

Veille scientifique en économie de la santé

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Assurance maladie	Politique de santé
Économie de la santé	Politique publique
État de santé	Prévision – Évaluation
Géographie de la santé	Psychiatrie
Hôpital	Soins de santé primaires
Inégalités de santé	Systemes de santé
Médicament	Travail et santé
Méthodologie – Statistique	Vieillessement

Doc Veille fait peau neuve et change de titre : Veille scientifique en économie de la santé

Présentation

Cette publication mensuelle, réalisée par les documentalistes de l'Irdes, rassemble de façon thématique les résultats de la veille documentaire sur les systèmes et les politiques de santé ainsi que sur l'économie de la santé : articles, littérature grise, ouvrages, rapports...

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Sommaire

Assurance maladie

- 9 **Growing Insurance Coverage Did Not Reduce Access to Care for the Continuously Insured**
Abdus S. et Hill S. C.
- 9 **The Effect of Complementary Private Health Insurance on the Use of Health Care Services**
Kiil A. et Arendt J. N.

Économie de la santé

- 9 **Future and Potential Spending on Health 2015-40: Development Assistance for Health, and Government, Prepaid Private, and Out-of-pocket Health Spending in 184 Countries**
Dieleman J. L., *et al.*
- 10 **A Comprehensive Approach to Assess the Costs of Renal Replacement Therapy for End-stage Renal Disease in France: The Importance of Age, Diabetes Status, and Clinical Events**
Couillerot-Peyrondet A. L., *et al.*
- 10 **Coût de la prise en charge des accidents vasculaires cérébraux en France**
De Pourville G.
- 10 **Analysis of Health Care Costs in Elderly Patients with Multiple Chronic Conditions Using A Finite Mixture of Generalized Linear Models**
Eckardt M., *et al.*
- 11 **Using Administrative Data to Look At Changes in the Level and Distribution of Out-of-pocket Medical Expenditure: An Example Using Medicare Data from Australia**
Hua X., *et al.*
- 11 **Counting the Time Lived, the Time Left Or Illness? Age, Proximity to Death, Morbidity and Prescribing Expenditures**
Moore P. V., *et al.*

État de santé

- 12 **The Health of European Populations: Introduction to the Special Supplement on the 2014 European Social Survey (ESS) Rotating Module on the Social Determinants of Health**
Beckfield J., *et al.*
- 12 **Mortality Risk Disparities in Children Receiving Chronic Renal Replacement Therapy for the Treatment of End-stage Renal Disease Across Europe: An ESPN-ERA/EDTA Registry Analysis**
Chesnaye N. C., *et al.*
- 12 **Global Kidney Health 2017 and Beyond: A Roadmap for Closing Gaps in Care, Research, and Policy**
Levin A., *et al.*
- 13 **Cross-sectional and Prospective Relationship Between Physical Activity and Chronic Diseases in European Older Adults**
Marques A., *et al.*
- 13 **Quality of Life and Living with Cancer: Findings from the European Social Survey (2014) Special Module on the Social Determinants of Health**
Ringdal K. et Ringdal G. I.

Géographie de la santé

- 14 **L'action locale en santé : rapprocher soins et santé et clarifier les rôles institutionnels**
Bourguet Y.
- 14 **The Effect of Context in Rural Mental Health Care: Understanding Integrated Services in A Small Town**
Fitzpatrick S. J., *et al.*
- 14 **Regional Inequalities in Self-reported Conditions and Non-communicable Diseases in European Countries: Findings from the European Social Survey (2014) Special Module on the Social Determinants of Health**
Thomson K. H., *et al.*

Hôpital

- 15 **Productivity Growth, Case Mix and Optimal Size of Hospitals. A 16-year Study of the Norwegian Hospital Sector**
Anthun K. S., *et al.*
- 15 **Les futurs du CHU : assises hospitalo-universitaires 2016. Dossier**
Baguet F.
- 15 **The Politics of Evidence Use in Health Policy Making in Germany-the Case of Regulating Hospital Minimum Volumes**
Ettelt S.
- 15 **Disparities in Potentially Preventable Hospitalizations: Near-National Estimates for Hispanics**
Feng C., *et al.*
- 16 **Évolution des admissions en soins de suite et de réadaptation (SSR) après une hospitalisation pour accident vasculaire cérébral, France, 2010–2014**
Gabet A., *et al.*
- 16 **Implementing Hospital Pay-for-performance: Lessons Learned from the French Pilot Program**
Girault A., *et al.*
- 16 **Hospitalizations for Ambulatory Care Sensitive Conditions Across Primary Care Models in Ontario, Canada**
Laberge M., *et al.*
- 17 **Emergency Department Use: Influence of Connection to A Family Physician on ED Use and Attempts to Avoid Presentation**
Krebs L. D., *et al.*
- 17 **Premier bilan de la tarification à l'activité (T2A) sur la variabilité des coûts hospitaliers**
Milcent C.
- 17 **Care Pathways and Healthcare Use of Stroke Survivors Six Months After Admission to An Acute-care Hospital in France in 2012**
Tuppin P., *et al.*

Inégalités de santé

- 18 **The Social Determinants of Inequalities in Self-reported Health in Europe: Findings from the European Social Survey (2014) Special Module on the Social Determinants of Health**
Balaj M., *et al.*
- 18 **Subjective Social Status, Social Network and Health Disparities: Empirical Evidence from Greece**
Charonis A., *et al.*
- 19 **Language Barriers and Immigrant Health**
Clarke A. I. et Isphording I. E.
- 19 **Unmet Healthcare Needs in Ireland: Analysis Using the EU-SILC Survey**
Connolly S. et Wren M. A.
- 19 **Subjective Perceptions of Unmet Need for Health Care in Europe Among Social Groups: Findings from the European Social Survey (2014) Special Module on the Social Determinants of Health**
Fjaer E. L., *et al.*
- 20 **Population Health and the Economy: Mortality and the Great Recession in Europe**
Tapia Granados J. A. et Ionides E. L.
- 20 **Does the Pattern of Occupational Class Inequalities in Self-reported Health Depend on the Choice of Survey? A Comparative Analysis of Four Surveys and 35 European Countries**
Toch-Marquardt M.

Médicament

- 21 **The New Regulatory Tools of the 2016 Health Law to Fight Drug Shortages in France**
Bocquet F., *et al.*
- 21 **Association Between Copayment, Medication Adherence and Outcomes in the Management of Patients with Diabetes and Heart Failure**
Gourzoulidis G., *et al.*

- 21 **Effect of Out-of-Pocket Cost on Medication Initiation, Adherence, and Persistence Among Patients with Type 2 Diabetes: The Diabetes Study of Northern California (DISTANCE)**

Karter A. J., *et al.*

- 22 **Therapeutic Adherence in Asthma in France: A General Review**

Laforest L., *et al.*

- 22 **Les molécules onéreuses en cancérologie : bilan de deux ans d'audit prospectif continu**

Le Corvaisier C., *et al.*

- 22 **Effects of An Intervention (SAKLAK) on Prescription of Potentially Inappropriate Medication in Elderly Patients**

Lenander C., *et al.*

- 23 **Morbidity and Medication Consumption Among Users of Home Telecare Services**

Millán-Calenti J. C., *et al.*

- 23 **Payers' Experiences with Confidential Pharmaceutical Price Discounts: A Survey of Public and Statutory Health Systems in North America, Europe, and Australasia**

Morgan S. G., *et al.*

- 23 **Self-medication Among People Living with Hypertension: A Review**

Rahmawati R. et Bajorek B. V.

- 24 **Out-of-pocket Expenditures for Pharmaceuticals: Lessons from the Austrian Household Budget Survey**

Sanwald A. et Theurl E.

- 24 **How Can Pricing and Reimbursement Policies Improve Affordable Access to Medicines? Lessons Learned from European Countries**

Vogler S., *et al.*

- 25 **The Role of Government Reimbursement in Drug Shortages**

Yurukoglu A., *et al.*

Méthodologie – Statistique

- 25 **A Two-Step Method to Identify Positive Deviant Physician Organizations of Accountable Care Organizations with Robust Performance Management Systems**

Pimperl A. F., *et al.*

Politique de santé

- 25 **XXX^e congrès national Émois : livre des résumés présentés au congrès. Nancy, 23-24 mars 2017**

Colin C., *et al.*

- 25 **L'Obamacare : principes fondateurs et premiers résultats**

Wittwer J.

- 26 **La diminution du soutien aux transferts universels en France : les conceptions du système de protection sociale ébranlées par la crise de 2008**

Grislain-Letrémy C. et Papuchon A.

- 26 **Principles for Health System Capacity Planning: Insights for Healthcare Leaders**

Shaw J., *et al.*

Politique publique

- 26 **L'indemnisation du chômage en France au regard des pratiques européennes**

Dhont-Peltrault E. et Milcent C.

Prévision – Évaluation

- 27 **A Literature-based Economic Evaluation of Healthcare Preventable Adverse Events in Europe**

Agbabiaka T. B., *et al.*

Psychiatrie

- 27 **L'avenir de la psychiatrie ne peut-il être que politique ? Le paradigme de Frantz Fanon**

Legrand P.

- 28 **Depressed During the Depression: Has the Economic Crisis Affected Mental Health Inequalities in Europe? Findings from the European Social Survey (2014) Special Module on the Determinants of Health**

Reibling N., *et al.*

Soins de santé primaires

- 28 **Selective Contracting and Channelling Patients to Preferred Providers: A Scoping Review**
Bes R. E., *et al.*
- 28 **The Impact of Alternative Payment in Chronically Ill and Older Patients in the Patient-centered Medical Home**
Salzberg A. C., *et al.*
- 29 **The Effect of Medicaid Physician Fee Increases on Health Care Access, Utilization, and Expenditures**
Callison K. et Nguyen B. T.
- 29 **Cooperation According to French Law “hospital, Patients, Health and Territories”: Pharmacists’ Involvement in Aquitaine Region**
D’Elbee M., *et al.*
- 29 **Does Enrollment in Multidisciplinary Team-based Primary Care Practice Improve Adherence to Guideline-recommended Processes of Care? Quebec’s Family Medicine Groups, 2002-2010**
Diop M., *et al.*
- 30 **Physician Associates in Primary Health Care in England: A Challenge to Professional Boundaries**
Drennan V. M., *et al.*
- 30 **Exploring the Differences in General Practitioner and Health Care Specialist Utilization According to Education, Occupation, Income and Social Networks Across Europe: Findings from the European Social Survey (2014) Special Module on the Social Determinants of Health**
Fjaer E. L., *et al.*
- 31 **Does Charging Different User Fees for Primary and Secondary Care Affect First-contacts with Primary Healthcare? A Systematic Review**
Hone T., *et al.*
- 31 **Physicians’ Responses to Financial and Social Incentives: A Medically Framed Real Effort Experiment**
Lagarde M. et Blaauw D.
- 31 **Work Motivation, Task Delegation and Job Satisfaction of General Practice Staff: A Cross-sectional Study**
Riisgaard H., *et al.*

- 32 **High-Price and Low-Price Physician Practices Do Not Differ Significantly on Care Quality Or Efficiency**
Roberts E. T., *et al.*
- 32 **Establishing A Primary Care Performance Measurement Framework For Ontario**
Wissam H.-A. et Brian H.

Systèmes de santé

- 32 **Economic Incentives and Diagnostic Coding in A Public Health Care System**
Anthun K. S., *et al.*
- 33 **Le patient dans le système de santé**
Berthod-Wurmser M. C.
- 33 **Productivity Growth in the English National Health Service from 1998/1999 to 2013/2014**
Bojke C., *et al.*
- 33 **La participation des usagers aux systèmes de santé. In : Le patient dans le système de santé**
Bousquet F.
- 34 **Inequality and the Health-care System in the USA**
Dickman S. L., *et al.*
- 34 **Mesures de l'accès aux soins : l'apport d'enquêtes sur les pratiques et perceptions des patients. In : Le patient dans le système de santé**
Nguyen-Khac A.
- 34 **The Value of Qualitative Description in Health Services and Policy Research**
Roger C.

Travail et santé

- 34 **The Long-Term Effects of Cancer on Employment and Earnings**
Jeon S. H.
- 35 **Introduction of A National Minimum Wage Reduced Depressive Symptoms in Low-Wage Workers: A Quasi-Natural Experiment in the UK**
Reeves A., *et al.*

- 35 **Employment and Income Losses Among Cancer Survivors: Estimates from A National Longitudinal Survey of American Families**
Zajacova A., *et al.*

Vieillessement

- 36 **Measuring Active and Healthy Ageing in Europe**
Aaide A., *et al.*
- 36 **Characteristics, Diseases and Mortality of People Admitted to Nursing Homes for Dependent Seniors During the First Quarter of 2013 in France**
Atramont A., *et al.*
- 36 **Let's Put the Pieces Together: Frailty, Social Vulnerability, the Continuum of Care, Prevention and Research Are Key Considerations for A Dementia Care Strategy**
Melissa K. A.
- 37 **Interventions to Prevent Or Reduce the Level of Frailty in Community-dwelling Older Adults: A Protocol for A Scoping Review of the Literature and International Policies**
Puts M. T., *et al.*
- 37 **Without Empowered Patients, Caregivers and Providers, A Community-Based Dementia Care Strategy Will Remain Just That**
Samir K. S.
- 37 **Effectiveness of An Intervention to Prevent Frailty in Pre-frail Community-dwelling Older People Consulting in Primary Care: A Randomised Controlled Trial**
Serra-Prat M., *et al.*
- 38 **Informal Care in Europe: Findings from the European Social Survey (2014) Special Module on the Social Determinants of Health**
Verbakel E., *et al.*

Assurance maladie

► Growing Insurance Coverage Did Not Reduce Access to Care for the Continuously Insured

ABDUS S. ET HILL S. C.
2017

Health Aff (Millwood) 36(5): 791-798

Recent expansions in health insurance coverage have raised concerns about health care providers' capacity to supply additional services and how that may have affected access to care for people who were already insured. When we examined data for the period 2008-14 from the Medical Expenditure Panel Survey, we found no consistent evidence that increases in the proportions of adults with insurance at the local-area level affected access to care for adults residing in the same areas who already had, and continued to have, insurance. This lack of an apparent relationship held true across eight measures of access, which included receipt of preventive care. It also held true among two adult subpopulations that may have been at greater risk for compromised access: people residing in health care professional shortage areas and Medicaid beneficiaries.

► The Effect of Complementary Private Health Insurance on the Use of Health Care Services

KIIL A. ET ARENDT J. N.
2017

Int J Health Econ Manag 17(1): 1-27

This study estimates the effect of complementary private health insurance (PHI) on the use of health care. The empirical analysis focuses on an institutional setting in which empirical findings are still limited; namely on PHI covering co-payment for treatments that are only partly financed by a universal health care system. The analysis is based on Danish data recently collected specifically for this purpose, which makes identification strategies assuming selection on observables only, and on both observables and unobservables also, both plausible and possible. We find evidence of a substantial positive and significant effect of complementary PHI on the use of prescription medicine and chiropractic care, a smaller but significant effect on dental care, weaker indications of effects for physiotherapy and general practice, and finally that the use of hospital-based outpatient care is largely unaffected. This implies that complementary PHI is generally not simply a marker of a higher propensity to use health care but induces additional use of some health care services over and above what would be used in the absence of such coverage.

Économie de la santé

► Future and Potential Spending on Health 2015-40: Development Assistance for Health, and Government, Prepaid Private, and Out-of-pocket Health Spending in 184 Countries

DIELEMAN J. L., *et al.*
2017

Lancet : Apr 19

The amount of resources, particularly prepaid resources, available for health can affect access to health care and health outcomes. Although health spending tends to increase with economic devel-

opment, tremendous variation exists among health financing systems. Estimates of future spending can be beneficial for policy makers and planners, and can identify financing gaps. In this study, we estimate future gross domestic product (GDP), all-sector government spending, and health spending disaggregated by source, and we compare expected future spending to potential future spending. We extracted GDP, government spending in 184 countries from 1980-2015, and health spend data from 1995-2014. We used a series of ensemble models to estimate future GDP, all-sector government spending, development assistance for health, and government, out-of-pocket, and pre-

paid private health spending through 2040. We used frontier analyses to identify patterns exhibited by the countries that dedicate the most funding to health, and used these frontiers to estimate potential health spending for each low-income or middle-income country. All estimates are inflation and purchasing power adjusted. Health spending is associated with economic development but past trends and relationships suggest that spending will remain variable, and low in some low-resource settings. Policy change could lead to increased health spending, although for the poorest countries external support might remain essential.

► **A Comprehensive Approach to Assess the Costs of Renal Replacement Therapy for End-stage Renal Disease in France: The Importance of Age, Diabetes Status, and Clinical Events**

COUILLEROT-PEYRONDET A. L., *et al.*

2017

Eur J Health Econ 18(4): 459-469

In the current pressured economic context, and to continue to treat the growing number of patients with high-quality standards, the first step is to have a better understanding of the costs related to end-stage renal disease (ESRD) treatment according to various renal replacement therapy, age, diabetes status, and clinical events. In order to estimate the direct costs of all adult ESRD patients, according to (RRT) modality, patient condition, and clinical events, data from the French national health insurance funds were used. RESULTS: The mean monthly costs for the 47,862 stable prevalent patients (73 % of the population) varied substantially according to treatment modality (from 7,300 euro for in-center hemodialysis to 1,100 euro for a functioning renal graft) and to clinical event (8,300 euro for the first month of dialysis, 11,000 euro for the last month before death, 22,800 euro for the first month after renal transplantation). Mean monthly costs varied according to diabetic status and to age to a lesser extent. These results demonstrate, for the first time in France and in Europe, the importance of a dynamic view of renal care and the bias likely when comparing treatments in cross-sectional studies.

► **Coût de la prise en charge des accidents vasculaires cérébraux en France**

DE POUVOURVILLE G.

2016

Archives of Cardiovascular Diseases Supplements 8(2): 161-168

Les accidents vasculaires cérébraux (AVC) sont en France la première cause de handicap acquis chez l'adulte, la deuxième cause de démence et la troisième cause de mortalité. Malgré cela, le coût qu'ils induisent pour la collectivité est mal connu. L'objectif de cette étude est de faire la synthèse des données françaises récentes publiées sur le coût de la prise en charge des AVC. Une revue et une analyse critique de la littérature publiée depuis 2000 sur des données françaises ont été réalisées. L'analyse des résultats démontre que les AVC génèrent une dépense importante pour la collectivité, qui ne se résume pas à la prise en charge de l'événement initial et qui va courir jusqu'au décès des patients. La prise en charge médico-sociale du handicap représente en particulier un poste important, qui reste mal connu dans le contexte français.

► **Analysis of Health Care Costs in Elderly Patients with Multiple Chronic Conditions Using A Finite Mixture of Generalized Linear Models**

ECKARDT M., *et al.*

2017

Health Econ 26(5): 582-599

In this paper, we analysed healthcare costs in a sample of elderly patients suffering from multimorbidity. On the one hand, multimorbid individuals consume a disproportionately large share of healthcare resources. On the other hand, the patient specific number and combination of co-occurring single diseases result in inhomogeneous data leading to biased estimates when using traditional regression techniques. Therefore, we applied a mixture of regressions in order to control for unobserved heterogeneity focussing on the identification of multimorbidity patterns. We used a subsample of N = 1050 patients from a multi-centre prospective cohort study of randomly selected multimorbid primary care patients aged 65 to 85 years in Germany (ISRCTN 89818205) who completed a detailed questionnaire on healthcare utilization during the 6-month period preceding the interview.

Disease combinations of 1047 were included. We detected four different groups of patients with regard to total costs. These groups corresponded largely to findings from the epidemiological literature. The effect of the presence of an additional disease on costs differed between groups. Moreover, two diametrically opposed cost trends were detected with respect to the number of co-occurring diseases. While in one group costs increased with the number of co-occurring diseases, in a second group costs tended to decrease.

► **Using Administrative Data to Look At Changes in the Level and Distribution of Out-of-pocket Medical Expenditure: An Example Using Medicare Data from Australia**

HUA X., *et al.*
2017

Health Policy 121(4): 426-433

Australia's universal health insurance system Medicare generates very large amounts of data on out-of-pocket expenditure (OOPE), but only highly aggregated statistics are routinely published. Our primary purpose is to develop indices from the Medicare administrative data to quantify changes in the level and distribution of OOPE on out-of-hospital medical services over time. Data were obtained from the Australian Hypertension and Absolute Risk Study, which involved patients aged 55 years and over (n=2653). Socio-economic and clinical information was collected and linked to Medicare records over a five-year period from March 2008. The Fisher price and quantity indices were used to evaluate year-to-year changes in OOPE. The relative concentration index was used to evaluate the distribution of OOPE across socio-economic strata. Our price index indicates that overall OOPE were not rising faster than inflation, but there was considerable variation across different types of services (e.g. OOPE on professional attendances rose by 20% over a five-year period, while all other items fell by around 14%). Concentration indices, adjusted for demographic factors and clinical need, indicate that OOPE tends to be higher among those on higher incomes. A major challenge in utilizing large administrative data sets is to develop reliable and easily interpretable statistics for policy makers. Price, quantity and concentration

indices represent statistics that move us beyond the average.

► **Counting the Time Lived, the Time Left Or Illness? Age, Proximity to Death, Morbidity and Prescribing Expenditures**

MOORE P. V., *et al.*
2017

Soc Sci Med 184: 1-14

The main objective is to understand what really drives prescription expenditure at the end of life in order to inform future expenditure projections and service planning. To achieve this objective an empirical analysis of public medication expenditure on the older population (individuals ≥ 70 years of age) in Ireland (n = 231,780) was undertaken. A two part model is used to analyse the individual effects of age, proximity to death (PTD) and morbidity using individual patient-level data from administrative pharmacy records for 2006-2009 covering the population of community medication users. Decedents (n = 14,084) consistently use more medications and incur larger expenditures than similar survivors, especially in the last 6 months of life. The data show a positive and statistically significant impact of PTD on prescribing expenditures with minimal effect for age alone even accounting for patient morbidities. Nevertheless improved measures of morbidity are required to fully test the hypothesis that age and PTD are proxies for morbidity. The evidence presented refutes age as a driver of prescription expenditure and highlights the importance of accounting for mortality in future expenditure projections.

État de santé

► **The Health of European Populations: Introduction to the Special Supplement on the 2014 European Social Survey (ESS) Rotating Module on the Social Determinants of Health**

BECKFIELD J., *et al.*

2017

Eur J Public Health 27(suppl_1): 3-7

This introduction summarizes the main findings of the Supplement 'Social inequalities in health and their determinants' to the European Journal of Public Health. The 16 articles that constitute this supplement use the new ESS (2014) health module data to analyze the distribution of health across European populations. Three main themes run across these articles: documentation of cross-national variation in the magnitude and patterning of health inequalities; assessment of health determinants variation across populations and in their contribution to health inequalities; and the examination of the effects of health outcomes across social groups. Social inequalities in health are investigated from an intersectional stance providing ample evidence of inequalities based on socioeconomic status (occupation, education, income), gender, age, geographical location, migrant status and their interactions. Comparison of results across these articles, which employ a wide range of health outcomes, social determinants and social stratification measures, is facilitated by a shared theoretical and analytical approach developed by the authors in this supplement.

► **Mortality Risk Disparities in Children Receiving Chronic Renal Replacement Therapy for the Treatment of End-stage Renal Disease Across Europe: An ESPN-ERA/EDTA Registry Analysis**

CHESNAYE N. C., *et al.*

2017

Lancet : Mar. 20

In this paper, we explored the variation in country mortality rates in the paediatric population receiving renal replacement therapy across Europe, and estimated how much of this variation could be explained by patient-level and country-level factors. In

this registry analysis, we extracted patient data from the European Society for Paediatric Nephrology/European Renal Association-European Dialysis and Transplant Association (ESPN/ERA-EDTA) Registry for 32 European countries. We included incident patients younger than 19 years receiving renal replacement therapy. Adjusted hazard ratios (aHR) and the explained variation were modelled for patient-level and country-level factors with multilevel Cox regression. The primary outcome studied was all-cause mortality while on renal replacement therapy. Substantial international variation exists in paediatric renal replacement therapy mortality rates across Europe, most of which was explained by disparities in public health expenditure, which seems to limit the availability and quality of paediatric renal care. Differences between countries in their ability to accept and treat the youngest patients, who are the most complex and costly to treat, form an important source of disparity within this population. Our findings can be used by policy makers and health-care providers to explore potential strategies to help reduce these health disparities.

► **Global Kidney Health 2017 and Beyond: A Roadmap for Closing Gaps in Care, Research, and Policy**

LEVIN A., *et al.*

2017

Lancet : Apr. 20

The global nephrology community recognises the need for a cohesive plan to address the problem of chronic kidney disease (CKD). In July, 2016, the International Society of Nephrology hosted a CKD summit of more than 85 people with diverse expertise and professional backgrounds from around the globe. The purpose was to identify and prioritise key activities for the next 5-10 years in the domains of clinical care, research, and advocacy and to create an action plan and performance framework based on ten themes: strengthen CKD surveillance; tackle major risk factors for CKD; reduce acute kidney injury-a special risk factor for CKD; enhance understanding of the genetic causes of CKD; establish better diagnostic methods in CKD; improve understanding of the natural course of CKD; assess and implement established

treatment options in patients with CKD; improve management of symptoms and complications of CKD; develop novel therapeutic interventions to slow CKD progression and reduce CKD complications; and increase the quantity and quality of clinical trials in CKD. Each group produced a prioritised list of goals, activities, and a set of key deliverable objectives for each of the themes. The intended users of this action plan are clinicians, patients, scientists, industry partners, governments, and advocacy organisations. Implementation of this integrated comprehensive plan will benefit people who are at risk for or affected by CKD worldwide.

► **Cross-sectional and Prospective Relationship Between Physical Activity and Chronic Diseases in European Older Adults**

MARQUES A., *et al.*

2017

Int J Public Health 62(4): 495-502

This study examined the relationship between physical activity (PA) and chronic diseases in European older adults, using a prospective analysis with data from 2011 and 2013. Participants were 37,524 older adults (16,204 men) who responded to the fourth (in 2011) and fifth (in 2013) wave of SHARE project, from 13 European countries. Participants' answers to interview questions about the presence of chronic conditions and PA. The cross-sectional and prospective association between PA and the number of chronic diseases was assessed using general linear models. Among men and women, moderate or vigorous physical activity (MVPA) in 2011 was associated with fewer reported chronic diseases in 2011 and 2013. In prospective analysis, MVPA in 2011 was inversely associated with the number of chronic diseases in 2013 in the unadjusted model. In the adjusted model MVPA more than once a week remained as a significant predictor of fewer chronic diseases. PA should be prescribed to older adults in order to prevent and reduce the number of chronic diseases, and, when possible, vigorous intensity PA should be recommended.

► **Quality of Life and Living with Cancer: Findings from the European Social Survey (2014) Special Module on the Social Determinants of Health**

RINGDAL K. ET RINGDAL G. I.

2017

Eur J Public Health 27(suppl_1): 115-119

This study is a comparison of quality of life (QOL) of current and previous cancer victims with people who never had experienced cancer in samples from the general population from the 19 countries in the European Social Survey (ESS) 2014. The study was based on the ESS 2014 with representative samples from 19 countries. QOL was measured by combining two questions on happiness and life satisfaction into a QOL scale. Multilevel modelling was used to examine whether the relationship between cancer status and QOL varies between countries in general and by welfare state regimes in particular. People with cancer at the time of the interview, showed lower general QOL than both people who previously have had cancer and people who never have experienced cancer. The unadjusted and the adjusted odds ratios (ORs) for poor QOL were respectively, OR = 2.38, (2.07, 2.74) and OR = 1.98, (1.71, 2.30). The difference between the 'Never' and the 'Previously' groups was minor but statistical significant. The welfare state classification was a strong predictor of country differences in QOL, but there was no significant statistical interaction effect between cancer status and the welfare state classification. The study also replicated well-documented findings on differences in QOL by education and social support. The QOL of people with a cancer disease is significantly impaired. People who previously have had cancer, scored only slightly lower on the QOL scale than people who never had experienced cancer. We found evidence indicating that these differences may vary between the countries, but this variation cannot be explained by the welfare state classification.

Géographie de la santé

► **L'action locale en santé : rapprocher soins et santé et clarifier les rôles institutionnels**

BOURGUEIL Y.

2017/03

Sciences sociales et santé 35(1)

Cet article est un commentaire de l'article de Marina Honta, qui s'appuie sur une exploitation secondaire d'une plus vaste enquête sur les coordinateurs d'Ateliers santé ville (ASV) et vise, dans une démarche heuristique, à révéler par l'analyse thématique d'entretiens réalisés auprès de 7 coordinateurs d'ASV actuels ou anciens les mutations de l'action publique en santé dans le cadre de la politique de la ville.

► **The Effect of Context in Rural Mental Health Care: Understanding Integrated Services in A Small Town**

FITZPATRICK S. J., *et al.*

2017

Health Place 45: 70-76

Unequal health care outcomes for those with mental illness mean that access to integrated models is critical to supporting good physical and mental health care. This is especially so in rural areas where geographic and structural issues constrain the provision of health services. Guided by a conceptual framework about rural and remote health, this study draws on interviews with health providers and other staff and examines the dynamics of integrated primary and community-based specialist care for people with severe and persistent mental illnesses living in rural Australia. Findings show that the facilitation of sustainable linkages between general practice and community mental health requires the skillful exercise of power, knowledge, and resources by partners in order to address the social and structural factors that influence local health situations. These findings suggest that incremental processes of integration that are responsive to patients' and stakeholders' needs and that build on success and increased trust may be more effective than those imposed from the 'top down' that pay insufficient attention to local contexts.

► **Regional Inequalities in Self-reported Conditions and Non-communicable Diseases in European Countries: Findings from the European Social Survey (2014) Special Module on the Social Determinants of Health**

THOMSON K. H., *et al.*

2017

Eur J Public Health 27(suppl_1): 14-21

Within the European Union (EU), substantial efforts are being made to achieve economic and social cohesion, and the reduction of health inequalities between EU regions is integral to this process. This paper is the first to examine how self-reported conditions and non-communicable diseases (NCDs) vary spatially between and within countries. Using 2014 European Social Survey (ESS) data from 20 countries, this paper examines how regional inequalities in self-reported conditions and NCDs vary for men and women in 174 regions (Levels 1 and 2 Nomenclature of Statistical Territorial Units, 'NUTS'). We document absolute and relative inequalities across Europe in the prevalence of eight conditions: general health, overweight/obesity, mental health, heart or circulation problems, high blood pressure, back, neck, muscular or joint pain, diabetes and cancer. There is considerable inequality in self-reported conditions and NCDs between the regions of Europe, with rates highest in the regions of continental Europe, some Scandinavian regions and parts of the UK and lowest around regions bordering the Alps, in Ireland and France. However, for mental health and cancer, rates are highest in regions of Eastern European and lowest in some Nordic regions, Ireland and isolated regions in continental Europe. There are also widespread and consistent absolute and relative regional inequalities in all conditions within countries. These are largest in France, Germany and the UK, and smallest in Denmark, Sweden and Norway. There were higher inequalities amongst women. : Using newly available harmonized morbidity data from across Europe, this paper shows that there are considerable regional inequalities within and between European countries in the distribution of self-reported conditions and NCDs.

Hôpital

► **Productivity Growth, Case Mix and Optimal Size of Hospitals. A 16-year Study of the Norwegian Hospital Sector**

ANTHUN K. S., *et al.*

2017

Health Policy 121(4): 418-425

This paper analyses productivity growth in the Norwegian hospital sector over a period of 16 years, 1999-2014. This period was characterized by a large ownership reform with subsequent hospital reorganizations and mergers. We describe how technological change, technical productivity, scale efficiency and the estimated optimal size of hospitals have evolved during this period. Hospital admissions were grouped into diagnosis-related groups using a fixed-grouper logic. Four composite outputs were defined and inputs were measured as operating costs. Productivity and efficiency were estimated with bootstrapped data envelopment analyses. This study addresses the issues of both cross-sectional and longitudinal comparability of case mix between hospitals, and thus provides a framework for future studies. The study adds to the discussion on optimal hospital size.

► **Les futurs du CHU : assises hospitalo-universitaires 2016. Dossier**

BAGUET F.

2017/02

Gestions hospitalières (563): 84-98

Crées il y a bientôt 60 ans par une réforme à l'époque révolutionnaire, les centres hospitaliers universitaires (CHU) se sont réunis les 8 et 9 décembre 2016 à Toulouse pour réfléchir à leur avenir. L'objectif était de proposer un «new deal» six mois après l'instauration des groupements hospitaliers de territoire (GHT) et six mois avant la présidentielle. Ce dossier rassemble les dix-sept propositions qui visent à redessiner le modèle CHU.

► **The Politics of Evidence Use in Health Policy Making in Germany-the Case of Regulating Hospital Minimum Volumes**

ETTELT S.

2017

J Health Polit Policy Law 42(3): 513-538

This article examines the role of scientific evidence in informing health policy decisions in Germany, using minimum volumes policy as a case study. It argues that scientific evidence was used strategically at various stages of the policy process both by individual corporatist actors and by the Federal Joint Committee as the regulator. Minimum volumes regulation was inspired by scientific evidence suggesting a positive relationship between service volume and patient outcomes for complex surgical interventions. Federal legislation was introduced in 2002 to delegate the selection of services and the setting of volumes to corporatist decision makers. Yet, despite being represented in the Federal Joint Committee, hospitals affected by its decisions took the Committee to court to seek legal redress and prevent policy implementation. Evidence has been key to support, and challenge, decisions about minimum volumes, including in court. The analysis of the role of scientific evidence in minimum volumes regulation in Germany highlights the dynamic relationship between evidence use and the political and institutional context of health policy making, which in this case is characterized by the legislative nature of policy making, corporatism, and the role of the judiciary in reviewing policy decisions.

► **Disparities in Potentially Preventable Hospitalizations: Near-National Estimates for Hispanics**

FENG C., *et al.*

2017

Health Serv Res. : Apr. 04

In this paper, we try to obtain near-national rates of potentially preventable hospitalization (PPH)-a marker of barriers to outpatient care access-for Hispanics; to examine their differences from other race-ethnic groups and by Hispanic national origin; and to identify key mediating factors. Data from all-payer inpatient discharge databases for 15 states accounting for

85 percent of Hispanics nationally. Combining counts of inpatient discharges with census population for adults aged 18 and older, we estimated age-sex-adjusted PPH rates. We examined county-level variation in race-ethnic disparities in these rates to identify the mediating role of area-level indicators of chronic condition prevalence, socioeconomic status (SES), health care access, acculturation, and provider availability. Hispanics and blacks face higher barriers to outpatient care access; the higher barriers among Hispanics (but not blacks) seem mediated by SES, lack of insurance, cost barriers, and limited provider availability.

► **Évolution des admissions en soins de suite et de réadaptation (SSR) après une hospitalisation pour accident vasculaire cérébral, France, 2010–2014**

GABET A., *et al.*

2017

Revue d'épidémiologie et de santé publique 65 (Supplement 1): S33

Dans le contexte d'une structuration en cours de la filière AVC, encouragée par le plan d'action national AVC 2010–2014, notre travail avait pour but d'étudier l'évolution du taux d'admission en SSR post-AVC sur la période 2010–2014, les facteurs associés à l'admission en SSR et les caractéristiques des patients pris en charge. Les patients hospitalisés pour AVC (codes CIM-10 I60 à I64) au premier semestre de chaque année entre 2010 et 2014 ont été sélectionnés dans les bases d'hospitalisation du PMSI-MCO à partir du diagnostic principal. Un séjour en SSR a été recherché dans les six mois suivant la sortie de l'hôpital. Les taux standardisés sur l'âge d'admission en SSR ont été calculés, et les évolutions annuelles moyennes analysées par régressions de Poisson. Le taux d'admission en SSR, estimé à 38 % en 2014, a peu évolué entre 2010 et 2014, malgré une augmentation relativement importante du nombre de patients admis en SSR. La présence de séquelles et l'âge demeurent les principaux facteurs d'admission. Au vu de l'amélioration observée du statut fonctionnel de la majorité des patients admis en SSR, celui-ci constitue une étape majeure du parcours de soin des AVC, dont le développement sur l'ensemble du territoire est à poursuivre.

► **Implementing Hospital Pay-for-performance: Lessons Learned from the French Pilot Program**

GIRAULT A., *et al.*

2017

Health Policy 121(4): 407-417

Despite a wide implementation of pay-for-performance (P4P) programs, evidence on their impact in hospitals is still limited. Our objective was to assess the implementation of the French P4P pilot program (IFAQ1) across 222 hospitals. The study consisted of a questionnaire among four leaders in each enrolled hospital, combined with a qualitative analysis based on 33 semi-structured interviews conducted with staff in four participating hospitals. For the questionnaire results, descriptive statistics were performed and responses were analyzed by job title. For the interviews, transcripts were analysed using coding techniques. Survey results showed that leaders were mostly positive about the program and reported a good level of awareness, in contrast to the frontline staff, who remained mostly unaware of the program's existence. The main barriers were attributed to lack of clarity in program rules, and to time constraints. Different strategies were then suggested by leaders. The qualitative results added further explanations for low program adoption among hospital staff, so far. Ultimately, although paying for quality is still an intuitive approach; gaps in program awareness within enrolled hospitals may pose an important challenge to P4P efficacy. Implementation evaluations are therefore necessary for policymakers to better understand P4P adoption processes among hospitals.

► **Hospitalizations for Ambulatory Care Sensitive Conditions Across Primary Care Models in Ontario, Canada**

LABERGE M., *et al.*

2017

Soc Sci Med 181: 24-33

The study analyzes the relationship between the risk of a hospitalization for an ambulatory care sensitive condition (ACSC), and the primary care payment and the organizational model used by the patient (fee-for-service, enhanced fee-for-service, blended capitation, blended capitation with interdisciplinary teams). The study used linked patient-level health administrative databases and census data housed at the Institute

for Clinical Evaluative Sciences in Ontario. Since the province provides universal health care, the data capture all patients in Ontario, Canada's most populous province, with about 13 million inhabitants. All Ontario patients diagnosed with an ACSC prior to April 1, 2012, who had at least one visit with a physician between April 1, 2012, and March 31, 2013, were included in the study ($n = 1,710,310$). Each patient was assigned to the primary care model of his/her physician. The different models were categorized as Fee-for-Service (FFS), enhanced-FFS, blended capitation, and interdisciplinary team. A logistic regression was used to model the risk of having an ACSC hospitalization during the one-year observation period. Adjustments were made for patient characteristics (age, sex, health status, and socio-economic status) and for the geographic location of the practice. Using patients belonging to FFS models as the reference group, the risk of an ACSC hospitalization was higher for patients belonging to the blended-capitation model using interdisciplinary teams (Adjusted Odds Ratio [AOR] = 1.06, 95% confidence interval [CI] = 1.00-1.12) and lower for enhanced-FFS (AOR = 0.78, CI = 0.74-0.82) and blended capitation patients (AOR = 0.91, CI = 0.86-0.96). Using patients with hypertension as the reference group, the odds of an ACSC hospitalization were much higher for patients with any other ACSC and increased with patients' morbidity. The risk was lower for patients of higher socio-economic status (AOR = 0.63, CI = 0.60-0.67) in the highest neighborhood income quintile.

► **Emergency Department Use: Influence of Connection to A Family Physician on ED Use and Attempts to Avoid Presentation**

KREBS L. D., *et al.*

2017

Healthcare Quarterly 19(4): 47-54

Some low-acuity emergency department (ED) presentations are potentially avoidable with improved primary care access. The majority of ED patients (74.4%) in this study had a family physician, but the frequency of visits varied substantially. The variable frequency of patients' visits to these providers calls into question the validity of linkage assumptions. Several sociodemographic factors were associated with having a family physician, including female sex, being married/common law, race (Caucasian), being employed over the previous 12 months and having received a

flu shot in the past year. These factors need to be explored further.

► **Premier bilan de la tarification à l'activité (T2A) sur la variabilité des coûts hospitaliers**

MILCENT C.

2017

Economie & prévision 210(1): 45-67

<http://www.cairn.info/revue-economie-et-prevision-2017-1-page-45.htm>

Ce papier étudie la variabilité des coûts hospitaliers pour des séjours comparables en pathologies et en procédures (GHM). À l'époque du budget global, une forte variabilité des coûts était observée entre les hôpitaux publics français. Qu'en est-il aujourd'hui ? Théoriquement, la T2A conduit les établissements à minimiser leurs coûts pour gagner la différence entre le forfait et le coût. Nous montrons une certaine homogénéisation des coûts et une réelle prise en compte de l'hétérogénéité des individus. Les forfaits par GHM ne capturent cependant pas toute l'hétérogénéité entre les établissements, ni entre les patients. Ainsi, les effets néfastes de sélection des patients ou de diminution du niveau de qualité ne sont pas évités par les forfaits actuels.

► **Care Pathways and Healthcare Use of Stroke Survivors Six Months After Admission to An Acute-care Hospital in France in 2012**

TUPPIN P., *et al.*

2016

Rev Neurol (Paris) 172(4-5): 295-306

Care pathways and healthcare management are not well described for patients hospitalized for stroke. METHODS: Among the 51 million beneficiaries of the French national health insurance general scheme (77% of the French population), patients hospitalized for a first stroke in 2012 and still alive six months after discharge were included using data from the national health insurance information system (Sniiram). Patient characteristics were described by discharge destination –home or rehabilitation center (for < 3 months)– and were followed during their first three months back home. The results illustrate the value of administrative databases to study stroke manage-

ment, care pathways and ambulatory care. These data should be used to improve care pathways, organization, discharge planning and treatments.

Inégalités de santé

► **The Social Determinants of Inequalities in Self-reported Health in Europe: Findings from the European Social Survey (2014) Special Module on the Social Determinants of Health**

BALAJ M., *et al.*

2017

Eur J Public Health 27(suppl_1): 107-114

Health inequalities persist between and within European countries. Such inequalities are usually explained by health behaviours and according to the conditions in which people work and live. However, little is known about the relative contribution of these factors to health inequalities in European countries. This paper aims to investigate the independent and joint contribution of a comprehensive set of behavioural, occupational and living conditions factors in explaining social inequalities in self-rated health (SRH). Data from 21 countries was obtained from the 2014 European Social Survey and examined for respondents aged 25-75. Absolute and relative inequalities in SRH were found in all countries and the magnitude of socio-economic inequalities varied considerably between countries. While factors were found to differentially contribute to the explanation of educational inequalities in different European countries, occupational and living conditions factors emerged as the leading causes of inequalities across most of the countries, contributing both independently and jointly with behavioural factors. The observed shared effects of different factors to health inequalities points to the interdependent nature of occupational, behavioural and living conditions factors. Tackling health inequalities should be a concerted effort that goes beyond interventions focused on single factors.

► **Subjective Social Status, Social Network and Health Disparities: Empirical Evidence from Greece**

CHARONIS A., *et al.*

2017

Int J Equity Health 16(1): 40

Several studies suggest that socioeconomic status affects (SES) affects self-rated health (SRH), both in Greece and internationally. However, prior research mainly uses objective measures of SES, instead of subjective evaluations of individuals' social status. Based on this, this paper aims to examine (a) the impact of the economic downturn on SRH in Greece and (b) the relationship between subjective social status (SSS), social network and SRH. METHODS: The descriptive analysis is based on four cross-sectional surveys conducted by the National School of Public Health, Athens, Greece (2002, 2006, 2011, 2015), while the data for the empirical investigation were derived from the 2015 survey (Health + Welfare Survey GR). The empirical strategy is based on an ordinal logistic regression model, aiming to examine how several variables affect SRH. Size of social network and SSS are among the independent variables employed for the empirical analysis. Our findings are consistent with the existing literature and confirm a social gradient in health. According to our analysis, health disparities can be largely attributed to socioeconomic inequalities. The adverse economic climate has impact on socioeconomic differences which in turn affect health disparities. Based on these, policy initiatives are necessary in order to mitigate the negative impact on health and the disparities caused by economic downturn and the occurring socioeconomic inequalities.

► **Language Barriers and Immigrant Health**

CLARKE A. I. ET ISPHORDING I. E.

2017

Health Econ 26(6): 765-778

We study the impact of language deficiency on the health status of childhood migrants to Australia. Our identification strategy relies on a quasi-experiment comparing immigrants arriving at different ages and from different linguistic origins. In the presence of considerable non-classical measurement error in self-reported language proficiency, our results provide lower and upper bounds for a strong negative effect of English deficiency on health of between one half and a full standard deviation in the health score.

► **Unmet Healthcare Needs in Ireland: Analysis Using the EU-SILC Survey**

CONNOLLY S. ET WREN M. A.

2017

Health Policy 121(4): 434-441

The analysis used the 2013 Survey of Income and Living Conditions to examine the extent and causes of unmet need for healthcare services in Ireland. The analysis found that almost four per cent of participants reported an unmet need for medical care. Overall, lower income groups, those with poorer health status and those without free primary care and/or private insurance were more likely to report an unmet healthcare need. The impact of income on the likelihood of reporting an unmet need was particularly strong for those without free primary care and/or private insurance, suggesting a role for the health system in eradicating income based inequalities in unmet need. Factors associated with the healthcare system - cost and waiting lists - accounted for the majority of unmet needs. Those with largely free public healthcare entitlement were more likely than all other eligibility categories to report that their unmet need was due to waiting lists (rather than cost). While not possible to explicitly examine in this analysis, it is probable that unmet need due to cost is picking up on the relatively high out-of-pocket payments for primary care for those who must pay for GP visits; while unmet need due to waiting is identifying the relatively long waiting times within the acute hospital sector for those within the public system.

► **Subjective Perceptions of Unmet Need for Health Care in Europe Among Social Groups: Findings from the European Social Survey (2014) Special Module on the Social Determinants of Health**

FJAER E. L., *et al.*

2017

Eur J Public Health 27(suppl_1): 82-89

Unmet need can be defined as the individually perceived subjective differences between services judged necessary to deal with health problems and the services actually received. This study examines what factors are associated with unmet need, as well as how reasons for unmet need are distributed across socioeconomic and demographic groups in Europe. Multilevel logistic regression models were employed using data from the 7th round of the European Social Survey, on people aged 25-75. Self-reported unmet need measured whether respondents had been unable to get medical consultation or treatment in the last 12 months. Reasons for unmet need were grouped into three categories: availability, accessibility and acceptability. Health status was measured by self-reported health, non-communicable diseases and depressive symptoms. Two-thirds of all unmet need were due to waiting lists and appointment availability. Females and young age groups reported more unmet need. We found no educational inequalities, while financial strain was found to be an important factor for all types of unmet need for health care in Europe. All types of health care use and poor health were associated with unmet need. Low physician density and high out-of-pocket payments were found to be associated with unmet need due to availability. Even though health care coverage is universal in many European welfare states, financial strain appeared as a major determinant for European citizens' access to health care. This may suggest that higher income groups are able to bypass waiting lists. European welfare states should, therefore, intensify their efforts in reducing barriers for receiving care.

► **Population Health and the Economy: Mortality and the Great Recession in Europe**

TAPIA GRANADOS J. A. ET IONIDES E. L.
2017

Health Econ. : Mar. 27

We analyze the evolution of mortality-based health indicators in 27 European countries before and after the start of the Great Recession. We find that in the countries where the crisis has been particularly severe, mortality reductions in 2007-2010 were considerably bigger than in 2004-2007. Panel models adjusted for space-invariant and time-invariant factors show that an increase of 1 percentage point in the national unemployment rate is associated with a reduction of 0.5% ($p < .001$) in the rate of age-adjusted mortality. The pattern of mortality oscillating procyclically is found for total and sex-specific mortality, cause-specific mortality due to major causes of death, and mortality for ages 30-44 and 75 and over, but not for ages 0-14. Suicides appear increasing when the economy decelerates-countercyclically-but the evidence is weak. Results are robust to using different weights in the regression, applying nonlinear methods for detrending, expanding the sample, and using as business cycle indicator gross domestic product per capita or employment-to-population ratios rather than the unemployment rate. We conclude that in the European experience of the past 20 years, recessions, on average, have beneficial short-term effects on mortality of the adult population.

► **Does the Pattern of Occupational Class Inequalities in Self-reported Health Depend on the Choice of Survey? A Comparative Analysis of Four Surveys and 35 European Countries**

TOCH-MARQUARDT M.
2017

Eur J Public Health 27(suppl_1): 34-39

Despite increasing overall life expectancy, substantial differences in health between socioeconomic groups persist. Research on inequalities in health often draws on data from different, single surveys. An important question that arises is whether these surveys reflect health and inequalities in the same way. When occupational class is utilized, data are often not analysed for women. The aim of this study therefore is to

investigate whether patterns of occupational class inequalities in self-reported health differ across sex and country, between four major European surveys. Data on self-reported health and occupational class are taken from the European Social Survey (ESS), the EU Statistics on Income and Living Conditions (EU-SILC), the European Working Conditions Survey (EWCS) and the International Social Survey Programme (ISSP). Data from 35 countries for men and women aged 25-65 years are analysed. Occupational class is measured according to manual and non-manual workers. Age-standardized prevalence rates, and prevalence ratios (PR) between non-manual and manual workers and likelihood ratio (LR) tests are estimated to determine occupational class inequalities in self-rated health in Europe. Results show that prevalence rates of less than good health differ noticeably between countries and surveys. Furthermore, occupational class inequalities in health differ between countries. In some countries inequalities are larger for women than for men. This is especially true in Eastern, Central and Baltic European countries. Besides that no regional patterns, consistent over all surveys, in inequalities could be detected. Inequalities differed significantly between surveys. The magnitude of inequalities in all countries depends on the survey used in the analysis. When undertaking a comparative analysis of inequalities in health, or other determinants, these differences have to be taken into account, as results might differ according to the data source used.

Médicament

► **The New Regulatory Tools of the 2016 Health Law to Fight Drug Shortages in France**

BOCQUET F., *et al.*

2017

Health Policy : Mar. 18

Drug shortages are becoming worrying for public health in the European Union. The French public authorities first took action against the causes of drug shortages in 2011 with a law, followed by a decree in 2012 to overcome the dysfunctions of the pharmaceutical distribution channel. These texts would establish emergency call centres implemented by pharmaceutical companies for pharmacists and for wholesalers to inform of shortages, and would oblige pharmaceutical companies to inform health authorities of any risk of potential shortage situation; they would also reinforce the declaration regime of the territory served by wholesalers. Through the Health Law of January 2016, France acquired new regulatory tools in order to fight against these shortages and wanted to target the drugs for which they are the most detrimental: the major therapeutic interest (MTI) drugs. Furthermore, this new text reinforces the legal obligations of pharmaceutical companies and of wholesalers for drug shortages and sets out the enforcement of sanctions in case of breach of these obligations. France's goal is ambitious: to implement coercive measures aiming at making the actors of the drug distribution channel aware of their responsibilities in order to take up the public health challenge triggered by drug shortages.

► **Association Between Copayment, Medication Adherence and Outcomes in the Management of Patients with Diabetes and Heart Failure**

GOURZOULIDIS G., *et al.*

2017

Health Policy 121(4): 363-377

This aim of this paper is to determine the association between copayment, medication adherence and outcomes in patients with Heart failure (HF) and Diabetes Mellitus (DM). PubMed, Scopus and Cochrane databases were searched using combina-

tions of four sets of key words for: drug cost sharing; resource use, health and economic outcomes; medication adherence; and chronic disease. Thirty eight studies were included in the review. Concerning the direct effect of copayment changes on outcomes, the scarcity and diversity of data, does not allow us to reach a clear conclusion, although there is some evidence indicating that higher copayments may result in poorer health and economic outcomes. Seven and one studies evaluating the relationship between copayment and medication adherence in DM and HF population, respectively, demonstrated an inverse statistically significant association. All studies (29) examining the relationship between medication adherence and outcomes, revealed that increased adherence is associated with health benefits in both DM and HF patients. Finally, the majority of studies in both populations, showed that medication adherence was related to lower resource utilization which in turn may lead to lower total healthcare cost. The results of our systematic review imply that lower copayments may result in higher medication adherence, which in turn may lead to better health outcomes and lower total healthcare expenses. Future studies are recommended to reinforce these findings.

► **Effect of Out-of-Pocket Cost on Medication Initiation, Adherence, and Persistence Among Patients with Type 2 Diabetes: The Diabetes Study of Northern California (DISTANCE)**

KARTER A. J., *et al.*

2017

Health Serv Res. : May 05

In this paper, we estimate the effect of out-of-pocket (OOP) cost on nonadherence to classes of cardiometabolic medications among patients with diabetes. The study is based on electronic health records from a large, health care delivery system for 223,730 patients with diabetes prescribed 842,899 new cardiometabolic medications during 2006-2012. Observational, new prescription cohort study of the effect of OOP cost on medication initiation and adherence is analyzed. Primary nonadherence (never dispensed) increased monotonically with OOP cost after adjusting for demographics, neighborhood socioeconomic status,

Medicare, medical financial assistance, OOP maximum, deductibles, mail order pharmacy incentive and use, drug type, generic or brand, day's supply, and comorbidity index; 7 percent were never dispensed the new medication when OOP cost ≥ 11 , 5 percent with OOP cost of \$1-\$10, and 3 percent when the medication was free of charge ($p < .0001$). Higher OOP cost was also strongly associated with inadequate secondary adherence (≥ 20 percent of time without adequate medication). There was no clinically significant or consistent relationship between OOP costs and early nonpersistence (dispensed once, never refilled) or later stage nonpersistence (discontinued within 24 months). Cost-sharing may deter clinically vulnerable patients from initiating essential medications, undermining adherence and risk factor control.

► **Therapeutic Adherence in Asthma in France: A General Review**

LAFORST L., *et al.*

2017

Rev Mal Respir 34(3): 194-222

Adherence in asthma is a paramount issue of disease management. A general review of the French publications on this topic has been conducted. Research equations used for bibliographic databases (MEDLINE, Science Direct, Banque de données en santé publique, Cochrane and Cairn.info) comprised the following keywords: "asthma", "therapeutic adherence" and "France". These publications unrelated to asthma, focused on asthma management without exploring adherence, or those conducted in populations without French patients were excluded. The present review highlights the sustainability of adherence-related issues in asthma and the need to improve patients' knowledge on asthma and the finality of therapy. It also highlights the need of an improved communication between patients and physicians is also advocated. Further studies with more recent data are desirable to assess changes in disease management of asthma and the impact of potential future corrective interventions.

► **Les molécules onéreuses en cancérologie : bilan de deux ans d'audit prospectif continu**

LE CORVAISIER C., *et al.*

2017/02

Gestions hospitalières (563): 119-123

En 2005, un contrat de bon usage national des médicaments onéreux a été institué pour justifier leur prescription. En 2013, afin de répondre aux exigences réglementaires, la pharmacie de l'institut de cancérologie Lucien-Neuwirth a mis en place un audit continu pour les molécules de cancérologie inscrites sur la liste en sus. Deux ans après, le bilan de l'audit constate un taux stable de prescription hors autorisation de mise sur le marché, doublé d'une conformité faible aux exigences du contrat de bon usage. Un référentiel local a été créé pour mettre à jour et consolider les données du référentiel national.

► **Effects of An Intervention (SAKLAK) on Prescription of Potentially Inappropriate Medication in Elderly Patients**

LENANDER C., *et al.*

2017

Fam Pract 34(2): 213-218

Polypharmacy is known to increase the risk for drug-related problems, and some drugs, potentially inappropriate medications (PIMs), are especially troublesome. The aim of this study is to analyse the effects on prescription of PIMs of the SAKLAK project, an intervention model created to improve medication safety for elderly patients in primary care. Data were collected from the Swedish Prescribed Drug Register on PIMs (long-acting benzodiazepines, anticholinergics, tramadol, propiomazine, antipsychotics and non-steroidal anti-inflammatory drugs) prescribed to patients aged 65 years and older. Total number of patients and change in patients using PIMs before and after intervention within groups was analysed as well as differences between intervention and comparison group. A total of 32566 prescriptions of PIMs were dispensed before the intervention, 19796 in the intervention group and 12770 in the comparison group. After intervention a decrease was seen in both groups, intervention-22.2% and comparison-8.8%. All groups of PIMs decreased, except for antipsychotics in the comparison group. For the intervention group, a significant decrease in mean dose/patient was

seen after the intervention but not in the comparison group. Conclusion: Our study shows this method has some effects on prescription of PIMs. The evaluation indicates this is a feasible method for improvement of medication use in primary care and the method should be tested on a larger scale.

► **Morbidity and Medication Consumption Among Users of Home Telecare Services**

MILLÁN-CALENTI J. C., *et al.*

2017

Health & Social Care in the Community 25(3): 888-900

<https://doi.org/10.1111/hsc.12377>

Telecare is a healthcare resource based on new technologies that, through the services offered, attempt to help elderly people to continue living in their homes. In this sense, first generation telecare services have quickly developed in Europe. The aim of this work was to define the profile, pattern of medication consumption and disease frequencies of elderly users of a telecare service. The cross sectional study involved 742 Spanish community dwelling elders (85.3% of the total users aged 65 years and over who used a telecare service before the end of the data collection period). Data were collected between March and September 2012. The mean Charlson comorbidity index score was 1.13 (SD 1.1), and the mean number of prescribed medications per day was 5.6 (SD 3.0). The most frequent diseases were hypertension (51.1%) and rheumatic disorders (44%); and the most consumed medications were those for the cardiovascular (75%) and nervous (65.2%) systems. For the total sample, the three main determinants of poly medication (five or more medications) were hypertension, anxiety, depressive symptoms and coronary heart disease. Regardless of the social elements contributing to the implementation of telecare services, specific health characteristics of potential users, such as morbidity and polypharmacy, should be carefully considered when implementing telecare services in the coming years.

► **Payers' Experiences with Confidential Pharmaceutical Price Discounts: A Survey of Public and Statutory Health Systems in North America, Europe, and Australasia**

MORGAN S. G., *et al.*

2017

Health Policy 121(4): 354-362

Institutional payers for pharmaceuticals worldwide appear to be increasingly negotiating confidential discounts off of the official list price of pharmaceuticals purchased in the community setting. We conducted an anonymous survey about experiences with and attitudes toward confidential discounts on patented pharmaceuticals in a sample of high-income countries. Confidential price discounts are now common among the ten health systems that participated in our study, though some had only recently begun to use these pricing arrangements on a routine basis. Several health systems had used a wide variety of discounting schemes in the past two years. The most frequent discount received by participating health systems was between 20% and 29% of official list prices; however, six participants reported their health system received one or more discount over the past two years that was valued at 60% or more of the list prices. On average, participants reported that confidential discounts were more common, complex, and significant for specialty pharmaceuticals than for primary care pharmaceuticals. Participants had a more favorable view of the impact of confidential discount schemes on their health systems than on the global marketplace. Overall, the frequency, complexity, and scale of confidential discounts being routinely negotiated suggest that the list prices for medicines bear limited resemblance to what many institutional payers actually pay.

► **Self-medication Among People Living with Hypertension: A Review**

RAHMAWATI R. ET BAJOREK B. V.

2017

Fam Pract 34(2): 147-153

Self-medication is commonly practised by patients, underpinned by health beliefs that affect their adherence to medication regimens, and impacting on treatment outcomes. This review explores the scope of self-medication practices among people with hypertension, in terms of the scale of use, types of med-

ication and influencing factors. A comprehensive search of English language, peer-reviewed literature published between 2000 and 2014 was performed. This review highlights a high proportion of people with hypertension practise self-medication. Further studies are needed to assess the impact of self-medication with OTC and anti-hypertensive medications on hypertension treatment. Health professionals involved in hypertension management should be mindful of any types of self-medication practices.

► **Out-of-pocket Expenditures for Pharmaceuticals: Lessons from the Austrian Household Budget Survey**

SANWALD A. ET THEURL E.

2017

Eur J Health Econ 18(4): 435-447

Paying pharmaceuticals out of pocket is an important source of financing pharmaceutical consumption. Only limited empirical knowledge is available on the determinants of these expenditures. In this article we analyze which characteristics of private households influence out-of-pocket pharmaceutical expenditure (OOPPE) in Austria. We use cross-sectional information on OOPPE and household characteristics provided by the Austrian household budget survey 2009/10. We split pharmaceutical expenditures into the two components prescription fees and over-the-counter (OTC) expenditures. To adjust for the specific characteristics of the data, we compare different econometric approaches: a two-part model, hurdle model, generalized linear model and zero-inflated negative binomial regression model. The article gives useful insights into the determinants of pharmaceutical expenditures of private households and supplements the previous research that focuses on the individual level.

► **How Can Pricing and Reimbursement Policies Improve Affordable Access to Medicines? Lessons Learned from European Countries**

VOGLER S., *et al.*

2017

Appl Health Econ Health Policy 15(3): 307-321

This article discusses pharmaceutical pricing and reimbursement policies in European countries with regard to their ability to ensure affordable access to medicines. A frequently applied pricing policy is external price referencing. While it provides some benchmark for policy-makers and has been shown to be able to generate savings, it may also contribute to delay in product launch in countries where medicine prices are low. Value-based pricing has been proposed as a policy that promotes access while rewarding useful innovation; however, implementing it has proven quite challenging. For high-priced medicines, managed-entry agreements are increasingly used. These agreements allow policy-makers to manage uncertainty and obtain lower prices. They can also facilitate earlier market access in case of limited evidence about added therapeutic value of the medicine. However, these agreements raise transparency concerns due to the confidentiality clause. Tendering as used in the hospital and offpatent outpatient sectors has been proven to reduce medicine prices but it requires a robust framework and appropriate design with clear strategic goals in order to prevent shortages. These pricing and reimbursement policies are supplemented by the widespread use of Health Technology Assessment to inform decision-making, and by strategies to improve the uptake of generics, and also biosimilars. While European countries have been implementing a set of policy options, there is a lack of thorough impact assessments of several pricing and reimbursement policies on affordable access. Increased cooperation between authorities, experience sharing and improving transparency on price information, including the disclosure of confidential discounts, are opportunities to address current challenges.

► **The Role of Government Reimbursement in Drug Shortages**

YURUKOGLU A., *et al.*
2017/05

American Economic Review 9(2) : 348-382

Beginning in the mid-2000s, the incidence of drug shortages rose, especially for generic injectable drugs such as anesthetics and chemotherapy treatments. We examine whether reimbursement changes

contributed to the shortages, focusing on a reduction in Medicare Part B reimbursement to providers for drugs. We hypothesize that lower reimbursement put downward pressure on manufacturers' prices, which reduced manufacturers' incentives to invest in capacity, reliability, and new launches. We show that after the policy change, shortages rose more for drugs with higher shares of patients insured by Medicare, greater decreases in provider reimbursement, and greater decreases in manufacturer prices.

Méthodologie – Statistique

► **A Two-Step Method to Identify Positive Deviant Physician Organizations of Accountable Care Organizations with Robust Performance Management Systems**

PIMPERL A. F., *et al.*
2017

Health Serv Res. : Apr. 06

This aim of this paper is to identify positive deviant (PD) physician organizations of Accountable Care Organizations (ACOs) with robust performance management systems (PMSYS). The analysis is based on on third National Survey of Physician Organizations

(NSPO3, n = 1,398). Linear regression estimated the association of internal and contextual factors on PMSYS. Two cutpoints (75th/90th percentiles) identified PDs with the largest residuals and highest PMSYS scores. A total of 65 and 41 PDs were identified using 75th and 90th percentiles cutpoints, respectively. The 90th percentile more strongly differentiated PDs from non-PDs. Having a high proportion of vulnerable patients appears to constrain PMSYS development. Our PD identification method increases the likelihood that PD organizations selected for in-depth inquiry are high-performing organizations that exceed expectations.

Politique de santé

► **XXX^e congrès national Émois : livre des résumés présentés au congrès. Nancy, 23-24 mars 2017**

COLIN C., *et al.*
2017/03

Revue d'épidémiologie et de santé publique 65(Supplément 1): 42p

Ce numéro rassemble les résumés des communications présentées au 30^e congrès Émois. Ces communications portaient sur les thématiques suivantes : qualité des pratiques et sécurité des soins, PMSI, partage des données de santé, parcours de soins...

► **L'Obamacare : principes fondateurs et premiers résultats**

WITTEWER J.
2017

Revue Française des Affaires Sociales(1): 231-248
<http://www.cairn.info/revue-francaise-des-affaires-sociales-2017-1-page-231.htm>

Aux États-Unis, les principales mesures de l'Affordable Care Act (ACA), mieux connu en France sous le nom d'« Obamacare », sont entrées en vigueur au début de l'année 2014. Il est dès maintenant possible de tirer un bilan des premiers mois d'application de cette réforme ambitieuse. Après avoir dressé un ra-

pide constat du système de santé américain avant la réforme et rappelé les objectifs centraux de l'ACA, les principaux dispositifs de la réforme et leurs difficultés de mise en œuvre sont discutés. Dans un dernier temps sont détaillés les effets de l'ACA tels qu'ils commencent à être mesurés dans la littérature, en particulier les effets sur le taux de couverture par une assurance santé de la population américaine.

► **La diminution du soutien aux transferts universels en France : les conceptions du système de protection sociale ébranlées par la crise de 2008**

GRISLAIN-LETRÉMY C. ET PAPUCHON A.

2017

Revue Française des Affaires Sociales(1): 205-229

<http://www.cairn.info/revue-francaise-des-affaires-sociales-2017-1-page-205.htm>

En France, la crise économique de 2008 a nettement infléchi la façon dont les individus définissent les objectifs à assigner au système de protection sociale. Le Baromètre d'opinion de la direction de la recherche, des études, de l'évaluation et des statistiques (DREES) permet d'établir qu'en dépit de la dominante bismarckienne du système, les opinions d'obédience universaliste étaient nettement majoritaires en France dans la période 2004-2008. La crise a été suivie d'une baisse rapide du soutien à l'universalité des prestations sociales et d'un accroissement de l'appui au renforcement du caractère contributif des prestations sociales, alors que les difficultés économiques sont plutôt considérées comme un facteur poussant à soutenir l'extension du système de protection sociale. Ces tendances touchent l'ensemble des

classes d'âge, les femmes et les hommes, les cadres et les professions libérales comme les ouvriers. Elles montrent comment peuvent se reconfigurer les rapports aux politiques de protection sociale dans le contexte d'une brusque détérioration des perspectives économiques, et donc que leur analyse ne doit pas se cantonner à des comparaisons établies en un seul point du temps. La crise, en survenant dans un contexte d'austérité permanente, semble avoir sensiblement affecté la confiance dans la pérennité du système de protection sociale.

► **Principles for Health System Capacity Planning: Insights for Healthcare Leaders**

SHAW J., et al.

2017

Healthcare Quarterly 19(4): 17-22

Jurisdictions across Canada and around the world face the challenge of planning high-performing and sustainable health systems in response to growing healthcare demands. In this paper, we report on the process of developing principles for health system capacity planning by the Ministry of Health and Long-Term Care in Ontario. Integrating the results of a literature review on health system planning and a symposium with representatives from local health integration networks, we describe the following six principles in detail: (1) develop an aspirational vision, (2) establish clear leadership, (3) commit to stakeholder engagement, (4) engage patients and the public, (5) build analytics infrastructure and (6) revise policy when necessary..

Politique publique

► **L'indemnisation du chômage en France au regard des pratiques européennes**

DHONT-PELTRAULT E. ET MILCENT C.

2017

Economie & prévision 210(1): 137-146

<http://www.cairn.info/revue-economie-et-prevision-2017-1-page-137.htm>

La comparaison internationale des dispositifs publics de soutien financier en direction des demandeurs d'emploi repose sur la prise en compte de nombreux paramètres relatifs aux conditions d'indemnisation par l'assurance-chômage (accès, montant, durée, etc.) mais également aux caractéristiques du système de protection sociale et d'imposition. Dans le paysage européen, la France se caractérise par un taux de remplacement net des demandeurs d'emploi modéré

en moyenne, mais élevé pour de hauts niveaux de salaire antérieurs, avec une part prépondérante des allocations chômage et une faible prise en compte de la situation familiale des demandeurs d'emploi. Les

conditions d'indemnisation du chômage apparaissent également relativement accommodantes en France avec notamment une facilité d'accès à l'assurance chômage pour une durée relativement élevée.

Prévision – Évaluation

► A Literature-based Economic Evaluation of Healthcare Preventable Adverse Events in Europe

AGBABIKA T. B., *et al.*

2017

[Int J Qual Health Care 29\(1\): 9-18](#)

In this paper, we establish from the literature, cost of preventable adverse events (PAEs) to member states of the Joint Action European Union Network for Patient Safety and Quality of Care. We searched MEDLINE, EMBASE and CINAHL for studies in Europe estimating cost of adverse events (AEs) and PAEs (2000-March 2016). Using data from the literature, we estimated PAE costs based on national 2013 total health expenditure (THE) data reported by World

Health Organization and converted to 2015 Euros. Published estimates of costs of AEs and PAEs vary based on the care setting, methodology, population and year conducted. Only one study was from primary care, the majority were conducted in acute care. Nine studies estimated percentage of THE caused by AEs, 13 studies calculated attributable length of stay. We estimated the annual cost of PAEs to the 30 nations in 2015 to be in the range of 17-38 billion Euros, total DALYs lost from AEs as 3.5 million, of which 1.5 million DALYs were likely due to PAEs. To conclude, the economic burden of AEs and PAEs is substantial. However, whether patient safety interventions will be 'cost saving' depends on the effectiveness and costs of the interventions.

Psychiatrie

► L'avenir de la psychiatrie ne peut-il être que politique ? Le paradigme de Frantz Fanon

LEGRAND P.

2017

[Informations psychiatriques 93\(3\): 199-203](#)

http://www.jle.com/fr/revues/ipe/e-docs/lavenir_de_la_psychiatrie_ne_peut_il_etre_que_politique_le_paradigme_de_frantz_fanon_309446/article.phtml

La psychiatrie est née dans le sillage d'un des plus grands mouvements révolutionnaires de tous les temps, elle ne pourra échapper à sa réduction opératoire dans une technique de contrôle de l'humain qu'en se refondant par la philosophie politique. Cette affirmation est évidemment polémique et je voudrais l'appuyer sur deux expériences : d'une part celle des comités d'éthique, d'autre part celle du message de Frantz Fanon auquel on peut accéder par la publica-

tion récente de ses écrits psychiatriques. L'éthique des soins en psychiatrie est passée d'un modèle à l'autre : d'abord le modèle de l'accès à la citoyenneté du malade mental du geste pinelien, ensuite le modèle de la liberté du mouvement de desinstitutionnalisation des années 70 et puis le modèle actuel de la gestion des risques. Ces modèles éthiques contaminent la clinique et l'organisation des soins. De même, Frantz Fanon illustre que c'est de la clinique phénoménale quotidienne d'une pratique de terrain que le psychiatre met en évidence les processus d'aliénation de l'humain sans se perdre dans les particularismes culturels ou pire raciaux. Même si les mécanismes de l'aliénation d'aujourd'hui sont plus subtils que la brutalité de la colonisation (individualisme, acculturation, désafférentation, etc...), il importe que le clinicien fonde son action thérapeutique sur la désaliénation comme éthique de la liberté.

► **Depressed During the Depression: Has the Economic Crisis Affected Mental Health Inequalities in Europe? Findings from the European Social Survey (2014) Special Module on the Determinants of Health**

REIBLING N., *et al.*

2017

Eur J Public Health 27(suppl_1): 47-54

Economic crises constitute a shock to societies with potentially harmful effects to the mental health status of the population, including depressive symptoms, and existing health inequalities. With recent data from the European Social Survey (2006-14), this study investigates how the economic recession in Europe starting in 2007 has affected health inequalities in 21 European nations. Depressive feelings were measured with the CES-D eight-item depression scale. We tested for measurement invariance across different

socio-economic groups. Overall, depressive feelings have decreased between 2006 and 2014 except for Cyprus and Spain. Inequalities between persons whose household income depends mainly on public benefits and those who do not have decreased, while the development of depressive feelings was less favorable among the precariously employed and the inactive than among the persons employed with an unlimited work contract. There are no robust effects of the crisis measure on health inequalities. Negative implications for mental health (in terms of depressive feelings) have been limited to some of the most strongly affected countries, while in the majority of Europe persons have felt less depressed over the course of the recession. Health inequalities have persisted in most countries during this time with little influence of the recession. Particular attention should be paid to the mental health of the inactive and the precariously employed.

Soins de santé primaires

► **Selective Contracting and Channelling Patients to Preferred Providers: A Scoping Review**

BES R. E., *et al.*

2017

Health Policy 121(5): 504-514

Selective contracting by health insurers and channelling patients to contracted providers is crucial in a health care system based on managed competition, as this should lead to better value for money delivery of healthcare. However, an important consequence for enrolees is that health insurers interfere with their choice of care provider. This scoping review aims to find out what is known about selective contracting from the enrolee's perspective. Is it being done and how do enrolees feel about the role of their health insurer in their care provider choice? A literature search was conducted, and, in addition, experts were consulted for extra information and documents. Results show that selective contracting and channelling are practised in several countries. This is mostly through negative financial incentives, which are also found to be the most effective strategy. However, enrolees are very negative about restrictions on provider choice introduced by their insurer. This results in enrolees

feeling less satisfaction with, and trust in, care providers and health insurers. Choice is crucial in this respect since enrolees are more satisfied with their health plans and care providers when they have chosen them themselves. Future research should focus on the role of trust and how people weigh different attributes of health plans if selective contracting and channelling is to be implemented in a manner acceptable to enrolees.

► **The Impact of Alternative Payment in Chronically Ill and Older Patients in the Patient-centered Medical Home**

SALZBERG A. C., *et al.*

2017

Med Care 55(5): 483-492

Patient-centered medical home (PCMH) has gained prominence as a promising model to encourage improved primary care delivery. There is a paucity of studies that evaluate the impact of payment models in the PCMH. We sought to examine whether coupling coordinated, team-based care transformation plan with a novel reimbursement model affects outcomes

related to expenditures and utilization. Interrupted time-series model with a difference-in-differences approach to assess differences between intervention and control groups, across time periods attributable to PCMH transformation and/or payment change. We conclude that PCMH implementation coupled with an innovative payment arrangement generated mixed results with modest improvements with respect to pharmacy expenditures, but no overall financial improvement. However, we did see improvement within specific groups, especially older patients and those with chronic conditions.

► **The Effect of Medicaid Physician Fee Increases on Health Care Access, Utilization, and Expenditures**

CALLISON K. ET NGUYEN B. T.

2017

Health Serv Res. : Apr. 16

This paper evaluates the effect of Medicaid fee changes on health care access, utilization, and spending for Medicaid beneficiaries. It uses the 2008 and 2012 waves of the Medical Expenditure Panel Survey linked to state-level Medicaid-to-Medicare primary care reimbursement ratios obtained through surveys conducted by the Urban Institute. This study also incorporates data from the Current Population Survey and the Area Resource Files. Using a control group made up of the low-income privately insured, the authors conduct a difference-in-differences analysis to assess the relationship between Medicaid fee changes and access to care, utilization of health care services, and out-of-pocket medical expenditures for Medicaid enrollees. Compared to the low-income privately insured, increased primary care reimbursement for Medicaid beneficiaries leads to higher utilization and out-of-pocket spending for Medicaid enrollees.

► **Cooperation According to French Law “hospital, Patients, Health and Territories”: Pharmacists’ Involvement in Aquitaine Region**

D’ELBEE M., *et al.*

2017

Rev Epidemiol Sante Publique 65(3): 231-239

In 2009, the French Act “Hospital, Patients, Health and Territories” (loi “Hôpital, Patients, Santé et Territoires”) reorganized the outpatient care pathway and defined missions aimed at improving cooperation between pharmaceutical and medical professionals. Five years later, we conducted a survey among community pharmacists in order to assess the appropriation of these missions and the way cooperation was implemented. We also aimed to investigate factors that could hamper or ease the development of these activities in order to identify actions needed to improve pharmacists’ involvement. The findings of this survey underlined pharmacists’ acceptance of these missions and suggest that better information and appropriate remuneration could enhance commitment. Recent changes in the legal framework (establishment of “pharmaceutical fees”, extension of the scope of pharmaceutical interviews) enable funding for collaborative practices between medical practitioners and pharmacists, thus encouraging better coordination in the patient care pathway.

► **Does Enrollment in Multidisciplinary Team-based Primary Care Practice Improve Adherence to Guideline-recommended Processes of Care? Quebec’s Family Medicine Groups, 2002-2010**

DIOP M., *et al.*

2017

Health Policy 121(4): 378-388

We investigated whether multidisciplinary team-based primary care practice improves adherence to process of care guidelines, in the absence of financial incentives related to pay-for-performance. We conducted a natural experiment including 135,119 patients, enrolled with a general practitioner (GP) in a multidisciplinary team Family Medicine Group (FMG) or non-FMG practice, using longitudinal data from Quebec’s universal insurer over the relevant time period (2000-2010). All study subjects had diabetes,

chronic obstructive pulmonary disease, or heart failure and were followed over a 7-year period, 2 years prior to enrollment and 5 years after. We constructed indicators on adherence to disease-specific guidelines and composite indicators across conditions. We evaluated the effect of FMGs using propensity score methods and Difference-in-Differences (DD) models. Rates of adherence to chronic disease guidelines increased for both FMG and non-FMG patients after enrollment, but not differentially so. Adherence to prescription-related guidelines improved less for FMG patients (DD [95% CI]=-2.83% [-4.08%, -1.58%]). We found no evidence of an FMG effect on adherence to consultation-related guidelines, (DD [95% CI]=-0.24% [-2.24%; 1.75%]). We found no evidence that FMGs increased adherence to the guidelines we evaluated. Future research is needed to assess why this reform did not improve performance on these quality-of-care indicators.

► **Physician Associates in Primary Health Care in England: A Challenge to Professional Boundaries**

DRENNAN V. M., *et al.*

2017

Soc Sci Med 181: 9-16

Like other health care systems, the National Health Service (NHS) in England has looked to new staffing configurations faced with medical staff shortages and rising costs. One solution has been to employ physician associates (PAs). PAs are trained in the medical model to assess, diagnose and commence treatment under the supervision of a physician. This paper explores the perceived effects on professional boundaries and relationships of introducing this completely new professional group. It draws on data from a study, completed in 2014, which examined the contribution of PAs working in general practice. Data were gathered at macro, meso and micro levels of the health care system. Analysis was both inductive and also framed by the existing theories of a dynamic system of professions. It is argued that professional boundaries become malleable and subject to negotiation at the micro level of service delivery. Stratification within professional groups created differing responses between those working at macro, meso and micro levels of the system; from acceptance to hostility in the face of a new and potentially competing, occupational group. Overarching this state agency was the

requirement to underpin legislatively the shifts in jurisdictional boundaries, such as prescribing required for vertical substitution for some of the work of doctors.

► **Exploring the Differences in General Practitioner and Health Care Specialist Utilization According to Education, Occupation, Income and Social Networks Across Europe: Findings from the European Social Survey (2014) Special Module on the Social Determinants of Health**

FJAER E. L., *et al.*

2017

Eur J Public Health 27(suppl_1): 73-81

Low socioeconomic position (SEP) tends to be linked to higher use of general practitioners (GPs), while the use of health care specialists is more common in higher SEPs. Despite extensive literature in this area, previous studies have, however, only studied health care use by income or education. The aim of this study is, therefore, to examine inequalities in GP and health care specialist use by four social markers that may be linked to health care utilization (educational level, occupational status, level of financial strain and size and frequency of social networks) across 20 European countries and Israel. Logistic regression models were employed using data from the seventh round of the European Social Survey; this study focused upon people aged 25-75 years, across 21 countries. Health care utilization was measured according to self-reported use of GP or specialist care within 12 months. Analyses tested four social markers: income (financial strain), occupational status, education and social networks. We observed a cross-national tendency that countries with higher or equal probability of GP utilization by lower SEP groups had a more consistent probability of specialist use among high SEP groups. Moreover, countries with inequalities in GP use in favour of high SEP groups had comparable levels of inequalities in specialist care utilization.

► **Does Charging Different User Fees for Primary and Secondary Care Affect First-contacts with Primary Healthcare? A Systematic Review**

HONE T., *et al.*

2017

Health Policy Plan 32(5): 723-731

Policy-makers are increasingly considering charging users different fees between primary and secondary care (differential user charges) to encourage utilisation of primary health care in health systems with limited gate keeping. A systematic review was conducted to evaluate the impact of introducing differential user charges on service utilisation. We reviewed studies published in MEDLINE, EMBASE, the Cochrane library, EconLIT, HMIC, and WHO library databases from January 1990 until June 2015. Eight studies from six countries met our eligibility criteria. The overall study quality was low, with diversity in populations, interventions, settings, and methods. Five studies examined the introduction of or increase in user charges for secondary care, with four showing decreased secondary care utilisation, and three showing increased primary care utilisation. One study identified an increase in primary care utilisation after primary care user charges were reduced. The introduction of a non-referral charge in secondary care was associated with lower primary care utilisation in one study. One study compared user charges across insurance plans, associating higher charges in secondary care with higher utilisation in both primary and secondary care. Overall, the impact of introducing differential user-charges on primary care utilisation remains uncertain. Further research is required to understand their impact as a demand side intervention, including implications for health system costs and on utilisation among low-income patients.

► **Physicians' Responses to Financial and Social Incentives: A Medically Framed Real Effort Experiment**

LAGARDE M. ET BLAAUW D.

2017

Soc Sci Med 179: 147-159

Because compensation policies have critical implications for the provision of health care, and evidence of their effects is limited and difficult to study in the real world, laboratory experiments may be a valuable

methodology to study the behavioural responses of health care providers. With this experiment undertaken in 2013, we add to this new literature by designing a new medically framed real effort task to test the effects of different remuneration schemes in a multi-tasking context. We assess the impact of different incentives on the quantity (productivity) and quality of outputs of 132 participants. We also test whether the existence of benefits to patients influences effort. The results show that salary yields the lowest quantity of output, and fee-for-service the highest. By contrast, we find that the highest quality is achieved when participants are paid by salary, followed by capitation. We also find a lot of heterogeneity in behaviour, with intrinsically motivated individuals hardly sensitive to financial incentives. Finally, we find that when work quality benefits patients directly, subjects improve the quality of their output, while maintaining the same levels of productivity. This paper adds to a nascent literature by providing a new approach to studying remuneration schemes and modelling the medical decision making environment in the lab.

► **Work Motivation, Task Delegation and Job Satisfaction of General Practice Staff: A Cross-sectional Study**

RIISGAARD H., *et al.*

2017

Fam Pract 34(2): 188-193

Recent research has shown that a high degree of task delegation is associated with the practice staff's overall job satisfaction, and this association is important to explore since job satisfaction is related to medical as well as patient-perceived quality of care. This study aimed: (1) to investigate associations between degrees of task delegation in the management of chronic disease in general practice, with chronic obstructive pulmonary disease (COPD) as a case and the staff's work motivation, (2) to investigate associations between the work motivation of the staff and their job satisfaction. In the first analysis, we found that 'maximal degree' of task delegation was significantly associated with the staff perceiving themselves to have a large degree of variation in tasks, odds ratio (OR) = 4.26, confidence interval (CI) = 1.09, 16.62. In the second analysis, we found that this perceived large degree of variation in tasks was significantly associated with their overall job satisfaction, OR = 2.81, confidence interval = 1.71, 4.61. Conclusion: The results

suggest that general practitioners could delegate highly complex tasks in the management of COPD to their staff without influencing the staff's work motivation, and thereby their job satisfaction, negatively, as long as they ensure sufficient variation in the tasks.

► **High-Price and Low-Price Physician Practices Do Not Differ Significantly on Care Quality Or Efficiency**

ROBERTS E. T., *et al.*

2017

Health Aff (Millwood) 36(5): 855-864

Consolidation of physician practices has intensified concerns that providers with greater market power may be able to charge higher prices without having to deliver better care, compared to providers with less market power. Providers have argued that higher prices cover the costs of delivering higher-quality care. We examined the relationship between physician practice prices for outpatient services and practices' quality and efficiency of care. Using commercial claims data, we classified practices as being high- or low-price. We used national data from the Consumer Assessment of Healthcare Providers and Systems survey and linked claims for Medicare beneficiaries to compare high- and low-price practices in the same geographic area in terms of care quality, utilization, and spending. Compared with low-price practices, high-price practices were much larger and received 36 percent higher prices. Patients of high-price practices reported significantly higher scores on some measures of care coordination and management but did not differ meaningfully in their overall care ratings, other domains of patient experiences (includ-

ing physician ratings and access to care), receipt of preventive services, acute care use, or total Medicare spending. This suggests an overall weak relationship between practice prices and the quality and efficiency of care and calls into question claims that high-price providers deliver substantially higher-value care.

► **Establishing A Primary Care Performance Measurement Framework For Ontario**

WISSAM H.-A. ET BRIAN H.

2017

Healthcare Policy 12(3): 66-79

A systematic approach to Primary Care Performance Measurement is needed to provide useful information on a regular basis to inform planning, management and quality improvement at both the practice and system levels. Based on an environmental scan, a summit of primary care stakeholders and a stakeholder survey and supported by Measures and Technical Working Groups, the Ontario Primary Care Performance Measurement Steering Committee, representing 20 stakeholder organizations, identified system- and practice-level measurement priorities and related specific performance measures across nine domains of primary care performance. This initiative addressed measures' selection and technical specification. It did not include data collection. Lessons learned in Ontario can assist other jurisdictions developing frameworks for monitoring and reporting on primary care performance. Cross-country alignment could lead to a coordinated approach to measure and target areas for primary care performance improvement in Canada.

Systèmes de santé

► **Economic Incentives and Diagnostic Coding in A Public Health Care System**

ANTHUN K. S., *et al.*

2017

Int J Health Econ Manag 17(1): 83-101

We analysed the association between economic incentives and diagnostic coding practice in the

Norwegian public health care system. Data included 3,180,578 hospital discharges in Norway covering the period 1999-2008. For reimbursement purposes, all discharges are grouped in diagnosis-related groups (DRGs). We examined pairs of DRGs where the addition of one or more specific diagnoses places the patient in a complicated rather than an uncomplicated group, yielding higher reimbursement. The economic

incentive was measured as the potential gain in income by coding a patient as complicated, and we analysed the association between this gain and the share of complicated discharges within the DRG pairs. Using multilevel linear regression modelling, we estimated both differences between hospitals for each DRG pair and changes within hospitals for each DRG pair over time. Over the whole period, a one-DRG-point difference in price was associated with an increased share of complicated discharges of 14.2 (95 % confidence interval [CI] 11.2-17.2) percentage points. However, a one-DRG-point change in prices between years was only associated with a 0.4 (95 % CI [Formula: see text] to 1.8) percentage point change of discharges into the most complicated diagnostic category. Although there was a strong increase in complicated discharges over time, this was not as closely related to price changes as expected.

► **Le patient dans le système de santé**

BERTHOD-WURMSER M. C.

2017/03

Revue Française des Affaires Sociales (1): 203p

Ce dossier sur « Le patient et le système de santé » est structuré autour de trois axes de réflexion : la prise en compte de la personne qu'est le patient par les institutions et les professionnels de santé ; l'évolution des compétences, comportements, attitudes, attentes et obligations des patients ; la démocratie sanitaire et la place des usagers dans le fonctionnement du système de santé. Ces développements sont suivis de comparaisons internationales ainsi que d'un focus sur la politique britannique d'implication des patients et du public. Puis, la place des patients dans les parcours de prise en charge du cancer est évoquée. Enfin, une revue de littérature développe le thème de l'accès aux soins.

► **Productivity Growth in the English National Health Service from 1998/1999 to 2013/2014**

BOJKE C., *et al.*

2017

Health Econ 26(5): 547-565

Productivity growth is a key measure against which National Health Service (NHS) achievements are judged. We measure NHS productivity growth as a set of paired year-on-year comparisons from 1998/1999-1999/2000 through 2012/2013-2013/2014, which are converted into a chained index that summarises productivity growth over the entire period. Our measure is as comprehensive as data permit and accounts for the multitude of diverse outputs and inputs involved in the production process and for regular revisions to the data used to quantify outputs and inputs. Over the full-time period, NHS output increased by 88.96% and inputs by 81.58%, delivering overall total factor productivity growth of 4.07%. Productivity growth was negative during the first two terms of Blair's government, with average yearly growth rate of -1.01% per annum (pa) during the first term (to 2000/2001) and -1.49% pa during the second term (2000/2001-2004/2005). Productivity growth was positive under Blair's third term (2004/2005-2007/2008) at 1.41% pa and under the Brown government (2007/2008-2010/2011), averaging 1.13% pa. Productivity growth remained positive under the Coalition (2010/2011-2013/2014), averaging 1.56% pa.

► **La participation des usagers aux systèmes de santé. In : Le patient dans le système de santé**

BOUSQUET F.

2017/03

Revue Française des Affaires Sociales (1): 116-127

<https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-1-p-116.htm>

Sur le plan international, la reconnaissance des droits des citoyens, des usagers ou des patients à participer à l'élaboration des politiques, à leur mise en œuvre ou encore à l'organisation de l'offre de soins remonte à la fin des années 1970, lorsque l'Organisation mondiale de la santé (OMS) a formellement inscrit ces droits dans le document fondateur connu aujourd'hui sous le nom de Déclaration d'Alma-Ata en 1978. Cet article passe en revue les différents modèles de par-

participation des usagers dans les systèmes de santé à l'international

► **Inequality and the Health-care System in the USA**

DICKMAN S. L., et al.

2017

Lancet 389(10077): 1431-1441

Widening economic inequality in the USA has been accompanied by increasing disparities in health outcomes. The life expectancy of the wealthiest Americans now exceeds that of the poorest by 10-15 years. This report, part of a Series on health and inequality in the USA, focuses on how the health-care system, which could reduce income-based disparities in health, instead often exacerbates them. Other articles in this Series address population health inequalities, and the health effects of racism, mass incarceration, and the Affordable Care Act (ACA). Poor Americans have worse access to care than do wealthy Americans, partly because many remain uninsured despite coverage expansions since 2010 due to the ACA. For individuals with private insurance, rising premiums and cost sharing have undermined wage gains and driven many households into debt and even bankruptcy. Meanwhile, the share of health-care resources devoted to care of the wealthy has risen. Additional reforms that move forward, rather than backward, from the ACA are sorely needed to mitigate health and health-care inequalities and reduce the financial burdens of medical care borne by non-wealthy Americans.

► **Mesures de l'accès aux soins : l'apport d'enquêtes sur les pratiques et perceptions des patients. In : Le patient dans le système de santé**

NGUYEN-KHAC A.

2017/03

Revue Française des Affaires Sociales(1): 187-195
<https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-1-p-116.htm>

L'accès aux soins de la population constitue un enjeu incontournable des politiques de santé actuelles, notamment sous l'angle de la répartition des professionnels de santé sur le territoire. Après une définition des indicateurs usuels de l'accès aux soins (distance, délais en se basant sur une revue de la littérature, d'attente, renoncement aux soins...), cet article étudie les apports d'enquêtes sur les pratiques et perception des patients.

► **The Value of Qualitative Description in Health Services and Policy Research**

ROGER C.

2017

Healthcare Policy 12(3): 12-18

Health services and policy (HSP) researchers have long used qualitative research methodologies to explore health system issues. However, the appropriateness of one approach, qualitative description, for HSP research is still often overlooked. In this article, I discuss the role that qualitative description can play in HSP research, and argue for its greater acceptance as a valid form of academic scholarship.

Travail et santé

► **The Long-Term Effects of Cancer on Employment and Earnings**

JEON S. H.

2017

Health Econ 26(5): 671-684

The study examines long-term effects of cancer on the work status and annual earnings of cancer survivors who had a strong attachment to the labor market prior to their cancer diagnosis. We use linkage data

combining Canadian 1991 Census microdata with administrative records from the Canadian Cancer Registry, the Vital Statistics Registry and longitudinal personal income tax records. We estimate changes in the magnitude of cancer effects during the first 3 years following the year of the diagnosis using a large sample of cancer survivors diagnosed at ages 25 to 61. The comparison group consists of similar workers never diagnosed with cancer. The empirical strategy combines coarsened exact matching and regression

models to deal with observed and unobserved differences between the cancer and comparison groups. The results show moderate negative cancer effects on work status and annual earnings. Over the 3-year period following the year of the diagnosis, the probability of working is 5 percentage points lower for cancer survivors than for the comparison group, and their earnings are 10% lower. Our findings also suggest that the effects of cancer on labor market outcomes differ for high and low survival rate cancer categories.

► **Introduction of A National Minimum Wage Reduced Depressive Symptoms in Low-Wage Workers: A Quasi-Natural Experiment in the UK**

REEVES A., *et al.*

2017

Health Econ 26(5): 639-655

Does increasing incomes improve health? In 1999, the UK government implemented minimum wage legislation, increasing hourly wages to at least pound 3.60. This policy experiment created intervention and control groups that can be used to assess the effects of increasing wages on health. Longitudinal data were taken from the British Household Panel Survey. We compared the health effects of higher wages on recipients of the minimum wage with otherwise similar persons who were likely unaffected because (1) their wages were between 100 and 110% of the eligibility threshold or (2) their firms did not increase wages to meet the threshold. We assessed the probability of mental ill health using the 12-item General Health Questionnaire. We also assessed changes in smoking, blood pressure, as well as hearing ability (control condition). The intervention group, whose wages rose above the minimum wage, experienced lower probability of mental ill health compared with both control group 1 and control group 2. This improvement represents 0.37 of a standard deviation, comparable with the effect of antidepressants (0.39 of a standard deviation) on depressive symptoms. The intervention group experienced no change in blood pressure, hearing ability, or smoking. Increasing wages significantly improves mental health by reducing financial strain in low-wage workers.

► **Employment and Income Losses Among Cancer Survivors: Estimates from A National Longitudinal Survey of American Families**

ZAJACOVA A., *et al.*

2015

Cancer 121(24): 4425-4432

Cancer presents a substantial hardship for patients and their families in multiple domains beyond health and survival. Relatively little is known about the economic impact of cancer. The authors present estimates of the aggregate effects of a cancer diagnosis on employment and income in a prospective, nationally representative sample of US adults. The authors used data from the 1990 through 2009 waves of the Panel Study of Income Dynamics, a nationally representative, prospective, population-based observational study with high-quality individual and family-level economic information. Significant effects of cancer on all 4 outcomes were observed. The probability of a cancer patient being employed dropped by almost 10 percentage points, and hours worked declined by up to 200 hours in the first year after diagnosis. Annual labor-market earnings dropped almost 40% within 2 years after diagnosis and remained low, whereas total family income declined by 20%, although it recovered within 4 years after the diagnosis. These economic impacts on survivors were driven by effects among men; the effects among women largely were not statistically significant. A cancer diagnosis has substantial effects on the economic well-being of affected adults and their families. With the increasing number of cancer survivors in the US population, there is a growing need for examining the long-term implications for economic well-being and ways to mitigate the economic hardship associated with cancer.

Vieillessement

► **Measuring Active and Healthy Ageing in Europe**

AAIDE A., *et al.*

2017

Journal of European Social Policy 27(2): 138-157
<http://ejournals.ebsco.com/direct.asp?ArticleID=4001A731285F48C9D753>

The active and healthy ageing measure reported here is calculated for the 28 European Union countries, with a specific focus on the current generation of older people and by using the latest data from multiple surveys. It covers diverse aspects of active and healthy ageing, by measuring older people's contribution with respect to not just employment but also their unpaid familial, social and cultural contributions and their independent, healthy and secure living. The article presents the first-of-its-kind quantitative measure of active and healthy ageing in the literature on active and healthy ageing which hitherto has focused largely on concepts, definitions and public policy strategies. In this pursuit, an important contribution of this measure, referred to as the Active Ageing Index ('AAI'), is that it also captures how countries differ with respect to capacity and enabling environments for active and healthy ageing.

► **Characteristics, Diseases and Mortality of People Admitted to Nursing Homes for Dependent Seniors During the First Quarter of 2013 in France**

ATRAMONT A., *et al.*

2017

Rev Epidemiol Sante Publique 65(3): 221-230

The aim of this paper is to describe the state of health, through healthcare consumption and mortality, of people admitted to nursing homes (Ehpad) in France. People over the age of 65 years admitted to an Ehpad institution during the first quarter of 2013, beneficiaries of the national health insurance general scheme (69% of the population of this age), were identified from the Resid-Ehpad database and their reimbursed health care was extracted from the SNIIRAM database, identifying 56 disease groups by means of algorithms (long-term disease diagnoses and hospitalisations, medicinal products, specific procedures).

Disease prevalences were compared to those of other beneficiaries by age- and sex-standardized morbidity/mortality ratios (SMR).

► **Let's Put the Pieces Together: Frailty, Social Vulnerability, the Continuum of Care, Prevention and Research Are Key Considerations for A Dementia Care Strategy**

MELISSA K. A.

2016

HealthcarePapers 16(2): 34-39

Improving dementia care in Canada is a challenge to which we must rise. Dementia care strategies with a strong community focus are a key means of doing so. This paper outlines and expands upon the following five core areas that will contribute to the success of dementia care strategies: 1) the relationship between frailty and dementia is critical to understanding and addressing dementia risk and management; 2) social circumstances are important to formally consider, both as risk factors for adverse outcomes and as practical factors that contribute to care and support planning; 3) a dementia care strategy must span the continuum of care, which has important ramifications for our systems of primary, acute and long-term care; 4) prevention and public education are essential components of dementia care strategies; 5) research and evaluation are critically important to any dementia care strategy, and must be seen as core components as we strive to learn what works in dementia care. Given that a coordinated effort is needed, Canada needs to join other countries that have recognized dementia as a momentous challenge to national and global health. The time for a comprehensive national dementia care strategy is now.

► **Interventions to Prevent Or Reduce the Level of Frailty in Community-dwelling Older Adults: A Protocol for A Scoping Review of the Literature and International Policies**

PUTS M. T., *et al.*

2016

BMJ Open 6(3): e010959

With ageing comes increased vulnerability such that older adults' ability to recover from acute illnesses, fall-related injuries and other stresses related to the physical ageing processes declines. This increased vulnerability, also known as frailty, is common in older adults and associated with increased healthcare service use and adverse health outcomes. Currently, there is no overview of available interventions to prevent or reduce the level of frailty (as defined by study's authors) which will help healthcare providers in community settings caring for older adults. We will address this gap by reviewing interventions and international policies that are designed to prevent or reduce the level of frailty in community-dwelling older adults. We will conduct a scoping review using the updated guidelines of Arksey and O'Malley to systematically search the peer-reviewed journal articles to identify interventions that aimed to prevent or reduce the level of frailty. We will search grey literature for international policies. The 6-stage scoping review model involves: (1) identifying the research question; (2) identifying relevant studies; (3) selecting studies; (4) charting the data; (5) collating, summarising and reporting the results and (6) consulting with key stakeholders. Our review will identify gaps in research and provide healthcare providers and policymakers with an overview of interventions that can be implemented to prevent or postpone frailty.

► **Without Empowered Patients, Caregivers and Providers, A Community-Based Dementia Care Strategy Will Remain Just That**

SAMIR K. S.

2016

HealthcarePapers 16(2): 64-70

In trying to cope with the needs of the growing number of people living with dementia (PLWD), jurisdictions around the world have been implementing a variety of strategies, policies and programs to enable better

access to the supports they and those who care for them require. Despite considerable efforts that have been undertaken, PLWD and their caregivers still face considerable challenges in pursuing care pathways and community-based supports that can help them avoid premature institutionalization. Morton-Chang *et al.* (2016) have comprehensively reviewed jurisdictional approaches towards the development of dementia strategies, policies and programs; there is a growing understanding and consensus around the things we need to do as societies to better meet the needs of PLWD and their caregivers; however, progress to date could be best characterized as top-down, patchy and fragmented. This paper builds on Morton-Chang *et al.*'s (2016) assertion that the development of a comprehensive person and caregiver-centred community-based dementia strategy in Ontario and other parts of Canada is likely achievable, particularly if implemented using a "ground-up" approach that is well-aligned with other government-related initiatives.

► **Effectiveness of An Intervention to Prevent Frailty in Pre-frail Community-dwelling Older People Consulting in Primary Care: A Randomised Controlled Trial**

SERRA-PRAT M., *et al.*

2017

Age Ageing [Epub ahead of print]

Evidence on the effectiveness of interventions to prevent frailty is scarce. The aim of this study is to assess the effect of an intervention in preventing frailty progression in pre-frail older people. A randomised, open label, controlled trial with two parallel arms is conducted among a community-dwelling pre-frail older people (≥ 70 years) consulting in primary care, with a nutritional assessment (and derivation to a Nutritional Unit for usual care in the event of nutritional risk) and a physical activity programme including aerobic exercise and a set of mixed strengthening, balance and coordination exercises. To conclude, an intervention focused on physical exercise and maintaining good nutritional status may be effective in preventing frailty in community-dwelling pre-frail older individuals.

► **Informal Care in Europe: Findings from the European Social Survey (2014) Special Module on the Social Determinants of Health**

VERBAKEL E., *et al.*

2017

Eur J Public Health 27(suppl_1): 90-95

Against the background of a rising demand for informal care in European societies, this study sets out to provide descriptive information by gender on (i) prevalence rates of (intensive) informal caregiving, (ii) characteristics of (intensive) informal caregivers and (iii) consequences of (intensive) informal caregiving in terms of mental well-being. Data from the European Social Survey, Round 7 were analysed with multilevel (logistic) regression techniques ($n = 28\,406$ respondents in $n = 20$ countries). Our results suggest support for both crowding-in and crowding-out effects of the welfare state. Middle-aged women may become increasingly time squeezed as they are likely to be the first to respond to higher demands for informal care, while they are also the major target groups in employment policies aiming for increased labour market participation. Caregivers, and especially female and intensive caregivers, report lower levels of mental well-being. Supportive policies such as respite care or training and counselling may therefore be needed in order to sustain informal care as an important resource of our health care systems.