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Veille bibliographique en économie de la santé / Watch on Health Economics Literature

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Sommaire

Assurance Maladie / Health Insurance

Fossen F.M., Konig J. 2015). Public Health Insurance and Entry into Self-employment. Berlin : DIW - 2015/01

We estimate the impact of a differential treatment of paid employees versus self-employed workers in a public health insurance system on the entry rate into entrepreneurship. In Germany, the public health insurance system is mandatory for most paid employees, but not for the self-employed, who usually buy private health insurance. Private health insurance contributions are relatively low for the young and healthy, and until 2013 also for males, but less attractive at the other ends of these dimensions and if membership in the public health insurance system allows other family members to be covered by contribution-free family insurance. Therefore, the health insurance system can create incentives or disincentives to starting up a business depending on the family's situation and health. We estimate a discrete time hazard rate model of entrepreneurial entry based on representative household panel data for Germany, which include personal health information, and we account for nonrandom sample selection. We estimate that an increase in the health insurance cost differential between self-employed workers and paid employees by 100 euro per month decreases the annual probability of entry into self-employment by 0.38 percentage points, i.e. about a third of the average annual entry rate. The results show that the phenomenon of entrepreneurship lock, which an emerging literature describes for the system of employer provided health insurance in the USA, can also occur in a public health insurance system. Therefore, entrepreneurial activity should be taken into account when discussing potential health care reforms, not only in the USA and in Germany.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2562991

Economie de la santé Health Economics

Rebba V. (2014). The Long-Term Sustainability Of European Health Care Systems. Padoue : Université de Padoue

Abstract: Over the past thirty years, health expenditure has grown at a faster rate than the economin almost every OECD country. The main drivers of public health spending are income growth, insurance coverage, demographics, and, above all, technological change. According to the projections of the major international institutions (European Commission, OECD, International Monetary Fund), public health spending for the of EU-15 countries could significantly increase by 2050. These projections vary in an extremely wide range, between +27% and +84%, depending on the assumptions made. However, the big challenge will be the growth of public spending on long-term care which could more than double over the 2010-2050 period, owing to the sharp rise of frailty and disability at older ages, especially amongst the very old (aged 80+) which will be the fastest growing segment of the EU population in the decades to come. The European countries are facing a common challenge: the need to secure the economic and financial sustainability of their health care systems without undermining the values of universal coverage and solidarity in financing. Command and control policies aimed at expenditure restraints and largely operating through regulatory controls (controls over inputs and wages, budget caps, etc.) are widely used during periods of recession. They can hold expenditures down in the short term. However, they do little or nothing to moderate the underlying pressures which push health spending up over the long-run. Other policies to guarantee both economic and financial sustainability in the long-run should be explored: 1) the adoption of new regulation tools on supply and demand side; 2) a new balanced mix of public and private financing, strengthening the role of supplementary private health insurance, to allow investment and innovation, without imposing unsustainable burdens on public budgets and without denying care to the disadvantaged. The former policies focus on economic sustainability, improving the way health

systems address the rise in chronic disease and seek to incentive and reward patients, providers and buyers for healthy behaviour, quality and efficiency of care. The latter policies could ensure long-term financial stability of the health care systems but may determine negative effects in terms of equity and, therefore, they must be carefully designed.
http:economia.unipd.it/sites/decon.unipd.it/files/20140191.pdf

Jeantet M., Lopez A., Destais N. (2014). Evaluation médico-économique de la santé. Rapport Igas ; 2014-066R. Paris : IGAS
Abstract: La présente mission, inscrite au programme d'activité de l'IGAS, a pour objet d'étudier, en France et dans d'autres pays européens, la relation existante entre les évaluations médico-économiques et la prise de décision publique. Elle a tout d'abord dressé un état des lieux des évaluations médico-économiques réalisées en France et dans quatre pays européens : le Royaume-Uni, l'Allemagne, la Suède, la Belgique. La mission a choisi de s'intéresser aux décisions publiques prises au niveau central et au niveau déconcentré, et d'investiguer un large champ d'application de l'évaluation médico-économique en santé. La mission expose ensuite son analyse des objections classiquement faites aux évaluations médico-économiques. Elle formule enfin plusieurs recommandations organisées selon deux axes : le premier concerne la fixation d'un cadre de principes structurant la décision publique au sein duquel les évaluations médico-économiques doivent prendre place ; le second détaille les dispositions à prendre afin de se doter d'une politique en matière d'évaluation médico-économique. Les annexes du rapport sont composées sous la forme de fiches. Elles décrivent le dispositif d'évaluation en France et à l'étranger et résument quelques exemples d'études menées par la Haute autorité de santé (HAS).
http:www.igas.gouv.fr/IMG/pdf/2014-066R_-_Rapport_DEF.pdf

Fontaine R., Plisson M., Zerrar N. (2015). Dans quelle mesure les préférences individuelles contraignent-elles le développement du marché de l'assurance dépendance ? *Economie et Statistique,* (474) :
Abstract: Dans un contexte de vieillissement de la population, différents scenarii sont envisagés pour réformer l'organisation et le financement de la prise en charge des personnes âgées dépendantes. La place de la prévoyance individuelle dans le financement de la dépendance est à ce titre largement débattue. À l'heure actuelle, malgré des restes à charge potentiellement conséquents, peu d'individus disposent d'une couverture assurantielle. Cet article vise à enrichir la littérature existante en évaluant dans quelle mesure les préférences observées dans la population limitent cette couverture. Nous mobilisons pour cela l'enquête Patrimoine et préférences vis-à-vis du temps et du risque (Pater) de 2011. À la demande de la Fondation Médéric Alzheimer, la vague 2011 de l'enquête Pater a intégré un questionnaire complémentaire relatif à la perception du risque dépendance et aux comportements d'assurance (Pated). L'enquête Pater permet la construction de scores quantifiant quatre dimensions des préférences susceptibles d'influencer la perception du risque et la probabilité de souscrire une assurance parmi les individus percevant le risque : la préférence pour le présent, l'aversion au risque, l'altruisme familial et le goût présumé pour l'aide informelle.
http:www.insee.fr/fr/ffc/docs_ffc/ES474B.pdf

Lakdawalla D., Malani A., Reif J. (2015). The Insurance Value of Medical Innovation. Cambridge : NBER
Abstract: Economists think of medical innovation as a valuable but risky good, producing health benefits but increasing financial risk. This perspective overlooks how innovation can lower physical risks borne by healthy patients facing the prospect of future disease. We present an alternative framework that accounts for all these aspects of value and links them to the value of health insurance. We show that any innovation worth buying reduces overall risk, thereby generating positive insurance value on its own. We conduct two empirical exercises to assess the significance of our insights. First, we calculate that conventional methods underestimate the value of historical

health gains by 30-80%. Second, we examine a large set of medical technologies and calculate that insurance value on average adds 100% to the conventional valuation of those treatments. Moreover, we find that the physical risk-reduction value of these technologies is ten times greater than the financial risk they pose and the corresponding value of health insurance that insures this financial risk. Our analysis also suggests standard methods disproportionately undervalue treatments for the most severe illnesses, where physical risk to consumers is most costly.
http:www.nber.org/papers/w21015

(2015). Comparative efficiency of health systems, corrected for selected lifestyle factors. Final report. Luxembourg: Publications Office of the European Union .
Abstract: The MACELI (Macro Cost Effectiveness corrected for Lifestyle) project studied the cost-effectiveness of European health systems, and the impact of differences in lifestyle, specifically smoking, overweight and alcohol consumption. Baseline analyses without standardizing for lifestyle showed on average more health spending was associated with better health. This effect was clearest for countries with lower levels of spending. Standardization towards a better lifestyle meant an upward shift of the health production function, but did not much alter the comparative efficiency of countries. The study covered the EU-28 Member States, Iceland, and Norway. Individual-level data were used to describe lifestyle across age and gender and to analyse its impact on health outcomes and health care use. Health outcomes and health spending were standardized for differences in lifestyle using a lifetable model (reference year 2010). Results were put into further perspective by additional qualitative research and through several sensitivity analyses, including an indirect disease-based approach. Finally, a systematic literature review was performed to investigate potential interventions to achieve lifestyle changes. Several shortcuts were taken to allow consistent estimates across a large number of countries, which imply that the results should be interpreted with care.
http:ec.europa.eu/health/systems_performance_assessment/docs/2015_maceli_report_en.pdf

Etat de santé / Health Status

(2014). Comment va la vie ? Mesurer le bien-être. Paris : OCDE
Abstract: Chaque semestre, Comment va la vie ? évalue le bien-être des citoyens des pays de l'OCDE et de certains pays émergents. Cette évaluation s'appuie sur un cadre pluridimensionnel qui couvre 11 aspects du bien-être, ainsi que sur un large éventail d'indicateurs de résultats. Chaque édition comprend aussi plusieurs chapitres consacrés à des aspects plus spécifiques du bien-être. L'édition 2013 aborde quatre thématiques: les conséquences de la crise financière mondiale sur le bien-être ; les disparités hommes-femmes en matière de bien-être ; le bien-être au travail ; et la durabilité du bien-être (résumé de l'éditeur).

(2015). Plan cancer 2014-2019 : premier rapport au président de la République. Paris : Institut National du Cancer .
Abstract: Ce rapport constitue une première évaluation de la première année du troisième Plan cancer. Des efforts importants ont été déployés en 2014 pour programmer la mise en œuvre des 185 actions qui composent le Plan et en organiser le pilotage et le suivi. Si trente-huit actions connaissent un retard, la grande majorité des actions programmées respecte le planning prévu et trois actions sont désormais achevées. Ce rapport fait un bilan de réalisation autour des 3 axes, avec pour objectif : Guérir plus de personnes malades ; L'annexe 1 du rapport (p. 31) regroupe les tableaux de suivi de toutes les actions au 1er janvier 2015.
http:www.e-cancer.fr/publications/93-plan-cancer/826-premier-rapport-au-president-de-la-republique-plan-cancer-2014-2019

Jousselme C., Cosquer M., Hassler C. (2015). Portraits d'adolescents - Enquête épidémiologique multicentrique en milieu scolaire en 2013. Paris : INSERM .
Abstract: Une grande enquête, coordonnée par l'Unité Inserm 1178 « Santé mentale et santé publique » et le pôle Universitaire de la Fondation Vallée, dresse un état des lieux des problématiques et enjeux actuels de l'adolescence. Ces données, recueillies au moyen d'auto-questionnaires, confrontent les perceptions de 15 235 jeunes scolarisés, âgés de 13 à 18 ans, concernant leur propre adolescence. L'étude aborde des sujets aussi divers que leur santé physique et mentale, leurs consommations, leurs loisirs, ou encore leur sexualité. Les résultats obtenus réaffirment le caractère complexe de ces adultes en devenir, avec une différence fille/garçon bien inscrite et un gradient selon l'âge. Ils devraient permettre d'améliorer les connaissances sur les comportements de ces derniers, et d'identifier de nouveaux indicateurs de difficultés, utiles à la mise en place d'actions de prévention.
http:presse-inserm.fr/wp-content/uploads/2015/03/Portraits-dadolescents-mars-2015-1.pdf

Hôpital / Hospitals

Boisguerin B., Brillault G. (2015). Le panorama des établissements de santé : édition 2014. Paris : Drees
Abstract: Cet ouvrage présente les principales données relatives au système hospitalier français : elles portent sur les équipements, personnels et financements qui concourent aux différentes prises en charge par les établissements, ainsi que sur leur activité et leur clientèle. Il comprend : des dossiers, qui permettent d'approfondir des questions structurelles et d'éclairer les mutations du monde hospitalier ; des fiches thématiques, qui comportent chacune une sélection de figures accompagnées d'un commentaire présentant les traits les plus caractéristiques des domaines abordés.
http:www.drees.sante.gouv.fr/IMG/pdf/panorama2014.pdf

Besstremyannaya G. (2015). Heterogeneous effect of residency matching and prospective payment on labor returns and hospital scale economies. Standford : Stanford Institute for Economic Policy Research
Abstract: The paper evaluates heterogeneous effect of participation in a residency matching program and changeover from fee-for-service to a prospective payment system on labor returns and economies of scale at acute-care public hospitals in Japan. A range of frontier technologies for multi-product output function is introduced with panel data quantile regression models, where endogenous treatment variables account for the fact that participation in both the residency matching program and the prospective payment reform was voluntary. The analysis exploits nationwide longitudinal databases on Japanese hospital participation in each of the reforms and on financial performance of regional and municipal hospitals in 2006-2012. The results demonstrate a labor-capital trade-o_ and lower labor intensity in the most productive hospitals. The residency matching program is positively associated with hospital production and labor productivity, especially in medium quantiles. Prospective payment has a negative effect on labor productivity, but it is only significant for hospitals in the highest quantiles.
http:siepr.stanford.edu/publicationsprofile/2835

Allin S. B., Baker M., Maripier I., et al. (2015). Physician Incentives and the Rise in C-sections: Evidence from Canada. Cambridge : NBER
Abstract: More than one in four births are delivered by Cesarean section across the OECD where fee-for-service remuneration schemes generally compensate C-sections more generously than vaginal deliveries. In this paper, we exploit unique features of the Canadian health care system to investigate

if physicians respond to financial incentives in obstetric care. Previous studies have investigated physicians' behavioral response to incentives using data from institutional contexts in which they can sort across remuneration schemes and patient types. The single payer and universal coverage nature of Medicare in Canada mitigates the threat that our estimates are contaminated by such a selection bias. Using administrative data from nearly five million hospital records, we find that doubling the compensation received for a C-section relative to a vaginal delivery increases by 5.6 percentage points the likelihood that a birth is delivered by C-section, all else equal. This result is mostly driven by obstetricians, rather than by general practitioners. We also find that physicians' response to financial incentives is greater among patients over 34, which may reflect physicians' greater informational advantage on the risks of different delivery methods for this category of mothers.
http:www.nber.org/papers/w21022

Huguier M., Milhaud G., Denoix De Saint Marc R. (2015). Pertinence économique de la chirurgie ambulatoire. Paris : Académie nationale de médecine .
Abstract: L'académie nationale de médecine, depuis plus de dix ans, considère la chirurgie ambulatoire avec un grand intérêt. Les estimations des économies qu'elle permettrait varient de 0.5 milliards à 6 milliard. Cela s'explique par l'absence d'études fondées sur des comparaisons factuelles bien établies. De plus, les estimations reposent, en partie, sur des comparaisons internationales qui sont biaisées par l'absence de définition claire et concrète de cette « chirurgie ». Les tarifications en France sont d'une remarquable complexité. Schématiquement, 1) les coûts pour le malade, pris en charge par l'assurance maladie et par les assurances complémentaires, sont basés sur la notion de prix de journée et sont en faveur de la chirurgie ambulatoire par rapport à la chirurgie conventionnelle ; 2) les coûts pour les établissements hospitaliers sont, pour l'essentiel, le ratio entre les allocations versées par l'assurance maladie qui reposent sur la tarification à l'activité (T2A) et ses dépenses, principalement salariales ; 3) le coût pour l'assurance maladie est celui qu'elle fixe elle-même pour chaque activité médicale (T2A) au sein de l'enveloppe globale de l'Objectif national des dépenses de santé (ONDAM), mais qui n'est pas un crédit budgétaire limitatif. L'Académie nationale de médecine, sans remettre en cause le bénéfice pour le patient de cette alternative à la chirurgie traditionnelle, insiste sur la nécessité de réaliser en France des études comparatives avec la chirurgie conventionnelle portant sur les coûts réels, directs et dérivés en s'appuyant sur une comptabilité analytique. L'analyse porterait sur des actes et des groupes de malades similaires. Par ailleurs, les propositions qu'elle avait faites pour une réforme de l'assurance maladie gardent toute leur valeur.
http:www.academie-medecine.fr/articles-du-bulletin/publication/?idpublication=100407

(2015). Analyse comparative de l'activité hospitalière entre les régions 2013. Paris : ATIH .
Abstract: L'ATIH reconduit en 2013 l'analyse de l'activité hospitalière régionale en application de la loi modifiant la loi HPST (Article 27 de la Loi n° 2011-940 du 10 août 2011). Dans la continuité de la photographie globale de l'activité 2013, ce rapport propose une déclinaison au niveau régional pour le champ médecine, chirurgie et obstétrique (MCO). En préambule, un panorama régional de l'activité MCO distingue les séjours et les séances. Différents indicateurs (répartition, évolution…) y sont analysés selon plusieurs agrégats comme les catégories d'activité de soins ou les types de séances. Les caractéristiques sociodémographiques des territoires de santé ainsi que celles de l'activité hospitalière évoluant de manière marginale en un an, les conclusions posées sur l'activité régionale 2012 restent d'actualité. L'atlas régional propose une fiche par région décrivant l'activité hospitalière en distinguant les établissements de santé selon leur secteur de financement. Cette approche souligne les différentes dynamiques d'activité.

Inégalités de santé / Health Inequalities

Weaver F., Goncalves J., Ryser V.A. (2015). Socioeconomic inequalities in subjective well-being among the 50+: contributions of income and health. Genève : Université de Genève
Abstract: Although there is a growing interest in subjective well-being (SWB) and its determinants, the extent of socioeconomic inequalities in SWB has not yet been analyzed. This study assesses socioeconomic inequalities in SWB in twelve European countries and the United States (US), by estimating concentration indices. They are then decomposed to document how individual income, relative income (i.e. how individual income compares to those of peers), individual health, and relative health contribute to these inequalities. The analysis focuses on the population aged 50 and over, using data from the 'Survey of Health, Ageing, and Retirement in Europe' and the 'Health and Retirement Study' for the US. All countries display some socioeconomic inequalities in SWB, with SWB being concentrated among individuals with higher socioeconomic status. Of the countries studied, the Netherlands and Belgium have the lowest socioeconomic inequalities in SWB, while Poland and the Czech Republic have the highest. The US has significantly higher inequalities than the former and significantly lower inequalities than the latter countries. The decomposition reveals that individual and relative health contribute largely to these inequalities in all countries. In contrast, individual and relative income matter in some countries, such as the US, and not in others, for example Spain. These results indicate that attention needs to be paid to socioeconomic inequalities in SWB of the baby boomers and elderly population and that, in most countries, policies focusing on health would be more effective at reducing them than targeting income.
http:www.unige.ch/ses/dsec/repec/files/15011.pdf

Worm H.C. (2015). Life Expectancy and Education: Evidence from the Cardiovascular Revolution. Copenhague : University of Copenhagen
Abstract: In this study we investigate the causal impact of increasing adult longevity on higher education. We exploit the fourth stage of the epidemiological transition, i.e. the unexpected decline of deaths from heart attack and stroke in the 1970s as a large positive health shock that affected predominantly old age mortality. Using a differences-in- differences estimation strategy we find across U.S. states that the cardiovascular revolution led to an increase in adult life expectancy by about 2 years, which caused higher education enrollment to increase by 7 percentage points, i.e. 30 percent of the observed increase from 1970 to 2000. Our findings are robust to the inclusion of state-specific health trends and a host of confounding variables. They suggest large effects of improving longevity on higher education enrollment.
http:papers.ssrn.com/sol3/papers.cfm?abstract_id=2557412

Goldring T. (2015). Testing for Changes in the SES-Mortality Gradient When the Distribution of Education Changes Too. Cambridge : NBER
Abstract: We develop a flexible test for changes in the SES-mortality gradient over time that directly accounts for changes in the distribution of education, the most commonly used marker of SES. We implement the test for the period between 1984 and 2006 using microdata from the Census, CPS, and NHIS linked to death records. Using our flexible test, we find that the evidence for a change in the education-mortality gradient is not as strong and universal as previous research has suggested. Our results indicate that the gradient increased for females during this time period, but we cannot rule out that the gradient among males has not changed. Informally, the results suggest that the changes for females are mainly driven by the bottom of the education distribution.
www.nber.org/papers/w20993

Mackenbach J.P., Buissonniere M., Cohen J. ,et al (2015). Reducing inequalities in health and health care. *Eurohealth,* 21 (1)
Abstract: This Eurohealth issue provides a reflection on the 7th European Public Health Conference which was held in late 2014 in Glasgow. Articles in the Observer section look specifically at health inequalities - How Roma communities are responding to these; adaptation of health promotion and

disease prevention interventions for migrant and ethnic minority populations; and the Glasgow Declaration. Other articles include: Learning from each other - where health promotion meets infectious diseases; Public health monitoring and reporting; Changing your health behaviour - regulate or not; Developing the public health workforce; Building sustainable and resilient health care systems; Leaving a legacy in Glasgow; Conclusions; and Eurohealth Monitor.
http:www.euro.who.int/__data/assets/pdf_file/0005/272660/EuroHealth_V21n1_WEB_060315.pdf

Médicaments / Pharmaceuticals

Herr A., Stuhmeier T., Wenzel T. (2014). Reference pricing and cost-sharing: Theory and evidence on German off-patent drugs., Beiträge zur Jahrestagung des Vereins für Socialpolitik 2014: Evidenzbasierte Wirtschaftspolitik - Session: Health III, No.C10-V1
Abstract: This paper evaluates the impact of reference pricing on prices and co-payments in the (German) market for off-patent pharmaceuticals. We present a theoretical model with price-sensitive and loyal consumers that shows that a decrease in the reference price affects the consumers' co-payments in a non-monotonic way: For high reference prices, a marginally lower reference price may lead to lower copayments. However, for low reference prices a further reduction may result into higher consumer co-payments. We use quarterly data on reference priced drugs covered by the social health insurance in Germany over the period 2007 - 2010 to analyze the empirical effects of reference price reductions. We find that, while prices decrease due to the reduction, co-payments behave non-monotonically and indeed increase if the reference price is sufficiently low.
http://www.econstor.eu/handle/10419/100556

Grennan M. (2015). Regulating Innovation with Uncertain Quality: Information, Risk, and Access in Medical Devices. Cambridge : NBER
Abstract: This paper examines optimal regulatory testing requirements when new product quality is uncertain but market participants may learn over time. We develop a model capturing the regulator's tradeoff between consumer risk exposure and access to innovation. Using new data and exogenous variation between EU and US medical device regulatory rules, we document patterns consistent with our model and estimate its parameters. We find: without information from regulatory testing, risk shuts down the market; US policy is close to the one that maximizes a measure of welfare derived from our theoretical model and our empirical estimates; EU surplus could increase 20 percent with more pre-market testing; and "post-market surveillance" could increase surplus 24 percent.
http:www.nber.org/papers/w20981

(2015). Financing drug policy in Europe in the wake of the economic recession. Lisbonne : European Monitoring Centre for Drugs and Drug Addiction .
Abstract: En 2008 et les années qui suivirent, l'Europe a connu une importante crise économique. Cette situation a engendré de nombreux défis pour les Etats et leurs finances publiques. Un rapport de l'Observatoire Européen des Médicaments et des Toxicomanies (European Monitoring Centre for Drugs and Drug Addiction ou EMCDDA en anglais) s'intéresse aux dépenses publiques (santé et protection sociale notamment). L'Observatoire conclut, en premier lieu, que l'austérité a conduit à une réduction des dépenses dans la plupart des postes liés aux médicaments. D'autre part, les pays ayant connu des niveaux plus importants d'austérité avaient tendance à montrer une plus grande réduction des dépenses.

Enfin, les réductions les plus conséquentes des dépenses publiques ont plus été identifiées dans les domaines de la santé que dans celui de la sécurité publique ou la protection sociale. Les estimations nationales disponibles des dépenses publiques liées aux médicaments ne révèlent pas le plein impact de la récession économique de 2008 à 2009 sur les dépenses en santé au sens large. Cependant, il est possible de conclure que l'impact de l'austérité sur la politique du médicament a été plus intense dans les pays qui ont été les plus durement touchés par la crise économique. Néanmoins, dans la plupart des pays européens, la récession a conduit à une réévaluation du financement des politiques spécifiques aux médicaments et souvent à leur ajustement. Les budgets alloués aux médicaments sont devenus plus susceptibles de faire l'objet d'une révision. Souvent ceci se traduit par des coupures. In fine, l'austérité a sensibilisé les décideurs à la nécessité d'avoir une vision plus « cout-efficace » et efficiente.
http:www.emcdda.europa.eu/attachements.cfm/att_233505_EN_TDAU14008ENN.PDF

Méthodologie / Methodology

Maclean J.C. (2015). Reporting error in weight and height among the elderly: Implications and recommendations for estimating healthcare costs. Philadelphie : Temple University
Abstract: A large literature has examined the healthcare consequences of obesity. A major barrier to careful study of these consequences is reliance on self-reported measures of weight and height. Previous research has developed algorithms to adjust for such error among working age adults. In this study we consider elderly adults, a group likely to differ in reporting error patterns from working age adults due to involuntary weight loss and changes in cognition, muscle mass, and bone density. We first provide evidence on the degree and type of reporting error in this population. Second, we consider how well standard approaches to adjusting for such error preform in an elderly population in terms of estimating obesity prevalence and regression coefficients. These findings have direct implications for evaluating anti-obesity programs among the elderly and estimating the obesity-related health costs to the Medicare program.
http://www.cla.temple.edu/RePEc/documents/DETU_15_01.pdf

Politique de santé / Health Policy

Calvez C. (2015). La loi de santé 2015 : dossier documentaire. Rennes : EHESP
Abstract: Basé sur la Stratégie Nationale de Santé lancée par le Gouvernement en 2013 ainsi que sur les propositions de nombreux rapports (notamment les rapports d'Alain Cordier, de Claire Compagnon et de Bernadette Devictor), le projet de loi de santé a été présenté le 15 octobre 2014 en Conseil des ministres et doit être discuté à l'Assemblée Nationale à partir du 17 mars prochain. Ce dossier documentaire fait un premier point sur le projet de loi : il revient sur ses grandes étapes de construction et propose une sélection de documents classés par thématiques : rapports préparatoires, présentation générale du projet de loi, questionnements face à la réforme….
http://documentation.ehesp.fr/2015/02/nouveau-dossier-documentaire-sur-la-loi-de-sante/

Jin L. (2015). Retrospective and Prospective Benefit-Cost Analysis of US Anti-Smoking Policies. Cambridge : NBER

Abstract: Regulatory policies designed to improve societal welfare by "nudging" consumers to make better choices are increasingly popular. The application of benefit-cost analysis (BCA) to this sort of regulation confronts difficult theoretical and applied issues. In this analysis we contribute a worked example of behavioral BCA of US anti-smoking policies. Our conceptual framework extends the standard market-based approach to BCA to allow for individual failures to make lifetime utility-maximizing choices of cigarette consumption. We discuss how our market-based approach compares to the health benefits approach and the "consumer surplus offset" controversy in recent BCAs of several health-related regulations. We use a dynamic population model to make counterfactual simulations of smoking prevalence rates and cigarette demand over time. In our retrospective BCA the simulation results imply that the overall impact of antismoking policies from 1964 – 2010 is to reduce total cigarette consumption by 28 percent. At a discount rate of 3 percent the 1964-present value of the consumer benefits from anti-smoking policies through 2010 is estimated to be $573 billion ($2010). Although we are unable to develop a hard estimate of the policies' costs, we discuss evidence that suggests the consumer benefits substantially outweigh the costs. We then turn to a prospective BCA of future anti-smoking FDA regulations. At a discount rate of 3 percent the 2010-present value of the consumer benefits 30 years into the future from a simulated FDA tobacco regulation is estimated to be $100 billion. However, the nature of potential FDA tobacco regulations suggests that they might impose additional costs on consumers that make it less clear that the net benefits of the regulations will be positive.
http:www.nber.org/papers/w20998

(2015). Le baromètre des droits des malades 2015. Paris : LH2 Opinion, Paris : CISS .
Abstract: Le Collectif Interassociatif sur la santé (Ciss) publie son baromètre LH2-CISS 2015 des droits des malades. Il comporte cinq axes d'enquête : l'information en matière de santé en général; zoom sur Internet en matière de santé; les droits des malades et la représentation de leurs intérêts; les difficultés d'accès au crédit; le renoncement aux soins.
http:www.leciss.org/sites/default/files/150304_BarometreDroitsMalades_CISS-LH2.pdf

Soins de santé primaires / Primary Health Care

Blanchard P., Eslous L., Yeni I., Louis P. (2014). Evaluation de la coordination d'appui aux soins. Rapport Igas ; 2014-010R. Paris : IGAS .
Abstract: A la demande de la ministre en charge de la santé, l'IGAS a été chargée de « procéder à un inventaire et à une analyse de l'ensemble des coordinations d'appui aujourd'hui déployées ». Cette mission a été envisagée dans le cadre de la Stratégie nationale de santé (SNS). Après un diagnostic de la situation, le rapport propose une nouvelle organisation de la coordination d'appui aux soins, reposant sur l'initiative des médecins. La coordination d'appui aux soins proposée est ainsi destinée à éviter toute rupture dans la prise en charge globale des patients grâce à la mobilisation de l'ensemble des professionnels qui peuvent y concourir. Concrètement, la mission propose que ce soit le médecin de premier recours, et lui seul, qui puisse la déclencher en concertation avec le patient. Le médecin de premier recours pourrait ainsi choisir de recourir à différentes modalités en fonction de sa pratique et de ses habitudes.
http:www.igas.gouv.fr/IMG/pdf/2014-010R_Evaluation_coordination_appui_soins.pdf

Pla A., Mikol F. (2015). Les revenus d'activité des médecins libéraux récemment installés : évolutions récentes et contrastes avec leurs aînés. Collection Insee Références. Paris : INSEE.
Abstract: Les médecins ayant une activité libérale peuvent avoir plusieurs sources de revenus (bénéfices non commerciaux, revenus salariés, etc.), avec différentes combinaisons possibles de ces modes de rémunération. Ils disposent d'une grande liberté dans la détermination de leur niveau et

de leur type d'activité. Les médecins à « honoraires libres » (secteur 2) peuvent en outre pratiquer des dépassements d'honoraires en sus du tarif conventionnel de chaque acte. Les jeunes médecins, installés depuis moins de cinq ans, se distinguent de leurs aînés par leurs caractéristiques sociodémographiques mais aussi dans la pratique de leur activité. Ils sont plus souvent chirurgiens ou anesthésistes et moins souvent généralistes. Parmi les jeunes généralistes, les femmes sont désormais majoritaires. Les jeunes médecins exercent plus fréquemment que leurs aînés une activité salariée en plus de leur activité libérale. Les jeunes spécialistes sont beaucoup plus fréquemment installés en secteur 2 (59 % contre 41 % en moyenne). Entre 2005 et 2011, les revenus globaux des jeunes médecins ont progressé, en euros constants, de 2 % pour les généralistes et de 11 % pour les spécialistes. Ils ont été tirés à la hausse par l'augmentation des revenus salariaux ainsi que, pour l'activité libérale, par le développement des rémunérations versées sous forme forfaitaire par l'Assurance-maladie.
http:www.insee.fr/fr/ffc/docs_ffc/REVAIND15_c_D2_sante.pdf

Drouais P.L. (2015). La place et le rôle de la Médecine générale dans le système de santé. Paris : Collège de la Médecine Générale.
Abstract: Ce rapport rassemble les conclusions des travaux re´alise´s a` la demande de Madame la Ministre des Affaires sociales, de la Sante´ et des Droits des femmes, sur la place de la médecine générale dans le système de santé. A l'instar de beaucoup de pays européens, le système de santé français doit se recentrer sur les soins de santé primaires. La hiérarchisation effective des recours médicaux nécessite de placer la Médecine générale comme la première étape du parcours de santé du patient, à travers un renforcement du rôle du médecin traitant. Le médecin généraliste doit être le premier contact du patient avec le système de santé et assurer une coordination des soins efficace. Pour remplir ce rôle, la Médecine générale doit disposer des moyens appropriés, tant sur le plan budgétaire qu'organisationnel. Ce rapport propose des recommandations à ce sujet, et notamment des mesures à rajouter au projet de loi santé 2015.
http:www.lecmg.fr/DocumentsCMG/RapportDruaisofficiel20150309.pdf

Alderwick H., Ham C., Buck D. (2015). Population health systems. Going beyond integrated care. Londres : King's Fund Institute .
Abstract: Integrated care has become a key focus of health service reform in England in recent years, as a response to fragmentation within the NHS and social care system. Yet efforts to integrate care services have rarely extended into a concern for the broader health of local populations and the impact of the wider determinants of health. This is a missed opportunity. This paper aims to challenge those involved in integrated care and public health to 'join up the dots', seeing integrated care as part of a broader shift away from fragmentation towards an approach focused on improving population health. Using examples from organisations and systems in other countries that are making this shift, the authors argue that improving population health is not just the responsibility of health and social care services or of public health professionals - it requires co-ordinated efforts across population health systems.

Kringos D.S. (2015), Boerma W.G.W. ,Hutchinson A., Bourgueil Y, Cartier T.. Building primary care in a changing Europe. Copenhague : Office des Publications du Bureau Régional de l'Europe
Abstract: This new study gives a wide-ranging overview of primary care in 31 European countries. Topics covered include governance, financing, workforce aspects and the breadth of the provision of services. As well as looking at how primary care relates to broader health-care outcomes, this volume describes the diversity of essential primary care features, such as accessibility, continuity and coordination, and suggests priority areas for review. A second, online volume contains structured summaries of the state of primary care in each of the 31 countries.
http:www.euro.who.int/en/about-us/partners/observatory/publications/studies/building-primary-care-in-a-changing-europe

Systèmes de santé / Health Systems

Edward N. (2015). Rationing in the NHS. *Policy Briefing,* (2) :
Abstract: This briefing looks at what public attitudes to rationing and policy-setting are; how rationing decisions are currently made and how much explicit rationing there is; how NICE and the Cancer Drugs Fund are working; and how much money rationing can save. With a series of messages for policy-makers, this briefing is intended to be a useful appraisal of current approaches to rationing for Members of Parliament (current and prospective) and does not seek to be a comprehensive exploration of what is a highly complex subject.

Sigurgeirsdottir S. W. (2014). Health system review : Iceland. *Health systems in transition ;* vol. 16, n°6. Copenhague : OMS Bureau régional de l'Europe
Abstract: Iceland's health outcomes are among the best of all OECD countries: life expectancy at birth is high and Icelandic men and women enjoy longer life in good health than the European average. However, this comes at a relatively high price. The health-care system faces challenges involving the financial sustainability of the current system in the context of an ageing population, new public health challenges (such as obesity) and the continued impact of the country's financial collapse in 2008. The most important challenge is to change the pattern of health-care utilization to steer it away from the most expensive end of the health services spectrum towards more cost-efficient and effective alternatives.

Costa-Font J., Zigante V. (2014). The Choice Agenda in European Health Systems: The Role of 'Middle Class Demands'. London : London School of Economics and Political Science
Abstract: We examine the role of political economy drivers of the choice agenda in European health systems including middle class electoral support. Building on the reform trajectories and current institutional framework in eight western European countries where there have been significant choice reforms, we explore the preferences for choice and health system satisfaction in those countries. We find provider choice to be supported by middle class demands and health systems satisfaction, but weak evidence of other alternative political motivations for the expansion of provider choice. We conclude that in addition to efficiency improvements, provider choice is largely correlated with the demands for choice among the middle class. The provider choice agenda responds as much to political economy consideration as it does to efficiency arguments.
http:papers.ssrn.com/sol3/papers.cfm?abstract_id=2522841

(2015). Health, health systems and the crisis in six countries : case studies. Copenhague : OMS Bureau régional de l'Europe
Abstract: The financial crisis of 2008/2009, and subsequent fiscal austerity policies, have created concerns that public health and health systems will be adversely affected. While a significant body of work has attempted to evaluate the susceptibility of health status to economic crises, there is relatively little analysis of how these downturns influence policies on health systems. This subject remains timely in Europe, as health ministers seek evidence that can inform decision-making and negotiations at the highest political levels about how to maximise health system efficiency during a period of budget constraint. As part of that wider analysis on the impact of the financial crisis on health systems and population health in the European Region, a set of six case studies has now been published. These provide in-depth analysis of how certain countries have addressed this situation. These countries - Estonia, Greece, Ireland, Latvia, Lithuania and Portugal - were affected relatively harder than most other European states. The management of the crisis and the immediate and medium-term consequences for health, budgets and equity are discussed in more detail. Each peer-reviewed study, led by authors from the country concerned, and drawing on an impressive amount of data, charts how a deteriorating fiscal position led to a mix of policy responses, with some

countries relying on spending cuts and coverage restrictions whilst others squeezed available resources through efficiency gains or mobilised additional revenue. These six case studies complement the broader analysis conducted jointly by the European Observatory on Health Systems and Policies and the WHO Regional Office for Europe.
http:www.euro.who.int/en/about-us/partners/observatory/activities/research-studies-and-projects/the-impact-of-financial-crisis-on-health-systems-in-europe

Travail et santé / Occupational Health

(2015). Fit Mind, Fit Job. From Evidence to Practice in Mental Health and Work. Paris : OCDE.
Abstract: The costs of mental ill-health for individuals, employers and society at large are enormous. Mental illness is responsible for a very significant loss of potential labour supply, high rates of unemployment, and a high incidence of sickness absence and reduced productivity at work. Following an introductory report (Sick on the Job: Myths and Realities about Mental Health and Work) and nine country reports, this final synthesis report summarizes the findings from the participating countries and makes the case for a stronger policy response.
http:www.oecd-ilibrary.org/employment/fit-mind-fit-job_9789264228283-en

Pichler F., ,Ziebarth N.R. (2015). The Pros and Cons of Sick Pay Schemes: A Method to Test for Contagious Presenteeism and Shirking Behavior. Bonn : IZA
Abstract: This paper proposes a test for the existence and the degree of contagious presenteeism and negative externalities in sickness insurance schemes. First, we theoretically decompose moral hazard into shirking and contagious presenteeism behavior. Then we derive testable conditions for reduced shirking, increased presenteeism, and the level of overall moral hazard when benefits are cut. We implement the test empirically exploiting German sick pay reforms and administrative industry-level data on certified sick leave by diagnoses. The labor supply adjustment for contagious diseases is significantly smaller than for non-contagious diseases, providing evidence for contagious presenteeism and negative externalities which arise in form of infections.
http:ftp.iza.org/dp8850.pdf

Neumark D. (2015). Does Protecting Older Workers from Discrimination Make It Harder to Get Hired? Revised with Additional Analysis of SIPP Data and Appendix of Disability Laws. Ann Arbor : University of Michigan Retirement Research Center
Abstract: We explore the effects of disability discrimination laws on hiring of older workers. A concern with anti-discrimination laws is that they may reduce hiring by raising the cost of terminations and - in the specific case of disability discrimination laws - raising the cost of employment because of the need to accommodate disabled workers. Moreover, disability discrimination laws can affect nondisabled older workers because they are fairly likely to develop work-related disabilities, yet are not protected by these laws. Using state variation in disability discrimination protections, we find little or no evidence that stronger disability discrimination laws lower the hiring of nondisabled older workers. We similarly find no evidence of adverse effects of disability discrimination laws on hiring of disabled older workers.
http:www.mrrc.isr.umich.edu/publications/papers/pdf/wp315.pdf

Candon D. (2015). Are Cancer Survivors who are Eligible for Social Security More Likely to Retire than Healthy Workers? Evidence from Difference-in-Differences. Beldfield : University College Dublin

Abstract: Despite the fact that there are over a million new cancer cases detected in the U.S. every year, none of retirement-health literature focuses specifically on the effect that cancer has on retirement. Social Security may offer a pathway to retirement for eligible workers but the separate effects of both cancer, and Social Security, on retirement, need to be accounted for. I use the fact that some workers will be eligible for Social Security when they are diagnosed with cancer, while some will not, as a source of exogenous variation to identify the joint effect of cancer diagnosis and Social Security eligibility on retirement. With data from the Health and Retirement Study (HRS), I use a difference-in-differences model to show that being eligible for Social Security, and surviving cancer, increases the probability of retirement by 11.2% for male workers. Given the increase in both cancer survival rates, and the number of older workers in the labour force, it is important to know if cancer is causing permanent exits, in a population who otherwise would continue working.
https:ideas.repec.org/p/ucn/wpaper/201504.html

Vieillissement / Ageing

Carrino L., Orso C.E.(2014). Eligibility and inclusiveness of Long-Term Care Institutional frameworks in Europe: a cross-country comparison. Venice : University Ca' Foscari of Venice.
Abstract: Although economic literature has recently started to concentrate on the design, the scope and the regulations of main public programmes of Long-Term-Care in Europe, no analysis have, so far, compared different systems in terms of their degree of inclusiveness with respect to vulnerable elderly's health status. Focusing on several European countries, this paper investigate how LTC regulations assess vulnerability, as well as how they define a minimum level of objective-dependency that would entitle individuals to receive public benefits (in-kind or in-cash) for home-based care. Our contribution is threefold. We provide detailed information on assessment and eligibility frameworks for eleven LTC programmes in Europe. We show that substantial heterogeneities exist both at the extensive margin (the health-outcomes that are included in the vulnerability-assessment) and at the intensive margin (the minimum vulnerability threshold that defines benefit eligibility) of the assessment strategies. Building on this information, we compare LTC programmes in terms of their degree of inclusiveness, i.e., we investigate the extent to which each programme is able to cover a standard population of elderly individuals facing functional and cognitive limitations. The comparison is performed following both a directly- and an indirectly-adjusted strategy using SHARE data.
http:papers.ssrn.com/sol3/papers.cfm?abstract_id=2541246

Becchetti L., Conzo P.L., Di Febbraro M. (2015). Education, health and subjective wellbeing in Europe. Working paper; 12-15. Turin : Université de Turin
Abstract: The hypothesis that active community involvement is beneficial for health finds strong support in the medical literature and in most policy guidelines for active ageing in OECD countries. We test it empirically documenting that lagged voluntary work is significantly correlated with later changes in various aggregated and disaggregated health indicators. However, when controlling for panel attrition, endogeneity and reverse causality, the positive effect of voluntary work remains robust only for a limited number of indicators. We calculate the monetary equivalent of health-related subjective wellbeing benefits of volunteer work with the compensating variation approach and compare it with benefits in terms of the social value of increased longevity.
http:www.est.unito.it/unitoWAR/ShowBinary/FSRepo/D031/Allegati/WP2015Dip/WP_12_2015.pdf

Kaiser B., Schmid C. (2015). Allocation of Expenditures in Elderly Households and the Cost of Widowhood. Bern : Bern Universität
Abstract: Widowhood and retirement are likely to change the economic environment of elderly households. While retirement primarily changes income and expenditure patterns, widowhood

fundamentally changes the structure of the household. Beside high non-monetary cost of losing the partner, resources are no longer shared and economies of scale arising from joint consumption are lost. This paper applies the Lewbel and Pendakur (2008) collective household model to expenditure data on elderly households in Switzerland. The findings suggest that between 40 and 50% of household resources are assigned to wives and both spouses save approximately 25% on expenditures due to economies of scale in consumption. Widowers tend to have higher wealth than widows. Estimates of indifference scales, however, indicate that the financial loss related to widowhood is larger for men than for women. Moreover, ignoring within household inequality, as implicitly done by traditional equivalence scales, underestimates total inequality among individuals.
http:www.vwl.unibe.ch/papers/dp/dp1503.pdf

Becchetti L., Conzo P.L., Salustri F. (2015). The (W)Health of Nations : The Contribution of Health expenditure to active ageing. Working paper; 13-15. Turin : Université de Turin
Abstract: We investigate the impact of health expenditure on health outcomes on a large sample of Europeans aged above 50 on individual and country level data. We find a significant negative impact on changes in the number of chronic diseases which varies according to age, health styles, gender, income and education subgroups. Our findings indicate potentially heterogeneous support to health expenditure across interest groups and are robust when we instrument health expenditure with parliament political composition.
http:www.est.unito.it/unitoWAR/ShowBinary/FSRepo/D031/Allegati/WP2015Dip/WP_13_2015.pdf

Aubert P., Rabate S. (2015). Durée passée en carrière et durée de vie en retraite : quel partage des gains d'espérance de vie ? *Economie et Statistique,* (474) :
Abstract: Cet article étudie l'évolution du rapport entre la durée passée en carrière et la durée passée à la retraite pour les générations nées entre 1943 et 1990, à l'aide du modèle de microsimulation Destinie de l'Insee. Ces résultats sont confrontés à l'objectif de partage des gains d'espérance de vie à 60 ans entre la durée d'activité et la durée passée à la retraite, tel qu'il avait été formulé lors de la réforme des retraites de 2003, et qui visait à maintenir constant au fil des générations le rapport entre ces deux durées. Les réformes de 2003, 2010 et 2014 ont un effet important en projection sur les âges de départ à la retraite des générations 1943-1990. Sans ces réformes, un peu plus des trois quarts des gains d'espérance de vie sur toute la période se seraient traduits en gains de durée de retraite. Avec l'effet cumulé de ces réformes, la hausse de la durée de retraite représente à peu près un tiers de la hausse projetée de l'espérance de vie entre les générations 1943 et 1990. Cette proportion est conforme à la cible formulée en 2003 mais elle tient aux effets combinés de l'allongement de la durée requise et du report des âges légaux – l'allongement seul aurait conduit à une hausse de la durée de retraite plus élevée, représentant plus de la moitié des gains d'espérance de vie.
http:www.insee.fr/fr/ffc/docs_ffc/ES474C.pdf

Albert C., Oliveau J.B. (2015). Prédire l'âge et la durée de la retraite : les enseignements des différents modèles sont-ils convergents ? Commentaire. *Economie et Statistique,* (474) :
Abstract: Depuis 1993, les réformes portant sur le système de retraite ont notamment eu pour effet de modifier l'âge de départ en retraite, soit directement – loi du 9 novembre 2010 portant l'âge légal de 60 à 62 ans – soit par le biais de la durée de carrière nécessaire pour l'obtention du taux plein. L'application des modifications législatives réparties à la fois dans le temps et au fil des générations, ainsi que la non-linéarité des conséquences de ces modifications, rendent extrêmement complexe l'exercice de projection des effets attendus. Chaque carrière peut subir ces modifications législatives de façon particulière, selon sa composition (entre emploi, chômage, invalidité, interruptions pour raisons familiales…) ce qui influe sur la capacité de partir en retraite au taux plein à un âge donné.
http:www.insee.fr/fr/ffc/docs_ffc/ES474D.pdf

(2015). Addressing Dementia. The OECD Response. Paris : OCDE.

Abstract: The large and growing human and financial cost of dementia provides an imperative for policy action. It is already the second largest cause of disability for the over-70s and it costs $645bn per year globally, and ageing populations mean that these costs will grow. There is no cure or effective treatment for dementia, and too often people do not get appropriate health and care services, leading to a poor quality of life. Our failure to tackle these issues provides a compelling illustration of some of today's most pressing policy challenges. We need to rethink our research an innovation model, since progress on dementia has stalled and investment is just a fraction of what it is for other diseases of similar importance and profile. But even then a cure will be decades away, so we need better policies to improve the lives of people living with dementia now. Communities need to adjust to become more accommodating of people with dementia and families who provide informal care must be better supported. Formal care services and care institutions need to promote dignity and independence, while coordination of health and care services must be improved. But there is hope: if we can harness big data we may be able to address the gaps in our knowledge around treatment and care (Résumé de l'éditeur).

http://www.oecd-ilibrary.org/social-issues-migration-health/addressing-dementia_9789264231726-en