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Sommaire

Assurance maladie / Health Insurance

Layton, T. J. and A. M. Ryan (2015). "Higher Incentive Payments in Medicare Advantage's Pay-for-Performance Program Did Not Improve Quality But Did Increase Plan Offerings." Health Serv Res **50**(6): 1810-1828.

OBJECTIVE: To evaluate the effects of the size of financial bonuses on quality of care and the number of plan offerings in the Medicare Advantage Quality Bonus Payment Demonstration. DATA SOURCES: Publicly available data from CMS from 2009 to 2014 on Medicare Advantage plan quality ratings, the counties in the service area of each plan, and the benchmarks used to construct plan payments. STUDY DESIGN: The Medicare Advantage Quality Bonus Payment Demonstration began in 2012. Under the Demonstration, all Medicare Advantage plans were eligible to receive bonus payments based on plan-level quality scores (star ratings). In some counties, plans were eligible to receive bonus payments that were twice as large as in other counties. We used this variation in incentives to evaluate the effects of bonus size on star ratings and the number of plan offerings in the Demonstration using a differences-in-differences identification strategy. We used matching to create a comparison group of counties that did not receive double bonuses but had similar levels of the preintervention outcomes. PRINCIPAL FINDINGS: Results from the difference-in-differences analysis suggest that the receipt of double bonuses was not associated with an increase in star ratings. In the matched sample, the receipt of double bonuses was associated with a statistically insignificant increase of +0.034 (approximately 1 percent) in the average star rating ($p > .10$, 95 percent CI: -0.015, 0.083). In contrast, the receipt of double bonuses was associated with an increase in the number of plans offered. In the matched sample, the receipt of double bonuses was associated with an overall increase of +0.814 plans (approximately 5.8 percent) ($p < .05$, 95 percent CI: 0.078, 1.549). We estimate that the double bonuses increased payments by $3.43 billion over the first 3 years of the Demonstration. CONCLUSIONS: At great expense to Medicare, double bonuses in the Medicare Advantage Quality Bonus Payment Demonstration were not associated with improved quality but were associated with more plan offerings.

Pendzialek, J. B., et al. (2016). "Differences in price elasticities of demand for health insurance: a systematic review." Eur J Health Econ **17**(1): 5-21.

Many health insurance systems apply managed competition principles to control costs and quality of health care. Besides other factors, managed competition relies on a sufficient price-elastic demand. This paper presents a systematic review of empirical studies on price elasticity of demand for health insurance. The objective was to identify the differing international ranges of price elasticity and to find socio-economic as well as setting-oriented factors that influence price elasticity. Relevant literature for the topic was identified through a two-step identification process including a systematic search in appropriate databases and further searches within the references of the results. A total of 45 studies from countries such as the USA, Germany, the Netherlands, and Switzerland were found. Clear differences in price elasticity by countries were identified. While empirical studies showed a range between -0.2 and -1.0 for optional primary health insurance in the US, higher price elasticities between -0.6 and -4.2 for Germany and around -2 for Switzerland were calculated for mandatory primary health insurance. Dutch studies found price elasticities below -0.5. In consideration of all relevant studies, age and poorer health status were identified to decrease price elasticity. Other socio-economic factors had an unclear impact or too limited evidence. Premium level, range of premiums, homogeneity of benefits/coverage and degree of forced decision were found to have a major influence on price elasticity in their settings. Further influence was found from supplementary insurance and premium-dependent employer contribution.

Vilcu, I. and I. Mathauer (2016). "State budget transfers to Health Insurance Funds for universal health coverage: institutional design patterns and challenges of covering those outside the formal sector in Eastern European high-income countries." Int J Equity Health **15**(1): 7.

INTRODUCTION: Many countries from the European region, which moved from a government financed and provided health system to social health insurance, would have had the risk of moving away from universal health coverage if they had followed a "traditional" approach. The Eastern

European high-income countries studied in this paper managed to avoid this potential pitfall by using state budget revenues to explicitly pay health insurance contributions on behalf of certain (vulnerable) population groups who have difficulties to pay these contributions themselves. The institutional design aspects of their government revenue transfer arrangements are analysed, as well as their impact on universal health coverage progress. METHODS: This regional study is based on literature review and review of databases for the performance assessment. The analytical framework focuses on the following institutional design features: rules on eligibility for contribution exemption, financing and pooling arrangements, and purchasing arrangements and benefit package design. RESULTS: More commonalities than differences can be identified across countries: a broad range of groups eligible for exemption from payment of health insurance contributions, full state contributions on behalf of the exempted groups, mostly mandatory participation, integrated pools for both the exempted and contributors, and relatively comprehensive benefit packages. In terms of performance, all countries have high total population coverage rates, but there are still challenges regarding financial protection and access to and utilization of health care services, especially for low income people. CONCLUSION: Overall, government revenue transfer arrangements to exempt vulnerable groups from contributions are one option to progress towards universal health coverage.

Economie de la santé / Health Economics

Baird, K. (2016). "High Out-of-Pocket Medical Spending among the Poor and Elderly in Nine Developed Countries." Health Serv Res. [Epub ahead of print]

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

Baird, K. E. (2016). "The incidence of high medical expenses by health status in seven developed countries." Health Policy **120**(1): 26-34.

Health care policy seeks to ensure that citizens are protected from the financial risk associated with needing health care. Yet rising health care costs in many countries are leading to a greater reliance on out-of-pocket (OOP) measures. This paper uses 2010 household survey data from seven countries to measure and compare the burden OOP expenses place on individuals. It compares countries based on the extent to which citizens with health problems devote a large share of their income to OOP expenses. The paper finds that in all countries but France, and to a lesser extent Slovenia, citizens with health problems face considerably higher medical costs than do those without. As many as one-quarter of less healthy citizens in the US, Poland, Russia and Israel devote a large share of their income to OOP expenses. The paper also finds a strong cross-national correlation between the degree to which citizens face high OOP expenses, and the disparities in OOP expenses between those with and without health problems. The levels of high OOP spending uncovered, and their inequitable impact on those with health problems in the seven countries, underscore the potential for OOP measures to undermine core objectives of health care systems, including those of equitable financing, equal access, and improved health among the population.

De Oliveira, C., et al. (2016). "Patients With High Mental Health Costs Incur Over 30 Percent More Costs Than Other High-Cost Patients." Health Aff (Millwood) **35**(1): 36-43.

A small proportion of health care users, called high-cost patients, account for a disproportionately large share of health care costs. Most literature on these patients has focused on the entire population. However, high-cost patients whose use of mental health care services is substantial are likely to differ from other members of the population. We defined a mental health high-cost patient as someone for whom mental health-related services accounted for at least 50 percent of total health care costs. We examined these patients' health care utilization and costs in Ontario, Canada. We found that their average cost for health care, in 2012 Canadian dollars, was $31,611. In contrast, the cost was $23,681 for other high-cost patients. Mental health high-cost patients were younger, lived in poorer neighborhoods, and had different health care utilization patterns, compared to other high-cost patients. These findings should be considered when implementing policies or interventions to address quality of care for mental health patients so as to ensure that mental health high-cost patients receive appropriate care in a cost-effective manner. Furthermore, efforts to manage mental health patients' health care use should address their complex profile through integrated multidisciplinary health care delivery.

Dunn, A., et al. (2016). "Health Care Spending Slowdown From 2000 To 2010 Was Driven By Lower Growth In Cost Per Case, According To A New Data Source." Health Aff (Millwood) **35**(1): 132-140.

In 2015 the Bureau of Economic Analysis released an experimental set of measures referred to as the Health Care Satellite Account, which tracks national health care spending by medical condition. These statistics improve the understanding of the health care sector by blending medical claims data and survey data to present measures of national spending and cost of treatment by condition. This article introduces key aspects of the new account and uses it to study the health spending slowdown that occurred in the period 2000-10. Our analysis of the account reveals that the slowdown was driven by a reduction of growth in cost per case but that spending trends varied greatly across conditions and differentially affected the slowdown. More than half of the overall slowdown was accounted for by a slowdown in spending on circulatory conditions. However, there were more dramatic slowdowns in spending on categories such as endocrine system and musculoskeletal conditions than in spending on other categories, such as cancers.

Flores, G. and O. O'Donnell (2016). "Catastrophic medical expenditure risk." J Health Econ **46**: 1-15.

We propose a measure of household exposure to particularly onerous medical expenses. The measure can be decomposed into the probability that medical expenditure exceeds a threshold, the loss due to predictably low consumption of other goods if it does and the further loss arising from the volatility of medical expenses above the threshold. Depending on the choice of threshold, the measure is consistent with a model of reference-dependent utility with loss aversion. Unlike the risk premium, the measure is only sensitive to particularly high expenses, and can identify households that expect to incur such expenses and would benefit from subsidised, but not actuarially fair, insurance. An empirical illustration using data from seven Asian countries demonstrates the importance of taking account of informal insurance and reveals clear differences in catastrophic medical expenditure risk across and within countries. In general, risk is higher among poorer, rural and chronically ill populations.

Lette, M., et al. (2016). "Health care costs attributable to overweight calculated in a standardized way for three European countries." Eur J Health Econ **17**(1): 61-69.

This article presents a tool to calculate health care costs attributable to overweight in a comparable and standardized way. The purpose is to describe the methodological principles of the tool and to put it into use by calculating and comparing the costs attributable to overweight for The Netherlands, Germany and Czech Republic. The tool uses a top-down and prevalence-based approach, consisting of five steps. Step one identifies overweight-related diseases and age- and gender-specific relative risks. Included diseases are ischemic heart disease, stroke, hypertension, type 2 diabetes mellitus, colorectal cancer, postmenopausal breast cancer, endometrial cancer, kidney cancer and osteoarthritis. Step two

consists of collecting data on the age- and gender-specific prevalence of these diseases. Step three uses the population-attributable prevalence to determine the part of the prevalence of these diseases that is attributable to overweight. Step four calculates the health care costs associated with these diseases. Step five calculates the costs of these diseases that are attributable to overweight. Overweight is responsible for 20-26 % of the direct costs of included diseases, with sensitivity analyses varying this percentage between 15-31 %. Percentage of costs attributable to obesity and preobesity is about the same. Diseases with the highest percentage of costs due to overweight are diabetes, endometrial cancer and osteoarthritis. Disease costs attributable to overweight as a percentage of total health care expenditures range from 2 to 4 %. Data are consistent for all three countries, resulting in roughly a quarter of costs of included diseases being attributable to overweight.

Martin, A. B., et al. (2016). "National Health Spending In 2014: Faster Growth Driven By Coverage Expansion And Prescription Drug Spending." Health Affairs **35**(1): 150-160.
US health care spending increased 5.3 percent to $3.0 trillion in 2014. On a per capita basis, health spending was $9,523 in 2014, an increase of 4.5 percent from 2013. The share of gross domestic product devoted to health care spending was 17.5 percent, up from 17.3 percent in 2013. The faster growth in 2014 that followed five consecutive years of historically low growth was primarily due to the major coverage expansions under the Affordable Care Act, particularly for Medicaid and private health insurance, which contributed to an increase in the insured share of the population. Additionally, the introduction of new hepatitis C drugs contributed to rapid growth in retail prescription drug expenditures, which increased by 12.2 percent in 2014. Spending by the federal government grew at a faster rate in 2014 than spending by other sponsors of health care, leading to a 2-percentage-point increase in its share of total health care spending between 2013 and 2014.

Etat de santé / Health Status

Apouey, B. H. and P.-Y. Geoffard (2016). "Parents' education and child body weight in France: The trajectory of the gradient in the early years." Economics & Human Biology **20**: 70-89.
This paper explores the relationship between parental education and offspring body weight in France. Using two large datasets spanning the 1991–2010 period, we examine the existence of inequalities in maternal and paternal education and reported child body weight measures, as well as their evolution across childhood. Our empirical specification is flexible and allows this evolution to be non-monotonic. Significant inequalities are observed for both parents' education – maternal (respectively paternal) high education is associated with a 7.20 (resp. 7.10) percentage points decrease in the probability that the child is reported to be overweight or obese, on average for children of all ages. The gradient with respect to parents' education follows an inverted U-shape across childhood, meaning that the association between parental education and child body weight widens from birth to age 8, and narrows afterward. Specifically, maternal high education is correlated with a 5.30 percentage points decrease in the probability that the child is reported to be overweight or obese at age 2, but a 9.62 percentage points decrease at age 8, and a 1.25 percentage point decrease at age 17. The figures for paternal high education are respectively 5.87, 9.11, and 4.52. This pattern seems robust, since it is found in the two datasets, when alternative variables for parental education and reported child body weight are employed, and when controls for potential confounding factors are included. The findings for the trajectory of the income gradient corroborate those of the education gradient. The results may be explained by an equalization in actual body weight across socioeconomic groups during youth, or by changes in reporting styles of height and weight.

Kuehnle, D. and C. Wunder (2016). "The Effects of Smoking Bans on Self-Assessed Health: Evidence from Germany." Health Econ. [Epub ahead of print]
We examine the effects of smoking bans on self-assessed health in Germany taking into account heterogeneities by smoking status, gender and age. We exploit regional variation in the dates of enactment and dates of enforcement across German federal states. Using data from the German

Socio-Economic Panel, our difference-in-differences estimates show that non-smokers' health improves, whereas smokers report no or even adverse health effects in response to bans. We find statistically significant health improvements especially for non-smokers living in households with at least one smoker. Non smokers' health improvements materialise largely with the enactment of smoking bans. Copyright (c) 2016 John Wiley & Sons, Ltd.

Meijering, L., et al. (2016). "Home-making after stroke. A qualitative study among Dutch stroke survivors." Health Place **37**: 35-42.

Stroke survivors may suffer from physical limitations as well as cognitive and behavioural difficulties. Many survivors work on their recovery in a rehabilitation clinic with the aim to return to their own home again. Since full recovery is often not feasible, they face the challenge of coming to terms with lasting effects of the stroke and of giving meaning to their home place again. Based on in-depth interviews with stroke survivors, we discuss the meaning of the home with respect to changed post-stroke identities. Our findings show how, for many participants, a formerly comfortable home becomes a space of struggle. Formerly stable bodily routines become time-consuming and demanding, reciprocal relationships with significant others change, often becoming unbalanced dependence. In conclusion, each stroke survivor faces a different struggle to accommodate a changed self in a house that does not feel like home anymore. These findings imply that stroke rehabilitation services need to address the individual and everyday challenges that stroke survivors and their families face at home, to improve their sense of home and well-being.

Präg, P., et al. (2016). "Subjective socioeconomic status and health in cross-national comparison." Social Science & Medicine **149**: 84-92.

Research has established a robust association between subjective socioeconomic status (SES) and health outcomes, which holds over and above the associations between objective markers of SES and health. Furthermore, comparative research on health inequalities has shown considerable variation in the relationship between different objective markers of SES and health across countries. Drawing on data from 29 countries, we present the first cross-national study on the subjective SES–health relationship. For two health outcomes, namely self-rated health (SRH) and psychological wellbeing, we are able to confirm that subjective SES is related to health in all countries under study, even when income, education, and occupational prestige are accounted for. Furthermore, we document considerable variation in the strength of the subjective SES–health association across countries. This variation however is largely independent of country differences in income inequality and country affluence. The health benefits of a high subjective SES appear to be slightly larger in more affluent countries, but only for SRH, not for psychological wellbeing.

Géographie de la santé / Geography of Health

Kroll, M. and R. Schnell (2016). "Anonymisation of geographical distance matrices via Lipschitz embedding." International Journal of Health Geographics **15**(1): 1-14.

Anonymisation of spatially referenced data has received increasing attention in recent years. Whereas the research focus has been on the anonymisation of point locations, the disclosure risk arising from the publishing of inter-point distances and corresponding anonymisation methods have not been studied systematically.

Pérez, S., et al. (2016). "Evolution of research in health geographics through the International Journal of Health Geographics (2002–2015)." International Journal of Health Geographics **15**(1): 1-9.

Health geographics is a fast-developing research area. Subjects broached in scientific literature are most varied, ranging from vectorial diseases to access to healthcare, with a recent revival of themes such as the implication of health in the Smart City, or a predominantly individual-centered approach. Far beyond standard meta-analyses, the present study deliberately adopts the standpoint of

questioning space in its foundations, through various authors of the International Journal of Health Geographics, a highly influential journal in that field. The idea is to find space as the common denominator in this specialized literature, as well as its relation to spatial analysis, without for all that trying to tend towards exhaustive approaches. 660 articles have being published in the journal since launch, but 359 articles were selected based on the presence of the word “Space” in either the title, or the abstract or the text over 13 years of the journal’s existence. From that database, a lexical analysis (tag cloud) reveals the perception of space in literature, and shows how approaches are evolving, thus underlining that the scope of health geographic is far from narrowing.

Roussot, A., et al. (2016). "The use of national administrative data to describe the spatial distribution of in-hospital mortality following stroke in France, 2008-2011." Int J Health Geogr **15**(1): 2.

BACKGROUND: In the context of implementing the National Stroke Plan in France, a spatial approach was used to measure inequalities in this disease. Using the national PMSI-MCO databases, we analyzed the in-hospital prevalence of stroke and established a map of in-hospital mortality rates with regard to the socio-demographic structure of the country. METHODS: The principal characteristics of patients identified according to ICD10 codes relative to stroke (in accordance with earlier validation work) were studied. A map of standardized mortality rates at the level of PMSI geographic codes was established. An exploratory analysis (principal component analysis followed by ascending hierarchical classification) using INSEE socio-economic data and mortality rates was also carried out to identify different area profiles. RESULTS: Between 2008 and 2011, the number of stroke patients increased by 3.85 %, notably for ischemic stroke in the 36-55 years age group (60 % of men). Over the same period, in-hospital mortality fell, and the map of standardized rates illustrated the diagonal of high mortality extending from the north-east to the south-west of the country. The most severely affected areas were also those with the least favorable socio-professional indicators. CONCLUSIONS: The PMSI-MCO database is a major source of data on the health status of the population. It can be used for the area-by-area observation of the performance of certain healthcare indicators, such as in-hospital mortality, or to follow the implementation of the National Stroke Plan. Our study showed the interplay between social and demographic factors and stroke-related in-hospital mortality. The map derived from the results of the exploratory analysis illustrated a variety of areas where social difficulties, aging and high mortality seemed to meet. The study raises questions about access to neuro-vascular care in isolated areas and in those in demographic decline. Telemedicine appears to be the solution favored by decision makers. The aging of the population managed for stroke must not mask the growing incidence in younger people, which raises questions about the development of classical (smoking, hypertension) or new (drug abuse) risk factors.

Hôpital / Hospitals

Clanet, R., et al. (2015). "Revue systématique sur les documents de sortie d’hospitalisation et les attentes des médecins généralistes." Santé Publique **27**(5): 701-711.

Le lien ville-hôpital est un des points faibles du parcours de soins en France [1-3] comme à l’étranger [4, 5]. Or le relais entre la prise en charge hospitalière et la prise en charge ambulatoire se déroule à un moment où l’état de santé des patients apparaît être précaire [6]. La Haute Autorité de santé (HAS) a défini en 2014 le document de sortie d’hospitalisation comme un élément devant contenir « *les principaux éléments relatifs au séjour du patient ainsi que les éléments utiles à la continuité des soins hôpital-ville* » [7]. Le compte-rendu d’hospitalisation (CRH) est le moyen le plus utilisé pour la transmission des informations auprès du médecin ou de la structure qui assurera la continuité des soins après l’hospitalisation concernée [8-11]. Bien que le CRH paraisse être un document-clé en termes de limitation du risque iatrogénique [5, 9, 12, 13], du nombre d’hospitalisations itératives [5, 6, 12-15], et de la réduction de la morbi-mortalité [2, 3, 13, 16], son contenu n’est pas

formalisé et sa qualité semble faible.

Koike, S., et al. (2016). "The effect of concentrating obstetrics services in fewer hospitals on patient access: a simulation." International Journal of Health Geographics **15**(1): 1-10.
In Japan, the number of obstetrics facilities has steadily decreased and the selection and concentration of obstetrics facilities is progressing rapidly. Obstetrics services should be concentrated in fewer hospitals to improve quality of care and reduce the workload of obstetricians. However, the impact of this intensification of services on access to obstetrics hospitals is not known. We undertook a simulation to examine how the intensification of obstetrics services would affect access to hospitals based on a variety of scenarios, and the implications for health policy.

Martin, S., et al. (2016). "Have hospital readmissions increased in the face of reductions in length of stay? Evidence from England." Health Policy **120**(1): 89-99.
We assess the relationship between changes in hospital length of stay (LoS) and hospital quality, as measured by 28-day emergency readmission. We estimate regression models to analyse LoS and other factors associated with readmission for all those admitted for hip replacement (n=496,334), hernia repair (n=413,712) or following a stroke (n=480,113) in England between 2002/3 and 2007/8. There were reductions in LoS over time while changes in crude readmission rates varied by condition. Given the high mortality rate for stroke, it is critical to account for the probability of surviving the initial admission when evaluating readmissions. Conditional upon survival, the probability of readmission was greater for stroke patients who originally had a shorter LoS and for hernia patients who had an overnight stay but there is no relationship between LoS and readmission for patients who had hip replacement. The evidence does not generally suggest that reductions in LoS were associated with an increased probability of emergency readmission.

McGarry, B. E., et al. (2016). "The Impact of the Medicare Hospital Readmission Reduction Program in New York State." Medical Care **54**(2): 162-171.
Background: Medicare's Hospital Readmission Reduction Program (HRRP) created clear financial incentives for hospitals to prevent readmissions. Although existing evidence suggests readmission rates have been declining, the direct contribution of this policy to these reductions is unclear. Furthermore, it is unknown whether HRRP has produced unintended effects, including the substitution of outpatient hospital care for readmissions. Objectives: To determine the effect of HRRP in New York State on both the likelihood of being readmitted and returning to hospital emergency department (ED) care within 30 days of discharge. Research Design: Difference-in-difference estimation using prepolicy and postpolicy hospital claims data and the proportion of a hospital's inpatient revenue at risk for HRRP penalization to identify policy exposure. Policy effects are estimated using multivariate logistic regressions. Results: We find significant global reductions in readmissions in the postpolicy years, but no evidence of a differential policy effect on patients discharged from hospitals at risk for proportionally larger HRRP penalties in either postpolicy year 1 [adjusted odd ratio (AOR) =1.00, P=0.733] or 2 (AOR=1.01, P=0.315). HRRP did increase the odds of patients from hospitals facing greater financial risk having a 30-day ED visit in both postpolicy years (AOR=1.04, P=0.009 and AOR=1.07, P<0.001). Conclusions: Our findings suggest that while readmissions have decreased in New York State, these declines may not be directly attributable to HRRP penalties. The policy did produce significant potentially unintended effects in the form of greater postdischarge ED utilization among facilities facing proportionally larger penalties.

Mehta, H. B., et al. (2016). "Comparison of Comorbidity Scores in Predicting Surgical Outcomes." Medical Care **54**(2): 180-187.
Introduction: The optimal methodology for assessing comorbidity to predict various surgical outcomes such as mortality, readmissions, complications, and failure to rescue (FTR) using claims data has not been established. Objective: Compare diagnosis-based and prescription-based comorbidity scores for predicting surgical outcomes. Methods: We used 100% Texas Medicare data (2006–2011) and included patients undergoing coronary artery bypass grafting, pulmonary lobectomy, endovascular repair of abdominal aortic aneurysm, open repair of abdominal aortic aneurysm, colectomy, and hip replacement (N=39,616). The ability of diagnosis-based [Charlson comorbidity score, Elixhauser

comorbidity score, Combined Comorbidity Score, Centers for Medicare and Medicaid Services-Hierarchical Condition Categories (CMS-HCC)] versus prescription-based Chronic disease score in predicting 30-day mortality, 1-year mortality, 30-day readmission, complications, and FTR were compared using c-statistics (c) and integrated discrimination improvement (IDI). Results: The overall 30-day mortality was 5.8%, 1-year mortality was 17.7%, 30-day readmission was 14.1%, complication rate was 39.7%, and FTR was 14.5%. CMS-HCC performed the best in predicting surgical outcomes (30-d mortality, c=0.797, IDI=4.59%; 1-y mortality, c=0.798, IDI=9.60%; 30-d readmission, c=0.630, IDI=1.27%; complications, c=0.766, IDI=9.37%; FTR, c=0.811, IDI=5.24%) followed by Elixhauser comorbidity index/disease categories (30-d mortality, c=0.750, IDI=2.37%; 1-y mortality, c=0.755, IDI=5.82%; 30-d readmission, c=0.629, IDI=1.43%; complications, c=0.730, IDI=3.99%; FTR, c=0.749, IDI=2.17%). Addition of prescription-based scores to diagnosis-based scores did not improve performance. Conclusions: The CMS-HCC had superior performance in predicting surgical outcomes. Prescription-based scores, alone or in addition to diagnosis-based scores, were not better than any diagnosis-based scoring system.

Nagendran, M., et al. (2016). "Mortality Among Older Adults Before Versus After Hospital Transition to Intensivist Staffing." Medical Care **54**(1): 67-73.

Background: A large body of research suggests that hospitals with intensive care units staffed by board-certified intensivists have lower mortality rates than those that do not. Objective: To determine whether hospitals can reduce their mortality by adopting an intensivist staffing model. Design: Retrospective, longitudinal study using 2003–2010 Medicare data and the Leapfrog Group Hospital surveys. Setting and Patients: In total, 2,916,801 Medicare patients at 488 US hospitals. Measurements: We studied 30-day and in-hospital mortality among patients with several common medical and surgical conditions. We first compared risk-adjusted mortality rates of 3 groups of hospitals: those that were intensivist staffed throughout this time period, those that were not intensivist staffed, and those that transitioned to intensivist staffing somewhere during the period. We then examined rates of mortality improvement within each of the 3 groups and used difference-in-differences techniques to assess the independent effect of intensivist staffing among the subset of hospitals that transitioned. Results: Hospitals with intensivist staffing at the beginning of our study period had lower mortality rates than those without. However, hospitals that adopted intensivist staffing during the study period did not substantially improve their mortality rates. In our difference-in-differences analysis, there was no significant independent improvement in mortality after transitioning to intensivist staffing either overall [relative risk (RR), 0.96; 95% confidence interval (CI), 0.90–1.02] or in the medical (RR, 0.95; 95% CI, 0.89–1.02) or surgical populations (RR, 0.97; 95% CI, 0.84–1.10). Limitations: Risk adjustment was based on administrative data. Categorization of exposure was by survey response at the hospital level. Conclusions: Adoption of an intensivist staffing model was not associated with improved mortality in Medicare beneficiaries. These findings suggest that the lower mortality rates previously observed at hospitals with intensivist staffing may be attributable to other factors.

Pilotto, A., et al. (2016). "The Multidimensional Prognostic Index predicts in-hospital length of stay in older patients: a multicentre prospective study." Age and Ageing **45**(1): 90-96.

Background: prediction of length of stay (LOS) may be useful to optimise care plans to reduce the negative outcomes related to hospitalisation. Objective: to evaluate whether the Multidimensional Prognostic Index (MPI), based on a Comprehensive Geriatric Assessment (CGA), may predict LOS in hospitalised older patients. Design: prospective multicentre cohort study.S etting: twenty Geriatrics Units. Participants: patients aged 65 and older consecutively admitted to Geriatrics Units. Measurement: at admission, the CGA-based MPI was calculated by using a validated algorithm that included information on basal and instrumental activities of daily living, cognitive status, nutritional status, the risk of pressures sores, co-morbidity, number of drugs and co-habitation status. According to validated cut-offs, subjects were divided into three groups of risk, i.e. MPI-1 low risk (value ≤0.33), MPI-2 moderate risk (value 0.34–0.66) and MPI-3 severe risk of mortality (value ≥0.67).Results: two thousand and thirty-three patients were included; 1,159 were women (57.0%). Age- and sex-adjusted mean LOS in patients divided according to the MPI grade was MPI-1 = 10.1 (95% CI 8.6–11.8), MPI-2 = 12.47 (95% CI 10.7–14.68) and MPI-3 = 13.41 (95% CI 11.5–15.7) days (P for trend <0.001). The overall accuracy of the MPI to predict LOS was good (C-statistic 0.74, 95% CI 0.72–0.76). Moreover, a

statistically significant trend of LOS means was found even in patients stratified according to their International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) main diagnosis. Conclusions: the MPI is an accurate predictor of LOS in older patients hospitalised with the most frequent diseases.

Rayburn, W. F., et al. (2012). "Drive times to hospitals with perinatal care in the United States." Obstet Gynecol **119**(3): 611-616.

OBJECTIVE: To evaluate access to inpatient obstetric care, we determined the proportions of women of reproductive age who resided within 30-minute and 60-minute driving times to the nearest hospital offering perinatal services. METHODS: Perinatal centers, identified from the 2007 American Hospital Association survey, were designated as being level I (uncomplicated obstetric and nursery care), level II (limited complicated care), or level III (full complement of care). The study population consisted of all reproductive-aged (18-39 years) women included in the 2010 U.S. Census Bureau estimates. We used geographic information system mapping software to map 30-minute and 60-minute drive times from the census block group centroid to the nearest perinatal center. RESULTS: A total of 2,606 hospitals in the United States offered some level of perinatal care for the 49.8 million reproductive-aged women. Access to perinatal centers within a 30-minute drive varied by the level of care: 87.5% of the population to any center; 78.6% to level II or level III centers; and 60.8% to level III facilities. Access to the centers within a 60-minute drive also varied: 97.3% of the population to any center; 93.1% to level II or level III centers; and 80.1% to level III facilities. The mostly rural western half of the United States (except for the Pacific Coast) and Alaska had the greatest geographic maldistribution of perinatal services. CONCLUSION: Driving times to hospitals offering perinatal care vary considerably. Using geographic information system software can be valuable for regional obstetric workforce planning and policy-making in relation to accessing care.

Rosen, A. K., et al. (2016). "Does Use of a Hospital-wide Readmission Measure Versus Condition-specific Readmission Measures Make a Difference for Hospital Profiling and Payment Penalties?" Medical Care **54**(2): 155-161.

Background: The Centers for Medicare and Medicaid Services (CMS) use public reporting and payment penalties as incentives for hospitals to reduce readmission rates. In contrast to the current condition-specific readmission measures, CMS recently developed an all-condition, 30-day all-cause hospital-wide readmission measure (HWR) to provide a more comprehensive view of hospital performance. Objectives: We examined whether assessment of hospital performance and payment penalties depends on the readmission measure used. Research Design: We used inpatient data to examine readmissions for patients discharged from VA acute-care hospitals from Fiscal Years 2007–2010. We calculated risk-standardized 30-day readmission rates for 3 condition-specific measures (heart failure, acute myocardial infarction, and pneumonia) and the HWR measure, and examined agreement between the HWR measure and each of the condition-specific measures on hospital performance. We also assessed the effect of using different readmission measures on hospitals' payment penalties. Results: We found poor agreement between the condition-specific measures and the HWR measure on those hospitals identified as low or high performers (eg, among those hospitals classified as poor performers by the heart failure readmission measure, only 28.6% were similarly classified by the HWR measure). We also found differences in whether a hospital would experience payment penalties. The HWR measure penalized only 60% of those hospitals that would have received penalties based on at least 1 of the condition-specific measures. Conclusions: The condition-specific measures and the HWR measure provide a different picture of hospital performance. Future research is needed to determine which measure aligns best with CMS's overall goals to reduce hospital readmissions and improve quality.

Inégalités de santé / Health Inequalities

Blanquet, M., et al. (2016). "Metabolic syndrome and social deprivation: results of a French

observational multicentre survey." Family Practice **33**(1): 17-22.
Background. Deprivation, a process that prevents people to assume their social responsibilities, is a main cause of inequalities in health. Metabolic syndrome has a growing prevalence in France. Objectives. To assess the association between deprivation and the metabolic syndrome and to identify the most relevant waist circumference cut-off point. Methods. A cross-sectional multicentre study was carried out of data extracted from health examination centres of two French areas in 2008. The harmonized definition of the metabolic syndrome contained five criteria with two thresholds for waist circumference. Deprivation was calculated by the Evaluation of Deprivation and Inequalities in Health Examination Centres score (EPICES). Eligible patients were at least 16 years old. The methodology of time to event analysis was used on patients having two criteria to identify the most relevant waist circumference threshold, taking waist circumference as event and computing it as a continuous variable. The median corresponded to the waist circumference threshold for which half of the patients switched from two to three criteria and so metabolic syndrome. Results. Of the 32374 persons included in the study, 39.4% were socially deprived. The prevalence of the metabolic syndrome varied from 16.3% to 22.2% in the overall sample depending on the published waist circumference thresholds chosen. Deprivation was an independent factor associated with the metabolic syndrome. The cut-off point for waist circumference was between 95 and 99cm for men and 88 and 97cm for women. Conclusion. Deprivation is associated with a higher prevalence of the metabolic syndrome. The most relevant threshold for waist circumference could be 94cm for men and 88cm for women.

Chen, J., et al. (2016). "Racial and Ethnic Disparities in Health Care Access and Utilization Under the Affordable Care Act." Medical Care **54**(2): 140-146.
Objective: To examine racial and ethnic disparities in health care access and utilization after the Affordable Care Act (ACA) health insurance mandate was fully implemented in 2014. Research Design: Using the 2011–2014 National Health Interview Survey, we examine changes in health care access and utilization for the nonelderly US adult population. Multivariate linear probability models are estimated to adjust for demographic and sociodemographic factors. Results: The implementation of the ACA (year indicator 2014) is associated with significant reductions in the probabilities of being uninsured (coef=−0.03, P<0.001), delaying any necessary care (coef=−0.03, P<0.001), forgoing any necessary care (coef=−0.02, P<0.001), and a significant increase in the probability of having any physician visits (coef=0.02, P<0.001), compared with the reference year 2011. Interaction terms between the 2014 year indicator and race/ethnicity demonstrate that uninsured rates decreased more substantially among non-Latino African Americans (African Americans) (coef=−0.04, P<0.001) and Latinos (coef=−0.03, P<0.001) compared with non-Latino whites (whites). Latinos were less likely than whites to delay (coef=−0.02, P<0.001) or forgo (coef=−0.02, P<0.001) any necessary care and were more likely to have physician visits (coef=0.03, P<0.005) in 2014. The association between year indicator of 2014 and the probability of having any emergency department visits is not significant. Conclusions: Health care access and insurance coverage are major factors that contributed to racial and ethnic disparities before the ACA implementation. Our results demonstrate that racial and ethnic disparities in access have been reduced significantly during the initial years of the ACA implementation that expanded access and mandated that individuals obtain health insurance.

O'Hara, K., et al. (2016). "Links between depressive symptoms and unmet health and social care needs among older prisoners." Age and Ageing **45**(1): 158-163.
Background: absolute numbers of older prisoners and their proportion of the total prison population are increasing. They have multiple health and social care needs that are prominent on entry into prison. No previous studies have identified older prisoners' health and social care needs at this crucial point. Objective: to examine unmet health and social care needs among older men entering prison and their links with depressive symptoms. Methods: a cross-sectional survey across nine prisons in the North of England was completed. One hundred male prisoners aged between 60 and 81 were interviewed, using the Camberwell Assessment of Need—Forensic short version (CANFOR-S) and Geriatric Depression Scale—Short Form (GDS-15). Descriptive statistics were generated and χ2 tests performed.Results: participants reported high levels of unmet needs as measured with the CANFOR-S, notably in the domains of knowledge about their condition and treatment (38%); psychological distress (34%); daytime activities (29%); benefits (28%); food (22%) and physical health (21%). The mean total number of unmet needs was 2.74, with a median of 2.0. More than half the sample (56%,

95% CI 45–66%) exhibited clinical signs of depression. A significant association between depressive symptomology and an unmet physical health need, as measured by the CANFOR-S, was detected ($\chi 2$ = 6.76, df = 1, P < 0.01).Conclusions: high levels of depressive symptoms were experienced by older prisoners on entry into prison. Personalised health and social care needs assessment and discrete depression screening are required on prison entry to facilitate effective management of unmet needs.

Sozmen, K. and B. Unal (2016). "Explaining inequalities in Health Care Utilization among Turkish adults: Findings from Health Survey 2008." Health Policy **120**(1): 100-110.

BACKGROUND: Turkish health system showed major improvements in health outcomes since initiation of the Health Transition Programme (HTP) in 2003, however little is known regarding income-related inequalities in health care use. The aim of this study was to assess horizontal inequities in health care use in Turkey. METHODS: We used the data from Turkish Health Survey 2008 with 14,655 respondents. We calculated concentration index (C) and horizontal inequity index (HI) to measure the socioeconomic inequalities in utilization of general practitioner (GP) care, specialist care, inpatient care, dental care and emergency care. Contributions of each factor to the observed inequality in health care utilization were assessed through decomposition method. RESULTS: There was a significant pro-rich inequality in specialist care and oral health care utilization among individuals as indicated by positive values of HI (=0.1149) and HI (=0.1137), respectively. However, the poor were more likely to utilize emergency care (HI=-0.0461) and inpatient care (HI=-0.0731). GP care was also slightly pro-poor distributed (HI=-0.0042). CONCLUSION: Pro-poor income-related inequalities in health care use were largely explained by greater health care need among low income groups, while non-need factors were the main determinants for pro-rich utilization (education, residence area). Inequalities in dental and specialist care linked to low income, low education level and rural areas should be given priority by decision makers to reduce the negative impact of utilization on health. Our results provide some evidence of inequity in 2008, after the introduction of HTP and provide a baseline against which the effects of the new reforms can be assessed.

Médicaments / Pharmaceuticals

Andrade, L. F., et al. (2016). "Entry time effects and follow-on drug competition." Eur J Health Econ **17**(1): 45-60.

Pharmaceutical firms have been criticized for concentrating efforts of R&D on the so-called me-too or follow-on drugs. There have been many comments for and against the dissemination of these incremental innovations but few papers have broached the subject from an econometric point of view, possibly because identification of me-too or follow-on drugs is not so obvious. This paper focuses on the impact of entry order on follow-on drug competition in the French market between the years 2001 and 2007. More precisely, this study examines the effects on market share of first entrants in the follow-on drug market and how this possible competitive advantage changes over time. First results are coherent with theoretical microeconomic issues concerning the importance of being first. We find evidence that first movers in the follow-on drug market have the ability to capture and maintain greater market share for a long period of time. The hierarchical market position of follow-on drugs does not seem to be affected by generic drug emergence. From a dynamic perspective, our analysis shows that market share is positively correlated with the ability of follow-on drugs to set prices higher than the average follow-on drug prices in a specific therapeutic class, which means that market power remains considerably important for first movers. Moreover, we found that the optimum level of innovation to maximize market share is the highest one.

Cullinan, S., et al. (2016). "Use of a frailty index to identify potentially inappropriate prescribing and adverse drug reaction risks in older patients." Age and Ageing **45**(1): 115-120.

Background: potentially inappropriate prescribing (PIP) is a significant problem in health care today. We hypothesise that if doctors were given a single indicator of PIP and adverse drug reaction (ADR) risk on a patient's prescription, it might stimulate them to review the medicines. We suggest that a frailty index (FI) score may be such a suitable indicator. Objectives: to determine whether a positive

relationship exists between a patient's frailty status, the appropriateness of their medications and their propensity to develop ADRs. Compare this to just using the number of medications a patient takes as an indicator of PIP/ADR risk.Setting and method: a frailty index was constructed and applied to a patient database. The associations between a patient's FI score, the number of instances of PIP on their prescription and their likelihood of developing an ADR were determined using Pearson correlation tests and χ2 tests. Results: significant correlation between FI score instances of PIP was shown (R = 0.92). The mean FI score above which patients experienced at least one instance of PIP was 0.16. Patients above this threshold were twice as likely to experience PIP (OR = 2.6, P < 0.0001) and twice as likely to develop an ADR (OR = 2.1, P < 0.0001). Patients taking more than six medications were 3 times more likely to experience PIP. Conclusion: an FI score is a potentially relevant clinical indicator for doctors to critically assess a patient's prescription for the presence of PIP and ultimately prevent ADRs, especially when used in tandem with the number of medications a patient takes.

Hawke, K. L., et al. (2016). "What do consumers want to know about antibiotics? Analysis of a medicines call centre database." Family Practice **33**(1): 75-81.

Background. Australia is one of the highest users of antibiotics in the developed world. Objective. This study aimed to identify consumer antibiotic information needs to improve targeting of medicines information. Methods. We conducted a retrospective, mixed-method study of consumers' antibiotic-related calls to Australia's National Prescribing Service (NPS) Medicines Line from September 2002 to June 2010. Demographic and question data were analysed, and the most common enquiry type in each age group was explored for key narrative themes. Relative antibiotic call frequencies were determined by comparing number of calls to antibiotic utilization in Australian Statistics on Medicines (ASM) data. Results. Between 2002 and 2010, consumers made 8696 antibiotic calls to Medicines Line. The most common reason was questions about the role of their medicine (22.4%). Patient age groups differed in enquiry pattern, with more questions about lactation in the 0- to 4-year age group (33.6%), administration (5–14 years: 32.4%), interactions (15–24 years: 33.4% and 25–54 years: 23.3%) and role of the medicine (55 years and over: 26.6%). Key themes were identified for each age group. Relative to use in the community, antibiotics most likely to attract consumer calls were ciprofloxacin (18.0 calls/100000 ASM prescriptions) and metronidazole (12.9 calls/100000 ASM prescriptions), with higher call rates than the most commonly prescribed antibiotic amoxicillin (3.9 calls/100000 ASM prescriptions).Conclusions. Consumers' knowledge gaps and concerns about antibiotics vary with age, and certain antibiotics generate greater concern relative to their usage. Clinicians should target medicines information to proactively address consumer concerns.

Utens, C. M., et al. (2016). "How to integrate research evidence on patient preferences in pharmaceutical coverage decisions and clinical practice guidelines: A qualitative study among Dutch stakeholders." Health Policy **120**(1): 120-128.

Despite the increasing number of research publications on patient preferences, their use in healthcare policy-making is limited. Integrating research evidence on patient preferences in policy-making is advocated by some, but several issues are put forward as well. There has been no systematic investigation of the stakeholders' view on this matter so far. Objective is to explore the opinions of Dutch stakeholders on how to integrate evidence on patient preferences in pharmaceutical coverage decisions and clinical practice guideline (CPG) development, and which issues may be encountered. METHODS: Qualitative study with semi-structured interviews with Dutch researchers (N=7), policy-makers and CPG developers (N=4) and patient representatives (N=4) involved in pharmaceutical coverage decisions and/or CPG development. The interview scheme focused on the definition of patient preferences; how to integrate evidence on patient preferences in decision-making; and barriers and facilitators. RESULTS: Respondents mentioned various barriers and facilitators for integration, of conceptual, normative, procedural, methodological and practical nature. There is also variety in the terms and definitions used for preferences, complicating searching and synthesising evidence. It is not clear how to integrate evidence on patient preferences in different decision contexts, and what weight preferences should have in relation to other decision criteria. CONCLUSIONS: This study revealed important issues that need guidance when integrating evidence on patient preferences in healthcare policy decisions.

Méthodologie – Statistique / Methodology - Statistics

Boudreaux, M. H., et al. (2015). "Measurement Error in Public Health Insurance Reporting in the American Community Survey: Evidence from Record Linkage." Health Serv Res **50**(6): 1973-1995.
OBJECTIVE: Examine measurement error to public health insurance in the American Community Survey (ACS). DATA SOURCES/STUDY SETTING: The ACS and the Medicaid Statistical Information System (MSIS). STUDY DESIGN: We tabulated the two data sources separately and then merged the data and examined health insurance reports among ACS cases known to be enrolled in Medicaid or expansion Children's Health Insurance Program (CHIP) benefits. DATA COLLECTION/EXTRACTION METHODS: The two data sources were merged using protected identification keys. ACS respondents were considered enrolled if they had full benefit Medicaid or expansion CHIP coverage on the date of interview. PRINCIPAL FINDINGS: On an aggregated basis, the ACS overcounts the MSIS. After merging the data, we estimate a false-negative rate in the 2009 ACS of 21.6 percent. The false-negative rate varies across states, demographic groups, and year. Of known Medicaid and expansion CHIP enrollees, 12.5 percent were coded to some other coverage and 9.1 percent were coded as uninsured. CONCLUSIONS: The false-negative rate in the ACS is on par with other federal surveys. However, unlike other surveys, the ACS overcounts the MSIS on an aggregated basis. Future work is needed to disentangle the causes of the ACS overcount.

Li, Q. and P. K. Trivedi (2016). "Adverse and Advantageous Selection in the Medicare Supplemental Market: A Bayesian Analysis of Prescription drug Expenditure." Health Econ **25**(2): 192-211.
This paper develops an extended specification of the two-part model, which controls for unobservable self-selection and heterogeneity of health insurance, and analyzes the impact of Medicare supplemental plans on the prescription drug expenditure of the elderly, using a linked data set based on the Medicare Current Beneficiary Survey data for 2003-2004. The econometric analysis is conducted using a Bayesian econometric framework. We estimate the treatment effects for different counterfactuals and find significant evidence of endogeneity in plan choice and the presence of both adverse and advantageous selections in the supplemental insurance market. The average incentive effect is estimated to be $757 (2004 value) or 41% increase per person per year for the elderly enrolled in supplemental plans with drug coverage against the Medicare fee-for-service counterfactual and is $350 or 21% against the supplemental plans without drug coverage counterfactual. The incentive effect varies by different sources of drug coverage: highest for employer-sponsored insurance plans, followed by Medigap and managed medicare plans. Copyright (c) 2014 John Wiley & Sons, Ltd.

Politique de santé / Health Policy

Carey, G., et al. (2015). "Systems science and systems thinking for public health: a systematic review of the field." BMJ Open **5**(12): e009002.
OBJECTIVES: This paper reports on findings from a systematic review designed to investigate the state of systems science research in public health. The objectives were to: (1) explore how systems methodologies are being applied within public health and (2) identify fruitful areas of activity. DESIGN: A systematic review was conducted from existing literature that draws on or uses systems science (in its various forms) and relates to key public health areas of action and concern, including tobacco, alcohol, obesity and the social determinants of health. DATA ANALYSIS: 117 articles were included in the review. An inductive qualitative content analysis was used for data extraction. The following were systematically extracted from the articles: approach, methodology, transparency, strengths and weaknesses. These were then organised according to theme (ie, commonalities between studies within each category), in order to provide an overview of the state of the field as a whole. The assessment of data quality was intrinsic to the goals of the review itself, and therefore, was carried out as part of the analysis. RESULTS: 4 categories of research were identified from the review, ranging from editorial and commentary pieces to complex system dynamic modelling. Our analysis of each of

these categories of research highlighted areas of potential for systems science to strengthen public health efforts, while also revealing a number of limitations in the dynamic systems modelling being carried out in public health. CONCLUSIONS: There is a great deal of interest in how the application of systems concepts and approach might aid public health. Our analysis suggests that soft systems modelling techniques are likely to be the most useful addition to public health, and align well with current debate around knowledge transfer and policy. However, the full range of systems methodologies is yet to be engaged with by public health researchers.

Lang, T. (2015). "Déterminants sociaux, santé et politiques publiques?: mobiliser toutes les connaissances." Santé Publique **27**(5): 619-621.

Politique publique / Public Policy

Wasmer (2014). "Evaluation_des_politiques_publiques_faut-il l'interdisciplinarité ?" Economie & Prévision(204-2015): 193-209.
L'évaluation des politiques publiques est devenue un champ de recherche très actif en sciences sociales, dont les travaux influencent de plus en plus les décisions publiques. Le choix de la méthodologie d'évaluation se pose dès lors avec plus d'acuité qu'elle n'est pas toujours neutre. Plus précisément, nous discutons des avantages et des inconvénients de l'interdisciplinarité lorsqu'il s'agit de porter un diagnostic pertinent. Par pertinent, nous entendons qui soit à la fois : de portée opérationnelle, exact empiriquement, démontré scientifiquement et tenant compte des effets informels, systémiques et difficilement quantifiables mais qui sont parfois de premier ordre pour évaluer de façon complète.

Prévention / Prevention

Jenkins, C. (2016). "Reframing health for COP21, Paris 2015." J Public Health Policy **37**(1): 123-125.

Prévision – Evaluation / Prevision - Evaluation

Erkel-Rouss H.. (2014). "Méthodes d'évaluation des politiques publique : introduction générale." Economie & Prévision(204-205): I-XII.

Dupin, C. M., et al. (2015). "Pistes de réflexion pour l'évaluation et le financement des interventions complexes en santé publique." Santé Publique **27**(5): 653-657.
Le contexte français, notamment marqué par des inégalités en santé grandissantes, nécessite la mise en œuvre d'actions sur l'environnement et sur les déterminants sociaux de la santé (DSS) [1], par des actions intersectorielles (transversales) et la conception de programmes participatifs [2]. Bien qu'encore insuffisamment développée en France, la recherche en prévention et promotion de la santé ambitionne de relever ces défis par le biais de la recherche interventionnelle (RI). La RI produit des connaissances sur les processus, les mécanismes, les effets et les impacts des interventions dans une visée d'utilité sociale [3]. Ce domaine contribue à l'avancement des connaissances sur les modes d'actions prometteurs, sur les déterminants sociaux de la santé [4], et sur le développement de stratégies pour leur évaluation.

Pitt, C., et al. (2016). "Economic Evaluation in Global Perspective: A Bibliometric Analysis of the

Recent Literature." Health Econ **25 Suppl 1**: 9-28.

We present a bibliometric analysis of recently published full economic evaluations of health interventions and reflect critically on the implications of our findings for this growing field. We created a database drawing on 14 health, economic, and/or general literature databases for articles published between 1 January 2012 and 3 May 2014 and identified 2844 economic evaluations meeting our criteria. We present findings regarding the sensitivity, specificity, and added value of searches in the different databases. We examine the distribution of publications between countries, regions, and health areas studied and compare the relative volume of research with disease burden. We analyse authors' country and institutional affiliations, journals and journal type, language, and type of economic evaluation conducted. More than 1200 economic evaluations were published annually, of which 4% addressed low-income countries, 4% lower-middle-income countries, 14% upper-middle-income countries, and 83% high-income countries. Across country income levels, 53, 54, 86, and 100% of articles, respectively, included an author based in a country within the income level studied. Biomedical journals published 74% of economic evaluations. The volume of research across health areas correlates more closely with disease burden in high-income than in low-income and middle-income countries. Our findings provide an empirical basis for further study on methods, research prioritization, and capacity development in health economic evaluation.

Terris-Prestholt, F., et al. (2016). "Parameterising User Uptake in Economic Evaluations: The role of discrete choice experiments." Health Econ **25 Suppl 1**: 116-123.

Model-based economic evaluations of new interventions have shown that user behaviour (uptake) is a critical driver of overall impact achieved. However, early economic evaluations, prior to introduction, often rely on assumed levels of uptake based on expert opinion or uptake of similar interventions. In addition to the likely uncertainty surrounding these uptake assumptions, they also do not allow for uptake to be a function of product, intervention, or user characteristics. This letter proposes using uptake projections from discrete choice experiments (DCE) to better parameterize uptake and substitution in cost-effectiveness models. A simple impact model is developed and illustrated using an example from the HIV prevention field in South Africa. Comparison between the conventional approach and the DCE-based approach shows that, in our example, DCE-based impact predictions varied by up to 50% from conventional estimates and provided far more nuanced projections. In the absence of observed uptake data and to model the effect of variations in intervention characteristics, DCE-based uptake predictions are likely to greatly improve models parameterizing uptake solely based on expert opinion. This is particularly important for global and national level decision making around introducing new and probably more expensive interventions, particularly where resources are most constrained.

Givord, P. (2014). "Méthodes économétriques pour l'évaluation de politiques publiques." Economie & Prévision **204-205**(1-2): 1-28.

Cet article présente les principales méthodes économétriques utilisées pour l'évaluation ex post de l'impact d'une politique publique. Il met l'accent sur les problèmes de sélection qui se posent lors d'une évaluation (en particulier en expliquant comment distinguer ce qui relève de l'effet d'une politique des spécificités éventuelles de ses bénéficiaires). Il trace les différentes étapes d'une feuille de route d'un tel exercice (données nécessaires, hypothèse d'identification, interprétation des résultats), illustrées par les exemples issus d'articles récents de la littérature économique. On commence par rappeler le cadre classique d'inférence causale dit "de Rubin", puis on décrit en détail les quatre principales méthodes empiriques d'évaluation : sélection sur observables, différence de différences, variables instrumentales et régression sur discontinuités.

Soins de santé primaires / Primary Health Care

Chen, C.-C. and S.-H. Cheng (2016). "Does pay-for-performance benefit patients with multiple chronic conditions? Evidence from a universal coverage health care system." Health Policy

and Planning **31**(1): 83-90.
Introduction: Numerous studies have examined the impact of pay-for-performance (P4P) programmes, yet little is known regarding their effects on continuity of care (COC) and the role of multiple chronic conditions (MCCs). This study aimed to examine the effects of a P4P programme for diabetes care on health care provision, COC and health care outcomes in diabetic patients with and without comorbid hypertension. Methods: This study utilized a large-scale natural experiment with a 4-year follow-up period under a compulsory universal health insurance programme in Taiwan. The intervention groups consisted of patients with diabetes who were enrolled in the P4P programme in 2005. The comparison groups were selected via propensity score matching with patients who were seen by the same group of physicians. A difference-in-differences analysis was conducted using generalized estimating equation models to examine the effects of the P4P programme. Results: Significant impacts were observed after the implementation of the P4P programme for diabetic patients with and without hypertension. The programme increased the number of necessary examinations/tests and improved the COC between patients and their physicians. The programme significantly reduced the likelihood of diabetes-related hospital admissions and emergency department visits [odds ratio (OR): 0.71; 95% confidence interval (CI): 0.63–0.80 for diabetic patients with hypertension; OR: 0.74; 95% CI: 0.64–0.86 for patients without hypertension]. However, the effects of the P4P programme diminished to some extent in the second year after its implementation. Conclusion: This study suggests that a financial incentive programme may improve the provision of necessary health care, COC and health care outcomes for diabetic patients both with and without comorbid hypertension. Health authorities could develop policies to increase participation in P4P programmes and encourage continued improvement in health care outcomes.

Coffman, J. M., et al. (2016). "Testing the Validity of Primary Care Physicians' Self-Reported Acceptance of New Patients by Insurance Status." Health Serv Res [Epub-Ahead of Print]

OBJECTIVE: To compare physicians' self-reported willingness to provide new patient appointments with the experience of research assistants posing as either a Medicaid beneficiary or privately insured person seeking a new patient appointment. DATA SOURCES/STUDY SETTING: Survey administered to California physicians and telephone calls placed to a subsample of respondents. STUDY DESIGN: Cross-sectional comparison. DATA COLLECTION/EXTRACTION METHODS: All physicians whose California licenses were due for renewal in June or July 2013 were mailed a survey, which included questions about acceptance of new Medicaid and new privately insured patients. Subsequently, research assistants using a script called the practices of a stratified random sample of 209 primary care physician respondents in an attempt to obtain a new patient appointment. By design, half of the physicians selected for the telephone validation reported on the survey that they accepted new Medicaid patients and half indicated that they did not. PRINCIPAL FINDINGS: The percentage of callers posing as Medicaid patients who could schedule new patient appointments was 18 percentage points lower than the percentage of physicians who self-reported on the survey that they accept new Medicaid patients. Callers were also less likely to obtain appointments when they posed as patients with private insurance. CONCLUSIONS: Physicians overestimate the extent to which their practices are accepting new patients, regardless of insurance status.

Colla, C. H., et al. (2016). "Accountability across the Continuum: The Participation of Postacute Care Providers in Accountable Care Organizations." Health Serv Res. [Epub-Ahead of Print]

OBJECTIVE: To examine the extent to which accountable care organizations (ACOs) formally incorporate postacute care providers. DATA SOURCES: The National Survey of ACOs (N = 269, response rate 66 percent). STUDY DESIGN: We report statistics on ACOs' formal inclusion of postacute care providers and the organizational characteristics and clinical capabilities of ACOs that have postacute care. PRINCIPAL FINDINGS: Half of ACOs formally include at least one postacute service, with inclusion at higher rates in ACOs with commercial (64 percent) and Medicaid contracts (70 percent) compared to ACOs with Medicare contracts only (45 percent). ACOs that have a formal relationship with a postacute provider are more likely to have advanced transition management, end of life planning, readmission prevention, and care management capabilities. CONCLUSIONS: Many ACOs have not formally engaged postacute care, which may leave room to improve service integration and care management.

Flye Sainte Marie, C., et al. (2015). "Difficultés des médecins généralistes dans la prise en charge de leurs patients précaires." Santé Publique **27**(5): 679-690.

La précarité est un état de fragilité, d'instabilité des conditions et des ressources nécessaires à la santé : se loger, accéder à l'éducation, se nourrir convenablement, disposer d'un certain revenu, bénéficier d'un écosystème stable, compter sur un apport stable de ressources, et avoir droit à la justice et à un traitement équitable. Quant à la pauvreté, définie par l'insuffisance de ressources, son taux au seuil fixé à 60 % du revenu médian, a augmenté en 2012 pour atteindre 14 % de la population générale. La loi du 29 juillet 1998 a initié des programmes de lutte contre les exclusions, à travers les Programmes régionaux d'accès à la prévention et aux soins (PRAPS) qui proposent notamment la mise en place des Permanences d'accès aux soins de santé (PASS). Elle est à l'origine de la Couverture maladie universelle (CMU) et de l'Aide médicale d'État (AME), puis de l'Aide complémentaire santé (ACS) en 2004. La mise en application de ces programmes a été relayée par les Agences régionales de santé (ARS), dans le cadre de la loi HSPT du 21 juillet 2009. Malgré ces mesures, le renoncement aux soins ne cesse d'augmenter pour atteindre 16,2 % en 2010, selon l'Institut de recherche et de développement en économie de la santé (IRDES).

Katz, A., et al. (2015). "Does a pay-for-performance program for primary care physicians alleviate health inequity in childhood vaccination rates?" Int J Equity Health **14**(1): 114.

INTRODUCTION: Childhood vaccination rates in Manitoba populations with low socioeconomic status (SES) fall significantly below the provincial average. This study examined the impact of a pay-for-performance (P4P) program called the Physician Integrated Network (PIN) on health inequity in childhood vaccination rates. METHODS: The study used administrative data housed at the Manitoba Centre for Health Policy. We included all children born in Manitoba between 2003 and 2010 who were patients at PIN clinics receiving P4P funding matched with controls at non-participating clinics. We examined the rate of completion of the childhood primary vaccination series by age 2 across income quintiles (Q1-Q5). We estimated the distribution of income using the Gini coefficient, and calculated concentration indices for vaccination to determine whether the P4P program altered SES-related differences in vaccination completion. We compared these measures between study cohorts before and after implementation of the P4P program, and over the course of the P4P program in each cohort. RESULTS: The PIN cohort included 6,185 children. Rates of vaccination completion at baseline were between 0.53 (Q1) and 0.69 (Q5). Inequality in income distribution was present at baseline and at study end in PIN and control cohorts. SES-related inequity in vaccination completion worsened in non-PIN clinics (difference in concentration index 0.037; 95 % CI 0.013, 0.060), but remained constant in P4P-funded clinics (difference in concentration index 0.006; 95 % CI 0.008, 0.021). CONCLUSIONS: The P4P program had a limited impact on vaccination rates and did not address health inequity.

Landmark, A. M. D., et al. (2016). "Negotiating treatment preferences: Physicians' formulations of patients' stance." Social Science & Medicine **149**: 26-36.

Eliciting patients' values and treatment preferences is an essential element in models of shared decision making, yet few studies have investigated the interactional realizations of how physicians do this in authentic encounters. Drawing on video-recorded encounters from Norwegian secondary care, the present study uses the fine-grained empirical methodology of conversation analysis (CA) to identify one conversational practice physicians use, namely, formulations of patients' stance, in which physicians summarize or paraphrase their understanding of the patient's stance towards treatment. The purpose of this study is twofold: (1) to explore what objectives formulations of patients' stance achieve while negotiating treatment and (2) to discuss these objectives in relation to core requirements in shared decision making. Our analysis demonstrates that formulating the patient's stance is a practice physicians use in order to elicit, check, and establish patients' attitudes towards treatment. This practice is in line with general recommendations for making shared decisions, such as exploring and checking patients' preferences and values. However, the formulations may function as a device for doing more than merely checking and establishing common ground and bringing up patients' preferences and views: Accompanied by subtle deprecating expressions, they work to delegitimize the patients' stances and indirectly convey the physicians' opposing stance. Once established, these positions can be used as a basis for challenging and potentially altering the patient's attitude towards the decision, thereby making it more congruent with the physician's view. Therefore, in addition to bringing up patients' views towards treatment, we argue that physicians may use

formulations of patients' stance as a resource for directing the patient towards decisions that are congruent with the physician's stance in situations with potential disagreement, whilst (ostensibly) avoiding a more authoritarian or paternalistic approach.

Leveille, S. G., et al. (2016). "Do Patients Who Access Clinical Information on Patient Internet Portals Have More Primary Care Visits?" Medical Care **54**(1): 17-23.

Background: As health care costs alarm the nation and the debate increases about the impact of health information technologies, patients are reviewing their medical records increasingly through secure Internet portals. Important questions remain about the impact of portal use on office visits. Objective: To evaluate whether use of patient Internet portals to access records is associated with increased primary care utilization. Research Design : A prospective cohort study. Subjects: Primary care patients registered on patient Internet portals, within an integrated health system serving rural Pennsylvania and an academic medical center in Boston. Measures: Frequency of “clinical portal use” (days/2 mo intervals over 2 y) included secure messaging about clinical issues and viewing laboratory and radiology findings. In year 2, a subset of patients also gained access to their primary care doctor’s visit notes. The main outcome was number of primary care office visits. Results: In the first 2 months of the 2-year period, 14% of 44,951 primary care patients engaged in clinical portal use 2 or more days per month, 31% did so 1 day per month, and the remainder had no clinical portal use. Overall, adjusted for age, sex, and chronic conditions, clinical portal use was not associated with subsequent office visits. Fewer than 0.1% of patients engaged in high levels of clinical portal use (31 or more login days in 2 mo) that were associated with 1 or more additional visits in the subsequent 2 months (months 3 and 4). However, the reverse was true: office visits led to subsequent clinical portal use. Similar trends were observed among patients with or without access to visit notes. Conclusions: Patients turn to their portals following visits, but clinical portal use does not contribute to an increase in primary care visits.

Liddy, C., et al. (2016). "Physician perspectives on a tailored multifaceted primary care practice facilitation intervention for improvement of cardiovascular care." Family Practice **33**(1): 89-94.

Background. Practice facilitation is an effective way to help physicians implement change in their clinics, but little is known about physicians’ perspectives on this service. Objectives. To examine physicians’ responses to a practice facilitation program, focussing on their overall satisfaction, perceived most significant clinical changes, and interactions with the facilitator. Methods. The Improved Delivery of Cardiovascular Care program investigated the impact of practice facilitation on improving the quality of cardiovascular primary care in Eastern Ontario, Canada, from 2007 to 2011. We conducted a qualitative content analysis of post-intervention surveys completed by participating physicians, using a constant comparison approach framed around the Chronic Care Model. Results. Ninety-five physicians completed the survey. Physicians overwhelmingly viewed the program positively, though descriptions of its benefits and impact varied widely. Facilitators filled three key roles for physicians, acting as a resource centre, motivator and outside perspective. Physicians adopted a number of changes in their practices. These changes include adoption of clinical information systems (diabetes registries), decision support tools (chart audits, guideline documents, flow sheets) and delivery system design (community resources).Conclusions. Most physicians appreciated having access to a practice facilitator and viewed the intervention positively. Insight into physicians’ perspectives on practice facilitation provides a valuable counterpoint to outcomes-based evaluations of such services. Further research should investigate potential obstacles in the group of physicians who make fewer practice changes, as well as the sustainability of this type of facilitation intervention.

McCarthy, M. (2016). "Sustainable general practice: looking across Europe." Br J Gen Pract **66**(642): 36.

An overview of findings from an inquiry by the European Union of General Practitioners (UEMO) on GP workload including responses from 25 Member States. “A profession under stress is a profession at risk. Maybe the answer is simply to reduce patient access to EU levels; to restrict doctor–patient contacts — both telephone and face-to-face consultations — to fewer than 25 a day. It may be possible to divert some demands to pharmacists, nurses, or other health professionals. It may also be possible to educate the public to self-care, at least for minor illnesses. GPs are expensive and time-

consuming to train. It would be sensible to use their skills carefully."

McHugh, M., et al. (2016). "Patient-Centered Medical Home Adoption: Results From Aligning Forces For Quality." Health Aff (Millwood) **35**(1): 141-149.

To improve health care quality within communities, increasing numbers of multistakeholder alliances-groups of payers, purchasers, providers, and consumers-have been created. We used data from two rounds (conducted in July 2007-March 2009 and January 2012-November 2013) of a large nationally representative survey of small and medium-size physician practices. We examined whether the adoption of patient-centered medical home processes spread more rapidly in fourteen Robert Wood Johnson Foundation Aligning Forces for Quality communities, where multistakeholder health care alliances promoted their use, than in other communities. We found no difference in the overall growth of adoption of the processes between the two types of communities. However, improvement on a care coordination subindex was 7.17 percentage points higher in Aligning Forces for Quality communities than in others. Despite the enthusiasm for quality improvement led by multistakeholder alliances, such alliances may not be a panacea for spreading patient-centered medical home processes across a community.

Reibling, N. and M. B. Rosenthal (2016). "The (Missed) Potential of the Patient-centered Medical Home for Disparities." Medical Care **54**(1): 9-16.

Background: Disparities in health care and health outcomes are a significant problem in the United States. Delivery system reforms such as the patient-centered medical home (PCMH) could have important implications for disparities. Objectives: To investigate what role disparities play in current PCMH initiatives and how their set-up might impact on disparities. Research Design: We selected 4 state-based PCMH initiatives (Colorado, Massachusetts, Pennsylvania, and Rhode Island), 1 regional initiative in New Orleans, and 1 multistate initiative. We interviewed 30 key actors in these initiatives and 3 health policy experts on disparities in the context of PCMH. Interview data were coded using the constant comparative method. Results: We find that disparities are not an explicit priority in PCMH initiatives. Nevertheless, many policymakers, providers, and initiative leaders believe that the model has the potential to reduce disparities. However, because of the funding structure of initiatives and the lack of adjustment of quality metrics, health policy experts do not share this optimism and safety-net providers report concerns and frustration. Conclusion: Even though disparities are currently not a priority in the PCMH community, the design of initiatives has important implications for disparities.

Stransky, M. L. (2016). "Recentering Patient-centered Care on the Patient: A Research Agenda." Medical Care **54**(1): 3-4.

Ugolini, C., et al. (2016). "Dealing with minor illnesses: The link between primary care characteristics and Walk-in Centres' attendances." Health Policy **120**(1): 72-80.

The reformulation of existing boundaries between primary and secondary care, in order to shift selected services traditionally provided by Emergency Departments (EDs) to community-based alternatives, has determined a variety of organisational solutions. One innovative change has been the introduction of fast-track systems for minor injuries or illnesses, whereby community care providers are involved in order to divert patients away from EDs. These facilities offer an open-access service for patients not requiring hospital treatments, and may be staffed by nurses and/or primary care general practitioners operating within, or alongside, the ED. To date little research has been undertaken on such experiences. To fill this gap, we analyse a Walk-in Centre (WiC) in the Italian city of Parma, consisting of a minor injury unit located alongside the teaching hospital's ED. We examine the link between the utilisation rates of the WiC and primary care characteristics, focusing on the main organisational features of the practices and estimating panel count data models for 2007-2010. Our main findings indicate that the extension of practice opening hours significantly lowers the number of attendances, after controlling for General Practitioner's and practice's characteristics.

van den Berg, M. J., et al. (2016). "Accessible and continuous primary care may help reduce rates of emergency department use. An international survey in 34 countries." Family Practice **33**(1): 42-50.

Background. Part of the visits to emergency departments (EDs) is related to complaints that may well be treated in primary care. Objectives. (i) To investigate how the likelihood of attending an ED is related to accessibility and continuity of primary care. (ii) To investigate the reasons for patients to visit EDs in different countries. Methods. Data were collected within the EU Seventh Framework project Quality and Costs in Primary Care (QUALICOPC) in 31 European countries, Australia, New Zealand and Canada. The data were collected between 2011 and 2013 and contain survey data from 60991 patients and 7005 GPs, within 7005 general practices. Outcome measure: whether the patient visited the ED in the previous year (yes/no). Multilevel logistic regression analyses were carried out to analyse the data. Results. Some 29.4% had visited the ED in the past year. Between countries, the percentages varied between 18% and 40%. ED visits show a significant and negative relation with better accessibility of primary care. Patients with a regular doctor who knows them personally were less likely to attend EDs. Only one-third of all patients who visited an ED indicated that the main reason for this was that their complaint could not be treated by a GP. Conclusions. Good accessibility and continuity of primary care may well reduce ED use. In some countries, it may be worthwhile to invest in more continuous relationships between patients and GPs or to eliminate factors that hamper people to use primary care (e.g. for costs or travelling).

van Dipten, C., et al. (2016). "Substitution scenario in follow-up of chronic cancer patients in primary care: prevalence, disease duration and estimated extra consultation time." Family Practice **33**(1): 4-9.

Background. The incidence of cancer as well as survival rates for it are increasing. It is debated whether care in the chronic phase of cancer can be positioned in primary care due to doubts about capacity and workload. Objective. To estimate GPs' extra consultation time if they assume responsibility for the care in the chronic phase of cancer. Method. Retrospective cohort study. Estimation of extra consultation time by quantifying prevalence, incidence, survival, number of chronic cancer patients, current practice contacts and registration of risk factors in patients with all types of cancers. Results. The most prevalent types of cancer (with 5-year survival rates) are as follows: breast cancer (91.5%), colorectal cancer (63.8%), prostate cancer (78.3%), melanoma (91.9%) and bladder and urinary tract cancer (77.3%). Primary care practices include ~32 chronic cancer patients, with a potential extra consultation time of ~19 hours per year per 1000 patients. One-third (35%) are already in a chronic disease management programme and 57% were diagnosed >5 years ago. Registration of risk factors for cancer is incomplete, but of better quality when comorbidity is present. Conclusion. Numbers of chronic cancer patients and possible time investment by primary care professionals in the case of a substitution scenario should not be a limiting factor for transition of follow-up from secondary to primary care, as most of the patients were diagnosed >5 years ago and a large proportion of these patients are already monitored in an existing chronic care programme.

Zaman, M. J., et al. (2016). "Association of increasing age with receipt of specialist care and long-term mortality in patients with non-ST elevation myocardial infarction." Age and Ageing **45**(1): 96-103.

Background: observational studies suggest that older patients are less likely to receive secondary prevention medicines following acute coronary syndrome (ACS).Objectives: to examine the association of increasing age with receipt of specialist care and influence of specialist care on long-term mortality in patients with non-ST elevation myocardial infarction (NSTEMI).Design: a cohort study. Setting: National ACS registry of England and Wales. Subjects: a total of 85,183 patients admitted with NSTEMI between 2006 and 2010.Methods: logistic regression analyses to assess receipt of secondary prevention medicines (ACE inhibitor, β-blocker, statin, aspirin) by age group; multivariate Cox regression models to examine longitudinal effect of cardiologist care on all-cause mortality by age group. Results: mean age 72.0 years (SD 13.0 years), mean follow-up was 2.13 years. Older patients received less cardiologist care (70.2% of NSTEMI patients ≥85 years compared with 94.7% of patients <65) years and had more co-morbidity. Cardiologists prescribed more secondary prevention in all age groups than generalists, but this was mostly explained away by co-morbidity (receipt of statin crude OR 1.51 (1.27,1.80), fully adjusted OR 1.11 (0.92,1.33) in patients ≥85 years). Receiving cardiologist care compared with generalist care was associated with a decreased risk of death in all even after adjustment for co-morbidity, disease severity and secondary prevention; this benefit reduced incrementally with older age group (adjusted hazard ratio (HR) 0.58 (0.49,0.68) aged <65; 0.87

(0.82,0.92) aged ≥85).Conclusion: older patients with NSTEMI were less likely to see a cardiologist, but reduced treatment by generalists was explained away by co-morbidity. Cardiologist care was associated with lower mortality in all age groups than a generalist, but this survival benefit was less pronounced in older patients.

Systèmes de santé / Health Systems

(2016). "Efforts To Improve Quality Of Care And Patient Satisfaction." Health Affairs **35**(2): 375-376.

Dowd, B. E., et al. (2016). "PQRS Participation, Inappropriate Utilization of Health Care Services, and Medicare Expenditures." Med Care Res Rev **73**(1): 106-123.
Medicare's Physician Quality Reporting System (PQRS) is the largest quality-reporting system in the U.S. health care system and a basis for the new value-based modifier system for physician payment. The PQRS allows health care providers to report measures of quality of care that include both the process of care and physiological outcomes. Using a multivariate difference-in-differences model, we examine the relationship of PQRS participation to three claims-computable measures of inappropriate utilization of health care services and risk-adjusted per capita Medicare expenditures. The data are a national random sample of PQRS-participating providers matched to nonparticipating providers by zip code and caseload. We found few significant relationships in the overall analysis. However, the magnitude and statistical significance of the desirable associations increased in subgroups of providers and beneficiaries more prone to overutilization (e.g., males, older beneficiaries, beneficiaries treated in larger medical practices or by nonphysicians, and practices in rural areas), and among beneficiaries with heart conditions, diabetes, and eye problems.

Nikpay, S., et al. (2016). "Affordable Care Act Medicaid Expansion Reduced Uninsured Hospital Stays In 2014." Health Affairs **35**(1): 106-110.
In states that expanded Medicaid, uninsured hospital stays decreased sharply and Medicaid stays increased sharply in the first two quarters of 2014. There was no change in payer mix in states that did not expand Medicaid.

Shartzer, A., et al. (2016). "Access To Care And Affordability Have Improved Following Affordable Care Act Implementation; Problems Remain." Health Aff (Millwood) **35**(1): 161-168.
There is growing evidence that millions of adults have gained insurance coverage under the Affordable Care Act, but less is known about how access to and affordability of care may be changing. This study used data from the Health Reform Monitoring Survey to describe changes in access and affordability for nonelderly adults from September 2013, just prior to the first open enrollment period in the Marketplace, to March 2015, after the end of the second open enrollment period. Overall, we found strong improvements in access to care for all nonelderly adults and across income and state Medicaid expansion groups. We also found improvements in the affordability of care for all adults and for low- and moderate-income adults. Despite this progress, there were still large gaps in access and affordability in March 2015, particularly for low-income adults.

Travail et santé / Occupational Health

Caroli, E. and M. Godard (2016). "Does job insecurity deteriorate health?" Health Econ **25**(2): 131-147.
This paper estimates the causal effect of perceived job insecurity - that is, the fear of involuntary job loss - on health in a sample of men from 22 European countries. We rely on an original instrumental variable approach on the basis of the idea that workers perceive greater job security in countries where employment is strongly protected by the law and more so if employed in industries where

employment protection legislation is more binding; that is, in industries with a higher natural rate of dismissals. Using cross-country data from the 2010 European Working Conditions Survey, we show that, when the potential endogeneity of job insecurity is not accounted for, the latter appears to deteriorate almost all health outcomes. When tackling the endogeneity issue by estimating an instrumental variable model and dealing with potential weak-instrument issues, the health-damaging effect of job insecurity is confirmed for a limited subgroup of health outcomes; namely, suffering from headaches or eyestrain and skin problems. As for other health variables, the impact of job insecurity appears to be insignificant at conventional levels. Copyright (c) 2014 John Wiley & Sons, Ltd.

Fanourgiakis, J. (2016). "Austerity, precariousness, and the health status of Greek labour market participants: A view from inside." J Public Health Policy **37**(1): 118-120.

Maruthappu, M., et al. (2016). "Unemployment, public-sector healthcare expenditure and colorectal cancer mortality in the European Union: 1990-2009." Int J Public Health **61**(1): 119-130.

OBJECTIVES: We examined the association between unemployment and government spending on healthcare with colorectal cancer mortality. METHODS: Retrospective observational study using data from the World Bank and WHO. Multivariate regression analysis was used, controlling for country-specific differences in infrastructure and demographics. RESULTS: A 1 % increase in unemployment was associated with a significant increase in colorectal cancer mortality in both men and women [men: coefficient (R) = 0.0995, 95 % confidence interval (CI) 0.0132-0.1858, P = 0.024; women: R = 0.0742, 95 % CI 0.0160-0.1324, P = 0.013]. A 1 % increase in government spending on healthcare was associated with a statistically significant decrease in colorectal cancer mortality across both sexes (men: R = -0.4307, 95 % CI -0.6057 to -0.2557, P < 0.001; women: R = -0.2162, 95 % CI -0.3407 to -0.0917, P = 0.001). The largest changes in mortality occurred 3-4 years following changes in either economic variable. CONCLUSIONS: Unemployment rises are associated with a significant increase in colorectal cancer mortality, whilst government healthcare spending rises are associated with falling mortality. This is likely due, in part, to reduced access to healthcare services and has major implications for clinicians and policy makers alike.

Vieillissement / Ageing

Blom, J., et al. (2016). "Effectiveness and cost-effectiveness of a proactive, goal-oriented, integrated care model in general practice for older people. A cluster randomised controlled trial: Integrated Systematic Care for older People—the ISCOPE study." Age and Ageing **45**(1): 30-41.

Background: older people often experience complex problems. Because of multiple problems, care for older people in general practice needs to shift from a 'problem-based, disease-oriented' care aiming at improvement of outcomes per disease to a 'goal-oriented care', aiming at improvement of functioning and personal quality of life, integrating all healthcare providers. Feasibility and cost-effectiveness of this proactive and integrated way of working are not yet established. Design: cluster randomised trial. Participants: all persons aged ≥75 in 59 general practices (30 intervention, 29 control), with a combination of problems, as identified with a structured postal questionnaire with 21 questions on four health domains. Intervention: for participants with problems on ≥3 domains, general practitioners (GPs) made an integrated care plan using a functional geriatric approach. Control practices: care as usual. Outcome measures: (i) quality of life (QoL), (ii) activities of daily living, (iii) satisfaction with delivered health care and (iv) cost-effectiveness of the intervention at 1-year follow-up. Trial registration: Netherlands trial register, NTR1946.Results: of the 11,476 registered eligible older persons, 7,285 (63%) participated in the screening. One thousand nine hundred and twenty-one (26%) had problems on ≥3 health domains. For 225 randomly chosen persons, a care plan was made. No beneficial effects were found on QoL, patients' functioning or healthcare use/costs. GPs experienced better overview of the care and stability, e.g. less unexpected demands, in the care. Conclusions: GPs

prefer proactive integrated care. 'Horizontal' care using care plans for older people with complex problems can be a valuable tool in general practice. However, no direct beneficial effect was found for older persons.

Iliffe, S. (2016). "Community-based interventions for older people with complex needs: time to think again?" Age and Ageing **45**(1): 2-3.

Pulford, E. C. (2016). "Advanced nurse practitioners in the care of frail older people: a challenge for geriatricians?" Age and Ageing **45**(1): 5-7.

Turner, A. J., et al. (2016). "The effect of living alone on the costs and benefits of surgery amongst older people." Social Science & Medicine **150**: 95-103.

Older people who live alone are a growing, high-cost group for health and social services. The literature on how living alone affects health and the costs and benefits of healthcare has focused on crude measures of health and utilisation and gives little consideration to other cost determinants and aspects of patient experience. We study the effect of living alone at each stage along an entire treatment pathway using a large dataset which provides information on pre-treatment experience, treatment benefits and costs of surgery for 105,843 patients receiving elective hip and knee replacements in England in 2009 and 2010. We find that patients who live alone are healthier prior to treatment and experience the same gains from treatment. However, living alone is associated with a 9.2% longer length of in-hospital stay and increased probabilities of readmission and discharge to expensive destinations. These increase the costs per patient by £179.88 (3.12%) and amount to an additional £4.9 million per annum. A lack of post-discharge support for those living alone is likely to be a key driver of these additional costs.