for epilepsy may be identified by a diagnosis in the database. Others can only be identified through their claims for antiepileptic drugs (AEDs) with the limitation that, among the 19 AEDs used, some are not specific for epilepsy. An algorithm was built to select patients to get a range of prevalence estimates whereas medical expenses of patients were derived on the fully covered sub-population. RESULTS: Only patients treated in polytherapy (>/=2AEDs) were deemed to be identified in a relevant way by an algorithm based on drug usage. The prevalence of epilepsy in this sub-group in 2009 was estimated between 1.83 and 2.79 per thousand (93,000-142,000 patients). A proportion of 70.1 to 71.6% were fully covered for their expenses, with epilepsy alone as a cause in only 27 to 33% of them. The most frequent other co-morbidities were psychiatric disorders and invalidating stroke. The annual per capita expenses were in the range 6.696-6.601euro in patients in polytherapy. Inpatient care and drug costs represented about 50 and 27% of overall expenses, respectively. The increase by 24.4% of polytherapy patients mean costs as compared to monotherapy raised to 72% (IC 95: 44-106%) after adjustment for age, gender and presence of severe co-morbidity. CONCLUSION: In France, in 2009, 93,000 to 142,000 epileptic patients have been treated for epilepsy with a

polytherapy. About one out of three patients only benefited from a full coverage of their medical expenses for epilepsy but half of them were fully covered for another disease. This resulted from the frequent presence of a severe co-morbidity especially psychiatric or due to a history of an invalidating stroke. Conversely, about 30% of epileptic patients in polytherapy, fully eligible to a full coverage did not benefit from it, which suggested an important sub-declaration of severe epilepsy.

Saiba A. (2013). Evaluation of the impact of the recent controversy over statins in France: The EVANS study. *Archives of Cardivascular Disease //,* (In press) :
Abstract: Les bénéfices des statines sur la prévention des événements cardiovasculaires sont aujourd’hui bien démontrés. Récemment, en France, une polémique a remis en cause l’intérêt des statines, notamment en prévention primaire. L'objectif de cet article est d'évaluer l’impact de cette polémique sur l’observance des patients vis-à-vis des statines.

Hoffmann R., Plug I., McKee M., Khoshaba B., Westerling R., Looman C., Rey G., Jougla E., Luis Alfonso J., Lang K., Parna K., Mackenbach J.P. (2013). Innovations in medical care and mortality trends from four circulatory diseases between 1970 and 2005. *The European Journal of Public Health,* 23 (5) : 852-857.
Abstract: Background: Governments have identified innovation in pharmaceuticals and medical technology as a priority for health policy. Although the contribution of medical care to health has been studied extensively in clinical settings, much less is known about its contribution to population health. We examine how innovations in the management of four circulatory disorders have influenced trends in cause-specific mortality at the population level. Methods: Based on literature reviews, we selected six medical innovations with proven effectiveness against hypertension, ischaemic heart disease, heart failure and cerebrovascular disease. We combined data on the timing of these innovations and cause-specific mortality trends (1970 - 2005) from seven European countries. We sought to identify associations between the introduction of innovations and favourable changes in mortality, using Joinpoint-models based on linear spline regression. Results: For both ischaemic heart disease and cerebrovascular disease, the timing of medical innovations was associated with improved mortality in four out of five countries and five out of seven countries, respectively, depending on the innovation. This suggests that innovation has impacted positively on mortality at the population level. For hypertension and heart failure, such associations could not be identified. Conclusion: Although improvements in cause-specific mortality coincide with the introduction of some innovations, this is not invariably true. This is likely to reflect the incremental effects of many interventions, the time taken for them to be adopted fully and the presence of contemporaneous changes in disease incidence. Research on the impact of medical innovations on population health is limited by unreliable data on their introduction.

Barnett M.L. (2013). Antibiotic Prescribing to Adults With Sore Throat in the United States, 1997-2010. *Jama Journal of the American Medical Association,* (In press) :
Abstract: Malgré les efforts déployés par les autorités sanitaires américaines, les médecins continuent à prescrire trop d'antibiotiques selon une étude publiée dans le Journal of the American Medical Association Internal Medicine. Les chercheurs ont recensé les consultations pour bronchite et maux de gorge auprès des médecins américains et des services d'urgence entre 1996 et 2010. Premier enseignement, si les consultations des médecins généralistes pour mal de gorge ont baissé (passant de 7,5% de toutes les consultations à 4,5%), celles en urgence ont augmenté. Par ailleurs, le nombre de consultations pour bronchite a triplé au cours de la même période, pour atteindre 3,4 millions en 2010 contre 1,1 million en 1996. Si en médecine générale le taux d'ordonnance suite à ces consultations reste stable à 60%, celui des urgences a bondi de 69 à 73% dans l'intervalle. Pourtant, seuls 10% de ces pathologies sont provoqués par une bactérie sensible aux antibiotiques. "Outre le fait de contribuer à l'augmentation de la résistance bactérienne aux antibiotiques, l'usage inutile de ces traitements accroît le coût financier pour le système de soins et produit des effets médicaux néfastes chez les personnes qui les prennent", rappellent les auteurs cités par Le Parisien qui rappelle que les Centres fédéraux de contrôle et de prévention des maladies (CDC) brandissent le spectre d'une ère post-antibiotiques, la résistance microbienne concernant deux millions d'Américains chaque année et causant 23.000 décès.

Méthodologie- Statistique / Methodology- Statistics

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,* 48 (5) : 1798-1817.
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 alterative to logistic regression to control confounding in observational studies.

Politique de santé / Health Policy

Lombrail P. (2013). Pour une stratégie nationale de santé qui ne se limite pas à l'optimisation des parcours de soins individuels. *Santé publique,* (4) : 385-387.

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. *Social Science & Medicine,* (Ahead of pub) :
Abstract: 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.

Mackenbach J.P., McKee M. (2013). A comparative analysis of health policy performance in 43 European countries. *Eur J Public Health,* 23 (2) : 195-201.
Abstract: BACKGROUND: It is unknown whether European countries differ systematically in their pursuit of health policies, and what the determinants of these differences are. In this article, we assess the extent to which European countries vary in the implementation of health policies in 10 different areas, and we exploit these variations to investigate the role of political, economic and social determinants of health policy. Data and METHODS: We reviewed policies in the field of tobacco; alcohol; food and nutrition; fertility, pregnancy and childbirth; child health; infectious diseases; hypertension detection and treatment; cancer screening; road safety and air pollution. We developed a set of 27 'process' and 'outcome' indicators, as well as a summary score indicating a country's overall success in implementing effective health policies. In exploratory regression analyses, we related these

indicators to six background factors: national income, survival/self-expression values, democracy, government effectiveness, left-party participation in government and ethnic fractionalization. RESULTS: We found striking variations between European countries in process and outcome indicators of health policies. On the whole, Sweden, Norway and Iceland perform best, and Ukraine, Russian Federation and Armenia perform worst. Within Western Europe, some countries, such as Denmark and Belgium, perform significantly worse than their neighbours. Survival/self-expression values and ethnic fractionalization were the main predictors of the health policy performance summary score. National income, survival/self-expression values and government effectiveness were the main predictors of countries' performance in specific areas of health policy. CONCLUSIONS: Although many new preventive interventions have been developed, their implementation appears to have varied enormously among European countries. Substantial health gains can be achieved if all countries would follow best practice, but this probably requires the removal of barriers related to both the 'will' and the 'means' to implement health policies.

Psychiatrie / Psychiatry

Fleury M.G., Grenier G. (2013). Parcours en milieu ordinaire des jeunes avec un handicap mental ou psychique. *Santé publique,* (4) : 453-463.

Soins de santé primaires / Primary Health Care

Wändell P., Carlsson A.C., Wettermark B., Lord G., Cars T., Ljunggren G. (2013). Most common diseases diagnosed in primary care in Stockholm, Sweden, in 2011. *Family Practice,* 30 (5) : 506-513.
Abstract: Background. The most commonly reported diagnoses in primary care are useful to identify and meet health care needs in society. We estimated the rates of the most common diagnoses in primary health care in total and also by gender. Methods. This was a cross-sectional study including all 2.0 million inhabitants living in Stockholm County, Sweden, on 1 January 2009. Data on all health care appointments made in primary care in 2011 and during 2009-11 were extracted from the Stockholm County Council data warehouse VAL (Vardanalysdatabasen; Stockholm regional health care data warehouse). Primary care data were analysed by underlying population and age. Appropriate specialist open care and inpatient data were used for comparison. Results. The five most common diagnoses in primary care (in 2011) were acute upper respiratory tract infections (6.0% of the population), essential hypertension (5.6%), coughing (2.6%), dorsalgia (2.6%) and acute tonsillitis (2.4%). Female-to-male ratios were higher for 27 of the 30 most common diagnoses, the exceptions being type 2 diabetes, unspecified types of diabetes and multiple wounds.Conclusions. The 30 most common diagnoses in primary care reflect the complexity of disorders cared for in the first line of health care. Knowledge of these patterns is important when aiming at using primary health care resources in a proper way.

Stramberg R., Backlund L.G., Johansson S.E., Lafvander M. (2013). Mortality in depressed and non-depressed primary care Swedish patients: a 12-year follow-up cohort study. *Family Practice,* 30 (5) : 514-519.
Abstract: Background. Data regarding mortality among depressed patients in Swedish primary care is limited. Objectives. We compared mortality in a cohort of depressed and non-depressed patients at long-term follow-up and compared these values with standardized mortality rates (SMRs) in the Swedish population. Hazards ratios (HRs) for the relationship between death and depression, psychosocial factors and lifestyle were analysed, and we explored the proportion of unnatural causes of deaths. Methods. Mortality was studied in a cohort of 124 depressed and 280 non-depressed patients 12 years after being diagnosed with depression in primary care. Mortality and the mortality

rates and SMRs in depressed and non-depressed patients were compared by gender. Cox regression was applied to calculate HRs for the risk of dying for explanatory variables, including depression, psychosocial factors and lifestyle. Results. A larger number of depressed patients, 11% (n = 14), compared with non-depressed patients, 4% (n = 12), died (P = 0.008), with significantly higher values among depressed men (P = 0.014). SMRs did not differ from those of the Swedish population. Depression was the only variable associated with a significantly elevated risk of death (HR, 3.34; 95% CI, 1.38-8.08). Nearly one-third of deaths had unnatural causes when alcohol-related deaths were included.Conclusion. This study underlines the importance of careful follow-up of all depressed patientsΓÇÖ mental and physical health and the intervention on unhealthy lifestyles. Large primary care database studies are needed to explore the association between depression, co-morbid somatic diseases, lifestyle and mortality.

Matthew M., Virginia W., James B., Chris B., Mark P., Chuan-Fen L. (2013). The Continuity and Quality of Primary Care. *Medical Care Research and Review,* 70 (5) : 497-513.
Abstract: Patients who have access to different health care systems, such as Medicare-eligible veterans, may obtain services in either or both health systems. We examined whether quality of diabetes care was associated with care continuity or veterans usual source of primary care in a retrospective cohort study of 1,867 Medicare-eligible veterans with diabetes in 2001 to 2004. Underprovision of quality of diabetes care was more common than overprovision. In adjusted analyses, veterans who relied only on Medicare fee-for-service (FFS) for primary care were more likely to be underprovided HbA1c testing than veterans who relied only on Veteran Affairs (VA) for primary care. Dual users of VA and Medicare FFS primary care were significantly more likely to be overprovided HbA1c and microalbumin testing than VA-only users. VA and Medicare providers may need to coordinate more effectively to ensure appropriate diabetes care to Medicare-eligible veterans, because VA reliance was a stronger predictor than care continuity.

Powell A.A., Bloomfield H.E., Burgess D.J., Wilt T.J., Partin M.R. (2013). A Conceptual Framework for Understanding and Reducing Overuse by Primary Care Providers. *Med Care Res Rev,* 70 (5) : 451-472.
Abstract: Primary care providers frequently recommend, administer, or prescribe health care services that are unlikely to benefit their patients. Yet little is known about how to reduce provider overuse behavior. In the absence of a theoretically grounded causal framework, it is difficult to predict the contexts under which different types of interventions to reduce provider overuse will succeed and under which they will fail. In this article, we present a framework based on the theory of planned behavior that is designed to guide overuse research and intervention development. We describe categories of primary care provider beliefs that lead to the formation of intentions to assess the appropriateness of services, and propose factors that may affect whether the presence of assessment intentions results in an appropriate recommendation. Interventions that have been commonly used to address provider overuse behavior are reviewed within the context of the framework.

Systèmes de santé / Health Systems

(2013). OECD Reviews of Health Care Quality: Denmark 2013: Raising Standards : Paris : OCDE
Abstract: This review of health care quality in Denmark examines policies related to quality and includes chapters covering primary and integrated care, hospital specialisation and equity. It finds that with a dense array of disease- and service-focused quality initiatives, and with information on the quality of care stored in separate data repositories, Denmark needs to create effective links and synergies between them to drive up quality in the healthcare system as a whole, rather than in disconnected elements. Primary care will be central in meeting Denmark's future healthcare challenges of an ageing population with multiple chronic conditions. Therefore, an urgent need is to create a national vision of how a modernised primary care sector will fulfill this new coordination role. National standards, clinical guidelines, accreditation of clinical pathways and targeted financial incentive programmes could support this role, along with more transparent and formalised continual professional development. To facilitate quality improvement from the ambitious hospital rationalisation, Denmark should collect and disseminate data on the quality of individual physicians as well as the hospitals. Undergraduate training and medical research should be reviewed in light of the new service

arrangements. Close surveillance will be needed to monitor whether certain patient groups forego healthcare because travel times to providers are too long. Limited data availability complicate Denmark's ability to monitor its commitment to equitable healthcare. There is an urgent need for renewed action to tackle risk factors of chronic ill-health that disproportionately affect low-income groups. Better information on the impact of user-charges on unmet need in low-income groups is needed.
http://www.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-care-quality-denmark-2013_9789264191136-en

Rice T. (2013). Health system review : United States of America. *Health systems in transition* ; vol. 15, n°3. Copenhague : OMS Bureau régional de l'Europe
Abstract: The Health system profiles (HiTs) are country-based reports that provide a detailed description of health systems and of policy initiatives in progress or under development. HiTs examine different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems. They also describe the institutional framework, process, content, and implementation of health and health care policies, highlighting challenges and areas that require more in-depth analysis. Sections include: Geography and sociodemography; Political and economic context; Health status; Organizational structure; Decentralization and centralization; Patient empowerment; Health care financing; Health expenditure; Population coverage; Pooling; Purchasing; Payment mechanisms; Regulation and planning; Physical and human resources; Provision of services; Public health; Primary care; Hospital care; Emergency care; Social care; Palliative care; Mental health care; Dental care; Pharmaceuticals; Health care reforms; Assessment of the health system.
http://www.euro.who.int/__data/assets/pdf_file/0019/215155/HiT-United-States-of-America.pdf

Travail et santé / Occupational Health

(2013). Conditions de travail. Bilan 2012.
Abstract: Cet ouvrage, dans cette nouvelle édition, décrit le système français de prévention des risques professionnels, les principaux volets de la politique conduite en 2012 en matière de santé et sécurité au travail ainsi que le cadre, les évolutions normatives de l'action européenne et internationale dans ce domaine. Il présente les principaux résultats statistiques permettant d'appréhender l'état des conditions de travail et de la sécurité sur les lieux de travail. Il met également en avant les actions prioritaires, nationales et territoriales, menées en lien avec le Plan santé au travail 2010-2014 en privilégiant une entrée thématique déclinée par l'ensemble des acteurs de la santé au travail. Les thèmes suivants sont ainsi développés : la prévention du risque amiante ; • La prévention des risques psychosociaux ; La prévention de la pénibilité ; la réforme de la médecine du travail ; la prévention du risque pyrotechnique. Les missions permanentes du ministère chargé du Travail et du ministère chargé de l'Agriculture en matière d'amélioration des conditions de travail font également l'objet de présentations dédiées. De plus, l'activité des instances de gouvernance et des organismes qui concourent à la prévention des risques professionnels et à l'amélioration des conditions de travail (COCT, Branche AT/MP, ANACT, Anses, InVS, IRSN, OPPBTP) est également retracée dans cet ouvrage (résumé de l'éditeur).
http://www.travailler-mieux.gouv.fr/IMG/pdf/Bilan_CT_2012.pdf

(2013). La prévention des risques professionnels vus par les médecins du travail.
DARES Analyses, (055) :
Abstract: En 2009-2010, 2400 médecins du travail et de prévention ont réalisé l'enquête Sumer, dont un volet décrit de façon succincte les pratiques formalisées de prévention des risques professionnels dans les établissements enquêtés. Selon les résultats de l'enquête, plus de la moitié des salariés sont couverts par un par un comité d'hygiène, de sécurité et des conditions de travail (CHSCT) et disposent dans leur établissement d'un document d'évaluation des risques professionnels actualisé. Seuls un peu plus d'un tiers des salariés travailleraient dans un établissement qui a mis à jour un plan de prévention.
http://travail-emploi.gouv.fr/IMG/pdf/2013-055-3.pdf

d'Errico A., Costa G. (2012). Socio-demographic and work-related risk factors for medium- and long-term sickness absence among Italian workers. *Eur J Public Health,* 22 (5) : 683-688.
Abstract: BACKGROUND: Few studies investigated determinants of sickness absence in representative samples of the general population, none of which in Italy. Aim of this study was to assess influence and relative importance of socio-demographic and work-related characteristics on medium- and long-term sickness absence in a random sample of Italian workers. METHODS: Approximately 60,000 workers participating in a national survey in 2007 were interviewed regarding sickness absence during the whole previous week, and on socio-demographics, employment characteristics and exposure to a set of physical and psychosocial hazards in the workplace. The association between sickness absence and potential determinants was estimated by multivariable logistic regression models stratified by gender. RESULTS: From the final multivariate models, in both genders sickness absence was statistically significantly associated with tenure employment, working in larger firms, exposure to risk of injury and to bullying or discrimination and, among employees, with shift work. In males, sickness absence was also associated with lower education, employment in the public administration and with exposure to noise or vibration, whereas among women also with manual work and ergonomic factors. In both genders, the attributable fraction for employment-related characteristics was higher than that for socio-demographic ones. CONCLUSIONS: The association with tenure or salaried jobs, and with employment in larger firms or in the public sector suggests that, besides illness, job security is the most important determinant of sickness absence, consistently with the results of previous studies. However, our results indicate that a reduction in exposure to workplace hazards may contribute to reduce absenteeism.

Vieillissement / Ageing

Hoeck S., Francois G., Geerts J., Van der Heyden J., Vandewoude M., Van Hal.G. (2012). Health-care and home-care utilization among frail elderly persons in Belgium. *Eur J Public Health,* 22 (5) : 671-677.
Abstract: BACKGROUND: The patterns of health- and home-care utilization among Belgian frail elderly persons living at home with varying socio-economic status are currently unknown. METHODS: In this cross-sectional study based on a representative sample of 4777 elderly participants (>/=65 years) in the Belgian Health Interview Survey the prevalence of frailty, as determined by items referring to the Fried phenotype, was estimated according to age, gender, comorbidity, place of residence, survey year, living situation and socio-economic status. Differing health-care utilization [contacts with a general practitioner (GP), specialist and emergency department; and hospital admission) and home-care utilization (home nursing, home help and meals-on-wheels] patterns among the frail, prefrail and robust subpopulations were examined. RESULTS: Overall, 9.3% respondents (426) were classified as frail, 30.7% (1636) as prefrail and 60.0% (2715) as robust. Frailty was associated with age, gender, comorbidity, region, survey year and socio-economic status. The frail and prefrail groups were more likely than the robust to contact a GP, a specialist or an emergency department and were more likely to be admitted to hospital, independent of age, gender, comorbidity, survey year, living situation, region and socio-economic status. They were also more likely to appeal to home nursing, home help and meals-on-wheels than the robust participants. CONCLUSION: Even after adjustment for potential confounders, including age, gender and comorbidity, frailty among Belgian elderly persons is associated with their socio-economic status and is strongly associated with their health- and home-care utilization.

Jagger C., McKee M., Christensen K., Lagiewka K., Nusselder W., Van Oyen H., Cambois E., Jeune B., Robine J.M. (2013). Mind the gap ! Reaching the European target of a 2-year increase in healthy life years in the next decade. *The European Journal of Public Health,* 23 (5) : 829-833.
Abstract: Background: The European Innovation Partnership on Active and Healthy Ageing seeks an increase of two healthy life years (HLY) at birth in the EU27 for the next 10 years. We assess the feasibility of doing so between 2010 and 2020 and the differential impact among countries by applying different scenarios to current trends in HLY. Methods: Data comprised HLY and life expectancy (LE) at birth 2004ΓÇô09 from Eurostat. We estimated HLY in 2010 in each country by multiplying the Eurostat projections of LE in 2010 by the ratio HLY/LE obtained either from country and sex-specific linear

regression models of HLY/LE on year (seven countries retaining same HLY question) or extrapolating the average of HLY/LE in 2008 and 2009 to 2010 (20 countries and EU27). The first scenario continued these trends with three other scenarios exploring different HLY gap reductions between 2010 and 2020. Results: The estimated gap in HLY in 2010 was 17.5 years (men) and 18.9 years (women). Assuming current trends continue, EU27 HLY increased by 1.4 years (men) and 0.9 years (women), below the European Innovation Partnership on Active and Healthy Ageing target, with the HLY gap between countries increasing to 18.3 years (men) and 19.5 years (women). To eliminate the HLY gap in 20 years, the EU27 must gain 4.4 HLY (men) and 4.8 HLY (women) in the next decade, which, for some countries, is substantially more than what the current trends suggest. Conclusion: Global targets for HLY move attention from inter-country differences and, alongside the current economic crisis, may contribute to increase health inequalities.

Winters-Van Der Meer S., Kool R.B., Klazinga N.S., Huijsman R. (2013). Are the Dutch long-term care organizations getting better? A trend study of quality indicators between 2007 and 2009 and the patterns of regional influences on performance. *Int J Qual.Health Care,* 25 (5) : 505-514.

Abstract: The Dutch long-term care organizations, providing somatic care, psycho-geriatric care and home care, have to measure the quality of care through client-related and professional indicators since 2007. At the same time, competition was introduced with regional stimuli from healthcare insurers. The first aim of this study is to determine the trends of the national performance on client-related and professional quality indicators for the period 2007-09 in long-term care organizations in the Netherlands. The second aim is to determine the influence of the region on the quality performance in 2009. DESIGN: and participants. We performed trend analyses on the indicators of clients of 2115 long-term care organizations. We used multivariate analyses to determine the difference in national performance between 2007 and 2009 and to calculate the influence of the region on the performance of 2009. INTERVENTION: None. MAIN OUTCOME MEASURES: Client-related and professional indicators. RESULTS: The national performance on client-related indicators for somatic care and home care increased and for psycho-geriatric care the quality performance became worse. The professional indicators for intramural care improved between 2007 and 2009. Region influences the performance. In general, organizations in the west of the Netherlands performed worse than other regions (with exception of home care). CONCLUSIONS: The study suggests that working with quality indicators in long-term care organizations for older people may lead to a better performance on several indicators. The influence of the region on the quality is significant, which could be caused by Dutch healthcare insurers.

Giovannetti E.R., Reider L., Wolff J.L., Frick K.D., Boult C., Steinwachs D., Boyd C.M. (2013). Do older patients and their family caregivers agree about the quality of chronic illness care? *Int J Qual.Health Care,* 25 (5) : 515-524.

Abstract: OBJECTIVE: Family caregivers often accompany patients to medical visits; however, it is unclear whether caregivers rate the quality of patients' care similarly to patients. This study aimed to (1) quantify the level of agreement between patients' and caregivers' reports on the quality of patients' care and (2) determine how the level of agreement varies by caregiver and patient characteristics. DESIGN: Cross-sectional analysis. PARTICIPANTS: Multimorbid older (aged 65 and above) adults and their family caregivers (n = 247). METHODS: Quality of care was rated separately by patients and their caregivers using the Patient Assessment of Chronic Illness Care (PACIC) instrument. The level of agreement was examined using a weighted kappa statistic (Kw). RESULTS: Agreement of caregivers' and patients' PACIC scores was low (Kw = 0.15). Patients taking ten or more medications per day showed less agreement with their caregivers about the quality of care than patients taking five or fewer medications (Kw = 0.03 and 0.34, respectively, P < 0.05). Caregivers who reported greater difficulty assisting patients with health care tasks had less agreement with patients about the quality of care being provided when compared with caregivers who reported no difficulty (Kw = -0.05 and 0.31, respectively, P < .05). Patient-caregiver dyads had greater agreement on objective questions than on subjective questions (Kw = 0.25 and 0.15, respectively, P > 0.05). CONCLUSION: Patient-caregiver dyads following a more complex treatment plan (i.e. taking many medications) or having more difficulty following a treatment plan (i.e. having difficulty with health care tasks) had less agreement. Future qualitative research is needed to elucidate the underlying reasons patients and caregivers rate the quality of care differently.