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Sommaire

Assurance maladie / Health Insurance

Hill M., Maestas N., Mullen K.J. (2013). Source of Health Insurance Coverage and Employment Survival Among Newly Disabled Workers: Evidence from the Health and Retirement Study : Santa Monica : Rand Corporation

Abstract: The onset of a work-limiting disability sets in motion a sequence of events that for a growing number of workers ends in early retirement from the labor force, SSDI application and, ultimately, long-term program participation. Exactly how this sequence of events plays out is not well understood. While there exist large bodies of literature that address the effects of health insurance coverage on a wide range of outcomes, few papers have sought to examine how source of health insurance coverage generally and employer sponsored health insurance (ESHI) specifically affect the employment trajectory following onset of disability. The authors use the nationally representative, longitudinal data from the Health and Retirement Study (HRS) to observe individuals before and after they experience a self-reported work limiting disability. To estimate the effect of ESHI on labor supply and disability claiming, they compare individuals covered by ESHI with no other employer-sponsored option (i.e., spousal coverage) with individuals covered by ESHI but whose spouses are offered coverage from their own employer. They find evidence of an "employment lock" effect of ESHI only among the 20 percent of individuals whose disabilities do not impact their immediate physical capacity but are associated with high medical costs. They do not find any evidence of differential disability insurance application rates between those with ESHI and the comparison group. With the passage of the Affordable Care Act, there is concern that disability insurance applications may swell because the incentive to remain employed will diminish for disabled workers reliant on ESHI. Their results suggest that the availability of non-employment-based health insurance may cause disabled workers with high cost/low severity conditions to leave the workforce but it will not necessarily lead to increased disability insurance application among individuals with ESHI.
http:www.rand.org/pubs/working_papers/WR1040.html

Buchmueller T.C., Muller S., Vujicic M. (2014). How Do Providers Respond to Public Health Insurance Expansions? Evidence from Adult Medicaid Dental Benefits.
Cambridge : NBER

Abstract: A large and growing number of adults are covered by public insurance, and the Affordable Care Act is predicted to dramatically increase public coverage over the next several years. This study evaluates how such large increases in public coverage affect provider behavior and patient wait times by analyzing a common type of primary care: dental services. We find that when states add dental benefit to adult Medicaid coverage, dentists' participation in Medicaid increases and dentists see more publicly insured patients without decreasing the number of visits provided to privately insured patients. Dentists increase the total number of visits they supply each week while only modestly increasing the amount of time they spend working. They achieve this primarily by making greater use of dental hygienists. As a result, dentists' income increases. Wait times increase modestly, with the largest increases in wait times observed in states with restrictive scope of practice laws governing dental hygienists. These changes are most pronounced among dentists who practice in poor areas where Medicaid coverage is greatest.
http:papers.nber.org/papers/w20053

Economie de la santé / Health Economics

Chung Y. (2013). Chronic Health Conditions and Economic Outcomes. Chicago : The Society of Labor Economist

Abstract: With nearly half of the adult population afflicted with a chronic disease, the first onset of a chronic condition is a major life event. This paper examines the relationship between the onset of a chronic disease and economic outcomes among the working-age male population. Fixed effects models are estimated to quantify the temporal patterns of earnings, after-tax family income and food expenditures, controlling for unobserved heterogeneity across individuals. Also, a multiplicative fixed effects model is introduced to include zero earnings in the analysis. Using the Panel Study of Income Dynamics (PSID), I find that initial chronic illness onset has a persistent effect on earnings. In the short run, earnings losses are mostly driven by changes at the intensive margin, however, in the long-run, adjustments at the extensive margin also play a role. Family income responses are smaller than those of earnings. Food expenditures respond in a muted fashion, recovering over time. Finally, there exists significant heterogeneity in the health effects across education groups over time.
http:www.sole-jole.org/14225.pdf

Glied S.A. (2014). Health Care in a Multipayer System: The Effects of Health Care Service Demand among Adults under 65 on Utilization and Outcomes in Medicare.
Cambridge : NBER

Abstract: Doctors and hospitals in the United States serve patients covered by many types of insurance. This overlap in the supply of health care services means that changes in the prices paid or the volume of services demanded by one group of patients may affect other patient groups. This paper examines how marginal shifts in the demand for services among the adult population under 65 (specifically, factors that affect the uninsurance rate) affect use in the Medicare population. I provide a simple theoretical framework for understanding how changes in the demand for care among adults under 65 may affect Medicare spending. I then examine how two demand factors-recent coverage eligibility changes for parents and the firm size composition of employment-affect insurance coverage among adults under 65 and how these factors affect per beneficiary Medicare spending. Factors that contribute to reductions in uninsurance rates are associated with contemporaneous decreases in per beneficiary Medicare spending, particularly in high variation Medicare services. Reductions in the demand for medical services among adults below age 65 are not associated with reductions in the total quantity of physician services supplied. The increased Medicare utilization that accompanies lower demand among those under 65 has few, if any, benefits for Medicare patients.
http:www.nber.org/papers/w20045

Chevreul K., Berg Brigham K., Bouche C. (2014). The burden and treatment of diabetes in France. *Globalization and Health,* 10 (6) :9p.

Abstract: Background: The objective of this review was to describe and situate the burden and treatment of diabetes within the broader context of the French health care system. Methods: Literature review on the burden, treatment and outcomes of diabetes in France, complemented by personal communication with diabetes experts in the Paris public hospital system. Results: Prevalence of diabetes in the French population is estimated at 6%. Diabetes has the highest prevalence among all chronic conditions covered 100% by France's statutory health insurance (SHI), and the number of covered patients has doubled in the past 10 years. In 2010, the SHI cost for pharmacologically-treated diabetes patients amounted to _17.7 billion, including an estimated _2.5 billion directly related to diabetes treatment and prevention and _4.2 billion for treatment of diabetes-related complications. In 2007, the average annual SHI cost was _6 930 for patients with type 1 diabetes and _4 890 for patients with type 2 diabetes. Complications are associated with significantly increased costs. Diabetes is a leading cause of adult blindness, amputation and dialysis in France, which also has one of the highest rates of end-stage renal disease in Europe. Cardiovascular disease is the leading cause of death among people with diabetes. Historically, the French health care system has been more oriented to curative acute care rather than preventive medicine and management of long-term chronic diseases. More recently, the government has focused on primary prevention as part of its national nutrition and health program, with the goal of reducing overweight and obesity in adults and children. It has also recognized the critical role of the patient in managing chronic diseases such as diabetes and has put into place a free patient support program called "sophia". Additional initiatives focus on therapeutic patient education (TPE) and the development of personalized patient pathways. Conclusions: While France has been successful in protecting patients from the financial consequences of diabetes through its SHI coverage, improvements are necessary in the areas of prevention, monitoring and reducing the incidence of complications.

http:www.globalizationandhealth.com/content/pdf/1744-8603-10-6.pdf

Koijen S.J., Philipson T.J., Uhlig H. (2014). Financial Health Economics. Cambridge : NBER

Abstract: We provide a theoretical and empirical analysis of the link between financial and real health care markets. We document a "medical innovation premium" of 4-6% annually for equity of medical firms and analyze the implications it has for the growth of the health care sector. We interpret the premium as compensating investors for government-induced profit risk. We provide supportive evidence for this hypothesis through company filings and abnormal return patterns surrounding threats of government intervention. We quantify the implications of the premium for growth in real health care spending by calibrating our model to match historical trends. Policies that had removed government risk would have lead to more than a doubling of medical R&D and would have increased the current share of health care spending by 4% of GDP, with a predicted long run share of 38%.
http:www.nber.org/papers/w20075

Etat de santé / Health Status

Giles E. Robalino S, Mc Coll H., et al. (2014). The Effectiveness of Financial Incentives for Health Behaviour Change: Systematic Review and Meta-Analysis. *Plos One* , 9 (3) :

Abstract: Background: Financial incentive interventions have been suggested as one method of promoting healthy behavior change. Objectives: To conduct a systematic review of the effectiveness of financial incentive interventions for encouraging healthy behaviour change; to explore whether effects vary according to the type of behaviour incentivised, post-intervention follow-up time, or incentive value. Data Sources: Searches were of relevant electronic databases, research registers, google, and the reference lists of previous reviews; and requests for information sent to relevant mailing lists. Eligibility Criteria: Controlled evaluations of the effectiveness of financial incentive interventions, compared to no intervention or usual care, to encourage healthy behaviour change, in non-clinical adult populations, living in high-income countries, were included. Study Appraisal and Synthesis: The Cochrane Risk of Bias tool was used to assess all included studies. Meta-analysis was used to explore the effect of financial incentive interventions within groups of similar behaviours and overall. Meta regression was used to determine if effect varied according to post-intervention follow up time, or incentive value. Results: Seventeen papers reporting on 16 studies on smoking cessation (n = 10), attendance for vaccination or screening (n = 5), and physical activity (n = 1) were included. In meta-analyses, the average effect of incentive interventions was greater than control for short-term (#six months) smoking cessation (relative risk (95% confidence intervals): 2.48 (1.77 to 3.46); long-term (.six months) smoking cessation (1.50 (1.05 to 2.14)); attendance for vaccination or screening (1.92 (1.46 to 2.53)); and for all behaviours combined (1.62 (1.38 to 1.91)). There was not convincing evidence that effects were different between different groups of behaviours. Meta-regression found some, limited, evidence that effect sizes decreased as post intervention follow-up period and incentive value increased. However, the latter effect may be confounded by the former. Conclusions: The available evidence suggests that financial incentive interventions are more effective than usual care or no intervention for encouraging healthy behaviour change.
http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0090347

Kenkel D.S., Schmeiser M.D., Urban C.J. (2014). Is Smoking Inferior? Evidence from Variation in the Earned Income Tax Credit. Cambridge : NBER

Abstract: In this paper we estimate the causal income elasticity of smoking participation, cessation, and cigarette demand conditional upon participation. Using an instrumental variables (IV) estimation strategy we find that smoking appears to be a normal good among low-income adults: higher instrumented income is associated with an increase in the number of cigarettes consumed and a decrease in smoking cessation. The magnitude and direction of the changes in the income coefficients from our OLS to IV estimates are consistent with the hypothesis that correlational estimates between

income and smoking related outcomes are biased by unobservable characteristics that differentiate higher income smokers from lower income smokers.
http:www.nber.org/papers/w20097

Fiorillio D., Nappo N. (2014). Formal and informal volunteering and health across European countries. York : HEDG

Abstract: In this paper we compare the correlation among formal and informal volunteering and self-perceived health across 14 European countries after controlling for socio-economic characteristics, housing features, neighborhood quality, size of municipality, social participation and regional dummies. we find that formal volunteering has a significantly positive association with self-perceived health in Finland and the Netherlands, but none in the other countries. By contrast, informal volunteering has a significantly positive correlation with self-perceived health in the Netherlands, France, Spain, Portugal and Greece, and a significantly negative relationship in Italy. Our conclusion is that formal and informal volunteering measure two different aspects of volunteering whose correlations with perceived health seem to depend on specific cultural and institutional characteristics of each country.
http:www.york.ac.uk/media/economics/documents/hedg/workingpapers/14_05.pdf

Géographie de la santé / Geography of Health

Ricci-Cabello I., Ruiz-Perez I., Rojas-Garcia A. (2013). Improving Diabetes Care in Rural Areas: A Systematic Review and Meta-Analysis of Quality Improvement Interventions in OECD Countries. *Plos One,* 8 (12) :

Abstract: Background and Aims: Despite well documented disparities in health and healthcare in rural communities, evidence in relation to quality improvement (QI) interventions in those settings is still lacking. The main goals of this work were to assess the effectiveness of QI strategies designed to improve diabetes care in rural areas, and identify characteristics associated with greater success. Methods: We conducted a systematic review and meta-analysis. Systematic electronic searches were conducted in MEDLINE, EMBASE, CINAHL, and 12 additional bibliographic sources. Experimental studies carried out in the OECD member countries assessing the effectiveness of QI interventions aiming to improve diabetes care in rural areas were included. The effect of the interventions and their impact on glycated hemoglobin was pooled using a random-effects meta-analysis. Results: Twenty-six studies assessing the effectiveness of twenty QI interventions were included. Interventions targeted patients (45%), clinicians (5%), the health system (15%), or several targets (35%), and consisted of the implementation of one or multiple QI strategies. Most of the interventions produced a positive impact on processes of care or diabetes self-management, but a lower effect on health outcomes was observed. Interventions with multiple strategies and targeting the health system and/or clinicians were more likely to be effective. Six QI interventions were included in the meta-analysis (1,496 patients), which showed a significant reduction in overall glycated hemoglobin of 0.41 points from baseline in those patients receiving the interventions (95% CI -0.75% to -0.07%). Conclusions: This work identified several characteristics associated with successful interventions to improve the quality of diabetes care in rural areas. Efforts to improve diabetes care in rural communities should focus on interventions with multiple strategies targeted at clinicians and/or the health system, rather than on traditional patient-oriented interventions.
http:www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0084464

Hôpital / Hospitals

Socha K. (2014). Mixed reimbursement of hospitals: Securing high activity and global expenditures control? Odense : University of Southern Denmark

Abstract: When introducing Diagnosis-Related Group (DRG) tariffs as the basis for paying hospitals in Europe, one of the major problems was to find a balancing point between the aim of increasing hospital activity and the need to control global expenditures on hospital care. Consequently, in several European countries, DRG-based reimbursement has been mixed with the already existing forms of hospital reimbursement, such as block budgets, instead of replacing the latter entirely. The mixed reimbursement is viewed as a cautious way of introducing DRG-based funding, which offers the potential for achieving activity expansion without jeopardizing global expenditures control. Denmark is one of the countries where DRG tariffs have been added to the system of block budgets coupled with activity targets. The transition to the mixed reimbursement occurred by replacing a part of each hospital's 'old' block budget by a 'new' DRG-based component. The DRG-based component depends on a hospital's case mix and applicable DRG tariffs, which are, however, reduced by, e.g. 30-50% as compared with a monetary value of a full tariff. The usual interpretation is that such a mix of reimbursement methods provides a specific set of incentives that is different from other hospital payment methods. Yet, the exact modus operandi of the mixed reimbursement remains obscure. It is not entirely clear whether and how the unit rate of reimbursement was changed after the transition? Was the entire volume of a hospital's activity affected or only certain treatments and/or higher levels of activity? Another question is what happened with the activity targets that traditionally accompanied the 'old' block budgets? The aim of this article is to provide a comprehensive description of the change in hospital incentive scheme that followed the transition to the mixed reimbursement in Denmark. In doing so, the paper provides a qualitative assessment of the mixed reimbursement with regard to the asserted exceptionality of its incentive structure, with a particular focus on its ability to balance incentives for activity expansion and global expenditures control. We show that the mixed reimbursement is simply a veiled version of the usual block budget system, which due to certain added complications might even distort activity/efficiency improvements in a new way. The cautions way of implementing DRG-based reimbursement resulted in a system that has hardly moved away from the historical patterns of activity and costs. The sum of the 'new' DRG-based component and the remaining part of the 'old' block budget simply added up to the total of the 'old' block budget (+/- standard annual corrections for inflation, etc.), which allowed hospitals to produce unchanged sort and volume of activity at unchanged unit cost. Only few percent of the annual activity volume is indeed subject to altered reimbursement incentives. In sum, the mixed reimbursement as implemented in Denmark does not present any innovation. Hence, any empirical research based on the assumption that the incentive scheme for the entire volume of hospital activity was changed by the transition to the mixed reimbursement might produce false conclusions.
http://ideas.repec.org/p/hhs/sduhec/2014_003.html

(2014). Exploring Accountable Care in Canada: Integrating Financial and Quality Incentives for Physicians and Hospitals. Ottawa : Canadian Foundation For Healthcare Improvement .

Abstract: Pioneered in the US, accountable care organizations (ACOs) are provider organizations that assume accountability for the costs and quality of care. This paper explores the feasibility of establishing ACOs in Ontario, and concludes that they are powerful vehicles for aligning physician and hospital interests in cost reduction and quality improvement.
http:www.cfhi-fcass.ca/sf-docs/default-source/reports/exploring-accountable-care-brown-en.pdf?sfvrsn=2

Inégalités de santé / Health Inequalities

Ottersen O.O. (2014). The political origins of health inequity: prospects for change.
The Lancet, 383 (9917)

Abstract: The unacceptable health inequities within and between countries cannot be addressed within the health sector, by technical measures, or at the national level alone, but require global political solutions. Norms, policies, and practices that arise from transnational interaction should be understood as political determinants of health that cause and maintain health inequities. Power asymmetry and global social norms limit the range of choice and constrain action on health inequity; these limitations

are reinforced by systemic global governance dysfunctions and require vigilance across all policy arenas. There should be independent monitoring of progress made in redressing health inequities, and in countering the global political forces that are detrimental to health. State and non-state stakeholders across global policy arenas must be better connected for transparent policy dialogue in decision-making processes that affect health. Global governance for health must be rooted in commitments to global solidarity and shared responsibility; sustainable and healthy development for all requires a global economic and political system that serves a global community of healthy people on a healthy planet.
http:download.thelancet.com/pdfs/journals/lancet/PIIS0140673613624071.pdf?id=aaaxcUHp78_bYhrMSTqtu

Scholte R., Van den Berg G.J., Lindenboom M. (2014). Does the Size of the Effect of Adverse Events at High Ages on Daily-Life Physical Functioning Depend on the Economic Conditions Around Birth? Bonn : IZA

Abstract: This paper considers determinants of physical-functional limitations in daily-life activities at high ages. Specifically, we quantify the extent to which the impact of adverse life events on this outcome is larger in case of exposure to adverse economic conditions early in life. Adverse life events include bereavement, severe illness in the family, and the onset of chronic diseases. We use a longitudinal data set of individuals born in the first decades of the 20th century. The business cycle around birth is used as an indicator of economic conditions early in life. We find that the extent to which functional limitations suffer from the onset of chronic diseases is larger if the individual was born in a recession. The long-run effect of economic conditions early in life on functional limitations at high ages runs primarily via this life event.
http:ftp.iza.org/dp8075.pdf

Guthmuller S. Jusot.F., Renaud T., Wittwer J. (2014). Comment expliquer le non recours à l'Aide à l'acquisition d'une complémentaire santé ? Les résultats d'une enquête auprès des bénéficiaires potentiels à Lille en 2009. *Questions d'Economie de la Santé (Irdes),* (195)

Abstract: L'Aide à l'acquisition d'une complémentaire santé (ACS) est un dispositif, sous la forme d'une aide financière, mis en place en 2005 pour favoriser l'accès aux soins des personnes ayant un revenu juste au-dessus du plafond de l'éligibilité à la Couverture maladie universelle complémentaire (CMU-C). Malgré sa montée en charge, le non-recours à l'ACS est important, seules 22 % des personnes éligibles auraient fait valoir leur droit en 2011 (Fonds CMU, 2012). Comprendre les raisons du non-recours apparaît, dans ce contexte, essentiel pour améliorer l'efficacité du dispositif et permettre aux personnes aux revenus modestes d'accéder à une complémentaire santé. Suite à une expérimentation sociale, une enquête a été réalisée en 2009 à Lille auprès de personnes potentiellement éligibles à l'ACS afin de mieux connaître leurs caractéristiques et leurs motivations ou blocages à recourir au dispositif. Les résultats de cette enquête montrent que la population identifiée comme éligible à l'ACS à Lille est confrontée à des difficultés économiques et sociales et fait face à des besoins de soins importants. Le taux de recours à l'ACS est néanmoins faible puisque seules 18 % des personnes ont entrepris des démarches pour l'obtenir. Les raisons les plus souvent invoquées pour expliquer ce non-recours sont : penser ne pas être éligible, le manque d'information, la complexité des démarches et, pour les personnes non couvertes, le prix de la complémentaire, même après déduction du chèque santé.
http:www.irdes.fr/recherche/questions-d-economie-de-la-sante/195-comment-expliquer-le-non-recours-a-l-aide-a-l-acquisition-d-une-complementaire-sante.pdf

Bouvier G., Jugnot S. (2014). Les personnes ayant des problèmes de santé ou de handicap sont plus nombreuses que les autres à faire part des comportements stigmatisants. *Economie et Statistique,* (464-465-466)

Abstract: Collectée en 2008, l'enquête Handicap-Santé permet pour la première fois de documenter statistiquement l'ampleur des discriminations liées à l'état de santé ou de handicap ressenties par les personnes vivant en France, dans des ménages ordinaires. 2,3 millions de personnes de 18 ans et plus vivant dans un logement ordinaire en France déclarent ainsi avoir subi des comportements stigmatisants au cours de leur vie en raison de leur état de santé ou de handicap : moquerie,

mise à l'écart, traitements injustes ou refus de droit. Les personnes ayant des problèmes de santé ou de handicap déclarent beaucoup plus fréquemment que les autres être confrontées à des comportements stigmatisants, et les plus jeunes sont particulièrement concernés. Ces expériences discriminatoires constituent donc une composante de leur vie. Ce constat est conforté lorsque les effets différenciés des caractéristiques sociodémographiques sur la propension à se dire discriminé sont pris en compte. L'ampleur de cette surdéclaration varie selon la nature des altérations fonctionnelles subies et selon la façon de percevoir subjectivement son état de santé. En particulier, les personnes ayant des altérations fonctionnelles cognitives sont nettement plus nombreuses que les autres à se déclarer victimes de comportements stigmatisants. Une reconnaissance administrative de handicap est également associée à un surcroît de ressenti significatif d'expériences discriminatoires. Une analyse plus fine suggère que des facteurs contextuels, transversaux aux différents types d'altérations fonctionnelles, comme l'existence de personnes pour les aider ou l'âge de survenue de l'altération fonctionnelle, pourraient jouer un rôle (résumé d'auteur)ordinaires. 2,3 millions de personnes de 18 ans et plus vivant dans un logement ordinaire en France déclarent ainsi avoir subi des comportements stigmatisants au cours de leur vie en raison de leur état de santé ou de handicap : moquerie, mise à l'écart, traitements injustes ou refus de droit. Les personnes ayant des problèmes de santé ou de handicap déclarent beaucoup plus fréquemment que les autres être confrontées à des comportements stigmatisants, et les plus jeunes sont particulièrement concernés. Ces expériences discriminatoires constituent donc une composante de leur vie. Ce constat est conforté lorsque les effets différenciés des caractéristiques sociodémographiques sur la propension à se dire discriminé sont pris en compte. L'ampleur de cette surdéclaration varie selon la nature des altérations fonctionnelles subies et selon la façon de percevoir subjectivement son état de santé. En particulier, les personnes ayant des altérations fonctionnelles cognitives sont nettement plus nombreuses que les autres à se déclarer victimes de comportements stigmatisants. Une reconnaissance administrative de handicap est également associée à un surcroît de ressenti significatif d'expériences discriminatoires. Une analyse plus fine suggère que des facteurs contextuels, transversaux aux différents types d'altérations fonctionnelles, comme l'existence de personnes pour les aider ou l'âge de survenue de l'altération fonctionnelle, pourraient jouer un rôle (résumé d'auteur).
http:www.insee.fr/fr/ffc/docs_ffc/ES464L.pdf

Daponte A., Bernal M., Bolivar J., Mateo I., Salmi L.R., Barsanti S., Berghmans L., Piznal E., Bourgueil Y., et al. (2014). Criteria for implementing interventions to reduce health inequalities in primary care settings in European regions. *European Journal of Public Health,* En ligne

Abstract: Background: The current social and political context is generating socio-economic inequalities between and within countries, causing and widening health inequalities. The development and implementation of interventions in primary health care (PHC) settings seem unavoidable. Attempts have been made to draw up adequate criteria to guide and evaluate interventions but none for the specific case of PHC. This methodological article aims to contribute to this field by developing and testing a set of criteria for guiding and evaluating real-life interventions to reduce health inequalities in PHC settings in European regions. Methods**:** A literature review, nominal group technique, survey and evaluation template were used to design and test a set of criteria. The questionnaire was answered by professionals in charge of 46 interventions carried out in 12 European countries, and collected detailed information about each intervention. Third-party experts scored the interventions using the set of evaluation criteria proposed. Results: Nine criteria to guide and evaluate interventions were proposed: relevance, appropriateness, applicability, innovation, quality assurance, adequacy of resources, effectiveness in the process, effectiveness in results and mainstreaming. A working definition was drawn up for each one. These criteria were then used to evaluate the interventions identified. Conclusions: The set of criteria drawn up to guide the design, implementation and evaluation of interventions to reduce health inequalities in PHC will be a useful instrument to be applied to interventions under development for culturally, politically and socio-economically diverse PHC contexts throughout Europe.
http:eurpub.oxfordjournals.org/content/early/2014/04/16/eurpub.cku044.abstract

Giuntella O., Mazzonna F. (2014). Do Immigrants Bring Good Health? Bonn : IZA

Abstract: This paper studies the effects of immigration on health. We merge information on individual characteristics from the German Socio-Economic Panel with detailed local labor market characteristics

for the period 1984 to 2009. We exploit the longitudinal component of the data to analyze how immigration affects the health of both immigrants and natives over time. Immigrants are shown to be healthier than natives upon their arrival ("healthy immigrant effect"), but their health deteriorates over time spent in Germany. We show that the convergence in health is heterogeneous across immigrants and faster among those working in more physically demanding jobs. Immigrants are significantly more likely to work in strenuous occupations. In light of these facts, we investigate whether changes in the spatial concentration of immigrants affect natives' health. Our results suggest that immigration reduces residents' likelihood to report negative health outcomes by improving their working conditions and reducing the average workload. We show that these effects are concentrated in blue-collar occupations and are larger among low educated natives and previous cohorts of immigrants.
http:ftp.iza.org/dp8073.pdf

Whitehead M., Povall S., Loring B. (2014). The equity action spectrum: taking a comprehensive approach. Guidance for addressing inequities in health. Copenhague : OMS .

Abstract: This guidance aims to support European policy-makers to improve the design and implementation of policies to reduce inequities in health. It brings together current evidence on how to develop comprehensive policy action plans to identify and address social determinants of health inequities. While great improvements have been made in health across the WHO European Region, there are still striking contrasts in the standards of health enjoyed by different countries within the Region and by different population groups within these countries. Reducing health inequities and improving governance for health and health equity are key strategic objectives of Health 2020 - the European policy framework for health and well-being endorsed by the 53 Member States of the WHO European Region in 2012. This guide seeks to assist European policy-makers in contributing to achieving the objectives of Health 2020 in a practical way. It draws on key evidence, including from the WHO Regional Office for Europe's Review of social determinants and the health divide in the WHO European Region. It also provides a framework that policy-makers at national, regional and local levels can apply to their own unique context, in order to consider the processes by which inequities might occur, and to suggest policy interventions that may be helpful in addressing these factors.
http:ec.europa.eu/health/social_determinants/docs/policybrief_equityaction_en.pdf

Loring B. (2014). Alcohol and inequities. Guidance for addressing inequities in alcohol-related harm. Copenhague : OMS .

Abstract: This policy guidance aims to support European policy-makers to improve the design and implementation of policies to reduce inequities in alcohol-related harm. The WHO European Region has the highest level of alcohol consumption and alcohol-related harm in the world. Within European countries, the burden of alcohol-related harm falls more heavily upon certain groups. Reducing health inequities is a key strategic objective of Health 2020 - the European policy framework for health and well-being endorsed by the 53 Member States of the WHO European Region in 2012. This guide seeks to assist European policy-makers in contributing to achieving the objectives of Health 2020 in a practical way. It draws on key evidence, including from the WHO Regional Office for Europe's Review of social determinants and the health divide in the WHO European Region. It sets out practical options to reduce the level and unequal distribution of alcohol-related harm in Europe, through approaches that address the social determinants of alcohol misuse and the related health, social and economic consequences.
http:ec.europa.eu/health/social_determinants/docs/policybrief_alcohol_en.pdf

Zambon F., Loring B. (2014). Injuries and inequities. Guidance for addressing inequities in unintentional injuries : Copenhague : OMS .

Abstract: This policy guidance aims to support national, regional and local policy-makers in Europe to prepare, implement and follow up policy actions and interventions to reduce inequities in unintentional injuries. Unintentional injuries, including road traffic injuries, falls, burns, drownings and poisonings still constitute a major public health problem, killing almost half a million people in the WHO European Region each year and causing many more cases of disability. The burden of unintentional injuries is unevenly distributed in the WHO European Region. Steep social gradients for death and morbidity exist across and within countries. Reducing health inequities is a key strategic objective of Health 2020 - the European policy framework for health and well-being endorsed by the 53 Member States of

the WHO European Region in 2012. This guide seeks to assist European policy-makers in contributing to achieving the objectives of Health 2020 in a practical way. It draws on key evidence, including from the WHO Regional Office for Europe's Review of social determinants and the health divide in the WHO European Region. It sets out options and practical methods to reduce the level and unequal distribution of unintentional injuries in Europe, through approaches that address the social determinants of unintended injuries and the related health, social and economic consequences.
http:ec.europa.eu/health/social_determinants/docs/policybrief_injuries_en.pdf

Loring B. (2014). Tobacco and inequities. Guidance for addressing inequities in tobacco-related harm : Copenhague : OMS .

Abstract: This policy guidance aims to support European policy-makers to improve the design and implementation of policies to reduce inequities in tobacco-related harm. Smoking kills more Europeans than any other avoidable factor. Socioeconomic inequities in tobacco consumption in Europe are extensive, and are widening. The overall reduction in smoking in Europe has been a public health success, but the effects have mainly been seen in middle- and high-income groups, causing a substantial widening of inequities. Reducing health inequities is a key strategic objective of Health 2020 - the European policy framework for health and well-being endorsed by the 53 Member States of the WHO European Region in 2012. This guide seeks to assist European policy-makers in contributing to achieving the objectives of Health 2020 in a practical way. It draws on key evidence, including from the WHO Regional Office for Europe's Review of social determinants and the health divide in the WHO European Region. It sets out options and practical methods to reduce the level and unequal distribution of tobacco use in Europe, through approaches that address the social determinants of tobacco use and the related health, social and economic consequences.
http:ec.europa.eu/health/social_determinants/docs/policybrief_tobacco_en.pdf

Loring B. (2014). Obesity and inequities. Guidance for addressing inequities in overweight and obesity : Copenhague : OMS .

Abstract: This policy guidance aims to support European policy-makers to improve the design, implementation and evaluation of interventions and policies to reduce inequities in overweight and obesity. The prevalence of obesity in Europe is rising in many countries, and rising fastest in low socioeconomic population groups. There is a strong relationship between obesity and low socioeconomic status, especially for women. Reducing health inequities is a key strategic objective of Health 2020 - the European policy framework for health and well-being endorsed by the 53 Member States of the WHO European Region in 2012. This guide seeks to assist European policy-makers in contributing to achieving the objectives of Health 2020 in a practical way. It draws on key evidence, including from the Review of social determinants and the health divide in the WHO European Region. It sets out options to reduce the unequal distribution of obesity in Europe, through approaches which address the social determinants of obesity and the related health, social and economic consequences of the obesity inequity gradient.
http:ec.europa.eu/health/social_determinants/docs/policybrief_obesity_en.pdf

Médicaments / Pharmaceuticals

Bouvenot G. (2014). Pour une information du public scientifiquement fondée - impartiale - facilement accessible et compréhensible dans le domaine du médicament. Paris : Académie nationale de médecine.

Abstract: L'Académie nationale de médecine et l'Académie nationale de pharmacie considèrent que le foisonnement et la diffusion incontrôlables dans les médias et sur Internet d'informations souvent contradictoires sur les médicaments, y compris les vaccins, aboutissent à une perte des repères et parfois à une perte de confiance dans les messages des institutions officielles. Préoccupées par les effets délétères pour la santé publique que sont susceptibles de provoquer certaines de ces informations, quand elles sont alarmantes, caricaturales, insuffisamment fondées ou même erronées, elles émettent un certain nombre de recommandations destinées à permettre de faire davantage

émerger, à titre de repère indiscuté, dans ce contexte de confusion et de dissonance, une information objective, impartiale, scientifiquement fondée, facilement accessible et compréhensible pour le public. Ces recommandations s'adressent aux émetteurs d'informations les plus qualifiés que sont d'abord les pouvoirs publics et les autorités et agences de santé dont les trop nombreux silences, mais aussi le manque de réactivité et la production de messages peu adaptés au grand public ne permettent pas une présence suffisamment forte et visible dans les débats et polémiques ; ensuite à l'Assurance maladie qui devrait davantage donner accès aux très nombreuses données dont elle dispose et davantage les exploiter ; aux sociétés savantes qui doivent se garder de cautionner et de promouvoir des informations prometteuses mais non encore confirmées ; aux professionnels de santé qui restent les sources principales d'information du public et les meilleurs relais des informations émanant des autorités et dont la crédibilité des messages repose non seulement sur l'actualisation de leurs connaissances mais aussi sur leur indépendance; enfin aux associations de patients et aux patients qui, dans leur quête d'informations, doivent prioritairement recourir à leurs médecins et à leurs pharmaciens, en particulier ne jamais interrompre brutalement un traitement en cours ou modifier sa posologie sans leur en avoir préalablement parlé et faire preuve de la plus grande prudence vis-à-vis de documents ou messages électroniques ou non dont l'origine et la qualité ne sont ni identifiées ni validées.
http:www.academie-medecine.fr/wp-content/uploads/2014/03/Bouvenot-amend%C3%A9-ANMmars2014.pdf

Fronstin P. (2014). Brand-Name and Generic Prescription Drug Use After Adoption of a Full-Replacement - Consumer-Directed Health Plan With a Health Savings Account.
Ebri Notes , 35 (3)

Abstract: The body of research on how consumer-directed health plans (CDHPs) affect the use and costs of health care services -- while still relatively small -- is growing. In recent work, the Employee Benefit Research Institute has examined these relationships using panel data from a large employer that implemented a full-replacement CDHP with a health savings account (HSA). Among other salient results, it was found that adoption of the HSA plan reduced both the number of prescriptions filled and overall pharmacy costs over a four-year follow-up period. A closer examination revealed that the reduction in prescription utilization also involved a decreased use of maintenance medications for chronic disease, and a worsening of adherence. This paper looks at the effects of the HSA plan on the absolute and relative use of brand-name and generic drugs. It was expected that patients were more likely to choose a generic over a brand-name drug under the terms of the newly imposed HSA plan. In the context of prescription-drug utilization, it is thought that the higher patient cost-sharing of CDHPs encourages enrollees to choose less expensive generics over brand names if they view those medications as equivalents or comparatively effective alternatives. In this analysis, evidence is mixed that this is the case. A full-replacement HSA plan was associated with a 4.7 percentage-point rise in the generic-drug dispensing rate (GDR) after one year, and settled 3.4 percentage points higher after four years. The GDR for maintenance medications experienced a similar effect, while for nonmaintenance conditions the GDR rose by 4.1 percentage points after one year, but was just 1.7 percentage points higher after four years. At the end of the four-year follow-up period, GDR was greater by 4.5 percentage points for hypertension, 15.4 percentage points for dyslipidemia, and 7.8 percentage points for asthma/COPD. No significant effects were detected for diabetes GDR, but the measure for depression was lower by 8.4 percentage points after 2010. GDR increases were due to individuals discontinuing use of brand-name drugs without substituting generic therapy. After one year under the full-replacement HSA plan, 0.43 fewer generic and 0.95 less brand-name prescriptions were filled, on average.

Mestre-Ferrandiz J., Deverka P., Pistollato M., et al. (2014). The Current Drug Development Paradigm: Responding to US and European Demands for Evidence of Comparative Effectiveness and Relative Effectiveness. Londres : OHE

Abstract: The project reported in this Occasional Paper was intended to determine how changing demands for evidence are affecting drug development in five global pharmaceutical companies: Amgen, Eli Lilly, GSK, Novartis and Sanofi-Aventis. A literature review helped elucidate concepts and define focus. The authors then conducted semi-structured interviews with an international sample of 19 senior pharmaceutical executives in various positions in the five companies: R&D, outcomes

research, medical affairs, and pricing and reimbursement. The intent was to capture information about the effect of CER/RE requirements on the drug development process now and in the future.
http:www.ohe.org/publications/article/the-drug-development-paradigm-and-effectiveness-evidence-143.cfm

Méthodologie – Statistique / Methodology – Statistics

(2014). Morbidity statistics in the EU - Report on pilot studies. Statistical Working papers. Luxembourg: Publications Office of the European Union.

Abstract: 16 Etats Membres ont conduit des études pilotes pour tester une méthodologie pour la collecte de statistiques de morbidité liée à certains diagnostics. Par la suite, une Task Force Eurostat a été mise en place pour réaliser une analyse approfondie et pour formuler des recommandations en vue de la faisabilité d'une telle collecte de données, notamment en ce qui concerne les sources et les meilleures estimations. Ce rapport résume les résultats de cette Task Force, qui ont été présentés au Groupe de travail sur la santé publique qui s'est réuni en décembre 2013 (résumé de l'éditeur).
http:epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-TC-14-003/EN/KS-TC-14-003-EN.PDF

Hussein M.A., Jorgensen M.M., Osterdal L.P. (2014). Refining Population Health Comparisons: A Multidimensional First Order Dominance Approach. Odense : University of Southern Denmark

Abstract: How to determine if a population group has better overall (multidimensional) health status than another is a central question in the health and social sciences. We apply a multidimensional first order dominance concept that does not rely on assumptions about the relative importance of each dimension or the complementarity/substitutability across dimensions. In particular, we suggest that one can explore the "depth" of dominances by sequentially refining the health dimensions to see which dominances persist. Using The Danish National Health Interview Survey, we conduct dominance comparisons between population groups based on education, gender, marital status, and ethnicity for given age intervals. Our empirical illustration shows that it is possible to operationalize and meaningfully apply the multidimensional first order dominance concept with sequential refinements of health status to as much as ten health dimensions activity was changed by the transition to the mixed reimbursement might produce false conclusions.
http://ideas.repec.org/p/hhs/sduhec/2014_005.html

Politique de santé / Health Policy

Pan Ke Shon J.L., Verdugo G. (2014). Forty Years of Immigrant Segregation in France, 1968-2007: How Different Is the New Immigration? Bonn : IZA

Abstract: Analysing restricted access census data, this paper examines the long-term trends of immigrant segregation in France from 1968 to 2007. Similar to other European countries, France experienced a rise in the proportion of immigrants in its population that was characterised by a new predominance of non-European immigration. Despite this, average segregation levels remained moderate. While the number of immigrant enclaves increased, particularly during the 2000s, the average concentration for most groups decreased because of a reduction of heavily concentrated census tracts and census tracts with few immigrants. Contradicting frequent assertions, neither mono-ethnic census tract nor ghettoes exist in France. By contrast, many immigrants live in census tracts characterised by a low proportion of immigrants from their own group and from all origins. A long residential period in France is correlated with lower concentrations and proportion of immigrants in the census tract for most groups, though these effects are sometimes modest.

http:ftp.iza.org/dp8062.pdf

Prévision - Evaluation / Prevision – Evaluation

(2014). Measuring the Level and Determinants of Health System Efficiency in Canada.

Ottawa : C.I.H.I. .
Abstract: Cette étude portant sur l'efficacité du système de santé canadien présente les facteurs qui permettent d'expliquer les écarts sur le plan de l'efficacité entre les régions sanitaires. Elle s'appuie sur les résultats d'un autre rapport de l'ICIS, Vers un modèle de mesure de l'efficacité du système de santé au Canada, pour répondre aux diverses questions, notamment pourquoi certaines régions sanitaires canadiennes sont plus efficaces que d'autres.
https:secure.cihi.ca/free_products/HSE_TechnicalReport_EN_web.pdf

Psychiatrie / Psychiatry

Coldefy M. (2014). Analyser le recours aux soins psychiatriques à partir du système d'information sur les établissements de santé : intérêts et limites.

In : Organisation de l'offre de soins en psychiatrie et santé mentale. Actes du séminaire recherche. *Série Etudes et Recherche - Document de Travail - Drees,* (129) .
http:www.drees.sante.gouv.fr/IMG/pdf/dt129.pdf

Soins de santé primaires / Primary Health Care

Dewulf B. (2013). Accessibility to primary health care in Belgium: an evaluation of policies awarding financial assistance in shortage areas.

Bmc Family Practice , 14 (122) :

Abstract: Background: In many countries, financial assistance is awarded to physicians who settle in an area that is designated as a shortage area to prevent unequal accessibility to primary health care. Today, however, policy makers use fairly simple methods to define health care accessibility, with physician-to-population ratios (PPRs) within predefined administrative boundaries being overwhelmingly favoured. Our purpose is to verify whether these simple methods are accurate enough for adequately designating medical shortage areas and explore how these perform relative to more advanced GIS-based methods. Methods: Using a geographical information system (GIS), we conduct a nation-wide study of accessibility to primary care physicians in Belgium using four different methods: PPR, distance to closest physician, cumulative opportunity, and floating catchment area (FCA) methods. Results: The official method used by policy makers in Belgium calculating PPR per physician zone) offers only a crude representation of health care accessibility, especially because large contiguous areas (physician zones) are considered. We found substantial differences in the number and spatial distribution of medical shortage areas when applying different methods. Conclusions: The assessment of spatial health care accessibility and concomitant policy initiatives are affected by and dependent on the methodology used. The major disadvantage of PPR methods is its aggregated approach, masking subtle local variations. Some simple GIS methods overcome this issue, but have limitations in terms of conceptualisation of physician interaction and distance decay. Conceptually, the enhanced 2-step floating catchment area (E2SFCA) method, an advanced FCA method, was found to be most appropriate for supporting areal health care policies, since this method is able to calculate accessibility at a small scale (e.g. census tracts), takes interaction between physicians into account, and considers distance decay. While at present in health care research methodological differences and modifiable areal unit problems have remained largely overlooked, this manuscript shows that these aspects have a significant influence on the insights obtained. Hence, it is important for policy

makers to ascertain to what extent their policy evaluations hold under different scales of analysis and when different methods are used.
http://www.biomedcentral.com/1471-2296/14/122

Mbemba G., Gagnon M., Pare G., et al. (2013). Interventions for supporting nurse retention in rural and remote areas: an umbrella review. *Human Resources for Health,* 11 (44)

Abstract: Context : Retention of nursing staff is a growing concern in many countries, especially in rural, remote or isolated regions, where it has major consequences on the accessibility of health services. Purpose: This umbrella review aims to synthesize the current evidence on the effectiveness of interventions to promote nurse retention in rural or remote areas, and to present a taxonomy of potential strategies to improve nurse retention in those regions. Methods : We conducted an overview of systematic reviews, including the following steps: exploring scientific literature through predetermined criteria and extracting relevant information by two independents reviewers. We used the PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) criteria in order to assess the quality of the reports. Findings : Of 517 screened publications, we included five reviews. Two reviews showed that financial-incentive programs have substantial evidence to improve the distribution of human resources for health. The other three reviews highlighted supportive relationships in nursing, information and communication technologies support and rural health career pathways as factors influencing nurse retention in rural and remote areas. Overall, the quality of the reviews was acceptable. Conclusions : This overview provides a guide to orient future rural and remote nurse retention interventions. We distinguish four broad types of interventions: education and continuous professional development interventions, regulatory interventions, financial incentives, and personal and professional support. More knowledge is needed regarding the effectiveness of specific strategies to address the factors known to contribute to nurse retention in rural and remote areas. In order to ensure knowledge translation, retention strategies should be rigorously evaluated using appropriate designs.
http:www.human-resources-health.com/content/11/1/44

Chandez C. (2014). Déterminants de l'installation en médecine générale libérale.
Médecine : Revue de l'Unaformec, 10 (2) :

Abstract: Depuis une dizaine d'années la médecine générale libérale souffre d'un désintérêt croissant. Les raisons de ce rejet sont connues : gestion administrative, peur de l'isolement, craintes sur la qualité, de vie et l'organisation du travail. Mais les jeunes médecins généralistes ne sont pas complètement opposés au libéral : en 2006, en première inscription … l'ordre, 10 % sont installés en libéral alors que, 5 ans plus tard, ils sont 35 % [1]. Ils souhaitent mieux connaître cette forme d'exercice, qui les attire pour la liberté,, l'autonomie et la polyvalence.
http:www.jle.com/fr/revues/medecine/med/sommaire.phtml?cle_parution=3949

Berrier S. (2014). Exercices regroupés : l'union fait la force. *Médecins : Bulletin d'Information de l'Ordre National des Médecins,* (34)

Abstract: A son émergence dans les années 1970, l'exercice regroupé s'appliquait exclusivement aux médecins de même spécialité. Depuis, ce mode d'exercice n'a cessé d'attirer les praticiens, à tel point qu'aujourd'hui 57,1 % des médecins libéraux (hors remplaçants) exercent en cabinet de groupe ou en société.
http:www.conseil-national.medecin.fr/sites/default/files/cn_bulletin/2014-04-08/master/sources/projet/MEDECINS-34.pdf

Bodenheimer T., Ghorob A., Willard-Grace R. (2014). The 10 Building Blocks of High-Performing Primary Care. *Annals of Family Medicine,* 12 (2) :

Abstract: Our experiences studying exemplar primary care practices, and our work assisting other practices to become more patient centered, led to a formulation of the essential elements of primary care, which we call the 10 building blocks of high performing primary care. The building blocks include 4 foundational elements- engaged leadership, data-driven improvement, empanelment, and team-based care-that assist the implementation of the other 6 building blocks-patient-team partnership,

population management, continuity of care, prompt access to care, comprehensiveness and care coordination, and a template of the future. The building blocks, which represent a synthesis of the innovative thinking that is transforming primary care in the United States, are both a description of existing high-performing practices and a model for improvement.
http:www.annfammed.org/content/12/2/166.full.pdf

Berdud M., Cabases J., Nieto J. (2014). A Pilot Inquiry on Incentives and Intrinsic Motivation in Health Care: the Motivational Capital Explained by Doctors. Pamplona : Universidad Publica de Navarra

Abstract: Where the contracts are incomplete, the resulting co-ordination problems may be attenuated if workers are intrinsically motivated to do the work. It is established by theoretical and empirical literature that workers within public organizations are intrinsically motivated to exert effort doing the job and have a strong sense of social agents with the mission of providing collective goods to citizens and tax payers. This paper is an empirical pilot study in the health care sector using methods of Qualitative Analysis research. We run semi structured interviews -la- Bewley to sixteen physicians of Navarre's health Care Servicio Navarro de Salud-Osasunbidea (SNS-O). The objective of the work is twofold: first, to find empirical evidence about doctors' non-monetary motives and second, to find evidence about how these non-monetary motives shape doctors' behavior. We formulate several testable hypotheses: (1) Doctors are intrinsically motivated agents, (2) Economic incentives and control policies may crowd- out intrinsic motivation and (3) Well designed incentives may crowd-in agents intrinsic motivation. Results confirm the hypotheses formulated above and coming from our theoretical findings [11], [12]. Finally, we also found empirical evidence of conflict between political advisors or health managers (principals) and physicians (agents). Results are a step forward in the optimal design of incentive schemes and policies which crowd in doctors' intrinsic motivation.
http:ideas.repec.org/p/nav/ecupna/1401.html

Berdud M., Cabases J., Nieto J. (2014). Motivational Capital and Incentives in Health Care Organizations : Pamplona : Universidad Publica de Navarra

Abstract: This paper explores optimal incentive schemes in public health institutions when agents (doctors) are intrinsically motivated. We develop a principal-agent dynamic model with moral hazard in which agents' intrinsic motivation could be promoted (crowding-in) by combining monetary and non-monetary rewards, but could also be discouraged (crowding-out) when the health manager uses only monetary incentives. We discuss the conditions under which investing in doctors' motivational capital by the use of well designed nonmonetary rewards is optimal for the health organizations manager. Our results show that such investments will be more efficient than pure monetary incentives in the long run. We will also prove that when doctors are risk averse, it is profitable for the health manager to invest in motivational capital.
ftp:ftp.econ.unavarra.es/pub/DocumentosTrab/DT1402.PDF

Systèmes de santé / Health Systems

Burkhauser R.V. (2014). Is the 2010 Affordable Care Act Minimum Standard to Identify Disability in All National Datasets Good Enough for Policy Purposes? Ann Arbor : Michigan Retirement Research Center (M.R.R.C.).

Abstract: Using linked 2009 Current Population Survey (CPS)-Annual Social and Economic Supplement/Social Security Administration records data and a definition of disability based on the six-question disability sequence (6QS) in the CPS-Basic Monthly Survey, we perform a face validity test that shows that the 6QS captures only 66.3 percent of those who administrative records confirm are receiving Social Security benefits based on their disability. Adding a work-activity question to the 6QS increases our capture rate by another 23.1 percentage points for a total of 89.3 percent. We find little difference in the distribution of conditions between those who only report a 6QS-based disability and those who only report a work activity-based disability. The four function-related questions in the 6QS do a relatively good job of capturing those receiving benefits based on these conditions. But the work-

activity question does a far better job of capturing those receiving benefits than the two activity-related questions in the 6QS.
http:papers.ssrn.com/sol3/papers.cfm?abstract_id=2416991

Fiorentini G., Ragazzi G., Robone S. (2014). Are bad health and pain making us grumpy? An empirical evaluation of reporting heterogeneity in rating health system responsiveness. Working Paper DSE; 933. Bologna : University of Bologna

Abstract: This paper considers the influence of patients' characteristics on their evaluation of a health system's responsiveness, that is, a system's ability to respond to the legitimate expectations of potential users regarding non-health enhancing aspects of care (Valentine et al. 2003a). Since responsiveness is evaluated by patients on a categorical scale, their self-evaluation can be affected by the phenomenon of reporting heterogeneity (Rice et al. 2012). A few studies have investigated how standard socio-demographic characteristics influence the reporting style of health care users with regard to the question of the health system's responsiveness (Sirven et al. 2012, Rice et al. 2012). However, we are not aware of any studies that focus explicitly on the influence that both the patients' state of health and their experiencing of pain have on the way in which they report on system responsiveness. This paper tries to bridge this gap by using data regarding a sample of patients hospitalized in four Local Health Authorities (LHA) in Italy's Emilia-Romagna region between 2010 and 2012. These patients have evaluated 27 different aspects of the quality of care, concerning five domains of responsiveness (communication, social support, privacy, dignity and quality of facilities). Data have been stratified into five sub-samples, according to these domains. We estimate a generalized ordered probit model (Terza, 1985), an extension of the standard ordered probit model which permits the reporting behaviour of respondents to be modelled as a function of certain respondents' characteristics, which in our analysis are represented by the variables "state of health" and "pain". Our results suggest that unhealthier patients are more likely to report a lower level of responsiveness, all other things being equal, while patients experiencing pain are more likely to make use of the extreme categories of responsiveness, that is, to choose the category "completely dissatisfied" or the category "completely satisfied". These results hold across all five domains of responsiveness.
http:www2.dse.unibo.it/wp/WP933.pdf

Frandsen B., Rebitzer J.B. (2014). Structuring Incentives Within Organizations: The Case of Accountable Care Organizations. Cambridge : NBER

Abstract: Accountable Care Organizations (ACOs) are new organizations created by the Affordable Care Act to encourage more efficient, integrated care delivery. To promote efficiency, ACOs sign contracts under which they keep a fraction of the savings from keeping costs below target provided they also maintain quality levels. To promote integration and facilitate measurement, ACOs are required to have at least 5,000 enrollees and so must coordinate across many providers. We calibrate a model of optimal ACO incentives using proprietary performance measures from a large insurer. Our key finding is that free-riding is a severe problem and causes optimal incentive payments to exceed cost savings unless ACOs simultaneously achieve extremely large efficiency gains. This implies that successful ACOs will likely rely on motivational strategies that amplify the effects of under-powered incentives. These motivational strategies raise important questions about the limits of ACOs as a policy for promoting more efficient, integrated care.
http:www.nber.org/papers/w20034

Hemmings P. (2014). How to Improve Israel's Health-care System. Paris : OCDE

Abstract: Israël se singularise par une espérance de vie plus élevée et une structure démographique nettement plus jeune que la plupart des autres pays de l'OCDE. Néanmoins, la demande de soins de santé augmente rapidement en raison de l'accroissement et du vieillissement de la population. Par ailleurs, les larges fractures socioéconomiques qui caractérisent le pays se traduisent par des disparités sur le plan de la santé. Pour l'heure, le système de santé, qui s'articule autour de quatre organismes d'assurance maladie, offre un ensemble de services universels, recouvrant des soins primaires et secondaires dont la qualité est largement reconnue, tout en satisfaisant la demande de soins de santé privés. Néanmoins, ce système est en proie à des difficultés et des tensions. Aujourd'hui, les autorités doivent rapidement accroître le nombre de places offertes dans les facultés de médecine et les formations aux soins infirmiers, car des cohortes nombreuses de professionnels

de la santé se préparent à prendre leur retraite. De manière plus générale, certains craignent que le principe fondamental d'universalité des soins correspondant à un ensemble de services ne soit en train d'être remis en cause par le système de participation aux frais médicaux, et par la demande croissante de services et options supplémentaires offerts par des assurances privés. Bien que les soins soient globalement de bonne qualité, il serait possible d'améliorer les données concernant les soins dispensés dans les hôpitaux et certains craignent que leur surpeuplement ne devienne chronique.
http:dx.doi.org/10.1787/5jz5j1sltwtb-en

Duggan M., Starc A., Vabson M. (2014). Who Benefits when the Government Pays More? Pass-Through in the Medicare Advantage Program. Cambridge : NBER

Abstract: Governments contract with private firms to provide a wide range of services. While a large body of previous work has estimated the effects of that contracting, surprisingly little has investigated how those effects vary with the generosity of the contract. In this paper we examine this issue in the Medicare Advantage (MA) program, through which the federal government contracts with private insurers to coordinate and finance health care for more than 15 million Medicare recipients. To do this, we exploit a substantial policy-induced increase in MA reimbursement in metropolitan areas with a population of 250 thousand or more relative to MSAs just below this threshold. Our results demonstrate that the additional reimbursement leads more private firms to enter this market and to an increase in the share of Medicare recipients enrolled in MA plans. Our findings also reveal that only about one-fifth of the additional reimbursement is passed through to consumers in the form of better coverage. A somewhat larger share accrues to private insurers in the form of higher profits and we find suggestive evidence of a large impact on advertising expenditures. Our results have implications for a key feature of the Affordable Care Act that will reduce reimbursement to MA plans by $156 billion from 2013 to 2022.
http:papers.nber.org/papers/W19989

Travail et santé / Occupational Health

Ravensteijn B., Van Kippersluis H., Van Doorslaer E. (2013). The Wear and Tear on Health: What Is the Role of Occupation? Berlin : DIW

Abstract: Although it seems evident that occupations affect health, effect estimates are scarce. We use a job characteristics matrix linked to German longitudinal data spanning 26 years to characterize occupations by their physical and psychosocial burdens. Employing a dynamic model to control for factors that simultaneously affect health and selection into occupations, we find that manual work and low job control both have a substantial negative effect on health that increases with age. The effects of late career exposure to high physical demands and low job control are comparable to a health deterioration due to aging 12 and 19 months, respectively.
http:www.diw.de/documents/publikationen/73/diw_01.c.441142.de/diw_sp0618.pdf

(2014). Point statistique AT-MP Allemagne - Données 2009-2012. Paris : Eurogip .

Abstract: Ce document livre des données statistiques relatives aux accidents du travail (AT) et maladies professionnelles (MP) en Allemagne.
http:www.eurogip.fr/images/publications/Eurogip_Point_Stat_All0912_93FR.pdf

Vieillissement / Aging

Somme D., Trouvé H., Passadori Y., et al. (2014). Prise de position de la Société française de gériatrie et gérontologie sur le concept d'intégration : texte intégral. Première partie. *Gériatrie et Psychologie et Neuropsychiatrie du Vieillissement,* 12 (1)

Abstract: Le concept d'intégration des soins et des services, bien que datant des années 1990 n'est que récemment apparu dans les politiques publiques en France. Afin de clarifier le concept et son adaptation à la réalité du système de soins et de services français, la Société française de gériatrie et de gérontologie a mandaté un groupe de travail interdisciplinaire. Les travaux de ce groupe sont synthétisés selon trois axes : la définition de l'intégration, les objectifs poursuivis par cette orientation organisationnelle et les moyens à mettre en œuvre. Il se dégage de l'analyse de la littérature que l'intégration est un processus qui vise à dépasser les frontières de la fragmentation des systèmes de services répondant à des populations en situation de vulnérabilité. Ce processus nécessite une réflexion multi-niveau, notamment sur la façon dont les politiques publiques et les systèmes de financement doivent être modifiés. Ainsi, à tous les niveaux concernés, doit se développer un partage de processus, d'outils, de moyens, de finances, d'actions et de retour sur ces actions. C'est ce partage qui est la preuve de l'évolution vers l'intégration. Dans cette première partie du rapport de leurs travaux, les auteurs ont analysé les définitions les plus utilisées dans la littérature internationale concernant le concept d'intégration. De cette comparaison de définition ils font ressortir les traits les plus saillants de l'intégration. Ce concept doit s'articuler avec celui de "coordination" qui a prévalu dans la conduite de la majorité des politiques publiques touchant le champ gérontologique depuis les années 1960 en France. Les caractéristiques de l'intégration permettent de saisir qu'il s'agit d'un processus ambitieux permettant une réelle modification systémique. Les auteurs ont mis en dialogue les aspirations des citoyens avec les objectifs de l'intégration afin de vérifier que ces derniers répondent bien à des besoins exprimés par les personnes à qui elle s'adresse.
http:www.jle.com/e-docs/00/04/94/19/vers_alt/VersionPDF.pdf

Vignoli D., Tanturri M., Acciai F. (2014). Home Bitter Home? Gender, Living Arrangements, and the Exclusion from Home-Ownership among Older Europeans.
Firenze : Universita degli Studi di Firenze

Abstract: Home-ownership is the most important asset among the elderly in Europe, but in this domain very little is known about gender differences. This paper aims at exploring the link between gender, living arrangements, monetary poverty and home tenure among older Europeans, in order to identify the profiles of the elderly at a higher risk of being excluded from home-ownership. The analysis is based on the fourth wave of SHARE, and includes a sub-sample of about 56,000 individuals aged 50 or over, living in 16 European countries: Austria, Belgium, Czech Republic, Estonia, France, Germany, Hungary, Italy, the Netherlands, Poland, Portugal, Slovenia, Spain, Sweden, and Switzerland. Our findings show that women are generally more likely to be excluded from homeownership than men. However, a closer look suggests that the gender gap in home ownership is essentially generated by compositional differences between men and women, with th e most relevant factor being the type of living arrangement.
http:local.disia.unifi.it/wp_disia/2014/wp_disia_2014_05.pdf

Bourreau-Dubois C., Gramain A., Lim H., Xing J. (2014). Impact du reste à charge sur le volume d'heures d'aide a domicile utilisé par les bénéficiaires de l'APA. Paris : Centre d'Economie de la Sorbonne

Abstract: Depuis 2001, en France, les personnes âgées dépendantes bénéficient d'une subvention publique (l'allocation personnalisée d'autonomie) pour financer l'achat d'heures d'aide à la réalisation des activités de la vie quotidienne. Cette subvention n'est que partielle et laisse à la charge des bénéficiaires un montant horaire qui varie selon plusieurs paramètres (son revenu, le prix facturé par le prestataire, les tarifs de solvabilisation fixés par l'autorité publique locale). A partir de données administratives issues d'un département, et en tenant compte des règles institutionnelles nationales et départementales, nous estimons l'élasticité de la demande à ce reste à charge, pour l'aide professionnelle à domicile fournie par des prestataires autorisés. Nous montrons que le reste à charge supporté par les personnes âgées dépendantes bénéficiaires de l'APA a bien un impact négatif sur leur consommation d'heures d'aide à domicile. Une augmentation du prix facturé de 10% induit une baisse du volume d'heures de 5.5%, soit 73 minutes pour l'allocataire qui utiliserait 22 heures d'aides, ie le volume moyen utilisé par les allocataires supportant un ticket modérateur non nul.
ftp:mse.univ-paris1.fr/pub/mse/CES2014/14024.pdf

Behaghel L., Blanchet D., Roger M. (2014). Retirement, Early Retirement and Disability: Explaining Labor Force Participation after 55 in France. Cambridge : NBER

Abstract: We analyze the influence of health and financial incentives on the retirement behavior of older workers in France, building upon Stock and Wise (1990) option value approach. The model accounts for three main retirement routes: the normal retirement, disability insurance (DI) and unemployment/preretirement pathways, and is estimated with a combination of microeconomic datasets that include the French data of the European SHARE survey. The estimates confirm that a decrease in the generosity of the pension and DI schemes induces people to stay longer in the labor market, and that people with better health tend to retire later. We present extreme situations simulating what individual's retirement behavior would have been if only one retirement route had existed and in the absence of constraints on work capabilities. We show that average years of work between 55 and 64 are nearly 14% greater when regular retirement incentives are applied to the whole population than when it is DI rules that are systematically applied.
http:www.nber.org/papers/w20030

De Stampa M., Vedel I., Ankri J., et al. (2014). Multidisciplinary teams of case managers in the implementation of an innovative integrated services delivery for the elderly in France. *Bmc Health Services Research,* 14 (159)

Abstract: En France, les équipes multidisciplinaires de gestion de cas sont des éléments importants pour la prestation de services intégrés aux personnes âgées. Cette étude examine leur rôle et conclut qu'elles ajoutent de la valeur en constituant un paradigme clinique complet.
http:www.biomedcentral.com/content/pdf/1472-6963-14-159.pdf

(2014). Ageing and Employment Policies: Netherlands 2014 : Working Better with Age. Paris : OCDE

Abstract: This report provides an overview of policy iniatives implemented over the past decade in the Netherlands and identifies areas where more should be done, covering both supply-side and demand-side aspects. To give better incentives to carry on working, the report recommends to promote longer contribution periods in the second-pillar pension schemes, and ensure better information and transparency of pension schemes, with a special focus on groups with low financial literacy. On the side of employers, it is important to progress towards more age-neutral hiring decisions and wage-setting procedures with more focus on performance and less on tenure and seniority. To improve the employability of older workers, the focus should be to promote training measures for older unemployed which are directly linked to a specific job. The large diversity in municipal "Work-First" programmes should be utilised in designing more effective activation policies targetted on those at risk of losing contact with the labour market.

Stroka M.A., Reichert A.R. (2014). Nursing Home Prices and Quality of Care - Evidence from Administrative Data. Bochum : Ruhr-Universitat Bochum

Abstract: There is widespread concern about the quality of care in nursing homes. Based on administrative data of a large health insurance fund, we investigate whether nursing home prices affect relevant quality of care indicators at the resident level. Our results indicate a significantly negative price effect on inappropriate and psychotropic medication. In contrast, we find no evidence for fewer painful physical sufferings for residents of nursing homes with higher prices.
http:repec.rwi-essen.de/files/REP_14_470.pdf

Lassila J., Valkonen T. (2014). Longevity- Working Lives and Public Finances. Helsinki : ETLA

Abstract: Can longer working lives bring sufficient tax revenues to pay for the growing public health and care expenditure that longer lifetimes cause? We review studies concerning retirement decisions and pension policies, the role of mortality in health and long-term care costs, and errors in mortality projections. We combine key results into a numerical OLG model where changes in mortality have direct effects both on working careers and on per capita use of health and long-term care services. The model has been calibrated to the Finnish economy and demographics. Although there are huge uncertainties concerning future health and long-term care expenditure when people live longer, our simulations show that without policies directed to disability admission rules and old-age pension

eligibility ages, working lives are unlikely to extend sufficiently. But, importantly, with such policies it seems quite possible that generations enjoying longer lifetimes can also pay for the full costs by working longer.
http:pub.etla.fi/ETLA-Working-Papers-24.pdf

Di Giorgio.L., Philippini M., Masiero G. (2014). The relationship between costs and quality in nonprofit nursing homes. Svizzera : Universita della Svizzera italiana- Faculty of Economics- Center for Economic and Political Research on Aging

Abstract: We investigate the relationship between costs and quality in non-profit nursing homes, a key issue in the present context of cost containment measures. In accordance with the economic theory of production, we estimate a three-inputs total cost function for nursing home services using data from 45 nursing homes in Switzerland between 2006 and 2010. Quality is measured by means of clinical indicators regarding process and outcome derived from the Minimum Data Set. We consider both composite and single quality indicators. Contrary to previous studies, we use panel data and control for unobserved heterogeneity. This allows to capture nursing homes specific features that may explain differences in structural quality or costs levels. We find evidence that poor levels of quality regarding outcome, as measured by the prevalence of severe pain and weight loss, lead to higher costs. Our results are robust to quality endogeneity concerns.
http:doc.rero.ch/record/209725/files/WP1402.pdf