

Wennberg International Collaborative  
2015 Fall Research Meeting  
September 2 – 4, 2015

**Wennberg International Collaborative 2015  
Conference Materials**

# Logistics

## Dates & Times

September 2, 2015 | noon  
through  
September 4, 2015 | 13:00

## Conference Location

The Royal College of Surgeons of England  
35-43 Lincoln's Inn Fields, London WC2A 3PE, United Kingdom

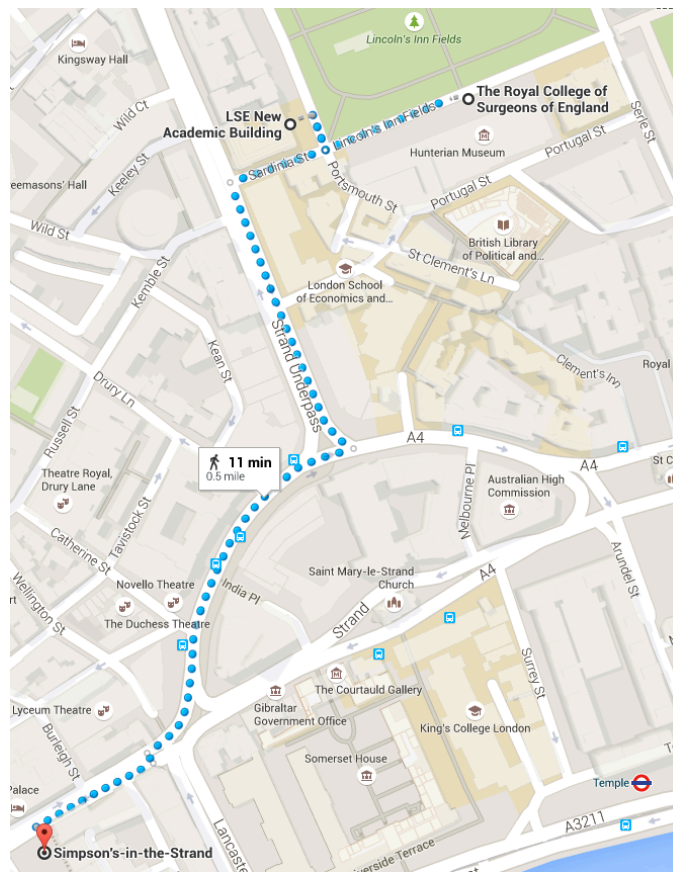
## Reception

September 2, 2015 | 6:00 – 9:00 PM  
8<sup>th</sup> Floor, New Academic Building, London School of Economics  
54 Lincoln's Inn Fields, London WC2A 3LJ, United Kingdom

## Dinner

September 3, 2015 | 6:00 – 10:00 PM  
Simpson's in the Strand  
100 Strand, London WC2R 0EW, United Kingdom

## Map



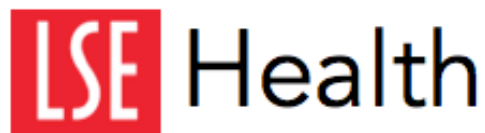
## Acknowledgments

Wennberg International Collaborative  
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The Wennberg International Collaborative is a partnership between The Dartmouth Institute for Health Policy & Clinical Practice and The London School of Economics and Political Science

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*Cover: Full Cover Design by Linnea Spelman*

*Map Graphics: Diane Watson (National Health Performance Authority - Australia) and Catherine Gerard (Health Quality & Safety Commission – New Zealand)*

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September 2 – 4, 2015

**Agenda**

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 September 2 – 4, 2015

**Wednesday, September 2, 2015**

<b>Time</b>	<b>Event</b>	<b>Location</b>
12:00 – 12:15	Welcome Professor David Goodman, The Dartmouth Institute Professor Gwyn Bevan, London School of Economics	Committee Room 3
12:15 – 12:30	Dominik von Stillfried (Germany) <i>Report on the Spring Policy Meeting</i>	Committee Room 3
12:30 – 13:00	Mike Barry (USA) <i>Getting to the Right Rate: The Role of Informed Patients</i>	Committee Room 3
13:00 – 13:25	Anne E.M. Brabers (The Netherlands) <i>Shared decision-making results in less variation between hospitals</i>	Committee Room 3
13:25 – 13:50	Milo Puhan (Switzerland) <i>Smarter Health Care - A National Research Program on Health Services Research</i>	Committee Room 3
13:50 – 14:15	Philipp Storz-Pfennig (Germany) <i>"Problems with Medical Science": Perception of research needs in the Dartmouth Atlas publications from 1996 to the present</i>	Committee Room 3
14:15 – 14:40	Catherine Gerard (New Zealand) <i>Engaging with policymakers to address the findings of variations analyses</i>	Committee Room 3
14:40 – 15:00	Panel Discussion Moderator: Mike Barry (USA)	Committee Room 3
15:00 – 15:30	Break	Council Rooms
15:30 – 15:55	Imo Keskimäki & Sonja Lumme (Finland) <i>Investigating geographic and time trends for equity in healthcare</i>	Committee Room 3
15:55 – 16:20	Frede Olesen (Denmark) <i>Towards explanations of variation</i>	Committee Room 3
16:20 – 16:45	William Weeks (USA) <i>Substantial geographic variation in French mental health admission rates suggest cultural differences in admitting practices</i>	Committee Room 3
16:45 – 17:10	Panel Discussion Moderator: Gwyn Bevan (UK)	Committee Room 3
17:10 – 17:40	Elliott Fisher (USA) <i>Policy and payment responses to variation in health care value</i>	Committee Room 3
17:40	Adjourn	

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Wennberg International Collaborative  
2015 Fall Research Meeting  
September 2 – 4, 2015

### Thursday, September 3, 2015

TIME	EVENT	LOCATION
8:00 – 8:40	Data Statement Discussion David Goodman (USA) and Gert Westert (The Netherlands)	Committee Room 3
8:40 – 9:10	Andreas H. Taenzer (USA) <i>Improving Effective Care: Reducing Deaths from Sepsis by Reducing Variation</i>	Committee Room 3
9:10 – 9:35	Shawn Ralston (USA) <i>Hospital Variation in Health Care Utilization by Children with Medical Complexity</i>	Committee Room 3
9:35 – 10:00	Jostein Grytten (Norway) <i>Interventions at birth - do they save lives? A micro data analysis over more than 40 years in Norway</i>	Committee Room 3
10:00 – 10:25	Céu Mateus (Portugal) <i>A spatiotemporal analysis of C-section rates in Portuguese NHS hospitals</i>	Committee Room 3
10:25 – 10:50	David Goodman & Wade Harrison (USA) <i>Regional variation in newborn special care in the United States</i>	Committee Room 3
10:50 – 11:15	Panel Discussion Moderator: Astrid Guttman (Canada)	Committee Room 3
11:15 – 11:45	Break	Council Rooms
11:45 – 12:10	Brendon Kearney (Australia) <i>Population Health Research Network: Activities and Opportunities</i>	Committee Room 3
12:10 – 12:35	Diane Watson (Australia) <i>Monitoring and reporting unwarranted variation across all of a nation's public and private hospitals and primary health care</i>	Committee Room 3
12:35 – 13:00	Laura Schang (UK) <i>Complementary logics of target setting: Hierarchist and experimentalist governance in the Scottish National Health Service</i>	Committee Room 3
13:00 – 13:25	Panel Discussion Moderator: Matthias Egger/ Milo Puhon (Switzerland)	Committee Room 3
13:25 – 14:25	Lunch	Council Rooms
13:55 – 14:25	Estella Geraghty (USA) Expanding GIS to create Smart Hospitals	Committee Room 3
14:25 – 14:50	Micaela Comendro & Enrique Bernal-Delgado (Spain) <i>Variation in excess cases of adverse events amenable to health care: Low value care with budgetary impact</i>	Committee Room 3
14:50 – 15:15	Jessica Sheringham (UK) <i>Variations in GP decisions to investigate suspected lung cancer: A factorial experiment using multimedia vignettes</i>	Committee Room 3

**Agenda**  
 Wennberg International Collaborative  
 2015 Fall Research Meeting  
 September 2 – 4, 2015

15:15 – 15:40	Sabina Nuti (Italy) <i>Variation in primary care: Insights from the Tuscany region</i>	Committee Room 3
15:40 – 16:00	Panel Discussion Moderator: Gert Westert (The Netherlands)	Committee Room 3
16:00 – 16:25	Break	Council Rooms
16:25 – 16:50	Marina Davoli (Italy) <i>Geographic variation of access and outcome of health care in Italy: Estimating the role of hospital and primary care</i>	Committee Room 3
16:50 – 17:15	Grégoire Mercier (France) <i>Geographic Variation in Potentially Avoidable Hospitalizations in the Languedoc-Roussillon Region, France</i>	Committee Room 3
17:15 – 17:40	Noriko Sasaki (Japan) <i>Sources of Variation in Implementing Evidence-Based Care: Focusing on ICT Infrastructure for Clinical Evidence</i>	Committee Room 3
17:40 – 18:00	Panel Discussion Moderator: Enrique Bernal-Delgado (Spain)	Committee Room 3
18:00	Adjourn	

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 Wennberg International Collaborative  
 2015 Fall Research Meeting  
 September 2 – 4, 2015

**Friday, September 4, 2015**

TIME	EVENT	LOCATION
8:15 – 9:00	David Goodman <i>State of the WIC</i>	Committee Room 3
9:00 – 9:25	Irene Papanicolas (UK) <i>Exploring Variations in Patient Satisfaction</i>	Committee Room 3
9:25 – 9:50	Philip Wilcock (UK) <i>Commissioning for Value in England</i>	Committee Room 3
9:50 – 10:15	Sandra Garcia-Armnesto (Spain) <i>Developing a disinvestment strategy for the Spanish National Health Service</i>	Committee Room 3
10:15 – 10:40	Anne Vestergaard (Denmark) <i>Geographical variation in use of intensive care: a nationwide study</i>	Committee Room 3
10:40 – 10:55	Panel Discussion Moderator: Marion Grote Westrick (Germany)	Committee Room 3
10:55 – 11:15	Break	Council Rooms
11:15 – 11:40	Dominik von Stillfried (Germany) <i>Variation in ambulatory care for non-institutionalized patients with dementia in Germany</i>	Committee Room 3
11:40 – 12:05	Jörg Bätzing-Feigenbaum (Germany) <i>Longitudinal regional analyses of antibiotic consumption in statutory health care insured patients in Germany since 2008</i>	Committee Room 3
12:05 – 12:30	Anne Kudsk (Denmark) <i>Regional variation in the treatment efforts for patients with lung cancer in Denmark</i>	Committee Room 3
12:30 – 13:00	Panel Discussion Moderator: Thérèse Stukel (Canada)	Committee Room 3
13:00	Adjourn	



Wennberg International Collaborative  
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September 2 – 4, 2015

## **Poster Presentations**

**Reception & Poster Presentations**  
Wennberg International Collaborative  
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**Poster Presentations**

September 2, 2015 from 18:00 – 21:00

8<sup>th</sup> Floor, New Academic Building, London School of Economics

54 Lincoln's Inn Fields, London WC2A 3LJ, United Kingdom

<b>Presenter</b>	<b>Title of Poster</b>
<b>Claudia Berlin (Switzerland)</b>	Do CVD and stroke mortality vary by distance to hospital in Switzerland?
<b>Ilir Hoxha (Kosovo)</b>	C sections in Kosovo: Who's responsible for the rise?!
<b>Pia Kristensen (Denmark)</b>	Variation in mortality among patients with hip fracture in Denmark: Studies on the role of structure and quality of care
<b>Xhyljeta Luta (Switzerland)</b>	Place of death in Switzerland: Dying in hospital or non-acute institutions?
<b>Mats Nilsson (Sweden)</b>	How do we know if the patients improve their health or not, and if so, how much?
<b>Tetsuya Otsubo (Japan)</b>	Relationship between outcome and process measures of ischemic stroke care at a regional perspective in Japan
<b>Adrian Pana (Romania)</b>	Multiple determinants of avoidable mortality in Romania
<b>Christina Petersson (Sweden)</b>	Children's experience of an intervention with a structured assessment of health-related quality of life
<b>Diane Watson (Australia)</b>	Comparable costs of admitted care across more than 80 Australian public hospitals

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September 2 – 4, 2015

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2015 Fall Research Meeting  
September 2 – 4, 2015

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## **Agenda Abstracts**

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**Title**

Longitudinal regional analyses of antibiotic consumption in statutory health care insured patients in Germany since 2008

**Background (500 characters or about 90 words)**

Increasing resistance to certain antibiotics is observed in bacterial pathogens. This development is caused, among other factors, by the medical use of antibiotics and has been leading to an intensive and ongoing debate about the rational use of antibiotics and the risk of inappropriate antibiotic medications. Therefore, a continuing monitoring of antimicrobial drug utilization is needed - over time and at regional levels.

**Objectives (500 characters or about 90 words)**

For the ambulatory health care sector in Germany, prescription data of statutory health insurance physicians can provide information about population-based antibiotic drug consumption. The aim of the present study was to analyze temporal trends in the rates of antibiotic use in the ambulatory health care sector. The study covers a seven-year period, 2008-2014.

**Methods (720 characters or about 125 words)**

The analysis is based on the nationwide drug prescription data of the 17 regional Associations of Statutory Health Insurance Physicians. Antibiotic prescriptions were identified by ATC codes of the group J01 ("anti-infectives"). Three indicators, number of packages, DDD and number of patients with at least one antibiotic prescription annually, were determined by region and year in relation to the total population of the statutory health insurees in Germany ("KM6 statistics"). We computed both age-adjusted and age-specific regional prescription. Temporal trends of these rates were analyzed using joinpoint regression and quantified with the annual percent change (APC).

**Results (720 characters or about 125 words)**

We found significantly declining trends of antibiotics use in the age group of children and adolescents nationwide and in all 17 regions, starting from different baseline levels in 2008. Cephalosporins were more frequently used in this age group, but some regions with declining prescription rates of this drug group were identified. The age range of 15 - 69 years did not reveal much general change, while the proportion of third generation cephalosporins drops nationwide like in the other age groups. However, the decrease varied by regions. Fluoroquinolone use declined in the age group of 70 years and older with, furthermore, a shift to group I quinolones.

**Conclusion (600 characters or about 100 words)**

Despite a declining trend of antibiotic prescriptions in children and adolescents, an increasing role of cephalosporins over all ages is obvious. The use of fluoroquinolones in adults is rather unchanged, but decreasing in the elderly. These trends show regional variations. Both drug groups are particularly involved in the development of multidrug-resistance in gram-negative bacteria. They should be used as second line antibiotics only. Our results point to specific intervention options by regions and age to counteract the further spread of bacterial resistances in Germany.

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**Title**

Shared decision-making results in less variation between hospitals

**Background (500 characters or about 90 words)**

It has been hypothesized that patient involvement, and especially shared decision-making (SDM), reduces variation in medical practice, because research shows that patients, through a combination of education and participation, were less ready to accept certain procedures. However, no clear evidence about the association between SDM and variation is available yet.

**Objectives (500 characters or about 90 words)**

This study addresses the question: does SDM reduce medical practice variation? The aim of the study is to examine how SDM is associated with variation in the choice of single embryo transfer (SET) or double embryo transfer (DET) after in vitro fertilisation (IVF). We examine variation both between and within hospitals.

**Methods (720 characters or about 125 words)**

A secondary analysis of a randomised controlled trial was performed. The intervention was SDM via a multifaceted strategy aimed to empower couples in deciding how many embryos should be transferred. The strategy consisted of a decision aid, support of an IVF nurse, and the offer of reimbursement for an extra treatment cycle. The control group received standard care for IVF. 222 couples (woman aged <40) on a waiting list for a first IVF cycle, who could choose between SET and DET (i.e.  $\geq 2$  embryos available) out of five hospitals in The Netherlands were included. With different methods, we calculated differences in variation due to SDM in the choice of SET or DET, both between and within hospitals.

**Results (720 characters or about 125 words)**

There was large variation in the choice of SET or DET between hospitals in the control group. Lower variation between hospitals was observed in the group with SDM. Within most hospitals variation in the choice of SET or DET appeared to increase due to SDM. This was particularly in hospitals where mainly DET was chosen in the control group.

**Conclusion (600 characters or about 100 words)**

Including patients' preferences through SDM results in less variation between hospitals, and indicates another pattern of variation within hospitals. The variation that results from patient preferences could be potentially named the informed patient rate. This study was the first to explore the relationship between including patients' preferences in medical decision-making and practice variation. The results of this study provide the starting point for further empirical research within this area.

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**Title**

Variation in excess cases of adverse events amenable to health care: low value care with budgetary impact

**Background (500 characters or about 90 words)**

Variations in patient safety events in public hospitals in Spain are dramatic. In the particular case of pulmonary thromboembolism and/or deep venous thrombosis (PTE/DVT), similar to the 7.6 PTE/DVT per 1,000 surgical interventions in English public hospitals, the incidence of 8 cases per 1,000 surgeries vary in a 3-fold factor across Spanish public hospitals. It is, of course, about avoidable harm but also about high opportunity costs.

**Objectives (500 characters or about 90 words)**

This work in progress aims to: 1) assess the fraction of variation in incidence rates amenable to the hospital of treatment in post-surgical pulmonary embolism or deep vein thrombosis; and 2) estimate and quantify the excess-cost attributable to the appearance of this specific adverse event.

**Methods (720 characters or about 125 words)**

Observational, cross-sectional study on all surgical discharges produced in 2009 and 2010 by the 50 largest Spanish public hospitals. Basal excess length of stay was estimated modelling a log-lineal multilevel regression considering both patient and hospital differences. The average and hospital-specific effect on length of stay of those patients with an adverse event (vs. those without) was estimated using Propensity Score Matching (kernel-based technique) to reduce the risk of selection bias. Median Odds Ratio (MOR) was used as an estimator of the average relative impact of the hospital of treatment in the appearance of PTE/DVT. As per budgetary impact, excess length of stay was converted into excess-costs.

**Results (720 characters or about 125 words)**

1,072,613 surgical episodes were analysed. 7,777 were signalled as having a PTE/DVT. The hospital of treatment was responsible of a 40% (MOR=1.4) of the variation in the incidence of PTE/DVT. Multilevel log-lineal specification showed that the appearance of this adverse event turned into a 40% increase of basal length of stay (5.4 excess days). After propensity score matching, multilevel analysis elicited an excess length of stay ranging from 4.6 days in the hospital with the shortest stay to 9.2 days in the hospital with the largest length of stay. Finally, the average cost per excess days was 5,500 euros, ranging from 3,800 € 7,600 euros depending on the hospital.

**Conclusion (600 characters or about 100 words)**

Beyond inexplicable differences in harm across Spanish hospitals, the global effect of excess days in hospital after an adverse event is noticeable: 68 million euros per year, in the hospitals of this study. Individual hospital excess costs went from 493,198 in the hospital with the lowest toll of excess days to 3,892,817 euros in the hospital with the highest toll.

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**Title**

Geographic variation of access and outcome of health care in Italy: estimating the role of hospital and primary care

**Background (500 characters or about 90 words)**

The National Health Care Outcome Evaluation Program (PNE) measures the outcome variability among providers and among Local Health Units in Italy. Although the Italian NHS provides universalistic access to treatment, PNE data show a huge geographic variability in access to evidence based treatments and outcome of care. In order to plan interventions aimed at reducing the variability, there is a need of identifying the different sources of variation beyond random and systematic errors.

**Objectives (500 characters or about 90 words)**

To measure geographic variability in incidence of major adverse cardiovascular and cerebrovascular events (MACCE) within 1 year after hospital discharge for AMI. To measure geographic variation of adherence to evidence based treatment in patients discharged after AMI (combined treatment with antiplatelets, beta blockers, agents acting on the renin-angiotensin system and statins) To measure the proportion of variation attributable to hospitals of discharge and primary care providers.

**Methods (720 characters or about 125 words)**

Geographic variation of incidence of MACCE within 1 year since discharge after AMI in Italy is measured according to PNE methods ([http://95.110.213.190/PNEed14\\_EN](http://95.110.213.190/PNEed14_EN)). We identified a subsample of patients discharged from hospital after AMI in Lazio region (5 million residents) for which linked drug claim data were available. Patients were followed-up for two years. Adherence to polytherapy was defined as medication possession ratio  $\geq 0.75$  for at least three evidence-based drugs. The variation among health care providers was analyzed applying Empirical Bayes methods. Cross-classified multilevel models were used to analyze the proportion of variability attributable to discharge hospitals and primary care providers.

**Results (720 characters or about 125 words)**

Risk of MACCE within 1 year since discharge after AMI, Italy: 13.5%-36.7% among health care units. We identified 9606 incident cases of AMI for 2156 general practitioners, 55 health districts, 12 local health units, and 93 hospitals. About 63% of MI patients were adherent to polytherapy. Determinants of poor adherence were older age, heart failure, arrhythmia and COPD. Variation between health districts was detected after controlling for patients' and general practitioners' characteristics. There was no variation among general practitioners of the same health district. Introducing the hospital of discharge in the model, the variation between health districts decreased, while variation among hospitals was higher

**Conclusion (600 characters or about 100 words)**

We observed poor adherence to chronic polytherapy after MI and high geographic variation. The reduction of the variation among health districts after considering the hospital level shows that variation in primary care is substantially affected by the clinical and organizational approach of the hospital of discharge, whose aims are both drug prescription at discharge, and planning patient monitoring. We believe that this methodology may help to identify the areas for more targeted health-care interventions aimed at reducing variation of health care outcomes.

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**Title**

Using big-data to visualise spatio-temporal variations in mortality across New Zealand

**Background (500 characters or about 90 words)**

Evidence suggests that the mortality rate of an area may be related to the characteristics of neighbouring areas, and that geographical disparities in mortality rates persist over time. However, few studies have applied integrated visualization techniques to explore the spatio-temporal variation of mortality rates.

**Objectives (500 characters or about 90 words)**

We examine the spatio-temporal variations in all-cause mortality rates among patients who had CVD and associated risk factors in New Zealand. "Small multiple" representations are used to investigate monthly and seasonal variations. Next, we use 3-D rod visualizations to compare changes between 2006 and 2013 by ethnicity and age group. We then use "ringmaps" to visualize spatio-temporal patterns of mortality rates in relation to smoking rates by DHB.

**Methods (720 characters or about 125 words)**

Using record linkage, we constructed a cohort of 73,046 people aged 30 to 84 from four routine health datasets: Primary Healthcare Organization (general practice) enrollments, medications dispensed at community pharmacies, hospitalizations and mortality. Additional demographic data were obtained from Statistics New Zealand. We calculated age-specific mortality rates and age-standardized mortality rates by DHB for different gender and ethnic groups using the New Zealand European population as the Standard. We used a range of visualization techniques to explore variations and integrated these into on-line maps for dissemination.

**Results (720 characters or about 125 words)**

We reveal distinct spatio-temporal patterns of mortality rates in association with smoking rates in New Zealand, and highlight disparities by DHB, season, age and ethnicity before discussing the implications of our research findings.

**Conclusion (600 characters or about 100 words)**

Using an array of visualization approaches, we found substantial seasonal and demographic patterns associated with mortality rates for CVD patients at the DHB level. These visualization techniques are flexible and data driven. They are interactive in the sense that different parameter settings produce different insights. Furthermore, these approaches may be integrated into contemporary on-line atlases enabling the results to be disseminated to practitioners, researchers, policy makers and the general public.



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**Title**

Developing a disinvestment strategy for the Spanish National Health Service

**Background (500 characters or about 90 words)**

Health systems bear substantial opportunity cost in using interventions deemed lower-value. Quantifying utilisation and systematic variation across policy-relevant geographical units offers insights about local room for realignment into value-based provision

In 2013 the Spanish Atlas VPM set out to support a disinvestment strategy for the NHS in collaboration with the National Network of Health Technology Assessment Agencies and the 17 regional health ministers.

**Objectives (500 characters or about 90 words)**

Minimising lower-value care (LVC) use in the SNS, fostering superior alternatives or reallocation of resources to other value-for-money activity: 1- Agreed list of LVC and superior alternatives; 2-How much of the activity is LVC? use rates and variation across areas; 3-Opportunity costs for provider and population? excess cases and excess costs using as benchmark areas with the lowest intensity of use; 4-Local margin for efficiency enhancing? minimisation scenarios

**Methods (720 characters or about 125 words)**

Structured review international literature, national white papers, HTA reports and clinical guidelines to identify LVC procedures and empirical validation of the list. Ecologic study on intensity of use of 17 LVC procedures (and superior alternatives) and its variation across 203healthcare areas 17 regions. Cross-section (2012) and time-trend (2002-2012)analyses. Multilevel models to obtain risk adjusted use rates at provider level and investigate the impact of local supply and demand features. National benchmarks: areas and providers in the 1st quartile of intensity of use per procedure.Excess-cases and costs estimated per area. Source: SNSAtlasVPM DWH patient level data on all discharges publicly funded in Spain

**Results (720 characters or about 125 words)**

1.Materials for decision makers to engage in discussion with clinicians:  
13 fact-sheets supporting the inclusion of each procedure in the list and the superior alternative.  
17 regional reports 'Keys for change': performance against national benchmark, margin for efficiency gains at area level. Local drivers of LVC based on the supply/demand features analysis.  
New module in the logged web-based Atlas VPM analytical tool (tailored and update analyses)  
2.Building high-value culture:

**Conclusion (600 characters or about 100 words)**

This project was conceived as a proof of concept: Sophisticated methods of analysis applied to routinely available data can produce practical information useful to prompt action in the SNS. New results delivery formats targeted to support engagement and negotiation at local level are particularly suited to trigger evidence-based decision making. Next steps involve continuous monitoring of case studies and widening the LVC list to include lower-value elective surgery: joint replacement, cataracts and prostatectomy out of main indication ) and assess adoption patterns of superior alternatives

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**Title**

Engaging with policymakers to address the findings of variations analyses

**Background (500 characters or about 90 words)**

Not all Atlas topics are equal, while some lend themselves to action at the practitioner level to improve for instance the delivery of effective care; others need policymakers to be involved to improve the quality of services.

**Objectives (500 characters or about 90 words)**

The talk will discuss present case study examples of ways we have engaged with local policymakers and with the sector more broadly and lessons learned.

**Methods (720 characters or about 125 words)**

Like many jurisdictions, New Zealand has in recent years, successfully utilised a target regime to make improvements in specific areas (largely around access and primary prevention) which have been the focus of political priority. While this approach undoubtedly has produced results (as it has elsewhere) it risks creating a “managerialist” mindset where the subjects of the target regime are the sole markers of health care quality and where the only use of data is as fuel for accountability systems.

**Results (720 characters or about 125 words)**

The Health Quality and Safety Commission has used the Atlas as a tool to develop quality indicators which provide a much broader view of how the health sector is performing and are intended to encourage local areas to analyse and understand their own data.

**Conclusion (600 characters or about 100 words)**

This approach naturally creates a tension with the prevailing mindset described above. The talk outlines potential responses to this tension, and describes how we have sought to negotiate this tension to date.

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**Title**

Regional variation in newborn special care in the United States

**Background (500 characters or about 90 words)**

In the past 40 years neonatal intensive care has been successful at reducing newborn morbidity and mortality leading to an expansion of units and neonatologists. Despite these successes, higher supply of beds and physicians are not correlated with newborn risk, and limited studies of risk adjusted outcomes show substantial region variation. No large scale population-based studies have been conducted of the epidemiology of newborn care utilization, quality, costs, and outcomes.

**Objectives (500 characters or about 90 words)**

As part of a new perinatal research portfolio at the Dartmouth Institute, this study examined national trends and regional variation in admissions for neonatal intensive care by newborn characteristics.

**Methods (720 characters or about 125 words)**

We analyzed the U.S. natality file records from 2007 - 2013 that use the 2003 revised form, which includes a field indicating neonatal intensive care unit (NICU) admission. Crude and stratified rates of NICU admissions were calculated. For trend analyses, Poisson regression models included birth weight, gestational age, weight-for-gestational age, 5-minute Apgar, plurality, delivery mode, sex, parity, race/ethnicity, maternal age and education. Trends of cohort composition were modeled with linear regression. Variation was analyzed across neonatal intensive care regions, which demonstrate a high degree of localization of newborn care to within region health systems.

**Results (720 characters or about 125 words)**

In 2012, 4.3% of normal birth weight (2,500-3,999 g.) and 84.4% of infants 500-1499 g were admitted to NICUs. Overall admission rates during 2007-13 increased from 6.4% to 7.8% per 1,000 live births (relative rate 1.21; 95% CI 1.21-1.22). Trends in adj. relative rates showed a similar 23% increase (95% confidence interval 1.22-1.23). Over the study period admitted newborns were larger, less premature and less likely to receive assisted ventilation. Regional variation of 2013 admission rates displayed low variation (coff. variation 0.11, IQ ratio 1.13) for infants 500-1499 g. There was a monotonic increase in variation with higher birth weights – example:  $\geq 4000$  g. (coff. variation 0.44, IQ ratio 1.71)

**Conclusion (600 characters or about 100 words)**

Rates of admission to level III/IV neonatal intensive care units are increasing, primarily for less ill newborns. The variation in admission rates suggests under use of intensive care in a few regions for the smallest newborns, and likely overuse in larger newborns. These larger and less ill newborns are now the most common admission to neonatal intensive care.

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**Title**

Interventions at birth - do they save lives? A micro data analysis over more than 40 years in Norway

**Background (500 characters or about 90 words)**

There has been a remarkable decline in infant mortality in most developed countries from the late 1960s. The general perception is that medical innovation and improvements in medical technology have had an effect in reducing mortality. The introduction of ventilators, antenatal steroids and surfactant is particularly highlighted. However, there are no real life studies where the contribution of new interventions to the decrease in infant mortality has been estimated.

**Objectives (500 characters or about 90 words)**

To estimate the effect of the introduction of surfactant, ventilators, antenatal steroids and insure on early neonatal mortality and infant mortality in Norway during the period 1967-2011.

**Methods (720 characters or about 125 words)**

Information about the time when the interventions were introduced was collected using a questionnaire filled out by the chief neonatologist in all 21 neonatal units in Norway. These data were merged with data from the Medical Birth Registry, which contains detailed medical information about the mothers and the infants for all births 1967-2011. Our analyses were done for all live born infants who were born in a hospital with a neonatal unit, altogether 1 612 789 deliveries. The data were analysed using a regression model with fixed effects for neonatal units, hospital-specific time trends and with several control variables measuring the risk factors of the infant and predisposing factors of the mother.

**Results (720 characters or about 125 words)**

Nearly all the departments had ventilators by the second half of the 1980s. Antenatal steroids were in use in 5 departments during the period 1975-1979. By the first half of the 1990s, 19 departments used antenatal steroids. Surfactant was introduced during a short time span from the second half of the 1980s to the first half of the 1990s. There was a negative and significant effect of all the interventions on infant mortality. The effects were greatest for babies with a birth weight under 1000g, and smallest for babies with a birth weight more than 2 500g. Altogether, the four types of intervention have contributed to a reduction in infant mortality of about 50 per cent during the period 1967-2011.

**Conclusion (600 characters or about 100 words)**

Our results highlight an important channel through which the decline in infant mortality occurred during the second half of the last century in Norway. That channel is through the introduction of the following interventions: ventilators, antenatal steroids, surfactant and insure. In supplementary analyses we tested for potential confounders, measurement error in the intervention variables and reversed causality. None of the results from these analyses weakened our main results.

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**Title**

Population Health Research Network: Activities and Opportunities

**Background (500 characters or about 90 words)**

The Population Health Research Network (PHRN) was established in Australia in 2009. Since then the PHRN has created facilities and enhanced existing capabilities to link population data in all Australian jurisdictions. There are now data linkage units servicing each state and territory and two national linkage units capable of linking data across jurisdictions. There are also a range of additional services that have been designed to improve access to linked data for researchers.

**Objectives (500 characters or about 90 words)**

This presentation aims to:

- Describe current PHRN governance arrangements and priorities;
- Present progress with the PHRN Proof of Concept (PoC) Collaborations;
- Highlight future opportunities for the PHRN.

**Methods (720 characters or about 125 words)**

The PoCs used population-based linked data from Australian jurisdictions. Data was linked using a two stage, privacy preserving process. This involved probabilistic linkage by data linkage units using linkage variables (name, address, date of birth). Research datasets were then put together using project specific linkage keys. In one project, data was placed in a secure, remote access data laboratory for access by designated researchers in different parts of Australia. PoC#1 linked hospital discharge and death registration data from four Australian states over a five year period. PoC#4 linked data from all live births in two Australian states over a 16 year period with immunisation, hospital and other data.

**Results (720 characters or about 125 words)**

With new governance arrangements established, current priorities for the PHRN include strategic planning and partnerships, as well as greater use of Australia's linked data to inform health decisions.

PoC#1 comprised of over 44 million records from 7.7 million patients. The study found that over 223,000 patients travelled across a state border to attend a hospital during the study period. Almost 49,000 patients moved their place of residence to another state between hospital visits. Linked data provided a more accurate calculation of hospital-related deaths.

The research dataset for PoC#4 has been assembled and comprises of over 35 million records from almost 2 million children.

**Conclusion (600 characters or about 100 words)**

Data linkage is a powerful tool that supports research and policy development across a range of health areas. In Australia, linked data is being used for a range of purposes including to improve the measurement of hospital related deaths and to quantify the risks and benefits of childhood immunisation. There are also significant opportunities including for a cost-effective approach to post-market surveillance which are currently being examined.

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**Title**

Investigating geographic and time trends for equity in healthcare

**Background (500 characters or about 90 words)**

Comprehensive health and population registers provide good premises for studying regional variations in health care in Finland. Using personal identification codes, healthcare registers can be individually linked to population registries for sociodemographic variables and over years allowing following-up patients. In addition to standard variation studies, the Finnish registers allow, for instance, studying changes over time in socioeconomic and geographical equity in health care.

**Objectives (500 characters or about 90 words)**

Our research group's general aim is to study factors impacting equity in healthcare in Finland. We use databases linking healthcare and population registers covering the years from the mid 90s to 2013. We show examples on the use of these data in addressing time-trends and geographical differences in equity. We study geographic and socioeconomic variation in hospitalisations due to ambulatory care sensitive conditions (ACSC) and trends in equity in coronary revascularisations.

**Methods (720 characters or about 125 words)**

The data for our empirical examples on coronary revascularisations and ACSC hospital admissions are extracted from the 1996-2013 National Hospital Discharge Register. The hospital data were linked to the causes of death and longitudinal population registers maintained by Statistics Finland. In addition to age and sex, the population register includes annual data for a host of sociodemographic variables, such as place of residence, employment and taxed income. In the studies, we focus on healthcare among the non-institutionalised population and analyses regional and socioeconomic variation using multilevel modelling technics but also applying modelled equity indices based on the Gini coefficient.

**Results (720 characters or about 125 words)**

We found substantial socioeconomic and geographic differences in ACSCs and revascularisations as well as clear changes in them over time. For ACSCs, a prominent trend was the steepening socioeconomic gradient favouring the well-off. For revascularisation, overall rates increased by 1.3-1.5-fold from 1996 to 2010. However, geographical differences not compatible with CHD morbidity remained. While regional and socioeconomic patterning in CHD morbidity was taken into account in modelling equity, the revascularisations displayed rather stable relative socioeconomic inequities in access. Despite the considerable geographic variations in revascularisations, there were no significant regional differences in equity.

**Conclusion (600 characters or about 100 words)**

Despite advances in the resources and performance of healthcare, geographic and socioeconomic differences have remained in Finland. Regarding our examples, while in general ACSC rates had fallen and coronary procedure rates increased, relative socioeconomic inequalities have remained stable or increased. For us, these findings suggest polarising socioeconomic tendencies in health and healthcare which are not adequately taken into account in developing the health care system. However, more research and improved analytical approaches are needed to ground reforms and to monitor them.

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**Title**

A spatiotemporal analysis of C-section rates in Portuguese NHS hospitals

**Background (500 characters or about 90 words)**

C-section rates have been high above the WHO threshold (15%) in Portuguese NHS hospitals. There are clinical implications concerning the overuse of this procedure not to mention the costly implications it presents in financially strained health care systems. To understand the spatiotemporal evolution of c-section rates and contextual factors influencing it can help in the design of effective policies on rates reduction.

**Objectives (500 characters or about 90 words)**

The current work aims to:

- i) Characterize the spatiotemporal pattern of c-section rates;
- ii) Understand which hospital characteristics affect those rates;
- iii) To identify the importance of the results for decision makers

**Methods (720 characters or about 125 words)**

Annual data for the period 2002-2014, covering all NHS hospitals, C-section ICD-9-CM codes considered were 74.0-74.2, 74.4 and 74.99. Crude and age standardised rates are reported per 1,000 live births. Hospitals characteristics such as hospital dimension, hospital specialization in obstetrics, obstetric resource management and teaching status are studied. Spatial variations in temporal trends will be also applied in order to identify hospitals with different trends during the time period in analysis. Bivariate and multivariate analyses with a spatiotemporal component are performed to understand which hospital characteristics are correlated with age standardized c-section rates.

**Results (720 characters or about 125 words)**

This work identifies different spatiotemporal patterns crossing the studied time-period. Globally, previous work points toward the growth of c-section rates until 2010. The analysis of the spatiotemporal statistics is still at a very preliminary stage.

**Conclusion (600 characters or about 100 words)**

Analysing the variability of c-section rates enables policy makers to understand where to focus the policies on rates reductions. Size, teaching status and obstetric resource management are characteristics that together seem to influence negatively the c-section rates.

These results support the idea that policies on c-section rates reduction should focus on the continuous training of doctors, peer reviews, second opinions and audit of c-sections cases.

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**Title**

Geographic Variation in Potentially Avoidable Hospitalizations in the Languedoc-Roussillon region, France.

**Background (500 characters or about 90 words)**

Potentially avoidable hospitalizations (PAH) are studied as an indirect measure of access to primary care and of the interface between primary and secondary care. A previous work (Mercier et al., Health Affairs 2015) unveils considerable geographic variation in the rate of PAH in France and suggest that primary care organization might play a role in this variation. However, a limitation of this work lies in the lack of data on actual primary care utilization.

**Objectives (500 characters or about 90 words)**

The aim of the study is to assess the geographic variation in the rate of potentially avoidable hospitalizations in the Languedoc-Roussillon region in France in 2014 and to analyze the role of primary care in this variation.

**Methods (720 characters or about 125 words)**

The analysis will be performed on the Languedoc-Roussillon region data, year 2014. Age- and sex-adjusted rates of potentially avoidable hospitalizations by ZIP codes (n=273) will be calculated from the hospital discharge database covering both public and private hospitals. Potential drivers will include demographic, epidemiological and socio-economic factors. Real-world data on geographic access to and actual utilization of primary care will be included in the model (i.e., general practitioner (GP) access and visits, ambulatory care nurses access and visits). In addition, the effect of primary care coordination at the GP and nurses levels will be assessed. A spatial regression model will be implemented.

**Results (720 characters or about 125 words)**

The study is ongoing. So far, we have cleared the following steps:

- partnership with the regional health authority;
- access to the hospital discharge database (PMSI);
- data collection regarding determinants (primary care utilization);
- ethical approval by the national health authority.

**Conclusion (600 characters or about 100 words)**

This work will be the first one combining primary care utilization data and advanced spatial regression methods to assess the determinants of the geographic variation in the rate of potentially avoidable hospitalizations in France. The early involvement of the regional health authority in the design, analysis and interpretation will increase the potential policy impact of the results.



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Variation in primary care: insights from the Tuscany Region

**Background (500 characters or about 90 words)**

Since 2005 the Tuscany Region (Italy) Health care system has adopted a Performance Evaluation System (PES) to support policy makers, manager and health professionals the quality improvement process. In 2014 for the first time the system has been developed at the primary care level. GP have been grouped into networks that include single profession organization, also known as Aggregazioni Funzionali Territoriali (AFT). AFTs serve a population of 30,000 patients, assisted by 25 GPs.

**Objectives (500 characters or about 90 words)**

Most studies on practice variation focus on a single level without taking into account the amount of variation potentially attributable to other levels within the care system. The goal of the research project is to analyse the phenomena of unwarranted variation among AFTs, considering differences in the amount of variation in selected indicators both across levels of care (individuals, AFTs, local health authority as facility) and by type of indicators (i.e. resource use, processes).

**Methods (720 characters or about 125 words)**

A set of indicators regarding quality of care, patients' experience and satisfaction and GPs' satisfaction and organization was calculated at AFTs level for the 2014. The PES considers a set of about 40 indicators. The patients' survey considers a sample of about 8000 patients representative at AFTs level; the GPs survey considers a representative sample of about 1.150 GPs. Clinical indicators refer to chronic disease management, pharmaceutical consumption and integrated care. Multilevel models have been applied for each indicator taking into account the structure of the data, which consists of patients receiving care from the same GP, providers who are clustered as groups (AFTs) and AFTs clustered within facility.

**Results (720 characters or about 125 words)**

Significant variation has been found at all level of analysis although with different magnitude. In line with previous findings most of the variance of the indicators is explained by heterogeneity among patients and less by the AFT and facility levels. However, measures related to local strategies and management tools contributed significantly in the explanation of the variation in the selected indicators.

**Conclusion (600 characters or about 100 words)**

First evidences can be useful to policy makers and managers to design and implement specific actions to reduce unwarranted variation, identifying which factors contribute to performance differences at the different governance level, including characteristics of the patient population and of the organizations.

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**Title**

Towards explanations of variation

**Background (500 characters or about 90 words)**

Physician and management awareness of reasons for unexplained variation in health care is scarce. They often attribute variation to quality deviations and often lack a theoretical framework for understanding explained and non-explained variation. Therefore, discussions about variation may become a non-constructive quarrel rather than a vehicle for evidence-based development of health care.

**Objectives (500 characters or about 90 words)**

The aim of this presentation is to describe and analyses reasons for unexplained variation in health care and to discuss ways forward for the next phase of health services research in reasons for variation.

**Methods (720 characters or about 125 words)**

A series of examples of large variations is described and reasons for variation are presented. Physicians' and health care planners' reaction to the presentation of unknown and unexpected variations is presented and discussed.

**Results (720 characters or about 125 words)**

Reasons for variation are often structure, culture, access to care and composition of health care staff. Physicians are often unaware of the large variations between different settings. The lack of knowledge about variation and its reasons is a severe obstacle to an evidence-based development of organization of care. Nearly no physicians are aware of the three Wennberg groups for health care need and delivery.

**Conclusion (600 characters or about 100 words)**

The descriptive part of research in variations in health care should be even more systematic in Danish health care. The next step in variation research should be a strengthened focus on the analysis and scientific understanding of reasons for variation and on scientifically sound, complex interventions to induce change in health care delivery. Knowledge about variations in health care should be strengthened in the education and postgraduate training of physicians and health care administrative staff.

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Exploring Variations in Patient Satisfaction

**Background (500 characters or about 90 words)**

The past years have seen an increase in public reporting schemes to comparatively assess providers. One of the key indicators many of these schemes report is patient reported satisfaction measures for different providers and/or aspects of care. While these schemes are meant to enable prospective patients to make more informed choices of provider, little research has studied the determinants or variation in patient satisfaction.

**Objectives (500 characters or about 90 words)**

This paper aims to explore the variation and determinants in patient satisfaction ratings for providers across England. In particular we will explore the consistency of star ratings to the sentiment of patient comments, and the relationship of both of these to other quality indicators (such as mortality, readmissions and Patient Reported Outcome Measures), as well as to particular aspects of care.

**Methods (720 characters or about 125 words)**

This paper uses satisfaction ratings from NHS Choices over the period 2007 - 2015 and employs regression analysis and sentiment analysis to examine the relationship between star ratings and free text and to better understand the variation between patient reports.

**Results (720 characters or about 125 words)**

Our results indicate a large variation in reporting as well as rating across providers. However, the majority of star ratings are polarized with most respondents reporting only when they have had a very positive experience (5-stars) or a very negative experience (1 star). However the patient reports show less of a difference in sentiment of the free text between the different ratings. The star ratings also show weak associations with other measures of quality.

**Conclusion (600 characters or about 100 words)**

More research needs to be done to truly understand what sentiments patient reported satisfaction is measuring.

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**Title**

Smarter Health Care - A National Research Program on Health Services Research

**Background (500 characters or about 90 words)**

The Swiss health system is often considered to be among the best health systems worldwide. However, little is known about how the Swiss health system deals with the challenges of adapting to the needs of an aging population and the growing prevalence of chronic diseases. This has led to the common notion that health services research needs to be strengthened in Switzerland in order to inform how to successfully shift the health system towards more long-term and patient-centered care.

**Objectives (500 characters or about 90 words)**

The goals of the National Research Program (NRP) "Smarter Health Care" of the Swiss National Science Foundation are to provide insight into health care structure and utilization in Switzerland, and into ways to improve health outcomes with a focus on prevention and treatment of patients with (multiple) chronic conditions. In addition, the NRP aims to contribute to improved health data and to create a strong community of health services researchers.

**Methods (720 characters or about 125 words)**

The first module of the NRP, "Countering under- and overuse to improve allocation of resources", includes methods development and studies to assess under- and overuse of health care services for patients with (multiple) chronic conditions as well as the evaluation of ways to minimize under- and overuse of health care services. The second module, "Coordination and collaboration among health care professionals", includes studies on the collaboration within and across medical and long-term settings, on patient flow along continuum of care and on novel health care and reimbursement models for medical and long-term care.

**Results (720 characters or about 125 words)**

The third module, "Caring for patients with multiple chronic conditions", includes research on health outcomes and associated costs of interventions and health care delivery systems, measures for quality performance, patients experience of different delivery systems and novel approaches for prioritizing health care services. These modules enable researchers to study the health care situation in Switzerland from different scientific and problem-oriented perspectives.

**Conclusion (600 characters or about 100 words)**

The NRP "Smarter Health Care" will be relevant for decision makers at an individual level (patients with chronic conditions and health care professionals), at an institutional level (in- and outpatient health care services, long-term care facilities) and for politicians and health authorities. Its results will provide a knowledge base to make evidence-based health care and public health decisions that are in line with the values and preferences of the Swiss population.

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Measuring health and health care equity

**Background (500 characters or about 90 words)**

There is a pressing need to step up the pace of change in health and care systems in the UK and internationally towards improving health and developing new models of care to increase outcomes including equity of access and use. Some new models were recently set out for England in the NHS Five Year Forward View. As the testing of these new approaches increases, there is need to examine the methods we have to evaluate them, robustly and in a timely way.

**Objectives (500 characters or about 90 words)**

To:

1. describe new and emerging approaches to the robust evaluation of equity in health care use;
2. focus on the strengths, appropriate applications and limitations of these approaches as well as the identification of key challenges and future research directions.

**Methods (720 characters or about 125 words)**

Having defined equity, I will describe and discuss the following issues:

1. The implications of not measuring vertical in addition to horizontal equity.
2. Examples of difficulties in (i) identifying the population in need of health care; (ii) defining need & (iii) risk adjustment.
3. Why it is important to examine whether inequalities matter.
4. Measuring the gap versus the gradient in health care use by SEG.
5. The need to consider macro, meso and micro causes of health care inequalities

**Results (720 characters or about 125 words)**

1. Ways to analyze vertical equity, including examining interactions between social factor of concern and a measure of need.
2. Approaches to address methodological issues outlined in (2) above.
3. a case study to illustrate the importance of examining outcomes of inequity.
4. an innovative approach to examining gradient in use.
5. Examples of examining the impact of (1) national policy, (2) care pathways and (3) beliefs and behaviors of health care professionals.

**Conclusion (600 characters or about 100 words)**

Measure horizontal & vertical equity.

- Be comprehensive in use of routine & ad hoc data. Data linkage across sectors & settings to identify source/s of inequity & whether it matters.
- Approaches to measuring the gradient.
- Innovative ways to capture health professional decision making.

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Hospital Variation in Health Care Utilization by Children with Medical Complexity

**Background (500 characters or about 90 words)**

While children with medical complexity have high health care needs and account for a disproportionate amount of pediatric medical expenditures, little is known about the variation in care provided to this population in the US. This information may be particularly useful in identifying opportunities to improve quality and reduce costs.

**Objectives (500 characters or about 90 words)**

The aim of the current study is to describe variation in patterns of care for a population-based cohort of children with medical complexity in northern New England.

**Methods (720 characters or about 125 words)**

We conducted a retrospective population-based observational cohort study using all payer claims databases for children aged 30 days to < 18 years residing in Maine, New Hampshire and Vermont from 2007 to 2010. We identified hospital-affiliated cohorts (N=6) of patients (N= 8216) with medical complexity using diagnostic codes from both inpatient and outpatient claims. Children were assigned to the hospital where they received the majority of inpatient days, or their outpatient visits if no hospitalization occurred. Outcomes of interest included patient encounters, medical imaging and diagnostic testing. Adjusted relative rates (RR) were calculated with over-dispersed Poisson regression models.

**Results (720 characters or about 125 words)**

Adjusting for patient characteristics, the number of inpatient (RR 0.84 vs. 2.28) and intensive care days (RR 0.45 vs. 1.28) varied by more than 2-fold, whereas office (RR 0.77 vs. 1.12) and emergency department visits (RR 0.71 vs. 1.37) varied to a lesser extent. There was also marked variation in the use of imaging, and other diagnostic tests, with particularly high variation in electrocardiography (RR 0.35 vs. 2.81) and head MRI (RR 0.72 vs 2.12).

**Conclusion (600 characters or about 100 words)**

Depending on where they receive care, children with medical complexity experience widely different patterns of utilization. These findings indicate the need for identifying best practices for this growing patient population.

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**Title**

Sources of Variation in Implementing Evidence-Based Care: Focusing on ICT Infrastructure for Clinical Evidence Retrieval

**Background (500 characters or about 90 words)**

Over 140 evidence-based clinical practice guidelines (CPGs) have been assessed and disseminated by the National Guideline Center, so-called MINDS, during the last decade, yet how CPGs are actually used remain unknown in Japan. Moreover, accessibility to medical evidence databases is growing its importance in this Information Age, and it is considered dependent on information and communication technology (ICT) infrastructure of hospitals, influencing unwarranted practice variation.

**Objectives (500 characters or about 90 words)**

To find sources of variation in implementing evidence-based care, the aim of this study consists of two steps: (1) to ascertain differences of ICT infrastructure among hospitals and clinical evidence retrieval behavior of young physicians, and (2) to investigate the actual usage of CPGs as well as system instruments such as quality indicators (QIs) and clinical pathways (CPs) which are also influential on practice variation in terms of measuring and facilitating evidence-based practice

**Methods (720 characters or about 125 words)**

We conducted a questionnaire survey by mailing to 1698 residents who worked in 109 hospitals participating Quality Indicator/Improvement Project from January to March 2015. Hospital ICT infrastructure including accessibility to internet using wireless LAN access services as well as feasibility to use multiple medical evidence databases such as PubMed, Cochrane Library or E-journals with and without charges were asked. Actual usage of CPGs, CPs and QIs in the clinical setting including frequency, when and how they retrieve required information, education they received and barriers they faced to retrieve the information were also asked.

**Results (720 characters or about 125 words)**

A total of 585 residents from 81 hospitals responded in the midterm results (response rate 34.5%). Approximately 80% of the respondents tended to use private smartphones, tablets or PCs, and 44% of them used wireless LAN provided by hospitals. The possible place to search required information were wards (46%) and out-patient clinics (22%). Almost all respondents thought CPGs were important, half of them looked CPGs up more than once a week, two-third of them got information mainly from online resources, mostly when they made a treatment decision. Approximately 60% were using CPs. Few knew the practical QIs. Only half of the respondents have learned about CPGs and faced difficulties in retrieving information.

**Conclusion (600 characters or about 100 words)**

ICT infrastructure including accessibility to the Internet and medical evidence databases widely varied even among teaching hospitals. Although the importance of CPGs is recognized by young physicians, their knowledge and use of CPs and QIs were far less and negligibly little. Education will be necessary to integrate CPs and QIs with evidence-based practice. In addition, providing sufficient accessibility to medical evidence databases may lead to reducing unwarranted practice variations. Much more attention should be paid to the hospital ICT infrastructure to implement evidence-based care.

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Complementary logics of target setting: Hierarchist and experimentalist governance in the Scottish National Health Service

**Background (500 characters or about 90 words)**

One possible strategy to manage unwarranted variations in health system performance is to set national targets for local organisations. However, where policy ends are contested and means for change are ambiguous, imposing central targets on local organisations – what we call hierarchist governance – is problematic.

**Objectives (500 characters or about 90 words)**

The concept of experimentalist governance suggests that target setting should rather be conceptualised as a learning process between central government. Yet, it is unclear to what extent and how measurement for learning and improvement might be fostered alongside attempts to strengthen accountability for results. Drawing on experiences from the Scottish HEAT target system, we argue that complementary use of hierarchist and experimentalist ideas is possible.

**Methods (720 characters or about 125 words)**

Using a comparative case study of two policy issues in the Scottish NHS, we examine two research questions:

1. Is it possible to examine empirically the co-existence of hierarchist and experimentalist elements in the same performance target regime?
2. Does the relative emphasis on experimentalist as opposed to hierarchist logics differ between policy issues depending on the degree of ambiguity over ends and means?

**Results (720 characters or about 125 words)**

We show that the emphasis on experimentalist ideas was stronger where ends and means were contested (the case of shifting the balance of care for older people) than where both ends and means seemed obvious initially (the case of healthcare-associated infections). However, management drifted towards the experimentalist realm when rising rates of community-acquired infections decreased clarity about effective interventions.

**Conclusion (600 characters or about 100 words)**

Hierarchist and experimentalist elements can be shown to exist in the same performance management regime. Thinking of hierarchism and experimentalism as a property of the performance management system as a whole may be analytically too coarse (from a research perspective) and neglect opportunities that arise from drawing on both logics (from a policy perspective). Regulators can and, arguably, should tailor models of governance to the nature of the policy issue.



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**Title**

Variations in GP' decisions to investigate suspected lung cancer: A factorial experiment using multimedia vignettes

**Background (500 characters or about 90 words)**

Understanding decision making during clinical consultations in primary care is central to reducing missed opportunities for diagnosis and unwarranted healthcare variation. There are well recognised challenges to its examination in clinical practice. In lung cancer, primary care physicians (called in this study general practitioners or GPs), face particular challenges deciding which of the many patients presenting with common non-specific symptoms require further investigations.

**Objectives (500 characters or about 90 words)**

We sought to examine how patients' clinical and socio-demographic characteristics influence GPs' decisions to initiate lung cancer investigations.

**Methods (720 characters or about 125 words)**

A multimedia interactive website simulated features of GP consultations using actors ('patients'). GPs made management decisions online for 6 'patients', with clinical and socio-demographic characteristics systematically varying across 3 levels of cancer risk. In low-risk vignettes, investigation by the GP (i.e. chest X-ray ordered or respiratory physician referral) was not indicated, in medium-risk investigation could be appropriate, in high-risk vignettes, investigation was definitely indicated. Each 'patient' had 2 lung cancer-related symptoms; one volunteered and the other elicited if GPs specifically asked. Variations in investigation likelihood were examined by logistic regression.

**Results (720 characters or about 125 words)**

226 GPs completed 1356 vignettes of which 1348 were included in analysis. GPs investigated lung cancer in 74% (1000/1348) of cases. Investigation likelihood did not increase with cancer risk. Investigations were more likely when GPs sought information on symptoms that 'patients' had but did not volunteer (adjusted odds ratio [AOR] 3.18 95% CI 2.27-4.70) but GPs omitted to seek this information in 42% (570/1348) of cases. GPs were less likely to investigate older than younger 'patients' (AOR 0.52 95% CI 0.39-0.71) and Black 'patients' compared with White (AOR 0.68 95% CI 0.48-0.95).

**Conclusion (600 characters or about 100 words)**

In this study when GPs explicitly sought relevant clinical information, most acted on it appropriately, but inequalities in cancer investigation by age and ethnicity remained. We are now using the findings of the study to inform development of training for doctors.

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Variation in ambulatory care for non-institutionalized patients with dementia in Germany

**Background (500 characters or about 90 words)**

In all industrialized societies demographic aging is becoming an increasing challenge. With increasing life expectancy and the decline of cardiovascular mortality dementia is zooming into focus as the number one example for the burden of demographic ageing. Prevalence increases fast and steadily. While medical therapy is still limited all efforts need to be directed at supporting strategies for concerned patient. However, little is known yet about the reality of care in Germany.

**Objectives (500 characters or about 90 words)**

To explore the present state of ambulatory care for patients with dementia who live at home, and to use the analysis of regional variations to identify the potential for systematic improvement. Regional variation may be of specific importance for rural regions which are particularly hard hit by outmigration of healthy young subpopulations in search of education and work.

**Methods (720 characters or about 125 words)**

Using our nationwide claims databases on ambulatory physician services and prescription drugs which cover 100% of the statutorily insured population (roughly 85% of the German population) we looked specifically at the diagnostic process and dementia-specific medication by the 16 federal states according to residence of patient. The data contains all claims by physician and patient (both pseudonomized) for the years 2009 to 2011. Testing and medication recommendations were taken from the relevant guidelines by the societies of family medicine, neurology, and psychiatry. Comparison by states was based on raw and standardized (age, gender) rates.

**Results (720 characters or about 125 words)**

We identified just over 1.014 million prevalent and 277,000 incident non-institutionalized patients with dementia (pwd) in 2011. Prevalence was 5.0%, the incidence rate was 1.1%. Diagnostic testing relied heavily on lab-tests (79%), less common were psychologic testing (34%) and radiology (18%). There are marked regional variations (metropolitan/rural, West/East). Medication: 42% of prevalent and 46% of incident patients with Alzheimer disease received recommended medication (Cholinesterase inhibitors, Memantine). More than one third of all pwd however received not recommended antipsychotic, sedating or anti-depressive drugs. Variation between the 16 federal states was 3 fold.

**Conclusion (600 characters or about 100 words)**

There is room for improvement in terms of diagnostic testing and medication. Guideline adherence tends to be higher in East German regions. Patients treated by GP plus specialist recieved the highest rates of both recommended and not recommended drugs. A close-up analysis using virtual provider networks shows the most specific use of diagnostic testing and the highest incidence rates for pwd for seemingly specialized GP practices (top 1% of virtual networks with > 20 incident pwd p.a.. Their medication patterns will be analyzed to identify best-practice examples for an improvement model.

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"Problems with Medical Science": Perception of research needs in the Dartmouth Atlas publications from 1996 to the present

**Background (500 characters or about 90 words)**

Why did principal findings of problematic variation not change much over decades, despite what seems like significant advances in fields like evidence based medicine, practice guidelines, quality improvement, shared decision making and much reviewing of intervention effectiveness? Current evidence might be too weak for such activities to live up to their full potential (e.g. effectiveness reviews and quality indicators depend on reliable evidence) – while powerful interest are at stake

**Objectives (500 characters or about 90 words)**

It is intended to investigate what actual or potential role has been ascribed to medical research (understood here as research concerned with intervention effectiveness) in mitigating unwarranted variation in designated interventions. The role of research in relation to other means of potentially limiting unexplained variation will also be questioned.

**Methods (720 characters or about 125 words)**

All Dartmouth Atlas publications from the first report in 1996 to the present (2014) are qualitatively analyzed regarding statements on the presence or lack of medical research findings that might guide appropriate utilization of interventions and thus might reduce unwarranted variation. These statement are categorized regarding: Type of intervention(s) addressed, Type of research (e. g. clinical trials, observational studies of effects in routine care), relation to other factors influencing decision making (e. g. patients role in decisions, physician perception, other quality issues, provider capacity and economic factors).

**Results (720 characters or about 125 words)**

The need for, and current lack, of reliable research is stressed. It is also mentioned that, even if reliable results from clinical trials are available they still might be interpreted differently. The focus on shared decision making is also prominent. Atlas reports mostly are unspecific regarding research needs and aim at addressing many potential factors regarding unwarranted variation simultaneously, not distinguishing the specific role of each. Associating interventions with categories like "Effective/Preference/Supply(-sensitive)-care" suggests limited expectations regarding obtaining more reliable evidence that might lead to changes e. g. from "Preference sensitive"- to "Effective" care.

**Conclusion (600 characters or about 100 words)**

Relying on Atlas Reports only is an obvious limitation. Discussion of research in reports is often unspecific and not well discerned from other types of proposed measures to address variation. As questionable variation persists over time, and other measures have shown limited impact, maybe reliable evidence of (in-)effectiveness will? – Longitudinal Studies of variation might be a future focus of the field anyway and it seems natural to look for the impact of research findings in those. The role of general research findings in shared decision making also needs to be discussed more.

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Reducing Deaths from Sepsis by Reducing Variation

**Background (500 characters or about 90 words)**

Sepsis is the overwhelming response of the immune system to an infection that can result in leaky blood vessels and impaired blood flow to organs, causing low blood pressure, organ failure and death. Annually, more than one million Americans are affected with an estimated mortality of 28 to 50%. Deaths from sepsis far exceed the US deaths from prostate and breast cancer and AIDS combined. Annual costs are estimated to be 20 billion dollars.

**Objectives (500 characters or about 90 words)**

Early intervention in the course of sepsis is known to improve outcomes, but the consistent delivery of the bundle treatment has been shown to be difficult and varies widely among health care systems. The goal of a collaborative of 13 healthcare systems (HVHC,) was to use a structured implementation process to optimize bundle treatment adherence and sharing of best practices to facilitate rapid accelerated improvement to improve outcomes and reduce costs.

**Methods (720 characters or about 125 words)**

Retrospective analysis of charts for 2010-2012 was performed to obtain information about the feasibility of automated electronic data pulls and to provide an estimate of baseline performance. HVHC members used a lean based, structured workshop at each institution to detect barriers and gaps to deliver recommended care. These implementation sessions included all involved parties, ranging from physicians to nurses, IT experts, pharmacy and laboratory personnel. Lean facilitators were used to structure and organize the workshops. Data collection was done in two categories: process data tracking time based measures of intervention bundle delivery and institutional and government outcomes data.

**Results (720 characters or about 125 words)**

Delivery of the bundle intervention varied widely between 5 and 80% as did mortality from 14 to over 50% before the initiative. At Dartmouth, adherence to the bundle increased from 5 to over 80% over the course of only 6 months with a corresponding 50% reduction in mortality and hospital charges. On the HVHC level, variation was reduced across all sites with most health care systems performing at the level of the initially best performers.

**Conclusion (600 characters or about 100 words)**

Rapid adoption of best practices associated with improved patient outcomes and reduced costs can be achieved by using structured implementation work in a collaborative of diverse health care systems. Monthly phone conferences and in person meetings twice a year provided opportunities to learn from others, exchange information and strategies to overcome obstacles. Sharing process and outcome data in a transparent fashion provides impetus to overcome doubts about institutional performance and strong leadership support facilitates rapid change.

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**Title**

Geographical variation in use of intensive care: a nationwide study

**Background (500 characters or about 90 words)**

Substantial variation in use of intensive care has been reported between countries and within the US, however, data on geographical variation in use within more homogenous tax-supported health care systems are sparse.

**Objectives (500 characters or about 90 words)**

To examine whether there is geographical variation in the use of intensive care resources in Denmark concerning both intensive care unit (ICU) admission and use of specific interventions.

**Methods (720 characters or about 125 words)**

We conducted a population-based cross-sectional study based on linkage of national medical registries including all Danish residents between 2008 and 2012 using population statistics from Statistics Denmark. Data on ICU admissions and interventions, including mechanical ventilation, non-invasive ventilation, acute renal replacement therapy, and treatment with inotropes/vasopressors, were obtained from the Danish Intensive Care Database. Data on patients' residence at the time of admission were obtained from the Danish National Registry of Patients.

**Results (720 characters or about 125 words)**

The overall age- and gender standardized number of ICU patients per 1,000 person-years for the 5-year period was 4.3 patients (95% CI, 4.2; 4.3) ranging from 3.7 (95% CI, 3.6; 3.7) to 5.1 patients per 1,000 person-years (95% CI, 5.0; 5.2) in the 5 regions of Denmark and from 2.8 (95% CI, 2.8; 3.0) to 23.1 patients per 1,000 person-years (95% CI, 13.0; 33.1) in the 98 municipalities.

The age-, gender-, and comorbidity standardized proportion of use of interventions among ICU patients also differed across regions and municipalities.

**Conclusion (600 characters or about 100 words)**

There was only minimal geographical variation in the use of intensive care admissions and interventions at the regional level in Denmark, but more pronounced variation at the municipality level.

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**Title**

Monitoring and reporting unwarranted variation across all of a nation's public and private hospitals and primary health care

**Background (500 characters or about 90 words)**

Australia's National Health Performance Authority was established to monitor and publicly report on the performance of local health care organisations. The Authority has reported on regional variation across more than 100 measures of access, equity and effectiveness for public and private hospitals and primary health care organisations.

**Objectives (500 characters or about 90 words)**

The Authority publicly reports locally relevant and nationally comparable information with the aim of identifying unwarranted variation, increasing transparency and accountability, and stimulating improvements in health care. Information on local variation is now available regarding, for example, child immunisation; primary healthcare use, expenditure, clinical practice and coordination of care; potentially avoidable hospitalisations; patient experiences; cancer surgery waiting times;

**Methods (720 characters or about 125 words)**

Data were sourced from national administrative and survey datasets including primary health care and pharmaceutical billing data, clinical and immunisation registry data, admitted patients hospital data and deaths data. Results are presented at organisation levels, as well as three, nested levels of geography. Methods used to support fair comparisons include peer grouping local areas and hospitals based on socioeconomic status, geographic remoteness, distance to health services, and hospital and patient characteristics. Findings are presented in reports in local area maps, innovative regional profiles and interactive web-based tools.

**Results (720 characters or about 125 words)**

Across Australia, almost one-third of postal areas had less than 90% of 5 year old children fully immunised. Medicare expenditure on primary care doctors varied across local areas from \$129 to \$330 per 100,000 people. Primary care management of chronic conditions varied, with prescribing of psychotropic medication for depression or anxiety ranging from 38% to 74%, and imaging for arthritis or chronic back pain from 8% to 20%. Age-standardised rates for potentially preventable hospitalisations for chronic conditions varied 10-fold. Patient experiences vary, with the population not seeking care from a primary care doctor due to cost ranging from 1% to 13%. Among patients needing surgery for malignant breast, bowe

**Conclusion (600 characters or about 100 words)**

The Authority is providing valuable new insights into the performance of the Australian health system by highlighting local area variation that is not seen when reporting at the national or state levels. The media and policy impact of its reports has been demonstrated, with more than 1,000 media stories published within 30 days of release of its two child immunisation reports combined, reaching an audience of more than 20 million people. Legislative changes have already occurred in some states and nationally to support increased immunisation.

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**Title**

Substantial geographic variation in French mental health admission rates suggest cultural differences in admitting practices

**Background (500 characters or about 90 words)**

Mental health disorders are common and are projected to account for substantial disability across all World Bank Income level countries through 2030. A survey study of six European countries in 2000 found high lifetime and 12-month prevalence rates of mental disorders. A recent study suggests that the number of Europeans with brain disorders and the costs associated with treating them are increasing rapidly and that France experiences the third highest total such costs in the EU.

**Objectives (500 characters or about 90 words)**

Though they might inform policymakers, no studies of geographic variation in admissions for mental health disorders in France have been conducted. We sought to examine trends in per-capita rates of admission for mental health conditions to non-psychiatric hospital in mainland France and to evaluate measures of geographic variation in those admission rates.

**Methods (720 characters or about 125 words)**

For 2008-2010, we calculated annual sex- and age-adjusted per-capita admission rates for hospitalizations that occurred in non-psychiatric hospitals that were precipitated by seven categories of mental health diagnoses in 94 departments in mainland France. We examined trends in admission rates over time, measures and causes of geographic variation in those rates, and resources consumed by these admissions.

**Results (720 characters or about 125 words)**

Non-psychiatric French hospitals had over 400,000 annual mental health admissions that consumed about 800 million euros and over 1.6 million bed days of care each year. We found age- and sex-specific patterns for these admissions and considerable geographic variation. High rates of admission for illicit drug disorders were concentrated in the northeast; for alcohol disorders, in the northwest; and for mood and anxiety disorders, around the Loire Valley. Geographic variation for alcohol and illicit drug disorders and their admission rates increased markedly during the time period examined. Admission rates were not well explained by ecological or supply factors, but were highly correlated across years.

**Conclusion (600 characters or about 100 words)**

The high degree of geographic variation that we found suggests cultural differences in admitting patterns for the mental health disorders. Within the EU, France experiences very high costs associated with mental health disorders; therefore, geographically targeted interventions, particularly to address alcohol and illicit drug disorder admissions, should become policy priorities.

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**Title**

Commissioning for Value in England

**Background (500 characters or about 90 words)**

Analyst working in the National Health Service in England on secondment from Civil Service. Previously worked in range of regional and sub regional health organisations.

**Objectives (500 characters or about 90 words)**

To help those organisations responsible for health budgets in England make optimal health investment decisions whilst improving patient experience and outcomes

**Methods (720 characters or about 125 words)**

Age/Sex standardisation of a range of health related datasets and comparison with similar areas (derived using algorithm) to help identify unwarranted variation by disease at sub national levels (Clinical Commissioning Groups). This provides the analysis for stage 1 of a 3 stage process which is: Stage 1 - use reports to identify potential diseases for improvement, this is called 'Where to look'; Stage 2 - create 'deep dives' for outlier diseases – this is called 'What to change?' and Phase 3 - implementation of change, called 'How to change?'. The three stage process enables local organisations to identify disease pathways which have scope for improvement, to study in more depth, and then to implement change.

**Results (720 characters or about 125 words)**

Series of three sets of reports, one for each commissioning organisation in England, highlighting potential diseases offering value improvement opportunities. Reports used to help those organisations set their priorities to improve health outcomes and re-allocate budgets. Reports accompanied by suite of supporting resources: tools, metadata, raw data, methodology and case studies

**Conclusion (600 characters or about 100 words)**

The approach, now called 'Commissioning for Value', is starting to gain traction in England, especially as budgets tighten. Case studies are now emerging to demonstrate how the approach is helping commissioning organisations to make real, practical changes to patient experience, outcomes and budget optimisation. All data, tools, reports and case studies available here:

<http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/>



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## **Poster Abstracts**

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**Title**

Do CVD and stroke mortality vary by distance to hospital in Switzerland?

**Background (500 characters or about 90 words)**

Geographical inequalities in the provision of health care in Switzerland may influence the likelihood of dying or dying from cardiovascular disease (CVD) and stroke, in particular. Remote areas often have long travel distance to the next hospital. Geographical accessibility is important in the provision of acute care services.

**Objectives (500 characters or about 90 words)**

Our aim is to investigate the relationship of cardiovascular diseases (CVD) and stroke mortality with the distance to the next hospital.

**Methods (720 characters or about 125 words)**

The Swiss National Cohort (SNC) is a longitudinal study of all residents of Switzerland, based on the national 2000 census and linkage to mortality records. We analyzed all persons older than 30 at the 2000 census and followed them for mortality until 31st December 2008. Outcomes were deaths of CVD and stroke. We calculated the Euclidean distance and drive time between the SNC residencies and the next hospitals. We fitted Cox proportional hazards for the association of Euclidean distance groups with CVD and stroke mortality. We report age and sex-adjusted hazard ratios (HR) with 95% CI as well as fully adjusted HRs (nationality, civil status, religion, education, household type, urbanization, language region).

**Results (720 characters or about 125 words)**

4,628,215 subjects were included in the analysis. 172,226 of them died of CVD and 26,770 of stroke. Compared to the group living less than 5 km, those living 15 to 20 km away from the nearest hospital had a 4% higher sex and age-adjusted hazard of dying from stroke (HR=1.04, 95% CI: 0.89-1.21), after full adjustment the HR was 1.02 (95% CI: 0.88-1.19). The corresponding results for CVD mortality were a HR of 1.07 (95% CI: 1.01-1.14) in the sex and age-adjusted model and a HR of 0.96 (95% CI: 0.90-1.02) in the fully adjusted model.

**Conclusion (600 characters or about 100 words)**

A large majority of the Swiss resident population lives in close proximity (less than 5 km) to an acute hospital. This might explain that we observed no association of hospital distance and CVD / stroke mortality. In further analyses we will explore the associations for the SNC individuals younger or older than 65 at census 2000 with the distance on the road network, as well as associations with nearest distance to specific hospital types.

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**Title**

C sections in Kosovo: who's responsible for the rise?!

**Background (500 characters or about 90 words)**

From 2000 to 2009 the rate of Caesarean sections (CS) in Kosovo increased from 7.5% to 20.1%, with a further increase of 50.6% in the private sector. This exceeds the World Health Organization statement that "there is no justification for any region to have CS higher than 10-15%." The variation of CS rates among regions and hospitals within a country is another dimension to the problem. In 2009, CS has varied across hospitals in Kosovo from 6.15% to 30.05 % of total births.

**Objectives (500 characters or about 90 words)**

With this study we want to test if (i) women who have been taken care in private sector during antenatal care; (ii) women taken care by single physician; and, (iii) women were attended at birth by same physician that provided most of antenatal care, are more likely to have a CS.

**Methods (720 characters or about 125 words)**

We used data that were obtained during a survey of woman who had birth in 2015 collected by NGO Action for Mother and Children that operates in Kosovo. The sample includes 898 births in about 5 maternity units at public hospitals in Kosovo. The sample includes a population of low-risk primiparous women.

Main outcome measure is C section. Variables that the study focuses are: the venue for antenatal care visits (public/private); antenatal care provided by single physician or several physicians (same/many); and whether the C section was performed by physician that provided antenatal care. Univariate and multivariate logistic regression was performed using SPSS.

**Results (720 characters or about 125 words)**

Initial results confirm that:

- the odds of women for having a C section increase with visits of private clinics during antenatal care (OR=3.080);
- visiting same physician or many during antenatal care doesn't seem to have significant effect on odds for C section (the results are not statistically significant);
- there is significant increase in odds of having C section if women was delivered by same physician who has performed most of antenatal care (OR=3.598).

**Conclusion (600 characters or about 100 words)**

Understanding the reasons behind CS increase and variation is critical in determining if CS is being used appropriately. In addition, overuse of CS is shifting resources to unnecessary care that could otherwise be used for procedures patients could benefit from.

The raising rates of CS in Kosovo have been a continuous concern over the last ten years and explanations for this increase have remained unverified. This study confirms that some indirect financial incentives may be playing an important role in rise and variation of CS rates in Kosovo.

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**Title**

Variation in mortality among patients with hip fracture in Denmark: Studies on the role of structure and quality of care

**Background (500 characters or about 90 words)**

Hip fracture patients age and comorbidity have been shown to predict mortality, whereas less is known about the role of the organisation and quality of care. Multidisciplinary care with involvement of orthopedic surgeons and geriatricians (orthogeriatric care) as well as centralization of care to departments with a higher patient volume has been suggested to benefit hip fracture patients, however data are sparse. In particular, little is known about the quality of care as a mediator.

**Objectives (500 characters or about 90 words)**

In three nationwide population-based cohort studies of patients admitted with hip fracture between 2010 and 2013 (n=25.354) at Danish hospitals, we will examine the associations between:

- The delivered in-hospital care and 30-day mortality.
- Admission to a department with orthogeriatric specialization and 30-day mortality and the quality of the delivered care.
- Admission to a department with higher patient volume and 30-day mortality and the quality of the delivered care.

**Methods (720 characters or about 125 words)**

Quality of in-hospital care was reflected by seven evidence based process performance measures: systematic pain assessment, early mobilization, receiving basic mobility assessment at arrival and at discharge, post discharge rehabilitation program, anti-osteoporotic medication and prevention of future fall accidents measures. Orthogeriatric units were defined as daily multidisciplinary care with involvement of both orthopedic surgeons and geriatricians and orthopaedic units with medical consultant service only on request. Patient volume was defined as the average number of hip fracture patients per year. Data was analyzed using multivariable regression with adjustment for potential confounders and cluster effects.

**Results (720 characters or about 125 words)**

All process were associated with lower mortality. After mutual adjustment, mobilization within 24 hours postoperatively (adjusted odds ratio (OR)= 0.85, 95%CI: 0.84-0.87) and receiving a post discharge rehabilitation program (OR= 0.92, 95%CI:0.90-0.94) remained independently associated with lower mortality. Admittance to orthogeriatric units was associated with lower mortality (OR= 0.69 (95% CI: 0.54-0.88) and a higher chance for fulfilling the process performance measures. In contrast, admission to high volume units was associated with higher mortality (OR= 1.37 (95% CI: 1.14-1.64)). The higher mortality appeared partly to be mediated by the lower quality of care.

**Conclusion (600 characters or about 100 words)**

Our findings regarding hip fracture patients in Denmark shows that detailed data from clinical quality databases can be valuable for understanding the causes of variation, including unwarranted variation in health care. This understanding is essential to implement targeted and effective interventions that can reduce the unwanted variation in health care.

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**Title**

Variation in point of care testing of HbA1c in diabetes care and use of health care services

**Background (500 characters or about 90 words)**

It has been suggested that Point-of-care testing (POCT) for HbA1c enhances the care experience and enable earlier therapeutic decisions in diabetes care. POCT may result in improved diabetic control, better patient outcomes and enhanced clinical efficiency with fewer patient visits and subsequent reductions in hospitalizations and costs. In 2008, the Danish regulators agreed to create a new tariff for remuneration of POCT of HbA1c in primary care. This new incentive requires that GPs h

**Objectives (500 characters or about 90 words)**

The aim of this study is to describe and analyze the variation in use and access to POCT of HbA1c among diabetes patients in Danish primary and assess whether there is a link between the use of point-of-care HbA1c-testing and the risk of preventable hospital admissions and treatment cost in both general practice and the hospital sector.

**Methods (720 characters or about 125 words)**

We use register data from 2011 and an algorithm based on The Danish Drug Register, the Danish Health Service Register and the National Patient Register to define a population of 172.906 diabetes patients. The POCT Fee (tariff 7403) recorded in The Danish National Health Service Register is used to measure the amount of POCT of HbA1c among diabetes patients. Next we apply descriptive statistics and regression analysis to analyze variation in the prevalence of POCT of HbA1c and whether there is a link to preventable hospitals admissions and cost of care. Preventable hospital admissions were assed though the ambulatory care sensitive conditions (ACSCs) classification of

**Results (720 characters or about 125 words)**

Our preliminary results indicate that there is a significant variation in the use and access to POCT of HbA1c testing among diabetes patients in Danish primary care. Only the Capital Region of Denmark has allowed GPs to use this incentive for POCT. In the Capital Region of Denmark there is significant variation in the use of POCT across patients, clinics and municipalities. Furthermore, there is a significant link between POCT of HbA1c and preventable hospitalizations of diabetes after adjusting for individual level patient characteristics. However, our preliminary results were not able to show that total cost of care across primary and secondary care was negatively linked to POCT of

**Conclusion (600 characters or about 100 words)**

There was variation in use and access to POCT of HbA1c for Diabetes patients across Danish Regions and municipalities in 2011. We revealed a significant link between use of POCT of HbA1c and consumption of health care services such as the amount of preventable hospital admissions. More POCT of HbA1c appears to result in fewer preventable hospitalizations (ACSCs) of diabetes patients. It may be relevant to implement this incentive in other Regions than the Capital Region to avoid preventable hospitalization and variations in POCT access which are not based on patients health needs and preference.

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**Title**

Place of death in Switzerland: dying in hospital or non-acute institutions?

**Background (500 characters or about 90 words)**

Place of death (PoD) is an important indicator for quality of end of life care (EOL). Many people express the desire to die at home. Yet research reports that nearly 40% of patients die in acute care hospitals.

**Objectives (500 characters or about 90 words)**

The study aims to describe differences in the proportion of deaths between hospitals and SOMED institutions (nursing homes, institutions for people with disabilities, addiction and psycho-social problems).

**Methods (720 characters or about 125 words)**

We conducted a retrospective study of people who died in 2010. Patients were identified from medical statistics of the Swiss hospitals (MedStat) and SOMED institutions. A conceptual framework was developed to guide analysis. We describe interactions between three levels of determinants: (1) individual (e.g. age, gender); (2) clinical (diagnosis); and (3) supply measures (e.g. hospital beds) across 71 health service areas (HSA).

**Results (720 characters or about 125 words)**

We identified 47,078 people who died in 2010. Deaths occurred more frequently in hospital (39.3%) than in SOMED (36.5%). Number of deaths across HSA ranged between 15 - 6112. At individual level, we identified age and gender differences in the place of death. We found that people who died in hospital were more likely to be males and younger. Among SOMED deaths 33.5 % were aged 91+ compared to hospital 18.7%. At clinical level, most common reason for hospital admission were neoplasms (28%), circulatory (24%) and respiratory illnesses (9.4%). At health system level, we found an association between place of death and supply measures (number of physicians, nurses, beds).

**Conclusion (600 characters or about 100 words)**

Hospitals remain the most frequent PoD in Switzerland. Socio-demographic factors such as age, gender and supply measures contribute to the difference in the proportion of hospital admission with death.

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**Title**

How do we know if the patients improve their health or not, and if so, how much?

**Background (500 characters or about 90 words)**

There are, as today, 105 National quality registers in the Swedish health care. To get funding from the Swedish health authorities the register among other things, should measure patient reported outcome and experiences (PROM and PREM). The National quality registers contains information on individual level about health problems, treatments and results in health service and care. A National quality register is evaluated and certified by the National Steering Group for Quality Registers.

**Objectives (500 characters or about 90 words)**

In the quality registers patients are often asked about their perceived health and quality of life with the help of some kind of instrument, i.e. RAND36, EQ5D, Disab-kids etc. These instruments often measure the perceived outcome with items that are ordered categorical data (Lickert, VAS or dichotomous). The items are then often used to calculate a score on the dimension they are intended to measure i.e. general health or physical activity, repeated over time for the same patient.

**Methods (720 characters or about 125 words)**

In the presentation a method developed by the professor in biostatistics, Elisabeth Svensson at Örebro University will be demonstrated. This method can be used for evaluation of paired ordered categorical data as well as validation of instruments for measuring perceived health. The method gives both a measure of the effect size and direction of change. As an example results from the validation of the new translation of RAND36 will be presented.

**Results (720 characters or about 125 words)**

Result will be presented for two groups of patients, dialysis and heart rehabilitation. In the first group, results from a test-retest of stability (within two weeks) and for the second group responsiveness of heart rehabilitation after a 90 day intervention will be presented. The main outcome parameter are percent agreement (PA), relative position (RP), relative concentration (RC), relative rank variance (RV), measure of disorder (D), relative transformable pattern (RTP) and ROC-curve to illustrate the marginal distributions.

**Conclusion (600 characters or about 100 words)**

It will be demonstrated that "Svenssons Method" is a suitable method to analyze paired ordered categorical data when there are self-reported patient data on perceived health. The method gives both information on direction and effect.

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**Title**

Relationship between outcome and process measures of ischemic stroke care at a regional perspective in Japan

**Background (500 characters or about 90 words)**

Geographic variations in health care within and across countries have been widely documented, but the number of reports addressing such variations in Japan is limited. Regional variations and their associated factors should continue to be investigated with considerations to the intrinsic differences in national health care systems.

**Objectives (500 characters or about 90 words)**

The objective of this study was to investigate the relationship between outcome and process measures of ischemic stroke care at regional level.

**Methods (720 characters or about 125 words)**

We used Japanese national claims data from between April 2010 and March 2012 from 51 of the 349 Secondary Medical Areas in Japan. The study cohort included NHI beneficiaries aged 65 years and older and all Long-Life Medical Care System beneficiaries who had been hospitalized with ischemic stroke (ICD-10 codes I63\$) and had received acute ischemic stroke care as described in the 2009 Japanese Guidelines for the Management of Stroke during the index hospitalization. The outcome measure was age- and sex-adjusted in-hospital mortality. For the process measures, (1) tissue plasminogen activator (tPA) utilization rate, (2) ICU admission rate, and (3) LOS. The other process measures included (4) regional continuity of care.

**Results (720 characters or about 125 words)**

We identified 49,440 patients from regions in the study area who had been hospitalized for acute ischemic stroke. In-hospital mortality was not correlated with spending but did show negative correlations with performance in the process measures. Hospitalization spending not only had a significantly negative correlation with regional continuity of care planning implementation rate but also a significantly positive correlation with rehabilitation rate.

**Conclusion (600 characters or about 100 words)**

We observed substantial geographic variations in inpatient outcomes, care processes, and spending among patients aged 65 years and older who had been admitted for acute ischemic stroke in Japan. Correlation analysis by Spearman's rho could not indicate clear association between regional in-hospital mortality and hospitalization spending in stroke care. Another method with less stringent assumptions may be needed. Among the process measures analyzed in our study, regional continuity of care planning rate and rehabilitation rate are possible determinants of regional variations in spending.



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**Title**

Multiple determinants of avoidable mortality in Romania

**Background (500 characters or about 90 words)**

The Romanian healthcare system is going through a process of ongoing health reform since 1990s. At the same time, is one of the most underfinanced systems in EU, facing major problems related to resources allocation, the quality of the services provided, and its main outcomes. In this respect, an analysis of the determinants of avoidable mortality might provide an useful insight in order to design better health policies in Romania.

**Objectives (500 characters or about 90 words)**

- to determine the dimension of avoidable deaths on major diseases of interest;
- to measure the heterogeneity of avoidable deaths across the country at district and community level;
- to test the relationship between a set of social determinants of health and avoidable mortality cases

**Methods (720 characters or about 125 words)**

- descriptive statistic analysis performed at different administrative levels (NUTS2 and NUTS3);
- cross-sectional and panel analysis (different type of estimation methods taking into consideration territorial heteroskedasticity and outliers);

**Results (720 characters or about 125 words)**

Although the trend is decreasing slowly in the last eight years (2005-2012), avoidable deaths represent in average about 18% of total deaths in Romania. There is a large heterogeneity across the country as well as for different causes of death.

**Conclusion (600 characters or about 100 words)**

Changing the architecture of health care provision, as well as more efficient and equitable allocation of resources might change the pattern of avoidable deaths in Romania.

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**Title**

Children's experience of an intervention with a structured assessment of health-related quality of life

**Background (500 characters or about 90 words)**

The outcome of health-related quality of life (HRQOL) is important because children with chronic health conditions need to handle their condition into adulthood. There is growing evidence that HRQOL assessments are important in clinical practice, and there is a need to increase the knowledge about how to present HRQOL information to the child. It is critical that children and healthcare professionals are provided with tools that are easy to use that can lead to actionable results.

**Objectives (500 characters or about 90 words)**

The aim was to explore children's experiences of an intervention based on a structured assessment of health-related quality of life. The results from a patient reported outcome measure (DISABKIDS) from the quality registry were used during the conversation between the child and the healthcare professional.

**Methods (720 characters or about 125 words)**

A qualitative descriptive design was chosen. Twenty-five interviews were conducted with children from 10-17 years of age. Prior to the start of the study an intervention was performed, which included development of a web-based report module for the assessment, which was built on the DISABKIDS Chronic Generic Measure – 37 (DCGM-37), and educational sessions for healthcare professionals about how to understand the results which was reviewed and discussed with the child during the patient encounter. Content analysis with an inductive approach was used in the analysis.

**Results (720 characters or about 125 words)**

The systematic assessment provided the children with insights and motivated them to change their lifestyle in order to improve their health. It encouraged them when the health care professionals requested and discussed their outcomes and became aware of the children's everyday life. More active involvement from the child in the patient encounter may lead to a management treatment plan that is structured from the individual's beliefs and lifestyle. An "active child" can be beneficial both within and beyond the consultation.

**Conclusion (600 characters or about 100 words)**

The use of a clinical assessment of HRQOL can make a contribution to facilitate priorities in healthcare shared by children and healthcare professionals. Using HRQOL results from the quality registry may promote insights about health and encourage children to discuss their outcomes with their healthcare professionals. Subsequently, it can be useful to identify areas for improvement and encourage children to share their thoughts about health-related issues with their healthcare professional.

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**Title**

Comparable costs of admitted care across more than 80 Australian public hospitals

**Background (500 characters or about 90 words)**

In 2011-12, about 30% of the \$140.2 billion that Australia spent on health was spent on the running costs for public hospitals, excluding property, plant and equipment). Having effective measures to help assess the efficiency of hospitals is therefore important, because the size of the hospital sector means efforts to improve efficiency, if well targeted, have a large potential to yield significant benefits.

**Objectives (500 characters or about 90 words)**

In 2015, the National Health Performance Authority (Performance Authority) released a public report that compared the relative efficiency of more than 80 Australian public hospitals. The report and resultant performance information is now available at [www.myhospitals.gov.au](http://www.myhospitals.gov.au)

**Methods (720 characters or about 125 words)**

Analyses used DRG and National Weighted Activity Unit information calculated from the National Admitted Patient Collection and the National Hospital Cost Data Collection. Two indicators were used – Costs per National Weighted Activity Unit and Comparable Costs of Care (CCC), both of which adjust as much as possible for factors that can push hospital costs up unavoidably and exclude costs that cannot be fairly compared based on accounting practices. The main difference between the measures is that CCC includes emergency department (ED) costs for patients admitted through EDs. Comparable costs of admission for 16 common clinical conditions were calculated for each hospital, as well as length of stay for these conditio

**Results (720 characters or about 125 words)**

Some public hospitals spend nearly twice as much money as others to provide similar services to similar groups of patients – even after adjusting for differences in the services hospitals provide and the severity of patients' illnesses. The report also finds large variations between hospitals in the costs per admission for a range of common conditions and procedures. Among the 16 common medical and surgical conditions, the report finds that some of these comparable costs could be almost three times higher depending on the hospital.

**Conclusion (600 characters or about 100 words)**

The report breaks new ground by being the first national comparison of hospital operational costs that fairly account for the fact that some hospitals perform more complicated operations or see sicker patients. No determination is made that a hospital with higher or lower costs delivers better or worse care or patient outcomes.

Wennberg International Collaborative  
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September 2 – 4, 2015

## **Biographies**

**Michael Barry**

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Boston, Massachusetts, USA

**Biography**

Michael's research career has focused on defining the outcomes of common strategies of medical care in terms that matter to patients, and on helping those patients to be informed about and involved in their health care decisions. He also has participated in clinical guideline panels on cancer screening for the American College of Physicians, the American Urological Association, the National Cancer Center Network, and the American Cancer Society. Michael has led many research teams serving as the Principal Investigator of the Patient Outcome Research Team (PORT-II) for Prostatic Diseases, a successful AHRQ-funded collaboration that published 189 papers over five years addressing the epidemiology, natural history, and management of prostate diseases. The results have had a worldwide impact on research and treatment of prostate diseases, including prostate cancer. A particular insight from the PORT-II work was the importance of supporting patients to participate in decision making through a shared decision-making process supported by patient decision aids. Michael developed and tested some of the first patient decision aids ever developed, and continue to work on these strategies to help disseminate the results of patient-centered outcomes research to patients and clinicians making health care decisions as part of day-to-day care. He also served as PI for the Practice-Based Research Network at Massachusetts General Hospital. Michael currently serves as President of the nonprofit Informed Medical Decisions Foundation. The Foundation ([www.informedmedicaldecisions.org](http://www.informedmedicaldecisions.org)) strives to improve the quality of medical decisions through better patient education and greater patient involvement in their fateful health care decisions. The Foundation recently merged with the nonprofit Healthwise, with the combined mission of helping people make better health decisions. Healthwise produces over 40,000 pages of patient education materials, as well as over 170 patient decision aids. 15% of U.S. physicians use Healthwise materials. He now also serves as Healthwise's Chief Science Officer. He is a past president of the Society for Medical Decision Making (SMDM) and the Society of General Internal Medicine in the United States. Michael continues to practice primary care and serves as medical director of the John D. Stoeckle Center for Primary Care Innovation at MGH. He is also a professor of medicine, part time, at Harvard Medical School and a Master of the American College of Physicians.

**Selected Publications**

1. **Barry MJ**, Fowler FJ, Mulley AG, Henderson JV, Wennberg JE. Patient reactions to a program designed to facilitate patient participation in decisions for benign prostatic hyperplasia. *Med Care* 1995; 33:771-782.

2. **Barry MJ**, Cherkin DC, Chang Y, Fowler FJ, Skates S. A randomized trial of a multimedia shared decision-making program for men facing a treatment decision for benign prostatic hyperplasia. *Disease Management and Clinical Outcomes* 1997; 1:5-14.
3. Lu-Yao G, Albertsen PC, Stanford JL, Stukel TA, Walker-Corkery E, **Barry MJ**. Screening, treatment, and prostate cancer mortality in the Seattle area and Connecticut: fifteen-year follow-up. *J Gen Intern Med* 2008; 23(11):1809-14.
4. Fowler FJ, Gerstein BS, **Barry MJ**. How patient centered are medical decisions? Results of national survey. *JAMA Intern Med* 2013:1-7.
5. **Barry MJ**, Wexler RM, Brackett CD, Sepucha KR, et al. Responses to a decision aid on prostate cancer screening in primary care practices. *Am J Prev Med* 2015 Apr 29. pii: S0749-3797(15)00092-6. doi: 10.1016/j.amepre.2015.03.002. [Epub ahead of print].

## **Jörg Bätzing-Feigenbaum**

Board-Certified Specialist in Family Medicine, Infectious Diseases,  
Tropical Medicine & Emergency Medicine  
Head of Unit V - Regional Health Care Analyses & Health Care Atlas  
Central Research Institute of Ambulatory Health Care in Germany (Zi)  
Herbert-Lewin-Platz 3  
10623 Berlin, Germany

## **Biography**

Jörg Bätzing-Feigenbaum has been Head of the Unit for Regional Health Care Analyses & Health Care Atlas at the Central Research Institute of Ambulatory Health Care in Berlin / Germany (Zi) since 2014. Zi collects and analyses pseudonymised prescription drug data and claims data from all 17 regions in Germany for purposes of health services research. Prior to his position at Zi, he had been Head of the Department of Infectious Disease Epidemiology & Protection at the State Office for Health & Social Affairs (LAGeSo) in Berlin and Senior Epidemiologist at the Unit for HIV/AIDS & other sexually or blood transmitted Infections at the Robert Koch-Institute (RKI) in Berlin.

After being a physician in departments for general and accident surgery, urology, internal medicine, tropical medicine and family medicine in Germany in the 1980s and 90s, he spent several years in Africa (Tanzania, Rwanda and Angola) and worked there as a physician in hospitals. From 2004 to 2006 he was Project Leader of a population-based HIV-Survey at the Africa Center for Health & Population Studies, University of kwaZulu-Natal in Mtubatuba / South Africa.

## **Recent Publications**

1. Padberg I, **Bätzing-Feigenbaum J**, Sagebiel D: Association of extrapulmonary tuberculosis with age, gender, and season differs depending on the affected organ. *Int J Tuberc Lung Dis* 2015, 19(6): 723-728
2. Santos-Hövenner C, Zimmermann R, Kücherer C, **Bätzing-Feigenbaum J**, Wildner S, Hamouda O, Marcus U: Conversation about serostatus decreases risk of acquiring HIV. Results from a case control study comparing MSM with recent HIV infection and HIV negative controls. *BMC Public Health* 2014, 14: 453
3. Marcus U, Vogel U, Schubert A, Claus H, **Bätzing-Feigenbaum J**, Hellenbrand W, Wichmann O: A cluster of invasive meningococcal disease in young men who have sex with men in Berlin, October 2012 to May 2013, *Euro Surveill* 2013, 18: pii=20523
4. **Bätzing-Feigenbaum J**, Kollan C, Kühne A, Matysiak-Klose D, Gunsenheimer-Bartmeyer B, Hamouda O, for the ClinSurv HIV Study Group: Cohort profile: the German ClinSurv HIV project - a multicentre open clinical cohort supplementing national HIV surveillance, *HIV Med* 2011, 12: 269-78

5. **Bätzing-Feigenbaum J**, Pruckner U, Beyer A, Sinn G, Dinter A, Mankertz A, Siedler A, Schubert A, Suckau M: Spotlight on measles 2010: Preliminary report of an ongoing measles outbreak in a subpopulation with low vaccination coverage in Berlin, Germany, January-March 2010, Euro Surveill 2010, 15: pii=19527



## **Claudia Berlin**

University of Bern  
Institute for Social and Preventive Medicine  
Bern, Switzerland

### **Biography**

Claudia is a PhD candidate at the Institute of Social and Preventive Medicine of the University of Bern, Switzerland. She is holding a degree in Geography of the University of Greifswald and has worked as a research fellow at the Institute of Community Medicine in Greifswald, Germany.

Claudia Berlin's main subjects during her PhD are Health service research and Health Geography. Her work is focused on the determinates of geographical and temporal variation in health care, the use of GIS for spatial analysis in Public Health and Epidemiology and the analysis of spatial accessibility of health care facilities and its impacts on the health outcome.

### **Selected Publications**

1. **Berlin C**, Busato A, Rosemann T, Djalali S, Maessen M: Avoidable hospitalizations in Switzerland: A small area analysis on regional variation, density of physicians, hospital supply and rurality. In: BMC Health Service Research 2014, 14:289.
2. **Berlin C**, Panczak R, Egger M: Versorgungsforschung mit Routinedaten in der Schweiz: eine Herausforderung. In: Schweizerische Ärztezeitung 2014, 50:1892.
3. Meinke, C.; **Berlin, C.**; Pieper, C.; van den Berg, N.; Hoffmann, W. (2011): Auswirkungen des demografischen Wandels auf die Grundbedürfnissicherung der Bevölkerung in Vorpommern unter besonderer Berücksichtigung der kinder- und jugendmedizinischen Versorgung im Landkreis Ostvorpommern. Greifswald. Download: [http://www.medicin.uni-greifswald.de/icm/fileadmin/user\\_upload/vcm/dokumente/ICM\\_Bericht\\_Ausw\\_demogr\\_Wandel\\_FE\\_S\\_Sept2011.pdf](http://www.medicin.uni-greifswald.de/icm/fileadmin/user_upload/vcm/dokumente/ICM_Bericht_Ausw_demogr_Wandel_FE_S_Sept2011.pdf)
4. **Berlin, C.**; van den Berg, N.; Hoffmann, W.: Expertise zur aktuellen Situation der medizinischen Versorgung in der Planungsregion Vorpommern. Greifswald. Download: [http://www.rpv-vorpommern.de/fileadmin/dateien/dokumente/pdf/Projekte/Medizinische\\_Versorgung/Expertise\\_ICM\\_medVers\\_Mai\\_2011.pdf](http://www.rpv-vorpommern.de/fileadmin/dateien/dokumente/pdf/Projekte/Medizinische_Versorgung/Expertise_ICM_medVers_Mai_2011.pdf)
5. **Berlin, C.**; Rulle, M. (2009): Demographischer Wandel und Daseinsgrundfunktionen: Erreichbarkeit von Hausärzten im Uecker-Randow-Kreis, Mecklenburg-Vorpommern. Geographische Rundschau, Bd. 61, Heft 7/8, S. 54-60.

## **Enrique Bernal-Delgado**

Senior Health Services and Policy Researcher, Co-founder of the Spanish Atlas of Variations in Medical Practice

Institute for Health Sciences IACS - IIS Aragon  
Zaragoza, Spain

### **Biography**

Enrique Bernal-Delgado is senior health services and policy researcher at the Institute for Health Sciences in Aragon, and principal investigator of the Atlas of Variations in Medical Practice in the Spanish National Health System ([www.atlasvpm.org](http://www.atlasvpm.org)) and the European Collaborative for Healthcare Optimization –ECHO ([www.echo-health.eu](http://www.echo-health.eu)). Both projects have raised his interest on the use of Real World Data to inform policy making. As a consequence, he is currently co-leading a European initiative, BRIDGEHEALTH ([www.bridge-health.eu](http://www.bridge-health.eu)), that aims to pave the way towards a sustainable and integrated European health information system for both informing health policy and enhance cross-national research. Particularly interested in Chronic Care, he is actively participating in REDISECC – Spanish Network for Health Services Research in Chronic Care ([www.redissec.com](http://www.redissec.com)) and CHRODIS JA – Joint Action on Chronic Diseases ([www.chrodis.eu](http://www.chrodis.eu)).

Currently, he is editor-in-chief of the Spanish Atlas of Variations and associate editor of BMC Health Services Research. His unit is a member of the European Observatory on Health Systems and Policies where the Spanish Healthcare System is monitored. (<http://hspm.org/countries/spain25062012/countrypage.aspx>)

He graduated as a Medical Doctor in 1988, serving as primary care practitioner for five years; afterward, he specialized in Public Health and Preventive Medicine. He took doctorate studies in Sociology receiving the PhD grade in 1993 from the University of Zaragoza, Spain. Finally, he received his Master Degree on Health Economics in 1997 from the Universities of Barcelona and Pompeu Fabra, Spain. In 2003, he was visiting scholar at the CECS, currently The Dartmouth Institute.

### **Selected Publications**

1. Unwarranted variations in health care performance in Europe: Lessons from the ECHO Project. **Eur J Public Health**. 2015; 25 Suppl 1. <http://echo-health.eu/supplement/>
2. Ibañez-Beroiz B, Librero L, Bernal-Delgado E, García-Armesto S, Villanueva-Ferragud S, Peiró S. Joint spatial modeling to identify shared patterns among chronic related potentially preventable hospitalizations **BMC Medical Research Methodology** 2014, 14:74. <http://www.biomedcentral.com/1471-2288/14/74>

3. Bernal-Delgado E, García-Armesto S, Peiró S on behalf of the Atlas VPM group. Atlas of Variations in Medical Practice: the Spanish National Health Service under scrutiny. **Health Policy** 2014; 114(1): 15-30 <http://www.ncbi.nlm.nih.gov/pubmed/24035101>
4. Bernal-Delgado E, García-Armesto S, Martínez-Lizaga N, Beltrán-Peribañez J, Peiró-Moreno S. Should Policy-makers and managers trust PSI? An empirical validation study of Five Patient Safety Indicators in a National Health Service. **BMC Medical Research Methodology** 2012; 12:19 <http://www.biomedcentral.com/1471-2288/12/19>
5. Ibañez B, Librero J, Peiró S, Bernal-Delgado E. Shared component modelling as an alternative to assess geographical variations in medical practice: gender inequalities in hospital admissions for chronic diseases. **BMC Medical Research Methodology** 2011; 11:172. <http://www.biomedcentral.com/1471-2288/11/172>

**Nathan Bertelsen**

Visiting Professor

Koç University School of Medicine

Istanbul, Turkey

Assistant Professor of Medicine and Population Health

New York University School of Medicine

462 First Avenue

New York, New York, 10016 USA

**Biography**

Nathan Bertelsen, M.D., is a clinician educator in internal medicine. He is currently a Visiting Professor at Koç University School of Medicine (KUSOM) in Istanbul, Turkey, and Assistant Professor of Medicine and Population Health at Bellevue Hospital / New York University School of Medicine (NYUSOM) in New York City, USA.

Dr. Bertelsen completed residency training in internal medicine at Cornell University/New York Presbyterian Hospital, received his M.D. from University of Minnesota Medical School, and has a B.A. in government/international relations at Georgetown University. At NYUSOM, he directs the Global Health Selective for medical students and Global Health Elective for residents in internal medicine, and at KUSOM, he organizes curriculum in bedside teaching and cross-cultural communication. In 2011, he was awarded Faculty of the Year in the NYU Division of General Internal Medicine, and in 2014, he completed the Merrin Master Clinician Bedside Teaching Fellowship Program from the NYU Program for Medical Education Innovations and Research, with his focus on teaching empathy in medical training. His research interest is in both medical education and non-communicable diseases.

**Publications**

1. Francis ER, Goodsmith N, Michelow M, Kulkarni A, McKinney AS, Tomei R, Kishore SP, **Bertelsen NS**, Fein O, Balsari S, Lemery J, Fitzgerald D, Johnson W, Finkel ML. "The Global Health Curriculum of Weill Cornell Medical College: How one school developed a global health program." *Academic Medicine*. 2012; 87(9):1296-1302. PMID: [22929431](#), ISSN: [1040-2446](#).
2. **Bertelsen N.**; DallaPiazza, M.; Ogedegbe, O.; Hopkins, M. A. "Global Health Selective: a novel interdisciplinary clerkship on clinical knowledge and skills for global health at New York University School of Medicine." *American Journal of Tropical Medicine and Hygiene*. 2013; 89(5):26-26. EMBASE: [71311916](#), ISSN: [0002-9637](#).
3. **Bertelsen N**, DallaPiazza M, Miller L, Schoenthaler A. "Designing and piloting a curriculum in clinical empathy for internal medicine residents, in order to improve clinical skills in cross-cultural patient care." *Journal of General Internal Medicine* 2014; 29:S514-S514. ISI000340996203102, ISSN: 1525-1497.

4. **Bertelsen NS**, Miller LH, DallaPiazza M, Altshuler L, Schoenthaler A. "Empathy in graduate medical education milestones: Bedside teaching in empathy to improve cross-cultural communication skills." MedEdPublish 2015; 4:6.
5. **Bertelsen NS**, Kanbay M. "A new risk factor for cardiovascular disease and for associated risk factors: Education." Journal of Clinical Hypertension 2015; 3(1) 1524-6175.

**Gwyn Bevan**

Professor of Policy Analysis  
Department of Management  
London School of Economics and Political Science  
London, UK

**Biography**

Gwyn Bevan is Professor of Policy Analysis in the Department of Management at the London School of Economics and Political Science. He has been head of LSE's Department of Management and a Director at the Commission for Health Improvement. He is a member of the Advisory Committee on Resource Allocation that advises the Secretary of State for Health on the formulas to be used in allocating resources for health care and public health in England. His research in health care includes evaluations of the 'natural experiment' of policy differences that have developed between the different countries of the UK after devolution and applying a new approach to improving the value of health care in austerity by the socio-technical allocation of resource (STAR) <<http://startool.org>>.

**Publications**

1. **Bevan G**, Karanikolos M, Exley J, Nolte E, Connolly S, Mays N. *Comparing the performance of the National Health Service in the four countries of the United Kingdom before and after devolution*. London: the Nuffield Trust, 2014. <<http://www.nuffieldtrust.org.uk/compare-UK-health>>
2. Schang L, De Poli C, Airoidi M, Morton A, Bohm N, Lakhanpaul M, Schilder A, **Bevan G**. Using an epidemiological model to investigate unwarranted variation: the case of ventilation tubes for otitis media with effusion in England. *Journal of Health Services Research and Policy*. 2014; **19**(4): 236-244.
3. Wennberg DE, Sharp SM, **Bevan G**, Skinner JS, Freedman JO, Gottlieb DJ, Wennberg JE, A population health approach to reducing observational intensity bias in health risk adjustment: cross sectional analysis of insurance claims. *BMJ* 2014; **348**: g2392.
4. Schang L, Morton A, DaSilva P, **Bevan G**. From data to decisions? Exploring how healthcare payers respond to the NHS Atlas of Variation in Healthcare in England. *Health Policy* 2014; **11**(1): 79-87.
5. Appleby J, Raleigh F, Frosini F, **Bevan G**, Gao H, Lyscom T. *Variations in health care the good, the bad and the inexplicable*. London: King's Fund, 2011. <<http://www.kingsfund.org.uk/publications/variations-health-care>>

**Jan Böcken, PhD**

Senior Project Manager  
Bertelsmann Foundation  
Bertelsman Stiftung  
Gütersloh, Germany

**Biography**

Dr. Jan Böcken has a degree in political sciences and macro-economics. In 1997 he started his health policy career with the EU project, Patient's rights and Patient's support in Europe. In 1998 Jan Böcken worked as a program manager in the contract department at Barmer Ersatzkasse (largest European sick fund) in Wuppertal. As a senior project manager he is responsible for health-policy projects within the Bertelsmann Foundation in Gütersloh since 1999. In 2009 he received his PhD at the institute of general medicine and family medicine at the University of Witten/Herdecke.

**Selected Publications**

1. Altenhöner T, Philippi M, **Böcken J**, Health behaviour and changes in health behaviour - are education and social status relevant? Gesundheitswesen. 2014 Jan;76(1):19-25. doi: 10.1055/s-0033-1333729. Epub 2013 Feb 19.
2. Huber CA, Rüesch P, Mielck A, **Böcken J**, Rosemann T, Meyer PC. Effects of cost sharing on seeking outpatient care: a propensity-matched study in Germany and Switzerland. J Eval Clin Pract. 2011 Apr 26. Doi: 10.1111/j.1365-2753.2011.01679.x.[Epub ahead of print] PubMed PMID: 21518398.
3. Kempkens D, Dieterle WE, Butzlaff M, Wilson A, **Böcken J**, Rieger MA, Wilm S, Vollmar HC. German ambulatory care physicians' perspectives on continuing medical education – a national survey. J Contin Educ Health Prof. 2009 Fall; 29(4):259-68. PubMed PMID:19998475.
4. Rückert IM, **Böcken J**, Mielck A. Are German patients burdened by the practice charge for physician visits ('Praxisgebuehr')? A cross sectional analysis of socio-economic and health related factors. BMC Health Serv Res. 2008 Nov 12;8:232. PubMed PMCID: 19014476; PubMed Central PMCID:PMC2605748.
5. Butzlaff M, Kempkens D, Schnee M, Dieterle WE, **Böcken J**, Rieger MA. German ambulatory care physicians' perspectives on clinical guidelines – a national survey. BMC Fam Pract. 2006 Jul 20;7:47. PubMed PMID: 16857051; PubMed Central PMCID: PMC1550714

**Anne E.M. Brabers**

Researcher

NIVEL

Utrecht, The Netherlands

**Biography**

Anne E.M. Brabers MSc. (1987) has graduated in Science and Innovation Management at Utrecht University in 2010. She wrote her master thesis on the subject of rare diseases, being her main research interest during her study. After graduation, she started to work at NIVEL, Netherlands Institute for Health Services Research. At NIVEL, Anne is a researcher in the Health care system and governance programme, mainly as researcher at the Dutch Health Care Consumer Panel. The aim of the Consumer Panel is to measure, at national level, opinions on and knowledge about health care and the expectations and experiences with health care. She is also involved in several other projects within the health care and governance programme, e.g. the Dutch eHealth-monitor. Currently, she also works on her PhD-thesis, which is about circumstances under which patients have an active role in medical decision-making as well as on what patient involvement in the decision-making process means for medical practice variation. One of the studies of her PhD shows that shared decision-making results in less variation between hospitals in the choice of single or double embryo transfer in IVF.

**Selected Publications**

1. **Brabers AEM**, Van Dijk L, Groenewegen PP, Van Peperstraten A, De Jong JD. Shared decision-making results in less variation between hospitals: examining the relationship between shared decision-making and practice variation (submitted)
2. **Brabers AEM**, De Jong JD, Groenewegen PP, Van Dijk L. Do people have a positive attitude towards having an active role in medical decision-making? The role of social resources (in preparation)
3. **Brabers AEM**, De Jong JD. Perceptions about affordability of care in the Netherlands. *Eurohealth*, 2014. vol 20 (4).
4. **Brabers AEM**, Van Dijk L, Bouvy ML, De Jong JD. Where to buy OTC medications? A cross-sectional survey investigating consumers' confidence in over-the-counter (OTC) skills and their attitudes towards the availability of OTC painkillers. *BMJ Open*, 2013. vol 3 (9).
5. **Brabers AEM**, Reitsma-van Rooijen M, De Jong JD. The Dutch health insurance system: mostly competition on price rather quality of care. *Eurohealth*, 2012. vol 18 (1).



**Kristen Bronner**

Managing Editor, *The Dartmouth Atlas of Health Care*

Research Associate, The Dartmouth Institute for Health Policy and Clinical Practice

Hanover, New Hampshire, USA

**Biography**

Ms. Bronner is a Research Associate with The Dartmouth Institute for Health Policy and Clinical Practice and the Managing Editor of *The Dartmouth Atlas of Health Care* series. She has been a member of the Dartmouth Atlas project team since 1995. She edits, designs graphics, and oversees production of Dartmouth Atlas publications, and works with the investigators, programmers, and analysts to improve and expand the Atlas database. She is also the Atlas webmaster and primary content developer for the Dartmouth Atlas web site. Ms. Bronner received her Master of Arts in Liberal Studies from Dartmouth College in 1996.

**Selected Publications**

1. Goodney PP, Dzebisashvili N, Goodman DC, **Bronner KK**, et al. *Variation in the Care of Surgical Conditions*. The Dartmouth Institute for Health Policy and Clinical Practice, December 2014.
2. Goodman DC, Morden NE, Ralston S, Chang CH, Parker D, Weinstein SJ, **Bronner KK**. *The Dartmouth Atlas of Children's Health Care in Northern New England*. The Dartmouth Institute for Health Policy and Clinical Practice, December 2013.
3. Munson JC, Morden NE, Goodman DC, Valle LF, Wennberg JE, **Bronner KK**. *The Dartmouth Atlas of Medicare Prescription Drug Use*. The Dartmouth Institute for Health Policy and Clinical Practice, October 2013.
4. Wennberg JE, **Bronner KK**, Skinner JS, Fisher ES, Goodman DC. Inpatient care intensity and patients' ratings of their hospital experiences. *Health Affairs* 2009 Jan;28(1):103-112.
5. Weinstein JN, **Bronner KK**, Morgan TS, Wennberg JE. Trends and geographic variations in major surgery for degenerative disease of the hip, knee and spine: Is there a roadmap for change? *Health Affairs* 2004;23(6):VAR-81-9.

**Ian Brownwood**

Health Policy Analyst, Health Division  
Directorate for Employment, Labour and Social Affairs  
OECD Headquarters  
Paris, France

**Biography**

Ian currently works in Paris for the Organisation for Economic Cooperation and Development in the Health Division. He is part of the Health Care Quality Indicator team that evaluates the performance of health systems and is working on country specific quality reviews, international health care quality indicator development and hospital level performance reporting.

Ian has academic qualifications in health economics and nursing and extensive experience working in both policy and clinical capacities in the health care sector. Before leaving Australia, Ian worked with the national health workforce planning agency where he coordinated the national strategic research and evaluation program of the organisation. Ian has worked for over two decades with regional health ministries in Australia focusing on strategic policy issues related to structural and funding reform and performance evaluation. During this time he participated in major reviews of both the South Australian and New South Wales health systems. Ian previously worked at the OECD in the HCQI team during 2007 to 2009 and more recently participated in the OECD Quality of Care Review of Australia in late 2013.

**Selected Publications (OECD)**

1. OECD (2014), *Geographic Variations in Health Care: What Do We Know and What Can Be Done to Improve Health System Performance?*, OECD Health Policy Studies, OECD Publishing. <http://dx.doi.org/10.1787/9789264216594-en>
2. OECD (2013), *Health at a Glance 2013: OECD Indicators*, OECD Publishing. [http://dx.doi.org/10.1787/health\\_glance-2013-en](http://dx.doi.org/10.1787/health_glance-2013-en)

**Paola Colais**

Senior Statistician

Unit "Statistical Methods for Epidemiology"

The Department of Epidemiology, Lazio Regional Health Service

Rome, Italy

**Biography**

Degree in Statistics – "Sapienza University of Rome" in 2002.

Master of Science (MSc) in Epidemiology – Università Cattolica del Sacro Cuore "Agostino Gemelli" of Rome in 2005.

Doctor of philosophy (PhD) degree in *Public health and Occupational Medicine* - Alma Mater Studiorum University of Bologna in 2009.

Main activities:

Comparative analysis of health care outcomes across hospitals and geographical areas for the National Outcome Evaluation Programme and the Lazio Regional Outcome evaluation programme.

Epidemiological studies and comparative effectiveness research on health care interventions.

**Selected Publications**

1. **Colais P**, Di Martino M, Fusco D, Davoli M, Aylin P, Perucci CA. Using clinical variables and drug prescription data to control for confounding in outcome comparisons between hospitals. *BMC Health Serv Res.* 2014 Oct 23;14:495.
2. Di Martino M, Fusco D, **Colais P**, Pinnarelli L, Davoli M, Perucci CA. Differential misclassification of confounders in comparative evaluation of hospital care quality: caesarean sections in Italy. *BMC Public Health.* 2014 Oct 8;14:1049.
3. **Colais P**, Pinnarelli L, Fusco D, Davoli M, Braga M, Perucci CA. The impact of a pay-for-performance system on timing to hip fracture surgery: experience from the Lazio Region (Italy). *BMC Health Serv Res.* 2013 Oct 7;13:393.
4. **Colais P**, Agabiti N, Fusco D, Pinnarelli L, Sorge C, Perucci CA, Davoli M. Inequality in 30-day mortality and the wait for surgery after hip fracture: the impact of the regional health care evaluation program in Lazio (Italy). *Int J Qual Health Care.* 2013 Jul;25(3):239-47.
5. **Colais P**, Fantini MP, Fusco D, Carretta E, Stivanello E, Lenzi J, Pieri G, Perucci CA. Risk adjustment models for interhospital comparison of CS rates using Robson's ten group classification system and other socio-demographic and clinical variables. *BMC Pregnancy Childbirth.* 2012 Jun 21;12:54.

**Gráinne Cosgrove**

Statistician

Information & Analysis Unit, Quality Improvement Division, Health Service Executive  
Dublin, Ireland

**Biography**

Gráinne Cosgrove is a statistician with a degree in mathematics and statistics, and a diploma in health economics. She worked in the Irish Department of Health for over 12 years until July 2015, where she had a particular focus on hospital activity data and health care quality indicators in the Irish health care system. She has been involved in a number of international projects including the OECD Health Care Quality Indicators project, the European Hospital Data Project and the European Community Health Indicators Monitoring Project. She also was involved in the development of a morbidity statistics data collection and was a member of the European Task Force on Morbidity Statistics. More recently she has moved to the Information and Analysis Unit in the Quality Improvement Division of the Health Service Executive, where her focus will be on the use of information and analysis for improvement.

**Publications**

1. National Healthcare Quality Reporting System, First Annual Report. Department of Health, 2015.
2. Health Care Quality Indicators in the Irish Health System, Examining the Potential of Hospital Discharge Data using the Hospital Inpatient Enquiry System. Department of Health, 2014.
3. Morbidity Statistics in the EU, Report on Pilot Studies. Eurostat, 2014.
4. Cosgrove G, Challenges in the Development of a Regular Morbidity Statistics Data Collection. Eur J Public Health (2014) 24 (suppl 2).

**Philip DaSilva**

Freelance

Derby, United Kingdom

**Biography**

Phil DaSilva is a clinical leader with a deep appreciation of health policy, commissioning, planning and delivery of health services. With a strong background in quality improvement, organisational development and change management he has enjoyed a successful career in a number of senior executive roles, at all levels of the NHS, where he has led and delivered significant change and transformation in many clinical services and organisations.

Phil is the co-founder of NHS Right Care, and retains a national leadership role in the large scale transformation programme which aims to improve outcomes and increase value. He is also the joint author of the NHS Atlas of Variation series ([www.rightcare.nhs.uk](http://www.rightcare.nhs.uk)) and is the sole author of "Increasing Value – Commissioning on the Front-line".

Phil has a first class honours degree in Nursing, a Master in Public Health and is a qualified Executive Coach. His passion and inquisitiveness to understand more about the concept of variation in health care led Phil to his doctorate and he has recently defended his thesis, "The imperative of dealing with unwarranted variation in health care: a UK perspective".

Phil continues to work with the NHS in England and increasingly with colleagues across Europe where he supports organisations to understand the importance of searching for and reducing unwarranted variation. He is developing a strong network, sharing examples and ideas of how to stimulate the search for unwarranted variation and take action to unlocking resources to deliver better care for patients and populations.

**Marina Davoli**

Scientific Director

Italian National Outcome Program

Roma, Italia

**Biography**

Medical Degree in 1985 at the University of Rome "La Sapienza"

Master of Science (MSc) in Epidemiology - London School of Hygiene and Tropical Medicine in 1991

Head of the Department of Epidemiology, Regional Health Service - Lazio Region, Operational Centre of the Italian National Outcome Program

- Member of the EC expert group on Health System Performance Assessment
- Member of the Regional Drug Formulary of the Lazio Region;
- Member of the Scientific Committee of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon;
- Coordinating Editor of the Cochrane Drugs and Alcohol Group;
- Member of the GRADE (Grading of Recommendations Assessment, Development and Evaluation) Working Group

Main activities:

- ✓ Systematic reviews of the scientific literature on the effectiveness of health care interventions
- ✓ Epidemiological studies on the health status of the population
- ✓ Comparative effectiveness research on drugs and other health care interventions
- ✓ Comparative analysis of health care outcomes across hospitals and geographical areas for the National Outcome Evaluation Programme and the Lazio Regional Outcome evaluation programme
- ✓ Coordination of the workpackage of the EU Project DECIDE on strategies for the dissemination of evidence to policy makers

**Selected Publications**

1. Dégano IR, Subirana I, Torre M, Grau M, Vila J, Fusco D, Kirchberger I, Ferrières J, Malmivaara A, Azevedo A, Meisinger C, Bongard V, Farmakis D, **Davoli M**, Häkkinen U, Araújo C, Lekakis J, Elosua R, Marrugat J; on behalf of the EURHOBOP investigators. A European benchmarking system to evaluate in-hospital mortality rates in acute coronary syndrome: The EURHOBOP project. *Int J Cardiol.* 2015 Jan 7;182C:509-516. PMID: 25655205
2. Di Martino M, Fusco D, Colais P, Pinnarelli L, **Davoli M**, Perucci CA. Differential misclassification of confounders in comparative evaluation of hospital care quality: caesarean sections in Italy. *BMC Public Health.* 2014 Oct 8;14(1):1049. PMID: 25297561

3. Colais P, Di Martino M, Fusco D, **Davoli M**, Aylin P, Perucci CA. Using clinical variables and drug prescription data to control for confounding in outcome comparisons between hospitals. BMC Health Serv Res. 2014 Oct 23;14(1):495. PMID: 25339263
4. Renzi C, Asta F, Fusco D, Agabiti N, **Davoli M**, Perucci CA. Does public reporting improve the quality of hospital care for acute myocardial infarction? Results from a regional outcome evaluation program in Italy. Int J Qual Health Care. 2014 Jun;26(3):223-30. Epub 2014 Apr 15. PMID: 24737832
5. Colais P, Agabiti N, Fusco D, Pinnarelli L, Sorge C, Perucci CA, **Davoli M**. *Inequality in 30-day mortality and the wait for surgery after hip fracture: the impact of the regional health care evaluation program in Lazio (Italy)*. Int J Qual Health Care. 2013 Jan 18. PMID: 23335054

**Judith de Jong**

Program Coordinator

Netherlands Institute for Health Services Research (NIVEL)

Utrecht, The Netherlands

**Biography**

J.D. (Judith) de Jong, PhD, MSc is Programme coordinator Health care system and governance at the Netherlands Institute for Health Services Research (NIVEL) and scientific coordinator of the Academic Collaborative Research Centre, a cooperation between the Open University, an insurance company and NIVEL.

She has graduated in Science and Policy at Utrecht University, the Netherlands. In 2008 she defended her PhD thesis 'Explaining medical practice variation. Social organization and institutional mechanisms' (cum laude) at Utrecht University, the Netherlands. Her research topics and publications include health care system reform, medical practice variations, comparative health systems research, and consumer experiences on health care. She is president of the section on Health Services Research of the European Public Health Association EUPHA, member of the executive council and the international conference council of EUPHA and associate editor for the international journal BMC Health Services Research.

**Selected Publications**

1. Kroneman, M., **Jong, J.D. de**. The basic benefit package: composition and exceptions to the rules. A case study. Health Policy, vol. 119, 2015, nr. 3
2. Victoor, A., Hansen, J., Akker-van Marle, M.E. van den, Berg, B. van den, Hout, W.B. van den, **Jong, J.D. de**. Choosing your health insurance package: a method for measuring the public's preferences for changes in the national health insurance plan. Health Policy, vol. 117, 2014, nr. 2
3. Dijk, C.E. van, Korevaar, J.C., Koopmans, B., **Jong, J.D. de**, Bakker, D.H. de  
The primary-secondary care interface: does provision of more services in primary care reduce referrals to medical specialists? Health Policy, 2014
4. **Jong, J.D. de**, Groenewegen PP, Spreeuwenberg P, Schellevis F, Westert GP. Do guidelines create uniformity in medical practice? Soc Sci Med 2010.
5. **Jong, J.D. de**. Explaining medical practice variations. Social organization and institutional mechanisms. Thesis. Utrecht, NIVEL, 2008.



**Mirko Di Martino**

Senior Biostatistician and Epidemiologist  
Department of Epidemiology  
Regional Health Service - Region Lazio  
Rome, Italy

**Biography**

Senior biostatistician in the Unit “*Statistical Methods for Epidemiology*” of the Department of Epidemiology, Lazio Regional Health Service, Rome, Italy. He achieved master degree in *Biostatistics* and doctor of philosophy (PhD) degree in *Statistical methodology for scientific research and Medical statistics*. He is contract professor of *Epidemiology and statistical modeling* at the University of Bologna, Italy and was Chair of Technical Boards at national level for Public Health Services Evaluation. He has 15-year experience in the area of pharmacoepidemiology, developing design and analysis strategies to assess effectiveness and safety of drug therapies. He has published about 40 scientific papers and 50 technical reports, and regularly does activities of peer review for international scientific journals. He currently is Principal Investigator of a multicenter, national research on medication adherence, funded by the Italian Ministry of Health.

**Selected Publications**

1. **Di Martino M**, Kirchmayer U, Agabiti N, Bauleo L, Fusco D, Perucci CA, Davoli M. The impact of time-window bias on the assessment of the long-term effect of medication adherence: the case of secondary prevention after myocardial infarction. *BMJ OPEN*, 2015; 5(6): e007866.
2. **Di Martino M**, Fusco D, Colais P, Pinnarelli L, Davoli M, Perucci CA. Differential misclassification of confounders in comparative evaluation of hospital care quality: caesarean sections in Italy. *BMC PUBLIC HEALTH*, 2014; vol. 14, ISSN: 1471-2458.
3. **Di Martino M**, Agabiti N, Bauleo L, Kirchmayer U, Cascini S, Pistelli R, Colamesta V, Paterno E, Pinnarelli L, Fusco D, Perucci CA, Davoli M. Use patterns of long-acting bronchodilators in routine COPD care: the OUTPUT study. *COPD*, 2014; 11(4): 414-423, ISSN: 1541-2555.
4. **Di Martino M**, Veronesi C, Degli Esposti L, Scarpa F, Buda S, Didoni G, Petracci E, Valpiani G, Degli Esposti E. Adherence to antihypertensive drug treatment and blood pressure control: a real practice analysis in Italy. *JOURNAL OF HUMAN HYPERTENSION*, 2008; vol. 22; p. 51-53, ISSN: 0950-9240.
5. **Di Martino M**, Degli Esposti L, Filigheddu F, Veronesi C, Salerno G, Saragoni S, Glorioso N, Didoni G, Degli Esposti E. Use of antihypertensive and lipid-lowering drugs: the management of cardiovascular risk in clinical practice. *JOURNAL OF HUMAN HYPERTENSION*, 2007; vol. 21; p. 53-59, ISSN: 0950-9240.

**Adrien Dozol**

Medical Advisor

Ministry of Social Affairs and Health

Paris, France

**Biography**

Adrien Dozol, MD, MSC, medical advisor, Ministère des affaires sociales, de la santé et des droits des femmes, direction générale de l'offre de soins, Sous-direction de la régulation de l'offre de soins

Bureau évaluation, modèles et méthode

He has a 10 years experience working at various level of the health care system, from university hospital to the Ministry of Health and international organizations, with a strong focus on hospital. His main areas of expertise are: Hospital Financing, Hospital Quality, Health Policy Analysis and Health Economics.

He currently works at the French Ministry of Social Affairs and Health working on reforms of the financing models for hospitals. His main responsibilities are the implementation of a P4P for public and private hospitals, based on quality indicators, and the introduction of "tapering scale" mechanism in hospital payment.

Prior to joining the Ministry, he worked in a University Hospital and for 2 years at the Health, Nutrition and Population Hub of the World Bank.

He has been trained in Medicine and Public Health in France and Health policy and Health economics at the London School of Economics and the London School of Hygiene and tropical Medicine.

**Selected Publications**

1. Laanani, M., **Dozol, A**, Meyer, L., David, S., Camara, S., Segouin, C., Troude P. Factors associated with failure to return for HIV test results in a free and anonymous screening centre. Int J STD AIDS. 2014 Aug 1
2. Troude, P., **Dozol, A**, Soyer, P., Girard, D., Martinez, F., Montagne, B., Segouin, C. Improvement of radiology requisition. Diagn Interv Imaging. 2014 Jan;95(1):69-75.
3. Dely, C., Sellier, P., **Dozol, A.**, Segouin, C., Moret, L., Lombrail, P. [Preventable readmissions of "community-acquired pneumonia": Usefulness and reliability of an indicator of the quality of care of patients' care pathways]. Presse Med. 2012; 41: e1–e9

4. **Dozol, A.**, Tribout, M., Labalette, C., Moreau, AC., Duteil, C., Bertrand, D., Segouin, C. [Public free anonymous HIV testing centers: cost analysis and financing options]. Santé Publique. 2011; 23(5):401-12
5. **Dozol, A.**, Gana, I., Cocagne, N., Conilleau, B., Brignone, M., Moreau, AC., et al. Identifying, managing and monitoring laboratory test over-utilization for inpatients. Pratiques et organisation des soins 2010 ; 41 (2):135-141

**Elliott S. Fisher**

Director, The Dartmouth Institute for Health Policy and Clinical Practice  
John E. Wennberg Distinguished Professor  
at the Geisel School of Medicine at Dartmouth  
Lebanon, New Hampshire, USA

**Biography**

Dr. Fisher is Director of the Dartmouth Institute for Health Policy and Clinical Practice and the John E Wennberg Distinguished Professor of Health Policy, Medicine and Community and Family Medicine at the Geisel School of Medicine at Dartmouth. He is also Co-Director of the Dartmouth Atlas of Health Care.

Dr. Fisher is recognized for several major contributions to research and policy. He led seminal research on the promise and perils of using large databases for health care research, work that helped to validate the quality of the data and demonstrated how such data could be used to answer important epidemiologic and policy questions. He then built on this work to explore the causes and consequences of the dramatic differences in spending observed across U.S. regions and academic medical centers. He then demonstrated that the 60% higher intensity of care in high cost U.S. regions and health systems did not result in better health outcomes and was largely due to differences in the use of discretionary and potentially avoidable care. This work was the first to reveal the magnitude of waste in U.S. healthcare and helped to provide the rationale for the transition to value-based payment that is now underway. Finally, he led the team that did the empirical research that provided the theoretical rationale for Accountable Care Organizations and worked with colleagues to adapt the concept in ways that helped lead to its inclusion in the Affordable Care Act and adoption by many private payers. His current research focuses on exploring the determinants of successful ACO formation and performance.

He has published over 150 research articles and commentaries. He received his undergraduate and medical degrees from Harvard University and completed his internal medicine residency and public health training at the University of Washington. He is a member of the Institute of Medicine of the National Academy of Sciences.

**Selected Publications**

1. **Fisher ES**, Whaley FS, Krushat WM, Malenka DJ, Fleming C, Baron JA, Hsia DC. The accuracy of Medicare's hospital claims data: progress has been made, but problems remain. Am J Public Health. 1992 Feb;82(2):243-8. PubMed PMID: [1739155](#)
2. **Fisher ES**, Wennberg JE, Stukel TA, Sharp SM. Hospital readmission rates for cohorts of Medicare beneficiaries in Boston and New Haven. N Engl J Med. 1994 Oct 13;331(15):989-95. PubMed PMID: [8084356](#).
3. **Fisher ES**, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of

care. Ann Intern Med. 2003 Feb 18;138(4):273-87. PubMed PMID: [12585825](#). Part 2: health outcomes and satisfaction with care. Ann Intern Med. 2003 Feb 18;138(4):288-98. PubMed PMID: [12585826](#)

4. **Fisher ES**, Bynum JP, Skinner JS. Slowing the growth of health care costs--lessons from regional variation. N Engl J Med. 2009 Feb 26;360(9):849-52. PubMed PMID: [19246356](#)
5. **Fisher ES**, Staiger DO, Bynum JP, Gottlieb DJ. Creating accountable care organizations: the extended hospital medical staff. Health Aff (Millwood). 2007 Jan-Feb;26(1):w44-57. PubMed PMID: [17148490](#)

## **Cecilia Ganduglia**

Assistant Professor in Health Services Research  
University of Texas (UT) School of Public Health  
Houston, Texas

### **Biography**

Cecilia Ganduglia is an assistant professor in health services research at the University of Texas (UT) school of Public Health. She teaches a course on how to use administrative databases in health services research and another on comparative health care systems. She is the associate director of the University of Texas School of Public Health (UTSPH) administrative data center where we house claims data for Medicaid, Medicare and the major commercial carrier in Texas. The main focus of her research has been looking into geographic variations in health care delivery and quality. She is currently involved in a multi-partner endeavor sponsored by the state of Texas to evaluate health care delivery and access to neonatal intensive care units in the state using Medicaid claims and birth certificate data. She is also a family physician trained in Buenos Aires, Argentina.

### **Selected Publications**

1. **Ganduglia CM**, Zezza M, Smith JD, John SD, Franzini L. Effect of Public Reporting on MR Imaging Use for Low Back Pain. *Radiology*. 2015 Jul;276(1):175-83.
2. K.B. Sonawane, J. Qian, K.B. Garza, B.M. Wright, P. Zeng, **C.M. Ganduglia Cazaban**, R.A. Hansen. Patterns of treatment modifications in newly treated hypertensive patients: does choice of modification strategy affect likelihood of treatment discontinuation? *Journal of Hypertension*. Accepted for publication.
3. I M Abbass · S S Virani · R Parikh · S Taychakhoonavudh · **C Ganduglia** · L Franzini. Patterns Of Care, Costs And Outcomes Of Chest Pain Patients Within Two Years Of Initial Visits To The ER Value in Health 05/2013; 16(3):A202. DOI:10.1016/j.jval.2013.03.1018
4. **Ganduglia, C**. Reforma de Salud en los Estados Unidos. *Medicina (Buenos Aires)*. 2011; 70(4):381-5. Spanish. PMID:20679063
5. Santamaría C, Urueña A, Videla C, Suarez A, **Ganduglia C**, Carballal G, Bonvehi P, Echavarría M. Epidemiological study of influenza virus infections in young adult outpatients from Buenos Aires, Argentina. *Influenza Other Respiratory Viruses*. 2008 Jul; 2(4):131-4. PMID: 19453464

**Sandra García-Armesto**

ARAI+D Senior Researcher  
Health Services Research & Health Policy Unit  
The Institute for Health Sciences in Aragón  
Zaragoza, Spain

**Biography**

Sandra García-Armesto is ARAI+D senior researcher at the Health Services Research and Health Policy Unit at the Institute for Health Sciences in Aragón (IACS). Prior to joining the IACS, she was health economist and policy analyst at the OECD Health Division headquarters, head of the Observatory of Madrid Health System (Regional Health Ministry), lecturer at the Public Health School of the Autonomous University of Madrid and health services researcher at the Institute of Health Carlos III (Ministry of Health). She has carried out substantive work in coordinating different lines within the OECD Health Care Quality Indicators Project. She is author of several reports and publications on OECD Health Systems Performance Assessment and has collaborated on WHO publications on international comparison of health systems. She has also contributed as expert in several European Commission Working Parties (indicators, patient safety, health systems) and liaison commissions between OECD, WHO and the European Commission.

**Selected Publications**

1. **Garcia-Armesto S**, Angulo-Pueyo E, Martinez-Lizaga N, Mateus C, Joaquim I, Bernal-Delgado E: Potential of geographical variation analysis for realigning providers to value-based care. ECHO case study on lower-value indications of C-section in five European countries. *European Journal of Public Health*, Vol. 25, Supplement 1, 2015, 44–51
2. Cookson R, Gutacker N, **Garcia-Armesto S**, Angulo-Pueyo E, Christiansen T, Bloor K, Bernal-Delgado E: Socioeconomic inequality in hip replacement in four European countries from 2002 to 2009—area-level analysis of hospital data. *European Journal of Public Health*, Vol. 25, Supplement 1, 2015, 21–27
3. Gutacker N, Bloor K, Cookson R, **Garcia-Armesto S**, Bernal-Delgado E: Comparing hospital performance within and across countries: an illustrative study of coronary artery bypass graft surgery in England and Spain. *European Journal of Public Health*, Vol. 25, Supplement 1, 2015, 28–34
4. Bernal-Delgado E, **García-Armesto S**, Peiró S: Atlas of Variations in Medical Practice in Spain: The Spanish National Health Service under scrutiny. *Health Policy* 01/2014; 114(1):15–30.

5. **García-Armesto S**, Campillo-Artero C, Bernal-Delgado E: Disinvestment in the age of cost-cutting sound and fury. Tools for the Spanish National Health System. Health Policy 01/2013



**Estella M. Geraghty**

Chief Medical Officer and Health Solutions Director at Esri and  
Associate Professor of Internal Medicine, University of California Davis  
Redlands, CA 92373

**Biography**

Dr. Geraghty is Esri's Chief Medical Officer and Health Solutions Director where she leads the health and human services sector team, focusing on the improvement of health through strategic use of geographic information systems (GIS). Formerly the Deputy Director of the Center for Health Statistics and Informatics with the California Department of Public Health, Dr. Geraghty led the state vital records and public health informatics programs. There she engaged in statewide initiatives in meaningful use, health information exchange, open data and interoperability.

Dr. Geraghty also maintains her affiliation as Associate Professor in the Department of Internal Medicine at the University of California at Davis. She has authored research in diabetes outcomes, pesticide exposure modeling, statewide mental health service access and utilization tracking systems; asset and disparity mapping of youth outcomes, telemedicine siting and environmental benefit, and index development for youth well-being and vulnerability among others. Dr. Geraghty is a recipient of the Larry L. Sautter Golden Award for innovation in Information Technology as a part of a team developing an electronic medical record data discovery solution.

In addition to her degrees in Medical Informatics and Public Health, Dr. Geraghty is also a board certified internist and public health professional (CPH) as well as a Geographic Information Systems Professional (GISP).

**Selected Publications**

1. Lyseen AK, Nohr C, Sorensen EM, Gudes O, **Geraghty EM**, Shaw NT, Bivona-Tellez C. A Review and Framework for Categorizing Current Research and Development in Health Related Geographical Information Systems (GIS) Studies. *Yearb Med Inform*, Aug 2014; 15;9(1):110-24.
2. Shelton JF, **Geraghty EM**, Tancredi DJ, Delwiche LD, Schmidt RJ, Ritz B, Hertz-Picciotto I. Neurodevelopmental disorders and prenatal residential proximity to agricultural pesticides: the CHARGE study. *Environ Health Perspect*, Oct 2014; 122(10):1103-9.

3. Stopka TJ, **Geraghty EM**, Azari R, Gold EB, DeRiemer K. Is crime associated with over-the-counter pharmacy syringe sales? Findings from Los Angeles, California. *Int J Drug Policy*, Mar 2014; 25(2):244-50.
4. **Geraghty EM**, Margolis HG, Kjemtrup A, Reisen W, Franks P. Correlation between aerial insecticide spraying to interrupt West Nile virus transmission and emergency department visits in Sacramento County, California. *Public Health Rep*, May-Jun 2013; 128(3):221-30.
5. White RH, **Geraghty EM**, Brunson A, Murin S, Wun T, Spencer F, Romano PS. High variation between hospitals in vena cava filter use for venous thromboembolism. *JAMA Intern Med*, Apr 8, 2013;173(7):506-12.

**Catherine Gerard**

Senior Analyst  
Health Quality & Safety Commission  
Wellington, New Zealand

**Biography**

Catherine Gerard is a Senior Analyst in Health Quality and Evaluation. She leads the *New Zealand Atlas of Healthcare Variation* work programme. Catherine's background includes clinical research, and design and implementation of a clinical research programme. Her previous role centered on the implementation of clinical guidelines, working across the health sector to deliver supports and systems for the translation of guidance into everyday clinical practice.

**Selected Publications**

1. Jackson G, **Gerard C**, Minko N and N Parsotam. Variation in benzodiazepine and antipsychotic use in people aged 65 years and over in New Zealand. *N Z Med J*. 2014 Jun 20;127(1396):67-78.
2. Jackson G, Dalbeth N, Te Karu L, Winnard D, Gow P, **Gerard C** and N Minko. Variation in gout care in Aotearoa New Zealand: a national analysis of quality markers. *N Z Med J*. 2014 Oct 17;127(1404):37-47.
3. Hamblin R, Bohm G, **Gerard C**, Shuker C, Wilson J and A Merry. The measurement of New Zealand health care. *NZMJ* 01 May 2015, Vol 128 No 1413; ISSN 1175-8716

## David Goodman

Professor of Pediatrics and Co-Founder of the Wennberg International Collaboration  
The Dartmouth Institute for Health Policy and Clinical Practice  
Hanover, New Hampshire, USA

### Biography

David C. Goodman is Professor of Pediatrics and of Health Policy at The Dartmouth Institute for Health Policy and Clinical Practice; and Co-Principal Investigator, *Dartmouth Atlas of Health Care*. He is also an Adjunct Professor at the Institute for Social and Preventive Medicine at the Univ. of Bern. Dr. Goodman's has a longstanding research interest in the causes and consequences of health care variation and a specific interest in investigating unwarranted variation in the use of neonatal intensive care.

Dr. Goodman is one of the founding investigators of the *Dartmouth Atlas of Health Care* and has led multiple Atlas projects on such topics as end-of-life cancer care, post hospital discharge care, and care for infants and children. Dr. Goodman has served on multiple journal editorial boards, and federal and Institute of Medicine committees. His research papers and editorials have been published in the *New England Journal of Medicine*, *JAMA*, *Health Affairs*, *Pediatrics*, and *The New York Times*.

Dr. Goodman received his medical degree from the State University of New York Upstate Medical Center and his master's degree in medical care epidemiology from Dartmouth College. He served his residency in pediatrics at The Johns Hopkins Hospital and received specialty training in Allergy and Clinical Immunology at Dartmouth.

### Selected Publications

1. Harrison W, **Goodman DC**. Epidemiologic Trends in Neonatal Intensive Care: 2007-2012, *JAMA Pediatr*. doi:10.1001/jamapediatrics.2015.1305 Published online July 27, 2015.
2. Ralston S, Wasserman JR, **Goodman DC**. Longitudinal Care of Medically Complex Children. *Pediatrics*, in press.
3. Weinstein SJ, House, SA, Chang CH, Wasserman J, **Goodman DC**, Morden N. Small geographic area variations in prescription drug use. *Pediatrics*, Aug. 11, 2014;[Online] DOI: 10.1542/peds.2013-4250.
4. Brown JR, Chang CH, Zhou W, MacKenzie TA, Malenka DJ, **Goodman DC**. Health system characteristics and rates of readmission after acute myocardial infarction in the United States. *Journal of the American Heart Association*. Jun 2014;3(3):e000714.
5. **Goodman DC**, Morden NE, Ralston SL, Chang CH, Parker DM, Weinstein SJ. *The Dartmouth Atlas of Children's Health Care in Northern New England*. Hanover: NH. The Trustees of Dartmouth College: December 2013.

**Tommaso Grillo Ruggieri**

Ph.D. Student

Laboratory of Management and Health

Scuola Superiore Sant'Anna

Pisa, Italy

**Biography**

Graduated in Economics and Management of Public Administrations and International Institutions at Bocconi University of Milan in 2011, he has been working at the Health and Management Laboratory since 2012. He is currently a Ph.D. Student in International Management (Innovation, Sustainability and Healthcare). Main research topics: hospital organization, teaching hospital performance, geographic variability in healthcare services, diabetes care.

**Marion Grote-Westrick**

Senior Project Manager  
The Bertelsmann Foundation  
Bertelsmann Stiftung  
Guetersloh, Germany

**Biography**

Marion Grote-Westrick is a Senior Project Manager at the Bertelsmann Foundation. She is responsible for health policy projects, and for the Healthcare Fact Check in particular. Having joined the Foundation in 2005, she led projects dealing with quality management in healthcare and international health policy. Marion studied in Trier and Lisbon and holds a degree in Economics. She started her career as a Research Analyst Economics at McKinsey & Company, followed by working as a Research Associate at the Chair of Social Politics and Health Economics at the University of Duisburg-Essen.

**Selected Publications**

1. **Grote-Westrick M**, Zich K, Deckenbach B, Klemperer D, Nolting H-D, Schwenk U, Healthcare Fact Check: Regional Variation in German Healthcare, Update 2014, Gütersloh: Bertelsmann Stiftung, 2015.
2. Nolting H-D, Zich K, Deckenbach B, Gottberg A, Lottmann K, Klemperer D, **Grote-Westrick M**, Schwenk U, Healthcare Fact Check: Regional Variation in German Healthcare, Gütersloh: Bertelsmann Stiftung, 2012.
3. Schwenk, U, **Grote-Westrick M**, Qualität in integrierten Versorgungsstrukturen: Qualitätsindikatoren für Medizinische Versorgungszentren. Gütersloh: Bertelsmann Stiftung, 2010.
4. **Grote-Westrick M**, Unser Gesundheitswesen braucht Qualitätstransparenz : Transparenz für Bürger, Transparenz für Ärzte, Politik für Transparenz, Gütersloh : Bertelsmann Stiftung, 2007.
5. **Grote-Westrick M**, Schmiedt-Kaehler S, Schwenk U, Kein Wettbewerb ohne Transparenz. Die BKK, 2007, 08, 95: 356-357.

**Jostein Grytten**

Professor  
Institute for Clinical Dentistry  
University of Oslo  
Oslo, Norway

**Biography**

Jostein Grytten has worked with research questions related to funding and distribution of health services. The main focus of the research has been on how competition, incentives, and different types of contract influence the availability, quality, cost and effectiveness of health services. A specific research question has been how physicians and dentists should be remunerated in order to ensure that they do not provide either too little or too much treatment.

**Selected Publications**

1. **Grytten J**, Skau I, Sørensen R. Do mothers decide? The impact of preferences in health care. *Journal of Human Resources* 2013; 48:142-168.
2. **Grytten J**, Monkerud L, Sørensen R. Adoption of diagnostic technology and variation in Caesarean section rates: a test of the practice style hypothesis in Norway. *Health Services Research* 2012; 47: 2169-2189.
3. **Grytten J**, Skau I, Sørensen R. Do expert patients get better treatment than others? Agency discrimination and statistical discrimination in obstetrics. *Journal of Health Economics* 2011;30:163-80.
4. Carlsen F, **Grytten J**, Skau I. Physician response to fee changes: using inheritance as a quasi-natural experiment. *Applied Economics*, 2011; 43: 1913-22.
5. **Grytten J**, Monkerud L, Skau I, Sørensen R. Regionalization and local hospital closure in Norwegian maternity care – the effect on neonatal and infant mortality. *Health Services Research* 2014; 49: 1184-1204.

## **Astrid Guttman**

Senior Scientist and Chief Science Officer, Institute for Clinical Evaluative Sciences  
Associate Professor Paediatrics and Health Policy, Management and Evaluation  
University of Toronto  
Toronto, Ontario, Canada

## **Biography**

Astrid Guttman is an Associate Professor of Paediatrics and Health Policy, Management and Evaluation at the University of Toronto, a General Paediatrician at the Hospital for Sick Children, and the Chief Science Officer at the Institute for Clinical Evaluative Sciences. She holds an Applied Chair in Child Health Services and Policy Research from the Canadian Institute for Health Research (CIHR) as well as numerous operating grants. Her research interests include health system performance reporting and the evaluation of health policies as they relate to children and youth. She sits on a number of provincial policy committees including the Provincial Council on Maternal and Child Health as well as the advisory board of the Institute of Human Development, Child and Youth Health at CIHR.

## **Selected Publications**

1. Li P, Goodman D, **Guttman A**. "Medical Practice Variations in Pediatric Care" in Health Services Research. Medical Practice Variations, Springer (forthcoming)
2. MHASEF Research Team (alphabetical order of authors Cairney J, Gandhi S, **Guttman A**, Iron K, Khan S, Kurdyak P, Lam K, Yang J). The Mental Health of Children and Youth in Ontario: A Baseline Scorecard. Toronto, ON: Institute for Clinical Evaluative Sciences; March 2015.
3. Moore Hepburn C, Cohen E, Bhawra J, Weiser N, Hayeems RZ, **Guttman A**. Health System Strategies Supporting Transition to Adult Care. *Arch Dis Child*. 2015 Feb 16. pii: archdischild-2014-307320.
4. Nicholls SG, Quach P, von Elm E, **Guttman A**, Moher D, Petersen I, Sørensen HT, Smeeth L, Langan SM, Benchimol EI. The REporting of studies Conducted using Observational Routinely-collected health Data (RECORD) Statement: Arriving at consensus through qualitative and quantitative surveys of stakeholders. *Plos One* 2015 May 12;10(5):e0125620. doi: 10.1371/journal.pone.0125620. eCollection.
5. Cohen E, Berry JG, Camacho X, Anderson G, Wodchis W, **Guttman A**. Patterns and costs of Health Care Use of Children With Medical Complexity. *Pediatrics* 2012 Dec;130(6):e1463-70. 2012 Nov 26 [Epub ahead of print]



**Dougal Hargreaves**

Improvement Science Fellow/Honorary Consultant Paediatrician  
UCL Institute of Child Health  
London, United Kingdom

**Biography**

Dougal Hargreaves is an Honorary Consultant Paediatrician at UCH and a Health Foundation Improvement Science Fellow at the UCL Institute of Child Health. He recently returned from a Harkness Fellowship at Harvard Medical School, where he studied disparities in, and long-term outcomes of, unmet healthcare need among children and young people. Previously, he worked as a Clinical Advisor at the English Department of Health, leading a national project to develop, validate and implement national quality standards for adolescent care within the NHS. Since qualifying from Cambridge University in 1999, he has worked in a wide range of clinical roles, including international work in Turkmenistan, Pakistan and Bosnia. He has a MD(Res) in Adolescent Health Services from University College London and additional postgraduate qualifications in public health and health economics.

**Selected Publications**

1. **Hargreaves DS**, Elliott MN, Viner RM, Richmond TK, Schuster MA. Unmet Healthcare Need in US Adolescents and Adult Health Outcomes. *Pediatrics*. In press (accepted 2 June 2015)
2. **Hargreaves DS**, Greaves FE, Levay CE et al. Comparison of healthcare experience and access between young and older adults in 11 high-income countries. *J Adolesc Health*. In press (accepted 22 May 2015).
3. Viner RM, **Hargreaves DS**, Coffey C, Patton GC, Wolfe I. Deaths in young people aged 0-24 years in the UK compared with the EU15+ countries, 1970-2008: analysis of the WHO Mortality Database. *Lancet*. 2014 Sept 6;384(9946):880-892
4. **Hargreaves DS** McDonagh JE, Viner RM. Validation of You're Welcome quality criteria for adolescent health services using data from national inpatient surveys in England. *J Adolesc Health*. 2013 Jan;52(1):50-57.
5. **Hargreaves DS**, Viner RM. Children's and young people's experience of the National Health Service in England: a review of national surveys 2001-2011. *Arch Dis Child*. 2012 Jul;97(7):661-6.

**Ilir Hoxha**

Project Advisor, Health Dialogue Program, Solidar Suisse

PhD Candidate, University of Bern, Switzerland

External Advisor, Ministry of Health, Kosovo

Prishtina Kosovo

**Biography**

Ilir Hoxha is Medical Doctor, researcher and consultant from Kosovo. His professional and academic interests lie in: medical practice variation and health services research; health economics and financing; and, regulation of health care service delivery - in particular related to mother and child health.

He holds a MD degree from University of Prishtina, Master of Science degree in Health Systems Management from London School of Hygiene and Tropical Medicine and has completed residency program in Public Health at National Institute for Public Health of Kosovo. In addition, he has a record of research/academic training at Dartmouth Medical School, Karl Franzens University, Graz, Austria, and New Bulgarian University. In 2009 he was awarded Fulbright Research Fellowship at The Dartmouth Institute for Health Policy and Clinical Practice. Currently he is affiliated with Institute for Social and Preventive Medicine at University of Bern where he is PhD candidate and member of health services research.

During the course of professional involvement he has performed work for The World Bank, UNICEF, UNFPA, USAID, in Kosovo. He has also been part of civil society initiatives with Action for Mother and Children, Institute for Advanced Studies GAP, Balkan Investigative and Reporting Network, Foundation Kosovo Luxembourg, Prishtina Institute for Political Studies and Center for Advanced Studies.

Between years 2010 to 2014 he has served as external adviser, in matters related to implementation of health insurance reform, for two Ministers of Health of Republic of Kosovo, Dr. Bujar Bukoshi, and Dr. Ferid Agani. As of 2011 he works for SOLIDAR Suisse as project adviser in the Kosana project that facilitates policy processes related to implementation of national health insurance scheme.

**Selected Publications**

1. **Hoxha I**, Busato A, Luta XH, "Medical Practice Variations in Reproductive, Obstetric, and Gynaecological Care" in Medical Practice Variations Volume, Health Services Research Series. Springer, 2015.
2. Stanculescu MS, Neculau G, Atanasov P, Benkovic V, Bjelovic M, Goldstein J, **Hoxha I**, Ljaljevic A, Mitevska L, Stikova E, The Performance of Public Health-care Systems in South-East Europe - A comparative qualitative study. Friedrich Ebert Stiftung, 2014.

3. **Hoxha I**, A Proposal for a Health Insurance Plan: How does it affect us? Solidar Suisse, 2013.
4. **Hoxha I**, Cela L, Lenjani B, Scheter K. Analysis of the Structure of Pediatric Emergency Cases at the Emergency Center of the UCCK, AIHA, 2011.
5. **Hoxha I**, Shaipi K. Comparative analysis of health care systems in SEE. Friedrich Ebert Stiftung, 2009.

**Beate Margrethe Huseby**

Director of the Department of Economy and Analysis  
Norwegian Directorate of Health  
Trondheim, Norway

**Biography**

Beate M. Huseby is the director of the Department of Economy and Analysis at the Norwegian Directorate of Health. The Department of Economy and Analysis delivers several annual reports on Health Performance in Norway, including analysis on access to hospital services, resource distribution, effectiveness, financing and integrated care.

Huseby has previously worked with Health Service Research at SINTEF Research Institute and the Department of Public Health and General Practice at the Norwegian University of Technology and Science.

Huseby graduated at the Department of Sociology and Political Science at the Norwegian University of Technology and Science with a master degree (Candidata rerum politicarum) in Sociology in 1993 and a PhD (Doctor rerum politicarum) in Political Science in 2000.

**Selected Publications**

1. Samdata spesialisthelsetjenesten (ed.)(Comparative analyses on the performance of the specialised health care sector in Norway). Annual publication from the Norwegian Directorate of Health. Contributions 1999-2014, Editor 2003, 2009-2015.
2. Sykehusstruktur og utviklingen i bruk av sykehustjenester 2003-13. (Centralisation and decentralisation in hospital use in Norway 2003-13). In Samdata spesialisthelsetjeneste 2014. The Norwegian Directorate of Health.
3. Samhandlingsstatistikk (ed). Comparative analyses on the Norwegian Reform of Integrate care; patients and resources. Annual publication from the Norwegian Directorate of Health.
4. Activity in somatic hospitals before and after The Norwegian Hospital Reform. In The Evaluation of the Norwegian Hospital Reform, The Norwegian Research Council 2007.
5. The Norwegian Hospital Reform and centralisation, specialisation and decentralisation of hospital services in Norway. In The Evaluation of the Norwegian Hospital Reform, The Norwegian Research Council 2007.

**Erica Ison**

NHS Atlas of Variation in Healthcare  
Public Health England  
London, United Kingdom

**Biography**

Erica Ison works for Public Health England (PHE) on The NHS Atlases of Variation in Healthcare, and has been involved since their inception in 2010. She was the Co-Editor with Professor Sir Muir Gray of both compendium Atlases (Atlas 1.0 and Atlas 2.0), and the subsequent specialist Atlases: Child Health, Diabetes, Kidney Care, Respiratory Disease, Liver Disease, and Diagnostic Services. At the time of writing, she is working on the third compendium atlas (Atlas 3.0), which will feature just over 100 indicators. After the publication of Atlas 3.0 in Autumn 2015, PHE and other partners including NHS England and Right Care will be determining the next phase of work for The NHS Atlas Series.

Since October 2013, Erica has also been a member of the team working on the Global Burden of Disease Project in England for PHE.

In addition, Erica is a specialist in health impact assessment (HIA) and Health in All Policies (HiAP). She is an Expert Adviser in HIA to the World Health Organization's European Network of Healthy Cities, and has also acted as an Expert Advisor in HIA and HiAP to WHO International in Geneva, and in HiAP to WHO Western Pacific Region and the Ministry of Health in Brunei. Work for the European Union includes developing indicators for health and regeneration as part of URBACT II "Building Healthy Communities", and developing HIA methods with an equity focus for Ministries of Health throughout Europe. In 2005, she was made an honorary member of the English Faculty of Public Health, and in 2006 she was awarded the "Individual Achievement in Impact Assessment" by the International Association of Impact Assessment (IAIA), the first HIA practitioner to be given this award.

**Selected Publications**

1. Public Health England, NHS England and Right Care (2010, 2011, 2012, 2013, 2015) The NHS Atlases of Variation in Healthcare. Reducing unwarranted variation to increase value and improve quality. Available at: <http://www.rightcare.nhs.uk/atlas/>
2. **Ison E.** (2013) Health Impact Assessment in a Network of European Cities. J Urban Health 90; Issue 1 Supplement 105-115. Available at: <http://link.springer.com/article/10.1007/s11524-011-9644-8>
3. **Ison E.** (2009) The introduction of health impact assessment in the WHO European Healthy Cities Network. Health Promot Int 24 (suppl 1): i64-i71. doi:10.1093/heapro/dap056 Available at: [http://heapro.oxfordjournals.org/content/24/suppl\\_1/i64.full?sid=d9e7acd8-89fb-41ad-8813-fa3a6d453927](http://heapro.oxfordjournals.org/content/24/suppl_1/i64.full?sid=d9e7acd8-89fb-41ad-8813-fa3a6d453927)

4. **Ison E.** (2002) Rapid Appraisal Tool for Health Impact Assessment. A task-based approach. Eleventh iteration. Available at: <http://www.apho.org.uk/resource/item.aspx?RID=44890>
5. Mindell J, **Ison E**, Joffe M. (2003) A glossary for health impact assessment. *J Epidemiol Community Health* 57;647-651.doi:10.1136/jech.57.9.647 Available at: <http://eprints.ucl.ac.uk/889/1/647.pdf>
6. **Ison E.** (2004) Rapid appraisal techniques. In Kemm J, Parry J and Palmer S (eds) *Health impact assessment*. Oxford University Press.

**Søren Paaske Johnsen**

Research Consultant, Associate Professor (Clinical Epidemiology)  
Department of Clinical Epidemiology  
Aarhus University Hospital  
Aarhus, Denmark

**Biography**

Søren Paaske Johnsen is research consultant and associate professor in clinical epidemiology at Aarhus University Hospital and Aarhus University, Denmark.

Dr. Johnsen's primary field of interest is quality of clinical care including use of evidence-based care, effectiveness and safety of recommended clinical interventions and evaluation of quality improvement strategies. The activities are primarily focused on scientific use of clinical quality databases and administrative registers.

Dr. Johnsen received his medical degree and PhD degree in epidemiology from Aarhus University. He has worked with clinical quality databases since the late 1990's and was for ten years head of Center for Clinical Databases at Department of Clinical Epidemiology, Aarhus University Hospital. This center is one of three national Danish centers supporting clinical databases with expertise in clinical epidemiology and biostatistics. He currently leads a research group working with quality of care at Aarhus University Hospital and Aarhus University.

**Selected Publications**

1. Kristensen PK, Thillemann TM, **Johnsen SP**. Is bigger always better? A nationwide study of hip fracture unit volume, 30-day mortality, quality of in-hospital care, and length of hospital stay. *Med Care*, 2014; 52:1023-1029.
2. Falstie-Jensen AM, Larsson H, Hollnagel E, Nørgaard M, Svendsen ML, **Johnsen SP**. Compliance with hospital accreditation and patient mortality: a Danish nationwide population-based study. *Int J Qual Health Care*, 2015; 27:165-74.
3. Andersen MS, **Johnsen SP**, Hansen AE, Skjaerseth E, Hansen CM, Sørensen JN, Jepsen SB, Hansen JB, Christensen EF. Preventable deaths following emergency medical dispatch--an audit study. *Scand J Trauma Resusc Emerg Med*, 2014; 22:74.
4. Kristiansen NS, Mainz J, Nørgård BM, Bartels PD, Andersen G, **Johnsen SP**. Off-hours admission and acute stroke care quality: a nationwide study of performance measures and case-fatality. *Stroke*, 2014; 45:3663-3669.
5. **Johnsen SP**, Svendsen ML, Hansen ML, Brandes A, Mehnert F, Husted SE. Preadmission Oral Anticoagulant Treatment and Clinical Outcome Among Patients Hospitalized With Acute Stroke and Atrial Fibrillation: A Nationwide Study. *Stroke*. 2014; 45:168-175.

**Jina Jun**

Associate Research Fellow  
Health Policy Research Department  
The Korea Institute for Health and Social Affairs  
Sejong, South Korea

**Biography**

Jina Jun is an Associate Research Fellow at the Korea Institute for Health and Social Affairs. Jina Jun has a keen research interest in the regional variation in health behaviors, mental health, and women health. Recently, she is conducting a research on regional healthcare variation, which includes a data analysis for healthcare utilization using the National Health Insurance claims data in Korea.

Jina Jun completed a MA degree in social welfare from the Seoul National University and received her doctor's degree in Social Work from the University of Texas at Austin. She has studied healthcare policy and multimorbidity in the Korea Institute for Health and Social Affairs. Jina Jun published research in *the American Journal of Public health*, *Journal of Maps*, and *Annals of surgery*.

**Selected Publications**

1. Claire Margerison-Zilko, Catherine Cubbin, **Jina Jun**, Kristen Marchi, Kathryn Fingar, and Paula Braveman. Beyond the cross-sectional: Neighborhood poverty histories and preterm birth. *American Journal of Public Health*, 2015; 105(6); 1174-1180.
2. **Jina Jun**, Hyunyoung Park, and Sunju Sohn. Trajectories of Korean adults' depressive symptoms and its associations with smoking and drinking: Using latent class growth modeling. *Mental health and Social Work*, 2013; 30; 68-94.
3. Catherine Cubbin, **Jina Jun**, Claire Margerison-Zilko, Nicolas Welch, James Sherman, Talia McCray, and Barbara Parmenter. Social inequalities in neighborhood conditions: Spatial relationships between sociodemographic and food environments in Alameda County, California. *Journal of Maps*, 2012; 8(4); 344-348.



**Brendon Kearney**

Clinical Professor  
University of Adelaide  
Adelaide, Australia

**Biography**

Professor Kearney presently works as a Clinical Professor in the Faculty of Medicine, University of Adelaide, practicing as a Consultant in the Haematology Unit of the Royal Adelaide Hospital (RAH) Cancer Service with a private practice based at the Royal Adelaide Hospital. He also has management responsibilities for pathology services at the RAH. He is the Chair of the Population Health Research Network Management Council.

For 10 years he was Deputy Chairman of the Medical Services Advisory Committee, Australia's Health Technology Assessment Committee for assessment and recommendations on procedures, devices and diagnostics. This involved the establishment of policies and systems for HTA assessment directly linked to reimbursement decisions.

Professor Kearney has chaired numerous committees, including, the Health Prioritizing Advisory Committee on Technology, of which he has chaired since 2003. He has been Chair and Chief Executive Office of the South Australian Health Service, Chief Health Officer and Chief Executive of the Royal Adelaide Hospital.

He has been the Director of South Australia's Institute of Medical and Veterinary Science from 1983-2008. He was a member of the Australian Productivity Commission Review that recommended the present Private Health Insurance scheme that has for two decades been a vital part of Australia's health system. He has served on the National Health and Medical Research Council for twelve years. He was awarded the Sydney Sax medal for services to health and an AM for contribution to emergency services and health research.

**Ilmo Keskimäki**

Research Professor

National Institute for Health and Welfare (THL)

Helsinki, Finland

**Biography**

**Ilmo Keskimäki** works as a research professor for health systems research at the Department of Health and Social Care Systems in the National Institute for Health and Welfare (THL). He affiliates to the School of Health Sciences, University of Tampere, as Professor of health services research and the Department of Public Health in the University of Helsinki as an adjunct professor. Formerly, he has worked in various research and administrative positions in the National Research and Development Centre for Welfare and Health (STAKES), the Ministry of Social Affairs and Health, the National Public Health Institute, and the Universities of Helsinki and Oulu. He graduated in medicine, is a specialist in public health medicine, and has a PhD in public health from the Faculty of Medicine in the University of Helsinki. His main research activities have been in health services research. He has particularly studied practice variations and social disparities in health services and focused on developing research methods for the use of register based longitudinal data in health services research. Keskimäki's current research activities focus on socioeconomic and geographic equality in health care and treatment of chronic diseases, and assessment of health care reforms.

**Selected Publications**

1. Manderbacka K, Arffman M, Lumme S, **Keskimäki I**. Are there socioeconomic differences in outcomes of coronary revascularisations – A register-based cohort study. *European Journal of Public Health*, DOI: <http://dx.doi.org/10.1093/eurpub/ckv086> First published online: 9 May 2015.
2. **Keskimäki I**, Forssas E, Rautiainen H, Rasilainen J, Gissler M. Finland: Geographic variations in health care. In: OECD, *Geographic Variations in Health Care: What Do We Know and What Can Be Done to Improve Health System Performance?*, OECD Health Policy Studies, OECD Publishing 2014. <http://dx.doi.org/10.1787/9789264216594-en>, pp 195-220.
3. Lumme S, Leyland A, **Keskimäki I**. Multilevel modeling of regional variation in equity in health care. *Medical Care* 2008;46(9): 976–983.
4. Hetemaa T, **Keskimäki I**, Manderbacka K, Leyland AH, Koskinen S. How did the recent increase in the supply of coronary operations in Finland affect socio-economic and gender equity in their use? *Journal of Epidemiology and Community Health* 2003;57:178-185.
5. **Keskimäki I**, Seitsalo S, Österman H, Rissanen P. Reoperations after lumbar disc surgery: A population-based study of regional and interspecialty variations. *Spine* 2000;25(12):1500-1507.

**Nam-Soon Kim**

Research Fellow and Director of Health Service Research Center  
Korea Institute for Health and Social Affairs  
Sejong City, Korea

**Biography**

Nam-Soon Kim is a Researcher Fellow and the Director of Health Service Research Center at the Korea Institute for Health and Social Affairs (KIHASA). Dr. Kim has a keen research interest in clinical practice guideline, healthcare utilization and quality. Recently, she has initiated a research program in examining variation and overuse problem of medical service by using the National Health Insurance claims data in Korea.

Dr. Kim has led multiple projects on such topics as depression, pay for performance, clinical guidelines and quality Indicators. Dr. Kim has served on editorial boards of KIHASA's official journal: *Health and Social Welfare Review* and scientific board of Korean Association for Health Technology Assessment. Her research papers and editorials have been published in the *Health Policy*, *Journal of Korean Medical Science* and *Journal of Korean Medical Association*.

Dr. Kim received his medical degree from the Wonju College of Medicine, Yonesi University and her doctoral degree in health policy and management from Graduate School of Public health, Seoul National University. She received training for family medicine and preventive medicine.

**Selected Publications**

1. KH Kim, SM Lee, JW Baek, **NS Kim**. The effects of continuous antidepressant treatment during the first 6 months on relapse or recurrence of depression. *Journal of Affective Disorders* 2011; 132(1-2);121-9.
2. JC Lee, KH Kim, HN Lim, **NS Kim**. Factors associated with diabetes outpatient use of tertiary or general hospitals as their usual source of care in Korea. *Journal of Korean Med Assoc* 2012; 55(12):1215-25.
3. JY Lee, SI Lee, **NS Kim**, SH Kim, WS Son, MW Jo. Healthcare organizations' attitude toward pay for performance in Korea. *Health Policy* 2012; 277-85.
4. MW Jo, JY Lee, **NS Kim**, SY Kim, SS Sheen, SH Kim, SI Lee. Assessment of the Quality of Clinical Practice Guidelines in Korea Using the AGREE Instrument. *J Korean Med Sci* 2013; 28: 357-65.
5. EH Lee, BY Park, **NS Kim**, HJ Seo, KL Ko, JW Min, et al. The Korean guideline for breast cancer screening. *Journal of Korean Med Assoc* 2015;58(5);408-19.

**Yoon Kim**

Chair, Department of Health Policy and Management  
Seoul National University College of Medicine  
Seoul, Republic of Korea

**Biography**

Yoon Kim is a chairman of the Department of Health Policy and Management at the Seoul National University College of Medicine. He has also served as secretary general of the Korea Association of Medical Colleges.

In addition, he was Head of the Research Institute in Health Insurance Review and Assessment Service (HIRA), vice chairman of the National Mental Health Commission of the Ministry of Health and Welfare in Korea, and has served on numerous boards and committees for preventive medicine, medical education, emergency medical service systems and mental health, among others.

Earlier in his career, he was also director of the Centre for Interoperable EHR (Electronic Health Record), a senior consultant to the Bureau of Healthcare Quality Improvement, HIRA, assistant professor at Sungkyunkwan University School of Medicine and senior researcher at the Korea Health Industry Development Institute.

**Selected Publications**

1. **Y Kim**, JW Oh, A Jha. Contribution of Hospital Mortality Variations to Socioeconomic Disparities in-hospital Mortality. *BMJ Quality & Safety* 2014 March (17):1-8
2. JA Lee, SY Kim, **Y Kim**, JW Oh, HJ Kim, DY Jo, TG Kwon, JH Park. Comparison of Health-related Quality of Life Between Cancer Survivors Treated in Designated Cancer Centers and the General Public in Korea. *Jpn J Clin Oncol* 2014 Feb;14(2):141-152
3. JA Lee, JH Park, EJ Lee, SY Kim, **Y Kim**, SI Lee. High-Quality, Low-Cost Gastrectomy Care at High-Volume Hospitals Results From a Population-Based Study in South Korea. *Archives of Surgery* 2011 Aug;146(8):930-936.
4. I Cho, J Kim, JH Kim, HY Kim, **Y Kim**. Design and Implementation of a Standards-based Interoperable Clinical Decision Support Architecture in the Context of the Korean EHR. *International Journal of Medical Informatics* 2010 Sep;79(9):611-622.
5. SY Kim, JK Park, SG Kim, HK Woo, JH Park, **Y Kim**, EC Park. Disparities in Utilization of High-Volume Hospitals for Cancer Surgery: Results of a Korean Population-based Study. *Annals of Surgical Oncology* 2010 Jun;17(11):2806-2815.

**Troels Kristensen**

Associate Professor of Health Economics and Health Policy at CHOERE  
Institute of Public Health (IST) and The Research Unit of General Practice  
University of Southern Denmark  
Odense, Denmark

**Biography**

Troels Kristensen is an Associate Professor of Health Economics and Health Policy at The University of Southern Denmark, Institute of Public Health; and group leader of Organization of General Practice at The Research Unit of General Practice. He is also a part of Centre of Health Economics Research (COHERE) embedded in the Department of Business and Economics and the Institute of Public Health. Based on interdisciplinary collaboration between general practitioners, economists and other professionals The Research Unit of General Practice and COHERE has a research interest in the causes and consequences of health care variation.

Dr. Kristensen has a research interest in organization of health care systems and consequences of variation in health care needs and risk adjustment within the case mix field and a specific interest in investigating integrated care, approaches to case mix adjustment and related resource allocation through mixed remunerations systems.

Dr. Kristensen is involved in a range of research projects such as an integrated care project (<http://www.integratedcare.dk/>) and projects related to applications of case mix systems for public health purposes and remuneration. Dr. Kristensen has served as a reviewer on multiple journals and conducted research funded by the Danish Regions and other Danish authorities. His working-papers and research papers as well as policy oriented reports have been published in International Journal such as Health Care Management Science, European Journal of Health Economics, Health Policy and working paper series.

Dr. Kristensen received his economics degree (MSc) from University of Southern Denmark and his PhD degree in Health Economics from University of Southern Denmark. During his PhD he was a visit researcher at the University of York (CHE) and received a part of his PhD training at the Swiss School of Public Health (SSPH).

**Selected Publications**

1. **Kristensen T**, Olsen KR, Schroll H, Thomsen JL, Halling A. Association between fee-for-service expenditures and morbidity burden in primary care. Eur J Health Econ 2013.
2. **Kristensen T**, Rose OK, Sortso C, Ejertsted C, Thomsen JL, Halling A. Resources allocation and health care needs in diabetes care in Danish GP clinics. Health Policy 2013; 113(1-2):206-215.

3. **Kristensen T**, Laudicella M, Ejerssted C, Street A. Cost variation in diabetes care delivered in English hospitals. *Diabetes Medicin* 2010; 27, 949-957.
4. Milton Bache SH, **Kristensen T**. A simple but efficient approach to the analysis of multilevel data. *Health Economic papers* 2013:6 University of Southern Denmark, Department of Business and Economics, Faculty of Social science.  
[http://econpapers.repec.org/paper/hhssduhec/2013\\_5f006.htm](http://econpapers.repec.org/paper/hhssduhec/2013_5f006.htm)
5. **Kristensen T**, Halling A. Can case mix-systems be applied in Danish primary care? Working paper. University of Southern Denmark, Department of public health. Report for Region of Zealand.  
[http://findresearcher.sdu.dk/portal/da/publications/kan-casemixsystemer-anvendes-i-den-danske-primaersektor\(fe16907e-aa80-4499-b3f1-799f0125539e\).html](http://findresearcher.sdu.dk/portal/da/publications/kan-casemixsystemer-anvendes-i-den-danske-primaersektor(fe16907e-aa80-4499-b3f1-799f0125539e).html) Abstract in English:  
[http://findresearcher.sdu.dk/portal/da/publications/can-casemixsystems-be-applied-in-danish-primary-care\(78d63ee1-ecb3-48ea-ab82-5a44a284dc1a\).html](http://findresearcher.sdu.dk/portal/da/publications/can-casemixsystems-be-applied-in-danish-primary-care(78d63ee1-ecb3-48ea-ab82-5a44a284dc1a).html)

## **Pia Kjær Kristensen**

PhD student, Master of Health Science and registered nurse  
Department of Clinical Epidemiology, Aarhus University Hospital, Science Center Skejby and  
Department of Orthopedic Surgery, Regional Hospital Horsens  
Aarhus, Denmark

### **Biography**

Pia Kjær Kristensen is a PhD student at Aarhus University, Aarhus University Hospital and Regional Hospital Horsens, Denmark.

Pia Kjær Kristensen primary field of interest is clinical epidemiology including quality of clinical care, the organisation of in-hospital care and evaluation of quality improvement strategies among patients with hip fracture.

Pia Kjær Kristensen was trained as an orthopedic nurse in 2004 and has been working as an orthopedic nurse for 10 years. She received her Master of Health Science from Aarhus University in 2013 and started her PhD in 2014. The main purpose of her thesis will be to identify links in health care quality by examining overall associations between selected aspects of structure of care (orthogeriatric specialization) and process performance measures, 30-day mortality, hospital bed-day use and hospital costs among patients with hip fracture. She is currently a part of the research group working with quality of care at Aarhus University Hospital and Aarhus University leading by Dr. Johnsen.

### **Selected Publications**

1. **Kristensen PK**, Thillemann TM, Johnsen SP. Is bigger always better? A nationwide study of hip fracture unit volume, 30-day mortality, quality of in-hospital care, and length of hospital stay. *Med Care*, 2014; 52:1023-1029.
2. **Kristensen PK**, Pfeiffer-Jensen M, Storm JO, Thillemann TM. Local infiltration analgesia is comparable to femoral nerve block after anterior cruciate ligament reconstruction with hamstring tendon graft - A randomized controlled trial. *Knee Surg Sports Traumatol Arthrosc*, 2013 jan (DOI: 10.1007/s00167-013-2399-x)
3. **Kristensen PK**, Thillemann TM, Søballe K, Johnsen SP. Can improved quality of care explain the success of the orthogeriatric units? A population based study. *In press Age and Ageing*
4. Kristiansen NS, **Kristensen PK**, Nørgård BM, Mainz J, Johnsen SP. Off-hours admission and quality of hip fracture care: A nationwide cohort study of performance measures and case fatality. *In press International Journal for Quality in Health Care*

**Anne Kudsk Fallesen**

PhD Candidate, Clinical Institute  
University of Southern Denmark  
Odense M, Denmark

**Biography**

Anne Kudsk Fallesen is currently affiliated to the Research Unit for Quality in Healthcare, University of Southern Denmark, as a PhD-student. Her research is about regional variation in the diagnosis and treatment of cancer in Denmark; specifically focusing on lung cancer. She has a background in nursing and has a master degree in Health Science. For the past 15 years, her main occupancy has been in the field of quality improvement and patient safety in health care with a focus on among others accreditation, organizational development, indicators, guidelines, evaluation etc.

**Selected Publications**

1. Myrdal G, Lamberg K, Lambe M et al. "Regional differences in treatment and outcome in non-small cell lung cancer: a population-based study (Sweden)". *Lung Cancer* 63 (2009), 16-22.
2. Bilimoria KY, Ko CY, Tomlinson JS et al. "Wait times for Cancer Surgery in the United States: Trends and Predictors of Delays". *Annals of Surgery* (2011), vol.253 (4), 779-785.
3. Jakobsen E, Green A, Oesterlind K et al. "Nation-wide quality improvement in lung cancer care: The role of the Danish Lung Cancer Group and Registry." *Journal of Thoracic Oncology*, Oct. 2013, vol.8(10); pp. 1238-1247.



Morgane Le Bail  
Medical Advisor  
French Ministry of Health  
Paris, France

### **Biography**

Morgane Le Bail is a medical Doctor, she joined the French Ministry of health in 2014 as a medical advisor. She currently works on medical practice variations and leads a task forces to produce data, guidelines and professional supports on 33 national priorities.

A medical school graduate in Public Health, she holds a Master (Kremlin Bicêtre, Paris) and a doctor's degree in Public Health (EHESP, Rennes).

Her 5 years experience in public health provides her with an expertise in clinical research but also in healthcare organization and patients pathway.

Realized a study on predictability of a rubric to evaluate the feasibility of clinical research projects. Collected data from the rubric. Monitored progress of projects.

Contributed to innovative companies' projects evaluation as a medical expert . Analyzed applications and realized interviews. Produced expertise reports.

Realized a study on cardiac surgery services for public hospitals of Paris. Conducted key strategic interviews. Designed action plans stating clear objectives and defining responsibilities.

Assisted several public hospitals to determine the main levers insuring the best patient pathway.

Helped regional regulatory agencies to organize their digital tracking system. Conducted key strategic interviews. Coordinated work of groups composed of hospital practitioners, caregivers and hospital directors.

Assessed public policies regarding the coordination healthcare pathway for the elderly, both inside and outside hospitals. Realized data analysis. Coordinated working groups. Produced final reports.

**Heeyoung Lee**

Assistant Professor  
Center for Preventive Medicine and Public Health  
Seoul National University Bundang Hospital  
Republic of Korea

**Biography**

Heeyoung Lee is Assistant Professor of Center for preventive medicine and public health, Seoul National University Bundang Hospital in South Korea.

Heeyoung Lee received her Ph.D in preventive medicine at Korea University in 2014. Before, She had studied at Seoul National University and graduated as MPH(Master of public health) in 2004 and graduated college of medicine, Korea University 2000,

Her main research interests are health policy, health care utilization, primary health care, comparative effectiveness research.

In 2005 she joined the Korea National Cancer Center as an research assistant and from 2008 to 2010 was worked at National Evidence based Healthcare Collaborating Agency(NECA) as associate research fellow. Since June 2010 she has been a research fellow at Korea National Health Insurance Service and from September 2014 is working at Seoul National University Bundang Hospital.

**Publications**

1. Tackeun Kim, **Heeyoung Lee**, Jae Seung Bang, O-Ki Kwon, Gyojun Hwang, Chang Wan Oh. Epidemiology of Moyamoya Disease in Korea: Based on National Health Insurance Service Data. J Korean Neurosurg Soc 2015; 57 (6) : 390-395.
2. Dae Kyung Sohn, Min Ju Kim, Younhee Park, Mina Suh, Aesun Shin, **Heeyoung Lee** et al. he Korean guideline for colorectal cancer screening. J Korean Med Assoc 2015 May; 58(5): 420-432
3. **Heeyoung Lee**, Jun Yim. Socio-Economic Inequality in Survival of Percutaneous Coronary Interventions Journal of the Korean Data Analysis Society 2014 August; 16( 4): 1745-1753
4. Sung NJ, Markuns JF, Park KH, Kim K, **Lee H**, Lee JH. Higher quality primary care is associated with good self-rated health status. Family Practice 2013; 30:568–575.
5. **Heeyoung Lee**, Jong-Heon Park, Yoon, Kim. Assessment and Improvement Strategies of Korean National Health Screening Program. Journal of Critical Social Welfare 2012; 11:285-323

**Juyeon Lee**

Research Assistant

Department of Health Policy and Management

Seoul National University College of Medicine

Seoul, Republic of Korea

**Biography**

Juyeon Lee is a research assistant in the department of health policy and management at Seoul National University College of Medicine. She recently received her MSc in Health Policy, Planning and Financing from the London School of Hygiene and Tropical Medicine and London School of Economics and Political Science. Her research interest focuses on 1) measuring quality of care with particular emphasis on equity and efficiency in the use of health care services and 2) improving delivery system of health care by strengthening the role of primary care.

**Linda Leivseth**

Researcher and epidemiologist  
Centre for Clinical Documentation and Evaluation  
Northern Norway Regional Health Authority  
Tromsø, Norway

**Biography**

Linda Leivseth is researcher at Centre for Clinical Documentation and Evaluation (SKDE), Northern Norway Regional Health Authority. Before starting her current job in November 2014 she worked at the Norwegian Patient Registry where she was in charge of producing national data files on all publicly financed patient activity at public and private somatic specialist health care institutions. The main applications of this data is activity based financing, national statistics and medical research. Due to the unique personal identification number of every resident in Norway it is possible to follow every patient over many years and between institutions. It is also possible to link patient data to other registry based data like education, income, family ties and cause of death. In her current job at SKDE Dr. Leivseth is analysing this data from the Norwegian Patient Registry with a focus on unwarranted geographical variation in health care.

SKDE published a day surgery atlas of variation of in January 2015, and a paediatric atlas of variation will be published this autumn. Dr. Leivseth is currently working on a chronic obstructive pulmonary disease atlas of variation, and on studies of geographical variation related to diverticular disease of the intestine.

Dr. Leivseth received her physiotherapy degree from Keele University in England and her master's degree in health science and her PhD in community medicine from the Norwegian University of Science and Technology. Both her master and her PhD theses are epidemiological studies on chronic obstructive pulmonary disease, and they are based on data from the large population based Nord-Trøndelag Health Study. In addition to her formal degrees Dr. Leivseth has attended several courses in statistics and epidemiology, health economy and ICD-10.

**Selected Publications**

1. Soriano JB, Lamprecht B, ... ,**Leivseth L**, Bakke P, Johannessen A, Roche N, Sin DD. Mortality prediction in chronic obstructive pulmonary disease comparing the GOLD 2007 and 2011 staging systems: a pooled analysis of individual patient data. Lancet Respir Med. 2015;3(6):443-50.
2. **Leivseth L.** Chronic obstructive pulmonary disease; lung function, respiratory symptoms, and mortality. The HUNT Lung Study 1995-97. Doctoral thesis. 2013.
3. **Leivseth L**, Brumpton BM, Nilsen TI, Mai XM, Johnsen R, Langhammer A. GOLD classifications and mortality in chronic obstructive pulmonary disease: the HUNT Study, Norway. Thorax. 2013;68(10):914-21.

4. **Leivseth L**, Nilsen TI, Mai XM, Johnsen R, Langhammer A. Lung function and respiratory symptoms in association with mortality: The HUNT Study. COPD. 2014;11(1):59-80.
5. **Leivseth L**, Nilsen TI, Mai XM, Johnsen R, Langhammer A. Lung function and anxiety in association with dyspnoea: the HUNT study. Respir Med. 2012;106(8):1148-57.

## **Sonja Lumme**

Researcher

National Institute for Health and Welfare (THL)

Helsinki, Finland

### **Biography**

Sonja Lumme works as a researcher for health systems research at the Department of Health and Social Care Systems in the National Institute for Health and Welfare (THL). She graduated in statistics from the Faculty of Social Sciences at the University of Helsinki. Currently she is finalizing PhD for the Department of Public Health at the University of Helsinki. Her PhD is about measuring socioeconomic inequities in health care using administrative databases. Formerly, she has worked as a researcher in the Finnish Cancer Registry and as a statistician and an IT-specialist handling and analysing register datasets in several projects in the National Research and Development Centre for Welfare and Health (STAKES). She has over ten years of experience in doing research using administrative register data compiled from several sources. Her special interest is health services research. She has particularly studied social disparities in health services and focused on developing research methods for the use of register based longitudinal data in health services research.

### **Selected Publications**

1. **Lumme S**, Leyland A, **Keskimäki I**. Multilevel modeling of regional variation in equity in health care. *Medical Care* 2008;46(9): 976–983.
2. **Lumme S**, Sund R, Leyland A, **Keskimäki I**. Socioeconomic equity in amenable mortality in Finland 1992-2008. *Soc Sci Med* 2012; Sep; 75(5):905-13. doi: 10.1016/j.socscimed.2012.04.007
3. Manderbacka K, Peltonen R, **Lumme S**, **Keskimäki I**, Tarkiainen L, Martikainen P. The contribution of health policy and care to income differences in life expectancy – a register based cohort study. *BMC Public Health* 2013; 13:812. doi:10.1186/1471-2458-13-812.
4. **Lumme S**, Sund R, Leyland A, **Keskimäki I**. A Monte Carlo method to estimate the confidence intervals for the concentration index using aggregated population register data. *Health services and outcomes research methodology* 2015;15(2), pp. 82-98. DOI: 10.1007/s10742-015-0137-1
5. Manderbacka K, Arffman M, **Lumme S**, **Keskimäki I**. Are there socioeconomic differences in outcomes of coronary revascularisations – A register-based cohort study. *European Journal of Public Health* 2015;1–6. doi:10.1093/eurpub/ckv086

**Xhyljeta Luta**

PhD Candidate

Institute of Social and Preventive Medicine

University of Bern

Bern, Switzerland

**Biography**

Field of work: End - of- Life Care, Health Services Research

PhD student at the Institute of Social and Preventive Medicine, University of Bern, Switzerland

Research project: Regional and temporal Variations in End - of – Life Care in Switzerland

Education:

Master of Public Health (MPH), 2010 University of Sheffield, United Kingdom

Master of Public Health (MPH), Advanced Public Health Methods, 2011 University of Copenhagen, Denmark

École des Hautes Études en Santé Publique, (2009) EUROPUBHEALTH, Public Health Rennes, France

**Selected Publications**

1. **Luta, X.** and T. Draebel (2013). "Kosovo-Serbs' experiences of seeking healthcare in a post-conflict and ethnically segregated health system." *Int J Public Health* 58(3): 377-383.
2. **Luta, X.**, et al. (2015). "Measuring intensity of end of life care: a systematic review." *PLoS One* 10(4): e0123764.

**Céu Mateus**

Research Fellow  
Division of Health Research  
Lancaster University  
Lancaster, UK

**Biography**

Céu Mateus is Research Fellow at the Division of Health Research in Lancaster University (UK). From 2001 until October 2014 she was an Assistant Professor of Health Economics at the National School of Public Health at University Nova of Lisbon. She worked for the Institute of Management and IT (Ministry of Health) in the Department of Information Systems Development from 1995 until 2000, where she was the Executive responsible for the Financing System/Classification System in Diagnoses Related Groups. She worked in the development and improvement of the funding model for NHS hospitals in what concerns inpatient care and, at the same time, was a member of the team that was being developing a capitation model for resource allocation in primary health care. She is currently undertaking studies of inequalities in the treatment in hospital care and variations in clinical practice. She was President of Patient Classification Systems International from 2002 until 2009. She was the President of the Portuguese Association of Health Economics between 2011 and 2014.

**Selected Publications**

1. **Mateus C**, Joaquim I, Nunes C. (2015). Measuring hospital efficiency--comparing four European countries. *Eur J Public Health*. Feb 2015;25 Suppl 1:52-8. (doi: 10.1093/eurpub/cku222).
2. García-Armesto S, Angulo-Pueyo E, Martínez-Lizaga N, **Mateus C**, Joaquim I, Bernal-Delgado E; ECHO Consortium (2015). Potential of geographical variation analysis for realigning providers to value-based care. ECHO case study on lower-value indications of C-section in five European countries. *Eur J Public Health*. Feb 2015;25 Suppl 1:44-51. (doi: 10.1093/eurpub/cku224).
3. Bernal-Delgado E, Christiansen T, Bloor K, **Mateus C** Yazbeck AM, Munck J, Bremner J; ECHO Consortium (2015). ECHO: health care performance assessment in several European health systems. *Eur J Public Health*. Feb 2015;25 Suppl 1:3-7. (doi: 10.1093/eurpub/cku219).
4. Azevedo H, **Mateus C**. (2014) Cost effects of hospital mergers in Portugal. *European Journal of Health Economics*. Dec. 2014, 15(9), pp 999-1010 (DOI: 10.1007/s10198-013-0552-6).
5. **Mateus C**, Joaquim I, Nunes C, Boto P, Campos L: Portugal: Geographic variations in health care in "Geographic Variations in Health Care: What Do We Know and What Can Be



Done to Improve Health System Performance?”, OECD Health Policy Studies, OECD Publishing, p. 317-342, 2014. (<http://dx.doi.org/10.1787/9789264216594-en>) (ISBN 978-92-64-21658-7 (print); ISBN 978-92-64-21659-4 (PDF))

**Dr. Duncan McPherson**

Department of Anaesthesia  
Queen Alexandra Hospital  
Portsmouth, UK

**Biography**

Duncan is a consultant anaesthetist (anesthesiologist) with a sub-specialty focus in acute pain management and regional anaesthesia. He is also lead for anaesthesia patient safety at Portsmouth Hospitals and a member of the Royal College of Anaesthetists Safe Anaesthesia Liaison Group.

While working at the National Patient Safety Agency in London, he investigated potential quantitative measures of system level patient safety. This led to a thesis that is nearing completion for a higher degree. The thesis attempted to quantify avoidable harm caused by unwarranted variation in availability of an innovative technological treatment in England. It illustrated the problem of studying geographic variation in availability of innovative treatments while diffusion of the innovation is happening. The disease studied was acute myocardial infarction and the treatment was primary angioplasty. In order to study this area, Duncan had to generate his own map of Hospital Service Areas for England specific to heart attack treatment, and invented a computerized algorithm for doing this based on the original HSA definition of the Dartmouth Atlas.

**Selected Publications**

1. (in draft) **McPherson, D.** *Avoidable harm, unwarranted variation and diffusion in the treatment of acute myocardial infarction*. MD thesis. Imperial College London, London, 2014.
2. **McPherson, D.**, Griffiths, C., Williams, M., Baker, A., Klodawski, E., Jacobson, B., & Donaldson, L. (2013). Sepsis-associated mortality in England: an analysis of multiple cause of death data from 2001 to 2010. *BMJ Open*, 3(8), e002586-. doi:10.1136/bmjopen-2013-002586

**Gregoire Mercier**

Head, Economic Evaluation Unit  
Montpellier Teaching Hospital (CHU Montpellier)  
Montpellier, France

**Biography**

A physician by training, I have worked in the outcomes research sector designing and implementing trials of pharmaceuticals and medical devices.

My current role is at Montpellier teaching hospital, managing a team in charge of the assessment of technological and organizational innovations. We provide national and regional policy-makers with research information about the effectiveness, costs and broader impact of innovations.

My research interests focus on three main areas:

- The costing of inpatient and outpatient services;
- The geographic variation in health care utilization;
- The interface between primary and secondary care.

Recently I have initiated a research program in examining geographic variations in potentially avoidable hospitalizations in France. The first research paper from this program has been published in *Health Affairs*.

I received my medical degree and my PhD in health management from the Montpellier University (France) and my master's degree in health economics and policy from the London School of Economics and Political Science.

**Selected Publications**

1. **Mercier G**, Georgescu V, Bousquet J. Geographic variation in potentially avoidable hospitalizations in France. *Health Aff (Millwood)*. 2015 May 1;34(5):836-43.
2. Bourret R, **Mercier G**, Mercier J, Jonquet O, de La Coussaye JE, Bousquet PJ, Robine JM and Bousquet J. Comparison of two methods to report potentially avoidable hospitalizations in France in 2012: a cross-sectional study. *BMC Health Services Research* 2015 Jan 22;15(1):4.
3. **Mercier G**, Naro G. Costing Hospital Surgery Services: The Method Matters. *PLoS ONE* 2014;9(5): e97290.
4. Bousquet J, Addis A, Adcock I, Agache I, Agusti A, Alonso A, Annesi-Maesano I, et al. Integrated care pathways for airway diseases (AIRWAYS-ICPs). *Eur Respir J*. 2014 Jun 12. pii: erj00146-2014.

**Albert G. Mulley, Jr.**

Director, The Dartmouth Center for Health Care Delivery Science  
Hanover, New Hampshire, USA

**Biography**

Dr. Mulley is Director of The Dartmouth Center for Health Care Delivery Science and Professor of Medicine at the Geisel School of Medicine at Dartmouth. Before joining The Dartmouth Center, Dr. Mulley spent 35 years on the Harvard faculty and the staff of Massachusetts General Hospital where he was the founding Chief of the General Medicine Division and Director of the Medical Practices Evaluation Center. He is founding Editor of the text, *Primary Care Medicine* now in its 7th edition, and founding Director of the Informed Medical Decisions Foundation.

Dr. Mulley's research focuses on measurement of processes, outcomes, and patient preferences to improve the quality of health care decision making and delivery. This work includes development of approaches to support clinical teams and patients in shared decision making and in collaborating in co-management of chronic conditions. It has been used to catalyze learning collaboratives and clinical trials that have shown that increased patient knowledge and attention to patients' informed preferences can be associated with decreased utilization of high cost medical and surgical interventions and better health outcomes.

Dr. Mulley is a member of the Institute of Medicine of the National Academy of Sciences. In 2011, he was named the first International Visiting Fellow at the King's Fund in London and appointed by the Health Foundation, also in London, as an inaugural member of the Improvement Science Development Group. That same year, he was named International Consultant to the Chinese Hospital Association and co-chair of the steering committee for a five-year strategic partnership between Dartmouth and the Ministry of Health of the People's Republic of China to advance health care reform globally. In 2013, he was appointed to the adjunct faculty of the Tsinghua Institute for Hospital Management Research.

**Selected Publications**

1. Barry MJ, **Mulley AG**, Fowler FJ, Wennberg JE. Watchful waiting vs immediate transurethral resection for Symptomatic Prostatism: The importance of patients' preferences. *J Amer Med Assoc.* 1988;259(20):3010–3017.
2. **Mulley AG**. Assessing patients' utilities. Can the ends justify the means? *Med Care.* 1989;27(3 Suppl):S269–81.
3. **Mulley AG**. Inconvenient truths about supplier induced demand and unwarranted variation in medical practice. *Brit Med J.* 2009;339:b4073.

4. **Mulley AG**, Trimble C, Elwyn G. Stop the silent misdiagnosis: Patients' preferences matter. *Brit Med J*. 2012;345:e6572.

5. **Mulley AG**. The global role of health care delivery science: Learning from variation to build health systems that avoid waste and harm. *J Gen Intern Med*. 2013:ePub ahead of print.

**Mats Nilsson, Ph.D.**

Statistician/ Epidemiologist  
Futurm – Academy for Health and Care  
Region Jönköping County  
551 85 Jönköping, Sweden

**Biography**

Mats Nilsson is a statistician/epidemiologist at Futurum, - Academy for Health and Care Region Jönköping County and a tutor for PhD students, lecturer and researcher in statistics and epidemiology.

Mr. Nilsson's main interests are analysis of geographical variation in public health, public health interventions, Patient Reported Measures (PROM and PREM), Quality registers, analysis of ordered categorical data, children's health, odontology, cancer genetics, immune deficiency, and skiing safety. Have experience of working in the public health area and register studies for more than 30 years.

Mr. Nilsson is a member of the steering committee for the Swedish quality register PID-Care (Primary Immune Deficiency) and collaborates with the Register Centre in South East Sweden (RCSO). Mr. Nilsson is a supervisor in statistics and epidemiology for PhD students in cancer-genetic research, head and neck cancer, cancer radiation therapy, public health, primary immune deficiency, hereditary angioedema, psoriasis, survival after dental implants and children's health.

Mr. Nilsson has BSc in Statistics and Economics, PhD student in Statistics, Master in Public Health and a PhD in medical science from Umeå University, Sweden. He has a wide training in epidemiology, psychometrics and biostatistics, from the Universities in Umeå, Stockholm, and Uppsala.

**Selected Publications**

1. Oliva D, Sandgren A, **Nilsson M**, Lewin F. Variations in self-reported nausea, vomiting, and well-being during the first 10 days post-chemotherapy in women with breast cancer. *Clin J Oncol Nurs*. 2014 Apr;18(2):E32-6. doi:10.1188/14.CJON.E32-E36. PubMed PMID: 24675268.
2. Andersson BÅ, Lewin F, Lundgren J, **Nilsson M**, Rutqvist LE, Löfgren S, Laytragoon-Lewin N. Plasma tumor necrosis factor- $\alpha$  and C-reactive protein as biomarker for survival in head and neck squamous cell carcinoma. *J Cancer Res Clin Oncol*. 2014 Mar;140(3):515-9. doi: 10.1007/s00432-014-1592-8.
3. Davidson T, Rohlin M, Hultin M, Jemt T, Nilner K, Sunnegårdh-Grönberg K, Tranæus S, **Nilsson M**. Reimbursement systems influence prosthodontic treatment of adult patients. *Acta Odontol Scand*. 2015 Aug; 73(6):414-20. doi: 10.3109/00016357.2014.976260. Epub 2015 Feb 2.

4. Flejmer AM, Dohlmar F, **Nilsson M**, Stenmarker M, Dasu A. Analytical anisotropic algorithm versus pencil beam convolution for treatment planning of breast cancer: Implications for target coverage and radiation burden of normal tissue. *Anticancer Res* 35: xxx-xxx. (2015) in press.
5. Persson LG, Lingfors H, **Nilsson M**, Mölsted S. The possibility of lifestyle and biological risk markers to predict morbidity and mortality in a cohort of young men after 26 years follow-up. *BMJ Open*. 2015 May 6; 5(5):e006798. doi: 10.1136/bmjopen-2014-006798.

**Sabina Nuti**

Full Professor

Health and Management Laboratory

Scuola Superiore Sant'Anna

Pisa, Italy

**Biography**

Sabina Nuti is full professor of Health Management and Rector's Delegate for the Organization and Budget at Scuola Superiore Sant'Anna, Pisa, a public university that holds a unique position within the Italian higher education system. She is in charge of the performance evaluation system for the health care sector in Tuscany Region and for a network of other eleven Italian Regions. She is a Member of the Scientific Committee for planning in healthcare at the Italian Ministry of Health, a Member of the Scientific Committee of the National Outcome Program at National Agency for Regional Health Services and a Member of the Independent Evaluation Organism for the Tuscany Region. She has been a visiting professor at the University of Toronto. She is responsible for European and national research projects regarding healthcare management, performance evaluation and policies, reviewer for ISI magazines of Health Management and author of various national and international publications.

**Selected Publications**

1. **Nuti S.**, Vola F., Bonini A., Vainieri M. (in press), Making governance work in the healthcare sector: evidence from a "natural experiment" in Italy, *Health Economics, Policy and Law*, Cambridge University Press.
2. Murante A.M., Vainieri M., Rojas D.C., **Nuti S.** (2014), Does feedback influence patient - professional communication? Empirical evidence from Italy. , *Health Policy*, Vol. 116, Issues 2-3, pp. 273-280.
3. **Nuti S.**, Seghieri C. (2014), Is variation management included in regional healthcare governance systems? Some proposals from Italy , *Health Policy*, Vol. 114 (2014) pp. 71-78.
4. Barsanti S., **Nuti S.** (2013), The equity lens in the Health care performance evaluation system, *International Journal of Health Planning and Management*, Vol. 29, Issue 3, pp. e233-e246.
5. **Nuti S.**, Vainieri M., Zett S., Seghieri C. (2012), Assessment and improvement of the Italian Healthcare system: first evidences from a pilot national performance evaluation system, *Journal of Healthcare Management*, Vol. 57, No. 3, pp. 182-199.



**Frede Olesen**

Professor

Department of Public Health

Aarhus University

Aarhus, Denmark

**Biography**

Physician, MD, DrMedSci, FRCGP (hon).

Trained as a GP and worked part time as such until 2007.

1992-2011 Head of the Research Unit for General Practice, Aarhus University.

1996 – present Professor at Aarhus University

Former president of WONCA Region Europe

Former chairman of the Danish Cancer Society

**Slected Publications**

More than 250 scientific publications, including papers and analyses focusing on variations in health care. Most papers with focus on health services research.

**Tetsuya Otsubo**

Assistant Professor at the School of Public Health  
Kyoto University  
Kyoto, Japan

**Biography**

Dr. Tetsuya Otsubo is an Assistant Professor at the Department of Healthcare Economics and Quality Management, School of Public Health, Graduate School of Medicine, Kyoto University, Japan.

He obtained a Masters of Engineering degree from Waseda University, Japan, and completed his Doctoral degree in Public Health (Healthcare Economics and Quality Management) at Kyoto University. He then worked for one year as Assistant Professor by Special Appointment before being appointed as an Assistant Professor in 2010.

His primary research focus is the use of an applied systems approach in the field of health economics and policy. Specifically, these interests include the economics of health care delivery systems, national health insurance, health care utilization, cost accounting and management, and health care financing. His research is broadly based on the manipulation of administrative databases, such as claims data. Dr. Otsubo has supported local governments in the design of regional health care system from 2009.

His current research interests include investigating regional variations in spending, outcomes, and access topics such as travel times to obtain specialized care and ambulance travel times. These investigations utilize a combination of GIS, administrative claims databases, annual routine health check databases, as well as qualitative studies conducted in collaboration with hospitals and local governments. Research results are consistently provided in feedback to hospitals and local governments, and in-depth discussions with clinicians, hospital management staff, and policymakers supports a dynamic approach to research themes; ensuring that research with real-world applications is conducted.

He was on academic sabbatical at The Dartmouth Institute for Health Policy & Clinical Practice from January to June 2014 under Dr. David Goodman's supervision. He studied at the Institute for Clinical Evaluative Sciences in Toronto from July until Dec 2014 under the guidance Of Dr. Jack Tu.

1. Lin HR, **Otsubo T**, Imanaka Y. The effects of dementia and long-term care services on the deterioration of care-needs levels of the elderly in Japan. *Medicine (Baltimore)*. 2015;94(7):e525.
2. **Otsubo T**, Goto E, Morishima T, Ikai H, Yokota C, Minematsu K, Imanaka Y. Regional variations in in-hospital mortality, care processes, and spending in acute ischemic stroke

patients in Japan. J Stroke Cerebrovasc Dis. 2015;24(1):239-51.

3. Sasaki H, **Otsubo T**, Imanaka Y. Widening disparity in the geographic distribution of pediatricians in Japan. Hum Resour Health. 2013;11:59. doi: 10.1186/1478-4491-11-59.

**Adrian Pana**

Health Consultant

PhD Student

Bucharest University of Economics

Bucharest, Romania

**Biography**

Adrian Pana, is a 47 years old Romanian, Public Health and Health Management senior consultant physician with a sound academic and professional background in public health and health policy and management. Currently he is working as a health consultant, being involved in several projects focused on health system governance, accountability and transformation, value –based health care services and their outcomes, reshaping & designing new models of delivery of healthcare services, multi sectorial approaches on social determinants of health and health inequities, and evidence based policies for assessment of new health technologies.

His professional background consists in over 15 years of working experience for the Romanian Government at the central level also for more than 5 years of work as a consultant in international projects on the health sector. He gained this, by working as a Secretary of State as well as a management executive in several departments for the National Health Insurance House and later on for the National Institute for Health Research and Development, the Ministry of Health, and for the Health Commission at the Romanian Parliament. During this period he had also the opportunity to be part in several projects in collaboration with international organizations (WHO, The World Bank, and the European Commission).

**Publications**

1. National Roma Integration Strategy (NRIS) and other national commitments in respect to Roma Health in Romania [http://equihealth.eea.iom.int/images/NRIS\\_Romania\\_Final.pdf](http://equihealth.eea.iom.int/images/NRIS_Romania_Final.pdf).
2. Multiple determinants and cross-country analysis of avoidable hospitalization in Romania, <http://www.wic-policy-conference.de/>
3. Socio-Economic Analysis Of Burden Of Premature Deliveries In Romania, [http://jaqm.ro/issues/volume-10,issue-2/pdfs/0\\_AD\\_AD\\_IO\\_.pdf](http://jaqm.ro/issues/volume-10,issue-2/pdfs/0_AD_AD_IO_.pdf)

**Eunja Park**

Associate Research Fellow  
Health Policy Research Department  
The Korea Institute for Health and Social Affairs  
Sejong, South Korea

**Biography**

Eunja Park is an Associate Research Fellow at the Korea Institute for Health and Social Affairs. Eunja Park has a research interest in the regional variation in health care and health behaviors. Recently she is conducting a research on regional healthcare variation, which includes a data analysis for healthcare utilization using the National Health Insurance claims data in Korea.

Eunja Park majored in pharmacy in university, and received her master's degree and doctor's degree in public health from the Seoul National University. She has studied pharmaceutical policy affairs and healthcare use in the Korea Institute for Health and Social Affairs.

**Selected Publications**

1. **Eun-Ja Park**, Hyun Soon Sohn, Eui-Kyung Lee, Jin-Won Kwon. Living arrangements, chronic diseases, and prescription drug expenditures among Korean elderly: vulnerability to potential medication underuse. *BMC Public Health*, 2014;14:1284.
2. Hee-Jin Kang, Eunjeong Kang, Min-Woo Jo, **Eun-Ja Park**, Seonyoung Yoon, Eui-Kyung Lee. The Utility score of epilepsy with partial seizure measured by TTO, VAS, and EQ-5D in the general Korean population. *Epilepsy Research*, 2014;108: 963-971.
3. **Eun-Ja Park**, Sung-il Cho, Soong-Nang Jang. Poor health in the Korean older population: Age effect or adverse socioeconomic position. *Archives of Gerontology and Geriatrics*, 2012; 55: 599–604.

## **Christina Petersson**

Specialist in Pediatric Nursing, PhD Student

Research School of Health and Welfare, School of Health Sciences Jönköping University

Jönköping Academy for Improvement of Health and Welfare

Centre for National Quality Registry Services, Southeast region of Sweden

Futurum Academy for Health and Care

Jönköping Sweden

## **Biography**

Christina Petersson is a PhD Student in Health and Caring sciences with focus on Quality improvement in the area of chronic care for children and adolescents. Her research area is about patient reported outcome measures (PROM) and how to use the measures in clinical practice to improve care, with the intention to develop the national quality registries in Sweden. She is working at the Centre for National Quality Registry services in the Southeast region of Sweden. The national Quality Registries are connected to the Centers aiming to support the development and improvement of Quality Registries.

Mrs Petersson has been working nearly 20 years as a RN with special training in Pediatrics at the County Hospital of Ryhov in Jönköping, Sweden. In 2013 she received a grant for GEDS (Global Education and Developmental Studies) at the University at Chapel Hill, NC, USA.

## **Selected Publications**

1. **Petersson C.**, Simeonsson RJ., Enskär K., Huus, K. (2013). Comparing children's self-report instruments for health-related quality of life using the International Classification of Functioning Disability Health for children and youth (ICF-CY). *Qual Life Outcomes* 11:75 <http://www.hqlo.com/content/11/1/75>
2. **Petersson C.**, Hanberger L., Samulesson U., Huus K., Åkesson K. (2013) Use of the national quality registry to monitor health-related quality of life for children with type 1 diabetes – a pilot study, August 23, 2013, doi: 10.1177/1367493513496674 *J Child Health Care March 2015 vol. 19 no. 1 30-42*
3. Darcy L., Granlund M., Simeonsson RJ., **Petersson C.**, Enskär K., Björk, M. (2014). Health and functioning in everyday life of children with cancer: Documenting with the International Classification of Functioning Disability and Health – Children and Youth (ICF-CY). *Child Health Care, Dev.*
4. **Petersson C.**, Åkesson K., Huus K., Enskär K. (2015). Children's experience of an intervention with a structured assessment of health-related quality of life during the patient encounter Submitted to: *J Child Health Care*.

5. **Petersson C.**, Hanberger L., Samuelsson U., Huus, K., Enskär K., Åkesson K. (2015). Health-related quality of life of children with type 1 diabetes in Sweden –self and proxy reports of DISABKIDS. In manuscript.

**Vittoria Polito**

Healthcare Variation and Value Lead  
Public Health England, Institute of Public Health,  
Cambridge, UK

**Biography**

Ms. Vittoria Polito is the newly appointed Healthcare Variation and Value Lead for Public Health England. Ms. Polito has spent a decade working in the public health arena, specifically in the area of data investigation and analysis. Prior to this role Ms. Polito was the Head of Health Information for the eastern region leading on national indicator production, primary care data and investigations in hospital admission for selected procedures of limited clinical effectiveness.

Ms. Polito has led projects ranging from equity of access to different service areas, producing clinically focused joint strategic needs assessments to inform priority setting and commissioning as well supporting projects around service redesign for both primary care trusts and local authorities. More recently Ms. Polito was embedded within NHS England specialised commissioning teams writing national commissioning policies, the most recent being genetic testing to identify carriers of the BRCA gene.

Ms. Polito has a degree from the University of Essex in Cell & Molecular Biology, followed by an MSc in Public Health from the same establishment.



**Milo Puhan**

Professor of Epidemiology and Public Health  
Director of Epidemiology, Biostatistics & Prevention Institute (EBPI)  
University of Zurich  
Zurich, Switzerland

**Biography**

Milo Puhan leads the EBPI of the University of Zurich, which offers a unique combination of academic and public health services. The EBPI carries out or coordinates much of the public health services and campaigns for the largest canton of Switzerland. This public health work is directly informed by the extensive research performed at the institute. The EBPI also trains the next generation of the public health force and researchers through a Master of Public Health, residency and PhD programs. Dr. Puhan has a longstanding interest in patient-centered research for patients with chronic diseases (trials and cohort studies) and works on and applies quantitative methods for benefit harm assessment and evidence synthesis. He is actively engaged in improving health data in Switzerland through improvements of data linkage, data harmonization and closure of data gaps in order to provide an evidence base for health care and public health decisions.

Dr. Puhan serves as president of the expert committee that prepared and will run the National Research Program on Health Services Research of the Swiss National Science Foundation. He serves on multiple journal editorial boards, and cantonal and federal research and public health committees. His research papers have been published in the *Lancet*, *Annals of Internal Medicine*, *JAMA*, or the *BMJ*.

Dr. Puhan received his medical degree from the University of Zurich and his PhD in Epidemiology from the University of Amsterdam. He served on the faculty of the Department of Epidemiology of the Johns Hopkins Bloomberg School of Public Health between 2008 and 2012 before he accepted his current role at the University of Zurich in 2013.

**Selected Publications**

1. **Puhan MA**, et al. A GRADE Working Group approach for rating the quality of treatment effect estimates from network meta-analysis. *BMJ* 2014;349:g5630.
2. Peytremann-Bridevaux I, et al. Mortality of patients with COPD participating in chronic disease management programmes: a happy end? *Thorax* 2014;69(9):865-6
3. Yu T et al. Benefits and harms of roflumilast in moderate to severe COPD. *Thorax*. 2014;69(7):616-22.
4. **Puhan MA.**, et al. Expansion of the prognostic assessment of patients with COPD: the updated BODE index and the ADO index. *Lancet* 2009;374(9691):704-11.

5. **Puhan MA**, et al. Interval vs. Continuous High Intensity Exercise in COPD: A Randomized Trial. *Annals of Internal Medicine* 2006;145:816-25.

**Rosalind Raine**

Professor of Health Care Evaluation  
Head of Department of Applied Health Research  
University College London  
Director, NIHR CLAHRC North Thames  
London, UK

**Biography**

Rosalind is Professor of Health Care Evaluation and Head of the Department of Applied Health Research at UCL, a public health medicine doctor and Assistant Director of R&D at University College London Hospitals NHS Foundation Trust (UCLH). She advises on health strategy internationally, nationally and regionally, and is concerned with improving the quality and the widespread implementation of effective models of care, often in the context of major reorganisation.

Rosalind led the bid to establish the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC), North Thames ([www.clahrc-norththames.nihr.ac.uk](http://www.clahrc-norththames.nihr.ac.uk)), which she now directs. This is the largest CLAHRC in the country, comprising 54 organisations including universities, NHS trusts and CCGs, local authorities and industry to deliver a step change in prompt evaluation and implementation of major health care and public health innovations.

Rosalind's other appointments include Scientific Advisor to the World Health Organisation; and Member of a Higher Education Funding Council for England (HEFCE) Research Excellence Framework Panel (whose recommendations determine the distribution of Government funding to UK universities). She holds honorary chairs at the London School of Hygiene & Tropical Medicine and Queen Mary, University of London, sits on international research advisory boards and has experience of advising the UK Department of Health and European Union policy makers and MEPs.

Before taking up her Chair at UCL, Rosalind held academic positions at LSHTM; public health medicine positions in London and Brighton, and worked as a junior doctor in tertiary, secondary and primary care.

**Selected Publications**

1. Wardle J, Von Wagner C, Kralj Hans I, Halloran S, Smith S, McGregor L, Vart G, Howe R, Snowball J, Handley G, Logan R, Rainbow S, Smith S, Thomas M, Counsell N, Morris S, Duffy S, Hackshaw A, Moss S, Atkin W, **RAINE R**. Reducing the socioeconomic gradient in uptake of colorectal cancer screening in the English NHS Bowel Cancer Screening Programme: results from four randomised controlled trials with 747,856 participants. *Lancet* 2015 *in press*

2. Bajekal, M., Scholes, S., Love, H., Hawkins, N., O'Flaherty, M., **RAINE, R**, Capewell, S. Analysing recent socioeconomic trends in coronary heart disease mortality in England, 2000-2007: a population modelling study. *PLoS Med* 2012, 9(6): e1001237. doi:10.1371/journal.pmed.100123
3. **RAINE R**, Scholes S, Wong W, Ashton C, Obichere A, Ambler G. Social variations in access to hospital care for patients with colorectal, breast and lung cancer between 1999 and 2006: a retrospective analysis of Hospital Episode Statistics BMJ 2010;340:b5479. doi: 10.1136/bmj.b5479
4. McBride D, Hardoon S, Walters K, Gilmore S, **RAINE R**. Explaining variation in referral from primary to secondary care- a cohort study. BMJ 2010; 341:c6267 doi: 10.1136/bmj.c6267
5. **RAINE R**. Wong W, Ambler G, Hardoon S, Petersen I, Morris R, Bartley M, Blane D. Examination of socio-demographic variations in the contribution of secondary drug prevention to stroke survival at middle and older ages. BMJ 2009;338:b1279 doi:10.1136/bmj.b1279

**Shawn Ralston**

Associate Professor of Pediatrics  
Geisel School of Medicine, Dartmouth College  
Section Chief, Department of Pediatrics  
Dartmouth-Hitchcock Medical Center  
Hanover, New Hampshire, USA

**Biography**

Dr. Ralston is section chief of Hospital Pediatrics at Dartmouth-Hitchcock Medical Center as well as Editor-in-Chief of Hospital Pediatrics, an American Academy of Pediatrics scholarly journal. Her primary research interest is in acute viral bronchiolitis and she recently chaired the AAP clinical practice guideline committee for that disease. Her research is motivated by a desire to reduce waste due to overtreatment in pediatrics and she has worked with Dr. David Goodman describing variation in pediatric care in northern New England.

Dr. Ralston received a master's degree in health care leadership from the Dartmouth Institute for Health Policy and Clinical Practice, a medical degree from a Texas A&M University and a master's degree in anthropology from the University of Texas at Austin. She did a pediatric internship at Duke University and residency at the University of New Mexico.

**Selected Publications**

1. **Ralston S**, Garber M; Rice-Conboy E, Mussman G, Walley S, Shadman K, Nichols E. A Multicenter Collaborative to Reduce Unnecessary Care in Inpatient Bronchiolitis. *Pediatrics* 2015; in press.
2. **Ralston SL**, Lieberthal AS, Meissner HC, Alverson BK, Baley JE, et al. Clinical Practice Guideline: The Diagnosis, Management, and Prevention of Bronchiolitis. *Pediatrics* 2014; 134(5):e1474-502.
3. **Ralston S**, Comick A, Nichols E, Parker D, Lanter P. Effectiveness of Quality Improvement in Hospitalization for Bronchiolitis: A Systematic Review. *Pediatrics*. 2014;134(3):571-81.
4. **Ralston S**, Garber M, Narang AS, Shen M, Pate B, et al. Reducing unnecessary utilization in acute bronchiolitis care: Results from the value in inpatient pediatrics network. *Journal of Hospital Medicine*. 2013;8:25-30.
5. Goodman DC, Morden NE, **Ralston SL**, Chang CH, Parker DM, Weinstein SJ. *The Dartmouth Atlas of Children's Health Care in Northern New England*. Trustees of Dartmouth College: Hanover, NH. December 2013.

**Ingvild Mathiesen Rosenlund, MD**

PhD student

Department of Clinical Medicine

UIT The Arctic University of Norway

Tromsø, Norway

**Biography**

Ingvild Mathiesen Rosenlund is a medical doctor and a PhD student. She started her PhD program with a special interest in overtreatment and utilization of health care. This has so far led to a study on geographical variation related to diverticular disease of the intestine in addition to a study on the need of diagnostic imaging of all urolithiasis patients.

Rosenlund received her medical degree from the UIT The Arctic University of Norway and worked briefly as a resident at the Department of Cardiothoracic Surgery at the University hospital of North Norway before starting her PhD program.

**Klaudia Sandholzer**

Evidence-based Economic Health Care Department  
Main Association of Austrian Social Security Institutions  
Vienna, Austria

**Biography**

Attended Medical University of Innsbruck and Vienna 1983 – 1993, with Doctor's degree from the Medical University of Vienna. General Practice trained at Kaiser-Franz-Josef-Hospital, Vienna from 1996 to 1999.

As of 2014, a team member within the Evidence-based Economic Health Care Department of the Main Association of Austrian Security Institutions. Employed within the Regional health insurance organisation for Vienna from 2004 to 2014, and 2000 to 2004 worked as a freelance journalist and editor for a medical journal. Experience as a Research Associate and diabetes educator within the Department of Medicine at the Rudolfstiftung Hospital, Vienna.

Additionally, working towards a Master's Degree in Epidemiology at the Johannes Gutenberg University in Mainz, Germany.

**Noriko Sasaki**

Senior Lecturer

Department of Healthcare Economics and Quality Management

Kyoto University Graduate School of Medicine

Kyoto, Japan

**Biography**

Noriko Sasaki is a cardiologist for more than 10 years of clinical experience including working at the former National Cardiovascular Center (now the National Cerebral and Cardiovascular Center), Osaka, with a special interest in heart failure. She received her PhD from Kyoto University Graduate School of Medicine in 2014. Now, she currently serves as a Senior Lecturer at Department of Healthcare Economics and Quality Management, Kyoto University Graduate School of Medicine, Japan. Also, she is a member and a fellow of the International Society for Quality in Health Care (ISQua).

Her research interests focus on assessing and improving quality in healthcare systems, and she is now involved in various projects such as investigating the evidence-practice gap in the context of the actual usage of clinical practice guidelines, supporting healthcare providers to improve their problems based on data analyses, and examining the healthcare disparities among hospitals/regions under “super-aged” society Japan with large-scale and diverse databases.

**Selected Publications**

1. **Sasaki N**, Kunisawa S, Otsubo T, Ikai H, Fushimi K, Yasumura Y, Kimura T, Imanaka Y. The relationship between the number of cardiologists and clinical practice patterns in acute heart failure — A cross-sectional observational study. *BMJ Open* 2014 Dec 30;4(12):e005988
2. **Sasaki N**, Lee J, Park S, Umegaki T, Kunisawa S, Otsubo T, Ikai H, and Imanaka Y. Development and validation of an acute heart failure-specific mortality predictive model based on administrative data. *Canadian Journal of Cardiology*. 29, 1055–61, 2013.
3. Goto E, Lee J, **Sasaki N**, Imanaka Y. Factors affecting regional variations in hospitalization expenditures of elderly residents in Japan. *Journal of Public Health* 2014 Volume 22, Issue 4, pp 361-370
4. Park S, **Sasaki N**, Morishima T, Ikai H, Imanaka Y. The number of cardiologists, case volume and in-hospital mortality in acute myocardial infarction patients. *International Journal of Cardiology* . 168, 4470–1, 2013.
5. Otsubo T., Imanaka Y., Morishima T., **Sasaki N.**, Park S., Lee J. Variations in Healthcare Spending and Quality among Institutions. In: Sobolev B Ed. *Handbook of Health Services Research*. Springer; 2015 [Electronic publication ahead of print from 2014].



**Laura Schang**

Department of Management  
London School of Economics and Political Science  
London, UK

**Biography**

Laura Schang recently defended her PhD thesis at the London School of Economics and Political Science. The constructive use of information on variations in healthcare is often hindered by the lack of a clear standard to evaluate what is “good” and “poor” performance. In her PhD thesis, Laura investigated options to address this ambiguity about the standard for evaluation in analyses of variations. She finds that both improved technical tools and social and political processes are required in order to move from the measurement of variations to the identification and management of unwarranted variations in health system performance.

She critically reviewed the concept of population capacity to benefit as a possible benchmark to identify unwarranted variations in healthcare. Her research also focused on developing an epidemiological model to investigate unwarranted variation in otitis media with effusion and on applying this model to clinical guidelines from the UK and the U.S. Laura further examined experimentalist and hierarchist models of setting performance targets in Scotland, explored healthcare applications of a robust approach to ranking organisations, and evaluated healthcare payers’ responses to the NHS Atlas of Variation in England for NHS Right Care.

She holds an MSc in International Health Policy/Health Economics from the LSE, a BSc in European Public Health and an Honours Research Certificate in Governance of Healthcare Innovations from Maastricht University.

**Selected Publications**

1. **Schang, L**, De Poli, C, Airolidi, M, Morton, A, Bohm, N, Lakhanpaul, M, Schilder, A, Bevan, G. (2014). Using an epidemiological model to investigate unwarranted variation: the case of ventilation tubes for OME in England. *The Journal of Health Services Research & Policy* 19(4): 236-44.
2. **Schang, L**, Morton, A., DaSilva, P., & Bevan, G. (2014). From data to decisions? Exploring how healthcare payers in England respond to the NHS Atlas of Variation in Healthcare. *Health Policy* 114 (1): 79-87.
3. Thomson, S., **Schang, L**, & Chernew, M.E. (2013). Value-Based Cost Sharing In The United States And Elsewhere Can Increase Patients’ Use Of High-Value Goods And Services. *Health Affairs*, 32, 704-712.

4. **Schang, L**, Waibel, S, & Thomson, S. (2013). Measuring care coordination: health system and patient perspectives. Report prepared for the Main Association of Austrian Social Security Institutions. London: LSE Health.
5. **Schang, L.**, Cypionka, T., & Thomson, S. (2013). Strengthening care coordination: comparative analysis of reform implementation in Austria and Germany, with options for Austria. Report prepared for the Main Association of Austrian Social Security Institutions. London: LSE Health.

**Jessica Sheringham**

Senior Research Associate  
University College London  
London, United Kingdom

**Biography**

Jessica Sheringham is a Senior Research Associate at University College London in England. She works in the Research Partnership Team for NIHR CLAHRC North Thames, a collaboration across academic, health and other partners to improve patient and population outcomes across the geographic area. She is also a Fellow of the Faculty of Public Health, holds an honorary Consultant in Public Health contract with Clinical Commissioning Groups in North East London and until 2014, was a Visiting Fellow at the Nuffield Trust (a health think-tank in England).

Jessica's interest in applied health research began whilst working at England's healthcare regulator, the Healthcare Commission (now the Care Quality Commission), where she developed and evaluated methods for monitoring healthcare quality in the NHS. Her current focus is on research questions that can have an impact on reducing inequalities in healthcare and access to appropriate healthcare. She completed a Medical Research Council Fellowship/PhD at UCL, examining socioeconomic inequalities in access to chlamydia testing in young people in December 2011. Her research now spans different medical specialties using both qualitative and quantitative data collection and analysis methods. She is, at present, involved in studies examining pathways to a cancer diagnosis and studies of care for chronic obstructive pulmonary disease (COPD) from both patient and professional perspectives, all through an inequalities lens.

**Selected Publications**

1. **Sheringham, J.**, Georghiou, T., Chitnis, X., Bardsley, M. (2014). Comparing primary and secondary healthcare use between diagnostic routes before a colorectal cancer diagnosis: Cohort study using linked data. *BJ Cancer*. DOI:10.1038/bjc.2014.424
2. Lewis, G. **Sheringham, J.** Lopez-Bernal, J. & Crayford, T. (2014), *Mastering Public Health*. 2nd edition. CRC Press, London
3. **Sheringham, J.**, Mann, S., Simms, I., Stafford, M., Hart, G.J., Raine, R. (2013). It matters what you measure: a systematic literature review examining whether young people in poorer socioeconomic circumstances are more at risk of chlamydia. *Sex Transm Infect*; 89:175-80.
4. **Sheringham, J.** Baraitser, P., Simms, I., Hart, G., Raine, R. (2012). Chlamydia screening in England: a qualitative study of the narrative behind the Policy. *BMC Public Health*; 12:317.
5. **Sheringham, J.** (2010). Screening for Chlamydia. *BMJ*; 340:c1698.

**Matthew Skellern**

Fellow in Health Economics  
Department of Social Policy  
London School of Economics  
London, UK

**Biography**

Matthew Skellern is a Fellow in Health Economics in the Department of Social Policy at the London School of Economics. He received his PhD from the Department of Economics at the London School of Economics in 2015, for a Dissertation on the economics of public services provision, with a particular focus on health care provision within the English NHS. Current areas of active research include the effects of targets regimes, patient choice of hospital and GP surgery, and independent sector providers within the English NHS.

Matthew has a particular interest in using new indicators of hospital quality, such as Patient Reported Outcome Measures, to measure the effect of market-based reforms to health care systems. Outside of health care, he also has conducted research within the fields of environmental economics, behavioural economics, and the economics of non-profit organisations.

**Publications**

1. [With R.G. Bevan] (2011), 'Does competition between hospitals improve clinical quality? A review of evidence from two eras of competition in the English NHS', *British Medical Journal* 343:d6470.
2. [With Zack Cooper and Stephen Gibbons] (2015), 'Independent Sector Treatment Centres in the English NHS: Effects on neighbouring NHS hospitals', mimeo
3. (2015), 'The hospital as a multi-product firm: Measuring the effect of hospital competition on quality using Patient-Reported Outcome Measures', mimeo
4. [With Sarah Sandford] (2015), '*Do do-gooders do good? Busan, ideologues and occupational choice*', mimeo

**Arnfinn Hykkerud Steindal**

Researcher

SKDE, Center for Clinical Documentation and Evaluation

Tromsø, Norway

**Biography**

Arnfinn Hykkerud Steindal is researcher at the Center for Clinical Documentation and Evaluation (SKDE) in Tromsø, Norway. In his current job at SKDE, Dr. Steindal is analysing data from the Norwegian Patient Registry with a focus on unwarranted geographical variation in health care.

Dr. Steindal is originally a biophysicist, receiving his master degree in Biophysics and Medical Technology from the Norwegian University of Science and Technology (NTNU) in 2005. In 2013, he defended his PhD in Quantum Chemistry at the University of Tromsø, the Arctic University of Norway. Up to November 2014 he held a postdoctoral position at the same university.

In January 2015, SKDE published a day surgery atlas of variation, looking at the 12 most common surgical interventions in Norway. This autumn, a paediatric atlas of variation will be published and Dr. Steindal is, at the moment, working on this.

**Thérèse A. Stukel, PhD**

Professor of Health Policy, Management & Evaluation and Biostatistics, University of Toronto  
Senior Scientist, Institute for Clinical Evaluative Sciences, Toronto, Canada

Professor, The Dartmouth Institute for Health Policy and Clinical Practice, Hanover NH USA

**Biography**

Thérèse A. Stukel, PhD, is a biostatistician focusing on health services and health policy research. She was statistical director of the Dartmouth Atlas of Health Care from 1995 to 2003 and co-authored two influential publications on the U.S. healthcare system demonstrating that higher healthcare spending did not lead to better outcomes, and a recent publication showing that in Canada, higher spending hospitals was associated with better outcomes for acute care patients. Other research interests are the analyses of observational studies, particularly the use of instrumental variables to remove unmeasured confounding and survival bias.

Her current research interests are on the effects of health system resources and organization on delivery of care and outcomes in Canada and the U.S., including international comparative studies. With the support of a Canadian CIHR Team Grant, she has created Ontario Multispecialty Physician Networks, virtual physician networks that mimic Accountable Care Organizations (ACOs), and is evaluating their efficiency (quality vs. costs) in managing patients with chronic disease. She has published over 180 peer-reviewed articles in medical and statistical journals. She was nominated Fellow of the American Statistical Association in 2007.

**Selected Publications**

1. Corallo AN, Croxford R, Goodman DC, Bryan E, Srivastava D, **Stukel TA**. A systematic review of medical practice variation in OECD countries. *Health Policy* 2014;114:5-14. Special issue on "Geographic Variation in Health Care – 40 Years of "Small-Area Variation".
2. **Stukel TA**, Glazier RH, Schultz SE, Guan J, Zagorski BM, Gozdyra P, Henry DA. Multispecialty physician networks in Ontario. *Open Medicine* 2013; 7(2):40-55.
3. **Stukel TA**, Fisher ES, Alter DA, et al. Association of hospital spending intensity with mortality and readmissions in Ontario hospitals. *JAMA* 2012; 307(10):1037-45.
4. **Stukel TA**, Fisher ES, Wennberg DE, et al. Analysis of observational studies in the presence of treatment selection bias: effects of invasive cardiac management on AMI survival using propensity score and instrumental variable methods. *JAMA*. 2007;297(3):278-285.
5. **Stukel TA**, Lucas FL, Wennberg DE. Long-term outcomes of regional variations in intensity of invasive vs. medical management of Medicare patients with acute myocardial infarction. *JAMA*. 2005; 293(11):1329-1337.

**Leonie Sundmacher**

Head, Department of Health Services Management  
Ludwig Maximilians University  
Munich, Germany

**Biography**

Leonie Sundmacher graduated from the University of York with a MSc in Health Economics and from the Free University in Berlin with a MA in Political Science. After working for the Health Economics Research Group at Brunel University in London, she joined the Department of Health Care Management in Berlin to work as a senior research fellow. In 2009 Leonie completed her PhD in Health Economics from the Berlin University of Technology and was appointed Assistant Professor for Economics of Primary Care three years later. Since October 2013 Leonie is the head of the Department of Health Services Management at the Ludwig Maximilians University in Munich. Her main research interests are management in health care, quality management and regional health care research.

**Selected Publications**

1. **Sundmacher L**, Kopetsch T (2014): The impact of office-based care on hospitalizations for ambulatory care sensitive conditions. *European Journal of Health Economics*, in press
2. Vogt V, Siegel M, **Sundmacher L** (2014): Examining regional variation in the use of cancer screening in Germany. *Social Science & Medicine*, in press
3. **Sundmacher L** (2012): Trends and levels of avoidable mortality among districts: "Healthy" benchmarking in Germany. *Health Policy*
4. **Sundmacher L** (2012): The effect of health shocks on smoking and obesity. *European Journal of Health Economics*. 13(4): 451-460
5. **Sundmacher L**, Busse R (2011): The impact of physician supply on avoidable cancer mortality in Germany. *Health Policy* 103: 53-62

**Dr. Philipp Storz-Pfennig**

Consultant, Department for Medicine  
GKV-Spitzenverband  
Berlin, Germany

**Biography**

Dr. Storz-Pfennig holds master degrees in Sociology and Public Health and a Doctors degree in, effectively, clinical epidemiology. After working for a privately owned health research institute (IGES GmbH, Berlin) up to 2009 in a number of health research related areas (technology assessment, health services research), he currently is with the GKV-Spitzenverband [National Association of Statutory Health Insurance Funds].

Research and management expertise and interests include (Health) Technology Assessment, Quality Improvement and Health services research, with a focus on health system wide application of process of generation and application of necessary knowledge needed in those fields.

Dr. Storz-Pfennigs special interests in practice variation relates to explaining and reducing unwarranted variation with a focus on impact of effectiveness research about established practice within the broader variation context.

**Selected Publications**

1. Storz-Pfennig P, Schmedders M, Dettloff M. Trials are needed before new devices are used in routine practice in Europe. BMJ. 2013 Mar 18;346:f1646
2. Storz-Pfennig P. Geografische Variationen in der stationären Versorgung. Internationale Erfahrungen [Geographic variation in hospital care. International experiences], in: Krankenhausreport 2012; ed. AOK-Bundesverband, Schattauer 2012, p. 33-44 [in German with an English abstract]
3. Storz-Pfennig P. OECD Project on "Medical Practice Variations". Country Report Germany [in: OECD 2014. Geographic Variations in Health Care. What Do We Know and What Can Be Done to Improve Health System Performance? (p. 245-266).
4. Storz-Pfennig P, Wolf K. Biomarkers in early breast cancer and beyond: who needs all those tests? The Lancet Oncology. 2014;15(9):919-20.
5. Storz-Pfennig P. Colorectal cancer metastases: evaluate current practice before introducing the "next new thing". BMJ. 2014;348:g3729.



**Andreas H Taenzer**

Associate Professor of Anesthesiology and Pediatrics  
Director, The Dartmouth Patient Deterioration Prediction Laboratory  
Co-Lead, High Value Healthcare Collaborative Sepsis Project  
Geisel School of Medicine at Dartmouth  
Hanover, New Hampshire, USA

**Biography**

Andreas H. Taenzer is Associate Professor of Anesthesiology and Pediatrics at the Geisel School of Medicine at Dartmouth; Director of the Dartmouth Patient Deterioration Prediction Laboratory; and Co-Lead of the High Value Healthcare Collaborative (HVHC) Sepsis Project. Dr. Taenzer has a long standing research interest in patient safety. His work on inpatient surveillance has been featured on the featured innovation website of the Agency for Healthcare Research and Quality (AHRQ) and has been adopted by hospitals as close as neighboring Vermont to Singapore.

Dr. Taenzer is the Co-Lead of the HVHC sepsis project. HVHC is a collaboration of 19 healthcare organizations, touching the lives of 70 million US-Americans. This effort has measured and reduced variation in recommended delivery of the evidence based best intervention for sepsis. He has lead the efforts in sepsis care at his own institution, improving compliance with recommended care dramatically, thereby reducing mortality and reducing cost. Dr. Taenzer serves as a reviewer for Journals such as the Journal of the Joint Commission, BMJ and Anesthesiology.

Dr. Taenzer received his medical degree from Medical University at Luebeck in Germany and his master's degree in evaluative clinical sciences from Dartmouth College. He served his residency in anesthesiology at Maine Medical Center and received specialty training in Pediatric Anesthesiology at Harvard.

**Selected Publications**

1. **Taenzer A**, Pyke J, McGrath S, Blike G. Impact of Pulse Oximetry Surveillance on Rescue Events and Intensive Care Unit Transfers: A Before-and-After Concurrence Study. *Anesthesiology* 112(2), 282-287; 2010.
2. **Taenzer AH**, Pyke JB, McGrath SP. A review of current and emerging approaches to address failure-to-rescue. *Anesthesiology*. 2011 Aug;115(2):421-31.
3. Pyke J, **Taenzer AH**, Renaud CE, McGrath SP. Developing a continuous monitoring infrastructure for detection of inpatient deterioration. *Joint Commission Journal on Quality and Patient Safety*. 2012;38(9):428-431.

4. **Taenzer AH**, Blike GT. Patient Surveillance - The Dartmouth Experience. APSF Newsletter. 2012;Spring-Summer:1-4
5. **Taenzer AH**, Pyke J, Herrick M, Dodds T, McGrath S. A Comparison of Oxygen Saturation Data in Inpatients with Low Oxygen Saturation Using Automated Continuous Monitoring and Intermittent Manual Data Charting. Anesth Analg 2014 Feb;118(2):326-31

**Anne Høy Seemann Vestergaard**

MD/PhD Student

Department of Clinical Epidemiology

Aarhus University Hospital

Aarhus, Denmark

**Biography**

Anne Høy Seemann Vestergaard finished her Bachelor of Science (BSc) in Medicine and started studies for Master's degree in Medicine in 2013.

Since third year of medical school, Anne has been working together with the Department of Clinical Epidemiology, Aarhus University Hospital parallel with her medical studies. In June 2015, she finished a full-time intercalated research year at the department.

In July 2015, she attended the combined study for a Doctorate of Medicine and of Philosophy (MD/PhD study) at Aarhus University in collaboration with Department of Clinical Epidemiology and Department of Oncology, Aarhus University Hospital. The PhD project is about end-of-life care and the role of underlying illness and socioeconomic status.

Anne was offered oral presentation at the European Association of Palliative Care Congress in May 2015 and at the forthcoming European Society of Intensive Care Medicine Annual Congress in October 2015.

**Publications**

1. Geographical variation in use of intensive care: a nationwide study. *Intensive Care Medicine*, 2015

**Dominik Graf von Stillfried**

Managing Director

Central Research Institute of Ambulatory Health Care in the Federal Republic of Germany (ZI)  
Berlin, Germany

**Biography**

Dominik is presently managing director of ZI, the central research institution for ambulatory health care in Germany.

ZI is a charitable foundation supported by the 17 Regional Associations of Statutory Health Insurance Physicians (KVs) in Germany and the Federal Association of Statutory Health Insurance Physicians (KBV) who are responsible for equitable access to ambulatory care for 72 million statutorily insured Germans and for the certification of office-based physicians, certificate-need planning, collective bargaining with third party payers, claims processing, quality management for roughly 140.000 physicians and psychological psychotherapists in Germany.

ZI collects pseudonymised prescription drug data and claims data from all 17 regions in Germany for purposes of health services research.

Dominik has held his present position since 2008. Prior to this he had been head of the Health Policy and Research Division at KBV for ten years, where he had been responsible for the development and introduction of nationwide disease-management programs and of a health risk adjusted physician payment scheme in Germany. Before joining KBV Dominik had been working for statutory health insurance organizations where his responsibilities included the introduction of a series of managed care projects.

Dominik has been trained as a health economist at the Universities of Bayreuth (Germany) and York (UK). He holds a PhD in Economics from the University of Bayreuth which was jointly supervised by Prof. Peter Oberender (Bayreuth) and Michael Arnold (Tuebingen) while Dominik was a research fellow at the medical faculty at the University of Tuebingen (Germany).

**Selected Publications**

1. **Von Stillfried**, Czihal T. (2013), Welchen Beitrag liefern funktional definierte Populationen zur Erklärung regionaler Unterschiede in der medizinischen Versorgung? Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz. 2014 Feb; 57(2):197-206.
2. **Von Stillfried**, Czihal T. (2014), Ärztliche Arbeitszeit beim Orientierungswert berücksichtigen, 01/2014, Deutsches Ärzteblatt

3. **Stillfried, D**, Czihal, T, Jansen, K (2011) Leistungsverlagerungen zwischen Krankenhäusern und niedergelassenen Ärzten – Ein Beitrag zur Methodik der Messung von Verlagerungseffekten und grobe Abschätzung der Bedeutung. Das Gesundheitswesen 73: 124-133
4. M. Schulz, T. Czihal, M. Erhart, **D. Stillfried**, Korrelation zwischen räumlichen Sozialstrukturfaktoren und Indikatoren des medizinischen Versorgungsbedarfs, in: Das Gesundheitswesen, Ausgabe 1/2015, Georg Thieme Verlag, 2015.
5. **Dominik Graf von Stillfried**, Michael Erhart, Thomas Czihal, Ambulante Versorgung, in: Medizinökonomie 1: Das System der medizinischen Versorgung (FOM-Edition), Springer Gabler, 2015, S. 295-350

**Diane Watson**

Chief Executive Officer  
National Health Performance Authority  
Sydney, Australia

**Biography**

Dr Diane Watson is the inaugural Chief Executive Officer of the National Health Performance Authority, taking up the position on 1 June 2012 after being interim CEO since February 2012. The Performance Authority supports health system improvements through independent reporting on the comparable performance of more than 1000 public and private hospitals and primary health care organisations. Its information is available on the MyHospitals and MyHealthyCommunities websites.

Dr Watson was the inaugural Chief Executive Officer of the Bureau of Health Information, established as an independent statutory body by the NSW Government in 2009. She has proven experience in organisations dedicated to independent monitoring and reporting of healthcare organisations and the comparable performance of health systems. She has held senior scientist and management positions for a number of national and state organisations. In 2005, she was a Harkness Fellow in the International Health Policy Program with the Commonwealth Fund.

**Selected Publications**

Dr. Watson has 50+ peer review articles and 100+ public reports on performance of health care systems.

**William B Weeks**

Professor of Psychiatry and of Community and Family Medicine  
The Geisel School of Medicine  
Senior Research Scientist  
The Dartmouth Institute for Health Policy and Clinical Practice  
Hanover, New Hampshire, USA

**Biography**

William B. Weeks, MD, PhD, MBA, is Professor of Psychiatry and of Community and Family Medicine at The Geisel School of Medicine at Dartmouth. There, he works at The Dartmouth Institute for Health Policy and Clinical Practice as a Senior Research Scientist, where he teaches in several masters programs and conducts research on health economics, healthcare value, physician incomes, the complementary and alternative medicine market, and geographic variation in health services utilization in France. He is also Director of Health Services Research at the Palmer Center for Chiropractic Research at Palmer College of Chiropractic in Davenport Iowa. There, he works on how doctors of chiropractic and other complementary and alternative medicine providers supply healthcare services, and how their patients use such services.

Dr. Weeks has published over 150 peer-reviewed manuscripts examining economic and business aspects of rural veterans' health care services utilization and delivery, physicians' return on educational investment, and health care delivery science, including patient safety, quality improvement, Accountable Care Organizations, complementary and alternative medicine, geographic variation, and healthcare value. He received his MD from the University of Texas Medical Branch at Galveston, his MBA from Columbia University, and his PhD in Economics from the Aix-Marseille School of Economics and Management.

**Selected Publications**

1. **Weeks WB**, Jardin M, Dufour J, Paraponaris A, Ventelou B. Geographic variation in admissions for knee replacement, hip replacement, and hip fracture in France: evidence of supplier-induced demand in for-profit and not-for profit hospitals. *Medical Care* 2014; 52(10): 909-17. PMID 25215648.
2. **Weeks WB**, Paraponaris A, Ventelou B. Geographic variation in rates of common surgical procedures in France in 2008-2010 and comparison to the US and Britain. *Health Policy* 2014; 118(2): 215-221. PMID 25260910.
3. **Weeks WB**, Jardin M, Paraponaris A. Characteristics and patterns of elective admissions to for-profit and not-for-profit hospitals in France in 2009 and 2010. *Social Science and Medicine* (in press). PMID: 25841095

4. **Weeks WB**, Venetlou B, Parponaris A. Rates of admission for ambulatory care sensitive conditions in France in 2009-2010: trends, geographic variation, costs, and an international comparison. *European Journal of Health Economics* (in press).



**Gert Westert, PhD**

Professor of Health Services Research and Quality of Care  
Director, Scientific Institute for Quality of Healthcare (IQ healthcare)  
Radboud University Medical Center  
Nijmegen, The Netherlands

**Biography**

Prof. Gert Westert (Msc, PhD) is director of IQ healthcare and full professor Quality of Health Care and Health Services Research at UMC St Radboud, Nijmegen, The Netherlands. IQ healthcare is a scientific centre for research, education and support of quality, safety and innovation in healthcare and one of the leading scientific institutes in this field in Europe. From 2004 - 2010 Westert was Head of the Dutch Health Care Performance Report 2006, 2008, 2010 at the National Institute of Public Health (RIVM) ([www.healthcareperformance.nl](http://www.healthcareperformance.nl)).

His background is medical sociology and research methodology/ statistics. Topics of interest: Health Systems and Health Care Performance; International comparisons of access and quality of health care ; Medical practice variation; Disparities in use of health care resources and health. He has 20 years of experience as a health services research and published more than 100 papers in various journals. He is member of the editorial board of the International Journal for Quality in Health Care and Health Services Research (BMC). Westert is editor of the book "Morbidity, Performance and Quality in Primary Care (2006, Radcliffe; Oxford/ Seattle) and co-author of three university text books in the field of Public Health, Health Services Research, and Health Economics. In 2010 Westert was honored with a Hood Fellowship by the University of Auckland, New Zealand where he spent two months as visiting professor.

**Selected Publications**

1. Effects of regulated competition on key outcomes of care: Cataract surgeries in the Netherlands. Heijink R, Mosca I, **Westert GP**. Health Policy. 2013 Jul 1. pii: S0168-8510(13)00165-6.doi: 10.1016/j.healthpol. 2013.06.003.
2. Variation in formulary adherence in general practice seems constant over time (2003-07). Van Dijk L, de Jong JD, **Westert GP**, de Bakker DH. Fam Pract. 2011 Jul 25.
3. Commentary: the Dutch approach to unwarranted medical practice variation. **Westert GP**, Faber M. BMJ. 2011 Mar 17;342:d1429. doi: 10.1136/bmj.d1429.

4. Rendering hospital budgets volume based and open ended to reduce waiting lists: does it work? Van de Vijzel AR, Engelfriet PM, **Westert GP**. Health Policy. 2011 Apr;100(1):60-70.
5. Do guidelines create uniformity in medical practice? de Jong JD, Groenewegen PP, Spreeuwenberg P, Schellevis F, **Westert GP**. Soc Sci Med. 2010 Jan;70(2):209-16. Epub 2009 Oct 29.

**Philip Wilcock**

Analyst

NHS England

Redditch, UK

### **Biography**

Phil has worked for 30 years as an analyst in the NHS and Department of Health in England. He has worked at local, regional and national levels. Most of his early career was spent in performance management and planning. In the last few years, Phil has worked in a small team, initially based at the Department of Health and now NHS England, to develop resources to help commissioners make more informed health investment decisions.