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7 mai 2015 / May the 7th, 2015

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Sommaire

Assurance Maladie / Health Insurance

Fronstin P., Elminger A (2014). Findings from the 2014EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey. Washington : EBRI

Abstract: This paper presents findings from the 2014 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS). This study was based on an online survey of 3,887 privately insured adults ages 21-64 that was designed to provide nationally representative data regarding the growth of consumer-driven health plans (CDHPs) and high-deductible health plans (HDHPs) and the impact of these plans and consumer engagement more generally on the behavior and attitudes of adults with private health insurance coverage. Findings from this survey are compared with findings from the 2005-2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey, and the 2008-2013 CEHCS. The 2014 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey finds that 15 percent of the privately insured population was enrolled in a consumer-driven health plan (CDHP); 11 percent was enrolled in a high-deductible health plan (HDHP); and 74 percent was enrolled in more traditional coverage. Overall, 26 million individuals with private insurance were enrolled in a CDHP--a health plan associated with a health savings account (HSA) or health reimbursement arrangement (HRA), or an HSA-eligible health plan. This study finds evidence that adults in a CDHP and those in an HDHP were more likely than those in a traditional plan to exhibit a number of cost-conscious behaviors. Specifically, those in a CDHP were more likely than those with traditional coverage to say that they had checked whether the plan would cover care; asked for a generic drug instead of a brand name; talked to their doctors about prescription options and costs; checked the price of a service before getting care; asked a doctor to recommend less costly prescriptions; talked to their doctors about other treatment options and costs; developed a budget to manage health care expenses; and used an online cost-tracking tool provided by the health plan. There is also some evidence that adults in a CDHP were more likely than those in a traditional plan to be engaged in their choice of health plan. Specifically, those in a CDHP were more likely than those with traditional coverage to say that they had attended a meeting where health plan choices were explained; consulted with their employer's human resources (HR) staff about health plan choices; and were more likely to have consulted with an insurance broker to understand plan choices. The survey also finds that CDHP enrollees were more likely than traditional-plan enrollees to take advantage of various wellness programs, such as health-risk assessments, health-promotion programs, as well as biometric screenings. In addition, financial incentives mattered more to CDHP enrollees than to traditional-plan enrollees.
http:papers.ssrn.com/sol3/papers.cfm?abstract_id=2540307

Bronfman M. (2014). Universal health insurance under a dual system, evidence of adverse selection against the public sector: the case of Chile. Münich : MRPA

Abstract: This paper examines health insurance choice and its dynamics using panel data from Chile's National Socio Economic Characterization Survey 1996-2001-2006. Evidence indicates that private insurance is losing customers to the public sector. Two different logistic models are used to explain the determinants of insurance choice as well as what drives the decision to move from the private to the public sector and vice versa. Income is a highly important determinant of choice, as well as age, education, geographical location and health status. Evidence of adverse selection against the public sector was found in both decision models. The results of this paper are in line with most of the previous investigations done on Chile's health insurance system but it advance previous knowledge on the topic by including the dynamism and power for causal inference that panel data permits.
http:mpra.ub.uni-muenchen.de/63262/1/MPRA_paper_63262.pdf

Bump J., Sparkes S. ,Tatar M., et al. (2014). Turkey on the Way of Universal Health Coverage through the Health Transformation Program (2003-13). Washington, DC : World Bank

Abstract: In 2003 Turkey initiated a series of reforms under the Health Transformation Program (HTP) that over the past decade have led to the achievement of universal health coverage (UHC). The progress of Turkey's health system has few — if any — parallels in scope and speed. Before the reforms, Turkey's aggregate health indicators lagged behind those of OECD member states and other middle-income countries. The health financing system was fragmented, with four separate insurance schemes and a "Green Card" program for the poor, each with distinct benefits packages and access rules. Both the Ministry of Labor and Social Security and Ministry of Health (MoH) were providers and financiers of the health system, and four different ministries were directly involved in public health care delivery. Turkey's reform have resulted in the rapid expansion of the proportion of the population covered and of the services to which they are entitled. At the same time, financial protection has improved. For example, (i) insurance coverage increased from 64 to 98 percent between 2002 and 2012; (ii) the share of pregnant women having four antenatal care visits increased from 54 to 82 percent between 2003 and 2010; and (iii) citizen satisfaction with health services increased from 39.5 to 75.9 percent between 2003 and 2011. Despite dramatic improvements there is still space for Turkey to continue to improve its citizens' health outcomes, and challenges lie ahead for improving services beyond primary care.

(2014). L'essentiel du RSI en chiffres - Données 2013. *L'Essentiel du Rsi en Chiffres (Rsi)*

Abstract: L'Essentiel 2013 constitue, comme les éditions précédentes, un document de référence permettant de disposer des principales statistiques caractérisant les assurés du régime – démographie, revenus, cotisations, prestations – et d'en mesurer leurs évolutions en écho aux profondes mutations socio-économiques que vivent les travailleurs indépendants.
https:www.rsi.fr/uploads/tx_rsirss/20141219_Essentiel_full.pdf

Haviland A.M. , Eisenberg D.M., Mehrotra A. (2015). Do "Consumer-Directed" Health Plans Bend the Cost Curve Over Time? Cambridge : NBER

Abstract: “Consumer-Directed” Health Plans (CDHPs) combine high deductibles with personal medical accounts and are intended to reduce health care spending through greater patient cost sharing. Prior research shows that CDHPs reduce spending in the first year. However, there is little research on the impact of CDHPs over the longer term. We add to this literature by using data from 13 million individuals in 54 large US firms to estimate the effects of a firm offering CDHPs on health care spending up to three years post offer. We use a difference-in-differences analysis and to further strengthen identification, we balance observables within firm, over time by developing weights through a machine learning algorithm. We find that spending is reduced for those in firms offering CDHPs in all three years post. The reductions are driven by spending decreases in outpatient care and pharmaceuticals, with no evidence of increases in emergency department or inpatient care.
http:www.nber.org/papers/w21022

Bunnings C., Schmitz (h.), Tauchmann H., et al. (2015). How Health Plan Enrollees Value Prices Relative to Supplemental Benefits and Service Quality. Berlin : DIW

Abstract: This paper empirically assesses the relative role of health plan prices, service quality and optional benefits in the decision to choose a health plan. We link representative German SOEP panel data from 2007 to 2010 to (i) health plan service quality indicators, (ii) measures of voluntary benefit provision on top of federally mandated benefits, and (iii) health plan prices for almost all German health plans. Mixed logit models incorporate a total of 1,700 health plan choices with more than 50

choice sets for each individual. The findings suggest that, compared to prices, health plan service quality and supplemental benefits play a minor role in making a health plan choice. http:www.diw-berlin.de/documents/publikationen/73/diw_01.c.498507.de/diw_sp0741.pdf

(2015). Statistiques des risques professionnels des salariés agricoles : Données nationales 2013. Bagnolet : CCMSA .

Abstract: Ce document présente le contexte statistique des risques professionnels des salariés agricoles en 2013. L'évolution des accidents est étudiée à partir des indicateurs officiels couramment utilisés (taux de fréquence, durée moyenne d'arrêt, ...) par les organismes de sécurité sociale. La nature du risque est appréhendée à partir des données présentes sur la déclaration d'accidents du travail (date de l'accident, caractéristiques de la victime, ancienneté dans l'entreprise, élément matériel, lieu, ...). Enfin, les données présentées sont issues d'une vision en date de paiement des prestations et non d'une vision en date d'événement des accidents.
http:www.msa.fr/lfr/documents/98830/11180475/Statistiques+des+risques+professionnels+des+salari%C3%A9s+agricoles+-+2013

Caby D., Eidelman A. (2015). Quel avenir pour le dispositif de prise en charge des affections de longue durée (ALD) ? *Lettre Trésor Eco,* (145)

Abstract: Face aux coûts que représente le dispositif de prise en charge des affections de longue durée, cette étude propose une réforme systémique de ce système en régulant la dépense publique et le reste à charge à partir de paramètres à définir (montant du plafond de reste à charge, niveau d'une éventuelle franchise, valeurs des tickets modérateurs...).Selon les auteurs, la prise en charge de la dépense de santé par l'assurance maladie obligatoire à partir de critères économiques rétablirait ainsi l'équité entre les malades, indépendamment de leur pathologie, tout en leur évitant des restes à charges trop élevés.
http:www.tresor.economie.gouv.fr/File/411847

Economie de la santé Health Economics

(2014). Measuring and Forecasting Global Health Expenditures. In R.SCHEFFLER (Ed.), Global Health Economics and Policy : Singapour : World Scientific

Abstract: Section I of this chapter briefly reviews the literature on medical spending, which suggests that health expenditures began small but steadily increased throughout history (from 1 percent to 4 percent of GDP), then began to increase rapidly among wealthier developed countries after 1950. Section II examines temporal and spatial dimensions of measurement, which suggest that the evolution of global health expenditures may be best observed by tracking health expenditures as a share of GDP over decades. Nominal and real per capita amounts are subject to distortions created by lags and currency valuation. Months and years are too short a span, while persons, households and provinces are too small. Section III covers growth in the components of health expenditures (population, income, inflation, excess due to technology and other factors). A model of national health expenditure decisions over time is presented and used to explain empirical findings of varying distributed lag responses to macroeconomic growth and development. Section IV considers the methods and accuracy of national health expenditure forecasting. Section V addresses some problems of variable identification, with specific applications to population aging and the aggregate fiscal burden of care for the elderly. Section VI discusses the sustainability of current trends and the boundaries between long-term care, retirement and medical expenditures. It concludes by proposing

that rising longevity and medical costs are best viewed as aspects of a process of economic and human development transforming the 20th and 21st centuries, rather than as isolated phenomena. The six sections each conclude with a discussion of policy implications, even the most technical sections regarding measurement, aggregation and lags, where the policy implications may not be immediately apparent. While nominal policies are publicly stated, it is often these "technical details" regarding boundary definition, timing and measurement that show how policy actually operates, that shape public opinion, and that drive future financial decisions.
http:papers.ssrn.com/sol3/papers.cfm?abstract_id=2542826

Schurer S. (2015). Lifecycle patterns in the socioeconomic gradient of risk preferences. Berlin : DIW

Abstract: Who is most likely to change their risk preferences over the life course? Using German nationally representative survey data and methods to separate age from cohort effects, we estimate the lifecycle patterns in the socioeconomic gradient of self-reported risk preferences. Tolerance to risk drops by 0.5 SD across all groups from late adolescence to age 40. From mid to old age, risk tolerance continues to drop for the most disadvantaged, while it stabilizes for all other groups. By age 65, the socioeconomic gradient reaches a maximum of 0.5 SD. Extreme risk aversion among the elderly poor has important policy implications.

(2015). Les dépenses de santé sont-elles hors de contrôle ? NOTES SOCIOECONOMIQUES. Montréal : IRIS .
Abstract: Hormis peut-être le niveau d'endettement public, aucune explication n'est plus utilisée que l'évolution des coûts de la sante´ pour justifier l'impossibilité´ de maintenir les services publics tels qu'ils sont offerts au Québec depuis la Révolution tranquille. L'augmentation de ces coûts serait insoutenable à moyen terme, notamment en raison d'un système de santé public trop lourd et inefficace. Dans cette note socio-économique, nous démontrerons en quoi ce point de vue catastrophiste sur les coûts de la sante´ est non seulement réducteur, mais qu'il génère aussi des solutions contre-productives, comme le possible accroissement du rôle du secteur privé.
http://iris-recherche.qc.ca/wp-content/uploads/2015/02/Note_couts_de_la_sante_WEB.pdf

Bojke C, Castelli A., Grasic K. ,et al.. (2015). Productivity of the English NHS: 2012/13 update. York : University of York

Abstract: The National Health Service (NHS) provides care to millions of patients every year, with almost everyone having at least some form of contact with the health service annually. The NHS is also the single largest employer in England, accounting for 1 out of 18 in the workforce (Office for National Statistics 2015). In 2012/13 health spending (including spending by central government departments) amounted to £104 billion and accounted for 7.9 per cent of GDP.1 As such an important part of the economy, it is essential to understand what the NHS achieves from the resources devoted to it. Productivity is one of the key measures against which NHS achievements can be judged and is the focus of this report. We update our previous analyses (Bojke et al. 2012; Bojke et al. 2014), focussing on the change in NHS productivity between 2011/12 and 2012/13, the latter financial year being the latest for which data are available. We follow national accounting conventions to measure the change in productivity over time (Eurostat 2001). This involves comparisons of changes in the total amount of health care 'output' produced with changes in the total amount of 'input' used to produce this output. We construct a set of paired year-on-year comparisons from 2004/05-2005/06 through to 2011/12-2012/13. These paired comparisons are then converted into a chained index that reports productivity change over the entire period. The structure of the report is as follows. The form of the constituent elements of the output and input indices used to construct our productivity measure is presented in section 2. We describe the data used to populate the output and input indices in section 3, detailing the particular challenges that

had to be addressed in comparing data between 2011/12 and 2012/13. The output index is populated in section 4 and section 5 reports the elements of the input index. Section 6 reports the productivity growth figures. A summary and concluding remarks are provided in section 7.
http:www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP110_NHS_productivity_update_2012-13.pdf

Rafenberg C. (2015). Estimation des coûts pour le système de soins français de cinq maladies respiratoires et des hospitalisations attribuables à la pollution de l'air. Collection Etudes et documents ; 122. Paris : Ministère chargé de l'Ecologie

Abstract: La mauvaise qualité de l'air entraîne une augmentation des maladies du système respiratoire. Les principales d'entre elles sont l'asthme, les bronchites aiguës ou chroniques, les cancers des voies respiratoires et les broncho-pneumopathies obstructives chroniques (ou BPCO). La qualité de l'air impacte aussi le système cardio-vasculaire. Ces impacts sont source d'une surmorbidité et d'une surmortalité. Cette étude a pour objet d'approcher au plus près les coûts dans le système de soin français des hospitalisations et des cinq maladies respiratoires les plus répandues attribuables à la pollution de l'air. Les coûts des maladies attribuables à la pollution de l'air sont générés par la prise en charge du patient par le système de soin. On trouve parmi eux des coûts de consultations, de traitements, d'examens ou encore d'hospitalisation, etc. L'étude approche les coûts des prestations sociales versées aux malades en considérant les arrêts de travail. Elle prend donc en compte les prestations médicales et sociales du malade dans le système de soin.
http:www.developpement-durable.gouv.fr/IMG/pdf/ED122.pdf

Sanwald A., Theurl E. (2015). Out-of-pocket payments in the Austrian healthcare system - a distributional analysis. Innsbruck : University of Innsbruck

Abstract: Introduction: Out-of-pocket spending is an important source of healthcare financing even in countries with established prepaid financing of healthcare. However, out-of-pocket payments (OOPP) may have undesirable effects from an equity perspective. In this study, we analyse the distributive effects of OOPP in Austria based on cross-sectional information from the Austrian Household Budget Survey 2009/10. Methods: We combine evidence from disaggregated measures (concentration curve and Lorenz curve) and summary indices (Gini coefficient, Kakwani index, and Reynolds-Smolensky index) to demonstrate the distributive effects of total OOPP and their subcomponents. Thereby, we use different specifications of household ability to pay. We follow the Aronson-Johnson-Lampert approach and split the distributive effect into its three components: progressivity, horizontal equity, and reranking. Results: OOPP in Austria have regressive effects on income distribution. These regressive effects are especially pronounced for the OOPP category prescription fees and over-the-counter pharmaceuticals. Dis- aggregated evidence shows that the effects differ between income groups. The decomposition analysis reveals a high degree of reranking and horizontal inequity for total OOPP, and particularly, for therapeutic aids and physician services. Conclusions: The results - especially those for prescription fees and therapeutic aids - are of high relevance for the recent and on-going discussion on the reform of benefit catalogues and cost-sharing schemes in the public health insurance system in Austria.
https:ideas.repec.org/p/inn/wpaper/2015-05.html

Démographie / Demography

Beaumel C., Bellamy V. (2015). La situation démographique en 2013. *Insee Résultats : Société,* (167)

Abstract: La situation démographique en 2013 permet de cerner en détail la situation actuelle et les évolutions de la population. Cette édition contient des données au niveau de la France métropolitaine mais également au niveau de la France entière (métropole et départements d'outre-mer hors Mayotte). De nombreux tableaux au niveau départemental sont également disponibles. Deux nouveaux tableaux sur la fécondité des hommes ont été ajoutés cette année.
http://www.insee.fr/fr/publications-et-services/irweb.asp?id=irsocsd2013

Etat de santé / Health Status

Denny K. (2015). Has Subjective General Health Declined with the Economic Crisis? A Comparison across European Countries. Beldfield : University College Dublin

Abstract: This note examines whether subjective general health in Europe has changed since the onset of the economic crisis. Subjective general health for Ireland, Spain and Portugal is compared before and after the onset of the recession. Two other European economies, Germany and United Kingdom, are also examined. The change in the proportion of respondents reporting good or very good health is also plotted against the change in the unemployment rate over the period 2007-2012. Subjective general health improves slightly in countries experiencing sharp recessions. Across European countries there is no link between changes in subjective general health and in unemployment: no evidence is found to suggest that the Great Recession has worsened morbidity in Europe.
https:ideas.repec.org/p/ucn/wpaper/201507.html

(2015). Empower Woman. Facing the Challenge of Tobacco Use in Europe. Copenhague : Office des Publications du Bureau Régional de l'Europe

Abstract: L'un des phénomènes les plus marquants que l'on ait pu observer ces deux dernières décennies dans la Région européenne eu égard à la prévalence du tabagisme est l'augmentation incessante de l'usage du tabac chez les femmes et les filles. Ce rapport examine les meilleurs exemples de politiques et de programmes de lutte antitabac à travers le monde. Fort d'un grand nombre d'études de cas portant sur la commercialisation, l'utilisation des médias, le marketing ciblant directement les femmes, la protection contre l'exposition, les services de sevrage et l'étiquetage, le rapport s'adresse à tous ceux qui s'intéressent à la santé publique et à la lutte antitabac. L'objectif d'une Région européenne sans tabac ne peut être atteint sans responsabiliser les femmes et relever les défis posés par la hausse du tabagisme chez les femmes et les filles de la Région (résumé de l'éditeur).
http:www.euro.who.int/__data/assets/pdf_file/0019/271162/EmpowerWomenFacingChallengeTobaccoUse1.pdf

Pikhart H., Pikhartova J. (2015). The relationship between psychosocial risk factors and health outcomes of chronic diseases. A review of the evidence for cancer and cardiovascular diseases. Health Evidence Network (HEN) synthesis report. Copenhague : Office des Publications du Bureau Régional de l'Europe

Abstract: Ce rapport résume les meilleures bases factuelles disponibles afin d'établir un lien entre, d'une part, les facteurs psychosociaux et, d'autre part, la morbidité et la mortalité dues aux maladies cardiovasculaires et au cancer dans la Région européenne de l'OMS. Les auteurs ont examiné un volume total de 1 822 articles publiés en anglais depuis janvier 2000 dans Medline et PubMed, et identifié 37 études systématiques et méta-analyses. Parmi les facteurs psychosociaux reconnus à

maintes reprises comme étant liés aux maladies chroniques, dans le cadre comme en dehors des activités professionnelles, il convient notamment de mentionner les suivants : les exigences élevées au travail, la faible autonomie, le contrôle limité ou l'important déséquilibre entre les efforts consentis et les récompenses, les conflits interpersonnels, ainsi que le faible soutien social ou le manque de confiance. Il ressort des bases factuelles que de multiples facteurs psychosociaux négatifs sont indépendamment associés à tout un ensemble de maladies chroniques à l'âge adulte. En outre, le gradient social en matière de santé observé à l'âge adulte peut en partie intervenir par l'intermédiaire de facteurs psychosociaux agissant entre les caractéristiques socioéconomiques et la santé. Les facteurs psychosociaux peuvent dès lors être pris en compte dans les mesures complexes et totales de réduction des risques principalement axées sur les facteurs de risque multiples (résumé de l'éditeur).
http:www.euro.who.int/fr/publications/abstracts/relationship-between-psychosocial-risk-factors-and-health-outcomes-of-chronic-diseases-a-review-of-the-evidence-for-cancer-and-cardiovascular-diseases-the-2015

Hardcastle A.C., Mounce L.T.A., Richards S.H.,et al (2015). The dynamics of quality: a national panel study of evidence-based standards. *Health Services and Delivery Research,* 3 (11) :

Abstract: People with long-term health conditions do not always receive the health care they need, and so may suffer avoidable poor health. We aimed to find out if the quality of health care received by people in England had improved over 6 years, for four common long-term health conditions: cardiovascular disease (including heart disease and high blood pressure treatment), depression, diabetes and osteoarthritis. We wanted to know if some people got better care than others, and if this was related to things such as their wealth, education or social context. We used information collected by interviewer and nurse visits to the homes of 16,773 people aged 50 years or older who had agreed to take part in a national survey called the English Longitudinal Study of Ageing. They were asked questions about their health, disability, health care, education, employment, money, social lives and well-being in 2004–5, 2006–7, 2008–9 and 2010–11. We found that many people were still not receiving the care they needed, with little change over 6 years. The percentage of good care received for osteoarthritis was only 32%, compared with 83% for cardiovascular disease, 65% for depression and 76% for diabetes. There were no types of people who consistently missed out on care, although people with cognitive impairment received worse care for diabetes. Poorer people with specific illness burden may be less likely than wealthier people to receive a diagnosis, but people with a diagnosis were generally equally likely to get good-quality care.
http:www.journalslibrary.nihr.ac.uk/hsdr/volume-3/issue-11

Sweet M.N., Kanaroglou P.S. (2015). Gender Differences: The Roles of Travel and Time Use in Subjective Well-Being. Hamilton : McMaster Research Data Centre

Abstract: This research employs time use data from the Canadian General Social Survey of 2010 to explore the links between travel, activity participation, and subjective well-being. Policymakers regularly advocate for better life quality, but research on this topic has been more nascent. In this study, structural equation models are estimated to identify links between daily travel times, time use, and subjective well-being (SWB), the extent to which the overall quality of life is positively assessed. Models are estimated independently for men and for women and results suggest important gender differences in how targeting travel and time use outcomes could improve SWB. Results provide evidence that quality of life outcomes could be improved more significantly by shifting policy objectives from conventional travel time savings towards activity participation. While travel time savings feature in transportation policy debates, findings from this study indicate that daily travel times are unassociated with SWB among either gender. But while employed women participate in more time-use incidents per day than employed men, study findings indicate that

participating in more activities is linked with greater SWB among women, but not among men. Using shadow prices of SWB to monetize the value of participating in additional activities, results suggest that modest increases can create valuable SWB-related benefits for women. These marginal benefits are highest for those women currently engaging in few activities and for those from high-income households.
http:socserv.mcmaster.ca/rdc/RDCwp64.pdf

Géographie de la santé / Geography of Health

(2015). Repères sur la santé en Ile-de-France. Paris : ORSIF

Abstract: Ce recueil dresse en introduction un portrait synthétique de l'état de santé à l'échelle de l'Île-de-France. Puis, une sélection d'indicateurs de l'état de santé de la population francilienne et de ses déterminants, construits à partir de sources multiples exploitées par l'ORS Île-de-France, sont présentés en sept chapitres : contexte démographique et social, les pathologies, les comportements de santé, l'environnement physicochimique, la santé au travail et l'offre de soins.
http://www.ors-idf.org/index.php/component/content/article/773

Hôpital / Hospitals

Hof S. F., Fugener A., Schoenfelder J. ,et al. (2015). A Research Agenda for Case Mix Planning in Hospitals.

Augsburg : University of Augsburg

Abstract: The problem of choosing the composition and volume of patients in a hospital is called the case mix planning problem. With many countries having recently changed to reimbursement systems where hospitals are reimbursed for patients according to their diagnosis, case mix planning has become an important tool in strategic and tactical hospital planning. Selecting patients in such a payment system can have a significant impact on a hospital's revenue. The contribution of this article is twofold. On the one hand, we provide the first literature review focusing on the case mix planning problem. We describe the problem, distinguish it from similar planning problems, and evaluate the existing literature with regard to problem structure and managerial impact. On the other hand, we identify gaps in the literature and present ideas that may help to close these gaps. We aim to further initiate research in the field of case mix planning, which only lately has received growing attention despite its fundamental economic impact on hospitals.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2588498

De Lagasnerie G., Paris V.,Mueller M., et al. (2015). Tapering payments in hospitals: Experiences in OECD countries. Paris : OCDE

Abstract: Ce rapport porte sur les politiques de dégressivité tarifaire appliquées au paiement des hôpitaux, c'est-à-dire les mécanismes liant les prix unitaires des services hospitaliers au volume de soins produits. Ce document de travail dresse tout d'abord un panorama de l'offre hospitalière et des modes de paiement des hôpitaux au sein des pays de l'OCDE en étudiant plus spécifiquement le paiement à l'activité. Il présente ensuite une revue des études portant sur les économies d'échelle

dans le secteur hospitalier, justification principale de la diminution des tarifs au-delà d'un seuil de production. Enfin, quatre études de cas en Allemagne, l'État du Maryland, la République tchèque et Israël sont présentées afin d'étudier finement les modalités d'instauration et l'impact de ce mécanisme de contrôle des volumes hospitaliers.

Naylor C., Alderwick H.,Honeyman M. (2015). Acute hospitals and integrated care. From hospitals to health systems. Londres : King's Fund .

Abstract: This report explores the role that acute hospitals can play in integrated care, drawing on learning from five case study sites in England where acute hospital providers have engaged actively with the integration agenda. Although integrated care remains a work in progress across the NHS, elements of the future can be seen today in some of the innovative practices developed within local health economies. The report is based primarily on case study research conducted with the following organisations and their local partners:Northumbria Healthcare NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, Airedale NHS Foundation Trust, Yeovil District Hospital NHS Foundation Trust and the South Warwickshire NHS Foundation Trust.
http:www.kingsfund.org.uk/publications/acute-hospitals-and-integrated-care

Médicaments / Pharmaceuticals

(2015). Access to new medicines in Europe:technical review of policy initiatives and opportunities for collaboration and research. Copenhague : Office des Publications du Bureau Régional de l'Europe

Abstract: This report, with a focus on sustainable access to new medicines, reviews policies that affect medicines throughout their lifecycle (from research and development to disinvestment), examining the current evidence base across Europe. While many European countries have not traditionally required active priority-setting for access to medicines, appraising new medicines using pharmacoeconomics is increasingly seen as critical in order to improve efficiency in spending while maintaining an appropriate balance between access and cost–effectiveness. The study features findings from 27 countries and explores different ways that health authorities in European countries are dealing with high spending on new medicines, including methods such as restrictive treatment guidelines, target levels for use of generics, and limitations on the use of particularly expensive drugs. It also outlines possible policy directions and choices that may help governments to reduce high prices when introducing new drugs.

Liccardo P.R. Powell D. ,Taylor E. (2015). Does Prescription Drug Coverage Increase Opioid Abuse? Evidence from Medicare Part D : Cambridge : NBER

Abstract: Opioid abuse, as measured by deaths involving opioid analgesics and substance abuse treatment admissions, has increased dramatically since 1999, including a 20% increase in opioid-related mortality between 2005 and 2006. This paper examines whether the introduction of the Medicare Prescription Drug Benefit Program (Part D) in 2006 may have contributed to the increase in prescription drug abuse by expanding access to prescription drug benefits among the elderly. We test whether opioid abuse increased not only for the population directly affected by Part D (ages 65+) but also for younger ages. We compare growth in opioid prescriptions and abuse in states with relatively large ages 65+ population shares to states with smaller elderly population shares. Using data from the Drug Enforcement Agency's Automation of Reports and Consolidated Orders System (ARCOS), we find opioid distribution increased faster in states with a larger fraction of its population impacted by Part D. We also find that this relative increase in opioids resulted in increases in opioid-

related substance abuse treatment admissions. Interestingly, these states experienced significant growth in opioid abuse among both the 65+ population and the under 65 population, though the latter was not directly impacted by the implementation of Medicare Part D. We also find that opioid-related mortality increased disproportionately in the high elderly share states, though this relationship is not statistically different from zero.
http:www.nber.org/papers/w21072

(2014). Plan national d'action pour une politique du médicament adapté aux besoins des personnes âgées : concertation sur le projet de loi "Adaptation de la société au vieillissement" : Paris : Ministère chargé de la Santé .

Abstract: Dans le cadre des travaux de préparation de la Loi d'orientation et de programmation pour l'adaptation de la société au vieillissement, la nécessité d'un plan d'action structurant pour une politique du médicament adaptée aux besoins des personnes âgées s'est imposée. Ce plan d'action s'intègre par ailleurs dans la stratégie nationale de santé et son volet relatif au bon usage des médicaments. Les orientations de ce plan seront inscrits dans le « rapport annexé » de la Loi et le plan lui-même sera transmis au Parlement en même temps que le texte enrichissant et concrétisant la prévention de la perte d'autonomie et la préservation de la santé des âgés.
http:www.unaf.fr/IMG/pdf/plan_medicaments___doc_de_concertation_10022014_vdef.pdf

(2015). Plan national d'action de promotion des médicaments génériques : Paris : Ministère chargé de la Santé .

Abstract: Le gouvernement veut économiser 350 millions d'euros supplémentaires sur le médicament générique. L'objectif a été annoncé mardi 24 mars, à l'occasion de la présentation au ministère de la Santé d'un plan national d'action de promotion des médicaments génériques prévu pour la période 2015/2017. Ce plan, dont le pilotage a été confié à Muriel Dahan (IGAS), vise à encourager la prescription et l'utilisation des médicaments génériques en ville, à l'hôpital et dans les Ehpad, tout en respectant la liberté de prescription. Le plan triennal cible en premier lieu les prescripteurs (libéraux et hospitaliers) et les pharmaciens, mais il vise aussi les fabricants, agences, sociétés savantes, la FMC et la formation initiale ; Composé de sept axes, dont le principal concerne le renforcement du générique à l'hôpital (en agissant notamment sur les achats), le plan est destiné à augmenter "la prescription de cinq points dans le répertoire". Il intègre une nouvelle ROSP des médecins et des pharmaciens avec une incitation à la prescription de génériques, la création d'ordonnances types par pathologie, des "contrats de bon usage" assortis de "stratégies de bonus-malus", un élargissement du répertoire des génériques, une chasse au substituable en renforçant les contrôles des prescripteurs utilisant " abusivement " la mention " Non substituable ", une généralisation du dispositif " tiers payant contre génériques " aux ordonnances hospitalières et aux patients en CMU, AME et AT-MP. Un effort spécifique doit, en parallèle, être mené à destination des personnes âgées dans les Ehpad. Une campagne grand public sur le générique sera lancée fin 2015. Ces mesures sont complétées par le tout nouveau décret n° 2015-309 du 18 mars 2015 relatif à la régulation des dépenses de médicaments inscrits au répertoire des groupes génériques résultant de prescriptions médicales établies par des professionnels de santé exerçant dans les établissements de santé et remboursées sur l'enveloppe de soins de ville.
http:www.social-sante.gouv.fr/actualite-presse,42/communiques,2322/presentation-du-plan-national-d,17755.html

Politique de santé / Health Policy

Decalf Y. 2015). Rapport de la mission sur la médecine spécialisée libérale : concertation du projet de loi santé. Paris : Ministère chargé de la Santé .

Abstract: En perspective du projet de loi de santé, une mission a également été chargée de travailler sur la médecine spécialisée libérale. Chargé de mener la concertation sur la médecine spécialisée libérale dans l'offre de soins de proximité, le Dr Yves Decalf a remis son rapport. La mission a constaté que le projet de loi de santé ne faisait que peu référence à la médecine spécialisée. Or, souligne le rapport, son rôle est particulièrement important s'agissant de soins de proximité et elle participe significativement à la qualité de l'offre de soins. La reconnaissance de la médecine spécialisée libérale devrait être renforcée, afin que celle-ci puisse jouer tout son rôle dans la prise en charge ambulatoire des patients ; La mission relève également que certains exercices spécialisés ne sont pas encore reconnus en termes de qualifications, et restent en zone indéfinie entre la médecine spécialisée généraliste et les autres spécialités. En réponse à ces constats, un ensemble de propositions générales sont formulées, ainsi que des propositions sur le projet de loi, article par article.
http:www.sante.gouv.fr/IMG/pdf/RAPPORT_MEDECINE_SPECIALISEE_LIBERALE_18_MARS_2015_Y_DECALF.pdf

Marguerit D., Reynaudi M. (2015). Quelle place pour la France sur le marché international des soins ? Note d'analyse de France Stratégie ; 27. Paris : France Stratégie - Commissariat général à la stratégie et à la prospective

Abstract: Le nombre de patients qui se rendent à l'étranger pour recevoir des soins aurait doublé en cinq ans, passant de 7,5 millions en 2007 à 16 millions en 2012. Ce marché mondial est aujourd'hui estimé à 60 milliards de dollars. De nombreux pays ont choisi d'investir dans le tourisme médical, les uns en misant sur le faible coût des soins prodigués (Thaïlande, Pologne), les autres sur leur qualité (États-Unis, Allemagne). La France, qui ne manque pas d'atouts, peine à se positionner sur ce marché. Certaines craintes ne sont pas entièrement levées : peur d'une médecine à deux vitesses, d'un moindre accès aux soins, doute sur les bénéfices économiques réels. De fait, il faut se garder de voir dans cette source de financement une solution aux difficultés financières de certains établissements et aux diminutions de budgets. Les enjeux n'en paraissent pas moins conséquents : aux retombées économiques directes pour le secteur de la santé, le tourisme, l'industrie des sciences ou le BTP s'ajoutent les retombées indirectes liées à la stratégie d'influence française (accroissement des partenariats de recherche, prestige à l'international, etc.). Développer le tourisme médical nécessiterait une stratégie nationale avec deux leviers complémentaires : la France doit à la fois organiser la venue de patients étrangers sur son territoire, de manière encadrée, et favoriser le rayonnement de son système de santé et la « projection » de ses compétences à l'étranger. Une telle stratégie devrait veiller à préserver les valeurs du système public de soins et servir à améliorer les prestations rendues aux assurés sociaux.
http:www.strategie.gouv.fr/publications/place-france-marche-international-soins

Soins de santé primaires / Primary Health Care

Kasteridis P., Mason A.R., Goddard M.K.,et al (2014). The Influence of Primary Care Quality on Hospital Admissions for People with Dementia in England: A Regression Analysis. *Plos One ,* 10 (3) :

Abstract: Cet article étudie les liens entre la qualité des soins de santé primaires et la réduction des hospitalisations des personnes démentes au Royaume-Uni. Le nouveau cadre de qualité et de résultats (Quality and Outcomes Framework) est associé à une réduction des admissions non planifiées et des admissions d'urgence pour des conditions sensibles aux soins ambulatoires dans cette population.

Mercier A., Benichou J., Auger-Aubin I., et al. (2015). How do GP practices and patient characteristics influence the prescription of antidepressants? A cross-sectional study. *Annals of General Psychiatry ,* 14 (3) :

Abstract: Background: Under-prescription of antidepressants (ADs) among people meeting the criteria for major depressive episodes and excessive prescription in less symptomatic patients have been reported. The reasons influencing general practitioners' (GPs) prescription of ADs remain little explored. This study aimed at assessing the influence of GP and patient characteristics on AD prescription. Methods: This cross-sectional study was based on a sample of 816 GPs working within the main health care insurance system in the Seine-Maritime district of France during 2010. Only GPs meeting the criteria for full-time GP practice were included. The ratio of AD prescription to overall prescription volume, a relative measure of AD prescription level, was calculated for each GP, using the defined daily dose (DDD) concept. Associations of this AD prescription ratio with GPs' age, gender, practice location, number of years of practice, number of days of sickness certificates prescribed, number of home visits and consultations, number and mean age of registered patients, mean patient income, and number of patients with a chronic condition were assessed using univariate and multivariate analysis. Results: The high prescribers were middle-aged (40–59) urban GPs, with a moderate number of consultations and fewer low-income and chronic patients. GPs' workload (e.g., volume of prescribed drug reimbursement and number of consultations) had no influence on the AD prescription ratio. GPs with more patients with risk factors for depression prescribed fewer ADs, however, which could suggest the medications were under-prescribed among the at-risk population. Conclusions: Our study described a profile of the typical higher AD prescriber that did not include heavy workload. In future work, a more detailed assessment of all biopsychosocial components of the consultation and other influences on GP behavior such as prior training would be useful to explain AD prescription in GP's practice.

Friedberg M.W., Chene P.G., White C., et al. (2015). Effects of Health Care Payment Models on Physician Practice in the United States. Santa Monica : Rand corporation .

Abstract: The project reported here, sponsored by the American Medical Association (AMA), aimed to describe the effects that alternative health care payment models (i.e., models other than fee-for-service payment) have on physicians and physician practices in the United States. These payment models included capitation, episode-based and bundled payment, shared savings, pay for performance, and retainer-based practice. Accountable care organizations and medical homes, which are two recently expanding practice and organizational models that frequently participate in one or more of these alternative payment models, were also included. Project findings are intended to help guide efforts by the AMA and other stakeholders to make improvements to current and future alternative payment programs and help physician practices succeed in these new payment models — i.e., to help practices simultaneously improve patient care, preserve or enhance physician professional satisfaction, satisfy multiple external stakeholders, and maintain economic viability as businesses. The report provides both findings and recommendations.
http:www.rand.org/pubs/research_reports/RR869.html

Miani C., Hinrichs S., Pitchforth E., et al (2015). Best practice. Medical training from an international perspective. Santa-Monica : Rand Corporation .

Abstract: This report seeks to help inform the further development of medical education and training for primary care in Germany. It explores approaches to medical education and training in a small number of high-income countries and how these seek to address shortages of doctors practising in primary or ambulatory care through reforming their education and training systems. It does so by means of an exploratory analysis of the experiences of three countries: England, France and the Netherlands, with Germany included for comparison. Data collection involved a review of the published and grey literature, using a structured template, complemented by information provided by key informants in the selected countries. The report sets out the general context within which the medical education and training systems in the four countries operate, and describe the education and training pathways for general practice for each. We highlight options for medical education and training in Germany that arise from this study by placing our observations in the context of ongoing reform activity. This study will be of relevance for decisionmakers and practitioners concerned with ensuring a medical workforce that is prepared for the demands in a changing healthcare environment.
http:www.rand.org/pubs/research_reports/RR622.html

Paddison C.A.M. (2015). Why Do Patients with Multimorbidity in England Report Worse Experiences in Primary Care? Evidence from the General Practice Patient Survey. *Bmj Open,* 5 (e006172)

Abstract: OBJECTIVES: To describe and explain the primary care experiences of people with multiple long-term conditions in England. DESIGN AND METHODS: Using questionnaire data from 906,578 responders to the English 2012 General Practice Patient Survey, we describe the primary care experiences of patients with long-term conditions, including 583,143 patients who reported one or more long-term conditions. We employed mixed effect logistic regressions to analyse data on six items covering three care domains (access, continuity and communication) and a single item on overall primary care experience. We controlled for sociodemographic characteristics, and for general practice using a random effect, and further, controlled for, and explored the importance of, health-related quality of life measured using the EuroQoL (EQ-5D) scale. RESULTS: Most patients with long-term conditions report a positive experience of care at their general practice (after adjusting for sociodemographic characteristics and general practice, range 74.0–93.1% reporting positive experience of care across seven questions) with only modest variation by type of condition. For all three domains of patient experience, an increasing number of comorbid conditions is associated with a reducing percentage of patients reporting a positive experience of care. For example, compared with respondents with no long-term condition, the OR for reporting a positive experience is 0.83 (95% CI 0.80 to 0.87) for respondents with four or more long-term conditions. However, this relationship is no longer observed after adjusting for health-related quality of life (OR (95% CI) single condition=1.23 (1.21 to 1.26); four or more conditions=1.31 (1.25 to 1.37)), with pain making the greatest difference among five quality of life variables included in the analysis. CONCLUSIONS: Patients with multiple long-term conditions more frequently report worse experiences in primary care. However, patient-centred measures of health-related quality of life, especially pain, are more important than the number of conditions in explaining why patients with multiple long-term conditions report worse experiences of care.
http:bmjopen.bmj.com/content/5/3/e006172

Kandel O. ,Bousquet M.A., Chouilly J. (2015). Manuel théorique de médecine générale : 41 concepts nécessaires à l'exercice de la médecine. Collection "Le plaisir de comprendre". Paris : GMsanté ; Paris : SFMG

Abstract: La médecine générale est une discipline universitaire depuis son inscription au Conseil national des universités en 2006. Toute discipline universitaire se caractérise par une définition claire, le développement d'une recherche propre et l'enseignement d'un savoir s'énonçant par des concepts spécifiques. Il n'existe actuellement pas de corpus regroupant les éléments théoriques justifiant la singularité de la médecine générale. On les retrouve pourtant, mais dispersés au sein de la littérature. Cet ouvrage regroupe les éléments conceptuels propres à la médecine générale et les éléments théoriques issus d'autres disciplines, mais indispensables à sa compréhension. Chacun des 41 concepts retenus est présenté sous forme d'une fiche constituée d'un titre, d'une description, d'une discussion, d'une illustration clinique, et de quelques références bibliographiques. Ces 41 concepts sont classés en quatre thèmes : caractéristiques de la médecine générale, relation médecin-malade, démarche diagnostique et démarche décisionnelle.
http:www.sfmg.org/actualites/publications/manuel_theorique_de_medecine_generale.html

Systèmes de santé / Health Systems

Baji P., Pentek M., Boncz I., et al (2015). The impact of the recession on health care expenditure — How does the Czech Republic, Hungary, Poland and Slovakia compare to other OECD countries? Budapest : Corvinus University of Budapest

Abstract: In the past few years, several papers have been published in the international literature on the impact of the economic crisis on health and health care. However, there is limited knowledge on this topic regarding the Central and Eastern European (CEE) countries. The main aims of this study are to examine the effect of the financial crisis on health care spending in four CEE countries (the Czech Republic, Hungary, Poland and Slovakia) in comparison with the OECD countries. In this paper we also revised the literature for economic crisis related impact on health and health care system in these countries. OECD data released in 2012 were used to examine the differences in growth rates before and after the financial crisis. We examined the ratio of the average yearly growth rates of health expenditure expressed in USD (PPP) between 2008–2010 and 2000–2008. The classification of the OECD countries regarding "development" and "relative growth" resul ted in four clusters. A large diversity of "relative growth" was observed across the countries in austerity conditions, however the changes significantly correlate with the average drop of GDP from 2008 to 2010. To conclude, it is difficult to capture visible evidence regarding the impact of the recession on the health and health care systems in the CEE countries due to the absence of the necessary data. For the same reason, governments in this region might have a limited capability to minimize the possible negative effects of the recession on health and health care systems.
http:unipub.lib.uni-corvinus.hu/1902/

Doyle J., Graves J., Gruber . (2015). Uncovering Waste in U.S. Healthcare. Cambridge : NBER

Abstract: There is widespread agreement that the US healthcare system wastes as much as 5% of GDP, yet little consensus on what care is actually unproductive. This partly arises because of the endogeneity of patient choice of treatment location. This paper uses the effective random assignment of patients to ambulance companies to generate comparisons across similar patients treated at different hospitals. We find that assignment to hospitals whose patients receive large amounts of care over the three months following a health emergency do not have meaningfully better survival outcomes compared to hospitals whose patients receive less. Outcomes are related to different types of treatment intensity, however: patients assigned to hospitals with high levels of inpatient spending are more likely to survive to one year, while those assigned to hospitals with high levels of outpatient spending are less likely to do so. This adverse effect of outpatient spending is

predominately driven by spending at skilled nursing facilities (SNF) following hospitalization. These results offer a new type of quality measure for hospitals based on utilization of SNFs. We find that patients quasi-randomized to hospitals with high rates of SNF discharge have poorer outcomes, as well as higher downstream spending once conditioning on initial hospital spending.
http:www.nber.org/papers/w21050

Hamon P., Rosenweg D. (2015). La fin de notre système de santé ? Paris : Albin Michel

Abstract: La Sécu a 70 ans. Sa branche « assurance maladie », chargée de rembourser nos soins, s'enfonce inexorablement dans le déficit. Pourtant, elle ne cesse de réduire ses prises en charge. Pendant ce temps, les médecins libéraux disparaissent, des cliniques ferment, les meilleurs spécialistes partent à l'étranger, les médicaments de pointe ne sont plus accessibles à tous. Pourtant, les Français paient. Partout et de plus en plus. Jusqu'à renoncer à se soigner. Le système continue en revanche d'engraisser les mêmes : industriels, assureurs et mutuelles, prestataires, mandarins, élus influents... Et les lois qui s'annoncent vont creuser le fossé : la privatisation va s'étendre, la santé à deux vitesses menace. Où donc va votre argent ? Comment en est-on arrivé là ? Et demain ? Jean-Paul Hamon et Daniel Rosenweg dénoncent, exemples à l'appui, les abus, gaspillages, dysfonctionnements et trafics d'influence qui gangrènent notre système de santé. Ils démontrent comment, sans perte de qualité, on peut rebâtir un système juste, égalitaire, et pérenne. Et économiser au passage trente milliards d'euros (4e de couverture).
http:www.albin-michel.fr/multimedia/Documents/espace_journalistes/communiques_de_presse/201504/HAMON-ROSENWEG.pdf

Travail et santé / Occupational Health

Candon D. (2015). The Effect of Cancer on the Employment of Older Males: Attenuating Selection Bias using a High Risk Sample. Beldfield : University College Dublin

Abstract: Estimating the unbiased effect of health shocks on employment is an important topic in both health and labour economics. This is particularly relevant to cancer, where improvements in screening and treatments have led to increases in survival for nearly all types of cancer. In order to address the issue of selection bias, I estimate the effect of cancer on employment for a high-risk cancer sample, male workers over the age of 65, thus attenuating the impact of many cancer risk factors. This identification strategy balances the covariates between the cancer and the non-cancer groups in numerous tests. Respondents who are diagnosed with cancer are 13.2 percentage points less likely to work than their non-cancer counterparts. The results also appear insensitive to omitted confounders.
https:ideas.repec.org/p/ucn/wpaper/201507.html

Cervini-Pla M., Vall Castello J. (2015). The Earnings and Employment Losses Before Entering the Disability System. Bonn : IZA

Abstract: Although a number of papers in the literature have shown the employment and wage differences between disabled and non-disabled individuals, not much is known about the potential employment and wage losses that disabled individuals suffer before being officially accepted into the disability insurance system (DI). Therefore, in this paper we distinguish between individuals that enter the DI system due to a working accident (sudden health shock) and individuals that become disabled due to an ordinary illness to identify the differences in employment and wages between

these two groups before they are officially accepted into the DI system. We combine matching models and difference-in-difference and we find that the wage (employment) growth patterns of both groups of workers become significantly different three (six) years before entering the DI system. More specifically, our estimates suggest that one year before entering the system, there is a difference of 27 Euros/month in the wages of the two groups (3% of average wage) as well as a 10 percentage point difference in employment probabilities.
http:ftp.iza.org/dp8913.pdf

Nie P., Otterbach S., Sousa-Poza A. (2015). Long Work Hours and Health in China. Bonn : IZA

Abstract: Using several waves of the China Health and Nutrition Survey (CHNS), this study analyzes the effect of long work hours on health and lifestyles in a sample of 18- to 65-year-old Chinese workers. Although working long hours does significantly increase the probabilities of high blood pressure and poorer reported health, the effects are small. Also small are the negative effects of long work hours on sleep time, fat intake, and the probabilities of sports participation or watching TV. We find no positive association between work time and different measures of obesity and no evidence of any association with calorie intake, food preparation and cooking time, or the sedentary activities of reading, writing, or drawing. In general, after controlling for a rich set of covariates and unobserved individual heterogeneity, we find little evidence that long work hours affect either the health or lifestyles of Chinese workers.
http:ftp.iza.org/dp8911.pdf

Chadi A., Goerke L. (2015). Missing at Work – Sickness-related Absence and Subsequent Job Mobility. Bonn : IZA
Abstract: Economists often interpret absenteeism as an indicator of effort. Using data from the German Socio-Economic Panel (SOEP) study, this paper offers a comprehensive discussion of this view by analysing various forms of job mobility. The evidence reveals a significantly negative (positive) link between sickness-related absence and the probability of a subsequent promotion (dismissal). In line with the interpretation of absenteeism as a proxy for effort, instrumental variable analyses suggest no causal impact of absence behaviour on the likelihood of such career events when variation in illness-related absence is triggered exogenously. We observe no consistent gender differences in the link between absence and subsequent career events.
http:www.iaaeg.de/images/DiscussionPaper/2015_04.pdf

Vieillissement / Ageing

Leroux H., Pestieau P., Ponthiere G. (2014). Longévité différentielle et redistribution : enjeux théoriques et empiriques. Louvain-la-Neuve : CORE

Abstract: Dans cet article, nous étudions l'impact des différences de longévité sur la conception des politiques publiques, en particulier celles liées au départ à la retraite. Nous montrons premièrement qu'alors même que l'espérance de vie a augmenté de manière très importante tout au long du siècle dernier, il subsiste encore de fortes disparités. Deuxièmement, nous étudions d'un point de vue normatif comment les différences de longévité sont généralement prises en compte dans les modèles de cycle de vie et montrons que certaines hypothèses peuvent avoir des implications fortes en terme de redistribution intra-générationnelle. Nous identifions au moins trois arguments en faveur d'une redistribution vers les agents à faible longévité: l'aversion à l'inégalité intertemporelle, l'aversion au risque de mortalité et la compensation pour des caractéristiques dont les agents ne sont pas responsables. Nous étendons ensuite notre analyse de manière à tenir compte du fait que

les individus puissent être en partie responsables de leur longévité. Finalement, nous lions ces résultats aux débats actuels sur la réforme des systèmes de retraite. Nous montrons qu'en général, parce que les pensions de retraite sont conditionnelles à la survie des bénéficiaires, les systèmes de retraite publics vont redistribuer des ressources des agents dont la durée de vie est courte vers ceux dont la durée de vie est longue. Nous fournissons des pistes de réformes qui viseraient à mieux prendre en compte ces différences de longévité et en particulier, celles relatives à la création d'une "rente longévité" telle que souhaitée par le Comité d'Amours et au développement de l'assurance autonomie, qu'elle soit privée ou publique.
http:uclouvain.be/cps/ucl/doc/core/documents/coredp2014_40web.pdf

Zasimova L., Sheluntcova M., Kalinin A. (2015). Measuring Active Aging for Cross-Country Comparisons and Policy Planning. Moscou : HSE

Abstract: An aging population and the low involvement of elderlies in social activities makes the measurement of active aging an important research question, since it gives an insight into the potential of the elderly. Policy agendas in many countries stress the need for active aging in terms of improved health and a greater degree of autonomy. This paper aims to investigate the potential and limits of international comparison for setting policy goals concerning older adults. We use World Health Organization (WHO) micro data from the Study of Global Ageing and Adult Health (SAGE) to measure active aging in five countries demonstrating similar macroeconomic outcomes, namely Russia, India, China, South Africa and Mexico. Following the WHO concept of active aging, we select indicators for three components of active aging (health, participation in social activities, and security) and aggregate them into three sub-indices, which become the outcome index of active aging. Our findings show significant variation in the proportion of actively aging individuals in selected countries (from 89% in China to 44% in South Africa) and in the sub-indices of health, participation and security. We compare our results with macro-level data and conclude that the active aging index could be a useful tool for measuring the proportion of actively aging individuals and understanding the challenges for policy makers in each country. However, one should understand the limits of micro-level data analysis and interpret the results carefully. We also argue that for international comparisons, active aging indexes should be studied with respect to the activity of non-elderlies in each country.

(2015). Quels seront les impacts du vieillissement de la population ? Notes S*ocioéconomiques*. Montréal : IRIS .

Abstract: La population du Québec est davantage préoccupée par le vieillissement de la population que par les changements climatiques ou la croissance des inégalités. Pourtant, aussi complexe soit-il, ce phénomène normal ne devrait pas semer la panique et ainsi risquer de nous faire adopter les mauvaises politiques publiques, voire même d'alimenter un certain ressentiment envers les personnes plus âgées. Dans cette note socio-économique, nous verrons que le vieillissement de la population est un phénomène mondial qui n'a rien d'une calamité et dont les effets anticipes sont variés. Nous présenterons ensuite quelques projections sur l'effet que ce vieillissement pourrait avoir sur les coûts de la santé à la lumière notamment des dernières prévisions démographiques. Enfin, nous aborderons quelques pistes à privilégier au moment d'adapter la société québécoise au vieillissement de sa population.