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Contacts

Espace documentation : documentation@irdes.fr
Marie-Odile Safon : safon@irdes.fr
Véronique Suhard : suhard@irdes.fr

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Assurance maladie / Health Insurance

Akosa Antwi,Y. et Maclean, C. (2017). State Health Insurance Mandates and Labor Market Outcomes: New Evidence on Old Questions. NBER Working Paper Series ; n° 23203. Cambridge NBER: www.nber.org/papers/w23203

In this study we re-visit the relationship between private health insurance mandates, access to employer-sponsored health insurance, and labor market outcomes. Specifically, we model employer-sponsored health insurance access and labor market outcomes across the lifecycle as a function of the number of high cost mandates in place at labor market entrance. Our analysis draws on a long panel of workers from the National Longitudinal Survey of Youth 1979 and exploits variation in five high cost state mandates between 1972 and 1989. Four principal findings emerge from our analysis. First, we find no strong evidence that high cost state health insurance mandates discourage employers from offering insurance to employees. Second, employers adjust both wages and labor demand to offset mandate costs, suggesting that employees place some value on the mandated benefits. Third, the effects are persistent, but not permanent. Fourth, the effects are heterogeneous across worker types. These findings have implications for thinking through the full labor market effects of health insurance expansions.

French, E. et Bailey Jones, J. (2017). Health, Health Insurance, and Retirement: A Survey. Working Paper 2017-03. Richmond Federal Reserve Bank of Richmond
https://www.richmondfed.org/-/media/richmondfedorg/publications/research/working_papers/2017/pdf/wp17-03.pdf

The degree to which retirement decisions are driven by health is a key concern for both academics and policymakers. In this paper we survey the economic literature on the health-retirement link in developed countries. We describe the mechanisms through which health affects labor supply and discuss how they interact with public pensions and public health insurance. The historical evidence suggests that health is not the primary source of variation in retirement across countries and over time. Furthermore, declining health with age can only explain a small share of the decline in employment near retirement age. Health considerations nonetheless play an important role, especially in explaining cross-sectional variation in employment and other outcomes within countries. We review the mechanisms through which health affects retirement and discuss recent empirical analyses.

Gaudette, E., et al. (2016). Long-Term Individual and Population Consequences of Early-Life Access to Health Insurance. Working Paper; 2016-355. Ann Arbor Michigan Retirement Research Center
https://papers.ssrn.com/sol3/papers2.cfm?abstract_id=2914437

Gaining access to health insurance in childhood has been associated with improved childhood health and educational attainment. Expansions in health insurance access have steadily lowered the rates of uninsured children and may have long term consequences for adult health and wellbeing. This paper analyzes the impact of gaining health insurance in childhood on health and economic outcomes during adulthood using dynamic microsimulation. We find disease prevalence at age 65 falls for most chronic conditions, with the exception of cancer. We also find increased access to health insurance in childhood results in 11 additional months of life expectancy and 16 additional months lived free of

disability. There is no change in total lifetime medical spending, although both Medicaid and Medicare expenditures fall. Lifetime earnings increase by about 8 percent for individuals who gain the benefits of childhood health insurance.

Pierre, A. et Jusot, F. (2017). The Likely Effects of Employer-Mandated Complementary Health Insurance on Health Coverage in France. Document de travail Irdes ; 67bis. Paris Irdes
http://www.irdes.fr/english/working-papers/067bis-the-likely-effects-of-employer-mandated-complementary-health-insurance-on-health-coverage-in-france.pdf

In France, access to health care greatly depends on having a Complementary Health Insurance coverage (CHI). Thus, the generalisation of CHI became a core factor in the national health strategy created by the government in 2013. The first measure has been to compulsorily extend employer-sponsored CHI to all private sector employees on January 1st, 2016 and improve its portability coverage for unemployed former employees for up to 12 months. Based on data from the 2012 Health, Health Care and Insurance survey, this article provides a simulation of the likely effects of this mandate on CHI coverage and related inequalities in the general population by age, health status, socio-economic characteristics and time and risk preferences. We show that the non-coverage rate that was estimated to be 5% in 2012 will drop to 4% following the generalisation of employer-sponsored CHI and to 3.7% after accounting for portability coverage. With its focus on private sector employees, the policy is likely to do little for populations that would benefit most from additional insurance coverage while expanding coverage for other populations that appear to place little value on CHI. Indeed, the mandate could reduce the relationship between non-coverage and time and risk preferences without eliminating social inequalities as the most vulnerable populations are expected to remain more often without CHI.

Slusky, D. et Ginther, D. (2017). Did Medicaid Expansion Reduce Medical Divorce? NBER Working Paper Series ; n° 23139. Cambridge NBER
www.nber.org/papers/w23139

Prior to the Affordable Care Act, many state Medicaid eligibility rules had maximum asset levels. This was a problem when one member of a couple was diagnosed with a degenerative disease requiring expensive care. Draining the couple's assets so that the sick individual could qualify for Medicaid would leave no resources for the retirement of the other member; thus divorce and separating assets was often the only option. The ACA's Medicaid expansion removed all asset tests. Using a difference-in-differences approach on states that did and did not expand Medicaid, we find that the expansion decreased the prevalence of divorce by 5.6% among those 50-64, strongly suggesting that it reduced medical divorce.

Economie de la santé / Health Economics

(2017). Loi de financement de la sécurité sociale 2017 en chiffres. Paris : Ministère de l'économie
http://www.securite-sociale.fr/IMG/pdf/plfss2017_web.pdf

La « LFSS 2017 en chiffres » est un outil pédagogique de référence qui présente les principales conséquences de la loi de financement de la Sécurité sociale pour 2017 sur les comptes du régime général, du Fonds de solidarité vieillesse et de l'ensemble des régimes de base de la Sécurité sociale. Réalisée par la direction de la Sécurité sociale, cette publication rassemble les principales données chiffrées de la Loi de financement de la Sécurité sociale pour 2017.

Didem, B., et al. (2017). The Distribution of Public Spending for Health Care in the United States on the Eve of Health Reform. NBER Working Paper Series ; n° 23150. Cambridge NBER
www.nber.org/papers/w23150

U.S. health care spending in 2012 totaled $2.8 trillion or 17.2 percent of gross domestic product. Given the magnitude of health care spending, the large public sector role in health care, and the reforms being implemented under the Patient Protection and Affordable Care Act (ACA), we believe it useful to examine several basic questions: What was the public share of national spending on the eve of reform? How has the public share evolved over time? And how are the benefits of public spending on health care distributed within the population by age, poverty level, insurance coverage, health status, and ACA-relevant subgroups? The questions we pose, while basic, cannot be answered with commonly-available statistics due to the sheer complexity of health care financing in the U.S. The objective of this paper is to provide answers by combining aggregate measures from the National Health Expenditure Accounts with micro-data from the Medical Expenditure Panel Survey.

Lorenzoni, L., et al. (2017). Cyclical vs structural effects on health care expenditure trends in OECD countries. OECD Health Working Papers ; 92. Paris OCDE
http://www.oecd-ilibrary.org/social-issues-migration-health/cyclical-vs-structural-effects-on-health-care-expenditure-trends-in-oecd-countries_be74e5c5-en

Health care expenditure per person, after accounting for changes in overall price levels, began to slow in many OECD countries in the early-to-mid 2000s, well before the economic and fiscal crisis. Using available estimates from the OECD's System of Health Accounts (SHA) database, we explore common trends in health care expenditure since 1996 in a set of 22 OECD countries. We assess the extent to which the trends observed are the results of cyclical economic influences, and the respective contributions of changes in relative prices, health care volumes and coverage to the slowdown in health care expenditure growth. Our analysis suggests that cyclical factors may account for a little less than one half of the estimated slowdown in health care spending since the crisis, suggesting that structural changes have contributed to the trends. Before the crisis the slowdown in health care expenditure growth was accounted for by health care prices growing less than general prices and a reduction in care volumes, whereas the latter accounts for most of the steeper deceleration after the crisis. Although both privately and publically financed health care expenditure grew at a reduced pace during the study period, the sharp post-crisis deceleration happened mostly in the public component. When examined by function, the slowdown in publicly-financed expenditure has been largest in curative and rehabilitative care (particularly after the crisis) and in medical goods (especially pharmaceuticals), whereas the deceleration in the privately financed component is largely in medical goods (including pharmaceuticals). We conclude that structural changes in publicly financed health care have constrained the growth of care volumes (especially) and prices leading to a marked reduction in health care expenditure growth rates, beyond what could be expected based on cyclical economic fluctuations. We examine a range of government policies enacted in a selection of OECD countries that likely contributed to the structural changes observed in our analysis.

Etat de santé / Health Status

Albreht, T. é. (2017). European guide on quality improvement in comprehensive cancer control.
Ljubljana : Institute of Public Health

www.cancercontrol.eu/uploads/images/Guide/pdf/CanCon_Guide.pdf

> The Guide aims to help to reduce not only the cancer burden throughout the EU but also the inequalities in cancer control and care that exist between Member states. The Guide is meant for governments, parliamentarians, health care providers and funders, and cancer care professionals at every level.

Atella, V., et al. (2017). The "Double Expansion of Morbidity" Hypothesis: Evidence from Italy. CEIS Research papers; 396. Rome Centre For Economic and International Studies
https://papers.ssrn.com/sol3/papers2.cfm?abstract_id=2911054

> The gains in life expectancy (LE) experienced over the last decades have been accompanied by the increases in the number of years lived in bad health, lending support to the "expansion of morbidity" hypothesis. In this paper we revise this theory and propose the "Double Expansion of Morbidity" (DEM) hypothesis, arguing that not only have life expectancy gains been transformed into years lived in bad health, but also, due to anticipated onset of chronic diseases, the number of years spent in "good health" is actually reducing. Limited to the Italian case, we present and discuss a set of empirical evidence confirming the DEM hypothesis. In particular, we find that from 2000 to 2014 the average number of years spent with chronic conditions in Italy has increased by 6.4 years, of which 3.4 years due to the increase in LE and 3 years due to the reduction in the onset age of chronic conditions. Compared to the year 2000, in 2014 this phenomenon has generated an extra public health expenditure of 8.7 billion euros. We discuss the policy implications of these findings.

Hollingsworth, A., et al. (2017). Macroeconomic Conditions and Opioid Abuse. NBER Working Paper Series ; n° 23192. Cambridge NBER
www.nber.org/papers/w23192

> Past research indicates that physical health measures (such as all-cause mortality) improve when economic conditions temporarily deteriorate, but the relationship between economic conditions and behavioral health remain unclear. The pro-cyclicality of mortality has declined in recent years while drug poisoning deaths have trended sharply upwards, suggesting a connection to the rising use of many types of drugs. We contribute new evidence to the literature by examining how severe, adverse outcomes related to use of opioid analgesics (hereafter abbreviated as opioids) and other drugs vary with short-term fluctuations in macroeconomic conditions. We use data on deaths and emergency department (ED) visits related to opioid and other drug poisonings together with information on state and county unemployment rates. We focus on opioids because they are a major driver of the recent, fatal drug epidemic. We use county-level mortality data for the entire U.S. from 1999-2014, and state and county level ED data covering 2002-2014 from a subset of states. We find that as the county unemployment rate increases by 1 percentage point, the opioid death rate (per 100,000) rises by 0.19 (3.6%) and the ED visit rate for opioid overdoses (per 100,000) increases by 0.95 (7.0%). We also uncover statistically significant increases in the overall drug death rate that are driven in most specifications by increases in opioid deaths. These results hold when performing a state, rather than county, level analysis. The results are primarily driven by adverse events among whites, although there is some sensitivity to choice of models in the results for nonwhites. Additionally, the findings are relatively stable across time periods; they do not pertain only to recession years, but instead represent a more generalizable and previously unexplored connection between economic development and the severe adverse consequences of substance abuse

Nagel, K. (2016). A Life Course Perspective on the Income-to-Health Relationship: Macro-Empirical Evidence from two Centuries. Berlin : German Economic Association
http://econpapers.repec.org/paper/zbwvfsc16/145810.htm

> The epidemiological literature discusses two contrary hypotheses that can represent the income-to-health relationship from a life course perspective: the "cumulative advantage" and the "age as leveller"' hypothesis. The aim of this study is to transfer the investigation of both hypotheses to a macro level with long time horizon. It asks whether increases in per capita income improves

population health and whether the improvements differ across population age groups. Using an unbalanced panel data set with 20 countries and with up to 211 years, the analysis relies on the Westerlund (2007) error correction methodology to detect long-run causality and on the Pesaran (2006) framework to quantify the effect magnitude. A significant effect of per capita income on survivability is only found for middle age groups. The analysis detects no significant effect on survivability of the very young and of old ages. These findings provide evidence for both hypotheses during several stages of life: while the "cumulative advantage" theory serves for describing the transition from young to middle ages, the transition from middle to old ages corresponds to the "age as leveller"' mechanism.

Pisarik, J., Rochereau T., et al. (2017). "Premiers résultats de l'Enquête santé européenne-Enquête santé et protection sociale 2014 " Questions d'Economie de La Santé (Irdes)(223): 1-8.
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/223-etat-de-sante-des-francais-et-facteurs-de-risque.pdf

Près d'un tiers de la population métropolitaine âgée de 15 ans ou plus déclare que son état de santé est assez bon, mauvais ou très mauvais, d'après les premiers résultats de l'Enquête santé européenne EHIS-ESPS 2014, menée auprès des ménages ordinaires (hors institution). Près de 40 % évoquent un problème de santé chronique et un quart une limitation dans les activités du quotidien. Ces indicateurs d'état de santé varient fortement selon les catégories socio-professionnelles, au détriment des catégories défavorisées, en particulier les ménages d'ouvriers non qualifiés. Presque une femme sur dix et un homme sur vingt présentent des symptômes dépressifs, qui s'accentuent à partir de 75 ans, et touchent particulièrement les ménages d'employés. Avec 7 % de personnes concernées, la France se situe dans la moyenne européenne. Parmi les facteurs de risque, l'excès de poids concerne 46 % de la population métropolitaine, le surpoids 31 % et l'obésité 15 %, soit moins que la plupart des autres pays européens participant à l'enquête. En revanche, 28 % des personnes fument, dont 22 % quotidiennement, soit un taux de fumeurs supérieur à la moyenne des pays européens. Ces deux facteurs de risque varient fortement selon les catégories socio-professionnelles, au détriment, notamment, des ménages d'ouvriers.

Schunemann, J., et al. (2016). Going from Bad to Worse: Adaptation to Poor Health, Health Spending, Longevity, and the Value of Life. Berlin : German Economic Association
https://ideas.repec.org/p/zbw/vfsc16/145571.html

Unhealthy persons adapt to their bad state of health and persons in bad health are usually happier than estimated by healthy persons. In this paper we investigate how adaptation to a deteriorating state of health affects health spending, life expectancy, and the value of life. We set up a life cycle model in which individuals are subject to physiological aging, calibrate it with data from gerontology, and compare behavior and outcomes of adapting and non-adapting individuals. While adaptation generally increases the life-time utility (by about 2 percent), its impact on health behavior and longevity depends crucially on whether individuals are aware of their adaptive behavior, i.e. whether they adapt in a naive or sophisticated way. We also compute the QALY change implied by health shocks and discuss whether and how adaptation influences results and the desireability of positive health innovations.

Géographie de la santé/ Geography of Health

Arnault, F. (2017). Améliorer l'offre de soins : initiatives réussies dans les territoires. Paris Conseil National de l'Ordre des médecins
https://www.conseil-national.medecin.fr/node/2045

Ce rapport du CNOM identifie les principales catégories d'initiatives en matière d'offre de soins qui portent d'ores et déjà leurs fruits dans les territoires : La création de maisons pluridisciplinaires de santé, accompagnée d'un travail mené par tous les acteurs pour en assurer la meilleure répartition géographique au sein d'un territoire ; L'accompagnement et l'encouragement aux stages

professionnalisants pour les étudiants en médecine ; La mise en œuvre de lieux multiples d'exercice pour les praticiens ; La promotion de l'assistanat auprès de médecins installés, sous toutes ses formes.

Handicap / Disability

Bougarel, S., et al. (2017). "Optimiser l'accès aux ressources sur les territoires dans un contexte contraint. Exemple des services de soins pour jeunes handicapés." Cybergeo : Revue Européenne de Géographie(808)
http://cybergeo.revues.org/27902

L'implantation géographique des services à domicile pour enfants et adolescents handicapés (Sessad) en région Provence-Alpes-Côte d'Azur semble en accord avec les besoins d'accompagnement : 93% des enfants accompagnés vivent à moins de 30 minutes d'un Sessad. Cependant seuls 69% des enfants sont accompagnés par un service implanté à moins de 30 minutes de leur domicile. L'analyse des déplacements, au moyen d'une modélisation par SIG, a permis de proposer une optimisation des relations enfants – Sessad, au moyen de plusieurs scénarios. De nouvelles affectations ont été proposées pour les enfants en fonction de leurs lieux de résidence et de nouvelles implantations pour les zones repérées comme dépourvues de service. Il est possible alors d'améliorer l'accès aux services, afin de dégager plus de temps éducatif ou thérapeutique.

Hôpital / Hospital

Doyle, J. J., et al. (2017). Evaluating Measures of Hospital Quality. NBER Working Paper Series ; n° 23166. Cambridge NBER
www.nber.org/papers/w23166

In response to unsustainable growth in health care spending, there is enormous interest in reforming the payment system to "pay for quality instead of quantity." While quality measures are crucial to such reforms, they face major criticisms largely over the potential failure of risk adjustment to overcome endogeneity concerns. In this paper we implement a methodology for estimating the causal relationship between hospital quality measures and patient outcomes. To compare similar patients across hospitals in the same market, we exploit ambulance company preferences as an instrument for patient assignment. We find that a variety of measures used by insurers to measure provider quality are successful: assignment to a higher-scoring hospital results in better patient outcomes. We estimate that a two-standard deviation improvement in a composite quality measure based on existing data collected by CMS is causally associated with reductions in readmissions and mortality of roughly 15%

Moes, H., et al. (2017). Rankings of unwarranted variation in healthcare treatments. CentER Discussion Paper; Vol. 2017-004). Le Tilburg Center for Economic Research

In this paper, we introduce a framework designed to identify and rank possible unwarranted variation of treatments in healthcare. The innovative aspect of this framework is a ranking procedure that aims to identify healthcare institutions where unwarranted variation is most severe, and diagnosis treatment combinations which appear to be the most sensitive to unwarranted variation. By adding a ranking procedure to our framework, we have taken our research a step beyond the existing literature. This ranking procedure is intended to assist health insurance companies in their search for violations, and to help find them more quickly, enabling more effective corrective and preventive actions on behalf of the healthcare institutions concerned.

Premkumar, D., et al. (2016). Hospital Closure and Hospital Choice: How Hospital Quality and Availability will Affect Rural Residents. Economics Working Papers. 10.

http://lib.dr.iastate.edu/econ_workingpapers/10/

This study estimates a model of rural patient hospital choice between the nearest rural hospital, the nearest urban hospital, or the nearest research hospital. We present separate estimates for inpatient and outpatient visits, for different diagnoses, and for emergency and nonemergency admissions. The analyses illustrate the tradeoffs between hospital quality and distance in deciding whether to choose the nearest hospital or to travel farther for an alternative. The model parameters are used to simulate two hospital closing scenarios for both outpatient and inpatient data: 1) closing 25% of lowest quality rural hospitals and 2) closing 15% of the least used rural hospitals. Closing 25% of the lowest quality rural hospitals results in a 20.7% increase in expected distance and a 7.7% increase in expected hospital quality for those with inpatient ailments. Closing the least used hospitals modestly increases average distance but lowers average quality. We conclude that closing the lowest quality rural hospitals is a better policy prescription than closing the least used hospitals since closing low quality hospitals results in a substantial increase in average quality of hospital with only a slight increase in distance travelled for chosen hospitals.

Inégalités de santé / Health Inequalities

Asaria, M. (2017). The economics of health inequality in the English NHS – the long view. CHE Research Paper Series ;142. York University of York
https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP142_economics_health_inequality_NHS.pdf

In this paper, I briefly outline some of the key milestones of health inequality policy in England. I describe how socioeconomic inequalities in health, government policy towards it, and the academic literature about it, have evolved over time and in relation to each other. Whilst this historical review is far from comprehensive, its aim is to provide sufficient context within which to interpret current NHS health inequality policy from the perspective of an economist.

Polton, D. (2017). "Égalité femmes - hommes en matière de santé et de recours aux soins." Regards(50): 35-45.

Les recherches sur les inégalités sociales de santé se sont développées en France depuis une dizaine d'années, sur l'état de santé des différents groupes sociaux et l'évolution des écarts dans le temps, sur l'accès et le renoncement aux soins, et y compris sur le caractère socialement différencié des réponses du système de soins et des pratiques des professionnels. En revanche, contrairement aux pays anglo-américains et européens, la dimension du genre est souvent négligée dans notre pays dans la recherche en santé publique. Si l'espérance de vie ne résume pas à elle seule l'état de santé, et si les femmes vivent plus longtemps que les hommes, elles se déclarent en plus mauvaise santé et vivent avec plus de maladies, d'incapacités et de situations de dépendance. Ce paradoxe aujourd'hui bien mis en évidence à l'échelle internationale sera développé dans une première partie. On s'attachera ensuite à analyser les différences en termes de recours aux soins, avec là encore un constat nuancé : globalement les femmes apparaissent plus soucieuses de leur santé et consultent plus fréquemment, sans pour autant avoir des dépenses de soins globalement supérieures. Lorsque l'on analyse des pathologies particulières, on constate des inégalités dans les deux sens, souvent liées au fait que la détection et la prise en charge des maladies sont influencées par des stéréotypes de genre qui peuvent induire des différences de traitement.

Revil, H. (2016). La Plateforme d'Intervention Départementale pour l'Accès aux Soins et à la Santé (PFIDASS). Regard sur un dispositif expérimental de détection du renoncement aux soins et d'action pour accompagner les personnes à la réalisation de leurs soins. Paris Odenore
https://odenore.msh-alpes.fr/documents/rapport_accompagnement_pfidass_-_version_revue_et_definitive_-_2016.pdf

La Cnamts expérimente la mise en place d'un dispositif de détection du renoncement en matière de santé et d'action pour accompagner les publics fragiles dans leurs parcours de soins. Ce nouveau dispositif s'articule autour de deux axes : la détection des situations individuelles de renoncement, et leur résolution par la Pfidass, la Plateforme d'intervention départementale pour l'accès aux soins et à la santé, un service dédié de l'assurance-maladie. Ce rapport dresse un état des lieux sur la mise en place de cette plateforme et en évalue la pertinence. Dans quelle mesure un dispositif tel celui de la PFIDASS, surplombé par des enjeux de frontières, de compétences et de professionnalité en interne de la CPAM, ainsi que par des enjeux de positionnement de la caisse par rapport à son environnement et d'orientation stratégique au niveau territorial, répond-il aux besoins de guidance et de soutien financier des personnes en renoncement aux soins et emporte-t-il un changement paradigmatique dans la prise en charge de situations sociales problématiques ?

Warin, P. (2016). L'action, au local, sur le non-recours Radioscopie des initiatives des collectivités locales : Radioscopie des initiatives des collectivités locales. Rapport final. Paris Odenore**:** 153.
https://odenore.msh-alpes.fr/documents/rapport_final_-_odenore_-_novembre_2016.pdf

Le non-recours aux prestations sociales est un facteur de fragilisation des populations les plus modestes. Dans ces conditions, l'action contre le non-recours devient un élément essentiel de la cohésion sociale et le suivi d'indicateurs dans ce domaine a été introduit dans le plan de lutte contre la pauvreté de 2013. L'objectif de ce rapport est l'introduction de la question du non-recours dans l'action sociale actuelle en France.

Médicaments / Pharmaceuticals

Buchmueller, T. C. et Ginther, D. (2017). The Effect of Prescription Drug Monitoring Programs on Opioid Utilization in Medicare. NBER Working Paper Series ; n° 23148. Cambridge NBER
www.nber.org/papers/w23148

The misuse of prescription opioids has become a serious epidemic in the US. In response, states have implemented Prescription Drug Monitoring Programs (PDMPs), which record a patient's opioid prescribing history. While few providers participated in early systems, states have recently begun to require providers to access the PDMP under certain circumstances. We find that "must access" PDMPs significantly reduce measures of misuse in Medicare Part D. In contrast, we find that PDMPs without such provisions have no effect. We find stronger effects when providers are required to access the PDMP under broad circumstances, not only when they are suspicious.

Morgan, S. G. et Lee, A. (2017). "Cost-related non-adherence to prescribed medicines among older adults: a cross-sectional analysis of a survey in 11 developed countries."
Bmj Open **7**(e014287)
http://bmjopen.bmj.com/content/7/1/e014287

The purpose of this study was to assess the effects of direct patient costs on access to medicines in 11 developed countries in Europe, North America and Australasia. We hypothesise that cost-related access barriers will be higher in countries without universal coverage for pharmaceuticals (the USA and Canada) than in countries providing universal coverage of prescription drugs at little or no direct cost to patients (eg, the UK). Further, because many of the health systems studied (including the USA and Canada) provide greater coverage of medication costs for persons over age 65, we hypothesise that access will be higher and cross-national differences lower among that age group.

Méthodologie – Statistique / Methodology - Statistics

Angrist, J. D. et Pischke, J. S. (2017). Undergraduate Econometrics Instruction: Through Our Classes, Darkly. NBER Working Paper Series ; n° 23144. Cambridge NBER
www.nber.org/papers/w23144

The past half-century has seen economic research become increasingly empirical, while the nature of empirical economic research has also changed. In the 1960s and 1970s, an empirical economist's typical mission was to "explain" economic variables like wages or GDP growth. Applied econometrics has since evolved to prioritize the estimation of specific causal effects and empirical policy analysis over general models of outcome determination. Yet econometric instruction remains mostly abstract, focusing on the search for "true models" and technical concerns associated with classical regression assumptions. Questions of research design and causality still take a back seat in the classroom, in spite of having risen to the top of the modern empirical agenda. This essay traces the divergent development of econometric teaching and empirical practice, arguing for a pedagogical paradigm shift.

Serafino, P. et Tonkin, R. (2017). Statistical matching of European Union statistics on income and living conditions (EU-SILC) and the household budget survey. Luxembourg : Publications Office of the European Union
http://ec.europa.eu/eurostat/documents/3888793/7882299/KS-TC-16-026-EN-N.pdf/3587dc1b-9f29-42cb-b0f9-0dfa21a47d41

L'objectif chiffré d'inclusion sociale de la stratégie Europe 2020 est mesuré sur la base de trois indicateurs calculés au départ des données EU-SILC (« Statistiques de l'UE sur le revenu et les conditions de vie »): l'attachement au travail, le revenu et la déprivation matérielle. Ces dernières années, on note un intérêt croissant concernant la question de savoir si les indicateurs de dépenses et de consommation ne permettent pas d'évaluer les conditions de vie de façon plus appropriée que le revenu. C'est pourquoi cette publication compare l'exposition des personnes à la pauvreté selon trois mesures différentes: revenu, dépenses et déprivation matérielle. Vu qu'aucune source de données unique ne fournit des informations sur toutes ces variables, cette publication décrit le travail méthodologique qui a été réalisé pour coupler statistiquement (apparier) la variable « dépenses » présente dans l'Enquête sur le Budget des Ménages avec les variables « revenu » et « déprivation matérielle » collectées dans EU-SILC. Ce travail a été effectué pour six pays de l'UE. Trois méthodes d'appariement ont été utilisées : paramétrique, non paramétrique et mixte. Dans l'ensemble, l'approche mixte permet un appariement légèrement plus satisfaisant sur la base de diverses mesures. Les implications de cette recherche pour la révision en cours de la base légale de EU-SILC sont aussi discutées.

Politique de santé / Health Policy

Gravesen, N. (2016). Intersectoral action for health – Experiences from small countries in the WHO European Region. Copenhague : OMS Bureau régional de l'Europe
http://www.euro.who.int/en/publications/abstracts/intersectoral-action-for-health-experiences-from-small-countries-in-the-who-european-region-2016

Health and well-being are affected by social, economic and environmental determinants. Intersectoral action can play a crucial role in addressing today's biggest public health challenges. This report shows how eight small countries, with a population of less than one million, used intersectoral action to address a diverse set of health needs, thus sharing their knowledge on implementing Health 2020. Many sectors were involved in the country case stories with the health sector taking the lead in most cases, coordinating action and engaging other players. The other main sectors involved were agriculture, education, family affairs, interior, labour, justice, sports and tourism. The case stories reveal a number of mechanisms that facilitated intersectoral action with lessons learnt focusing on the importance of establishing common goals, engaging sectors and implementing mechanisms for intersectoral work.

Heim, A. (2017). Comment estimer le rendement de l'investissement social ? Document de travail n°2017-02. Paris France Stratégie
http://www.strategie.gouv.fr/publications/estimer-rendement-de-linvestissement-social-0

L'investissement social apparaît à la fin des années 1990 comme un modèle d'action sociale renouvelé pour faire face à l'évolution de sociétés fragilisées par l'émergence de nouveaux risques sociaux. Il consiste à investir dans le capital humain des individus de façon à augmenter et à maintenir leurs compétences et leur capacité à supporter les chocs. La notion s'appuie en outre largement sur la promesse que la dépense sociale d'aujourd'hui rapportera à un moment donné. Sa crédibilité repose donc sur l'existence de travaux permettant d'identifier ce rendement. Ce document de travail analyse les recherches existantes sur les impacts de l'investissement social. Il montre que l'approche consistant à lier les dépenses d'investissement social aux performances macroéconomiques des États n'est pas en mesure d'identifier de façon crédible l'effet causal de l'investissement social et a fortiori son rendement. Ce document propose en outre d'adopter une vision plus locale et de séparer en deux étapes l'identification du rendement de l'investissement social. La première consiste à recourir à des évaluations d'impact en adoptant des méthodes qui permettent d'interpréter les résultats comme un lien de cause à effet. Une littérature scientifique abondante évalue déjà l'effet de politiques assimilables à de l'investissement social : la collecte de ces informations est un prérequis pour engager de nouvelles réformes d'investissement social. Nous proposons d'adopter une démarche de collecte systématique et d'analyses statistiques, en produisant davantage de méta-analyses. La deuxième étape consiste à intégrer les résultats des évaluations d'impact dans des modèles de calculs socioéconomiques, afin de comparer les bénéfices des investissements ainsi identifiés aux coûts réels et sociaux de leur mise en œuvre. Le succès de cette étape suppose toutefois de surmonter deux obstacles importants : - améliorer les données disponibles sur le coût des investissements sociaux mais aussi trouver la valeur monétaire des effets induits par l'investissement social ; - prendre en compte la grande incertitude des estimations d'impact et de coût (résumé de l'auteur)

St-Pierre, L. (2017). Quelques outils pour faciliter l'intégration de la santé dans toutes les politiques publiques, Québec : Centre de collaboration nationale sur les politiques publiques et la santé.
http://www.ccnpps.ca/docs/2017_SdTP_OutilsLentillesSante_FR.pdf

Cette note documentaire vise à faire connaitre quelques outils développés au cours des dernières années afin de faciliter l'intégration des questions de santé dans les processus de décision sectoriels. Ce document est ancré dans l'approche de la santé dans toutes les politiques (SdTP) mise en avant par l'Organisation mondiale de la Santé (OMS) et qui a rapidement été reconnue comme une stratégie permettant de prévenir les problèmes de santé complexes en agissant à l'échelle des politiques. Dans cette optique, cette note documentaire présente et compare cinq outils favorisant une prise en compte systématique des questions de santé dans les politiques sectorielles. Les outils sélectionnés font partie de la grande famille des outils de soutien à la décision, mais ont la caractéristique de s'intéresser à la santé de la population et de s'adresser à d'autres secteurs que celui de la santé.

Prévention / Prevention

(2017). The Structure of Health Incentives: Evidence from a Field Experiment. NBER Working Paper Series ; n° 23188. Cambridge NBER
www.nber.org/papers/w23188

The use of incentives to encourage healthy behaviors is increasingly widespread, but we have little evidence about how best to structure these programs. We explore how different incentive designs affect behavior on the extensive and intensive margins through an experiment offering incentives to employees of a Fortune 500 company to use their workplace gym. Overall the likelihood of joining the gym was not strongly affected by the incentive design. Notably, front-loading incentives to encourage initial participation was not more effective than an incentive kept constant over time. For those who

were already at least occasional users of the gym, however, we find more evidence that the design of incentives matters. For this group, front-loading incentives appears to be detrimental relative to a constant incentive, but a novel design that spreads out the incentive budget by turning incentives on and off over a longer period of time is effective.

(2016). Costs of unsafe care and cost effectiveness of patient safety programmes. Bruxelles European Commission**:** (129)
https://ec.europa.eu/health/sites/health/files/systems_performance_assessment/docs/2016_costs_psp_en.pdf

Les trois principaux objectifs de cette étude sont: de fournir un tableau complet de l'impact financier de la mauvaise sécurité des patients, y compris d'une mauvaise prévention et contrôle des infections associées aux soins, sur les systèmes de santé de l'Union européenne ; d'identifier les programmes de sécurité des patients rentables mis en œuvre dans les États membres de l'UE/EEE et de développer une analyse identifiant les facteurs de réussite; d'évaluer le rapport coût-efficacité et l'efficience de l'investissement dans les programmes de sécurité des patients.

(2010). Recommandations de l'OMS sur l'activité physique pour la santé. Copenhague OMS
http://www.sports.gouv.fr/IMG/pdf/2-1_recommandations_aps_oms.pdf

Les Recommandations mondiales sur l'activité physique pour la santé sont essentiellement axées sur la prévention primaire des maladies non transmissibles par l'activité physique au niveau des populations et s'adressent principalement aux décideurs à l'échelle nationale. Le présent document ne traite pas de la lutte clinique contre les maladies et de leur prise en charge au moyen de l'activité physique. Il ne donne pas non plus d'indications sur la mise en place d'interventions et d'approches visant à promouvoir l'activité physique dans les différents groupes de population.

Psychiatrie / Psychiatry

Coldefy, M., et al. (2017). "Les soins sans consentement en psychiatrie : bilan après quatre années de mise en oeuvre de la loi du 5 juillet 2011." Questions d'Economie de la Santé (Irdes)(222)
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/222-les-soins-sans-consentement-en-psychiatrie.pdf

La législation française concernant les soins sans consentement en psychiatrie a été transformée par la loi du 5 juillet 2011. Elle réaffirme les droits des personnes prises en charge dans ces conditions et introduit deux mesures phares : l'intervention du juge des libertés et de la détention dans le contrôle de la mesure de soins sans consentement, et la possibilité de soins ambulatoires sans consentement dans le cadre de programmes de soins. D'autre part, un nouveau mode d'admission en « soins en cas de péril imminent » est mis en place pour favoriser l'accès aux soins des personnes isolées ou désocialisées. Réalisée à partir de données médico-administratives, cette étude analyse l'évolution du recours aux soins sans consentement en psychiatrie, depuis la mise en place de la loi en 2011. 92 000 personnes ont été prises en charge sous ce mode en 2015, soit 12 000 de plus qu'en 2012. Cette hausse est expliquée par plusieurs facteurs : l'extension de la durée des soins sans consentement en dehors de l'hôpital, dans le cadre des programmes de soins, et la montée en charge des soins pour péril imminent. Utilisé pour faciliter l'admission dans un contexte d'urgence et décharger le tiers de cette difficile démarche, ce dispositif est déployé de façon disparate selon les territoires.

Soins de santé primaires / Primary Health Care

(2017). Coopérations entre professionnels de santé : Bilan de cinq ans de mise en œuvre du dispositif en Ile-de-France. Paris ARSIF

http://www.iledefrance.paps.sante.fr/fileadmin/ILE-DE-FRANCE/PAPS/Rapports_et_etudes/Pole_RH_Sante/Bilan_Cooperation_Final.pdf

Ce bilan de la coopération des professionnels de santé a été réalisé à partir de données quantitatives, issues du suivi de l'instruction des dossiers par l'ARS Île-de-France, et de données qualitatives collectées auprès de personnes participant à la mise en œuvre du dispositif. Les principaux résultats montrent des aspects positifs avec une satisfaction des patients et des professionnels impliqués, un intérêt pour le dispositif permettant de répondre à des problématiques de soins et d'en tirer des bénéfices pour tous les acteurs. Ils montrent également des difficultés et des limites. Elles sont relatives aux délais d'instruction longs (en moyenne 25 mois pour les protocoles autorisés), au financement, à l'organisation et la valorisation des professionnels, aux dispositions législatives et réglementaires, à l'applicabilité des protocoles autorisés, à la gouvernance du dispositif, aux moyens mobilisés et aux coûts de sa mise en œuvre.

Brosig-Koch, J., et al. (2016). The effects of competition on medical service provision. Nashville : American Economics Association
http://ageconsearch.umn.edu/bitstream/250115/2/Health%20Care%20Expenditure.pdf

We explore how competition between physicians affects medical service provision. Previous research has shown that, in the absence of competition, physicians deviate from patient-optimal treatment under payment systems like capitation and fee-for-service. While competition might potentially eliminate or reduce these distortions, physicians usually interact with each other repeatedly over time. This leaves scope for collusive behavior. Moreover, only a fraction of patients switches providers at all. Both patterns might prevent competition to work in the desired direction. To analyze the behavioral effects of competition, we develop a theoretical benchmark which is then tested in a controlled laboratory experiment. Experimental conditions vary regarding physician payment (fee-for-service vs. capitation) and the severity of patients' illness (low vs. high). In our setting, two physicians repeatedly treat patients from a homogeneous patient population. While half of the patients always attend the physician providing the highest patient benefit, the other ones always visit the same physician. Treatment decisions made in the experiment affect real patients' health. Our results reveal that, in line with the theoretical prediction, introducing competition can reduce overprovision and underprovision, respectively. The observed effects depend on patient characteristics, though. Compared to related experimental research on price competition, collusive behavior is less frequently observed in our setting of medical service provision.

Chadwick, D. J. et Listl, S. (2017). First Do No Harm – The Impact of Financial Incentives on Dental X-rays. CHE Research Paper Series ;143. York University of York
https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP143_impact_financial_incentives_dental_xrays.pdf

This paper assesses the impact of dentist remuneration on the incidence of potentially harmful dental x-rays. We use unique panel data which provide details of 1.3 million treatment claims by Scottish NHS dentists made between 1998 and 2007. Controlling for unobserved heterogeneity of both patients and dentists we estimate a series of fixed-effects models that are informed by a theoretical model of x-ray delivery and identify the effects on dental x-raying of dentists moving from a fixed salary to fee-for-service and patients moving from co-payment to exemption. We establish that there are significant increases in x-rays when dentists receive fee for service rather than salary payments and patients are made exempt from payment. There are further increases in x-rays when a patient switches to a fee for service dentist relative to them switching to a salaried one.

Chalkley, M., et al. (2016). Paying for performance for health care in low- and middle-income countries: an economic perspective. CHE Research Paper Series ;140. York University of York
https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP140_payment_performance_healthcare_LMIC.pdf

Pay for Performance (P4P) arrangements, which are fixtures of health systems in high-income countries (HIC), have been deployed across many low- and middle-income country (LMIC) settings as well. P4P programs in HICs have typically addressed the challenge of 'over delivery', controlling costs while maintaining adequate services and getting the best clinical practice, or quality of care. In LMICs, health systems are similarly concerned with issues of quality, but they may also grapple with problems of low demand, lack of resources and poor governance. By revisiting the overall framework for understanding P4P arrangements, their benefits and their risks in the context of healthcare delivery, this paper draws on experiences with P4P in HIC to assess how the insights from economic theory apply in practice in LMICs. Issues of programme design and unintended consequences are summarized and LMIC case examples of where these concepts apply and are missing from the evidence of P4P programs in LMIC settings are also reviewed. The evidence on P4P in LMICs is still in its infancy, both in terms of evidence of impact (especially as far as health outcomes are concerned), and in in terms of the attention to potential unintended consequences. However, it is critical to return to basic economic understanding of how the contractual arrangements and incentives of P4P inform program design and ultimately impact health outcomes and service delivery.

Erny-Albrecht, K. et Bywood, P. (2016). Corporatisation of general practice — impact and implications. Flinders Primary Health Care Research & Information Service
http://www.phcris.org.au/download.php?id=8460&spi=14&typ=full

In Australia, general practice is largely private, ranging from small sole traders through to large partnerships comprising six or more practitioners. Over time, a number of corporate practices, which are registered under the Corporations Act 2001, have emerged on the Australian health care landscape. The corporate model also varies in size, depending on location (urban, rural) and types of services provided by the company. This review examines the impact and implications of corporatisation of general practice in Australia in terms of market competition, quality of care, patient outcomes, costs of care, and the health care workforce.

Jiang, H., et al. (2017). Improving Patient Access to Care: Performance Incentives and Competition in Healthcare Markets. Working Paper No . 01/2017. Cambridge University of Cambridge
https://ideas.repec.org/p/jbs/wpaper/201701.html

Performance-based compensation is gaining popularity as a mechanism for incentivizing providers of health-care services to improve the quality of patient care. This paper investigates the effects of introducing performance-based incentives in a competitive healthcare market. In particular, we consider a market in which a payer (e.g. a government agency) applies a compensation contract to competing healthcare service providers in order to achieve a certain level of patient access to care, as measured by the expected time patients have to wait to receive care. In our model, we use M/M/1 queueing dynamics to describe patient service processes and assume that patient demand for care delivered by a particular provider is increasing in the level of access to care the provider ensures and decreasing in the levels of access to care at competing providers. Our analysis indicates that the presence of competition between providers may signi cantly alter the intended effect of performance-based incentives. In particular, we show that the joint effect of incentives and competition depends on two factors: 1) the aggressiveness of patient access targets that the payer imposes on providers, and 2) patient sensitivity to the level of access to care. When the payer uses a "soft" approach to performance-based compensation by incentivizing but not requiring that providers reach an access-level target, the incentives and competition can produce opposing effects on patient access to care when aggressive service-level targets are used in the presence of access-sensitive patients or when moderate service-level targets are introduced in environments where patients a exhibit low degree of sensitivity to the level of access to care. In particular, we show that while moderate service-level targets can lead to an improvement in patient access to care when applied to a monopolistic provider, competition in settings with access-insensitive patients may diminish or even reverse this improvement. Under the "strict" approach to performance-based compensation, when the payer designs performance incentives to minimize the cost of imposing a common access-level target on all providers, the impact of competition on the level of incentivization required is also influenced by the patient population type: for access-sensitive patients, competitive pressure lowers the level of

incentivization required to achieve a particular level of patient access to care, while for patients with low access sensitivity the effect of competition is to increase the incentivization level required. At the same time, the reduction in payers' costs resulting from the presence of competition is more pronounced in environments with access-insensitive patients

Scott, A. et Sivey, P. (2017). Motivation and Competition in Health Care. Working paper; 5/17. Victoria Melbourne Institute of Applied Economic and Social Research
https://papers.ssrn.com/sol3/papers2.cfm?abstract_id=2905491

Non-pecuniary sources of motivation are a strong feature of the health care sector and the impact of competitive incentives may be lower where pecuniary motivation is low. We test this hypothesis by measuring the marginal utility of income of physicians from a stated-choice experiment, and examining whether this measure influences the response of physicians to changes in competition on prices charged. We find that physicians exploit a lack of competition with higher prices only if they have a high marginal utility of income.

Systèmes de santé / Health Systems

(2017). Health and social care integration. Londres NAO
https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf

This report looked at how integration is progressing within and between the separate adult social care and health systems and the extent to which it has benefitted patients. It examined: the case for integrating health and social care (Part One); the progress of national initiatives, including the first year of implementation of the Better Care Fund (Part Two); and the plans for increased integration (Part Three). The report focuses on services providing direct care to patients and does not cover other public services that affect people’s wellbeing, such as housing and leisure services.

(2017). State of the health system – Beds in the NHS: UK. Londres British Medical Association
https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/policy%20research/nhs%20structure%20and%20delivery/nhs%20bed%20occupancy/nhs-bed-occupancy-report-feb2017.pdf

Pressures on NHS hospital beds are well documented. Although not the only indicator, data on how beds are used within the NHS provide an excellent insight into the healthcare system. This paper presents NHS bed data from across the UK in one place. The data demonstrates the increasing pressures on the system in each nation. It provides evidence of the underlying cracks within the NHS, such as funding constraints, changes and increases in demand, disjointed care and workforce pressures. The evidence will inform the debate and help build a sustainable future for the NHS. The first section of this paper identifies core themes from a literature search on beds within healthcare systems. This section provides context for the data and should therefore be read alongside the data section to improve understanding of the evidence. The next section sets out our asks on how beds are used within the NHS. The main section of the paper sets out the data from each nation on beds. A technical note on the data and a glossary of the definitions used can be found in the annex.

Frandsen, B., et al. (2017). Sticking Points: Common-Agency Problems and Contracting in the U.S. Healthcare System. NBER Working Paper Series ; n° 23177. Cambridge NBER
www.nber.org/papers/w23177

We propose a "common-agency" model for explaining inefficient contracting in the U.S. healthcare system. In our setting, common-agency problems arise when multiple payers seek to motivate a shared provider to invest in improved care coordination. Our approach differs from other common-agency models in that we analyze "sticking points," that is, equilibria in which payers coordinate around Pareto-dominated contracts that do not offer providers incentives to implement efficient

investments. These sticking points offer a straightforward explanation for three long observed but hard to explain features of the U.S. healthcare system: the ubiquity of fee-for-service contracting arrangements outside of Medicare; problematic care coordination; and the historic reliance on small, single specialty practices rather than larger multi-specialty group practices to deliver care. The common-agency model also provides insights on the effects of policies, such as Accountable Care Organizations, that aim to promote more efficient forms of contracting between payers and providers.

Mikkers, M. C. (2016). The Dutch Healthcare System in International Perspective. Tilburg Tilburg University

In this address, important aspects of the Dutch system of managed competition are discussed from the economic perspective, highlighting both its merits and the major challenges posed by the development of this system. Reasons for government intervention in healthcare markets are provided, and the outline the different types of healthcare systems are sketched. Followed by a description of the Dutch healthcare system and healthcare outcomes in different countries are compared. The inaugural address concludes with some suggestions for improving the Dutch system.

Travail et santé / Occupational Health

Halla, M., et al. (2017). The effect of statutory sick-pay on workers' labor supply and subsequent health. Working Papers in Economics and Statistics; 2017-04. Innsbruck University of Innsbruck
https://ideas.repec.org/p/inn/wpaper/2017-04.html

Social insurance programs typically comprise sick-leave insurance. An important policy parameter is how the costs of lost productivity due to sick leave are shared between workers, firms, and the social security system. We show that this sharing rule affects not only absence behavior but also workers' subsequent health. To inform our empirical analysis, we propose a model in which workers' absence decisions are conditional on the sharing rule, health, and a dismissal probability. Our empirical analysis is based on high-quality administrative data sources from Austria. Identification is based on idiosyncratic variation in the sharing rule caused by different policy reforms and sharp discontinuities at certain job tenure levels and firm sizes. An increase in either the workers' or the firms' cost share, both at public expense, decreases the number of sick-leave days. Policy-induced variation in sick leave has a significant effect on subsequent healthcare costs. The average worker in our sample is in the domain of presenteeism, that is, an increase in sick leave due to reductions in workers' or firms' cost share would reduce healthcare costs and the incidence of workplace accidents.

Vieillissement / Ageing

(2017). Evaluation des dispositifs MAIA et appui à la mise en œuvre des recommandations. Paris CNSA

Tout en tenant compte de la diversité des territoires et des contextes institutionnels dans lesquels se déploient les dispositifs MAIA , l'évaluation devait permettre :de bien comprendre le fonctionnement des dispositifs MAIA qui ont été généralisés en 2011 et confortés par le plan Maladies neurodégénératives ainsi que par la loi d'adaptation de la société au vieillissement ;d'identifier les facteurs favorables et défavorables à l'intégration des services d'aide et de soins pour un meilleur parcours des personnes âgées et éclairer les effets de la coopération à l'échelle territoriale. Le dossier se compose du rapport final et de 4 annexes : l'analyse documentaire, l'enquête exhaustive auprès de l'ensemble des MAIA et élaboration d'une typologie MAIA, l'enquête qualitative auprès des agences régionales de santé et de conseils départementaux ; l'enquête transversale sur le dispositif de la gestion de cas.

Blanpain, N. et Buisson, G. (2016). "Projections de population à l'horizon 2070. Deux fois plus de personnes de 75 ans ou plus qu'en 2013." Insee Première(1619)
https://www.insee.fr/fr/statistiques/2496228

Si les tendances démographiques récentes se poursuivaient, la France compterait 76,5 millions d'habitants au 1er janvier 2070. Par rapport à 2013, la population augmenterait donc de 10,7 millions d'habitants, essentiellement des personnes de 65 ans ou plus (+ 10,4 millions). En particulier, la population âgée de 75 ans ou plus serait deux fois plus nombreuse en 2070 qu'en 2013 (+ 7,8 millions). Jusqu'en 2040, la proportion de personnes âgées de 65 ans ou plus progressera fortement, quelles que soient les hypothèses retenues sur l'évolution de la fécondité, des migrations ou de l'espérance de vie : à cette date, environ un habitant sur quatre aura 65 ans ou plus (contre 18 % en 2013). Cette forte hausse correspond à l'arrivée dans cette classe d'âge de toutes les générations du baby-boom. L'évolution serait ensuite plus modérée : selon les hypothèses, 25 % à 34 % de la population dépasserait cet âge en 2070. Le nombre d'habitants à l'horizon 2070 dépend des hypothèses, surtout celles retenues sur la fécondité et les migrations. En revanche, la structure de la population par âge à cette date dépend peu des hypothèses. En 2070, la France compterait plus d'une personne âgée de 65 ans ou plus pour deux personnes âgées de 20 à 64 ans.

Di Pollina, L., et al. (2017). "Integrated care at home reduces unnecessary hospitalizations of community-dwelling frail older adults: a prospective controlled trial." Bmc Geriatrics **17**(53)
http://bmcgeriatr.biomedcentral.com/articles/10.1186/s12877-017-0449-9

We conducted a prospective controlled study performed in real-life clinical practice settings to evaluate the efficacy of formally coordinating existing resources: 2 home visiting nursing service centers (HVNS) and a community geriatric unit (CGU) that included a physician to perform in-home multidimensional geriatric assessment, and a 24h/ 7 days a week call service for frail older adults. We hypothesized that this approach could decrease the number of hospitalizations, decrease or delay unnecessary hospitalizations, emergency room visits, and institutionalization, as well as increase the probability of respecting care goals of patients with advanced illness who wish to remain at home.

Dubois, Y. et Koubi, M. (2016). Relèvement de l'âge de départ à la retraite : quel impact sur l'activité des séniors de la réforme des retraites de 2010 ? G2015/15. Paris INSEE
https://www.insee.fr/fr/statistiques/2121629

Cette étude s'intéresse à l'évolution du taux d'activité des séniors induite par l'augmentation des âges légaux de la retraite programmée par la réforme de 2010. À âge et autres caractéristiques égaux par ailleurs, le taux d'activité des salariés impactés par la réforme, entre 2008 et 2014, serait entre 19 et 22 points plus élevé que celui des salariés non impactés. Ce résultat confirme une évaluation ex ante réalisée à l'aide du modèle de microsimulation Destinie de l'Insee. La microsimulation permet en outre de relativiser la difficulté potentielle pour l'évaluation résultant des interactions potentielles entre la réforme évaluée (celle des âges) et deux autres réformes : l'augmentation de la durée de cotisation nécessaire pour obtenir le taux plein (réforme 2003 et extension 2014) et le dispositif des carrières longues. Ces interactions seraient assez faibles sur la période considérée. Le surcroît d'activité induit par la réforme se traduit surtout par un accroissement de l'emploi mais également par un accroissement du chômage. L'inactivité (hors retraite) augmente également pour les hommes.