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SOMMAIRE

Assurance maladie / Health Insurance

Sood N. Wu Y.(2013). The Impact of Insurance and HIV Treatment Technology on HIV Testing : Cambridge : NBER
Abstract: This paper investigates the effects of health insurance and new antiviral treatments on HIV testing rates among the U.S. general population using nationally representative data from the Behavioral Risk Factor Surveillance Survey (BRFSS) for the years 1993 to 2002. We estimate recursive bivariate probit models with insurance coverage and HIV testing as the dependent variables. We use changes in Medicaid eligibility and distribution of firm size over time within a state as instruments for insurance coverage. The results suggest that (a) insurance coverage increases HIV testing rates, (b) insurance coverage increases HIV testing rates more among the high risk population, and (c) the advent of Highly Active Antiretroviral Therapy (HAART) increases the effects of insurance coverage on HIV testing for high risk populations.
http:www.nber.org/papers/w19397

Handel B.R., Hendel I., Whinston M.D. (2013). Equilibria in Health Exchanges: Adverse Selection vs. Reclassification Risk : Cambridge : NBER
Abstract: This paper studies regulated health insurance markets known as exchanges, motivated by their inclusion in the Affordable Care Act (ACA). We use detailed health plan choice and utilization data to model individual-level projected health risk and risk preferences. We combine the estimated joint distribution of risk and risk preferences with a model of competitive insurance markets to predict outcomes under different regulations that govern insurers' ability to use health status information in pricing. We investigate the welfare implications of these regulations with an emphasis on two potential sources of inefficiency: (i) adverse selection and (ii) premium reclassification risk. We find that market unravelling from adverse selection is substantial under the proposed pricing rules in the Affordable Care Act (ACA), implying limited coverage for individuals beyond the lowest coverage (Bronze) health plan permitted. Although adverse selection can be attenuated by allowing (partial) pricing of health status, our estimated risk preferences imply that this would create a welfare loss from reclassification risk that is substantially larger than the gains from increasing within-year coverage, provided that consumers can borrow when young to smooth consumption or that age-based pricing is allowed. We extend the analysis to investigate some related issues, including (i) age-based pricing regulation (ii) exchange participation if the individual mandate is unenforceable and (iii) insurer risk-adjustment transfers.
http:www.nber.org/papers/w19399

Economie de la santé / Health Economics

Kemptner D. (2013). Health-Related Life Cycle Risks and Public Insurance : Berlin : DIW
Abstract: This paper proposes a dynamic life cycle model of health risks, employment, early retirement, and wealth accumulation in order to analyze the health-related risks of consumption and old age poverty. In particular, the model includes a health process, the interaction between health and employment risks, and an explicit modeling of the German public insurance schemes. I rely on a dynamic programming discrete choice framework and estimate the model using data from the German Socio-Economic Panel. I quantify the health-related life cycle risks by simulating scenarios where health shocks do or do not occur at different points in the life cycle for individuals with differing endowments. Moreover, a policy simulation investigates minimum pension benefits as an insurance against old age poverty. While such a reform raises a concern about an increase in abuse of the early retirement option, the simulations indicate that a means test mitigates the moral hazard problem substantially.
http:www.diw.de/documents/publikationen/73/diw_01.c.426643.de/diw_sp0583.pdf

Kobelt G. (2013). Health Economics : an introduction to economic evaluation : Londres : OHE .
Abstract: Since the second edition of this publication appeared in 2002, economic evaluation of new medical technologies as a basis for decisions about their use has expanded to an increasing number of countries and types of technology. At the same time, the methods themselves have evolved in response to experience and to changes in the ability to capture and analyse data. This book presents a comprehensive overview of today's approaches to health economic evaluation, illustrated throughout with examples and with guidance about what methods are appropriate in which situations. What distinguishes this book from other such reviews are its fifteen concrete "study examples," which focus on pharmaceuticals and include cost-of-illness studies, cost-minimization analysis, cost-effectiveness analysis, cost-utility analysis and cost-benefit analysis (Résumé éditeur).
http://www.ohe.org/publications/article/introduction-to-health-economic-evaluation-134.cfm

Stabile M. Thomson S. (2013). The Changing Role of Government in Financing Health Care: An International Perspective : Cambridge : NBER
Abstract: This paper explores the changing role of government involvement in health care financing policy outside the United States. It provides a review of the economics literature in this area to understand the implications of recent policy changes on efficiency, costs and quality. Our review reveals that there has been some convergence in policies adopted across countries to improve financing incentives and encourage efficient use of health services. In the case of risk pooling, all countries with competing pools experience similar difficulties with selection and are adopting more sophisticated forms of risk adjustment. In the case of hospital competition, the key drivers of success appear to be what is competed on and measurable rather than whether the system is public or private. In the case of both the success of performance-related pay for providers and issues resulting from wait times, evidence differs both within and across jurisdictions. However, the evidence does suggest that some governments have effectively reduced wait times when they have chosen explicitly to focus on achieving this goal. Many countries are exploring new ways of generating revenues for health care to enable them to cope with significant cost growth. However, there is little evidence to suggest that collection mechanisms alone are effective in managing the cost or quality of care.
http:www.nber.org/papers/w19439

Etat de santé / Health Status

Atella V., Deb P. (2013). Heterogeneity in Long Term Health Outcomes of Migrants within Italy. Cambridge : NBER
Abstract: This article examines the long term physical and mental health effects of internal migration focusing on a relatively unique migration experience from Southern and Northeastern regions of Italy to Northwestern regions and to the region around Rome concentrated over a relatively short period from 1950-1970. OLS regression estimates show significant evidence of a migration effect among early-cohort females on physical health. We find no evidence of migration-health effects for the later cohort, nor for males in the early cohort. We use finite mixture models to further explore the possibility of heterogeneous effects and find that there is a significant and substantial improvement in physical and mental health for a fraction of migrant females in the early cohort but not for others. Analysis of the group for which effects are significant suggest that health effects are concentrated among rural females in the early cohort.
http:www.nber.org/papers/w19422

Kuehnle D., Wunder P. (2013). The Effects of Smoking Bans on Self-Assessed Health: Evidence from Germany : Berlin : DIW
Abstract: The 16 German federal states introduced smoking bans on different dates during 2007 and 2008. These bans restricted smoking in enclosed public places, particularly in restaurants and bars. This study examines the effects of smoking bans on self-assessed health. Using data from the Socio-Economic Panel (SOEP), difference-in-differences estimations provide evidence for health improvements for the population at large. Health benefits from the secondhand smoke-free

environment are equivalent to an increase in household income of approximately 30%. Further subgroup analyses show that health improvements are largest among young non-smokers (below 30 years) whereas smokers report no or even adverse health effects in response to bans. Exploiting differences in the dates of introduction and enforcement, we find no evidence that the effects of bans depend on enforcement measures.
http:papers.ssrn.com/sol3/papers.cfm?abstract_id=2322700

Banks J., Kelly E., Smith J.P. (2013). Spousal Health Effects - the Role of Selection : Cambridge : NBER
Abstract: In this paper, we investigate the issue of partner selection in the health of individuals who are at least fifty years old in England and the United States. We find a strong and positive association in family background variables including education of partners and their parents. Adult health behaviors such as smoking, drinking, and exercise are more positively associated in England compared to the United States. Childhood health indicators are also positively associated across partners. We also investigated pre and post partnership smoking behavior of couples. There exists strong positive assortative mating in smoking in that smokers are much more likely to partner with smokers and non-smokers with non-smokers. This relationship is far stronger in England compared to the United States. In the United States, we find evidence of asymmetric partner influence in smoking in that men's pre marriage smoking behavior influences his female partner's post marriage smoking behavior but there does not appear to be a parallel influence of women's pre-marriage smoking on their male partner's post-marital smoking. These relationships are much more parallel across genders in England.
http:papers.nber.org/papers/w19438

Mocan N., Raschke C., Unel B. (2013). The Impact of Mothers' Earnings on Health Inputs and Infant Health : Cambridge : NBER
Abstract: This paper investigates the impact of mothers' earnings on birth weight and gestational age of infants. It also analyzes the impact of earnings on mothers' consumption of prenatal medical care, and their propensity to smoke and drink during pregnancy. The paper uses census-division- and year-specific skill-biased technology shocks as an instrument for mothers' earnings and employs a two-sample instrumental variables strategy. About 14 million records of births between 1989 and 2004 are used from the Natality Detail files along with the CPS Annual Demographic Files from the same period. The results reveal that an increase in weekly earnings prompts an increase in prenatal care of low-skill mothers (those who have at most a high school degree) who are not likely to be on Medicaid, and that earnings have a small positive impact on birth weight and gestational age of the newborns of these mothers. An increase in earnings does not influence the health of newborns of high-skill mothers (those with at least some college education). Variations in earnings have no impact on birth weight for mothers who are likely to be on Medicaid.
http:papers.nber.org/papers/w19434

Currie J., Graff Zivin J., Mullins J., Neidell M. (2013). What Do We Know About Short and Long Term Effects of Early Life Exposure to Pollution? Cambridge : NBER
Abstract: Pollution exposure early in life is detrimental to near-term health and an increasing body of evidence suggests that early childhood health influences health and human capital outcomes later in life. This paper reviews the economic research that brings these two literatures together. We begin with a conceptual model that highlights the core relationships across the lifecycle. We then review the literature concerned with such estimates, focusing particularly on identification strategies to mitigate concerns regarding endogenous exposure. The nascent empirical literature provides both direct and indirect evidence that early childhood exposure to pollution significantly impacts later life outcomes. We discuss the potential policy implications of these long-lasting effects, and conclude with a number of promising avenues for future research.
http:www.nber.org/papers/w19571

Géographie de la santé / Geography of Health

(2013). SROMS - Bilan national de la première génération des schémas régionaux d'organisation médico-sociale 2012-2016 : Paris : CNSA .
Abstract: Ce document de la CNSA présente l'analyse des vingt-six schémas adoptés par les ARS conduite par la direction des établissements et services médico-sociaux de la Caisse nationale de solidarité pour l'autonomie. Cette synthèse est illustrée par les initiatives les plus significatives identifiées dans les régions.
http:www.cnsa.fr/IMG/pdf/cnsa-DT-sroms-26-09-2013.pdf

Courtemanche C., Soneji S.,Tchernis R. (2013). Modeling Area-Level Health Rankings : Cambridge : NBER
Abstract: We propose a Bayesian factor analysis model to rank the health of localities. Mortality and morbidity variables empirically contribute to the resulting rank, and population and spatial correlation are incorporated into a measure of uncertainty. We use county-level data from Texas and Wisconsin to compare our approach to conventional rankings that assign deterministic factor weights and ignore uncertainty. Greater discrepancies in rankings emerge for Texas than Wisconsin since the differences between the empirically-derived and deterministic weights are more substantial. Uncertainty is evident in both states but becomes especially large in Texas after incorporating noise from imputing its considerable missing data.
http:papers.nber.org/papers/w19450

Hôpital / Hospitals

Dor A., Deb P., Grossman M. (2013). Impact of Mortality-Based Performance Measures on Hospital Pricing: the Case of Colon Cancer Surgeries : Cambridge : NBER
Abstract: We estimate price regressions for surgical procedures used to treat colon cancer, a leading cause of cancer mortality. Using a claims database for self-insured employers, we focus on transaction prices, rather than more commonly available billing data that do not reflect actual payments made. Although the responsiveness of prices to hospital performance depends on the impact of quality on the slope of the quantity-demand of the payers, which are not known a priory, it is often assumed that higher performing hospitals are able to command higher prices. To test this hypothesis we construct performance rankings, based on hospital excess-mortality and incorporate them into our price models. We are interested in the type information available to large payers who negotiate prices on behalf of their members. To get a cancer-specific index we emulate the widely-reported risk-adjustment methodology used in the federal Hospital Compare reporting system for ranking cardiac performance. The effects were consistently negative in all models (adverse quality reduces price), though not significant. However, we observe a rational pricing structure whereby higher treatment complexity is reflected in higher price differentials, controlling for patient characteristics and market structure.
http:www.nber.org/papers/w19447

Romley J.A., Sood N. (2013). Identifying the Health Production Function: The Case of Hospitals : Cambridge : NBER
Abstract: Estimates of the returns to medical care may reflect not only the efficacy of more intensive care, but also unmeasured differences in patient severity or the productivity of health-care providers. We use a variety of instruments that are plausibly orthogonal to heterogeneity among providers as well as patients to analyze the intensity of care and 30-day survival among Medicare patients hospitalized for heart attack, congestive heart failure and pneumonia. We find that the intensity of care is endogenous for two out of three conditions. The elasticity of 30-day mortality with respect to care intensity increases in magnitude from -0.27 to -0.71 for pneumonia and from -0.16 to -0.33 for congestive heart failure, when we address the identification problem. This finding is consistent with the hypotheses that care intensity at hospitals tends to decrease with hospital productivity, or increase with unmeasured patient severity.
http:www.nber.org/papers/w19490

Ho K., Lee R.S. (2013). Insurer Competition and Negotiated Hospital Prices : Cambridge : NBER
Abstract: We examine the impact of increased health insurer competition on negotiated hospital prices. Insurer competition can lead to lower premiums and reduced industry surplus, thereby depressing hospital prices; however, hospitals may also leverage fiercer insurer competition when bargaining in order to negotiate higher prices. We rely on a theoretical bargaining model to derive a regression equation relating negotiated prices to the degree of insurer competition, and use the presence of Kaiser Permanente in a hospital's market as a measure of insurer competition. We estimate a model of consumer demand for hospitals and use it to derive many of the other independent variables specified in the regression equation. Leveraging a unique dataset on negotiated prices between hospitals and commercial insurers in California in 2004, we find that increased insurer competition reduces hospital prices on average, but has a positive and empirically meaningful effect on the prices of attractive and high utility generating hospitals. This heterogeneous effect across hospitals—which has not been emphasized in the recent literature on hospital-insurer bargaining—provides incentives for hospital investment and consolidation, and implies that hospital market power can lead to high input prices even in markets where many insurers are present.
http://papers.nber.org/papers/W19401

Inégalités de santé/ Health Inequalities

Douai C. (2013). Observatoire de l'accès aux soins de la mission France de Médecins du Monde : rapport 2012 : Paris : Médecins du Monde .
Abstract: A l'occasion du 17 octobre, Journée internationale du refus de la misère, Médecins du Monde publie son rapport annuel sur l'accès aux soins des plus démunis en France. En 2012, en France, les conséquences de la crise économique sur la santé et l'accès aux soins sont prégnantes. Les inégalités sociales de santé s'accentuent chez les plus démunis. À cela s'ajoutent des réponses publiques souvent plus sécuritaires que sociales, notamment envers les migrants, les personnes se prostituant et les usagers de drogues. Ces personnes accèdent de plus en plus difficilement au système de soins, avec pour conséquence une détérioration de leur état de santé.
http:www.medecinsdumonde.org/Publications/Les-Rapports/En-France/Rapport-complet-de-l-Observatoire-de-l-acces-aux-soins-2013

Fonseca R., Zheng Y. (2013). The Effect of Education on Health: Cross-Country Evidence : Québec : CIRPEE
Abstract: This paper uses comparable micro-data from over 15 OECD countries to study the causal relationship between education and health outcomes. We combine three surveys (SHARE, HRS and ELSA) that include nationally representative samples of people aged 50 and over in these countries. We use variation in the timing of educational reforms across these countries as an instrument for the effect of education on health. Using instrumental variables Probit models (IV-Probit), we find causal evidence that more years of education lead to better health for a limited number of health markers. We find lower probabilities of reporting poor health, of having limitations in functional status (ADLs and iADLs) and of having been diagnosed with diabetes. These effects are larger than those from a Probit that does not control for the endogeneity of education. We cannot find evidence of a causal effect of education on other health conditions. Interestingly, the relationship between education and cancer is positive in both Probit and IV-Probit models, which we interpret as evidence that education fosters early detection.
http:www.cirpee.org/fileadmin/documents/Cahiers_2013/CIRPEE13-25.pdf

(2013). Report on health inequalities in the European Union : Bruxelles : European commission
Abstract: The report therefore begins with an overview of the size of, and trends in, health inequalities in the EU since 2000 with a focus on recent years. It goes on to describe the main actions that the Commission has taken to implement the communication on health inequalities since 2009. Further information, including the graphs and tables referred to, are in the annex.
http:ec.europa.eu/health/social_determinants/docs/report_healthinequalities_swd_2013_328_en.pdf

Gibney S. M., Mc Govern M.E. (2013). Social Relationships in Later Life: The Role of Childhood Circumstances : Beldfield : University College Dublin
Abstract: Social relationships predict health and emotional wellbeing across the life course. However, it is not known whether gradients in social engagement, social network size or quality in later life mirror socio-economic and health gradients in childhood. This study investigates the long-term impact of childhood circumstances on social relationships. Data are from the Survey of Health, Aging and Retirement in Europe; a panel survey of people aged 50+. Current social network attributes (size, satisfaction and emotional closeness) and retrospective life history data on childhood health, cognition, SES, and parental characteristics are utilized. Regression analysis indicates that childhood circumstances predict social network attributes in later life. Emotional closeness partly mediates the relationship between childhood circumstances and social network satisfaction. A strong but differential association between aspects of childhood circumstance and social network attributes was evident. Therefore we critique the index measurement approach which conflates diverse pathways linking childhood and late-life outcomes.
http:www.ucd.ie/geary/static/publications/workingpapers/gearywp201319.pdf

Eberharter V.V. (2013). The Intergenerational Dynamics of Social Inequality: Empirical Evidence from Europe and the United States : Berlin : DIW
Abstract: Based on nationally representative data from the German Socio-Economic Panel (SOEP), the Panel Study of Income Dynamics (PSID), and the British Household Panel Survey (BHPS) we analyze the intergenerational transmission of economic and social (dis-)advantages in Germany, the United States and Great Britain. We test with the hypotheses that the extent and the determinants of intergenerational income mobility and the relative risk of poverty differ with respect to the existing welfare state regime, family role patterns, and social policy design. The empirical results indicate a higher intergenerational income elasticity in the United States than in Germany and Great Britain, and country differences concerning the influence of individual and parental socio-economic characteristics, and social exclusion attributes on intergenerational income mobility and the relative risk of poverty.
http://www.diw.de/documents/publikationen/73/diw_01.c.428091.de/diw_sp0588.pdf

Informatique médicale / Medical Informatics

Picard R. (2013). Prospective organisationnelle pour un usage performant des technologies nouvelles en Santé : Paris : C.G.E.I.E.T.
Abstract: Ce rapport apporte un éclairage prospectif sur les conditions organisationnelles pour un usage performant des technologies nouvelles en Santé, avec un regard particulier sur la télémédecine et plus largement sur la télésanté.
http://www.cgeiet.economie.gouv.fr/Rapports/2013_10_10_2012_12_rapport_RP.pdf

Médicaments / Pharmaceuticals

(2013). Mémento du médicament 2013 : Paris : FNMF .
Abstract: Le Mémento Médicament de la Mutualité Française fournit chaque année aux décideurs mutualistes et aux acteurs de la politique du médicament, les principales données sur le marché du médicament et son financement par les mutuelles en France. Cette édition 2013 se penche plus particulièrement sur les prescriptions et les médicaments génériques comme levier d'amélioration de la qualité des soins.
http:www.mutualite.fr/L-actualite/Kiosque/Communiques-de-presse/Le-Memento-du-Medicament-edition-2013-pour-tout-savoir-sur-le-marche-du-medicament

Budish E. Roin B.N., Williams H. (2013). Do fixed patent terms distort innovation? Evidence from cancer clinical trials : Cambridge : NBER
Abstract: Patents award innovators a fixed period of market exclusivity, e.g., 20 years in the United States. Yet, since in many industries firms file patents at the time of discovery ("invention") rather than first sale ("commercialization"), effective patent terms vary: inventions that commercialize at the time of invention receive a full patent term, whereas inventions that have a long time lag between invention and commercialization receive substantially reduced - or in extreme cases, zero - effective patent terms. We present a simple model formalizing how this variation may distort research and development (R&D). We then explore this distortion empirically in the context of cancer R&D, where clinical trials are shorter - and hence, effective patent terms longer - for drugs targeting late-stage cancer patients, relative to drugs targeting early-stage cancer patients or cancer prevention. Using a newly constructed data set on cancer clinical trial investments, we provide several sources of evidence consistent with fixed patent terms distorting cancer R&D. Back-of-the-envelope calculations suggest that the number of life-years at stake is large. We discuss three specific policy levers that could eliminate this distortion - patent design, targeted R&D subsidies, and surrogate (non-mortality) clinical trial endpoints - and provide empirical evidence that surrogate endpoints can be effective in practice.
http:www.nber.org/papers/w19430

Aitken M.L., Berndt E.R., Bosworth H., et al. (2013). The Regulation of Prescription Drug Competition and Market Responses: Patterns in Prices and Sales Following Loss of Exclusivity : Cambridge : NBER
Abstract: We examine six molecules facing initial loss of US exclusivity (LOE, from patent expiration or challenges) between June 2009 and May 2013 that were among the 50 most prescribed molecules in May 2013. We examine prices per day of therapy (from the perspective of average revenue received by retail pharmacy per day of therapy) and utilization separately for four payer types (cash, Medicare Part D, Medicaid, and other third party payer – TPP) and age under vs. 65 and older. We find that quantity substitutions away from the brand are much larger proportionately and more rapid than average price reductions during the first six months following initial LOE. Brands continue to raise prices after generics enter. Expansion of total molecule sales (brand plus generic) following LOE is an increasingly common phenomenon compared with earlier eras. The number of days of therapy in a prescription has generally increased over time. Generic penetration rates are typically highest and most rapid for TPPs, and lowest and slowest for Medicaid. Cash customers and seniors generally pay the highest prices for brands and generics, third party payers and those under 65 pay the lowest prices, with Medicaid and Medicare Part D in between. The presence of an authorized generic during the 180-day exclusivity period has a significant impact on prices and volumes of prescriptions, but this varies across molecules.
http:www.nber.org/papers/w19487

Koulayev S., Skipper N., Simeonova E. (2013). Who Is in Control? The Determinants of Patient Adherence with Medication Therapy : Cambridge : NBER
Abstract: Non-compliance with medication therapy remains an unsolved and expensive problem for health care systems around the world. Yet we know little about the factors that determine a patient's decision to follow treatment recommendations. This study uses a unique panel dataset comprising all prescription drug users, physicians, and all prescription drug sales in Denmark over seven years to analyze the contributions of doctor-, patient-, and drug-specific factors to the adherence decision. Our findings have important implications for the design of incentive schemes targeted at improving chronic disease management.
http:www.nber.org/papers/w19496

Arcidiacono P., Ellickson P.B., Landry P. (2013). Pharmaceutical Followers : Cambridge : NBER
Abstract: We estimate a model of drug demand and supply that incorporates insurance, advertising, and competition between branded and generic drugs within and across therapeutic classes. We use data on antiulcer drugs from 1991 to 2010. Our simulations show generics and ``me-too'' drugs each increased consumer welfare more than $100 million in 2010, holding insurance premiums constant. However, insurance payments in 2010 fell by nearly $1 billion due to generics and rose by over $7 billion due to me-too antiulcer drugs.
http:papers.nber.org/papers/w19522

Méthodologie – Statistique / Methodology - Statistics

Heffetz O., Ligett K. (2013). Privacy and Data-Based Research : Cambridge : NBER
Abstract: What can we, as users of microdata, formally guarantee to the individuals (or firms) in our dataset, regarding their privacy? We retell a few stories, well-known in data-privacy circles, of failed anonymization attempts in publicly released datasets. We then provide a mostly informal introduction to several ideas from the literature on differential privacy, an active literature in computer science that studies formal approaches to preserving the privacy of individuals in statistical databases. We apply some of its insights to situations routinely faced by applied economists, emphasizing big-data contexts.
http:www.nber.org/papers/w19433

Degen R.G. (2013). Satisfaction of Patients in Health Care: Some Critical Issues with Research Projects that Measure Satisfaction : Leira : Polytechnic Institute of Leiria
Abstract: This paper presents three critical issues that researchers need to consider when preparing a research project that measures the satisfaction of patients in health care. These issues are: the correct interpretation of the research objective and formulation of the research questions, selection the appropriate research design, and the credibility of the research project and its conclusions.
http:ideas.repec.org/p/pil/wpaper/95.html

Feeny D.H. (2013). A Primer for Systematic Reviewers on the Measurement of Functional Status and Health-Related Quality of Life in Older Adults : Rockville : AHRQ .
Abstract: Objectives. Provide a primer for systematic reviewers, clinicians, and researchers on assessing functional status and health-related quality of life (HRQL) in older adults. Systematic reviewers are increasingly focusing on interventions that address the problems of older people, who often have functional impairments and multiple morbidities. Key outcomes are function and HRQL. The paper provides an overview of the methods for assessing function and HRQL, and evidence on the measurement properties of prominent measures. Methods. The paper provides an overview of the methods for assessing function and HRQL, and evidence on the measurement properties of prominent instruments. Results. Key measurement properties include construct validity (does the instrument measure what it is supposed to measure?), responsiveness (the ability to detect meaningful change) and interpretation (is the magnitude of change trivial or important?). Special challenges in older adult populations include sometimes sparse evidence on the measurement properties; using proxy respondents; a paucity of evidence on the magnitude of change that is patient-important; and threats to detecting patient-important changes due to floor and ceiling effects. Discussion. While further study of the measurement properties of measures in older populations is needed, studies of older adults should include measures of HRQL and function. Further, to generate rigorous evidence on effectiveness, older adults should be included in randomized controlled clinical trials. HRQL evidence from natural-history cohorts is important in interpreting results from intervention studies.
http:www.effectivehealthcare.ahrq.gov/ehc/products/518/1727/QOL-measurement-white-paper-130923.pdf

Prévention / Prevention

Bailey J. (2013). Who Pays the High Health Costs of Older Workers? Evidence from Prostate Cancer Screening Mandates : Philadelphie : Temple University
Abstract: Between 1992 and 2009, 30 US states adopted laws mandating that health insurance plans cover screenings for prostate cancer. Because prostate cancer screenings are used almost exclusively by men over age 50, these mandates raise the cost of insuring older men relative to other groups. This paper uses a triple-difference empirical strategy to take advantage of this quasi-random natural experiment in raising the cost of employing older workers. Using IPUMS data from the March

Supplement of the Current Population Survey, this paper finds that the increased cost of insuring older workers results in their receiving 2.8% lower hourly wages, being 2% less likely to be employed, and being 0.7% less likely to have employer-sponsored health insurance.
http:www.cla.temple.edu/RePEc/documents/DETU_13_02.pdf

Prévision – Evaluation / Prevision – Evaluation

Chancel L. (2013). Quels enjeux pour la protection sociale dans une économie post-croissance ? Paris : IDDRI

Abstract: Ce document de travail dresse une synthèse des discussions menées lors du séminaire "Croissance et Prospérité" (juin 2013), augmentée d'un travail de recherche, ayant pour objectif de faire ressortir les éléments clés du débat et d'esquisser des solutions aux problèmes soulevés. Il présente dans un premier temps une description rapide du système de protection sociale en France, puis analyse les conséquences de l'hypothèse de croissance faible dans le cas des retraites et de la santé. Le cas français a évidemment des spécificités, mais les enjeux et options de réformes discutées pourront servir d'éclairage pour d'autres pays développés.
http:www.iddri.org/Publications/Collections/Idees-pour-le-debat/WP1713_LC%20DD_protection%20sociale%20post-croissance.pdf

Bernard C. (2013). Quel modèle social dans 10 ans? Paris : Commissariat Général à la Stratégie et à la Prospective. (C.G.S.P.)

Abstract: Le modèle social français a accompagné le développement économique et social de notre pays et demeure une composante centrale de notre cohésion nationale. Mais il est confronté à une triple crise de légitimité, de solvabilité et d'efficacité. Face aux nouveaux risques sociaux et à la montée des inégalités, l'enjeu consiste à repenser les objectifs et les moyens du modèle social, dans une économie européenne et mondialisée.
http:www.strategie.gouv.fr/blog/wp-content/uploads/2013/09/CGSP-note-model-social-v7.pdf

(2013). Évaluation du deuxième Plan national Santé-Environnement. Synthèse et préconisations : Paris : HCSP .

Abstract: Ce rapport produit, grâce à l'exploitation de bases de données publiques et parapubliques, des informations sur l'évolution de la qualité des milieux de vie et de travail, cibles du PNSE2. Neuf domaines sont analysés : Qualité de l'air extérieur, de l'air intérieur et de l'eau ; expositions au bruit et aux substances toxiques ; expositions professionnelles ; points noirs environnementaux ; habitat indigne ; expositions des populations vulnérables aux substances toxiques préoccupantes, reprotoxiques et à des perturbateurs endocriniens. La contribution du PNSE2 à la réduction des inégalités sociales et territoriales d'exposition aux risques résultant de ces pollutions et nuisances a aussi été recherchée. Les résultats des actions du PNSE2 restent difficiles à mesurer sur les niveaux d'exposition de la population, compte tenu des échelles de temps très longues que nécessitent la mise en oeuvre des actions et ensuite l'observation concrète de leurs effets. Les conclusions concernant l'évolution de la situation en santé-environnement durant ces dix dernières années varient selon les milieux (air extérieur, air intérieur, eaux, etc.) et polluants (particules, pesticides, métaux, etc.) ou nuisances (habitat indigne, bruit, etc.) analysés. L'insuffisance des informations disponibles ne permet pas de se prononcer sur la réduction des inégalités sociales et territoriales d'exposition aux risques résultant de ces pollutions et nuisances. Le HCSP souligne les faiblesses des systèmes d'information sur la qualité des milieux et les expositions de la population : éclatés et difficiles d'accès, ils sont peu adaptés pour cette analyse et celle des inégalités environnementales. Le HCSP formule des préconisations pour la préparation du PNSE3 et des PRSE3 sur des objectifs précis que pourraient s'assigner les prochains plans, la gouvernance et l'articulation entre le plan national et les plans régionaux.
http:www.hcsp.fr/Explore.cgi/Telecharger?NomFichier=hcsps20130919_evalpnse2.pdf

Unicancer. (2013). Quelle prise en charge des cancers en 2020 ? Paris : Unicancer
Abstract:Cette étude avait pour but d'identifier et qualifier les principales évolutions de la cancérologie dans les années à venir afin de permettre aux Centres de lutte contre le cancer de mieux orienter leur offre de soins. De février à juin 2013, UNICANCER a réalisé 40 entretiens avec des experts intervenant dans les Centres de lutte contre le cancer, mais aussi, afin d'avoir la vision la plus large possible, des professionnels issus d'autres structures de soins en France (CHU, cliniques privées) et à l'étranger (hôpitaux spécialisés dans les traitements des cancers aux Pays Bas, aux États-Unis et au Royaume-Uni). Six pistes d'évolution les plus structurantes à l'avenir pour la prise en charge des patients atteints d'un cancer ont été retenues : L'augmentation de la chirurgie ambulatoire, permettant au patient de quitter l'hôpital le jour même de son admission, et qui devra plus que doubler dans la cancérologie, La réduction du nombre de séances de radiothérapie grâce à des techniques plus performantes ; Les évolutions concernant la chimiothérapie qui permettront de plus en plus au patient d'être soigné chez lui grâce au développement des traitements oraux et de l'hospitalisation à domicile ; La caractérisation des tumeurs permettant de mieux les connaître pour mieux les soigner ; Le développement de la radiologie interventionnelle qui utilise les techniques d'imagerie pour des actes plus précis et moins invasifs pour les patients ; Le développement des soins de support pour prendre en charge le patient dans sa globalité pendant et après sa maladie.
http:www.unicancer.fr/sites/default/files/DP_UNICANCER_6_tendances_prise_en_charge_cancers_2020.pdf

Soins de santé primaires / Primary Health Care

Kauhanen A., Salmi J., Torkki P. (2013). Performance Measurement in Healthcare Incentive Plans : Helsinki : ETLA
Abstract: By using quantitative survey data and conducting a case study, we examine performance measurement of incentive plans in Finnish private sector health care organizations. We find that the performance measures used in the incentive plans are in line with recent economic theories of performance measurement. The findings from the case study emphasize the importance of choosing appropriate performance measures and designing the pay package as a whole. Inadequate performance measurement leads to incentive plans that do not help organizations reach their goals.
http:www.etla.fi/wp-content/uploads/ETLA-Working-Papers-18.pdf

Bodine-Baron E. Nowak S., Varadavas R. (2013). Conforming and Non-conforming Peer Effects in Vaccination Decisions : Cambridge : NBER
Abstract: Traditional economic models of vaccination assume that agents free-ride on the vaccination decision of others. These models show that private vaccination rates are always below the social optimal and even large subsidies cannot achieve disease eradication. In this paper, we build a model where in addition to the desire to free-ride, agents have a desire to conform to the vaccination decisions of their peers. In this model privately optimal vaccination rates can be higher or lower than the social optimal and thus subsidies for vaccination are not always optimal. However, in certain cases, even small subsidies can achieve disease eradication.
http:papers.nber.org/papers/w19528

Coulter A. (2013). Delivering better services for people with long-term conditions. Building the house of care : Londres : King's Fund .
Abstract: As of 1 April 2013, clinical commissioning groups (CCGs) are responsible for the majority of the NHS budget more than £65 billion of public money. At the same time, public health budgets of £2.7 billion are transferring to local authorities, while NHS England (formerly the NHS Commissioning Board), through its 27 area teams, takes responsibility for commissioning primary care (£13 billion) and specialised services (£12 billion). It is hoped that the new health and wellbeing boards, convened by local authorities, will play a key role in co-ordinating the activities of these different groups of commissioners, while commissioning support units ? also new ? will provide a range of services to clinical commissioning groups and NHS England to help them to perform their functions effectively. The new commissioning landscape is summarised in the figure below. Collectively, the task of this

new set of commissioners is to deliver a sustainable health care system in the face of one of the most challenging financial and organisational environments the NHS has ever experienced. The task is especially daunting in the context of a population in which the burden of disease is growing and medical advances offer increasing opportunities to treat disease, but at a cost. The result, if nothing else changes in the NHS, will be significant unmet need and threats to the quality of care.
http:www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

Systèmes de santé / Health Care Systems

Clemens J., Gottlieb J.D. (2013). Bargaining in the Shadow of a Giant: Medicare's Influence on Private Payment Systems : Cambridge : NBER

Abstract: We analyze Medicare's influence on private payments for physicians' services. Using a large administrative change in payments for surgical procedures relative to other medical services, we find that private payments follow Medicare's lead. On average, a $1 change in Medicare's relative payments results in a $1.30 change in private payments. We find that Medicare similarly moves the level of private payments when it alters fees across the board. Medicare thus strongly influences both relative valuations and aggregate expenditures on physicians' services. We show further that Medicare's price transmission is strongest in markets with large numbers of physicians and low provider consolidation. Transaction and bargaining costs may lead the development of payment systems to suffer from a classic coordination problem. By extension, improvements in Medicare's payment models may have the qualities of public goods.
http:www.nber.org/papers/w19503

Marzilli Ericson K.M., Starc A. (2013). How Product Standardization Affects Choice: Evidence from the Massachusetts Health Insurance Exchange : Cambridge : NBER

Abstract: Standardization of complex products is touted as improving consumer decisions and intensifying price competition, but evidence on standardization is limited. We examine a natural experiment: the standardization of health insurance plans on the Massachusetts Health Insurance Exchange. Pre-standardization, firms had wide latitude to design plans. A regulatory change then required firms to standardize the cost-sharing parameters of plans and offer seven defined options; plans remained differentiated on network, brand, and price. Standardization led consumers on the HIX to choose more generous health insurance plans and led to substantial shifts in brands' market shares. We decompose the sources of this shift into three effects: price, product availability, and valuation. A discrete choice model shows that standardization changed the weights consumers attach to plan attributes (a valuation effect), increasing the salience of tier. The availability effect explains the bulk of the brand shifts. Standardization increased consumer welfare in our models, but firms captured some of the surplus by reoptimizing premiums. We use hypothetical choice experiments to replicate the effect of standardization and conduct alternative counterfactuals.
http:papers.nber.org/papers/w19527

Mulligan C.B. (2013). Is the Affordable Act different from Romney Care ? A labor economic perspective : Cambridge : NBER

Abstract: Measured in percentage points, the Affordable Care Act will, by 2015, add about twelve times more to average marginal labor income tax rates nationwide than the Massachusetts health reform added to average rates in Massachusetts following its 2006 statewide health reform. The rate impacts are different between the two laws for several reasons, especially that: the populations subject to the two laws are different, the Affordable Care Act's employer penalty is an order of magnitude greater, before either reform Massachusetts had already been offering more means-tested and employment-tested health insurance assistance than other states had, and the subsidized health insurance plans created by the Massachusetts reform were less substitutable for employer-provided insurance than are the subsidized plans to be created nationwide next year.
http:papers.nber.org/papers/w19366

Meagher G. (2013). Marketisation in Nordic eldercare : a research report on legislation, oversight, extent and consequences : Stockholm : Stockholm University .

Abstract: The Nordic countries share a tradition of universal, tax-financed eldercare services, centred on public provision. Yet Nordic eldercare has not escaped the influence of the global wave of marketisation in recent years. Marketinspired measures, such as competitive tendering and user choice models, have been introduced in all Nordic countries, and in some countries, there has been an increase of private, for-profit provision of care services. This report is the first effort to comprehensively document the process of marketisation in Sweden, Finland, Denmark and Norway. The report seeks to answer the following questions: What kinds of market reforms have been carried out in Nordic eldercare systems? What is the extent of privately provided services? How is the quality of marketised eldercare monitored? What has the impact of marketisation been on users of eldercare, on care workers and on eldercare systems? Are marketisation trends similar in the four countries, or are there major differences between them? The report also includes analyses of aspects of marketisation in Canada and the United States, where there is a longer history of markets in care. These contributions offer some perhaps salutary warnings for the Nordic countries about the risks of increasing competition and private provision in eldercare (résumé des éditeurs).
http:www.normacare.net/wp-content/uploads/2013/09/Marketisation-in-nordic-eldercare-webbversion-med-omslag1.pdf

(2013). Reducing Wait Times for Health Care: What Canada Can Learn from Theory and International Experience : Vancouver : The Fraser Institute .

Abstract: This book collects articles by Canadian health policy experts about waiting lists for healthcare services. Topics include health system economics, policy approaches, labour market consequences, comparative international experiences, and the complexity of comparing wait times between countries.
http:www.fraserinstitute.org/uploadedFiles/fraser-ca/Content/research-news/research/publications/reducing-wait-times-for-health-care.pdf

Travail et santé / Occupational Health

Peng L., Meyerhoefer C.D., Zukevas S.H. (2013). The Effect of Depression on Labor Market Outcomes : Cambridge : NBER

Abstract: We estimated the effect of depression on labor market outcomes using data from the 2004-2009 Medical Expenditure Panel Survey. After accounting for the endogeneity of depression through a correlated random effects panel data specification, we found that depression reduces the likelihood of employment. We did not, however, find evidence of a causal relationship between depression and hourly wages or weekly hours worked. Our estimates are substantially smaller than those from previous studies, and imply that depression reduces the probability of employment by 2.6 percentage points. In addition, we examined the effect of depression on work impairment and found that depression increases annual work loss days by about 1.4 days (33 percent), which implies that the annual aggregate productivity loses due to depression-induced absenteeism range from $700 million to 1.4 billion in 2009 USD.
http:papers.nber.org/papers/w19451

Josephson M., Karnehed E., Lindahl E., Persson H. (2013). Intergenerational transmission of long-term sick leave : Uppsala : IFAU

Abstract: The aim of this study is to investigate the importance of intergenerational transmission of sick leave using universal Swedish register data on the rate of sickness benefits. We find that there is a positive correlation between parents' and their children's sick leave. The child–parent correlation is of about the same magnitude irrespective of the gender of the parent and the child, but it is larger the more sick leave the parent had when observed. Furthermore, there is a positive correlation between the sick leave level of the children and that of the parents-in-law, implying that persons tend to live with a partner whose sick leave resembles that of their parents. Finally, a comparison between siblings of different birth order shows that firstborn daughters report fewer spells of sick leave than their younger siblings of the same gender. This gap only emerges in the group of daughters with parents who lack

sick le ave themselves, suggesting that the birth-order effect is only of importance among women with low levels of sick leave.
http:www.ifau.se/Upload/pdf/se/2013/wp2013-19-Intergenerational-transmission-of-long-term-sick-leave.pdf

Addabbo T., Krishnakumar J., Sarti E. (2013). To what extent does disability discourage from work? An empirical analysis of labour force participation of disabled people in Italy : Modène : C.A.P.P.
Abstract: This paper is an empirical study on the work opportunities of people with disability using Italian data collected through a survey carried out by ISTAT in 2004. Our analysis is guided by the conceptual framework of the capability approach and investigates the role of conversion factors in the ability to be employed and the type of employment. We first use a simple probit for labour force participation and then a sequential logit for the outcomes of participation as well as employment status. In all variants we and that chronic illness is a stronger deterrent for labour force participation than disability. Women are more discouraged by disability compared to men. Among the various types of disabilities, `intellectual' disability is the strongest barrier as can be expected and hearing the least influential. In a sequential decision-making process, we and that disability affects both labour force participation decision and the ability to be employed but not so much the choice between part-time and full-time.
http:www.capp.unimore.it/pubbl/cappapers/Capp_p109.pdf

Vieillissement / Ageing

Fleurbaey M., Leroux M., Pestieau P., Ponthière G. (2013). Fair Retirement under Risky Lifetime : Paris : Paris School of economics
Abstract: A premature death unexpectedly brings a life and a career to their end, leading to substantial welfare losses. We study the retirement decision in an economy with risky lifetime, and compare the laissez-faire with egalitarian social optima. We consider two social objectives: (1) the maximin on expected lifetime welfare (ex ante), allowing for a compensation for unequal life expectancies; (2) the maximin on realized lifetime welfare (ex post), allowing for a compensation for unequal lifetimes. The latter optimum involves, in general, decreasing lifetime consumption profiles, as well as raising the retirement age, unlike the ex ante egalitarian optimum. This result is robust to the introduction of unequal life expectancies and unequal productivities. Hence, the postponement of the retirement age can, quite surprisingly, be defended on egalitarian grounds --although the conclusion is reversed when mortality strikes only after retirement.
http:halshs.archives-ouvertes.fr/docs/00/85/79/45/PDF/wp201331.pdf

Hashimoto H. (2013). Health Consequences of Transitioning to Retirement and Social Participation: Results based on JSTAR panel data : Tokyo : Research Institute of Economy, Trade and Industry
Abstract: Despite an extensive amount of published economic, psychological, and public health research, a consensual view on the causal relationship between retirement and health remains to be articulated. This lack of consensus is arguably due to the diversity in the transitional process from employment to full retirement, the usage of various characteristics of outcome measures, social and economic conditions affecting the retirement decision, and the impact of crowding-out by activities not related to formal work (e.g., in the family and community network). We used panel data from the Japanese Study of Aging and Retirement (JSTAR) to scrutinize the complex relationships among employment status transition; physical, functional, and cognitive aspects of health measures; and types of social participation. We confirmed that transitioning from employment to retirement is a diverse and gradual process with distinct gender-related aspects. Social participation is significantly related to exiting formal work situations for men, but not for women. There were distinct patterns of health transition across employment status transition, by types of health measures, and by reasons for retirement. Regression analyses were conducted to identify the effect of retirement, as leave from paid work, on health conditions. Variables included in the analyses accounted for social participation, stress received from the former job, and reasons for retirement. The results which included propensity

weighting reveal that psychological distress and cognitive function decline after retirement for men, but not for women. Retirement from jobs with high stress was followed by an improvement in health, especially among men. Additional results indicate that retirement is accompanied by increased social participation. Social participation ameliorates psychological distress and cognitive decline among men, but not among women. Limitations in the instrumental activities of daily life as well as in grip strength are not considerably affected by retirement. Among women, retirement to engage in family care significantly and heavily affected the level of psychological distress. These results indicate that the theories on which aspects of health status determine—and are determined by—the mode of employment status transition should be improved. Policies on work and health in the elderly population should not seek a one-size-fits-all solution, but should target different segments in terms of work characteristics, economic and social needs, and gender roles in the household.
http:www.rieti.go.jp/jp/publications/dp/13e078.pdf

Burtless G. (2013). Can Educational Attainment Explain the Rise in Labor Force Participation at Older Ages? Chestnut Hill : Center for Retirement Research at Boston College
Abstract: Over the past 25 years, the labor force participation of men age 60-74 jumped from 35 percent to 44 percent. At the same time, the educational levels of older workers increased dramatically in both absolute terms and relative to prime-age workers. Better educated workers are healthier and have more opportunities. Indeed, the analysis suggests that rising education levels account for more than half of the increase in labor force participation. Going forward, gains in education by older workers will slow considerably, which will slow further increases in their labor force participation.
http:crr.bc.edu/wp-content/uploads/2013/08/IB_13-13.pdf

Lippi-Bruni M., Ugolini C. (2013). Delegating home care for the elderly to external caregivers? An empirical study on Italian data. Working Paper DSE; 905. Bologne : University of Bologna
Abstract: We study care arrangement decisions in Italy, where families are increasingly delegating the role of primary caregiver to external (paid) people also for the provision of home care. We consider a sample of households with a dependent elderly person cared for either at home or in a residential home, extracted from a survey representative of the population of Italy's Emilia-Romagna region. We investigate the determinants of a household's decision to opt for one of the following three alternatives: the institutionalisation of elderly family members, informal home care, or paid home care. We estimate two model specifications, based on a simultaneous and a sequential decision process respectively, the results of which are fairly consistent. Disability related variables, rather than family characteristics, emerge as the main determinants of institutionalisation. On the other hand, household characteristics and socio-economic variables are more influential when it comes to choosing between informal and formal home care provisions.
http:www2.dse.unibo.it/wp/WP905.pdf

De Donder P., Pestieau P. (2013). Private, social and self-insurance for long-term care in the presence of family help: A political economy analysis : Munich : Center for Economic Studies
Abstract: We study the political determination of the level of social long-term care insurance when voters also choose private insurance and saving amounts. Agents differ in income, probability of becoming dependent and of receiving family help. Social insurance redistributes across income and risk levels, while private insurance is actuarially fair. The income-to-risk ratio of agents determines whether they prefer social or private insurance. Family support crowds out the demand for both social and, especially, private insurance, as strong prospects of family help drive the demand for private insurance to zero. The availability of private insurance decreases the demand for social insurance but need not decrease its majority chosen level.
http://ideas.repec.org/p/ces/ceswps/_4352.html