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Assurance maladie / Health Insurance

Rice T., Jacobson G., Cubanski J., Neuman T. (2014). The Private Health Insurance Choices of Medicare Beneficiaries: How Much Does Price Matter? *Med Care Res Rev*, 71 (6) : 661-689.

Abstract: This article presents, critiques, and analyzes the influence of prices on insurance choices made by Medicare beneficiaries in the Medicare Advantage, Part D, and Medigap markets. We define price as health insurance premiums for the Medicare Advantage and Medigap markets, and total out-of-pocket costs (including premiums and cost sharing) for the Part D market. In Medicare Advantage and Part D, prices only partly explain insurance choices. Enrollment decisions also may be influenced by other factors such as the perceived quality of the higher-premium plans, better provider networks, lower cost-sharing for services, more generous benefits, and a preference for certain brand-name products. In contrast, the one study available on the Medigap market concludes that price appears to be associated with plan selection. This may be because Medigap benefits are fully standardized, making it easier for beneficiaries to compare alternative policies. The article concludes by discussing policy options available to Medicare.

Economie de la santé / Health Economics

Rolden H.J., Van Bodegum D., Westendorp R.G. (2014). Variation in the costs of dying and the role of different health services, socio-demographic characteristics, and preceding health care expenses. *Soc Sci Med*, 120C 110-117.

Abstract: The health care costs of population ageing are for an important part attributable to higher mortality rates in combination with high costs of dying. This paper answers three questions that remain unanswered regarding the costs of dying: (1) contributions of different health services to the costs of dying; (2) variation in the costs of dying; and (3) the influence of preceding health care expenses on the costs of dying. We retrieved data on 61,495 Dutch subjects aged 65 and older from July 2007 through 2010 from a regional health care insurer. We included all deceased subjects of whom health care expenses were known for 26 months prior to death (n = 2833). Costs of dying were defined as health care expenses made in the last six months before death. Lorenz curves, generalized linear models and a two-part model were used for our analyses. (1) The average costs of dying are euro25,919. Medical care contributes to 57% of this total, and long-term care 43%. The costs of dying mainly relate to hospital care (40%). (2) In the costs of dying, 75% is attributable to the costliest half of the population. For medical care, this distribution figure is 86%, and for long-term care 92%. Age and preceding expenses are significant determinants of this variation in the costs of dying. (3) Overall, higher preceding health care expenses are associated with higher costs of dying, indicating that the costs of dying are higher for those with a longer patient history. To summarize, there is not a large variation in the costs of dying, but there are large differences in the nature of these costs. Before death, the oldest old utilize more long-term care while their younger counterparts visit hospitals more often. To curb the health care costs of population ageing, a further understanding of the costs of dying is crucial.

Gregersen F.A. (2014). The impact of ageing on health care expenditures: a study of steepening. *Eur J Health Econ*, 15 (9) : 979-989.

Abstract: Some researchers claim that health care expenditures for older people are growing faster than for the rest of the population. This process is referred to as steepening. The aim of this paper is

to test steepening, applying new data and revised methods. Furthermore, we explain the connection between the terms red herring hypothesis, i.e., that time to death and not age per se drives the health care expenditures, and steepening. We also present the mechanisms that may induce steepening, as presented in the literature. When testing steepening, we apply data from all inpatient stays in somatic hospitals in Norway in the period 1998-2009, i.e., the data has no self-selection and covers the entire population of Norway (5 million). Our analysis does not reject steepening, with the exception of the 0-year-olds. The results also hold when controlling for mortality-related expenditures. Furthermore, we observe an increase in expenditures for the 0-year-olds. Finally, we find increasing mortality-related expenditures over time. We find the link between steepening and the red herring hypothesis to be vague, and we find steepening and the red herring hypothesis to be independent.

Moore P.V., Bennett K., Normand C. (2014). The importance of proximity to death in modelling community medication expenditures for older people: evidence from New Zealand. *Appl. Health Econ Health Policy*, 12 (6) : 623-633.

Abstract: BACKGROUND: Concerns about the long-term sustainability of health care expenditures (HCEs), particularly prescribing expenditures, has become an important policy issue in most developed countries. Previous studies suggest that proximity to death (PTD) has a significant effect on total HCEs, with its exclusion leading to an overestimation of likely growth. There are limited studies of pharmaceutical expenditures in which PTD is taken into account. OBJECTIVE: This study presents an empirical analysis of public medication expenditure on older individuals in New Zealand (NZ). The aim of the study was to examine the individual effects of age and PTD using individual-level data. METHODS: This study uses individual-level dispensing data from 2008/2009 covering the whole population of medication users aged 70 years or older and resident in NZ. A case-control methodology was used to examine individual cost and medication use for a 12-month period for decedents (cases) and survivors (controls). A random effects two-part model, with a Probit and generalized linear model (GLM) was used to explore the effect of age and PTD on expenditures. RESULTS: The impact of PTD on prescription expenditure is not as dramatic as studies reporting on acute and/or long-term care. The 12-month decedent-to-survivor mean expenditure ratio was 1.95; 2.09 for males and 1.82 for females. The additional cost of dying in terms of prescription drugs decreases with age, with those who die at 90 years of age or older consuming fewer drugs on average and having a lower mean expenditure than those who died in their 70s and 80s. The following variables were found to have a decreasing effect on the mean monthly prescription expenditures: a reduction of 2.2 % for each additional year of age, 4.2 % being in the Maori ethnic group, and 7.8 % for Pacific Islanders. Increases in monthly expenditure were associated with being a decedent 32.1-62.6 % (depending on month), being of Asian origin 16.2 %, or being a male 12.6 %. CONCLUSIONS: Given the variance reported between survivors and decedents, future projections should include PTD in their models to improve accuracy. Policies targeted at reducing expenditures should not focus on age but on ensuring appropriate and cost-effective prescribing, particularly towards the end of life.

Kaiser B., Schmid C. (2014). Does physician dispensing increase drug expenditures? Empirical evidence from Switzerland. *Health Econ; on line*

Abstract: This paper analyzes whether the opportunity for physicians to dispense drugs increases healthcare expenditures. We study the case of Switzerland, where dispensing physicians face financial incentives to overprescribe and sell more expensive pharmaceuticals. Using comprehensive physician-level data, we exploit the regional variation in the dispensing regime to estimate causal effects. The empirical strategy consists of a doubly-robust estimation that combines inverse

probability weighting with regression. Our main finding suggests that dispensing leads to higher drug costs on the order of 34% per patient.

Etat de santé / Health Status

Lefèvre T., D'Ivernois J.F., De Andrade V., et al (2014). Qu'entendons-nous par : « polypathologie chronique » ? Une analyse de la littérature des mesures, des facteurs associés et de l'impact sur l'organisation des soins de la polypathologie chronique. *Revue d'Epidémiologie et de Santé Publique*, 62 (5) : 305-314.

Abstract: Position du problèmeLa polypathologie chronique est une conséquence de la double transition épidémiologique et démographique. Distincte de la comorbidité, il n'en existe aujourd'hui aucune définition consensuelle, ce qui rend délicates l'évaluation de son poids épidémiologique et socio-économique, l'organisation raisonnée et adaptée des services de santé ou encore la détermination des compétences nécessaires à l'autonomie des patients. Le but de ce travail est de délimiter un spectre de la polypathologie chronique et d'en discuter les implications actuelles quant à l'organisation des soins. Méthodes : Analyse de la littérature référencée par PubMed, Embase, CINAHL et Scopus par deux relecteurs indépendants. Résultats : La recherche bibliographique a permis d'identifier 2287 articles au 16/07/2013 (PubMed : 670, Embase : 666, Scopus : 582, CINAHL : 369). Au total 108 articles ont été retenus. La polypathologie chronique est désignée sous différents termes, dont aucun n'est un terme MeSH. Il n'existe pas de mesure unique de la polypathologie chronique, cette entité étant plus souvent étudiée pour ses conséquences fonctionnelles ou économiques, non pour ses causes. Selon les mesures et les populations étudiées, la prévalence varie considérablement. Les facteurs récurrents associés à la polypathologie chronique sont l'âge, le sexe et les caractéristiques socio-économiques des populations. Les résultats des évaluations visant l'organisation des soins sont peu concluants ou les études présentent des insuffisances. Conclusion : La polypathologie chronique se pose comme un avatar des problèmes fondamentaux récurrents de la médecine moderne et de l'organisation des soins. Elle pose la question de sa définition, à partir de ses causes ou de ses conséquences, et renvoie à notre conception à la fois de la santé individuelle et de sa gestion collective. Il existe des outils permettant une mesure plus adaptée de cette entité, qu'il serait intéressant de mobiliser afin de marier réalité médicale et besoins des patients.

Géographie de la santé / Geography of Health

Kopetsch T., Schmitz H. (2014). Regional variation in the utilisation of ambulatory services in Germany. *Health Econ*, 23 (12) : 1481-1492.

Abstract: We used an administrative dataset covering approximately 90% of all Germans to investigate the determinants of regional differences in the utilisation of ambulatory services in the year 2008. There are great regional differences in Germany, in GP, specialist and psychotherapist consultations. By means of a regression model taking account of the spatial dependencies of the error terms, we can explain a considerable part of the variation in terms of differences in demography, health status and socio-economic features. In addition, we made use of data on pollutants, the supply of services and the number of hospital cases as explanatory variables, which all have a significant influence on utilisation but contribute considerably less to explaining the

differences. Overall, we are in a position to explain 29-40% of the regional differences in ambulatory case numbers at the level of the 413 counties and 55-70% at the level of the 16 German states (Lander) by observable differences.

Augurzky B., Kopetsch T., Schmitz H. (2013). What accounts for the regional differences in the utilisation of hospitals in Germany? *Eur J Health Econ*, 14 (4) : 615-627.

Abstract: There are huge regional variations in the utilisation of hospital services in Germany. In 2007 and 2008 the states of Hamburg and Baden-Wurttemberg had on average just under 38 % fewer hospitalisations per capita than Saxony-Anhalt. We use data from the DRG statistics aggregated at the county level in combination with numerous other data sources (e.g. INKAR Database, accounting data from the National Association of Statutory Health Insurance Physicians (KBV), Federal Medical Registry, Germany Hospital Directory, population structure per county) to establish the proportion of the observed regional differences that can be explained at county and state levels. Overall we are able to account for 73 % of the variation at state level in terms of observable factors. By far the most important reason for the regional variation in the utilisation of in-patient services is differences in medical needs. Differences in the supply of medical services and the substitutability of outpatient and inpatient treatment are also relevant, but to a lesser extent.

Dejardin O., Jones A.P., Rachet B., Morris E., Bouvier V., Jooste V., Coombes E., Forman D., Bouvier A.M., Launoy G. (2014). The influence of geographical access to health care and material deprivation on colorectal cancer survival: Evidence from France and England. *Health Place*, 30C 36-44.

Abstract: This article investigates the influence of distance to health care and material deprivation on cancer survival for patients diagnosed with a colorectal cancer between 1997 and 2004 in France and England. This population-based study included all cases of colorectal cancer diagnosed between 1997 and 2004 in 3 cancer registries in France and 1 cancer registry in England (N=40,613). After adjustment for material deprivation, travel times in England were no longer significantly associated with survival. In France patients living between 20 and 90min from the nearest cancer unit tended to have a poorer survival, although this was not statistically significant. In England, the better prognosis observed for remote patients can be explained by associations with material deprivation; distance to health services alone did not affect survival whilst material deprivation level had a major influence, with lower survival for patients living in deprived areas. Increases in travel times to health services in France were associated with poorer survival rates. The pattern of this influence seems to follow an inverse U distribution, i.e. maximal for average travel times.

Mazumdar S., Feng X., Konings P., McRae I., Girosi F. (2014). A brief report on Primary Care Service Area catchment geographies in New South Wales Australia. *Int J Health Geogr.*, 13 38.

Abstract: BACKGROUND: To develop a method to use survey data to establish catchment areas of primary care or Primary Care Service Areas. Primary Care Service Areas are small areas, the majority of patients resident in which obtain their primary care services from within the geography. METHODS: The data are from a large health survey (n =267,153, year 2006-2009) linked to General Practitioner service use data (year 2002-2010) from New South Wales, Australia. Our methods broadly follow those used previously by researchers in the United States of America and Switzerland, with significant modifications to improve robustness. This algorithm allocates post code areas to Primary Care Service Areas that receive the plurality of patient visits from the post code area. RESULTS: Consistent with international findings the median Localization Index or the median percentage of patients that obtain their primary care from within a Primary Care Service Area is 55% with localization increasing with rurality. CONCLUSIONS: With the additional methodological

refinements in this study, Australian Primary Care Service Areas have great potential to be of value to policymakers and researchers.

Pilkington H., Blondel B., Drewniak N., Zeitlin J. (2014). Where does distance matter? Distance to the closest maternity unit and risk of foetal and neonatal mortality in France. *Eur J Public Health*, 24 (6) : 904-909.

Abstract: BACKGROUND: The number of maternity units has declined in France, raising concerns about the possible impact of increasing travel distances on perinatal health outcomes. We investigated impact of distance to closest maternity unit on perinatal mortality. METHODS: Data from the French National Vital Statistics Registry were used to construct foetal and neonatal mortality rates over 2001-08 by distance from mother's municipality of residence and the closest municipality with a maternity unit. Data from French neonatal mortality certificates were used to compute neonatal death rates after out-of-hospital birth. Relative risks by distance were estimated, adjusting for individual and municipal-level characteristics. RESULTS: Seven percent of births occurred to women residing at ≥ 30 km from a maternity unit and 1% at ≥ 45 km. Foetal and neonatal mortality rates were highest for women living at < 5 km from a maternity unit. For foetal mortality, rates increased at ≥ 45 km compared with 5-45 km. In adjusted models, long distance to a maternity unit had no impact on overall mortality but women living closer to a maternity unit had a higher risk of neonatal mortality. Neonatal deaths associated with out-of-hospital birth were rare but more frequent at longer distances. At the municipal-level, higher percentages of unemployment and foreign-born residents were associated with increased mortality. CONCLUSION: Overall mortality was not associated with living far from a maternity unit. Mortality was elevated in municipalities with social risk factors and located closest to a maternity unit, reflecting the location of maternity units in deprived areas with risk factors for poor outcome.

Hôpital / Hospitals

Jenkins C., Price F. (2014). VOICES: the value of 6-month clinical evaluation in stroke. The protocol for a planned qualitative study to ascertain the value of stroke follow-up to people affected by stroke. *BMJ Open*, 4 (10) : e006384.

Abstract: INTRODUCTION: The National Clinical Guidelines for Stroke recommend 'routine follow-up of patients 6 months post discharge'. The Sentinel Stroke National Audit Programme sets a standard of 6 months postadmission follow-up, capturing data on process and outcomes. There appears to be no convincing model of stroke follow-up at 6 months, and despite evidence of unmet need in almost 50% of stroke survivors 1-5 years after their stroke, little work focuses on the first 12 months of recovery. By listening to the living experiences of stroke, the research aims to tailor the stroke care pathway to the needs of those affected. METHODS AND ANALYSIS: A focus group of six stroke survivors and carers will be invited to identify appropriate interview questions about the value of follow-up at 6 months, ensuring that this study has its genesis in the participant experience. A pilot study of four stroke survivors will ascertain the feasibility of the method. Thirty stroke survivors from the follow-up clinic will be invited to take part in semistructured interviews. Raw data, in the form of digital recordings of the interviews, will be transcribed. Interview transcriptions will be checked by the participant for accuracy prior to analysis using NVivo software. Literal and reflective narrative analysis will be used to code transcribed text to examine shared themes and reflect on content. ETHICS AND DISSEMINATION: Study documentation has been reviewed by the Coventry and Warwickshire Research Ethics Committee; the chief investigator met with the committee to

scrutinise the study and justify its methodology. The committee has approved this study. A copy of the final report will be given to participants, the Stroke Association, the local Clinical Commissioning Group and participants' general practitioners. It is intended to disseminate the results locally by presentation to the Trust board, at academic conferences and by publication in a peer-reviewed scientific journal.

Allen T., Fichera E., Sutton M. (2014). Can payers use prices to improve quality? Evidence from English Hospitals. *Health Econ*,

Abstract: In most activity-based financing systems, payers set prices reactively based on historical averages of hospital reported costs. If hospitals respond to prices, payers might set prices proactively to affect the volume of particular treatments or clinical practice. We evaluate the effects of a unique initiative in England in which the price offered to hospitals for discharging patients on the same day as a particular procedure was increased by 24%, while the price for inpatient treatment remained unchanged. Using national hospital records for 205 784 patients admitted for the incentivised procedure and 838 369 patients admitted for a range of non-incentivised procedures between 1 December 2007 and 31 March 2011, we consider whether this price change had the intended effect and/or produced unintended effects. We find that the price change led to an almost six percentage point increase in the daycase rate and an 11 percentage point increase in the planned daycase rate. Patients benefited from a lower proportion of procedures reverted to open surgery during a planned laparoscopic procedure and from a reduction in long stays. There was no evidence that readmission and death rates were affected. The results suggest that payers can set prices proactively to incentivise hospitals to improve quality.

Beukers P.D., Kemp R.G., Varkevisser M. (2014). Patient hospital choice for hip replacement: empirical evidence from the Netherlands. *Eur J Health Econ*, 15 (9) : 927-936.

Abstract: In the Dutch health care system, hospitals are expected to compete. A necessary condition for competition among hospitals is that patients do not automatically choose the nearest hospital, but are at least to some extent sensitive to differences in hospital quality. In this study, an analysis is performed on the underlying features of patient hospital choice in a setting where prices do not matter for patients as a result of health insurance coverage. Using claims data from all Dutch hospitals over the years 2008-2010, a conditional logit model examines the relationship between patient characteristics (age, gender and reoperations) and hospital attributes (hospital quality information, waiting times on treatments and travel time for patients to the hospitals) in the market for general non-emergency hip replacement treatments. The results show that travel time is the most important determinant in-patient hospital choice. From our analysis, however, it follows that publicly available hospital quality ratings and waiting times also have a significant impact on patient hospital choice. The panel data used for this study (2008-2010) is rather short, which may explain why no coherent and persistent changes in patient hospital choice behaviour over time are found.

Kristensen P.K., Thillemann T.M., Johnsen S.P. (2014). Is bigger always better? A nationwide study of hip fracture unit volume, 30-day mortality, quality of in-hospital care, and length of hospital stay. *Med Care*, 52 (12) : 1023-1029.

Abstract: BACKGROUND: Higher patient volume has been linked with better clinical outcomes for a range of surgical procedures; however, little is known about the impact of volume on quality of care and clinical outcome among patients with hip fracture. OBJECTIVES: To examine the association between hip fracture patient volume and 30-day mortality, quality of in-hospital care, time to surgery, and length of hospital stay, respectively. DESIGN: Population-based follow-up study. SUBJECTS: Using prospectively collected data from the Danish Multidisciplinary Hip Fracture Registry, we identified 12,065 patients 65 years and older who were admitted with a hip fracture between

March 1, 2010 and November 30, 2011. MEASURES: Patient volume was divided into 3 groups; ≤ 151 hip fracture admissions per year, 152-350, and ≥ 351 admissions per year based on the distribution of the hospitals and to ensure a reasonable proportion of hospitals in each category. Data were analyzed using regression techniques while controlling for potential confounders. RESULTS: Admission to high-volume units was associated with higher 30-day mortality [adjusted odds ratio (OR)=1.37 (95% confidence interval (CI), 1.14-1.64)] and a longer length of hospital stay (adjusted relative time=1.25 (95% CI, 1.02-1.52)]. Furthermore, patients had lower odds for being mobilized within 24 hours postoperatively and for receiving basic mobility assessment and a postdischarge rehabilitation program. Time to surgery was nonsignificantly increased [adjusted relative time=1.25 (95% CI, 0.99-1.58)]. CONCLUSIONS: Patients admitted to high-volume hip fracture units had higher mortality rates, received a lower quality of in-hospital care, and had longer length of hospital stay.

Hilbert J.P., Zasadil S., Keyser D.J., Peele P.B. (2014). Using decision trees to manage hospital readmission risk for acute myocardial infarction, heart failure, and pneumonia. *Appl. Health Econ Health Policy*, 12 (6) : 573-585.

Abstract: To improve healthcare quality and reduce costs, the Affordable Care Act places hospitals at financial risk for excessive readmissions associated with acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN). Although predictive analytics is increasingly looked to as a means for measuring, comparing, and managing this risk, many modeling tools require data inputs that are not readily available and/or additional resources to yield actionable information. This article demonstrates how hospitals and clinicians can use their own structured discharge data to create decision trees that produce highly transparent, clinically relevant decision rules for better managing readmission risk associated with AMI, HF, and PN. For illustrative purposes, basic decision trees are trained and tested using publically available data from the California State Inpatient Databases and an open-source statistical package. As expected, these simple models perform less well than other more sophisticated tools, with areas under the receiver operating characteristic (ROC) curve (or AUC) of 0.612, 0.583, and 0.650, respectively, but achieve a lift of at least 1.5 or greater for higher-risk patients with any of the three conditions. More importantly, they are shown to offer substantial advantages in terms of transparency and interpretability, comprehensiveness, and adaptability. By enabling hospitals and clinicians to identify important factors associated with readmissions, target subgroups of patients at both high and low risk, and design and implement interventions that are appropriate to the risk levels observed, decision trees serve as an ideal application for addressing the challenge of reducing hospital readmissions.

Franzini L., White C., Taychakhoonavudh S., Parikh R., Zezza M., Mikhail O. (2014). Variation in inpatient hospital prices and outpatient service quantities drive geographic differences in private spending in Texas. *Health Serv Res*, 49 (6) : 1944-1963.

Abstract: OBJECTIVE: To measure the contribution of market-level prices, utilization, and health risk to medical spending variation among the Blue Cross Blue Shield of Texas (BCBSTX) privately insured population and the Texas Medicare population. DATA SOURCES: Claims data for all BCBSTX members and publicly available CMS data for Texas in 2011. STUDY DESIGN: We used observational data and decomposed overall and service-specific spending into health status and health status adjusted utilization and input prices and input prices adjusted for the BCBSTX and Medicare populations. PRINCIPAL FINDINGS: Variation in overall BCBSTX spending across HRRs appeared driven by price variation, whereas utilization variation factored more prominently in Medicare. The contribution of price to spending variation differed by service category. Price drove inpatient spending variation, while utilization drove outpatient and professional spending variation in BCBSTX. The context in which negotiations occur may help explain the patterns across services. CONCLUSIONS: The conventional wisdom that Medicare does a better job of controlling prices and private plans do a

better job of controlling volume is an oversimplification. BCBSTX does a good job of controlling outpatient and professional prices, but not at controlling inpatient prices. Strategies to manage the variation in spending may need to differ substantially depending on the service and payer.

Xu X., Li S.X., Lin H., Normand S.L., Kim N., Ott L.S., Lagu T., Duan M., Kroch E.A., Krumholz H.M. (2014). "Phenotyping" hospital value of care for patients with heart failure. *Health Serv Res*, 49 (6) : 2000-2016.

Abstract: OBJECTIVE: To characterize hospitals based on patterns of their combined financial and clinical outcomes for heart failure hospitalizations longitudinally. DATA SOURCE: Detailed cost and administrative data on hospitalizations for heart failure from 424 hospitals in the 2005-2011 Premier database. STUDY DESIGN: Using a mixture modeling approach, we identified groups of hospitals with distinct joint trajectories of risk-standardized cost (RSC) per hospitalization and risk-standardized in-hospital mortality rate (RSMR), and assessed hospital characteristics associated with the distinct patterns using multinomial logistic regression. PRINCIPAL FINDINGS: During 2005-2011, mean hospital RSC decreased from \$12,003 to \$10,782, while mean hospital RSMR declined from 3.9 to 3.2 percent. We identified five distinct hospital patterns: highest cost and low mortality (3.2 percent of the hospitals), high cost and low mortality (20.4 percent), medium cost and low mortality (34.6 percent), medium cost and high mortality (6.2 percent), and low cost and low mortality (35.6 percent). Longer hospital stay and greater use of intensive care unit and surgical procedures were associated with phenotypes with higher costs or greater mortality. CONCLUSIONS: Hospitals vary substantially in the joint longitudinal patterns of cost and mortality, suggesting marked difference in value of care. Understanding determinants of the variation will inform strategies for improving the value of hospital care.

McCann M., Grundy E., O'Reilly D. (2014). Urban and rural differences in risk of admission to a care home: A census-based follow-up study. *Health Place*, 30C 171-176.

Abstract: Research on admissions to care homes for older people has paid more attention to individual and social characteristics than to geographical factors. This paper considers rural-urban differences in household composition and admission rates. Cohort: 51,619 people aged 65 years or older at the time of the 2001 Census and not living in a care home, drawn from a data linkage study based on c.28% of the Northern Ireland population. Living alone was less common in rural areas; 25% of older people in rural areas lived with children compared to 18% in urban areas. Care home admission was more common in urban (4.7%) and intermediate (4.3%) areas than in rural areas (3.2%). Even after adjusting for age, sex, health and living arrangements, the rate of care home admission in rural areas was still only 75% of that in urban areas. People in rural areas experience better family support by living as part of two or three generation households. Even after accounting for this difference, older rural dwellers are less likely to enter care homes; suggesting that neighbours and relatives in rural areas provide more informal care; or that there may be differential deployment of formal home care services.

Tan S.S., Geissler A., Serden L., et al. (2014). DRG systems in Europe: variations in cost accounting systems among 12 countries. *Eur J Public Health*, 24 (6) : 1022-1027.

Abstract: BACKGROUND: Diagnosis-related group (DRG)-based hospital payment systems have gradually become the principal means of reimbursing hospitals in many European countries. Owing to the absence or inaccuracy of costs related to DRGs, these countries have started to routinely collect cost accounting data. The aim of the present article was to compare the cost accounting systems of 12 European countries. METHODS: A standardized questionnaire was developed to guide comprehensive cost accounting system descriptions for each of the 12 participating countries. RESULTS: The cost accounting systems of European countries vary widely by the share of hospital

costs reimbursed through DRG payment, the presence of mandatory cost accounting and/or costing guidelines, the share of cost collecting hospitals, costing methods and data checks on reported cost data. Each of these aspects entails a trade-off between accuracy of the cost data and feasibility constraints. CONCLUSION: Although a 'best' cost accounting system does not exist, our cross-country comparison gives insight into international differences and may help regulatory authorities and hospital managers to identify and improve areas of weakness in their cost accounting systems. Moreover, it may help health policymakers to underpin the development of a cost accounting system.

Magdelijns F.J., Stassen P.M., Stehouwer C.D., Pijpers E. (2014). Direct health care costs of hospital admissions due to adverse events in the Netherlands. *Eur J Public Health*, 24 (6) : 1027-1032.

Abstract: BACKGROUND: Health care-related adverse events (AEs) are common, and the economic burden is substantial. Information on costs of health care-related AEs 'leading' to hospitalization is limited and has focused on adverse drug events. AIM: To provide insight into costs of admissions due to (preventable) health care-related AEs, not limited to adverse drug events. METHODS: This study was conducted during a 5-month period (May-September 2010) in the Netherlands, in a 600-bed university medical centre. All patients who were admitted via the emergency department to an internal medicine department because of a health care-related AE were included. We retrospectively retrieved all data on medical information as well as health care resource utilization from the patient's medical record. The cost of the admission was estimated (for each patient individually) by multiplying the number of resources by their specific unit cost and then summing all costs per patient. RESULTS: In total, 324 admissions due to a health care-related AE were included (28.7% of all admissions). Total direct health care costs of these hospitalizations amounted to euro1 404 070 in a 5-month period. Medication-related AEs were most common (43.5%) and contributed most to the costs (euro587 550; 41.8%). Inpatient days were most expensive (euro1 076 385; 77.3%). Preventable health care-related AEs accounted for euro277 665 (19.8%). CONCLUSION: We found that health care-related AEs are expensive, with preventable health care-related AEs accounting for one-fifth of the costs. Awareness of possible health care-related AEs following medical actions is necessary to reduce already high health care costs.

Inégalités de santé / Health Inequalities

Huschke S. (2014). Performing deservingness. Humanitarian health care provision for migrants in Germany. *Soc Sci Med*, [epub]

Abstract: In this paper, I critically investigate humanitarian aid for migrant populations in Germany. I aim to enhance the existing literature on migrant deservingness and humanitarian aid by focusing on the performative aspects of concrete face-to-face interactions between physicians/volunteers and patients. I argue that despite efforts of volunteers to provide non-discriminatory care, the encounters between patients as aid-receivers and volunteers/physicians as aid-providers are inevitably shaped by power inequalities. These immanent power inequalities may lead patients to perform their deservingness, that is, to present themselves as helpless sufferers rather than empowered subjects. Simultaneously, patient-solicitors are prevented from feeling and enacting a sense of entitlement. Those patients who do not heed to the social mechanisms of humanitarian aid, such as being thankful and humble, cause disenchantment on the side of some medical professionals who provide care as part of humanitarian networks and subsequently, they may be turned away. The research project focused on the migration trajectories and illness experiences of undocumented

Latin American migrants and their access to healthcare. The analysis draws on my long-term ethnographic fieldwork with 35 Latin American migrants in Berlin (2008-2011), 22 interviews with healthcare providers, and my experience as an activist/volunteer for a Berlin-based humanitarian NGO (2008-2012).

Bjornstrom E.E., Kuhl D.C. (2014). A different look at the epidemiological paradox: Self-rated health, perceived social cohesion, and neighborhood immigrant context. *Soc Sci Med*, 120C 118-125.

Abstract: We use data from Waves 1 and 2 of the Los Angeles Family and Neighborhood Survey to examine the effects of neighborhood immigrant concentration, race-ethnicity, nativity, and perceived cohesion on self-rated physical health. We limit our sample to adults whose addresses do not change between waves in order to explore neighborhood effects. Foreign-born Latinos were significantly less likely to report fair or poor health than African Americans and U.S.-born whites, but did not differ from U.S.-born Latinos. The main effect of immigrant concentration was not significant, but it interacted with nativity status to predict health: U.S.-born Latinos benefited more from neighborhood immigrant concentration than foreign-born Latinos. Perceived cohesion predicted health but immigrant concentration did not moderate the effect. Finally, U.S.-born Latinos differed from others in the way cohesion is associated with their health. Results are discussed within the framework of the epidemiological paradox.

Ben Halima M.A., Rococo E. (2014). Wage differences according to health status in France. *Soc Sci Med*, 120C 260-268.

Abstract: Many OECD countries have implemented anti-discrimination laws in recent decades. However, according to the annual report published in 2010 by the French High Authority for the Fight against Discrimination and for Equality, the second most commonly cited factor in discrimination claims since 2005 is a handicap or health status. The aim of this research is to estimate the level of unexplained components in the wage gap that can be attributed to wage discrimination based on health status in France in 2010 utilizing data from the Health, Healthcare and Insurance survey among 1594 individuals. Three health indicators are used: self-perceived health status, activity limitations and long-term chronic illness. To measure the wage gap according to an individual's health status, the analysis considers the endogenous selection of health status and unobserved differences in productivity. The results demonstrate that wage discrimination is experienced by individuals in poor health regardless of the health indicator utilized. The hourly wage rate among individuals with poor self-assessed health status is on average 14.2% lower than among individuals with good self-assessed health status. However, for individuals suffering from a long-term chronic illness or an activity limitation, the gap is 6.3% and 4.5%, respectively. The decomposition performed on wage differences according to health status by correcting for health status selection bias and controlling for unobserved differences in productivity indicates that the 'unexplained component' that can be attributed to wage discrimination is equal to 50%.

Horner-Johnson W., Dobbertin K., Lee J.C., Andresen E.M. (2014). Disparities in health care access and receipt of preventive services by disability type: analysis of the medical expenditure panel survey. *Health Serv Res*, 49 (6) : 1980-1999.

Abstract: OBJECTIVE: To examine differences in access to health care and receipt of clinical preventive services by type of disability among working-age adults with disabilities. DATA SOURCE: Secondary analysis of Medical Expenditure Panel Survey (MEPS) data from 2002 to 2008. STUDY DESIGN: We conducted cross-sectional logistic regression analyses comparing people with different types of disabilities on health insurance status and type; presence of a usual source of health care; delayed or forgone care; and receipt of dental checkups and cancer screening. DATA COLLECTION:

We pooled annualized MEPS data files across years. Our analytic sample consisted of adults (18-64 years) with physical, sensory, or cognitive disabilities and nonmissing data for all variables of interest. **PRINCIPAL FINDINGS:** Individuals with hearing impairment had better health care access and receipt than people with other disability types. People with multiple types of limitations were especially likely to have health care access problems and unmet health care needs. **CONCLUSIONS:** There are differences in health care access and receipt of preventive care depending on what type of disability people have. More in-depth research is needed to identify specific causes of these disparities and assess interventions to address health care barriers for particular disability groups.

Filippidis F.T., Schoretsaniti S., Dimitrakaki C., Vardavas C.I., Behrakis P., Connolly G.N., Tountas Y. (2014). Trends in cardiovascular risk factors in Greece before and during the financial crisis: the impact of social disparities. *Eur J Public Health*, 24 (6) : 973-978.

Abstract: **BACKGROUND:** Economic crises may have a significant impact on public health. The objective of this study was to assess trends in health-related behaviours and cardiovascular risk factors within Greece before, at the beginning and during the current financial crisis by comparing data from three waves of the Greek cross-sectional household 'Hellas Health' surveys. **METHODS:** Data from three waves were analysed. The first wave was conducted in 2006 (n = 1005), the second in 2008 (n = 1490) and the third in 2011 (n = 1008). Samples were representative of the Greek adult population in terms of age and residency. Smoking status, height, weight and fruit and vegetable consumption were self-reported. Physical activity levels were assessed with the International Physical Activity Questionnaire. **RESULTS:** The prevalence of smoking in Greece decreased from 42.6 to 38.1% during the crisis period 2008-11 (P = 0.026), but not during 2006-8. The prevalence of high levels of physical activity increased among Greek adults (from 21.9 to 31.7%, P < 0.001) in all socio-economic and demographic groups, with the exception of the highest socio-economic status (SES) group. On the contrary, the consumption of at least five portions of fruit and vegetables per day significantly decreased during the crisis among those of lower SES (from 9.0 to 4.1%, P = 0.006). Prevalence of obesity did not show significant trends. **CONCLUSIONS:** During the economic crisis, fruit and vegetable consumption alarmingly decreased, especially among those of lower SES, whereas trends in smoking prevalence and physical activity levels seem favourable. These results indicate that the economic crisis may unequally impact cardiovascular risk factors among different socio-economic groups.

Médicaments / Pharmaceuticals

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

Abstract: Although pharmaceutical companies cannot make comparative claims in direct-to-consumer (DTC) ads for prescription drugs without substantial evidence, the U.S. Food and Drug Administration permits some comparisons based on labeled attributes of the drug, such as dosing. Researchers have examined comparative advertising for packaged goods; however, scant research has examined comparative DTC advertising. We conducted two studies to determine if comparative claims in DTC ads influence consumers' perceptions and recall of drug information. In Experiment 1, participants with osteoarthritis (n = 1934) viewed a fictitious print or video DTC ad that had no comparative claim or made an efficacy comparison to a named or unnamed competitor. Participants who viewed print (but not video) ads with named competitors had greater efficacy and lower risk

perceptions than participants who viewed unnamed competitor and noncomparative ads. In Experiment 2, participants with high cholesterol or high body mass index (n = 5317) viewed a fictitious print or video DTC ad that had no comparative claim or made a comparison to a named or unnamed competitor. We varied the type of comparison (of indication, dosing, or mechanism of action) and whether the comparison was accompanied by a visual depiction. Participants who viewed print and video ads with named competitors had greater efficacy perceptions than participants who viewed unnamed competitor and noncomparative ads. Unlike Experiment 1, named competitors in print ads resulted in higher risk perceptions than unnamed competitors. In video ads, participants who saw an indication comparison had greater benefit recall than participants who saw dosing or mechanism of action comparisons. In addition, visual depictions of the comparison decreased risk recall for video ads. Overall, the results suggest that comparative claims in DTC ads could mislead consumers about a drug's efficacy and risk; therefore, caution should be used when presenting comparative claims in DTC ads.

Alpern J.D., Stauffer W.M., Kesselheim A.S. (2014). High-cost generic drugs--implications for patients and policymakers. *N Engl J Med*, 371 (20) : 1859-1862.

Abstract: Some older generic drugs have become very expensive, owing to factors including drug shortages, supply disruptions, and consolidations in the generic-drug industry. But generics manufacturers that legally obtain a market monopoly can also unilaterally raise prices.

Brekke K.R., Dalen D.M., Holmas T.H. (2014). Diffusion of pharmaceuticals: cross-country evidence of anti-TNF drugs. *Eur J Health Econ*, 15 (9) : 937-951.

Abstract: This article studies the diffusion of biopharmaceuticals across European countries, focusing on anti-TNF drugs, which are used to treat autoimmune diseases (e.g., rheumatism, psoriasis). We use detailed sales information on the three brands Remicade, Enbrel and Humira for nine European countries covering the period from the first launch in 2000 until becoming blockbusters in 2009. Descriptive statistics reveal large variations across countries in per-capita consumption and price levels both overall and at the brand level. We explore potential sources for the cross-country consumption differences by estimating several multivariate regression models. Our results show that large parts of the cross-country variation are explained by time-invariant country-specific factors (e.g., disease prevalence, demographics, health care system). We also find that differences in income [gross domestic product (GDP) per capita] and health spending (share of GDP) explain the cross-country variation in consumption, while relative price differences seem to have limited impact.

Fischer M.A., Choudhry N.K., Bykov K., Brill G., Bopp G., Wurst A.M., Shrank W.H. (2014). Pharmacy-based Interventions to Reduce Primary Medication Nonadherence to Cardiovascular Medications. *Med Care*, 52 (12) : 1050-1054.

Abstract: BACKGROUND: Primary medication nonadherence (PMN) occurs when patients do not fill new prescriptions. Interventions to reduce PMN have not been well described. OBJECTIVES: To determine whether 2 pharmacy-based interventions could decrease PMN. DESIGN: Two sequential interventions with a control group were evaluated after completion. The automated intervention began in 2007 and consisted of phone calls to patients on the third and seventh days after a prescription was processed but remained unpurchased. The live intervention began in 2009 and used calls from a pharmacist or technician to patients who still had not picked up their prescriptions after 8 days. SUBJECTS: Patients with newly prescribed cardiovascular medications received at CVS community pharmacies. Patients with randomly selected birthdays served as the control population. MEASURES: Patient abandonment of new prescription, defined as not picking up medications within

30 days of initial processing at the pharmacy. RESULTS: The automated intervention included 852,612 patients and 1.2 million prescriptions, with a control group of 9282 patients and 13,178 prescriptions. The live intervention included 121,155 patients and 139,502 prescriptions with a control group of 2976 patients and 3407 prescriptions. The groups were balanced by age, sex, and patterns of prior prescription use. For the automated intervention, 4.2% of prescriptions were abandoned in the intervention group and 4.5% in the control group ($P>0.1$), with no significant differences for any individual classes of medications. The live intervention was used in a group that had not purchased prescriptions after 8 days and thus had much higher PMN. In this setting 36.9% of prescriptions were abandoned in the intervention group and 41.7% in the control group, a difference of 4.8% ($P<0.0001$). The difference in abandoned prescriptions for antihypertensives was 6.9% ($P<0.0001$) but for antihyperlipidemics was only 1.4% ($P>0.1$). CONCLUSIONS: Automated reminder calls had no effect on PMN. Live calls from pharmacists decreased antihypertensive PMN significantly, although many patients still abandoned their prescriptions.

Haastrup P., Paulsen M.S., Begtrup L.M., Hansen J.M., Jarbol D.E. (2014). Strategies for discontinuation of proton pump inhibitors: a systematic review. *Fam Pract*, 31 (6) : 625-630.

Abstract: PURPOSE: Proton pump inhibitors (PPIs) are considered to be overprescribed. Consensus on how to attempt discontinuation is, however, lacking. We therefore conducted a systematic review of clinical studies on discontinuation of PPIs. METHODS: Systematic review based on clinical studies investigating discontinuation strategies and discontinuation rates for users of antisecretory medication judged eligible for withdrawal. The databases Medline, Embase and Cochrane Library were searched to December 2013 using the terms antisecretory, anti-ulcer, PPI, acid suppressant, discontinuation, step-down, step down, cessation, tapering, withdrawal and withhold. Search terms were used either singularly or in combination. Papers written in English or Scandinavian were included. Concurrent hand searching was undertaken to pursue references of references. The website ClinicalTrials.gov was searched for unpublished results and ongoing studies. A total of 371 abstracts were scrutinized to determine relevancy. RESULTS: The thorough search resulted in six clinical studies on strategies for discontinuation of PPIs. All discontinuation regimens used in the studies differed, and several interventions have been tested in order to decrease use of PPIs. Discontinuations were reported across all studies ranging from 14% to 64% without deteriorating symptom control. Tapering seems to be a more effective discontinuation strategy than abrupt discontinuation. CONCLUSION: Discontinuation of PPIs is feasible in a clinical setting, and a substantial number of the patients treated without a clear indication can safely reduce or discontinue treatment. Tapering seems to be the most effective way of doing this.

Doos L., Roberts E.O., Corp N., Kadam U.T. (2014). Multi-drug therapy in chronic condition multimorbidity: a systematic review. *Fam Pract*, 31 (6) : 654-663.

Abstract: BACKGROUND: Older populations often suffer from multimorbidity and guidelines for each condition are often associated with recommended drug therapy management. Yet, how different and specific multimorbidity is associated with number and type of multi-drug therapies in general populations is unknown. AIM: The aim of this systematic review was to synthesize the current evidence on patterns of multi-drug prescribing in family practice. METHODS: A systematic review on six common chronic conditions: diabetes mellitus, cardiovascular disease, cerebrovascular disease, chronic obstructive pulmonary disease (COPD), osteoarthritis and depression was conducted, with a focus on studies which looked at any potential combination of two or more multimorbidity. Studies were identified from searches of MEDLINE, EMBASE, PsychINFO, the Allied and Complementary Medicine Database (AMED) and the Health Management Information Consortium (HMIC) databases from 1960 to 2013. RESULTS: A total of eleven articles were selected based on study criteria. Our review identified very few specific studies which had explicitly investigated the association between

multimorbidity and multi-drug therapy. Relevant chronic conditions literature showed nine observational studies and two reviews of comorbid depression drug treatment. Most (seven) of the articles had focused on the chronic condition and comorbid depression and whether antidepressant management had been optimal or not, while four studies focused on other multimorbidities mainly heart failure, COPD and diabetes. CONCLUSIONS: Very few studies have investigated associations between specific multimorbidity and multi-drug therapy, and most currently focus on chronic disease comorbid depression outcomes. Further research needs to identify this area as key priority for older populations who are prescribed high levels of multiple drug therapy.

Kasteleyn M.J., Wezendonk A., Vos R.C., Numans M.E., Jansen H., Rutten G.E. (2014). Repeat prescriptions of guideline-based secondary prevention medication in patients with type 2 diabetes and previous myocardial infarction in Dutch primary care. *Fam Pract*, 31 (6) : 688-693.

Abstract: BACKGROUND: Secondary prevention is efficient in reducing morbidity and mortality after a myocardial infarction (MI). However, both short-term and long-term mortality after MI remains relatively high in type 2 diabetes patients. OBJECTIVE: To evaluate repeat prescriptions of secondary prevention medication (anti-thrombotic agent, beta-blocker and statin) in type 2 diabetes patients with a previous MI. METHODS: Data of 1009 type 2 diabetes patients with a previous MI were extracted from the Julius General Practitioners' Network database. The proportion of patients with recent repeat prescriptions of guideline-based medication was determined. Furthermore, repeat prescriptions was determined 6 months, 1 year, 2 years and 5 years after MI. Generalized linear models were used to examine changes over time. Multivariate logistic regression analysis was used to analyse the association between patient characteristics and prescription. RESULTS: Only 46% of all type 2 diabetes patients with a previous MI had a recent repeat prescription for all three medicines. An increase in prescription over time was found for statins ($P = 0.001$). Older aged people [odds ratio (OR): 0.99, 95% confidence interval (CI): 0.98-1.00] were less likely to receive the combination of all three. CONCLUSION: A substantial proportion of type 2 diabetes patients with a previous MI did not receive guideline-based secondary prevention. Prescription rates were quite stable over time. This study confirms the need for a different approach to achieve an improvement of secondary prevention in type 2 diabetes patient with a previous MI. GPs can play an important role in this respect by being extra alert that prescription occurs according to the guidelines.

Méthodologie – Statistique / Methodology – Statistics

Kang M.I., Ikeda S. (2014). Time discounting and smoking behavior: evidence from a panel survey(*). *Health Econ*, 23 (12) : 1443-1464.

Abstract: By using a panel survey of Japanese adults, we show that smoking behavior is associated with personal time discounting and its biases, such as hyperbolic discounting and the sign effect, in the way that theory predicts: smoking depends positively on the discount rate and the degree of hyperbolic discounting and negatively on the presence of the sign effect. Positive effects of hyperbolic discounting on smoking are salient for naive people, who are not aware of their self-control problem. By estimating smoking participation and smokers' cigarette consumption in Cragg's two-part model, we find that the two smoking decisions depend on different sets of time-discounting variables. Particularly, smoking participation is affected by being a naive hyperbolic discounter, whereas the discount rate, the presence of the sign effect, and a hyperbolic discounting proxy constructed from procrastination behavior vis-a-vis doing homework assignments affect both types of decision making. The panel data enable us to analyze the over-time instability of elicited discount rates. The instability is shown to come from measurement errors, rather than preference shocks on time preference. Several evidences indicate that the detected associations between time preferences and smoking behavior are interpersonal one, rather than within-personal one.

Shwartz M., Pekoz E.A., Burgess J.F., Jr., Christiansen C.L., Rosen A.K., Berlowitz D. (2014). A Probability Metric for Identifying High-Performing Facilities: An Application for Pay-for-Performance Programs. *Med Care*, 52 (12) : 1030-1036.

Abstract: BACKGROUND: Two approaches are commonly used for identifying high-performing facilities on a performance measure: one, that the facility is in a top quantile (eg, quintile or quartile); and two, that a confidence interval is below (or above) the average of the measure for all facilities. This type of yes/no designation often does not do well in distinguishing high-performing from average-performing facilities. OBJECTIVE: To illustrate an alternative continuous-valued metric for profiling facilities-the probability a facility is in a top quantile-and show the implications of using this metric for profiling and pay-for-performance. METHODS: We created a composite measure of quality from fiscal year 2007 data based on 28 quality indicators from 112 Veterans Health Administration nursing homes. A Bayesian hierarchical multivariate normal-binomial model was used to estimate shrunken rates of the 28 quality indicators, which were combined into a composite measure using opportunity-based weights. Rates were estimated using Markov Chain Monte Carlo methods as implemented in WinBUGS. The probability metric was calculated from the simulation replications. RESULTS: Our probability metric allowed better discrimination of high performers than the point or interval estimate of the composite score. In a pay-for-performance program, a smaller top quantile (eg, a quintile) resulted in more resources being allocated to the highest performers, whereas a larger top quantile (eg, being above the median) distinguished less among high performers and allocated more resources to average performers. CONCLUSION: The probability metric has potential but needs to be evaluated by stakeholders in different types of delivery systems.

Baker J., White N., Mengersen K. (2014). Missing in space: an evaluation of imputation methods for missing data in spatial analysis of risk factors for type II diabetes. *Int J Health Geogr.*, 13 (1) : 47.

Abstract: BACKGROUND: Spatial analysis is increasingly important for identifying modifiable geographic risk factors for disease. However, spatial health data from surveys are often incomplete, ranging from missing data for only a few variables, to missing data for many variables. For spatial analyses of health outcomes, selection of an appropriate imputation method is critical in order to

produce the most accurate inferences. METHODS: We present a cross-validation approach to select between three imputation methods for health survey data with correlated lifestyle covariates, using as a case study, type II diabetes mellitus (DM II) risk across 71 Queensland Local Government Areas (LGAs). We compare the accuracy of mean imputation to imputation using multivariate normal and conditional autoregressive prior distributions. RESULTS: Choice of imputation method depends upon the application and is not necessarily the most complex method. Mean imputation was selected as the most accurate method in this application. CONCLUSIONS: Selecting an appropriate imputation method for health survey data, after accounting for spatial correlation and correlation between covariates, allows more complete analysis of geographic risk factors for disease with more confidence in the results to inform public policy decision-making.

Dasgupta P., Cramb S.M., Aitken J.F., Turrell G., Baade P.D. (2014). Comparing multilevel and Bayesian spatial random effects survival models to assess geographical inequalities in colorectal cancer survival: a case study. *Int J Health Geogr.*, 13 36.

Abstract: BACKGROUND: Multilevel and spatial models are being increasingly used to obtain substantive information on area-level inequalities in cancer survival. Multilevel models assume independent geographical areas, whereas spatial models explicitly incorporate geographical correlation, often via a conditional autoregressive prior. However the relative merits of these methods for large population-based studies have not been explored. Using a case-study approach, we report on the implications of using multilevel and spatial survival models to study geographical inequalities in all-cause survival. METHODS: Multilevel discrete-time and Bayesian spatial survival models were used to study geographical inequalities in all-cause survival for a population-based colorectal cancer cohort of 22,727 cases aged 20-84 years diagnosed during 1997-2007 from Queensland, Australia. RESULTS: Both approaches were viable on this large dataset, and produced similar estimates of the fixed effects. After adding area-level covariates, the between-area variability in survival using multilevel discrete-time models was no longer significant. Spatial inequalities in survival were also markedly reduced after adjusting for aggregated area-level covariates. Only the multilevel approach however, provided an estimation of the contribution of geographical variation to the total variation in survival between individual patients. CONCLUSIONS: With little difference observed between the two approaches in the estimation of fixed effects, multilevel models should be favored if there is a clear hierarchical data structure and measuring the independent impact of individual- and area-level effects on survival differences is of primary interest. Bayesian spatial analyses may be preferred if spatial correlation between areas is important and if the priority is to assess small-area variations in survival and map spatial patterns. Both approaches can be readily fitted to geographically enabled survival data from international settings.

Tolonen H., Koponen P., Mindell J.S., Mannisto S., Giampaoli S., Dias C.M., Tuovinen T., Gobetawald A., Kuulasmaa K. (2014). Under-estimation of obesity, hypertension and high cholesterol by self-reported data: comparison of self-reported information and objective measures from health examination surveys. *Eur J Public Health*, 24 (6) : 940-947.

Abstract: BACKGROUND: Non-communicable diseases (NCDs) cause 63% of deaths worldwide. The leading NCD risk factor is raised blood pressure, contributing to 13% of deaths. A large proportion of NCDs are preventable by modifying risk factor levels. Effective prevention programmes and health policy decisions need to be evidence based. Currently, self-reported information in general populations or data from patients receiving healthcare provides the best available information on the prevalence of obesity, hypertension, diabetes, etc. in most countries. METHODS: In the European Health Examination Survey Pilot Project, 12 countries conducted a pilot survey among the working-age population. Information was collected using standardized questionnaires, physical measurement and blood sampling protocols. This allowed comparison of self-reported and measured data on

prevalence of overweight, obesity, hypertension, high blood cholesterol and diabetes. RESULTS: Self-reported data under-estimated population means and prevalence for health indicators assessed. The self-reported data provided prevalence of obesity four percentage points lower for both men and women. For hypertension, the self-reported prevalence was 10 percentage points lower, only in men. For elevated total cholesterol, the difference was 50 percentage point among men and 44 percentage points among women. For diabetes, again only in men, the self-reported prevalence was 1 percentage point lower than measured. With self-reported data only, almost 70% of population at risk of elevated total cholesterol is missed compared with data from objective measurements. CONCLUSIONS: Health indicators based on measurements in the general population include undiagnosed cases, therefore providing more accurate surveillance data than reliance on self-reported or healthcare-based information only.

Steventon A., Roberts A. (2014). Estimating lifetime costs of social care: costs of social care: a bayesian approach using linked administrative datasets from three geographical areas. *Health Econ,*

Abstract: We estimated lifetime costs of publicly funded social care, covering services such as residential and nursing care homes, domiciliary care and meals. Like previous studies, we constructed microsimulation models. However, our transition probabilities were estimated from longitudinal, linked administrative health and social care datasets, rather than from survey data. Administrative data were obtained from three geographical areas of England, and we estimated transition probabilities in each of these sites flexibly using Bayesian methods. This allowed us to quantify regional variation as well as the impact of structural and parameter uncertainty regarding the transition probabilities. Expected lifetime costs at age 65 were pound20,200-27,000 for men and pound38,700-49,000 for women, depending on which of the three areas was used to calibrate the model. Thus, patterns of social care spending differed markedly between areas, with mean costs varying by almost pound10,000 (25%) across the lifetime for people of the same age and gender. Allowing for structural and parameter uncertainty had little impact on expected lifetime costs, but slightly increased the risk of very high costs, which will have implications for insurance products for social care through increasing requirements for capital reserves.

Politique de santé / Health Policy

Stryjewski T.P., Zhang F., Elliott D., Wharam J.F. (2014). Effect of Massachusetts health reform on chronic disease outcomes. *Health Serv Res,* 49 Suppl 2 2086-2103.

Abstract: OBJECTIVE: To determine whether Massachusetts Health Reform improved health outcomes in uninsured patients with hyperlipidemia, diabetes, or hypertension. DATA SOURCE: Partners HealthCare Research Patient Data Registry (RPDR). STUDY DESIGN: We examined 1,463 patients with hyperlipidemia, diabetes, or hypertension who were uninsured in the 3 years before the 2006 Massachusetts Health Reform implementation. We assessed mean quarterly total cholesterol, glycosylated hemoglobin, and systolic blood pressure in the respective cohorts for five follow-up years compared with 3,448 propensity score-matched controls who remained insured for the full 8-year study period. We used person-level interrupted time series analysis to estimate changes in outcomes adjusting for sex, age, race, estimated household income, and comorbidity. We also analyzed the subgroups of uninsured patients with poorly controlled disease at baseline, no evidence of established primary care in the baseline period, and those who received insurance in the first follow-up year. PRINCIPAL FINDINGS: In 5 years after Massachusetts Health Reform, patients

who were uninsured at baseline did not experience detectable trend changes in total cholesterol (-0.39 mg/dl per quarter, 95 percent confidence interval [-1.11 to 0.33]), glycosylated hemoglobin (-0.02 percent per quarter [-0.06 to 0.03]), or systolic blood pressure (-0.06 mmHg per quarter [-0.29 to 0.18]). Analyses of uninsured patients with poorly controlled disease, no evidence of established primary care in the baseline period, and those who received insurance in the first follow-up year yielded similar findings. **CONCLUSIONS:** Massachusetts Health Reform was not associated with improvements in hyperlipidemia, diabetes, or hypertension control after 5 years. Interventions beyond insurance coverage might be needed to improve the health of chronically ill uninsured persons.

Basu K., Pak M. (2014). Will the needs-based-planning of health human resources currently undertaken in several countries lead to excess supply and inefficiency? *Health Econ*,

Abstract: Recently, the emphasis on health human resources (HHR) planning has shifted away from a utilization-based approach toward a needs-based one in which planning is based on the projected health needs of the population. However, needs-based models that are currently in use rely on a definition of 'needs' that include only the medical circumstances of individuals and not personal preferences or other socio-economic factors. We examine whether planning based on such a narrow definition will maximize social welfare. We show that, in a publicly funded healthcare system, if the planner seeks to meet the aggregate need without taking utilization into consideration, then oversupply of HHR is likely because 'needs' do not necessarily translate into 'usage.' Our result suggests that HHR planning should track the healthcare system as access gradually improves because, even if health care is fully accessible, individuals may not fully utilize it to the degree prescribed by their medical circumstances.

Gilson L. (2014). Qualitative research synthesis for health policy analysis: what does it entail and what does it offer? *Health Policy Plan*.

Prévention / Prevention

(2014). 2e colloque de l'ITMO Santé publique – Médecine « personnalisée » et innovations biomédicales : enjeux de santé publique, économiques, éthiques et sociaux (Paris, 5 décembre 2013). Numéro spécial. *Médecine/Sciences*, 30 (Numéro HS) : 1-43.

Marti J. (2014). The impact of tobacco control expenditures on smoking initiation and cessation. *Health Econ*, 23 (12) : 1397-1410.

Abstract: Between 1997 and 2007, smoking prevalence declined from 33% to 28% in Switzerland. Over the same period, funding for tobacco control activities significantly increased, resulting in the implementation of a large variety of national and regional interventions. In this paper, I exploit variation over time and across cantons of tobacco control expenditures to examine the impact of these policies on smoking decisions. I use retrospective smoking information from the Swiss Health Survey (2007) and find that tobacco control expenditures decreased the probability of smoking initiation among adolescents and young adults and increased cessation rates in the general population of smokers. I estimate that if funding had been kept at the 1997 level, there would have been 107,000 additional smokers in 2007.

Psychiatrie / Psychiatry

Bell A. (2014). Life-course and cohort trajectories of mental health in the UK, 1991-2. *Soc Sci Med*, 120C 21-30.

Abstract: There is ongoing debate regarding the shape of life-course trajectories in mental health. Many argue the relationship is U-shaped, with mental health declining with age to mid-life, then improving. However, I argue that these models are beset by the age-period-cohort (APC) identification problem, whereby age, cohort and year of measurement are exactly collinear and their effects cannot be meaningfully separated. This means an apparent life-course effect could be explained by cohorts. This paper critiques two sets of literature: the substantive literature regarding life-course trajectories in mental health, and the methodological literature that claims erroneously to have 'solved' the APC identification problem statistically (e.g. using Yang and Land's Hierarchical APC-HAPC-model). I then use a variant of the HAPC model, making strong but justified assumptions that allow the modelling of life-course trajectories in mental health (measured by the General Health Questionnaire) net of any cohort effects, using data from the British Household Panel Survey, 1991-2008. The model additionally employs a complex multilevel structure that allows the relative importance of spatial (households, local authority districts) and temporal (periods, cohorts) levels to be assessed. Mental health is found to increase throughout the life-course; this slows at mid-life before worsening again into old age, but there is no evidence of a U-shape - I argue that such findings result from confounding with cohort processes (whereby more recent cohorts have generally worse mental health). Other covariates were also evaluated; income, smoking, education, social class, urbanity, ethnicity, gender and marriage were all related to mental health, with the latter two in particular affecting life-course and cohort trajectories. The paper shows the importance of understanding APC in life-course research generally, and mental health research in particular.

White J., Gutacker N., Jacobs R., Mason A. (2014). Hospital admissions for severe mental illness in England: Changes in equity of utilisation at the small area level between 2006 and 2010. *Soc Sci Med*, 120C 243-251.

Abstract: Severe Mental Illness (SMI) encompasses a range of chronic conditions including schizophrenia, bipolar disorder and psychoses. Patients with SMI often require inpatient psychiatric care. Despite equity being a key objective in the English National Health Service (NHS) and in many other health care systems worldwide, little is known about the socio-economic equity of hospital care utilisation for patients with SMI and how it has changed over time. This analysis seeks to address that gap in the evidence base. We exploit a five-year (2006-2010) panel dataset of admission rates at small area level ($n = 162,410$). The choice of control variables was informed by a systematic literature search. To assess changes in socio-economic equity of utilisation, OLS-based standardisation was first used to conduct analysis of discrete deprivation groups. Geographical inequity was then illustrated by plotting standardised and crude admission rates at local purchaser level. Lastly, formal statistical tests for changes in socio-economic equity of utilisation were applied to a continuous measure of deprivation using pooled negative binomial regression analysis, adjusting for a range of risk factors. Our results suggest that one additional percentage point of area income deprivation is associated with a 1.5% ($p < 0.001$) increase in admissions for SMI after controlling for population size, age, sex, prevalence of SMI in the local population, as well as other need and supply factors. This finding is robust to sensitivity analyses, suggesting that a pro-poor inequality in utilisation exists for SMI-related inpatient services. One possible explanation is that the supply or quality of primary, community or social care for people with mental health problems is suboptimal in deprived areas. Although there is some evidence that inequity has reduced over time, the changes are small and not always robust to sensitivity analyses.

Mondoloni A., Buard M., Nargeot J., Vacheron M.N. (2014). [The imminent peril in the law of July the fifth 2011, two years later: The impact on health?]. *Encephale*, 40 (6) : 468-473

Abstract: In 1938, the French government decided to enact a first legislation to enforce admission of the mentally ill to hospitals. Later in 1990, the law took into consideration the evolution of practices with an increase of free admissions and the right to maintain the mentally ill in cities. Three types of psychiatric hospitalization were defined: free, on third party request and for involuntary confinement. A review had theoretically to be conducted every 5 years. In practice this was not the case, probably due to the balance between individual freedom, patient care and public safety always hard to find. However, considering the imperative European harmonization and the fact the Constitutional Council declared a double unconstitutionality of the law, the Act of July 5th was enacted in a hurry during the summer 2011. The Act defines the "rights and the protection of people subject to psychiatric care and methods of coverage". In this document, we will briefly review the context of this law. We will also explore the clinical implications of the very innovative measure: the "peril imminent". We will use the admissions at the Sainte-Anne hospital in Paris in 2010 to 2012. Three major key points were introduced in the law: a judge controls an agreeable release after 15 days and 6 months of continuous hospitalization. The law let the new possibility to provide ambulatory cares under constraints, and these to make an involuntary confinement without a third party request, using the "imminent peril". This law implies the involvement of the judge and the lawyer. This one has to defend a client who needs care, he controls the formal validity of decisions concerning the patient. To provide treatment without consent in "imminent peril" to someone, conditions are requested: these mental disorders make his consent impossible and his mental state requires immediate care with immediate care of constant medical monitoring justifying a full hospitalization or regular medical monitoring for support under another form of full hospitalization (Article L.3212. 1 of the Code of Public Health). Moreover, a demand for care by a third party has also to be impossible to obtain and an imminent peril to the person's health has to exist, supported by a medical certificate from a doctor who does not belong to the patient's psychiatric hospital. The imminent peril would be an immediate danger to the health or life of the patient. What has been the impact of this law adopted in emergency at Sainte-Anne hospital? This psychiatric hospital is in charge of the population in southern Paris, where reside about 655,000 people. This work observes the evolution of the type of hospitalization and care before and after the adoption of the law. We can observe an overall increase in entries under constraints. There is a decrease in admissions for involuntary confinement for the benefit of imminent peril. This imminent peril corresponds to only a small proportion of hospitalizations without consent but are rising between 2011 and 2012, perhaps in part due to a better understanding of the law. But this progression is to monitor to ensure compliance with the restrictive conditions laid down by this law. Also note that the imminent peril may be used at the refusal of the family or entourage to make the demand for care. The number of hospitalizations at the request of a third party with two certificates is down, which is probably due to a change in status of the CPOA, emergency structure within Sainte-Anne, which is no longer seen as extraterritorial. The imminent peril has advantages: it allows access to the care of people isolated and desocialized, of people whose identity is unknown, of pathological travellers. It avoids hospitalization at the request of the representative of the State for social reasons and not for risks to the safety of persons, even when this type of hospitalization is more stigmatizing and often more difficult to remove. It protects the entourage sometimes, when the family is ambivalent or hostile to care, or has been designated as a persecutor. The imminent peril also has disadvantages. One of them is the risk of its misuse to allow rapid hospitalization without taking the time to seek a third party. The imminent danger made when there is an entourage but which refuses to request care can undermine the development work on information about the disease, the need for care and treatment and the importance of the involvement of the entourage in the care plan. The alliance with the patient may be compromised. In some cases, a decision of care by the request of the representative of the State is more appropriate than the "imminent peril". The "imminent peril" may

be preferred because of the administrative burden of prefectural measures when patient presents clinical improvement and we would go up to the ambulatory care in a care program. Yet, the use of a symbolic third, carrying authority, can avoid the too direct confrontation with the patient. Do not use it can complicate the management of the patient. Finally, with desocialized patients, imminent peril can facilitate access to care, but not continuity of care. Indeed, for the care program it is necessary to have an address for the patient. Once the crisis is not to develop a plan of care. Finally in some situations of desocialized patients, the imminent peril can promote access to care but not the continuity of care as to the care program it is necessary to have an address for the patient. Once the crisis is past, it is impossible to implement a program of care. The Law of 5 July 2011 marks a change in the practice of psychiatrists. Take into account the fundamental rights of the patient and to harmonize legislation at EU level was necessary. Some measures are designed to promote access to care as the "imminent peril", we now need to be vigilant to ensure that it is not diverted to promote an increase in care under constraints and that psychiatrists remain in an obligation of means and not of result.

Forsman A.K., Ventus D.B., van der Feltz-Cornelis CM, Wahlbeck K. (2014). Public mental health research in Europe: a systematic mapping for the ROAMER project. *Eur J Public Health*, 24 (6) : 954-959.

Abstract: BACKGROUND: As part of the ROAMER (ROAdmap for MEntal health Research in Europe) project, aiming to create an integrated European roadmap for mental health research, we set out to map the hitherto unmapped territory of public mental health research in Europe. METHODS: Five electronic databases (CINAHL, Health Management, Medline, PsycINFO, Social Services Abstracts) were used for identifying public mental health research articles published between January 2007 and April 2012. The number of publications for each European country in five research domains (i.e. mental health epidemiology, mental health promotion, mental disorder prevention, mental health policy and mental health services) was analysed by population size and gross domestic product (GDP), and mean impact factors were compared. RESULTS: In all, 8143 unique publications were identified. Epidemiology research dominates public mental health research, while promotion, prevention and policy research are scarce. Mental health promotion is the fastest growing research area. Research targeting older adults is under-represented. Publications per capita were highest in northwestern Europe, and similar trends were found also when adjusting the number of publications by GDP per capita. The most widely cited research origins from Italy, Switzerland, the UK, the Nordic countries, the Netherlands, Greece and France. CONCLUSION: In Europe, public mental health research is currently a matter of the affluent northern and western European countries, and major efforts will be needed to promote public mental health research in south and east Europe. In spite of a smaller public mental health research output, some Mediterranean countries produce highly cited public mental health research.

Pignon B., Rolland B., Tebeka S., Zouitina-Lietaert N., Cottencin O., Vaiva G. (2014). [Clinical criteria of involuntary psychiatric treatment: A literature review and a synthesis of recommendations.]. *Presse Med*, 43 (11) : 1195-1205

Abstract: Though the carrying out of involuntary psychiatric care (IPC) mainly follows from a subjective appraisal of the patient's state, some specific clinical criteria have been proposed on regards to the underlying disorder. French national recommendations are synthesized hereby, and completed by a literature review. In psychotic disorders, the level of insight and the impact of delusion(s) are the essential criteria that should recommend to carry out IPC. In mood disorders, the appraisal is different depending on the underlying clinical state. In depressive or mixed states, IPC should be considered mainly in case of suicidal risk or jeopardizing physical consequences. In mania, IPC should result from a poor level of insight, or from the onset of significant social or occupational

aftermaths. For suicidal states, it is necessary to appreciate suicidal risk and underlying psychiatric disorder. In addictive disorders, repeated risk-taking and denial should be the main criteria for considering IPC. In eating disorders, the occurring of both danger of death and denial of care should lead to possible IPC. Personality disorders are severity factors of emergency psychiatric states which can result in IPC. They are not criteria for IPC by themselves. For patients with dementia, mostly behavioural disturbances can require IPC.

Soins de santé primaires / Primary Health Care

Daponte A., Bernal M., Bolivar J., Mateo I., Salmi L.R., Barsanti S., Berghmans L., Piznal E., Bourgueil Y., Marquez S., Gonzalez I., Carriazo A., Maros-Szabo Z., Ménival S., (2014). Criteria for implementing interventions to reduce health inequalities in primary care settings in European regions. *The European Journal of Public Health*, 24 (6) : 979-989.

Abstract : Background: The current social and political context is generating socio-economic inequalities between and within countries, causing and widening health inequalities. The development and implementation of interventions in primary health care (PHC) settings seem unavoidable. Attempts have been made to draw up adequate criteria to guide and evaluate interventions but none for the specific case of PHC. This methodological article aims to contribute to this field by developing and testing a set of criteria for guiding and evaluating real-life interventions to reduce health inequalities in PHC settings in European regions. Methods: A literature review, nominal group technique, survey and evaluation template were used to design and test a set of criteria. The questionnaire was answered by professionals in charge of 46 interventions carried out in 12 European countries, and collected detailed information about each intervention. Third-party experts scored the interventions using the set of evaluation criteria proposed. Results: Nine criteria to guide and evaluate interventions were proposed: relevance, appropriateness, applicability, innovation, quality assurance, adequacy of resources, effectiveness in the process, effectiveness in results and mainstreaming. A working definition was drawn up for each one. These criteria were then used to evaluate the interventions identified. Conclusions: The set of criteria drawn up to guide the design, implementation and evaluation of interventions to reduce health inequalities in PHC will be a useful instrument to be applied to interventions under development for culturally, politically and socio-economically diverse PHC contexts throughout Europe.

Mattessich P.W., Rausch E.J. (2014). Cross-sector collaboration to improve community health: a view of the current landscape. *Health Aff.(Millwood.)*, 33 (11) : 1968-1974.

Abstract: Collaboration between the health and community development sectors has gained increased attention as a means of accelerating progress to improve community health. This article offers an empirical perspective on the general status of such collaboration based on results from a national survey of practitioners in the community development and health fields. Study results show that cross-sector efforts to improve health are widespread across the United States. Community development organizations, including community development financial institutions, support a wide spectrum of activities addressing both social determinants of health and the immediate needs of communities. However, the means of assessing the impacts of these joint community health improvement initiatives appear limited. We highlight opportunities for building on present momentum and for measuring results in a way that expands the evidence base on effective collaborative efforts between the two sectors.

Blendon R.J., Benson J.M., Hero J.O. (2014). Public trust in physicians--U.S. medicine in international perspective. *N Engl J Med*, 371 (17) : 1570-1572.

Romaine M.A., Haber S.G., Wensky S.G., McCall N. (2014). Primary care and specialty providers: an assessment of continuity of care, utilization, and expenditures. *Med Care*, 52 (12) : 1042-1049.

Abstract: BACKGROUND: Little is known as to whether medical home principles, such as continuity of care (COC), would have the same effect on health service use for individuals whose primary (or predominant) provider is a specialist instead of a primary care provider (PCP). OBJECTIVE: To test associations between health service use and expenditures and (1) beneficiaries' predominant provider type (PCP or specialist) and (2) COC among beneficiaries who primarily see a PCP and those who primarily see a specialist. RESEARCH DESIGN: This is a cross-sectional analysis of Medicare fee-for-service claims data from July 2007 to June 2009. Negative binomial and generalized linear models were used in multivariate regression modeling. SUBJECTS: The study cohort comprised 613,471 community-residing Medicare fee-for-service beneficiaries. MEASURES: Beneficiaries' predominant provider type and COC index during a baseline period (July 2007-June 2008) were studied. All-cause and ambulatory care sensitive condition (ACSC) hospitalizations and emergency department (ED) visits and related expenditures and total expenditures in a 1-year follow-up period (July 2008-June 2009) were also reported. RESULTS: Twenty-five percent of beneficiaries primarily saw a specialist. Having a specialist predominant provider was associated with 9% fewer ED visits, 14% fewer ACSC ED visits, and 8% fewer ACSC hospitalizations (all $P < 0.001$). Regardless of whether the beneficiary's predominant provider was a specialist or a PCP, higher continuity was associated with fewer all-cause hospitalizations and ED visits and lower expenditures for these services. Higher continuity was also associated with lower total expenditures. CONCLUSIONS: Regardless of the predominant provider's specialty, greater continuity was associated with less use of high-cost services and lower expenditures for these services.

Sylling P.W., Wong E.S., Liu C.F., Hernandez S.E., Batten A.J., Helfrich C.D., Nelson K., Fihn S.D., Hebert P.L. (2014). Patient-centered medical home implementation and primary care provider turnover. *Med Care*, 52 (12) : 1017-1022.

Abstract: BACKGROUND: The Veterans Health Administration (VHA) began implementing a patient-centered medical home (PCMH) model of care delivery in April 2010 through its Patient Aligned Care Team (PACT) initiative. PACT represents a substantial system reengineering of VHA primary care and its potential effect on primary care provider (PCP) turnover is an important but unexplored relationship. This study examined the association between a system-wide PCMH implementation and PCP turnover. METHODS: This was a retrospective, longitudinal study of VHA-employed PCPs spanning 29 calendar quarters before PACT and eight quarters of PACT implementation. PCP employment periods were identified from administrative data and turnover was defined by an indicator on the last quarter of each uncensored period. An interrupted time series model was used to estimate the association between PACT and turnover, adjusting for secular trend and seasonality, provider and job characteristics, and local unemployment. We calculated average marginal effects (AME), which reflected the change in turnover probability associated with PACT implementation. RESULTS: The quarterly rate of PCP turnover was 3.06% before PACT and 3.38% after initiation of PACT. In adjusted analysis, PACT was associated with a modest increase in turnover (AME=4.0 additional PCPs per 1000 PCPs per quarter, $P=0.004$). Models with interaction terms suggested that the PACT-related change in turnover was increasing in provider age and experience. CONCLUSIONS: PACT was associated with a modest increase in PCP turnover, concentrated among older and more experienced providers, during initial implementation. Our findings suggest that policymakers should evaluate potential workforce effects when implementing PCMH.

Schieber A.C., Delpierre C., Lepage B., Afrite A., Pascal J., Cases C., Lombraill P., Lang T., Kelly-Irving M. (2014). Do gender differences affect the doctor-patient interaction during consultations in general practice? Results from the INTERMEDE study. *Fam Pract*, 31 (6) : 706-713.

Abstract: OBJECTIVE: The aim of the study was to ascertain whether disagreement between GPs and patients on advice given on nutrition, exercise and weight loss is related to patient-doctor gender discordance. Our hypothesis is that a patient interacting with a physician of the same gender may perceive more social proximity, notably on health care beliefs and may be more inclined to trust them. METHODS: The analysis used the Intermede project's quantitative data collected via mirrored questionnaires at the end of the consultation. Multilevel logistic regressions were carried out to explore associations between patient-doctor gender discordance and their disagreement on advice given during the consultation adjusted on patients' and physicians' characteristics. The sample consists of 585 eligible patients and 27 GPs. RESULTS: Disagreement on advice given on nutrition was observed less often for female concordant dyads: OR = 0.25 (95% CI = 0.08-0.78), and for female doctors-male patients dyads: OR = 0.24 (95% CI = 0.07-0.84), taking the male concordant dyads as reference. For advice given on exercise, disagreement was found less often for female concordant dyads OR = 0.38 (95% CI = 0.15-0.98) and an interdoctor effect was found ($P < 0.05$). For advice given on weight loss, the probability of disagreement was significantly increased (OR: 2.87 95% CI = 1.29-6.41) when consultations consisted of female patient and male GP. CONCLUSION: Patient-doctor gender concordance/discordance is associated with their agreement/disagreement on advice given during the consultation. Physicians need to be conscious that their own demographic characteristics and perceptions might influence the quality of prevention counseling delivered to their patients.

Wang J.J., Cha J., Sebek K.M., McCullough C.M., Parsons A.S., Singer J., Shih S.C. (2014). Factors Related to Clinical Quality Improvement for Small Practices Using an EHR. *Health Serv Res*, 49 (6) : 1729-1746.

Abstract: OBJECTIVE: To analyze the impact of three primary care practice transformation program models on performance: Meaningful Use (MU), Patient-Centered Medical Home (PCMH), and a pay-for-performance program (eHearts). DATA SOURCES/STUDY SETTING: Data for seven quality measures (QM) were retrospectively collected from 192 small primary care practices between October 2009 and October 2012; practice demographics and program participation status were extracted from in-house data. STUDY DESIGN: Bivariate analyses were conducted to measure the impact of individual programs, and a Generalized Estimating Equation model was built to test the impact of each program alongside the others. DATA COLLECTION/EXTRACTION METHODS: Monthly data were extracted via a structured query data network and were compared to program participation status, adjusting for variables including practice size and patient volume. Seven QMs were analyzed related to smoking prevention, blood pressure control, BMI, diabetes, and antithrombotic therapy. PRINCIPAL FINDINGS: In bivariate analysis, MU practices tended to perform better on process measures, PCMH practices on more complex process measures, and eHearts practices on measures for which they were incentivized; in multivariate analysis, PCMH recognition was associated with better performance on more QMs than any other program. CONCLUSIONS: Results suggest each of the programs can positively impact performance. In our data, PCMH appears to have the most positive impact.

Edwards S.T., Landon B.E. (2014). Medicare's chronic care management payment--payment reform for primary care. *N Engl J Med*, 371 (22) : 2049-2051.

Ashcroft R. (2014). Inadequate Performance Measures Affecting Practices, Organizations and Outcomes of Ontario's Family Health Teams. *Healthc.Policy*, 10 (1) : 86-96.

Abstract: Background: Emphasis on quantity as the main performance measure may be posing challenges for Family Health Team (FHT) practices and organizational structures. This study asked: What healthcare practices and organizational structures are encouraged by the FHT model? Methods: An exploratory qualitative design guided by discourse analysis was used. This paper presents findings from in-depth semi-structured interviews conducted with seven policy informants and 29 FHT leaders. Results: Participants report that performance measures value quantity and are not inclusive of the broad scope of attributes that comprise primary healthcare. Performance measures do not appear to be accurately capturing the demand for healthcare services, or the actual amount of services being provided by FHTs. Results suggest that unintended consequences of performance measures may be posing challenges to access and health outcomes. Conclusion: It is recommended that performance measures be developed and used to measure, support and encourage FHTs to achieve the goals of PHC.

Steele L.S., Durbin A., Lin E., Charles V.J., Klein-Geltink J., Glazier R.H., Zagorski B., Kopp A. (2014). Primary Care Reform and Service Use by People with Serious Mental Illness in Ontario. *Healthc. Policy*, 10 (1) : 31-45.

Abstract: Purpose: To examine service use by adults with serious mental illness (SMI) rostered in new primary care models: enhanced fee-for-service (FFS), blended-capitation (CAP) and team-based capitation (TBC) models with and without mental health workers (MHW) in Ontario. Methods: This cross-sectional study used administrative health service databases to compare use of mental health and general health services among persons with SMI enrolled in new models (n = 125,233). Results: Relative to persons rostered in enhanced FFS, those in CAP and TBC had fewer mental health primary care visits (adjusted rate ratios and 95% confidence limits: CAP: 0.77 [0.74, 0.81]; TBC with MHW: 0.72 [0.68, 0.76]; TBC with no MHW: 0.81 [0.72, 0.93]). Compared to patients in enhanced FFS, those in TBC models also had more mental health hospital admissions (TBC with MHW: 1.12 [1.05, 1.20]; TBC with no MHW: 1.22 [1.05, 1.41]). Patterns of use of general services were similar. Conclusion: Further attention to financial incentives in capitation that influence care of persons with SMI is necessary to determine if they are aligned with aims of primary care reform.

Systemes de santé / Health Systems

Goldsmith J. (2011). Accountable care organizations: the case for flexible partnerships between health plans and providers. *Health Aff.(Millwood.)*, 30 (1) : 32-40.

Abstract: Under the Affordable Care Act, the new Center for Medicare and Medicaid Innovation will guide a number of experimental programs in health care payment and delivery. Among the most ambitious of the reform models is the accountable care organization (ACO), which will offer providers economic rewards if they can reduce Medicare's cost growth in their communities. However, the dismal history of provider-led attempts to manage costs suggests that this program is unlikely to accomplish its objectives. What's more, if ACOs foster more market concentration among providers, they have the potential to shift costs onto private insurers. This paper proposes a more flexible payment model for providers and private insurers that would divide health care services into three categories: long-term, low-intensity primary care; unscheduled care, including unscheduled emergency services; and major clinical interventions that usually involve hospitalization or organized outpatient care. Each category of care would be paid for differently, with each containing different

elements of financial risk for the providers. Health plans would then be encouraged to provide logistical and analytic support to providers in managing health costs in these categories.

Vieillesse / Ageing

De Stampa, Bagaragaza E., Herr M. et al. (2014). Utilisation des services d'aide et de soins à domicile pour les personnes âgées en situations complexes: comparaison entre trois types de coordination gérontologique. *Revue d'Epidémiologie et de Santé Publique*, 62 (5) : 315-322

Abstract: Objectif : La population âgée en situation complexe vit majoritairement à domicile et plusieurs types de coordinations gérontologiques ont été mises en place sur le territoire français pour répondre à leurs besoins et mettre en place des services d'aide et de soins. Mais on ne dispose pas d'information sur l'utilisation de ces services à domicile en fonction de la coordination mobilisée. Méthode : Nous avons comparé l'utilisation des services à domicile pour une population âgée en situation complexe dans trois types de coordinations sur un suivi de 12 mois. Les trois coordinations regroupaient un réseau gérontologique avec gestion de cas ($n=105$ personnes), un service de soins infirmiers à domicile (SSIAD) avec une infirmière de coordination ($n=206$ personnes) et une coordination informelle avec un aidant non professionnel ($n=117$ personnes). Résultats : À t0, les personnes âgées adressées vers le réseau gérontologique présentaient un moindre accès vers l'offre de services à domicile ; celles suivies par le SSIAD avaient un nombre de services et de passages hebdomadaires les plus élevés et les personnes âgées avec une coordination informelle avaient le double d'heures hebdomadaires de services. À t12, il y avait une amélioration de l'accès vers les services pour le groupe réseau avec gestion de cas et il y avait une augmentation globale dans l'utilisation des services professionnels à domicile sans différence significative entre les trois groupes. Conclusion : L'utilisation des services d'aide et de soins à domicile présentait des différences selon la coordination gérontologique mobilisée. L'évolution sur les 12 mois de l'utilisation des services était comparable entre les groupes sans explosion du nombre de services dans le groupe réseau avec gestion de cas.

Ellen V. (2014). Informal caregiving and well-being in Europe: What can ease the negative consequences for caregivers? *Journal of European Social Policy*, 24 (5) : 424-441.

Abstract: Against the background of an ageing society with an increasing demand for informal caregivers, this study examines (1) to what extent informal caregiving is negatively related to well-being, (2) to what extent the relationship between informal caregiving and well-being varies over countries and (3) to what extent national policies and countries' normative climates reduce the well-being gap between caregivers and non-caregivers. Analyses on the European Quality of Life Survey 2007 ($N=20,396$ in 18 countries), applying multilevel regression techniques, confirmed previous findings that caregivers have lower levels of well-being than non-caregivers. This relationship varied between countries. Generous availability of formal long-term resources reduces the well-being gap between caregivers and non-caregivers. Surprisingly, services that are designed to support informal caregivers do not alleviate the negative well-being consequences. A strong country-level family norm does not affect the well-being gap between caregivers and non-caregivers, but reduces the negative well-being consequences of intensive caregiving.

Cammer A., Morgan D., Stewart N., McGilton K., Rycroft-Malone J., Dopson S., Estabrooks C. (2014). The hidden complexity of long-term care: how context mediates knowledge translation and use of best practices. *Gerontologist*, 54 (6) : 1013-1023.

Abstract: PURPOSE: Context is increasingly recognized as a key factor to be considered when addressing healthcare practice. This study describes features of context as they pertain to knowledge use in long-term care (LTC). DESIGN AND METHODS: As one component of the research program Translating Research in Elder Care, an in-depth qualitative case study was conducted to examine the research question "How does organizational context mediate the use of knowledge in practice in long-term care facilities?" A representative facility was chosen from the province of Saskatchewan, Canada. Data included document review, direct observation of daily care practices, and interviews with direct care, allied provider, and administrative staff. RESULTS: The Hidden Complexity of Long-Term Care model consists of 8 categories that enmesh to create a context within which knowledge exchange and best practice are executed. These categories range from the most easily identifiable to the least observable: physical environment, resources, ambiguity, flux, relationships, and philosophies. Two categories (experience and confidence, leadership and mentoring) mediate the impact of other contextual factors. Inappropriate physical environments, inadequate resources, ambiguous situations, continual change, multiple relationships, and contradictory philosophies make for a complicated context that impacts care provision. IMPLICATIONS: A hidden complexity underlays healthcare practices in LTC and each care provider must negotiate this complexity when providing care. Attending to this complexity in which care decisions are made will lead to improvements in knowledge exchange mechanisms and best practice uptake in LTC.