2017 International Health Policy Conference

16th – 19th February 2017
London School of Economics & Political Science
Houghton Street, London, WC2A 2AE
Conference dinner

Date and time:
Saturday 18 February 2017, 19:30 – 23:00.

Programme:
Drinks reception begins at 19.30, followed by hot buffet dinner.

Location:
The Royal College of Surgeons, 35–43 Lincoln’s Inn Fields, London WC2A 3PE (see map).

Transport and directions:
Please make your own way to the conference dinner venue. The venue is walking distance from LSE.
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<td>THURSDAY 16 FEBRUARY</td>
<td>WELCOME AND DRINKS RECEPTION</td>
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<td>11.15</td>
<td>FRIDAY 17 FEBRUARY</td>
<td>PLENARY: Keynote speaker: VARUN GAURI The right to health (Chair: Martin Knapp)</td>
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<td>12.15</td>
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<td>Trygve Ottersen, Justin Parkhurst</td>
<td>Giula Schneider, Stefanie Ettelt</td>
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<td>Richard Scheffer, Daniel Lungu</td>
<td>Jessica Spagnolo, Ulrika Wrintz, Ya-Ming Liu, Kenneth Shaad, Felix Gottschalk</td>
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<td>Antonio Duran, Kaisa Tynkkynen</td>
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<td>16.30</td>
<td>SESSION 4</td>
<td>Alex Waddan, Margherita Giannon</td>
<td>Patios Kasteridis, Lorraine Oliveira, Diana Beatriz Bayani, Nori Pace</td>
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<td>Scott Greer, Nadine Rebling</td>
<td>Henri Salikangas, Samantha Murray, Joseph Kamara, Matthew Quaife</td>
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<td>Isabel Perera, Michael Woods, Giovanni Fattore, Adam Oliver</td>
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<td>19.30</td>
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<td>Keynote speaker: AARON KESSELHEIM Regulation &amp; innovation in the health care product</td>
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<td>Maria Airoldi, James Lopez Bernal, Maximilian Salcher, Camilla Olsen</td>
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* LG.01 = Wolfson Lecture Theatre, LG.03 = Thai Lecture Theatre, LG.08 = Sheikh Zayed Lecture Theatre, LG.09 = Alumni Lecture Theatre
THE RIGHT TO HEALTH

Dr Gauri’s current research addresses three themes: how to use behavioural insights to enhance development policy, when public agencies comply with human rights orders, and why individuals support public goods.

He was Co-Director of the World Development Report 2015: Mind, Society, and Behavior. He serves on the editorial boards of the journals Behavioral Public Policy and Health and Human Rights, the World Economic Forum Council on Behavior, the Advisory Board of Academics Stand Against Poverty and is a member of the RSA (London). In addition to over 40 articles and book chapters, he has published the books Courting Social Justice: The Judicial Enforcement of Social and Economics Rights in the Developing World School and School Choice in Chile. His work has been covered in many media outlets, including The New York Times, The Economist, The Washington Post and The Hindu.

He has BA from the University of Chicago and a PhD from Princeton University and Washington outlets, including The New York Times, The Economist, The Washington Post and The Hindu.

He has BA from the University of Chicago and a PhD from Princeton University and has held positions as Visiting Lecturer in Public and International Affairs at Princeton University and Visiting Professor in the Department of Economics at ILIDES in Santiago, Chile.

REGULATION AND INNOVATION IN THE HEALTH CARE PRODUCT MARKET: THE PAST, PRESENT AND FUTURE

Professor Kesselheim’s research focuses on the effects of intellectual property laws and regulatory policies on pharmaceutical development, the drug approval process, and the costs, availability and use of prescription drugs both domestically and in resource-poor settings. He has also investigated how other issues at the intersection of law and public health can affect the health care system, including health care fraud, expert testimony in malpractice cases, and insurance reimbursement practices.

He is a faculty member in the Division of Pharmacoepidemiology and Pharmacoeconomics in the Department of Medicine at Brigham and Women’s Hospital. He graduated from Harvard College and received his postgraduate training at the University of Pennsylvania School of Medicine and Law School and, most recently, at the Harvard School of Public Health. He is Board Certified in Internal Medicine and serves as a primary care physician at the Phyllis Jen Center for Primary Care at BWH. He is a member of the New York State Bar and is a Patent Attorney.

AARON KESSELHEIM
Associate Professor of Medicine, Brigham and Women’s Hospital/ Harvard Medical School and Director, Program On Regulation, Therapeutics, And Law (PORTAL)

VARUN GAURI
Head of the Global Insights Initiative (GNI) and Senior Economist, Development Research Group, World Bank

SYMPOSIUM 1
FRIDAY
17 FEBRUARY
14:30
The politics, ethics and law of a ‘sustainable’ National Health Service
TED SCHRECKER
Interrogating scarcity and the politics of NHS ‘reform’

LUCY FRITH
The ethics of sustainability

ALLYSON POLLOCK
The pernicious politics of ‘sustainability’

SYMPOSIUM 2
SATURDAY
18 FEBRUARY
9:30
International actors’ policy influence: case studies on abortion and family planning policy in sub-Saharan Africa
KATHERINE Y. STORENG
Working “behind the scenes”: international NGOs’ role in the global-national transfer of safe abortion policy

JENNIFER PALMER
Managing reproductive sensitivities to ‘deliver’ a new nation in South Sudan

MAREN OLENE KLOSTER
A struggle for legitimacy – liberalizing the abortion law in Malawi

SYMPOSIUM 3
SATURDAY
18 FEBRUARY
10:50
Health systems and abortion care in low- and middle-income countries
EMILY FREEMAN
Understanding conscientious objection to abortion in Zambia

ERENSTINA COAST AND TAMARA FETTERS
Adolescent access to abortion services in sub-Saharan Africa

GIULIA GRECO
The economic burden on households of safe and unsafe abortion in Madhya Pradesh, India

ANN MOORE, RAGNAR ANDERSON AND MARIE DIENIS
Accessing and using abortion services: a comparison of India and Zambia

SYMPOSIUM 4
SATURDAY
18 FEBRUARY
12:00
Economics of long-term care
RAPHAEL WITTENBERG
Funding long-term care services, now and in the future

JULIEN FORGER
Quality and outcomes in long-term care: a production function approach

JOSE-LUIS FERNANDEZ, ALISTAIR MCGUIRE AND MARIA RAIKOU
Coordination failures between health and social care services: evidence from English hospital discharges

SYMPOSIUM 5
SATURDAY
18 FEBRUARY
14:00
Behavioural experiments in health
MATTEO M. GALIZZI
Temporal stability, cross-validity and external validity of risk preferences measures: experimental evidence from a UK representative sample

MYLEN LAGARDE
Carrots, sticks or competition? An experiment on incentives to improve quality in healthcare

SEVERINE TOUSSAERT
You’ve got a friend: evaluating mobile-based peer mentoring for smoking cessation

SYMPOSIUM 6
SATURDAY
18 FEBRUARY
15:10
Medical marijuana legislation, opioid policies and the opioid abuse epidemic in the United States
AMANDA J. ABRAHAM
Medical marijuana legislation and treatment for opioid use disorders

ASHLEY BRADFORD
Medical marijuana legalization and prescription medication use in Medicaid

GRACE BAGWELL ADAMS
The effect of medical marijuana legalization on opioid overdose deaths
SESSION 1
LAURALynn
The coverage cube and its many permutations: how can it promote fair progress toward universal health coverage?

JUSTIN PARKHURST
Governance implications of the drive for effectiveness: political reflections on global health efforts to improve capacity to use evidence in health policymaking

SESSION 2
RICHARD SCHEFFLER
The need and demand for health workers for improved health systems performance to reach SDG 3

DANIEL LUNGU
Rewarding managers or providers: What drives performance in the healthcare sector? Evidence from two Italian regions

SESSION 3
ANTONIO DURAN
Grapping with public hospital governance in 21st Century Europe: incrementalism, ideology and the pressure for Institutional Innovation

LIINA-KAISA TYNKKYNEN
The role of country specific contextual factors in the development of Voluntary Private Health Insurance in the Nordic countries

SESSION 4
ALEX WADDAN
Escaping the past? The problems of implementing health care reform in the US

MARGHERITA GIANNONI
Financial problems and health disparities in Europe

SESSION 5
SCOTT GREER
Claiming authority over health care in Germany, the United Kingdom and the USA

NADINE REBLING
How many worlds of healthcare? A new healthcare system classification of 30 OECD countries

SESSION 6
ANA CRISTINA CASTRO
Care Quality Commission (CQC) inspections reduce adverse events on acute hospitals with poor performance: interrupted time series analysis

KATHLEEN CAREY
Do ambulatory surgery centers reap the advantages of specialization?

SESSION 7
GWYN BEVAN
Reputations count: why benchmarking performance is improving health care across the world

MINAISHI RAJ
Assessing the landscape: provider and consumer perspectives on quality of care in India

SESSION 8
VIOLA BURA
How to make radical decisions in health policy: moving beyond DRGs in Denmark

TANJA KLEINK
What is the performance of performance management in health care? A meta-analysis of existing studies

SESSION 9
ELLEN MCRORIE
How do targets set by global actors influence national-level priority setting and resource allocation? Findings from a qualitative study in Ghana and Uganda

HONGQIAO FU
An evaluation of systemic reforms of public hospitals: the Sanming model in China

SESSION 10
DANIELLE CATTLE
Value-based payments in healthcare: key features and fundamental design issues

MIRELLA CACACE
Managed care in the social health insurance systems of Central and Eastern European countries

SESSION 11
JEAN-LOUIS DENIS
Transformative capacities of health systems: a research program on health reforms in Canada

RICHARD COOKSON
Primary care and health inequality: natural experiment comparing England and Ontario

SESSION 12
STEFANO NERI
The Italian NHS under transformation: is a policy drift taking place?

CAROLYN TUOHY
Domains of choice: the high politics of scale and pace in health care reform
SESSION 1
DAVID MCDaid
Facilitating implementation of effective approaches to promoting mental health and preventing mental illness across the OECD

SESSION 2
JESSICA SPAGNOLO
Building mental health capacity in Tunisia by training general practitioners: preliminary results

SESSION 3
MORGANE MICHEL
Mental illnesses and somatic comorbidities: delayed medical care and associated severity

SESSION 4
PANOS KASTERIDIS
Does pay-for-performance influence outcomes for people with serious mental illness: analysis of linked longitudinal primary and secondary care data in England

SESSION 5
HENRI SALOKANGAS
Finnish evidence from World War II

SESSION 6
ISABEL PERERA
Organising psychiatry: state, labor and the politics of a policy transformation

SESSION 7
AUSTIN WARTERS
Integration of health and social care for children with complex health conditions: policy and organisational challenges across Europe

SESSION 8
LOUISE THERESA BOUIC

SESSION 9
HARA AIROLI
Improving policy in dementia care: met and unmet needs

SESSION 10
MARA AIROLI
Improving policy in dementia care: met and unmet needs

SESSION 11
HARA AIROLI
Improving policy in dementia care: met and unmet needs

SESSION 12
AMÉLIE PRIGENT
Socio-demographic, clinical characteristics and utilization of mental health care services associated with SF-6D utility scores in patients with mental disorders – contributions of the quartile regression

SESSION 13
GIULIA SCHNEIDER
A regulatory transparency challenge: can commercial confidentiality in clinical trials be overcome?

SESSION 2
YA-MING LIU
Price and utilization of new drugs under a single public payer system: evidence from Taiwan

SESSION 3
ARIS ANGELIS
Multiple Criteria Decision Analysis (MCDA) for evaluating new medicines in HTA and beyond: the Advance Value Framework

SESSION 4
DIANA BEATRIZ BAYANI
Establishing a health technology assessment institution in a low-middle income country: lessons learned from the Philippines

SESSION 5
IBTEHAL ATTAELMANAN
The development and diffusion of surgical frugal innovations – lessons for the NHS

SESSION 6
MICHAEL CALNN
Still elegantly muddling through? NICE and the management of uncertainty in decision making about the rationing of expensive medicines in England

SESSION 7
KATERINA CHEPNYOGA
Drivers of unfavourable medication for chronic noncommunicable diseases in low- and lower-middle income countries: procurement price, retail price or both?

SESSION 8
MARCELL CSANÁDI
The HTA office in Hungary: how much does it matter?

SESSION 9
MIRCELA CSANÁDI
The HTA office in Hungary: how much does it matter?

SESSION 10
MICHAEL GUSMANO
The political economy of Health Technology Assessment in the US

SESSION 11
MAXIMILIAN SALCHER
Avoidable costs of stenting for acute coarctation in the United Kingdom: an economic model

SESSION 12
JOANA VILAD
The institutionalisation of Health Technology Assessment in two middle-income countries: Thailand and the Philippines

SESSION 13
CAROLINE CLARKE
Treatment duration and cost-effectiveness: is more always better?
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<td>Ascertain user preferences for delivery of health: a mixed methods study on allergic laryngitis services in the West Midlands</td>
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<td>ELEANOR MACKILLOP</td>
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<td>Quantifying life: understanding the historical emergence of Quality-Adjusted Life-Years (QALYs)</td>
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<td>An empirical test of inequality aversion towards income and health</td>
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<td>YANIV HANOCH</td>
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<td>Using choice architecture to improve health insurance decisions: experimental evidence from two studies with large US samples</td>
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<td>CAMILLA FABBRI</td>
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<td>Information and the demand for preventative healthcare: an RCT of improving household perceptions on the efficacy of immunisation in Uttar Pradesh, India</td>
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<td>The effect of HIV prevention products on incentives to supply unprotected commercial sex in South Africa: exploring the stated preferences of female sex workers</td>
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<td>Did removing user fees improve access to maternal health care in Zambia? A difference-in-difference study</td>
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<td>What factors impact on patient access and engagement with clubfoot treatment in low and middle-income countries?: a meta-synthesis of existing qualitative studies using a social ecological model</td>
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<td>HASSAN HAGHPARAST-BIGDOLI</td>
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<td>Impact of a diagonal intervention on utilization of sexual reproductive health among the most vulnerable female sex workers in India, Kenya, Mozambique and South Africa</td>
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<td>Evaluating the effectiveness of conditional cash transfer programme on child health: evidence from the Philippines</td>
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<td>HARINI SWAPINATHAN</td>
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<td>PETER BAKER</td>
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<td>Econometric analysis of the macroeconomic determinants of inequalities in infant mortality rates in low and middle-income countries from 1990-2013</td>
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<td>Implications of resource allocation on live births in public hospitals: a production frontier approach</td>
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<td>SOFIA SVERES</td>
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<td>Socioeconomic distribution of primary care utilisation – results before and after Swedish patient choice reforms</td>
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<td>Disparities in avoidable mortality by demographic and socioeconomic characteristics: a longitudinal study of over one million individuals</td>
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<td>YUBRAJ ACHARYA</td>
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<td>Barriers to inter-ethnic interactions in healthcare: evidence from a field experiment</td>
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<td>Ethnicity, displacement and quality of prenatal care in post-conflict Kosovo</td>
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<td>The patients behind national cancer experience scores: ‘Understanding patients’ differing priorities for cancer care improvement through population segmentation</td>
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<td>Death amenable to health care: converging trends in the EU?</td>
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<td>KANGHYOOL KHOH</td>
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<td>Crowding out effects of an old-age pension programme on intergenerational transfers: evidence from South Korea</td>
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<td>RANJEETA THOMAS</td>
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<td>Richer but poorer in health? The income gradient in chronic conditions: new evidence from South Africa</td>
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<td>CHARITIN STAVROPOULOU</td>
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<td>Unemployment and health effects of the Greek economic crisis: empirical analysis of total and cause-specific mortality</td>
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<td>NISHA HAZRA</td>
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<td>Is longer life really related to higher health care costs? Cohort study using electronic health records in the UK</td>
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<td>DANILO ROLAND</td>
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<td>A longitudinal view on the effects of ADHD on life outcomes – evidence from the UK</td>
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<td>ANJA HOHMANN</td>
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<td>Regional differences in diagnoses for long-term absence from work in Germany</td>
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<td>BENEDETTA PONGIGLIONE</td>
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<td>Valuing direct, indirect and adverse effects from vaccination: results from a discrete choice experiment</td>
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LSE Health and Social Care was established as a research centre in 2000, when two existing research groups, which had been very successful in their own right, were brought together under its umbrella: LSE Health and the Personal Social Services Research Unit (PSSRU). Both of these groups were established at the London School of Economics and Political Science (LSE) in the 1980s; LSE Health in 1993 and PSSRU in 1996.

Since then, LSE Health and Social Care has developed significantly, now incorporating both the European Observatory on Health Systems and Policies and the NIHR School for Social Care Research (SSCR).

PSSRU

The Personal Social Services Research Unit is the foremost social care and mental health economics research group in the UK and one of the leading such groups internationally. Its mission is to conduct high-quality policy analysis, evaluation, research and consultancy to inform and influence policy, practice and theory.

PSSRU’s methodological expertise includes a focus on economics, and it has substantial expertise in economic evaluations of services across a number of themes. Its impact has been widely recognised and it is regularly commended for its ‘exceptional track record in adult social care research’ and ‘significant and it is regularly commended for its impact has been widely recognised for its economic evaluations of services across a number of themes. Its impact has been widely recognised and it is regularly commended for its ‘exceptional track record in adult social care research’ and ‘significant contribution to strengthening the evidence-base for policymaking in key areas’.

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SSCR

The NIHR School for Social Care Research was set up in 2009 to develop the evidence base for adult social care practice in England by commissioning and conducting high-quality research, and received renewed funding in 2014.

Funded by the UK National Institute for Health Research, SSCR is a partnership between the London School of Economics and Political Science, and the Universities of Bristol, Kent, Manchester and York.

The School has commissioned 117 studies with over 260 Fellows funded through its grants. As part of its mission, SSCR is exploring ways to increase research capacity in the sector, as well as ways in which practitioners and researchers can better work together.

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LSE Health

Affiliated with the Departments of Social Policy, Management and Accounting, LSE Health’s unique research base contributes to the LSE’s established reputation in health policy, health economics and demography.

The Centre’s work brings together diverse disciplinary perspectives and cutting edge methods to tackle current and future challenges to health care in the UK, Europe and beyond.

The Centre is a founding member of the European Observatory on Health Systems and Policies, a WHO commission and the World Bank. The Observatory supports evidence-based policy-making via analysis of health systems across Europe.

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POSTER PRESENTATIONS

IHP CONFERENCE 2017

Posters will be displayed on the Lower Ground Floor of the New Academic Building on Friday and Saturday. Presenters will be on hand to give informal presentations of their posters during coffee and lunch breaks. A list of the posters displayed on each day is provided below.

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<td>Martin</td>
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<td>Small Family, Healthy Family, Healthy Economy</td>
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<td>Pantee RAND Graduate School</td>
<td>Factors influencing financial risk protection for universal health coverage in sub-Saharan Africa</td>
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<td>Evaluation of community-led sanitation to promote open defecation free villages and improve hygiene and sanitation practices in Odisha, India</td>
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**SATURDAY**

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Yubraj ACHARYA

**Barriers to inter-ethnic interactions in healthcare: evidence from a field experiment**

Outreach workers are used in many countries to improve access to health services, particularly for minority groups. The difference in ethnicity of an outreach worker and that of a prospective patient can limit the success of such efforts, as outreach workers may find it difficult to interact with individuals from a different ethnicity. Using a field experiment in Nepal, we document the extent of this problem and investigate if differential incentives can help overcome it. We varied the amount of financial incentives provided to health outreach workers by the ethnicity of the client they recruited for a free sugar-level assessment, and the amount the clients received for appearing for the assessment. We find that the barriers due to ethnicity are high. Even a highly differential incentive in the ratio of 5:2, geared toward encouraging a cross-ethnic interaction, is insufficient to offset the barriers. In sub-group analysis, we find suggestive evidence that differential incentives to traditionally advantaged outreach workers have the potential to improve access for disadvantaged groups. We also find that the disadvantaged health workers face a “stereotype threat”. Financial incentives to the clients had no effect on their decision to appear for the assessment.

Mara AIROLDI (Chiara De Polli, Jan Oyebode, Richard Glover)

**Improving policy in dementia care: met and unmet needs**

There is an extensive and growing literature on effective and cost-effective interventions in dementia care. For England, there has also been a clear national strategy for dementia care since 2009, a revised strategy in preparation, a care pathway disseminated by the National Institute for Health and Clinical Excellence. Yet despite this evidence and national strategy, care for those suffering from dementia varies.

In this paper we discuss the extent to which the existing strategy and national guidelines: (i) identify the bio-psycho-social needs of people with dementia; (ii) identify interventions or strategies to meet these needs; (ii) are implemented at the local level. The analysis is based on interviews and one focus group with people with dementia and carers in the North of England. The analytical framework for the interviews consist of 3x3 matrix with type of needs (biological or physical, psychological, social) and strategies adopted by interviewees to meet these needs (met by available services, met informally, remained unmet).

Sara ALLIN (Derek King, David Ruddler)

**Public-private mix in home care: a comparison of the UK and Canada**

Over the past decade home care use has increased in high-income countries. This trend reflects efforts to shift care into the community, a growing recognition of the preferences of older people, and evidence of the cost-effectiveness of home care compared to institutional care. Few studies have considered the important role privately funded home care plays in the delivery of services to older adults.

The objective of this study is to compare the extent of public and self-pay/private home care in Canada and England, considering both health and support services. In both jurisdictions there is a system of publicly-funded home care that is either largely needs-based (Canada) or needs-based and means-tested (UK) alongside an active private sector. We draw on comparable national surveys – the Canadian Community Health Survey, the English Longitudinal Study of Ageing and the Health Survey for England – to compare the patterns of home care use and unmet need in both countries.

Results will be presented and discussed in the context of the institutional arrangements for health and social care, and specifically the role of home care in both countries. The implications of these findings will be discussed in relation to policy goals of equitable access to services and efficiency.

Aris ANGELIS (Panos Kanavos)

**Multiple Criteria Decision Analysis (MCDA) for evaluating new medicines in health technology assessment and beyond: The Advance Value Framework**

Escalating drug prices have catalysed the generation of numerous “value frameworks” with the aim to inform payers, clinicians and patients around the evaluation process of new medicines. However, aspects of these frameworks are based on weak methodologies and could potentially result in misleading recommendations or decisions. A Multiple Criteria Decision Analysis (MCDA) methodological process based on Multi Attribute Value Theory (MAVT) is adopted for building a multi-criteria evaluation model. A five-stage model-building process is followed, using a “top-down”—value-focused thinking approach, involving literature reviews and expert consultations. A generic value tree is structured that captures decision-makers’ concerns for assessing the value of new medicines in the context of Health Technology Assessment (HTA) and in alignment with decision theory. The resulting value trees span three levels of criteria relating to five key domains that can be measured and assessed: (a) burden of disease, (b) therapeutic impact, (c) safety profile (d) innovation level, and (e) socioeconomic impact. A combination of MAVT modeling techniques is proposed for operationalising the model: an indirect elicitation technique for scoring through value functions, an indirect swing weighting technique for assigning weights of relative importance, and a simple additive aggregation technique for combining scores and weights together.

Overall, the combination of these MCDA modeling techniques for the elicitation and construction of value preferences across the general value tree provides a new value framework (Advance Value Framework) enabling the comprehensive measurement of value in a transparent and structured way. Given its flexibility to meet diverse requirements and become readily adaptable across different settings, the value framework has the prospects to be tested as a decision-support tool in the evaluation of new medicines as part of coverage and reimbursement decisions.

Ibethel ATTAELMANAN (Yasser Bhatti, Matthew Prime, Matthew Harris, Ara Darzi)

**The development and diffusion of surgical frugal innovations – lessons for the NHS**

This work sought to identify less well known examples of frugal innovations in surgery and specifically analyse their development process. We interviewed founders and leaders of 11 surgery related frugal innovations, focussing on understanding the process of development from conception to application. We compared this process carried out by founders of frugal innovations with published accounts of ‘new product development’ (NPD) in the literature. We found it to be generally similar to the NPD process as described in the business and engineering literature but also tested in healthcare. However, we found five key factors deemed influential to the development process for frugal innovations: need, quality, feedback, multidisciplinary teams, and role of existing offerings. To leverage potential of frugal innovations and remain competitive in the face of rising costs and growing demand, healthcare systems need to adapt and revisit their NPD process. This can be achieved with a frugal approach and mind-set but needs policy support to promote how and where these solutions are conceptualized, developed, tested, and implemented.

Peter BAKER (Thomas Hone, Aaron Reeves, Mauricio Avendano, Christopher Millett)

**Does government expenditure reduce inequalities in infant mortality rates in low- and middle-income countries? A time-series, ecological analysis of 62 countries from 1993–2013**

Inequalities in infant mortality rates (IMR) are rising in some Low and Middle-Income Countries (LMICs) and falling in others; but the explanation for these divergent trends is unclear. We investigate whether government expenditures and redistribution are associated with reductions in inequalities in IMR. We estimated country-level fixed-effects panel regressions for 62 LMICs (156 country observations). Slope and relative indices of inequality in IMR (Sii and rii) were calculated from Demographic and Health Surveys between 1993–2013. RII and SII were regressed on government expenditure (total, health, and non-health) and redistribution, controlling for GDP per capita, private health expenditures, a democracy indicator, country fixed effects, and time. In multivariate models, one percentage point increase in total government expenditure (as a % of GDP) was associated with a decrease in SII of -2.47 (CIs: -4.173, -0.764) and an RII decrease of -0.026 (CIs: -0.047, -0.004). Lower inequalities in IMR were associated with higher non-health government expenditure, but not higher government health expenditure. Associations with inequalities in IMR were non-significant for GDP, government redistribution, and private health expenditure. Understanding how non-health government expenditure reduces IMR inequalities, and why health expenditures do not, may help accelerate progress towards the Sustainable Development Goals.
Diana Beatriz BAYANI (Jhanna Uy, Christian Edward Nuevo, Katherine Ann Reyes, Beverly Lorraine Ho, John Wong)

Establishing a health technology assessment institution in a low-middle income country: lessons learned from the Philippines

With the goal of achieving universal health coverage through better priority-setting, the Philippines established a health technology assessment (HTA) mechanism to guide coverage and investment decisions of the national health insurance agency, PhilHealth, and the Department of Health (DOH). The process adheres to principles manifested in the procedures and criteria developed through a series of literature reviews and consultations with stakeholder groups, including experts and policy makers. It was designed with consideration to existing decision-making structures to more closely link the process to policy makers in PhilHealth and DOH. The HTA process builds on the existing legislation within PhilHealth that states the use of HTA as basis for inclusion or exclusion of health services and technologies in benefit packages. Moreover, DOH and PhilHealth have increased funding for HTA research, and international agencies provide additional technical and financial support. Despite these positive developments, a number of challenges remain: there is no clear HTA focal point within PhilHealth and DOH to facilitate administrative and technical roles; the culture of evidence-informed decision making is still weak; high quality epidemiological and unit cost data are lacking; and there is a dearth of local training for HTA, leading to limited capacity of human resources.

Gwyn BEVAN (Alice Evans, Sabina Nuti)

Reputations count: why benchmarking performance is improving health care across the world

This paper explores what motivates improved health care governance. Previously, many have thought that performance would either improve via choice and competition or trust and altruism. But neither assumption is supported by available evidence. So instead we explore a third driver: reputational concerns.

Drawing on natural experiments in Italy and the UK, as well as ethnographic research in Zambia, we illustrate how publicly benchmarking outcomes and peer learning can motivate improved performance at both the sub-national and national level. In each of these different settings, reputational concerns appear to have motivated improved performance. Reputations count, and policy-makers could use this to improve public services more widely.

Louise BOUCI

Capacity, English mental health law and John Rawls’s ‘justice as fairness’– a vision for the future?

This paper focuses on the detention and treatment of capacitous people, whose presence or conduct exposes others to significant risk of serious harm. Within England and Wales, people with mental disorder can be detained and treated, irrespective of capacity, on the basis of risk they may present. Conversely, capacitous people with physical disorders can be treated only with valid consent. Using John Rawls’s ‘justice as fairness’, this paper argues for equality, focused on risk rather than disorder. The two-part framework proposes that detention decisions are made on the basis of risk to others, and treatment decisions are made on the basis of valid consent, or in the best interests of the incapax. The proposed criterion for detention is: ‘the individual’s presence or conduct exposes others to significant risk of serious harm and as such the individual may be detained, whether competent or not, with a view to the protection of other people’. The criteria for treatment would be that: ‘treatment is available, is therapeutic, and will alleviate the condition or prevent deterioration of the condition; and treatment cannot be imposed on a competent individual, it may only be given with valid consent, or in the best interests of an incapax’.

Viola BURAU (Hanne Marlene Dahl, Lotte Groth Jensen, Stina Lou)

How to make radical decisions in health policy: moving beyond DRGs in Denmark

DRGs are widespread across Europe and are meant to improve activity and efficiency of hospitals. However, there are many examples that DRGs have negative side effects. Thus, it is highly interesting that Central Denmark Region in 2013 decided to test a radically different system for hospital governance based on the Triple Aim approach.

The paper presents the results of a study that asks, how new definitions of policy problems about hospital governance emerge, and how they get coupled to new policy solutions. The study uses Carol Bacchi’s ‘what’s the problem’ approach to identify the basic ideas and assumptions underlying the political and administrative decision making process. The analysis is based on data gathered as part of a qualitative case study, including policy documents and interviews.

The analysis suggests that the decision to test a radically different model of hospital governance met surprisingly little resistance. Instead, the policy decision benefited from the coming together of a number of circumstances: that the critique of DRGs was ripe both nationally and internationally; that clarity emerged as an alternative framework for understanding ‘good hospital governance’; and that there were regional and national champions committed to driving the process.

Arturo Vargas BUSTAMANTE (Lucía Félix, James Macinko)

Access to care and financial burden under private insurance coverage in Latin America

Background: Latin America has experienced considerable improvement in population health and access to care as health insurance coverage has expanded. Few studies have investigated the differences in access to care and financial burden by type of health insurance coverage.

Objective: To analyse the role of private insurance in enabling access to care and protecting against financial burden in six Latin American countries.

Methods: We conducted a secondary data analysis of a Latin American survey on experiences of care by urban adults in Brazil, Colombia, Mexico, Jamaica, Panama and El Salvador. We first implement a descriptive and comparison of means analyses across countries. Logistic regression models investigate the main predictors of access to private health services and financial distress across countries.

Results: The six countries report a wide variation in access and financial burden measures. Adults in El Salvador report the lowest utilization, with 64.7% reporting a physician visit in the previous year. Mexico had the highest utilization with approximately 80% of urban adults reporting a physician visit. Adults from countries with unified health care delivery systems, Brazil and Colombia, were less likely to report high OOP payments (i.e. above the country median) in the last year compared to countries with fragmented health care delivery systems. The role of private health insurance is mixed across countries, with private insurance both reducing the odds of high OOP payments in Brazil and increasing them El Salvador and Mexico.

Conclusions: Our study provides preliminary evidence about the role of private insurance coverage in enabling access to care and protecting from financial burden. Outcomes across countries can be explained by financing and regulatory differences across countries.

Mirella CACACE (Monika Ewa Kaminska-Visser)

Managed Care in the Social Health Insurance Systems of Central and Eastern European Countries

Our contribution aims at detecting managed care elements in Central and Eastern European Countries (CEEC) in order to find out whether these countries use this potential to regulate their healthcare systems. Managed care entails a diverse array of instruments for the (micro-) regulation of healthcare systems and can be found in different healthcare system types (NHS, SHI, PHI). However, the experiences of different countries displaying differing institutional healthcare settings have proven difficult to compare. For a systematic comparative analysis, we propose an innovative approach to examine managed care instruments following the relationships between payers, providers, and beneficiaries. In an inductive approach, we use the available evidence in the US and in Western European countries, where managed care is firmly established, to illustrate our framework. We test this approach by applying it in the context of six CEEC (Czech Republic, Estonia, Hungary, Poland, Slovakia, and Slovenia) thereby exploring differences and similarities between the selected CEEC to complete the picture of healthcare regulation in CEEC. Further, we can show that our framework is useful in detecting and analysing managed care instruments in a diversity of cases thus also contributing to the advancement of the comparative method.
Sharon CADOGAN (John Browne, Colin P Bradley, Anthony P Fitzgerald, Mary R Cahill)

Guidelines combined with educational messages to improve the use of immunoglobulin tests in primary care: an interrupted time series with segmented regression analysis

Background. Implementation science experts recommend that theory-based strategies, developed in collaboration with healthcare professionals, have a greater chance of success. In this study, the impact of a theory-based strategy for optimising the use of serum immunoglobulin testing in primary care is evaluated.

Methods. We devised an intervention comprising of a combined guideline and educational messages based strategy, targeting previously identified general practitioner barriers and enablers for requesting serum immunoglobulins in the South of Ireland. The intervention was evaluated using an interrupted time series with segmented Poisson regression models using routine laboratory data from January 2012–July 2016. The data was organised into fortnightly segments (96 time points pre and 20 post-intervention) and analysed using incidence rate ratios with their corresponding 95% confidence intervals along with parameter coefficients and standard errors.

Results. In the most parsimonious regression model (change in slope pre- and post-intervention), the change in trend before and after the introduction of the intervention was statistically significant. The intervention was associated with a 1.5% percent reduction in the slope per fortnight (1.51; 95% CI: -1.16, -1.86, p<0.001).

Conclusion. Our tailored guideline combined with educational messages reduced serum immunoglobulin test ordering in primary care. Given the rarity of the conditions for which the test is utilised and the fact that we only have population (and not individual patient level) data, further investigation is required to examine the clinical effects of this change in test ordering patterns.

Michael CALJAN (Ferhana Hashem, Patrick Brown)

Still elegantly muddling through? NICE and the management of uncertainty in decision making about the rationing of expensive medicines in England.

This paper examines the ‘technological appraisals’ carried out by NICE (National Institute for Health and Care Excellence) as it regulates the provision of expensive new drugs within the English NHS on cost-effectiveness grounds. Ostensibly this is a highly rational process by which the regulatory mechanisms absorb uncertainty but in practice decision-making remains highly complex and uncertain. This paper draws on ethnographic data – interviews with a range of stakeholders and decision-makers (n=41), observations of public and closed appraisal meetings, and documentary analysis – regarding the decision-making processes involving three different pharmaceutical products. The study explores the various ways in which different forms of uncertainty are perceived and tackled within these Single Technology Appraisals (STAs). Difficulties of dealing with the various levels of uncertainty were manifest and often rendered straightforward decision-making problematic. Uncertainties associated with epistemology, procedures, interpersonal relations and technicality were particularly evident.

The need to exercise discretion within a more formal institutional framework shaped a pragmatic combining of explicit and informal, collective and individual, strategies and tactics to navigate through the layers of complexity and uncertainty in making decisions. Potential solutions to some of the problems raised by the study suggested.

Colin CANNONIER (Monica Galloway Burke, Kathryn Steward)

Smoking, health and academic outcomes – evidence from a limited smoking campus policy

Although there is a substantial literature on the impact of smoking laws, the number of studies that investigate the impact of such policies on college campuses is sparse.

Using a rich data set from various waves of the American College Health Association (ACHA) National College Health Assessment (NCHA) survey for a mid-sized public university in the southern United States, we investigate a possible causal link between a limited smoking policy and smoking behaviours, health and academic outcomes among college students. We employ propensity score matching methods to control for endogeneity of unobservable characteristics.

Our results show a significant reduction in the propensity to smoke cigarettes and cigars following the introduction of the policy. Further, we find that the policy has increased academic outcomes; however, it has no significant effect on student health. These findings have important policy implications for schools which are considering instituting comprehensive smoking bans on college campuses.

Kathleen CAREY (Jean M. Mitchell)

Specialization and production cost efficiency: evidence from ambulatory surgery centers

In the US health care sector, the economic logic of specialization as an organizing principle has come under active debate in recent years. An understudied case is that of ambulatory surgery centers (ASCs), which recently have become the dominant provider of specific surgical procedures. While the majority of ASCs focus on a single specialty, a growing number are diversifying to offer a wide range of surgical services.

We take a multiple output cost function approach to an empirical investigation that compares production economies in single specialty ASCs with those in multispecialty ASCs. We applied generalized estimating equation techniques to a sample of Pennsylvania ASCs for the period 2004-2014, including 73 ASCs that specialized in gastrointestinal procedures and 60 ASCs that performed gastrointestinal as well as other specialties procedures.

Results indicated that both types of ASC had considerable room for expansion. In simulation analysis, production of GI services in specialized ASCs had a cost advantage over joint production of GI with other specialty procedures. Our results provide support for the focused factory model of production in the ASC sector.

Sarah CARR (Alison Faulkner)

‘The girls who kicked the horns’ nest’: perspectives from a user-led study on service user experiences of mental-health related violence and abuse in the context of adult safeguarding

This paper will explore the background, methodology and ethical considerations of a user-led, co-produced study into service user experiences of mental health related violence and abuse in the context of Care Act (2014) adult safeguarding reforms (‘Making Safeguarding Personal’). The aim of the study is to inform safeguarding policy implementation in mental health and social care by bringing mental health service user voices into dialogue with multidisciplinary adult safeguarding stakeholders responsible for implementing the Making Safeguarding Personal policy.

The principal investigator and research lead for service user interviews will describe the innovations in process and ethical conduct required for user-led research into a sensitive subject, with a population who are constructed as ‘vulnerable’. They will look at the unique approaches taken to conceptualising ‘harm’ and ‘benefit’ in research and practice; the development of a participant and researcher distress protocol and the role of peer training.

The researchers will discuss some of the unanticipated interview findings and their effects on the direction of the study, and on the service user researchers conducting the interviews. They will also explore the findings of a post-interview participant survey on the experience of being involved in a user-led mental health study and being interviewed by service user researchers. They will conclude by reflecting on the lessons from the conduct of the user-led study for applied qualitative mental health research designed to inform policy implementation.

Ana Cristina CASTRO (Carl Thompson, Karen Bloore)

Effect of Care Quality Commission (CQC) inspections on adverse events of acute hospitals by performance: controlled interrupted time-series analysis.

Aim. To compare the new and old regime of CQC inspections on English NHS Trusts safety as measured by adverse event rates.

Methods. Controlled interrupted time-series study using a mixed-effect multilevel random-coefficients model. Falls with harm and pressure ulcers from April 2012 to June 2016 were retrieved alongside the date and type of CQC inspection using publicly available data. The time series interruption was month of CQC inspection and its announcement (4 months prior).

Results. 149 (96%) acute Trusts were included. Mean (SD) falls were 0.008 (0.009) and pressure ulcers were 0.05 (0.02) before inspection. Trusts failing to improve safety had a small, but unlikely to be clinically or cost-effective, improvement after the announcement of an imminent CQC inspection. No change of trend was seen after CQC visit. Hospitals that were improving prior to any CQC inspection saw no changes in falls or pressure ulcer rates after announcement or inspection.

Conclusion: Hospitals with poor safety performance seem to get some small benefit from CQC inspections. However, hospitals that were improving safety without CQC intervention experienced no benefit from a CQC inspection.
Danielle CATTEL (Frank Eijkenaar, ErikSchut )
Value-based payments to healthcare providers
Worldwide, policymakers and purchasers are exploring innovative payment strategies promoting value in healthcare (value-based payment, VBP). However, both literature on the specific purposes of VBP and a framework describing the theoretically ideal structure of VBP is lacking. This paper aims at: (1) providing a specification of value dimensions that are typically aimed for by VBP; (2) presenting a framework of key features of VBP; (3) describing fundamental design issues regarding VBP; and (4) explicating fundamental trade-offs in the operationalization.

We distinguish five value dimensions: high-quality care, cost-conscious behaviour, good coordination, cost-effective innovation, and cost-effective prevention. We argue that VBP fulfilling these dimensions ideally consist of (1) a base component, a variable component that explicitly rewards value dimensions not sufficiently incentivized by the base payment. The base payment should ideally consist of a prospectively determined global payment to a multidisciplinary provider group for providing a cohesive set of care activities to a target population. This payment should be fixed for a defined period, adjusted for risk-characteristics of the population, and should include arrangements to limit excessive risk exposure of the provider group. We explain why operationalization of the base payment involves inherent trade-offs, depending on preferences and context.

Stamatina CHEILARI
Pricing and reimbursement policies for personalised medicine based on oncology example. Comparative analysis among the USA, Canada, the UK and France
This study aimed to highlight discrepancies and similarities in existing pricing and reimbursement policies for Personalised Medicine (PM). PM is based on the example of oncology that four countries, the USA, Canada, the UK and France. It focused on identifying policies’ appropriateness for ensuring affordable and equitable access to effective targeted medicines in different health care systems. A narrative review of secondary data was conducted to provide a comprehensive knowledge and understanding of the role of PM in the four health systems and find out which is best practice of providing targeted therapies equally to patients. A first analysis of approval processes and existing pricing mechanisms for therapeutics (PM) and then for Companion Diagnostics (CDx) and respectively for reimbursement policies was conducted. CDxs and Rx are certified and approved with different processes and criteria in the four countries, while the EMA appears to be very precise and reserved in comparison with the FDA and Health Canada. France with its governmental pricing control mechanisms obtained the lowest prices for targeted therapies, while the USA purchase the highest. Cost-effectiveness analysis for reimbursement decisions are strictly adopted only by the NICE in the UK. France is remunerating 100% its patients for the CDs and the Rx, while US citizens spend the most out of pocket for covering the price of the drugs. A paradigmatic shift to health outcome-based approaches is promising to give solutions on the pricing and reimbursement decisions for targeted therapies and the adoption of PM.

Kateryna CHEPYNOGA (Gabriela Flores, Jürgen Maurer)
Drivers of unaffordable medication for chronic non-communicable diseases in low- and lower-middle income countries: procurement price, retail price or both?
Despite numerous policy efforts medicines are often unaffordable for individuals with chronic non-communicable diseases (NCDs) across low income countries (LIC and LMIC). Current study aimed to estimate drivers of drugs unaffordability decomposing its prices into procurement component and aggregated mark-ups imposed in the retail sector.

Medicines were considered to be unaffordable for individuals with NCDs pushed (further) below the poverty line reasoned from paying for medicines out-of-pocket. Three hypothetical scenarios were estimated firstly, assuming that individuals pay procurement price, secondly, that they additionally pay aggregated mark-ups imposed on it and finally, assuming implementation of mark-ups regulation policy. Less than 1.5 per cent of individuals with NCD would not be able to purchase drugs without being impoverished even if hypothetically purchasing it at the procurement price. Up to 9 per cent of individuals would be additionally pushed into poverty due to paying mark-ups. However, assuming implementation of a certain price cap policy unaffordability of medicines could be reduced to the level less than 2%.

Results suggested that subsidies support is highly required when individuals cannot afford drugs even at the procurement price. Furthermore, implementation of mark-ups control policies would permit to substantially decrease medicines’ unaffordability across LIC and LMIC.

Caroline CLARKE (Victoria Serra-Sastre, Ian Shemilt, Rachael M. Hunter)
Treatment duration and cost-effectiveness: is more always better?
Drug regulatory and approval bodies are often constrained by treatment durations chosen by manufacturers, and the idea that “more is better”, when in fact it could be that “less is not worse”. A reduction in the recommended duration of treatment with an expensive drug can have an important impact on total treatment costs and therefore on cost-effectiveness and likelihood of approval. Any decision on reducing treatment duration therefore requires knowledge of how much extra treatment effect is gained from using longer durations of treatment.

We discuss this issue via a case study in which a three-arm cost-effectiveness analysis of zero, 9- and 52-week treatments with an expensive and widely used breast cancer drug (trastuzumab) (and found the 9-week duration to be substantially more cost-effective than the manufacturer’s recommended 12-month duration (NHS cost perspective)). This was driven by the higher cost of the 52-week arm (primarily due to the drug’s high cost) and by the similar effectiveness of 9- and 52-week durations in terms of quality-adjusted life-years (QALYs). The issue of treatment duration selection in phase 3 trials and its impact on cost-effectiveness and decision making warrants closer attention. Duration selection could more often be based on evidence from earlier phase trials.

Adelina COMAS-HERRERA (Martin Prince, Martin Knapp, Maelenn Glucert, Maria Karagianidou)
Expanding the coverage of healthcare for people with dementia affordably: exploring the costs of task-shifted dementia healthcare pathways in low, middle and high income countries
People with dementia have poor access to appropriate healthcare to manage their conditions, even in most High-Income Countries (HiC), where only about 50% of people living with dementia receive a diagnostic. In Low- and Middle-Income Countries (LMIC) the rate of diagnosis is estimated to be much lower, around 5 to 10%. As the number of people living with dementia increases, particularly in low- and middle-income countries where the population is ageing very fast, it appears unlikely, both in terms of financial cost and workforce availability, that the traditional specialist-led approach to dementia care can expand fast enough to keep up with increases in need and it is even more unlikely that coverage could be improved.

In this study we explore a task-shifted approach to expanding dementia healthcare coverage, led by primary care practitioners with specially trained nursing and care staff. We outline a task-shifted dementia healthcare pathway, based on available evidence, and investigate the cost and healthcare system implications of implementing this pathway by 2030 in Canada, China, Indonesia, Mexico, South Africa, South Korea and Switzerland, assuming that diagnostic coverage expands to reach 75% in HiC and 50% in LMIC. For the three high income countries we also compare the costs of implementing the task-shifted pathway to the cost of expanding specialist healthcare approaches.

Primary care and health inequality: natural experiment comparing England and Ontario
Objective: To provide evidence on whether equity-oriented reforms of universal primary care systems can reduce health inequality by comparing England, which implemented equity-oriented primary care reforms in the mid-to-late 2000s, with Ontario, Canada, which did not emphasize equity in its primary care reforms.

Design: We analysed whole-population data from England and Ontario from 2004–11 and quantified trends in mortality amenable to healthcare by decile groups of neighbourhood deprivation within each jurisdiction. We used linear models to estimate absolute and relative gaps in amenable mortality between most and least deprived groups, considering the gradient between these extremes, and evaluated difference-in-difference comparisons between the two jurisdictions.

Results: Inequality trends were comparable in both jurisdictions from 2004–6 but diverged from 2007–11. Compared with Ontario, the absolute gap in amenable mortality in England fell between 2004–6 and 2007–11 by 19.8 per 100,000 population (95% CI: 4.8–34.9); and the relative gap in amenable mortality fell by 10 percentage points (95% CI: 1–19). The biggest divergence occurred in the most deprived decile neighbourhoods.

Conclusion: In comparison to Ontario, England succeeded in reducing absolute socioeconomic gaps in mortality amenable to healthcare, and prevented them from growing in relative terms. Equity-oriented primary care reform in England may have helped to reduce socioeconomic inequality in health.
jurisdiction to achieve reforms, and (3) the contextual factors that enable or limit the implementation of reforms.

This paper examines health technology assessment’s (HTA) institutional context, impact and associated benefits and costs in Hungary within public reimbursement procedures. We focus on the HTA Department, established in 2004 to evaluate health technologies and support reimbursement policy of the National Health Insurance Fund (NHIF). We conducted 26 in-depth, semi-structured interviews with purposively sampled representatives of manufacturer companies, consultancies preparing HTA submissions, HTA Department, NHIF, Ministry of Health, academia and patient organizations.

We found that, first, while in some areas the HTA Department fulfilled its intended formal role in supporting evidence-based policymaking, it faced several major institutional constraints, including limited transparency and insufficient consultation with experts and manufacturers. Second, the perceived influence of the Department on reimbursement process was limited, as indicated by its inferior position in relationships with NHIF and health policymakers. Third, the HTA Department had a positive impact on the development of broader HTA system in Hungary, constituting an infrastructure of evidence-based policymaking. While costs and benefits of such system were difficult to quantify, there was strong scepticism as to whether it represented “good value for money”. Our findings suggest the need for immediate improvements of the transparency of HTA and drug reimbursement process in Hungary.

Diabetes prevention in England: a simulation model

Prevention of Type 2 diabetes (T2DM) is a top priority for England, urged by the diabetes epidemic and the mounting costs associated with it. Lifestyle interventions aimed at preventing the onset of T2DM in individuals at high-risk are nowadays widely implemented across the country. We aim to understand the impact of these interventions on the number of diabetics prevented.

We developed a ‘requisite’ Markov chain model estimating the impact of four interventions on the volume of diabetics in 20-years model. Model inputs were retrieved from the literature. Evidence gaps were overcome with estimates generated by experts during a consensus workshop. Results of the model show that individual-based, lifestyle interventions targeting those at high-risk of T2DM have a negligible impact on reducing the number of diabetics in the long term. Despite the cost-effectiveness of the interventions currently targeting those at high-risk of T2DM, their actual impact on the diabetes epidemic seems limited, as they are not implemented at scale (nor can they be, for affordability reasons) and are characterized by high attrition rate and low long-term adherence. Population approaches aiming to trigger small changes in risk factors across the whole population, regardless of the individual level of risk, should be considered.

Transformative capacities of health systems: a research on health reforms in Canada

Reforms of healthcare systems are on the political agendas of all OECD countries and include a wide range of policies aiming at improving healthcare delivery systems, optimizing the use of resources, and advancing population health. Canada is no exception and has seen repeated reorganizations or reforms (and often deceiving) responding to pressing contingencies and conditioned by predominant political ideologies. Provinces in Canada, which operate under a common set of principles (Canada Health Act) but rely on different approaches to reform, represent a unique natural laboratory to understand processes of change and their impact on health systems’ performance and adaptation. In this paper, using a longitudinal comparative case study research design we analyse in two Canadian provinces, namely Ontario and Quebec, processes of reforms. Data sources include policy documents, performance reports and data, and interviews with key informants. Preliminary findings on policy work and transformative mechanisms within reforms are presented. Three aspects of reforms will be discussed with their consequences on health systems’ evolution: (1) the influence of the strategies pursued to reform the healthcare system, (2) the nature of mechanisms mobilized in a given jurisdiction to achieve reforms, and (3) the contextual factors that enable or limit the implementation of reforms.
Brian ELBEL (Kosuke Tamura, Zachary McDermott, Amy Ellen Schwartz)

Childhood obesity and the food environment: a population-based sample of public school students in New York City

Some correlational studies have indicated that the food environment may play a role in shaping childhood obesity in the US. There has been limited research on to investigate this relationship using large detailed address information that takes into account selection into neighborhoods, endogeneity, and confounding. We examine the relationships between the distance from a child's home to the nearest of four different types of food outlets and childhood obesity.

We used yearly body mass index measurements on 3,631,561 student-year observations (2000-2010) from New York City public school K-12 graders. We combined these data with the exact location of each food outlet type – fast-food restaurants, wait-service restaurants, corner stores, and supermarkets – to calculate the distance to the nearest food outlet. Our primary estimation strategy used census-tract level fixed effects.

Distances to nearest fast-food restaurant and corner stores were consistently, inversely related to childhood obesity. These findings can help better inform policies focused on food access in urban areas, which could, in turn, reduce childhood obesity.

Stefanie ETTELT

Courts as health policy makers – examples from Germany

In Germany, courts have emerged as important actors in health policy, to the extent that they can be seen as policy-makers in their own right. Social courts (a specialist branch of the judiciary with responsibility for adjudicating matters of social security) become involved in a variety of health policy issues through adjudicating health policy disputes such as those relating to access to health technologies and hospital regulation. This talk will present key findings from two studies analysing recent court cases related to (a) access to cancer treatment and (b) the introduction of minimum volumes to improve the quality of hospital services. The analysis suggests that courts have substantial influence on the application, and at times survival, of policy decisions, with some judgements limiting the scope of what is feasible in policy-making. Courts apply a rights based approach by interpreting existing legal frameworks and applying them on a case by case basis, which can limit the ability of the regulator to exclude treatment and impose rules on provider organisations. There are substantial tensions between principles of evidence based medicine and policy that have become increasingly relevant to regulation and the legal practices of courts, which courts, regulators and legislators have struggled to reconcile. However, it can also be argued that courts occupy the space opened by regulation and legislation being inconsistent, contested and insufficiently supported by evidence.

Camilla FABBRI (Timothy Powell-Jackson, Yaran Dutt, Sarah Tougher, Kultar Singh)

Information and the demand for preventative healthcare: a randomised controlled trial of improving household perceptions on the efficacy of immunisation in Uttar Pradesh, India

Many children in India fail to get vaccinated despite well-documented evidence on the health and developmental benefits of immunisation. We report on a three-arm randomised controlled trial assessing an information intervention targeted at the mothers of unvaccinated children aged between 0 and 36 months. The intervention focused on tetanus, giving information to mothers face-to-face on its symptoms and causes, possible health consequences, and the efficacy of the combined DPT vaccination. There were two versions of the message, one was positively framed (gains of vaccination) and one was negatively framed (losses of not getting vaccinated). Information increased DPT3 vaccination by 14.6 percentage points (96% CI 7 to 20) compared to the control group that did not receive any information. It also had an indirect effect, increasing measles vaccination by 22 percentage points (95% CI 14 to 30) even though tetanus was the sole focus of the intervention.

There was no significant difference in the effect according to how the information was framed. The cost of the intervention as implemented was estimated to be $175 per DALY averted. Under a plausible scale-up scenario, the cost would fall to $89 per DALY averted. Results show that the information appears to have worked by increasing knowledge, and not by improving perceptions of efficacy. At a low cost, targeted information may offer an effective strategy to increase vaccination coverage in India.

Giovanni FATTORE (Giannario Cinelli)

The desired and undesired effects of patients’ mobility: an empirical investigation

Patients’ mobility may be beneficial because creates incentives to increase quality and efficiency and may promote the proliferation of regional, national and even international highly specialised networks focused on specific conditions and diseases. However, traveling to reach distant providers requires economic and immaterial resources and thus may create disparities in access.

We investigated patients’ mobility by presenting the Italian case and then by running a statistical model for a major cardiovascular procedure using individual patient data for the entire Italian population from 2007 to 2014. In addition to gender, age and diagnostic information, the dataset contains information on patient’s level of education and allows mapping of potential and actual providers of care. The statistical model ran on 124,653 medical records shows that patients coming from the north of Italy living in the south tend to be younger, less severe and better educated. Availability of local providers reduced the probability of inter-regional mobility while the effect of average income of the municipality of residency depends on the model specification.

Some patients’ mobility is desirable to exploit the opportunities of specialisation and to foster competition but some incentives for quality. However, the Italian case shows that equity concerns are important. This domestic case is instructive for other countries and for the EU as it shows that patients’ mobility may have undesired consequences and thus needs to be monitored and governed.

Kelsey FLOTT (Luke Hounsome, Ara Darzi, Erik Mayer)

The patients behind national cancer experience scores: understanding patients’ differing priorities for cancer care improvement through population segmentation

What groups exist within the cancer patient population, and what are their respective priorities for patient experience improvement?

Using urological cancers as a case study, this study uses data from the UK National Cancer Patient Experience Survey to segment the patient population. An initial two-step cluster analysis identified previously unknown clusters within the population. Profiles were created for each cluster based on demographic variables, and a regression analysis assessed the significance of each demographic variable in determining cluster membership. A secondary two-step cluster analysis was conducted on patients who had a very poor experience of care. A framework was created to outline the demographics and priorities for patient experience improvement of each sub-cluster. The initial analysis yielded three clusters based on patient experience: Positive, Middling and Negative. Women, younger and more deprived patients were more prevalent in the Negative experience cluster. The cluster analysis on the Negative cluster resulted in three sub-clusters based on the types of concerns patients in each group identified.

The segmented framework below details the groups of patients that exist within the population, their priorities for patient experience improvement and their demographic profiles. This granular understanding of the patient population will allow services to make more meaningful patient-centric improvements.

Hongqiao FU (Ling Li, Minqiang Li, Chunyu Yang, William Hsiao)

An evaluation of systemic reforms of public hospitals: the Sanming Model in China

Low- and middle-income countries (LMICs) have been searching for effective strategies to reform their inefficient and wasteful public hospitals. Recently, China developed a model of systemic reform called the Sanming model to address the inefficiency and waste at public hospitals. We explain and evaluate how the Sanming model works and compare it to public hospitals in Fujian province, where we find that the Sanming model has reduced medical costs significantly without measurably sacrificing clinical quality and productive efficiency. The systemic reform, on average, has reduced the medical care cost per outpatient visit and per inpatient admission by 6.3% (p-value < 0.001) and 16.8% (p-value < 0.001) respectively. It is largely accomplished through a decrease in drug expenditures per outpatient visit and per inpatient admission of more than 30% (p-value < 0.001) and 80% (p-value < 0.001). These results show that the Sanming model has achieved at least a short-term success in improving the performance of the public hospitals. These findings suggest that such a systemic transformation of public hospitals, where the governance structure, payment system and physician compensation methods are aligned, are crucial to improving their performance; it holds critical lessons for China and other LMICs.
Coralie GANDRÉ (Jeanne Gervais, Julien Thillard, Jean-Marc Macé, Jean-Luc Roelandt, Karine Chevreul)

A decrease in involuntary psychiatric admissions is associated with a higher development of psychiatric services providing an alternative to full-time hospitalizations: results from a French study.

The development of alternatives to full-time hospitalizations (AFTH) in psychiatry is still limited due to an absence of consensus regarding their benefits. Our objective was to assess if this development in French psychiatric sectors was associated with a reduction in involuntary inpatient care, taking into account the other factors potentially associated with involuntary admissions.

Data on whether a patient had an involuntary full-time admission over the year 2012 was extracted from the French national discharge database for psychiatric care and the development of AFTH was estimated by the share of human resources allocated to those alternatives. Other factors potentially associated with involuntary admissions were extracted from administrative databases and a multi-level logistic model was carried out. Significant variations were observed in involuntary full-time admission rates between psychiatric sectors. A large part of those variations were explained by sectors’ characteristics. Results show a significant negative association between involuntary full-time admissions and the development of AFTH after adjusting for other factors associated with involuntary care.

This study suggests that the development of AFTH is beneficial for quality of care as it is negatively associated with involuntary full-time admissions whose reduction aligns with international recommendations for mental health care.

Margherita GIANNONI (Massimo Filippini, William Greene)

Financial problems and health disparities in Europe

This paper analyses the effects of financial difficulties on the determinants of self-reported health in Europe, providing initial evidence on the pathway through which over indebtedness can influence physical health that is lacking in the literature.

A socioecological conceptual model for the analysis of socioeconomic determinants of health from the literature on health inequalities in Europe is adapted in order to test if over indebtedness and home ownership can be considered autonomous determinants of European individuals’ health. The data used are from the Eurostat 2010 – 2014 waves of EU-SILC panel for 26 European countries (N=962,704). A set of random effects panel Logit and Probit models are estimated for the probability of reporting poor physical health status, chronic conditions and limitations in daily life, while controlling for several demographic and socioeconomic (income, education, occupational status; measures for households over indebtedness and house tenure status) individual characteristics. In order to deal with the potential endogeneity of the indebtedness-health relationship, we used an instrumental variables approach (two-stage residual inclusion approach) and bivariate recursive bivariate recursive models. Moreover, the estimation of recursive bivariate models with random effects is explored.

First results show that being in a household in arrears with payments and at risk of over indebtedness is a consistent and robust predictor of poor health outcomes, whereas home ownership positively affects individual self-reported health. More importantly, among socio-economic determinants of health, over indebtedness showed the largest odds ratios.

Philippe GORRY (Cyril Benoît)

Orphan drugs: why the US approves more than the EU?

Since the early 2000s, the EU has implemented a policy agenda in favour of rare diseases. Key-milestone legislation was the adoption of the Orphan regulation in 1999, in order to encourage the development of “orphan drugs”. Mainly operating through the European Medicines Agency (EMA) regulatory framework, this project aims to foster rare diseases research and development while ensuring fair access for patients. In this respect, several incentives are provided to sponsors who successfully applied for an orphan drug status, such as a ten-year marketing exclusivity and tax reductions. However, the number of orphan drug approved in Europe with an orphan designation is significantly lower than in the US.

We provide quantitative materials to explain this discrepancy on the basis of an analysis of the decisions delivered by the EMA. Three explanations are further explored: (1) effects of bureaucratic politics at the EMA (avoiding “salary-slicing”); (2) smaller engagement from academics and biotechnology companies; (3) the effect of the structure of tax-credits (US vs. EU).

Felix GOTTSCHALK (Wanda Mimra, Christian Waibel)

Health Services as Credence Goods: a Field Experiment

We present the first large-scale field experiment that studies the determinants of overtreatment in an OECD health care market. Health care is often provided under asymmetric information. Physicians may exploit their informational advantage by overtreatment, i.e. providing more services than necessary. The overtreatment of health services is inefficient and may harm patients.

In our experiment, we vary two factors: First, the extent of the information asymmetry by varying whether the patient is a standard or an informed patient. Second, the perceived income by varying whether the test-patient is perceived as a low- or high-income patient. Furthermore, we collect data on market and practice characteristics as well as demand.

We find that physicians overall give an overtreatment recommendation in more than every fourth visit. A low short-term demand, indicating excess capacities, leads to significantly more overtreatment recommendation than a high short-term demand. We observe significantly less overtreatment recommendations when the test patient is a high- than a low-income patient given that the patient is a standard patient. If the patient is informed those differences diminish. These results indicate a complex role of the patients’ socioeconomic status.

Scott GREER (Margitta Mätzke)

Claiming authority over health care in Germany, England and the USA

Many analyses of comparative health policy argue for simple path-dependent divergence between countries or convergence on more markets and individual payment at the expense of collective provision.

We argue, by contrast, that the common thread is the increasing assertiveness of the state as the guarantor of health care access, financial stability, and cost containment. Thus, all three countries’ health sectors had authority dispersed across territorial and functional domains.

Dispensed power and the varied models of self governance came into conflict with the central governments’ goals and ambitions as cost containment started to dominate the agenda of health policy-making as early as in the mid-1970s. As cost pressures mounted, expanding or maintaining citizens’ access to high quality health care increasingly meant that politicians and state bureaucracies directly intervened in organization and service delivery in health care to control costs while preserving access and improving quality.

Jenny GUADAMUZ


Antihyperlipidemics are proven effective for the secondary prevention of cardiovascular disease (CVD). Comparative analysis on the prevalence of antihyperlipidemic use for secondary prevention of CVD has not been completed between the US and England.


Over seventy percent of English respondents with CVD use antihyperlipidemics (73.2%), compared to 62.3% of American respondents (11.0pp difference, p<0.10). Low-income Americans report lower prevalence of antihyperlipidemic use than their English counterparts, 51.8% and 76.5% respectively (24.7pp difference, p<0.01). American respondents have reduced odds of using antihyperlipidics compared to the English (OR 0.72; p<0.01). This association persisted after accounting for sociodemographic, CVD, and insurance factors. In models restricted to individual country, lower socioeconomic status was associated with significantly reduced odds of using antihyperlipidics in the US but not in England.

Differences in the use of antihyperlipidemics exist between and within the US and England. Universal health insurance may explain the greater, more equitable use of antihyperlipidemics among respondents with CVD in England compared to the US.
MichaelK GUSMANO (Karen Maschkie)

The political economy of health technology assessment in the US

Competing ideas about science and evidence, political ideology and material interests frame debates about the potential benefits and harms of biomedical technologies. This paper explores how these factors have shaped debates about the evaluation of health care technologies in the United States.

To do so, the paper draws on three recent cases. The first is the debate about the value of regular mammography screening among women under the age of 50. The second explores debates over the clinical utility of genomic testing. The third is the FDA’s decision to revoke the approval of Avastin, a drug to treat metastatic breast cancer. All of these cases involve elements of controversy about the evidentiary standards by public agencies and private insurance companies in the US—and all three illustrate how the evaluation of health technologies can become embroiled in larger ideological and partisan debates about clinical autonomy and the role of government in the health system.

Christina HACKETT (David Feeny, Gillian Mulvale)

The health-related quality of life of Indigenous Canadians

Although there is substantial variation in health outcomes among certain demographically, culturally and ethnically delineated populations in Canada, Indigenous Canadians face unique disparities in health and mental as well as in the social determinants of health (SDH) they experience. We investigate population health differences with respect to health-related quality of life (HRQoL).

Using a nationally representative Canadian survey, we employ multivariate regression analyses to estimate the variation in the Health Utilities Index Mark 3 (HUI3) scores for Indigenous and non-Indigenous populations. We test the degree to which control variables account for the difference in HUI3 between the populations, to understand how the experience of being Indigenous may extend beyond differences in access to structural resources and SDH documented for these two groups.

After controlling for several sets of SDH and factors related to HRQoL, indigenous men and women living in Canada, report lower HUI3 than non-Indigenous Canadians. This difference remains statistically significant and clinically important after controlling for a number of SDH. As at least 80% of Indigenous peoples in high-income countries rely on non-Indigenous health systems as their primary source of healthcare, thus health policy and service practice must be directed towards culturally informed care to address health disparities.

Hassan HAGHPARAST-BIDGOLI (Rehan Mirza, Anni-Maria Pulkki-Brännström, Yves Lafort, Letitia Greener, Ross Green, Jenni Smit, Sushena Reza-Paul, KT Venukumar, Michele Andina, Wilkister Ombidi, Peter Gichangi, Sally Griffin, Jolene Skorodis-Wonall)

Impact of a diagonal intervention on utilization of sexual reproductive health among the most vulnerable female sex workers in India, Kenya, Mozambique and South Africa

Female sex workers (FSWs) have the greatest need for sexual and reproductive health (SRH) services however their access is limited. The DIFFER project, which was implemented in four sites in South Africa, Kenya, Mozambique and India, aimed to improve access to SRH services for FSWs. The current paper assesses whether DIFFER intervention succeeded in reaching the most vulnerable FSWs and whether access to SRH has improved among this group?

Data for this analysis are from two cross sectional surveys conducted as part of baseline and endline evaluation of DIFFER intervention. All participants for the surveys (1,589 FSWs at baseline and 1,569 FSWs at end-line) were recruited from the interventions sites using a respondent-driven sampling (RDS) approach. Utilization of HIV care and SRH services were analyzed by vulnerability status of sex workers. A vulnerability index was created by combining different measures of vulnerability in each site, using a principle components analysis. The findings showed that a considerable number of FSWs were among the most vulnerable and this figure varied between different sites. The findings indicated some improvements in the use of SRH services among the most vulnerable sex workers in all sites.

Yaniv HANOCH (Andrew Barnes, Michael Karpman, Sharon K. Long, Thomas Rice)

More intelligent designs: comparing the effectiveness of choice architectures used in health insurance marketplaces

Health insurance is one the most significant financial and health-related decisions that people make. The current study examines how different choice architectures within the existing marketplaces influence consumers’ decision-making ability. 8,253 individuals ages 18-64 responding to the fall 2016 Health Reform Monitoring Survey were given a high care cost scenario and randomized to one of three choice environments that varied on whether and how total estimated costs were presented. More than one-third of adults were not sure which was the plan with the lowest total expected costs. Compared to Marketplace 1, where plans were sorted by premiums but total expected costs were not shown, sorting by premium and showing total expected costs in Marketplace 2 increased the probability that respondents chose the lowest cost plan by 3.3 percentage points (p<0.01). Sorting by total expected costs in Marketplace 3 increased probability of choosing the plan with the lowest total expected costs by 5.1 percentage points compared to Marketplace 2 (p<0.01). More vulnerable consumers tended to experience larger benefits from marketplaces that relied more heavily on choice architecture. How these marketplaces are designed have a crucial impact on consumers’ ability to compare and choose health insurance plans that provide adequate risk protection and are affordable. Our results indicate that a simple, cheap, and policy feasible mechanism—namely sorting by and highlighting the total estimated cost in a prominent place—could help improve the quality of health insurance choices, saving money for consumers and the government alike.

Nisha HAZRA (Caroline Rudisill, Martin Guifford)

Is longer life really related to higher health care costs? Cohort study using electronic health records

Increasing age is assumed to be associated with higher health care expenditures, but few studies have evaluated groups over 80 years. This study aimed to investigate whether health-related factors have a greater impact than age on cost of health care in over-80s.

Primary care electronic health records, linked with Hospital Episode Statistics (HES) data, were analysed for 98,269 participants aged 80 years and over. Health care utilisation was enumerated including primary care consultations, hospital episodes, and prescriptions. A two-part regression model was employed to estimate predicted health care costs.

Home visits and out-of-hours consultations increased with age but practice-based consultations and hospital utilisation declined after 90 years. Compared to people aged 80-84 years, incremental costs were £3,119 higher at 95-99 years, but the increment was smaller in centenarians, at £2,086. Multiple morbidity had a greater impact on cost compared to age, but proximity to death had an even larger impact, with an incremental cost of £9,313 during year of death.

Multiple morbidity and proximity to death, rather than age, are key drivers of costs. Health care costs do not continue to increase over the age of 95 years, which might be explained by substitution of social care.

David HERR (Anja Hofmann, Wolfgang Greiner)

Musculoskeletal and mental disorders as major drivers of long-term sickness absence in Germany

Statutory health funds in Germany provide sick pay in case of long-term incapacity for work. Sick pay expenditures have nearly doubled since 2000, exceeding 10 billion euros in 2014. In order to implement adequate health policy measures, it is highly relevant to identify the underlying conditions.

We used a comprehensive dataset of all sick pay recipients among the 70 million statutory insured persons (provided by the Federal Insurance Office) to calculate the prevalence of diagnoses among them in 2014 and changes from 2009. Next, we analysed data of eight statutory health funds to investigate sick pay cases, days and expenditures in greater detail.

Sick pay cases are often associated with musculoskeletal and mental disorders. We show that some diagnoses are particularly prevalent among recipients, e.g. back pain (ICD-10: M54, 49 per cent) and depressive episode (F32, 33 per cent). Mental disorders are more prominent in females and musculoskeletal in males. Regarding sick pay days and expenditures, depressive episode is leading in both sexes. For various mental disorders, the average case duration is long. A rising contribution of mental disorders suggests a necessity of earlier interventions. In general, more coordinated and cross-sectorial care is needed. Several recent innovative models are promising.
Anja HOHMANN (Jens Welllling, David Herr)

Regional differences in diagnoses for long-term absence from work in Germany

Germany’s reunification can be considered a large-scale natural experiment that allows assessing long-term effects of differences in socioeconomic and political environments on health. After more than 25 years, the gap in life expectancy for East Germans has almost disappeared, yet prevailing regional economic differences, such as the labour market, show an impact on individual health.

Nationwide, the two most common diagnoses among persons receiving benefits for long-term absence from work are Depressive Episode (ICD-10: F32) and Dorsalgia (MS5). To analyse regional variation in administrative prevalence, the Federal Insurance Office (BfA) provided a comprehensive data set at district level (NUTS 3) for 2011, based on the SH’s morbidity-based risk-adjustment scheme (Morbi-RSA). This allowed conducting regional analyses for these two major conditions among beneficiaries.

Findings suggest that in the former East, a lower proportion of long-term absentees is diagnosed with depression as well as back pain than in the former West. Furthermore, around major cities like Berlin or Hamburg, percentage of these diagnoses is higher. The observed east-west gradient in prevalence needs further evaluation. Notwithstanding, the findings should be considered for effective workplace health promotion, for example through regionally tailored prevention programmes.

Joseph KAMARA (Minea Jofre-Bonet, Alice Mesnard)

Willingness to Pay for Health Insurance among Informal Sector Workers in Sierra Leone: A Discrete Choice Experiment Approach

The current health care financing method in Sierra Leone is unsustainable and poses challenges ranging from increase in out of pocket (OOP) health expenditure to accessibility problems, more so in rural areas where living standards are low and there is absence of health care facilities. Health insurance, it is argued, will play an important role in giving access to medical care and reducing the high OOP health expenditure.

This study estimates the willingness to pay (WTP) for health insurance among informal sector workers in Sierra Leone using a discrete choice experiment approach. Eight informal sector activities were selected namely – petty trading, subsistence farming, commercial bike riding, cattle rearing, fishing, tailoring, mining and quarrying. A random effect logit model was used to estimate households’ WTP for an improvement in coverage, choice of health care provider and a reduction in waiting time.

Our study revealed that households were WTP more to have all attributes except the attribute waiting time wherein they were willing to accept compensation for an increase in waiting time. Our findings also suggest that location – rural versus urban – matters in determining WTP. Rural and urban households were WTP $725,550.4SLL ($8.0) and $541,548.5SLL ($6.7) respectively. Our results show that urban households are WTP more for health insurance than their rural counterparts.

Panos KASTERIDIS (Christoph Kronenberg, Nils Gutacker, Tim Doran, Anne Mason, Nigel Rice, Hugh Gravelle, Maria Goddard, Tony Kendrick, Najma Siddiqi, Simon Gilbody, Ceri R Dare, Lauren Aylott, Rachael Williams, Rowena Jacobs)

Does pay-for-performance influence outcomes for people with serious mental illness (SMI): Analysis of linked longitudinal primary and secondary care data in England

The Quality and Outcomes Framework (QOF) is the largest pay-for-performance programme in primary care worldwide. The QOF offers payments to general practices for achieving a range of quality indicators for individuals with SMI, including making comprehensive care plans (CPs). Well-coordinated primary care may reduce the need for hospital admissions. However, previous studies have failed to establish a causal link between CPs and risk of hospital admission because they have relied on aggregate practice-level data and could not ascertain which patients received CPs or the timing of events.

We use primary care, secondary care, and mortality data linked at the patient level. This linkage provides information on the timing of events, most crucially whether QOF-incentivised care precedes or follows relevant outcomes (e.g. admissions). We estimate Cox survival models for over 5,200 patients newly diagnosed with SMI between 2006/07 and 2013/14. The hazards of three events – first SMI admission, Ambulatory Care Sensitive Condition (ACSC) admission, and death – are specified as functions of whether they have a current CP, demographics, local area characteristics and proxies of severity of illness.

Results show that having a current CPs is associated with decreased time to SMI admissions and increased time to death.
Kanghyoek KOH (Hyunjoo Yang)

Crowding out effects of an old-age pension program on intergenerational transfers: evidence from South Korea

Governmental public transfers through welfare programs are widely used to tackle elderly poverty. These programmes often influence the level of pre-existing supports from other family members, and may crowd out private supports. In this paper, we study the effects of new old-age pension program on intergenerational financial transfer in South Korea.

Applying various empirical approaches, we find robust evidence that the pension program completely crowded out financial transfers from adult children to parents. We find little evidence for other alternative hypotheses for crowding out effects such as the effects of global financial crisis and endogenous labor supply of the elderly. The results imply that the effectiveness of governmental antipoverty program through public transfer could be dampened by a reduction in intergenerational transfers.

Ekaterina KUZNETSOVA (Mireia Jofre-Bonet, Alice Mesnard)

Risk preferences of immigrants in the United Kingdom: comparison of financial and health domain

The objective of the study is to explore general and domain-specific risk preferences and engagement in risky health behaviours of immigrant population in the UK, and make a comparison with the native population. We exploit Understanding Society Innovation Panel, containing the module on risk preferences, to answer the questions on interest. We focus on the self-assessed measures of risk attitude. They were experimentally validated and shown to be good predictors of individuals’ actual behaviour. The exploratory analysis was supported by regression analysis.

We show that immigrants are more willing to take risks than native UK population. This holds for risks in general, for the financial and health domains. Distinguishing by the country of origin, we found non-EU immigrants are more likely (by 12 percentage points) to report high willingness to take risks, whereas EU immigrants tend not to be significantly different from the native population. Non-EU immigrants are more likely to engage in heavy and binge drinking, while EU immigrants smoke 1.5 cigarettes per day more than native citizens. Determining whether immigrants have higher risk tolerance will contribute to the design of targeted programmes that will save future healthcare costs and wellbeing by promoting prevention and healthy lifestyle among immigrants.

Samia LAOKRI (David Hotchkiss, Rieza Soelaeman)

Do under-resourced health systems have the ability to offer financial risk protection for primary healthcare? A baseline study of outpatient expenditure to inform health financing and universal coverage reform in the Democratic Republic of Congo

Aim: To describe health care expenditure levels, distributions and main drivers, and to investigate whether incurring excessive expenditure is associated with a series of demand- and supply-side factors.

Method: As part of a quasi-experimental evaluation to assess the impact of a DFID-funded health systems strengthening project in DRC, a baseline population-based household survey was conducted in four provinces in 2014. Data included type, level and utilization of healthcare services, accessibility to care, patient satisfaction and disaggregated expenditure.

Multivariable logistic regressions of excessive expenditure for outpatient care – set at various thresholds such as greater than double the median expenditure – were performed to explore incidence and predictors of atypically high expenditure incurred by individuals.

Findings: Of 3,341 individuals, 65.6% of those reporting an illness in the past four weeks sought outpatient care with an average of 1.1 visit per episode of illness. Overall mean expenditure per visit was US$5.7 (SD=10.4) with 29.4% incurring excessive expenditure. Main predictors of excessive expenditure included utilizing public services offering the complementary benefit package, expenditure composition, severity of illness, residence and wealth (p<0.05).

Conclusion: With limited cost-sharing mechanisms available, burdensome expenditure for health is a health financing challenge. The current Congolese reform should learn from expenditure studies.
The effect of GP-led commissioning on specialist visits and hospitalisations: evaluation of the 2012 Health and Social Care Act in England

The 2012 Health and Social Care Act in England gave control of £67 billion of the NHS budget for secondary care to GP-led Clinical Commissioning Groups. An expected outcome was that patient care would shift away from expensive hospital and specialist settings towards less expensive community-based models. However, there is little evidence for the effectiveness of this approach. This study aimed to assess the effect of NHS reforms on hospital admissions and outpatient specialist visits.

Using routine National Health Service hospital administrative data from 2007 to 2015, we used a controlled interrupted time series design to examine changes in trends in quarterly specialist visits and hospitalisations before and after the implementation of the Health and Social Care Act. We compared effects in England with those in Scotland as a control population. Outcomes included total, elective and emergency hospitalisations, and total and GP referred specialist visits.

Both countries had stable trends in all outcomes at baseline. In England, after the policy, there was very strong evidence of an increase in slope of 1.09% (95%CI 0.69–1.49%) more visits per quarter for total specialist visits and 1.60% more visits (95%CI 1.19–2.01%) per quarter for GP referred specialist visits, equivalent to 12.7% and 19.1% more visits by the end of 2015 respectively. In Scotland, there was no change in specialist visits. Neither country experienced a change in trends in hospitalisations: change in slope for total, elective and emergency hospitalisations were -0.22% (95%CI -0.62–0.16%), -0.22% (95%CI -0.59–0.14%) and -0.04 (-0.51–0.43%) per quarter in England.

Our findings suggest that giving control of healthcare budgets to GP-led Clinical Commissioning Groups was not associated with a reduction in overall hospitalisations, and may have increased specialist visits.

Samantha MACHEN
The National Institute for Health and Care Excellence (NICE) and the Cancer Drugs Fund (CDF) reimbursement decisions of oncology drugs from 2007–2016: an international comparison

Due to the expensive nature of cancer drugs and their marginal benefits, Health Technology Assessment (HTA) agencies are used worldwide to assess the clinical and economic value of a drug. England and its HTA agency, the National Institute for Health and Care Excellence (NICE), has come under criticism that its use of economic evaluation is too strict. Limited research suggests that England may reimburse fewer drug indications compared internationally and to improve this, the Cancer Drugs Fund (CDF) was introduced in 2010 to bring England more ‘in line’ with other westernised countries.

The main objective of this study was to identify key trends within NICE recommendations between 2007–2016 and compare these with CDF decisions with 4 other countries’ HTAs. The secondary objective was to ascertain the impact of the CDF upon NICE recommendations and trends and to compare the CDF’s decisions with the 4 other HTA bodies to see if the existence of the CDF increased agreement internationally.

From the period 2007–2016, 86 indications were assessed by NICE and 28 assessed by the CDF from 2010–2016. The 86 indications were compared to HTA agencies in Sweden (TLV), Germany (G-BA), Scotland (SMIC) and Australia (PBAC).

Quantitative agreement was determined by the Kappa statistical test. Across the 86 indications, the agreement between NICE and other HTA agencies was fair to poor with NICE recommending the fewest indications out of the HTA bodies. However, for the 30 indications not recommended by NICE, there was unanimous poor agreement between the 4 countries. Therefore, policy solutions, such as the CDF, aiming to bring England ‘in line’ with other countries may be flawed and unable to bring about realistic and meaningful change to access to oncology medicines in England.

Eleanor MACKILLOP
Quantifying life: understanding the historical emergence of Quality-Adjusted Life-Years (QALYs)

Quality-Adjusted Life-Years (QALYs) measurements are central to health care decision-making in Britain and abroad (Weinstein et al. 2009). Yet, their emergence remains obscure. I argue that what is needed is a more in-depth and political history of QALYs, allowing to better understand and critically evaluate its current dominance. In doing so, I mobilise Multiple Streams Analysis (MSA). Initially developed by Kingdon (1984; 1993), this framework builds a complex picture of how policy ideas ‘catch on’. Rather than recounting historical ‘trumps’, I focus on problematising the emergence of QALYs.

After reviewing the literature on the history of QALYs, I present the theoretical framework mobilised in this paper, Multiple Streams Analysis, at the same time as the empirical data. I problematize the emergence of QALYs in particular, characterising the three streams, policy entrepreneurs and windows of opportunity in the inception of QALYs, based on data collected from DH files, interviews with key players at the time such as civil servants and academics, and secondary literature. Finally, the conclusion offers some leads for future research, notably around discursive issues.

David MCDAID (A-La park, Emily Hewlett)
Facilitating implementation of effective approaches to promoting mental health and preventing mental illness across the OECD

In January 2016, the OECD published policy guidelines for an integrated approach to address the impact of poor mental health on health, education, employment and social outcomes. This paper presents the results of a subsequent survey and document review that has been conducted across all 35 OECD Members and four associate countries mapping and analysing policy, legislative initiatives and actions to promote mental health right across the life course. Despite an increasingly compelling evidence base on effective actions, there still appears to be a substantial disparity in the profile of promotion and prevention between OECD Member States.

The paper reflects on reasons as to why a number of countries have clearly recognised the importance and potential of preventive activities in the field of mental health. It also reflects on why actions are concentrated on infant, child and adolescent mental health promotion and disorder prevention, along with suicide prevention, in contrast to actions in workplaces, for the unemployed and those with poor job security as well as older people. It then sets out a series of policy and practice actions, including the use of financial mechanisms to help facilitate the scale up of implementation.
Ellen MCBRIOIE (Fred Matovu, Aisha Nanyiti, Justice Novvignon, Daniel Nana Yaw Abankwah, Kelsey Case, Timothy Hallett, Johanna Hanefeld, Lesong Conteh)

How do targets set by global actors influence national level priority setting and resource allocation? Findings from a qualitative study in Ghana and Uganda

The setting of health targets by global actors, intended for adoption at the national level, is widely supported as a means of focusing the attention of funders, implementers and national-level policy-makers. In 2014, the Joint UN Programme on HIV/AIDS set ‘ambitious’ treatment targets for country adoption: 90% of HIV-positive persons should know their status; 90% of those on treatment; 90% of those achieving viral suppression.

Using case studies from Ghana and Uganda, we explore how the target, and its associated policy content, has been transferred to the national level. A document review of National Strategic Plans for HIV/AIDS assessed commitments to 90-90-90. Semi-structured interviews with key informants involved in programme planning and resource allocation in HIV (16 in Ghana, 20 in Uganda) were analysed thematically, inductively and deductively, guided by pre-existing policy theories.

Both countries showed alignment to the target and associated policies despite potential programmatic and contextual constraints; the more emphatic commitment to 90-90-90 in Ghana was considered to be for advocacy purposes to mobilise additional domestic revenue. Both settings recognized the need to leverage current and potential resources through prioritization, program efficiencies, and devising novel financing mechanisms.

Morgane MICHEL (Jeanne Gervaix, Georges Haour, Karine Chevreul)

Mental illnesses and somatic comorbidities: delayed medical care and associated severity

People with a mental illness have a shorter lifespan and higher rates of somatic illnesses than the general population. We aimed to assess the effect of mental illness on the timeliness and access to healthcare for somatic reasons.

A longitudinal study was carried out using exhaustive national hospital discharge databases. All patients hospitalized for acute somatic reasons between 2009 and 2013 were included and those with a mental illness identified by their admissions for a psychiatric reason and contacts with psychiatric hospitals. The quality of prior somatic care was assessed using the number of admissions, admissions through the emergency room, avoidable hospitalizations, high severity hospitalizations, mean length of stay, and in-hospital death. Generalized linear models studied the factors associated with poor quality of primary care. 17,761,280 patients were included and 6.6% were mentally ill. Mental illness significantly increased the number of hospitalizations (+37%), high-severity hospitalizations (+45%), admissions through the ER (+70%), avoidable hospitalizations (+5%), and length of stay (+19%). However, it decreased the risk of in-hospital death (-13%).

Conclusion: Inadequate primary care of mentally ill patients leads more serious conditions upon admission to hospital. It is necessary to improve primary care and prevention for those patients.

Rosalind MILLER (Catherine Goodman)

Are chain pharmacies the answer to quality challenges in the retail sector? Evidence from India.

Pharmacies are typically patients’ first point of care in many low and middle-income countries (LMIC), but their practice is often sub-optimal. India has seen a growth in pharmacy chains, and it has been argued these may provide higher quality of care than independents, but this has been little studied. A standardised patient survey was conducted in 933 randomly selected chain and independent pharmacies in Bangalore, to measure quality of case management for childhood diarrhoea and tuberculosis. 108 exit interviews determined socioeconomic profile of customers. Quality of prior somatic care was assessed using the number of hospitalizations, admissions through the emergency room, avoidable hospitalizations, high severity hospitalizations, mean length of stay, and in-hospital death. Generalized linear models studied the factors associated with poor quality of primary care. 17,761,280 patients were included and 6.6% were mentally ill. Mental illness significantly increased the number of hospitalizations (+37%), high-severity hospitalizations (+45%), admissions through the ER (+70%), avoidable hospitalizations (+5%), and length of stay (+19%). However, it decreased the risk of in-hospital death (-13%).

Conclusion: Inadequate primary care of mentally ill patients leads more serious conditions upon admission to hospital. It is necessary to improve primary care and prevention for those patients.

Cristian MONTENEGRO (Flora Cornish)

Historicizing involvement, visibility and participation. User groups and the modernization of the Chilean mental health system

The modernisation of the Chilean mental health system after dictatorship has been praised for its technical adequacy. The deinstitutionalisation process and development of a network of local services and treatment guarantees have been promoted as a model for other countries in the region. But, given the current prominence of users’ organisations in high-level international frameworks, their voice and collective action constitute a complicated absence in that story. What explains this absence? Based on interviews with policy-makers, high-level professionals, involved users, ex-users, family activists and policy makers, this article presents a reconstruction of the emergence of ANUSSAM, the first mental health services users’ organisation in Chile. Situated between early 1990s and mid-2000s, using principles of oral history and a constructivist view of policy, it argues that the role and status of mental health service user organisations cannot be understood without considering the fragile reformation and institutional consolidation of psychiatry beyond the asylum, within the Chilean public health system. In the context of current global calls for the active involvement of users in mental health policy, a historical-qualitative approach could shed light into how users and their organisations have been imagined, approached and engaged by policy. In this sense, calls, plans and assessment instruments circulated by global policy agents such as the WHO run the risk of ignoring local conditions of agency and visibility, and this begs for further methodological discussion and innovation.

Giuseppe MOSCELLI (Rowena Jacobs, Nils Gutacker, María José Aragón, Martin Chalkley, Anne Mason, Jan R. Böhneke)

Categorising mental health patients for payment purposes: does the hospital matter? Evidence from English mental health providers

NHS Mental Health (MH) Trusts in England are moving away from being paid by block contracts to a new funding method similar to that used in acute hospitals, known as episodic payment. This reimbursement system provides the potential for clinicians to directly influence the level of reimbursement the provider hospital receives, and, since clustering is not based on diagnostic or procedure codes, it is difficult to audit. Given the current financial pressure on MH Trusts, it is important to assess whether the clustering process is fair or subject to some potential for gaming.

We investigate the presence of a systematic provider effect on patients’ assignment to clusters by using multinomial multilevel models on the MH Services Dataset (MHSDS) for the financial year 2014/15. The analysis includes only newly clustered patients to prevent lagged effects of previous clustering assignments. Our results for each of the three Superclasses show that there is significant unexplained variation at Trust level, which has an effect on the probability of being assigned to a given cluster or of a mismatch between the clinician’s and the MH Clustering Tool algorithm assignment. This may have important implications for policymakers in the design and operation of the MH payment system.

Samantha MURRAY

The episodic self/selves: bipolar disorder and the experience of the void

Bipolar disorder involves alternating episodes of mania, depression and ‘normal’ mood. This episodic lived experience undermines a culturally valued notion of a continuous, knowable ‘self’. In the modern West, the discovery and nurturance of one’s ‘authentic’ self has been installed as a necessary personal quest and key cultural narrative, yet the notion of a stable ‘true’ self has been contested by many. Poststructuralist thinkers reject the singular, innate self, arguing our identities are always multiple and in flux. Many scholars agree with this reading, but if the conception of the ‘true’ self is a cultural fiction, what of those with bipolar who desire a ‘true’, authentic, self? Personal bipolar narratives describe a confused self, defined by insubstantiality (Inder et al. 2008) and fracture (Chouinard, 2012; Potter, 2013). Some with bipolar perceive an unformed or lost self, opening a ‘void’ within. Some are uncertain about whether ‘genuine’ facets of their self are experienced episodically, or are mere manifestations of the disorder.

This paper presents an autoethnography of my own bipolar experience, navigating my persistent desire to conjure a stable, knowable self out of the ‘void’ within me. This analysis will foreground bipolar behavioural insights to better inform mental health care provision and treatment priorities.
Stefano NERI (Emmauelle Pavolini, Giovanna Vicarelli)

The Italian NHS in the era of austerity: is a "gradual transformation" taking place?

The paper describes the recent evolution of the Italian NHS, and addresses three issues. First, it compares the performance of the Italian health service with that of other Western European healthcare systems. Second, it offers an interpretation of the emerging trajectories of change, suggesting that a "gradual transformation" is taking place in the Italian NHS, slowly but progressively changing its universalist nature into a system more characterized by retrenchment and privatization. Third, the paper argues that retrenchment through different types of incremental transformative changes has been made possible also thanks to a dual weakening of the main veto points in NHS policy-making and the political system and of the main veto players (such as doctors’ associations and regional governments). This dual process is occurring at a time when the Italian NHS is under pressure from the economic crisis and austerity policies.

Mónica OLIVEIRA (Carlos A. Bana e Costa, Teresa C. Rodrigues)

The contribution of portfolio decision analysis for improved resource allocation in health care

In this presentation we describe and reflect upon the use of multicriteria portfolio selection models in three real case-studies: in the health technology assessment context, to select a portfolio of robotic innovations for minimal invasive surgical interventions under a limited budget, and to assist the Group of Health Centres of Northern Lisbon, in Portugal, to prioritize community care programmes in view of allocating scarce human resources; and in the public strategic planning context, to assist the Pernambuco State Department of Social Development and Human Rights, in Brazil, to prioritize health and competing non-health programmes considering their value-for-effort.

Participatory requirements and critical technical issues to be dealt with, so that the models are soundly developed, are then discussed, and we conclude with highlighting how advantageous would be the use of multicriteria portfolio selection models in healthcare contexts, particularly under the current pressure of budget cuts and the need of transparency in maximising value-for-money.

Camilla OLSEN (Hans Olav Melberg)

Did adolescents in Norway respond to the elimination of co-payments for General Practitioner services?

Co-payments for primary care services may lead to decreased access to and under-consumption of necessary health care for vulnerable patient groups, such as adolescents. Using a natural experiment form Norway, where, as of 2010, adolescents aged 12 to 15 were exempted from co-payments for general practitioner services, we estimate adolescents’ degree of sensitivity to co-payments. Since we have a large number of potential control groups (ages 0 to 67) we use a data-driven approach to construct a relevant counterfactual. We apply the synthetic control method, but use an elastic net regression to weight the control groups instead. Data on the number of GP consultations for males and females from 2006 to 2013 is obtained from the Norwegian Health Economics Administration and Statistics Norway.

We find that the effect of the exempting adolescents from co-payments was an increase in GP consultations per person of 22.1% for females and 13.8% for males in the post-intervention period. This indicates that adolescents between the ages of 12 and 15 were sensitive to having to pay a co-payment before the reform.

Trygve OTTERSEN (Matthew McCoy, Harald Schmidt)

The universal health coverage cube and its many variations: a systematic review and the way forward

With its inclusion in the Sustainable Development Goals, universal health coverage (UHC) is set to remain high on the global health agenda until 2030 and beyond. A graphical element – the UHC cube – has become central in the quest for UHC and has appeared in ever new forms and variations following its inclusion in the 2010 World Health Report. The cube is offered to help decision-makers and others understand, measure and take action towards UHC, and is thus meant to influence how countries pursue this goal. Yet, little is known about the range of cubes that have been proposed and how the UHC cube best can guide the fair and effective pursuit of UHC. This study examined the range of proposed UHC cubes, to identify strengths and weaknesses in existing designs and uses of the cube, and to propose a practical way forward to maximize utility of using the cube in working towards UHC. We conducted a systematic review of published and grey literature from 2010. After excluding duplicate and ineligible records, we conducted a full-text search to indentify instances of the UHC cube. We analyzed all cubes using a formal 6-category data extraction tool designed to capture variations in design. We found 40 variations [as of winter 2016] of the original WHR cube: these had their axes reabeled, stratified, or completely replaced. These modifications changed what it means to achieve UHC, how progress is best measured, and what policy options appear most promising.

he UHC cube is widely used and comes in numerous forms. The link between cube design and guidance towards UHC calls for care in the design and use of the UCH cube. With ever increasing complexity, the growing number of variations on cube risk becoming unintelligible. Against this background, we propose an essential UHC cube. We also propose a checklist that can support the use of this and other cubes and that highlights fairness and the link to the SDGs.

Piotr OZIERANSKI (Natalia Nicholls, Olga Lőlővölgy, Marcell Csandai, University of Pecs, Zoltan Kalo Syreon, Martin McKee, Lawrence King)

Formal vs practical transparency of the drug reimbursement process. Evidence from "verification analyses" issued by the Polish Agency for Health Technology Assessment in 2012-2015

In the last few years, the Polish Agency for Health Technology Assessment (AHTApOl) has been developing policies seeking to improve the transparency of publicly available information regarding its work. We evaluate likely impact of these policies by considering the transparency of the HTA process and its outcomes. We compare changes in the levels of transparency attained by the AHTApOl with evidence from appraisals undertaken by the National Institute for Health and Care Excellence (NICE) in England. In so doing, we consider all 332 assessment reports, called Verification Analyses, that the AHTApOl issued from 2012 to 2015, and a stratified sample of 22 Evidence Review Group reports published by NICE in the same period. The comparison with NICE suggests that the AHTApOl considerably improved the transparency of HTA outcomes, yet it made less progress in the transparency of the HTA process, especially in relation to sourcing and managing expert opinions. We conclude by setting our findings in a broader context of research on transparency in HTA and use them to formulate some practical recommendations for policymakers.

Noemi PACE (Jolene Skordis-Worrall, Marcos Vera-Hernandez, Imran Rasul, David Osirin, Dharma Manandhar, Anthony Costello)

Family networks and healthy behaviour: evidence from Nepal

Models of household decision-making commonly focus on nuclear family members as primary decision-makers. If extended families shape the objectives and constraints of households, then neglecting the role of this network may lead to an incomplete understanding of health seeking behaviour. Understanding the decision-making processes behind care seeking may improve behaviour change interventions, better intervention targeting and support health-related development goals.

This paper uses data from a cluster-randomized trial of a participatory learning and action cycle through women’s groups (PLA), to assess the role of extended family networks as a determinant of gains in health knowledge and health practise. We estimate three models along a continuum of health seeking behaviour: one that explores access to PLA groups as a conduit of knowledge, another measuring whether women’s health knowledge improves after exposure to the PLA groups, and a third exploring the determinants of their ability to act on knowledge gained.

We find that, in this context, a larger network of family will not affect women’s likelihood of attending groups or acquiring new knowledge but a larger network of husband’s family will have a significant and negative effect on their ability to act on that knowledge during pregnancy and the post partum period.
Jung-Min PARK (Bup-rae Roh, Hong Soo Kim)
Disparities in avoidable mortality by demographic and socioeconomic characteristics: a longitudinal study of over one million individuals

This prospective cohort study examines: (1) the rate of all-cause and avoidable mortality by demographic and socioeconomic characteristics, clinical conditions, and disability status; and (2) the risk of avoidable mortality by sex, income, and disability, after adjusted for other characteristics.

The data is composed of a nationally representative sample of 1,099,920 individuals in South Korea. The cohort was followed from 2002 to 2013. Avoidable mortality is all deaths defined as preventable and/or amenable. Cox regression was used to estimate the hazard ratio of mortality by population characteristics.

Risk of avoidable mortality was higher for individuals who are male, have low-income, have a disability, and live in rural areas. Being in a low-income group nearly doubled the risk of avoidable mortality compared to being in a high-income group. The risk of preventable deaths was considerably high for males. The risk of amenable deaths was substantially high for individuals with disability.

This study shows that information on avoidable mortality can be an indicator of social and economic inequality. This study also identifies high risk groups for preventable and amenable deaths, suggesting the directions for future interventions.

Justin PARKHURST
Governance implications of the drive for effectiveness: Political reflections on global health efforts to improve capacity to use evidence in health policymaking

There has been a dramatic proliferation of activities within the global health community to institutionalise tools of evidence review to inform health policy decisions. The primary justification for such activities is one of improving the effectiveness or efficiency of policy decisions, reflecting what Weiss (1979) described as a ‘problem-solving’ role for research evidence. Yet policy scholars (including Weiss) have argued that only a small minority of policy decisions are conducive to simple problem-solving approaches. Instead, the vast majority of policy decisions involve decisions between multiple competing and contested interests, with multiple possible pieces of relevant evidence. The use of particular bodies of evidence, or of particular evidentiary tools and approaches, will thus have decided political implications.

Within the policy studies community, institutionalisation is recognised as an inherently normative process – described by Selznick (1957) as a process of ‘infusing’ values into organisations, or by March and Olsen (1969) as establishing ‘logics of appropriateness’ which set the goals and expectations seen to direct activities within institutional settings. As such, institutionalising new ways of using evidence must be framed as a governance agenda – with ‘improvements’ in evidence use requiring an explicit consideration of what ‘good governance’ means in relation to evidence utilisation.

Isabel PERERA
Organising psychiatry: state, labour, and the politics of a policy transformation

The decline of patient populations in psychiatric hospitals transformed mental health policy across the West. Yet the results of this transformation, known as "deinstitutionalization," vary. In the United States, deinstitutionalisation privatized mental health care, limiting access to these services for middle and lower class Americans; but in France, the process boosted public provision, over time expanding the range of care available to citizens, even as social services confronted severe fiscal stress.

This paper examines why these two countries, which share a strong tradition of private medical practice, produced such different policy outcomes. A comparative-historical analysis attributes this divergence to a wholly overlooked factor: the organisational structure of medical labour. Where confederated medical unions have represented physicians, public psychiatrists have developed greater political autonomy, and more successfully defended public mental health care. Where medical labour has been more unified, however, the interests of dominant members have taken precedence. The result is that the winner-take-all politics of American medical labour has disadvantaged public psychiatrists in the United States, while its decentralised counterpart in France has benefitted this group. Historical primary sources identify how these differences shaped key policy developments, with lasting effects on citizens’ access to services in each country.

Benedetta PONGIGLIONE (George Pioubidis, Bianca DeStavola)
Disability-free life expectancy over a decade in England: understanding trends

The aim of this work is to assess how disability-free life expectancy (DFLE) has evolved over a decade in England distinguishing three levels of disability, and propose possible explanations for observed changes and differences across gender and severity levels.

We used data from the English Longitudinal Study of Ageing and considered both cross-sectional and longitudinal samples interviewed from 2002 to 2012. Disability classes were estimated using latent class analysis. DFLE was measured applying the Sullivan’s method. Additionally, years lost due to disability (YLD) were estimated to perform individual-level analysis and explore the role of BMI and year of birth in explaining changes.

Over the decade, changes in DFLE differed across gender and disability levels. Severe and moderate disability compressed for women and stayed constant for men. Preliminary evidence showed interactive role of cohort and BMI in changes in YLD, such that high BMI resulted particularly detrimental to younger cohorts.

Amélie PRIGENT (Blaise Kamendje-Tchokobou, Karine Chevreuil)
Socio-demographic, clinical characteristics and utilization of mental health care services associated with SF-6D utility scores in patients with mental disorders - Contributions of the quantile regression

Organizational changes in mental health care delivery are still needed. However, few studies on the relationships between patients’ Health-Related Quality of Life, measured by utility scores, and mental health care service utilization have been undertaken to support decision. This study aimed to investigate the links between utility scores and associated factors in patients with mental disorders.

Patients were recruited in four psychiatric sectors in France. Their responses to the SF-36 were used to calculate SF-6D utility scores. The relationships between utility scores and patient socio-demographic, clinical characteristics and mental health care utilization were studied using OLS and quantile regressions.

176 patients were included. Women, severely ill patients and those hospitalized full-time tended to report lower utility scores, whereas psychotic disorders and part-time care were associated with higher scores. The quantile regression highlighted that the size of the associations between utility scores and some patients’ characteristics varied along with the score distribution.

The fact that full-time hospitalization was associated with lower utility scores while part-time care was associated with higher scores supports the further development of alternatives to full-time hospitalization. The quantile regression may constitute a relevant complement for the analysis of factors associated with utility scores.

Dima QATO
The politics of medicines in refugee communities: the case of the Palestinians

Despite the promotion of essential medicines programs by UN agencies as critical mechanisms that promote the right to health, little is known about medication use practices in refugee communities. This paper will:

(1) Discuss the limitations of ongoing humanitarian efforts related to essential medicines in refugee populations;
(2) Discuss findings from an in-home survey, including a medication inventory, conducted in UNRWA Palestinian refugee households in Jordan and Palestine. Several case studies are presented that illustrate how the UN has failed to address barriers in accessing affordable medicines, the prevention of unsafe medication use, and the underutilization of existing UNRWA pharmacies. This study provides strong evidence that medication use practices are inextricably linked to the political environment that permeates daily life and may be contributing to poor health outcomes. Limited research on the role of medications in a post-conflict refugee setting have been conducted, and the results of this study can guide future efforts to improve the use of medicines in these communities.
(3) Identify innovative strategies that target priority areas aimed at improving access and safe use of medicines in Palestinian refugee populations. This is particularly important given UN accountability for protecting the health of Palestine refugee populations.
Matthew QUAFE (Fem Terris-Prestholt, Peter Vickerman)

The effect of HIV prevention products on incentives to supply unprotected commercial sex

This paper explores whether financial incentives for unprotected commercial sex will be affected by the introduction of new HIV prevention products. We collected stated preference data from 122 HIV-negative female sex workers (FSWs) in urban South Africa, using a repeated discrete choice experiment to simulate the impact of using an effective HIV prevention product on FSW preferences.

Results suggest that the price premium for unprotected sex will decrease when FSWs are protected from HIV. Act price is not a significant driver of choice in current practice, however strongly influences choices under full HIV protection. The utility offered by condoms is significantly reduced by use of alternative HIV prevention products. Because new HIV prevention products only have partial HIV efficacy and do not protect against other STIs or pregnancy, their total health impact may be reduced if not consistently used alongside condoms. The unintended consequences of introducing HIV prevention products should be closely monitored.

Diana QUIRMACH (Laura Cornelsen, Richard Smith, Mario Mazzocchi, Susan Jebb, Theresa Martea)

What is the impact on alcohol purchases of increasing the price of sugary drinks?

The UK government is set to implement an industry levy on sugar-sweetened beverages (SSB) in 2018. However, even if the levy were to be passed through fully and result in higher prices for SSBS, the overall health impact depends on the complement and substitution relationships across the whole diet. An aspect that receives less attention is the contribution of alcoholic beverages to the energy intake of households, with beer and wine providing on average 43 and 85 kilocalories per 100 ml, respectively; compared to 40 kcal in 100 ml of Coca drink. Limited references in the literature are available considering alcohol consumption from the energy intake perspective, but it is not clear how public health policies targeting either the price of non-alcoholic or alcoholic beverages affect the consumption of alcoholic drinks vis-a-vis SSBS.

In this paper we draw on a comprehensive dataset of individual purchases of food and drinks for 30,000 households in the UK (2012-2013) to estimate the own- and cross-price elasticities for SSBS, considering alcoholic and non-alcoholic drinks.

The estimated demand model accounts for (i) censoring of expenditure at zero, (ii) endogeneity of prices and expenditure, as well as (iii) unobserved heterogeneity at the household level.

Emma RADOVICH (Emma Rodovich, Mardieh Dennis, Kerry Wong, Moazam Ali, Caroline A. Lynch, John Cleland, Onikepe Ovolabi, Mark Lyons-Amos, Lenka Benova)

Who meets the contraceptive needs of young women? A cross-sectional study of first providers of family planning in 33 sub-Saharan African countries

Despite widespread efforts to expand contraceptive access, little is known about where young women (age 15-24) in low- and middle-income countries obtain modern contraceptives. We utilised data from 33 sub-Saharan African countries with a Demographic & Health Survey since 2000 about first source of respondent's current contraceptive method. We classified women according to sector (public or private) and capacity (limited or comprehensive) to provide a range of short- and long-term methods. We compared content of care received by younger and older women from different providers. Both public and private providers are important sources of contraception for young women.

Use of long-term methods among young women is low, but among those who use them, more than 70% report a public sector source. Older women (25+u) are significantly more likely to access a comprehensive provider in either sector compared to young women. While users of all ages report poor quality content of care across all providers, young women have even lower content of care. The results suggest that method and provider choice are strongly linked. Interventions to increase adolescent family planning access and improve quality of care should target providers frequently used by young people, including limited capacity, private sector providers.
Avoidable costs of stenting for aortic coarctation in the United Kingdom: an economic model

Maximilian SALCHER (Alistair Mcguire, Vivek Muthurangu, Marcus Kelm, Titus Kuehne, Huseyn Naci)

The scope for cost savings through the achievement of improved patient outcomes is unknown for congenital heart disease, where follow-up monitoring and reinterventions after initial treatment are costly and common. Our aim was to quantify the costs that could be avoided through improved treatment effectiveness and reduced complication rates associated with stenting treatment of coarctation of the aorta (CoA) in the United Kingdom.

We first calculated expected costs per patient associated with stenting for CoA as currently used in clinical routine. We then specified four hypothetical scenarios of improved treatment effectiveness and reduced complication rates, including a best-case scenario with ideal outcomes. We compared the costs of each scenario to the baseline costs to obtain estimates of avoidable costs. Compared to baseline (£16,668 total costs per patient over a five-year period), avoidable costs ranged from £137 per patient in a scenario assuming a 10% reduction in complications at follow-up, to £1,627 in the best-case scenario with 100% treatment success and no complications. Probabilistic sensitivity analysis showed a considerable degree of uncertainty for avoidable costs with widely overlapping 95% confidence intervals.

Conclusions: Costs associated with theoretically avoidable complications and potential room for improvement provide an attractive target for cost reduction efforts in health care. In stenting treatment of CoA, significant improvements in the treatment effectiveness and reductions in complication rates are required to realise discernible cost savings.
Giulia SCHNEIDER

A regulatory transparency challenge: can commercial confidentiality in clinical trials data be overcome?

This paper aims to define a legal framework of clinical trials data, by testing international the European rules of data secrecy against the expanding demands for disclosure.

Information embedded in clinical trial protocols is essential for the evaluation of drug’s safety and efficacy. However, clinical trials data do not only have a public informational value, but also an intrinsic regulatory- and therefore commercial- value, being key to the granting of drugs’ marketing license.

The study compares the general disclosure provision provided by art. 81(4) of Regulation EU 536/2014 establishing a publicly accessible European clinical trials database, with specific intellectual property measures providing guarantees of exclusivity to clinical testing data used to obtain marketing approval.

Research-based companies aiming to protect their “sweat of the brow” from competitors’ free-riding have invoked art. 39.3 TRIPS and the European data exclusivity regimes, as a legal basis for regulatory agencies’ non-disclosure obligation. This paper illustrates how drug’s safety information disclosure is not prevented by clinical trials protection rules. To the contrary, it provides a systemic justification for disclosure.

Ken SHADLEN (Bhaven Sampat)

Secondary pharmaceutical patenting: a global perspective

Pharmaceutical firms’ use of secondary patents to extend periods of exclusivity generates concerns among policymakers worldwide. In response, some developing countries have introduced measures to curb the grant of these patents. While these measures have received considerable attention, there is limited evidence on their effectiveness. We follow a large sample of international patent applications in the US, Japan, the European Patent Office, and corresponding filings in three developing countries with restrictions on secondary patents, India, Brazil, and Argentina. We examine cross-country comparisons of primary vs. secondary grant rates, consider the differential rates of “twin” applications filed in multiple countries, and undertake detailed analyses of patent prosecution in the three developing countries. Our analyses indicate that measures to restrict secondary patents in developing countries are having limited impact. In none of these three countries are specific policies toward secondary patents the principal determinant of grant rates. Our analyses also suggest the importance of other procedural aspects of patent systems, beyond the formal policies targeting secondary applications, that affect outcomes for these applications in developing countries.

Laura SOCHAS

Did removing user fees improve access to maternal health care in Zambia? A Difference-In-Difference Study

The removal of user fees charged for health services is a popular intervention to improve access to care. While there has been a long-standing debate about the effectiveness of this policy, few studies have used methods that allow for causal conclusions. This study investigates the effect of a 2006 policy removing health user fees in Zambia on the level of access to facility childbirth, using a difference-in-difference design.

Results suggest that the policy had no impact on access to facility births, a result that contradicts other studies in the Zambian context. Analysis of reasons given for not accessing care suggest that this may be linked to the multiple concurrent barriers to care that remain unaddressed by the policy. This study contributes to the literature through rigorous methods of causal inference and its conclusion that removing user fees is not always sufficient to deliver hoped-for gains in coverage for facility childbirth.
**Sofia SVERÉUS (Gustav Kjellson, Clas Rehnberg)**

**SOCIOECONOMIC DISTRIBUTION OF GP VISITS – RESULTS BEFORE AND AFTER SWEDISH PATIENT CHOICE REFORMS**

**Objective:** To assess the effect of patient choice reform and differences in reimbursement systems on the socioeconomic distribution of GP visits in Sweden, with specific focus on per visit payments.

**Methods:** Pre and post reform absolute concentration indices (ACIs) were computed using total population registry data from three Swedish counties (N=4 million). ACIs were decomposed by first, normal and recurrent visits (visits within 14 days from a previous visit), and related to inter-county differences in reform content.

**Results:** Visits increased over time in all counties and all socioeconomic groups. Total visit ACIs were increasingly pro poor, whereas ACIs for first visits remained relatively stable. Time trends were more distinct and clearly timed to reform implementation in Stockholm, where per visit payment were introduced, whilst they appear to have started pre reform in the other two counties. Recurrent visits, although a small share of total visits, explained half of the pro poor time trend.

**Conclusion:** Patient choice reform led to increases in the number of GP visits, but only marginally affected their socioeconomic distribution. Visits increased more where part of provider remuneration was through per visit payments, particularly among older and poorer individuals, and partly through increases in recurrent visits.

**Harini SWAMINATHAN (Narendra G Shah, Anurag Sharma)**

**CONSTRUCTING A HOUSEHOLD LEVEL HUMAN DEVELOPMENT INDEX FOR ESTIMATING DISTRIBUTIONAL DIFFERENCES: EVIDENCE FROM INDIA**

The Human Development Index (HDI) has been widely utilised to rank nations according to economic progress and overall well being of citizens. A major drawback of the HDI remains the inability to highlight the distributional differences within a country.

We propose a methodology to build an index at the household level. As economic inequality continues to increase among various states of India, leading to disparate development, this method will help in analysing differences as per population sub-groups and varying socio-economic status. We carry out the analysis for all states of India, using household level information on dimension indices that constitute the HDI. We additionally account for a child’s nutritional status at the household level as a complementary dimension, reflecting human capital development.

We find that inequality between states has primarily been driven by sizeable differences in the income and education component of the index. Inequality in the nutrition dimension is concentrated at the bottom of the distribution. An index such as this, will assist policy makers in effectively identifying areas that require appropriate resource allocation and enable effective performance measurement.

**Ranjeeta THOMAS (Ronelle Burger, Katharina Hauck)**

**RICHER BUT POORER IN HEALTH? THE INCOME GRADIENT IN CHRONIC CONDITIONS: NEW EVIDENCE FROM SOUTH AFRICA**

Extant evidence from developing countries is ambiguous on the relationship between income and chronic health conditions. The human capital framework (Grossman, 1972) suggests that individuals with higher incomes should be more likely to be aware of their health status and take preventive or remedial action. Using a uniquely nationally representative dataset from South Africa with objective health measures we analyse the differential effects of income on the prevalence and unawareness of having hypertension. Applying a finite mixture modeling approach we find that prevalence is concentrated amongst the rich, but only in a subgroup of men who are likely to be young and of either White or Asian race. There is no evidence of an income gradient for women. Using a censored bivariate probit model we find that a high proportion of hypertensive individuals are unaware of their status, but this unawareness is not concentrated amongst the poor indicating it is a serious public health concern across all income groups in South Africa.

**Aleksandra TORBICA (Rosanna Tamicone, Michael F. Drummond)**

**USE OF ECONOMIC EVALUATION IN HEALTHCARE PRIORITY SETTING: WHAT ROLE OF CULTURE, VALUES AND INSTITUTIONAL CONTEXT**

We investigate how the approach to economic evaluation in healthcare priority setting is influenced by the underlying culture, values and institutional context in a given country and provide insights for those considering expanding the role of economic evaluation. We developed and tested a conceptual framework in the five largest member states in the European Union that exhibit considerable differences in attitudes towards economic evaluation.

Our findings show that underlying culture and social values embedded in the institutional context deeply influence and shape the methods and use of economic evaluation in healthcare decision making. National health services emphasize universality and equity and the existence of a fixed budget. Social health insurance systems emphasize plurality, liberty and solidarity and place less emphasis on a fixed budget. The ‘Anglo-American’ administrative tradition encourages independent action on the part of decision makers and transparency in decision making. The ‘Napoleonic’ tradition encourages law making and the internalization of public decision-making, sometimes at the expense of transparency. The more regionalized a country is, the harder it is to establish a comprehensive and consistent approach to economic evaluation. These findings can inform policies aimed to foster the use of economic evaluation in decision-making, in the US and elsewhere.

**Carolyn TUOHY**

**THE HIGH POLITICS OF SCALE AND PACE IN HEALTH CARE REFORM**

This paper presents ten cases of major change in health policy over seven decades (1945-2015) in four nations (USA, UK, Netherlands, Canada). It offers an original approach to understanding the conditions under which such discontinuous changes in public policy occur.

First, it explains the occurrence of windows of opportunity for change; second, it deconstructs the decision processes that are made within these windows. These decisions involve two dimensions of change: the scale of change in prevailing policy frameworks and the pace at which those changes are pursued, yielding four possible strategies: large-scale and fast-paced (big-bang), large-scale and slow-paced (“blueprint”), small-scale and rapid (“mosaic”), and small-scale and gradual (incremental). Each type is a product of “high politics” beyond the health care arena itself, as political actors at the centre of government, individually and collectively, assess their ability to overcome vetoes in the present and over time.

**Liina-Kaisa TYNKKYHEN** (Nina Alexandersen, Oddvar Kaarboe, Anders Anell, Juhani Lehto, Karsten Vrangbæk)

**DEVELOPMENT OF VOLUNTARY PRIVATE HEALTH INSURANCE IN NORDIC COUNTRIES – AN EXPLORATORY STUDY ON COUNTRY-SPECIFIC CONTEXTUAL FACTORS**

The Nordic countries are healthcare states with tax-based financing and ambitions for universal access to comprehensive and high quality care. The distribution of healthcare resources should be based on individual needs, not on the ability to pay. Despite this ideological tradition, significant expansion in voluntary private health insurance (VPHI) contracts has occurred in recent decades. The development and role of VPHIs are different across Nordic countries. Complementary VPHI plays a significant role in Denmark and in Finland while duplicate VPHI is prominent in Norway and Sweden.

We describe and analyze country-specific contextual factors related to national political and institutional contexts that influence the type and scope of VPHI markets in the Nordic countries. We argue the early developments in VPHI markets have been an answer to the gaps and inefficiencies in the national health systems created by institutional contexts, political decisions, and cultural interpretations on the functioning of the system. However, once the market for VPHI is created it introduces new dynamics that have less to do with gaps and inefficiencies and more with cultural factors.
Ioana VLAD
The institutionalisation of Health Technology Assessment (HTA) in two middle-income countries: Thailand and the Philippines

HTA agencies are increasingly being established in low and middle-income countries, as a response to pressures on health systems to adopt new, expensive technologies, while expanding health coverage, ensuring financial health protection and delivering high-quality services. HTA agencies are among the more clearly institutionalised forms of evidence advisory bodies in health, as often they are or aim to be government-mandated bodies. This research explores the institutionalisation of HTA as a policy process. We develop a framework applying theoretical insights from political science to conceptualise the institutional structure of HTA bodies as a combination of rules, practices and norms that constrain the agency of stakeholders. The framework enables exploration of how politics – conceptualised as ideas, interest, institutions – will influence the creation of HTA bodies, including the choices made for their design, as well as their functioning. This project consists of comparative research in Thailand and the Philippines, which differ in their trajectories for HTA institutionalisation, but have a long history of engagement with HTA. It employs qualitative case study methodology, specifically a multiple case study design, to identify how politics plays out differently or similarly between the two cases of HTA development. The analysis draws links between the objectives, scope and processes for the two bodies of concern and the existing local institutional environments. It thus sheds light on the often-unexplored issue of how the wider institutional context and power struggles can shape the sustainability of emerging HTA bodies and processes. As a counter-balance to the fact that HTA and other evidence-informed policy-making initiatives are often promoted in a de-contextualised manner, applying insights from political science is helpful in exploring both the context-specificity of HTA and its international, policy transfer components.

Alex WADDAN (Daniel Béland, Philip Rocco)
Escaping the past? The problems of implementing health care reform in the US

This paper draws on the historical institutionalist literature on policy feedback to reflect on the political fate of the ACA since its enactment in 2010, with a particular focus on the Republican mobilization against this reform at both the federal and the state level. Due to its sheer complexity, the ACA generates both positive and negative feedback effects that can either facilitate or impede conservative reform. In other words, breaking down the ACA into different reform areas is the only way to assess the practical weight of its policy legacies on ongoing reform attempts. At the same time, we show that several institutional characteristics of the ACA create particular conditions to reform. These characteristics are (1) the lack of maturity of the ACA, which has not been fully implemented yet; (2) the territorial fragmentation of ACA policies and the related absence of a centralized administrative apparatus that could push for its preservation and its expansion; and finally, as a consequence of this fragmentation and of the overall complexity, an opaque nature that tends to push the public to support or oppose the reform based on partisan valence rather than a direct assessment of the benefits it might provide.

Marjan WALLI-ATTAEI (Jeremiah Hurley)
An empirical test of inequality aversion towards income and health

Objective: We estimate inequality aversion towards income inequality, health inequality, and income-related health inequality.

Methods: We use a stated-preference experiment to empirically estimate the inequality aversion parameters for residents of Ontario, Canada. Respondents are presented with choice scenarios containing two distributions of the relevant outcome, constructed such that if the respondent has an inequality-aversion parameter equal to a pre-specified value they will be indifferent between the distributions. Depending on which distribution they choose, we can infer that their inequality aversion is greater or less than the value assumed. We also examine the association between inequality aversion and individual characteristics.

Results: 1,964 participants took part in the survey. We presented participants with pre-specified inequality aversion (IA) parameters that range from little aversion of inequality (IA parameter = 1.0) to considerable aversion to inequality (IA > 3.0). For income, we find substantial inequality aversion, with a median IA greater than 3; median IA is between 1.5 and 2.0 for income-related health inequality – exactly in line with the assumed value for the standard concentration index used in much health economics. For health, however, preferences appear to be more heterogeneous and complex. There appears to be a strongly bi-modal distribution of inequality in the population, with approximately 51% displaying little inequality aversion (IA < 1.0) and 47.5% displaying substantial inequality aversion (IA > 3.0).

Austin WARTERS (Patricia Keithly, Maria Brenner)
Integration of health and social care for children with complex health conditions: policy and organisational challenges across Europe

Across Europe, there is a growing interest in integrated and personalised social care services for vulnerable groups, such as older people with long term care needs. However, relatively little is known about the policy, organisational and practical aspects of integrated health and social care for children with complex health conditions (CNN) in Europe. This study, which is part of a large EU funded project on children’s primary health care, Models of Child Health Appraised (MOCHA), seeks to examine the legal, organisational and policy structures to meet the social care needs of children with CNN. Using a network of child health and social care experts in 30 EU countries a standard set of questions were asked on the legal, organisational and policy structures to meet the social care needs of CNN. The questions included a case vignette to explore the integration of primary care and social care. The results of this study found that while some countries deliver social care service through government agencies, many outsource to non-profit and commercial organisations. One third of countries have an established policy framework with specific recommendations on the integration of social care with health for children. Ongoing work will explore if this improved practice.

Anke WEBER (Marie Clerc)
Deaths amenable to health care: Converging trends in the EU?

Amenable mortality is included in the monitoring tool of the European Commission to assess a country’s health system performance. Amenable deaths are premature deaths, which should not have occurred in the light of timely and effective health care. This paper provides annual amenable mortality rates for 28 EU countries and the EU average for the period 1994-2013 based on the recently published list of amenable deaths by Eurostat. Thereby, it offers a consistent calculation of amenable mortality across European Member States.

While great improvements were made in reducing amenable deaths overall, substantial variations persist among Member States. Most of the decreases in amenable mortality are explained by a steep reduction of deaths due to circulatory system diseases. In addition, even in countries with good national performance on amenable mortality, sub-national analysis shows that great regional disparities exist. Our sensitivity analysis revealed that for the majority of countries results are stable across different attributional weights used for ischaemic heart diseases and cerebrovascular diseases. However, consistent monitoring of countries’ developments and comparisons across countries and time of amenable mortality must be based on a single list and fixed attributional weights of diseases.

Lorraine WILLIAMS (Raphael Wittenberg, Stefanie Ettelt, Jackie Damant, Margaret Perkins, Daniel Lombard)
Direct Payments in residential care: evaluation of trailblazers

Personalisation, choice and control are important policy objectives for adult social care in England. One mechanism for promoting these objectives is the use of direct payments, which are cash payments to individuals to meet some or all of their eligible care and support needs. In 2012, the Department of Health (DH) piloted direct payments in long-term residential care within 20 local authority ‘trailblazers’, across England, ending in autumn 2015. DH commissioned the Policy Innovation Research Unit (PIRU) to conduct an independent evaluation of the programme. Its objectives were to understand the different ways in which direct payments were delivered to residents of care homes and the challenges surrounding implementation; to assess the impact of the scheme on service users, their families and other stakeholders; and to examine the relative costs and cost-effectiveness of different direct payment models, if possible. A mixed method approach was employed, involving surveys and interviews with service users and family members as well as local authority and care home staff. 14 trailblazers developed three models: full payment covering the whole care home fee; part payment to fund day activities/services; or extra payments to fund one-off activities. The take-up of direct payments was far lower than expected, with around 30 in place when the trailblazer programme formally ended. The available evidence suggests that there have been challenges associated with setting up and implementing direct payments, and many local authority and care home staff expressed doubts about whether they were the best way to promote choice and control for care home residents. There were also concerns about whether they might adversely affect the financial viability of care homes. However, most service users who received direct payments in residential care or their family members were satisfied with them.
Ulrika WINBLAD (Andreas Karlsson, Paula Blomqvist)

Do for-profit providers in nursing home care provide lower quality? Evidence from Sweden

Private providers have become more common in Swedish elder care over the last two decades. The vast majority of these are for-profit firms, most with ownership by private equity companies. The growing number of commercially oriented providers in a key welfare area such as elder care have given rise to questions regarding quality development and whether there is a risk of quality reduction due to strong profit motives. In this article, we investigate whether for-profit providers, and especially private equity companies, provide lower quality of care compared to public providers of nursing home care in Sweden.

The data source was a national survey conducted by the National Board of Health and Welfare at 2,710 nursing homes. Data from 14 quality indicators were analyzed, including structure and process measures such as staff levels, staff competence, resident participation, screening for pressure ulcers, nutrition status and risk of falling. The main statistical method employed was t-tests to compare means and multiple OLS regression analysis.

Conducting the critics, private elder care providers tended to score better on process-based quality indicators such as meal choices and screening for falls and malnutrition. Public providers, however, had higher scores on structural quality indicators such as staffing levels and a larger share of permanently employed staff compared to for-profit nursing homes. The differences between public and private providers were mostly driven by private equity-owned nursing homes, as these show lower ratings on some quality indicators, particularly those relating to staff density.

Ownership does seem to be related to quality in nursing home care in Sweden, even though the same financial conditions and public regulations apply for public and private providers to safeguard equal quality of care. Since earlier research has shown that staffing is an important determinant of quality in nursing home care this implies that the presence of profit motives in elder care may influence the quality of care in a negative way, even if profit-driven providers tend to score higher on some other quality indicators, related to processual quality.

Michael WOODS (Serena Yu)

Aged care reform in Australia: lessons from the policy process

The twin pressures of population ageing and fiscal stress increasingly challenge the sustainable provision of home-based and residential care to the elderly in many countries. This paper explores how sound public policy processes, a focus on system design, and the alignment of system incentives can combine to provide a pathway for sustainable reform. It examines the development of a system-level policy framework founded on evidence-based research, community dialogue and active stakeholder engagement in the period 2010–12 in Australia and the incremental implementation of reform in the subsequent three years.

This case study highlights three important reforms. First, the shift to a consumer-oriented, entitlement-based model has sought to deliver greater choice to Australia’s elderly. Second, the relaxation of supply-side constraints has addressed significant unmet demand. Finally, an overhaul of funding arrangements through more targeted public subsidies and consistent private co-contributions has been important for addressing fiscal challenges and equity concerns. A year-long review of these reforms has commenced, and this paper identifies some of the key questions that Australia, and other governments, needs to address in developing sustainable aged care systems.

Kanako YOSHIKAWA

Financial incentives and their impact on maternal and child health coverage: the case of the Philippines

Maternal and child health remain major issues in low- and middle-income countries. Conditional cash transfers (CCTs) provide as an intervention in promoting maternal and child health. CCTs help poor households overcome the direct treatment and indirect travel costs to a health facility and reimburse opportunity costs related to taking time off work. This study aimed to evaluate the effectiveness of a CCT in the Philippines, namely, the Pantawid Pamilyang Pilipino Program (4Ps) on child immunisation coverage and safe delivery. By applying a logistic regression on household data from the 2013 National Demographic and Health Survey, this study finds that 4Ps helps children from poor households to take immunisations. However, this study finds the poor timeliness of child immunisation uptake and postnatal care (PNC) use even though beneficiaries have to follow the planned schedule. In addition, there is no significant impact on safe delivery. By applying an instrumental variable (IV) method, this study suggests that complying with the first condition to receive grants (i.e. taking BCG immunisation for child health and taking antenatal care (ANC) service use for maternal health) motivates 4Ps households to complete all required vaccination for children and to take PNC service for pregnant women.
ACKNOWLEDGEMENTS

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Our thanks go to all Session Chairs for their support in leading the conference sessions and to the organising committee for their input over the last year in putting the event together. Particular thanks to Adam, David, Huseyin, Matteo and Mark for their leadership across the five themes and their time reviewing and selecting papers. Also to Beth, Anthony and Mina for organisational and administrative support and to Sarah Moncrieff for booklet design.