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http://www.irdes.fr/english/documentation/watch-on-health-economics-literature.html

SOMMAIRE

Assurance maladie / Health Insurance

Buchmueller T., Carey C., Levy H.G. (2013). Will employers drop health insurance coverage because of the affordable care act? *Health Aff.(Millwood.),* 32 (9) : 1522-1530.
Abstract: Since the passage of the Affordable Care Act, there has been much speculation about how many employers will stop offering health insurance once the act's major coverage provisions take effect. Some observers predict little aggregate effect, but others believe that 2014 will mark the beginning of the end for our current system of employer-sponsored insurance. We use theoretical and empirical evidence to address the question, "How will employers' offerings of health insurance change under health reform?" First, we describe the economic reasons why employers offer insurance. Second, we recap the relevant provisions of health reform and use our economic framework to consider how they may affect employers' offerings. Third, we review the various predictions that have been made about those offerings under health reform. Finally, we offer some observations on interpreting early data from 2014.

Long S.K. (2013). Physicians may need more than higher reimbursements to expand medicaid participation: findings from Washington state. *Health Aff.(Millwood.),* 32 (9) : 1560-1567.
Abstract: The expansion of insurance coverage under the Affordable Care Act is expected to put considerable pressure on the capacity of the primary care workforce to meet the needs of the Medicaid population beginning in 2014. The results from a 2011 survey and focus-group sessions with Washington State primary care physicians suggest that doctors welcome planned increases in Medicaid reimbursement rates. However, the data also show that other approaches could be even more effective in increasing physicians' willingness to see Medicaid patients. Those approaches include lowering the costs of participating in Medicaid by simplifying administrative processes, speeding up reimbursement, and reducing the costs associated with caring for those patients. In focus groups, physicians were cautiously optimistic about the potential of the Affordable Care Act to make a difference in each of these areas, with electronic health records, medical homes, and accountable care organizations all seen as promising developments.

Kuziemko I., Meckel K., Rossin-Slater M. (2013). Do Insurers Risk-Select Against Each Other? Evidence from Medicaid and Implications for Health Reform : Cambridge : NBER
Abstract: Increasingly in U.S. public insurance programs, the state finances and regulates competing, capitated private health plans but does not itself directly insure beneficiaries through a public fee-for-service (FFS) plan. We develop a simple model of risk-selection in such settings. Capitation incentivizes insurers to retain low-cost clients and thus improve their care relative to high-cost clients, who they prefer would switch to a competitor. We test this prediction using county transitions from FFS Medicaid to capitated Medicaid managed care (MMC) for pregnant women and infants. We first document the large health disparities and corresponding cost differences between blacks and Hispanics (who make up the large majority of Medicaid enrollees in our data), with black births costing nearly double that of Hispanics. Consistent with the model, black-Hispanic infant health disparities widen under MMC (e.g., the black-Hispanic mortality gap grows by 42 percent) and black mothers' pre-natal care worsens relative to that of Hispanics. Remarkably, black birth rates fall (and abortions rise) significantly after MMC--consistent with mothers reacting to poor care by reducing fertility or plans discouraging births from high-cost groups. Implications for the ACA exchanges are discussed.
http://papers.nber.org/papers/W19198

Warin P. (2013). Informer pour éviter le non-recours à la CMU-C et à l'ACS : Grenoble : ODENORE

Abstract: Informer les publics « vulnérables » est un objectif complexe qui suppose une intervention sur deux plans : celui de la communication institutionnelle sur les droits et celui de l'apprentissage des droits. À cet égard, le travail engagé par l'Assurance maladie pour agir sur le non-recours à une complémentaire santé, gratuite (Couverture maladie universelle complémentaire – CMU-C) ou aidée (Aide à l'acquisition d'une complémentaire – ACS), illustre le besoin de coupler une information en masse et une explication ciblée, à la fois pour combler la méconnaissance des droits et pour rapprocher les publics vulnérables de leurs droits. Les éléments d'évaluation disponibles pour expliquer le non-recours à la CMU-C et à l'ACS ont tous souligné la méconnaissance de ces dispositifs, aussi bien chez les bénéficiaires potentiels que chez les agents censés les informer. Ce document de travail passe en revue les initiatives institutionnelles pour améliorer l'information des usagers sur leurs droits ainsi que les études publiées sur le sujet.
http://odenore.msh-alpes.fr/documents/wp15.pdf

Etat de santé / Health Status

Ruhm C.J. (2013). Recessions, Healthy No More? Cambridge : NBER
Abstract: Using data from multiple sources, over the 1976-2009 period, I show that total mortality has shifted over time from strongly procyclical to being essentially unrelated to macroeconomic conditions. The relationship also shows some instability over time and is likely to be poorly measured when using short (less than 15 or 20 year) analysis periods. The secular change in the association between macroeconomic conditions and overall mortality primarily reflects trends in effects for specific causes of death, rather than changes in the composition of total mortality across causes. Deaths due to cardiovascular disease and transport accidents continue to be procyclical (although possibly less so than in the past), whereas strong countercyclical patterns of cancer fatalities and some external sources of death (particularly those due to accidental poisoning) have emerged over time. The changing effect of macroeconomic conditions on cancer deaths may partially reflect the increasing protective influence of financial resources, perhaps because these can be used to obtain sophisticated (and expensive) treatments that have become available in recent years. That observed for accidental poisoning probably has occurred because declines in mental health during economic downturns are increasingly associated with the use of prescribed or illicitly obtained medications that carry risks of fatal overdoses.
http://papers.nber.org/papers/W19287

Mitra S., Sambamoorthi U. (2013). Disability Prevalence among Adults: Estimates for 54 Countries and Progress towards a Global Estimate. *Discussion Paper Series* ; 2013-06. Bronx : Fordham University
Abstract: This study estimated disability prevalence among adults at global, regional and country levels using internationally comparable disability data and measure. It conducted a retrospective analysis of data from the World Health Survey (WHS) (2002--2004) for nationally representative samples of civilian, non-institutionalized populations in 54 countries. A disability was measured as having at least one severe or extreme difficulty with bodily functions (seeing, concentrating) and activities (moving around, self-care) based on an individual's self-reports. Results: In the 54 countries under study, severe or extreme functional or activity difficulties are highly prevalent. For all countries, disability prevalence is estimated at 14% for all adults. Low and middle income countries have higher disability prevalence compared to high income countries. Among subgroups, disability prevalence stands at 12% among working age adults and 39% among the elderly. Women have higher prevalence than men. Disability is found to be highly prevalent among adults, with an

estimated global prevalence at 14%. Disability deserves enhanced policy attention and resources in public health and international development.
http://www.fordham.edu/images/academics/graduate_schools/gsas/economics/DP2013_06_Mitra_Sambamoorthi.pdf

Sole-Auro A., Michaud P.C., Hurd M.D. (2013). Disease Incidence and Mortality Among Older Americans and Europeans : Santa Monica : The Rand Corporation
Abstract: Recent research has shown a widening gap in life expectancy at age 50 between the U.S. and Europe, as well as large differences in the prevalence of diseases at these ages. Little is known about the processes determining international differences in the prevalence of chronic diseases. Higher prevalence of disease could result from either higher incidence or longer disease-specific survival. This paper uses comparable longitudinal data from 2004 and 2006 for populations aged 50 to 79 from the U.S. and a selected group of European countries to examine age-specific differences in prevalence and incidence of heart disease, stroke, lung disease, diabetes, hypertension, and cancer as well as mortality associated with each disease. Not surprisingly, it finds that Americans have higher disease prevalence. However, incidence of most diseases and survival conditional on disease is higher in Europe at older ages, in particular after age 60. The survival advantage in Europe tends to disappear when we control for co-morbidities but does not suggest a survival advantage in the U.S. Therefore, the origin of the higher disease prevalence at older ages in the U.S. is to be found in higher incidence and prevalence earlier in the life course
http://www.rand.org/content/dam/rand/pubs/working_papers/WR1000/WR1006/RAND_WR1006.pdf

Géographie de la santé / Geography of Health

Macé J.M. (2013). Géographie de la santé : pour analyser ce qui se passe. *Réseaux, Santé et Territoire,* n° 51, (pp. 26-27).
Abstract : Le métier de géographe de la santé a obtenu une nouvelle reconnaissance avec l'installation des agences régionales de santé (ARS). Plusieurs d'entre elles recourent à leurs services. Des géographes de la santé interviennent également à l'Ordre national des médecins, dans les unions régionales des professions de santé (URPS) et des structures de recherche et d'études comme l'Institut de recherche - et documentation en économie de la santé (IRDES).

Vayssette P. (2013). ARS Rhône-Alpes : géographie de la santé appliquée. *Réseaux, Santé et Territoire*, n° 51, (pp. 29-31).
L'Agence régionale de santé Rhône-Alpes, comme beaucoup d'ARS s'est dotée de compétences dans le domaine de la géographie de la santé. Cette ARS a la particularité de devoir établir des territoires de santé non calés sur les départements et un zonage pluriprofessionnel construit autour de pôles d'attractivité, sans délimiter des frontières précises. L'ARS s'intéresse aussi aux parcours des patients sur des territoires.

Noin D. (2009). Le nouvel espace français. Cursus. Paris : Armand Colin/
Abstract: L'espace français s'est transformé en profondeur pendant le dernier quart du XXe siècle. Les changements économiques ont bouleversé la répartition des activités. L'essor des transports rapides a raccourci les distances. De nouveaux équipements ont été mis en service. L'urbanisation et la périurbanisation ont considérablement progressé. Plus que jamais, les villes sont devenues les points forts du pays autour desquels gravite toute la vie économique et sociale. Avec le XXIè siècle, les problèmes ne sont donc plus les mêmes qu'à

l'époque où la politique d'aménagement du territoire a été mise en œuvre. Quels sont désormais les clivages essentiels du territoire? La disparité Paris-province est-elle toujours marquée? L'opposition Est-Ouest est-elle encore nette? Les différences régionales sont-elles marquées en matière de niveau de vie? La dégradation de l'environnement n'est-elle pas devenue un élément important à prendre en compte? Le problème prioritaire n'est-il pas aujourd'hui le développement des activités plutôt que celui de leur répartition plus ou moins équilibrée dans le pays ? C'est à ces questions que ce livre cherche à répondre. Les interrogations soulevées par la gestion du territoire sont nombreuses. Elles sont sérieuses et complexes. Elles appellent des réponses nuancées. Elles réclament des analyses attentives.

Mao L., Nekorchuk D. (2013). Measuring Spatial Accessibility to Healthcare for Populations with Multiple Transportation Modes. *Health & Place,* (In press)
Few measures of healthcare accessibility have considered multiple transportation modes when people seek healthcare. Based on the framework of the 2 Step Floating Catchment Area Method (2SFCAM), we proposed an innovative method to incorporate transportation modes into the accessibility estimation. Taking Florida, USA, as a study area, we illustrated the implementation of the multi-mode 2SFCAM, and compared the accessibility estimates with those from the traditional single-mode 2SFCAM. The results suggest that the multi-modal method, by accounting for heterogeneity in populations, provides more realistic accessibility estimations, and thus offers a better guidance for policy makers to mitigate health inequity issues.

Lanham H.J., Leykum L.K., Taylor B.S., McCannon C.J., Lindberg C., Lester R.T. (2013). How complexity science can inform scale-up and spread in health care: Understanding the role of self-organization in variation across local contexts. *Soc Sci Med,* 93 194-202.
Abstract: Health care systems struggle to scale-up and spread effective practices across diverse settings. Failures in scale-up and spread (SUS) are often attributed to a lack of consideration for variation in local contexts among different health care delivery settings. We argue that SUS occurs within complex systems and that self-organization plays an important role in the success, or failure, of SUS. Self-organization is a process whereby local interactions give rise to patterns of organizing. These patterns may be stable or unstable, and they evolve over time. Self-organization is a major contributor to local variations across health care delivery settings. Thus, better understanding of self-organization in the context of SUS is needed. We re-examine two cases of successful SUS: 1) the application of a mobile phone short message service intervention to improve adherence to medications during HIV treatment scale up in resource-limited settings, and 2) MRSA prevention in hospital inpatient settings in the United States. Based on insights from these cases, we discuss the role of interdependencies and sensemaking in leveraging self-organization in SUS initiatives. We argue that self-organization, while not completely controllable, can be influenced, and that improving interdependencies and sensemaking among SUS stakeholders is a strategy for facilitating self-organization processes that increase the probability of spreading effective practices across diverse settings.

Hôpital / Hospitals

Kristensen S.R., Bech M., Lauridsen J. (2013). Who to pay for performance? The choice of organisational level for hospital performance incentives : Odense : University of Southern Denmark
Abstract: When implementing a pay for performance (P4P) scheme, designers must decide

to whom the financial incentive for performance should be directed. This paper compares department level hospital reported performance on the Danish Case Management Scheme at hospitals that did and did not redistribute performance payments to the department level. Across a range of models we find that hospital reported performance at departments that operate under a direct financial incentive is about 5 percentage points higher than performance at departments at hospital where performance payments are not directly redistributed to the department level. This result is in line with the theoretical expectations but due to the non-experimental design of the study, our results only have a causal interpretation under certain assumptions discussed in the paper.
http://static.sdu.dk/mediafiles//3/F/2/%7B3F2BD73D-46D1-4569-8498-8B68928788BE%7D20135.pdf

Kristensen S.R., Fe E., Bech M. (2013). Is the quality of hospital care price sensitive? Regression kink estimates from a volume dependent price setting scheme : Odense : University of Southern Denmark
Abstract: This paper estimates the price sensitivity of the quality of acute stroke care using a regression kink design. When Danish hospitals reach a production target, marginal tariffs for treating acute stroke patients falls by 50%-100%. This reimbursement scheme allow us to identify local average treatment effects of reimbursement tariffs on the quality of hospital care. A rich data set of the process quality of stroke care allows us to detect minor changes in the quality of care that are important for the long term outcomes but do not lead to dead or readmission captured by commonly employed outcome indicators. Hospitals that were exposed to reductions in the marginal tariffs of less than 100% did not appear to respond in quality to reductions in tariffs. Hospital for which the marginal tariff for acute stroke patients dropped to 0 responded to tariff reductions by slightly decreasing the level of quality for acute stroke care patients. The estimated size of the effect is minor but robust to various tests of sensitivity, indicating that the estimated effect is not spurious.
http://static.sdu.dk/mediafiles//E/9/5/%7BE952D2FE-9EEA-4319-88E0-F68D538271CE%7D20134%20(2).pdf

Doherty C., Saunders M.M. (2013). Elective surgical patients' narratives of hospitalization: The co-construction of safety. *Social Science & Medicine,* (In press) :
Abstract: Abstract This research explores how elective surgical patients make sense of their hospitalization experiences. We explore sensemaking using longitudinal narrative interviews (n=72) with 38 patients undergoing elective surgical procedures between June 2010 and February 2011. We consider patients' narratives, the stories they tell of their prior expectations, and subsequent post-surgery experiences of their care in a United Kingdom (UK) hospital. An emergent pre-surgery theme is that of a paradoxical position in which they choose to make themselves vulnerable by agreeing to surgery to enhance their health, this necessitating trust of clinicians (doctors and nurses). To make sense of their situation, patients draw on technical (doctors' expert knowledge and skills), bureaucratic (National Health Service as a revered institution) and ideological (hospitals as places of safety), discourses. Post-operatively, themes of "chaos" and "suffering" emerge from the narratives of patients whose pre-surgery expectations (and trust) have been violated. Their stories tell of unmet expectations and of inability to make shared sense of experiences with clinicians who are responsible for their care. We add to knowledge of how patients play a critical part in the co-construction of safety by demonstrating how patient-clinician intersubjectivity contributes to the type of harm that patients describe. Our results suggest that approaches to enhancing patients' safety will be limited if they fail to reflect patients' involvement in the negotiated process of healthcare. We also provide further evidence of the contribution narrative inquiry can make to patient safety.

Hannigan B. (2013). Connections and consequences in complex systems: Insights from a case study of the emergence and local impact of crisis resolution and home

treatment services. *Soc Sci Med,* 93 212-219.
Abstract: In this article the broad contours of a complexity perspective are outlined. Complexity ideas are then drawn on to frame an empirical examination of the connections running between different levels of organisation in health and social care, and to underpin investigation into the intended and unintended local system consequences of service development. Data are used from a study conducted in the UK's mental health field. Here, macro-level policy has led to the supplementing of longstanding community mental health teams by newer, more specialised, services. An example includes teams providing crisis resolution and home treatment (CRHT) care as an alternative to hospital admission. Using an embedded case study design, where 'the case' examined was a new CRHT team set in its surrounding organisational environment, ethnographic data (with interviews predominating) were generated in a single site in Wales over 18 months from the middle of 2007. In a large-scale context favourable to local decision-making, and against a background of a partial and disputed evidence base, the move to establish the new standalone service was contested. Whilst users valued the work of the team, and local practitioners recognised the quality of its contribution, powerful effects were also triggered across the locality's horizontal interfaces. Participants described parts of the interconnected system being closed to release resources, staff gravitating to new crisis services leaving holes elsewhere, and the most needy service users being cared for by the least experienced workers. Some community mental health team staff described unexpected increases in workload, and disputes over eligibility for crisis care with implications for system-wide working relations. Detailed data extracts are used to illustrate these connections and consequences. Concluding lessons are drawn on the use of evidence to inform policy, on the significance of local contexts and system interfaces, and on anticipating the unexpected at times of change.

Nimptsch U., Mansky T. (2013). Quality measurement combined with peer review improved german in-hospital mortality rates for four diseases. *Health Aff.(Millwood.),* 32 (9) : 1616-1623.
Abstract: Mortality rates during hospital stays for common diseases show considerable variation at the hospital level, which suggests that there is potential for outcome improvement. We studied changes in mortality after an intervention that aimed to improve medical outcomes through quality measurement combined with peer review. We examined eighteen acute care hospitals purchased by the Helios Hospital Group in Germany from one year before to three years after the start of the intervention. In-hospital mortality for myocardial infarction, heart failure, ischemic stroke, and pneumonia was stratified by initial hospital performance and compared to the German average. Following the intervention, hospitals whose performance was initially subpar significantly reduced in-hospital mortality for all four diseases. In hospitals that initially performed well, no significant changes in mortality were observed. The observational nonrandomized data suggest that the quality management approach was associated with improved outcomes in initially subpar hospitals. Disease-specific measures of mortality, combined with peer reviews, can be used to direct actions to areas of potential improvement.

Lammers E. (2013). The effect of hospital-physician integration on health information technology adoption. *Health Econ,* 22 (10) : 1215-1229.
Abstract: The US federal government has recently made a substantial investment to enhance the US health information technology (IT) infrastructure. Previous literature on the impact of IT on firm performance across multiple industries has emphasized the importance of a process of co-invention whereby organizations develop complementary practices to achieve greater benefit from their IT investments. In health care, employment of physicians by hospitals can confer greater administrative control to hospitals over physicians' actions and resources and thus enable the implementation of new technology and initiatives aimed at maximizing benefit from use of the technology. In this study, I tested for the relationship between hospital employment of physicians and hospitals' propensity to use health IT. I used

state laws that prohibit hospital employment of physicians as an instrument to account for the endogenous relationship with hospital IT use. Hospital employment of physicians is associated with significant increases in the probability of hospital health IT use. Therefore, subsidization of health IT among hospitals not employing physicians may be less efficient. Furthermore, state laws prohibiting hospitals from employing physicians may inhibit adoption of health IT, thus working against policy initiatives aimed at promoting use of the technology.

Rivera C., Cancalon C., Schmidt A., Mazieres J., Falcoz P.E., Dahan M., Benard S. (2013). [Hospital undertaking of patients with a resection of lung cancer]. *Rev Mal.Respir.,* 30 (7) : 529-536.
Abstract: INTRODUCTION: The aim of the study is to describe the hospital management of patients undergoing pulmonary resection for lung cancer in France. METHODS: Data from patients who underwent resection for "malignant neoplasm of bronchus and lung" in 2008 were analyzed from French PMSI database. Hospitalizations, chemotherapy and radiotherapy sessions were analyzed one year before and after the procedure. RESULTS: In 2008, 9161 patients were hospitalized for a resection of lung tumor. Sex ratio was 2.8 (n=6736 men) and average age was 62.8 years. During hospitalization for surgery, 3.5% of patients (n=323) died. In the year before the procedure, 10% of patients (n=961) received neoadjuvant chemotherapy (mean number: 5.2 sessions per patient). In the year after the procedure, 41% of patients (n=3796) received adjuvant chemotherapy (6.6 sessions per patient), 9% (n=812) received adjuvant radiotherapy (16.8 sessions per patient), 6% (n=562) were re-hospitalized for surgery for an additional procedure. CONCLUSION: In France, pulmonary resection for lung cancer was associated for about half of patients in a multimodal treatment with combination between chemotherapy and/or radiotherapy.

Inégalités de santé / Health Inequalities

Härkönen A. J., Dahlin J. (2013). Cross-national differences in the gender gap in subjective health in Europe: Does country-level gender equality matter? *Social Science & Medicine,* (In press) :
Abstract: Abstract Multiple studies have found that women report being in worse health despite living longer. Gender gaps vary cross-nationally, but relatively little is known about the causes of comparative differences. Existing literature is inconclusive as to whether gender gaps in health are smaller in more gender equal societies. We analyze gender gaps in self-rated health (SRH) and limiting longstanding illness (LLI) with five waves of European Social Survey data for 191,104 respondents from 28 countries. We use means, odds ratios, logistic regressions, and multilevel random slopes logistic regressions. Gender gaps in subjective health vary visibly across Europe. In many countries (especially in Eastern and Southern Europe), women report distinctly worse health, while in others (such as Estonia, Finland, and Great Britain) there are small or no differences. Logistic regressions ran separately for each country revealed that individual-level socioeconomic and demographic variables explain a majority of these gaps in some countries, but contribute little to their understanding in most countries. In yet other countries, men had worse health when these variables were controlled for. Cross-national variation in the gender gaps exists after accounting for individual level factors. Against expectations, the remaining gaps are not systematically related to societal-level gender inequality in the multilevel analyses. Our findings stress persistent cross-national variability in gender gaps in health and call for further analysis.

Wang L., Hu W. (2013). Immigrant health, place effect and regional disparities in Canada. *Social Science & Medicine,* 98 (0) : 8-17.

Abstract: Abstract The paper addresses a critically important area in Canadian immigration and health from both a social and a spatial perspective. It employs multilevel and contextual approaches to examine the social determinants of immigrant health as well as the place effects on self-reported health at a regional and neighborhood scale. The data come from the raw microdata file of the 2005-10 Canadian Community Health Survey (a random national health survey) and the publicly available Canadian Marginalization index based on the 2006 Census. Three populations are compared: Canadian-born, overall foreign-born, and Chinese immigrants. The results suggest various degrees of association between self-reported health, individual and lifestyle behavioral characteristics, and neighborhood material deprivation and ethnic concentration in census tracts. These factors contribute differently to the reported health of Chinese immigrants, Canada's largest recent immigrant group. A healthy immigrant effect is partially evident in the overall foreign-born population, but appears to be relatively weak in Chinese immigrants. For all groups, neighborhood deprivation moderately increases the likelihood of reporting poor health. Ethnic concentration negatively affects self-rated health, with the exception of the slight protective effect of Chinese-specific ethnic density in census tracts. The multilevel models reveal significant area inequalities across Census Metropolitan Areas/Census Agglomerations in risk of reporting unhealthy status, with greater magnitude in the foreign-born population. The vast regional variations in health among Chinese immigrants should be interpreted carefully due to the group's heavy concentration in large cities. The study contributes to the literature on ethnicity and health by systematically incorporating neighborhood contextual effects in modeling the social determinants of immigrant health status. It fills a gap in the literature on neighborhoods and health by focusing on ethnically disparate groups rather than on the general population. By revealing regional disparities in health, the paper adds a spatial perspective to the work on immigrant health.

Médicaments / Pharmaceuticals

Paris V., Belloni A. (2013). Value in Pharmaceutical Pricing : Paris : OCDE
Abstract: Cette étude analyse comment 14 pays de l'OCDE prennent en compte la “valeur” dans leurs décisions concernant le remboursement et le prix des nouveaux médicaments. Elle décrit le type de « résultats » pris en compte, la perspective et les méthodes adoptées pour l'évaluation économique là où elle est utilisée, ainsi que la prise en compte de l'impact budgétaire. Elle décrit quelles dimensions sont prises en compte pour évaluer le caractère innovant et les conséquences de cette évaluation en termes de prix ; elle confirme que les pays accordent souvent une valeur plus élevée aux traitements pour les maladies sévères et/ou rares et montre comment les pays utilisent les accords « par produit » pour tenter de mieux adapter le prix à la valeur.
http://dx.doi.org/10.1787/5k43jc9v6knx-en

Jacobson M., Chang T.Y., Newhouse J.P. (2013). Physician Agency and Competition: Evidence from a Major Change to Medicare Chemotherapy Reimbursement Policy : Cambridge : NBER
Abstract: We investigate the role of physician agency and competition in determining health care supply and patient outcomes. A 2005 change to Medicare fees had a large, negative impact on physician profit margins for providing chemotherapy treatment. In response to these cuts, physicians increased their provision of chemotherapy and changed the mix of chemotherapy drugs they administered. The increase in treatment improved patient survival. These changes were larger in states that experienced larger decreases in physician profit margins. Finally while physician response was larger in more competitive markets, survival

improvements were larger in less competitive markets.
http://papers.nber.org/papers/W19247

Lybecker K.M. (2013). The Bulk Purchase of Pharmaceuticals: The Experiences of the United States, Europe, and New Zealand : Vancouver : Fraser Institute
Abstract: Pharmaceutical costs are escalating at a rate that outpaces inflation, forcing government providers to balance consumer needs against budgetary realities. Several strategies for better managing drug expenditures are attracting significant attention, including bulk purchase agreements. These agreements seek to reduce per unit costs by increasing the volume of product purchased. In pharmaceutical markets this is done by combining multiple purchasing entities, such as employers, states, provinces or municipalities, and the drugs they buy to secure lower prices for their medicines. However, because bulk purchase agreements are always employed in combination with multiple other cost-saving strategies, it is virtually impossible to tease out the singular impact or cost savings accruing to the bulk purchase agreement alone. This study gathers ample anecdotal evidence to establish that these agreements consistently generate cost savings, ranging from modest to quite impressive. But while bulk purchasing agreements are beneficial to coverage and for taxpayers, they may not be good for patients' health. Bulk purchase agreements may result in a situation in which the insured receive optimal brands in some areas, but less optimal brands in others. Frequent renegotiation (annually in some cases) can lead to abrupt changes in treatment for insured patients, leading to patient dissatisfaction and a potential for adverse outcomes, including lack of adherence, which in turn can lead to a requirement for more expensive treatment options, such as hospital admission. Another potential problem with bulk purchasing agreements may be a reduction in competition, leading to drug monopolies or limited numbers of drug suppliers. At the extreme, this reduction in competition may lead to drug shortages, which would harm patients. Bulk purchasing agreements also have the potential to limit access to other medications that are not included in the agreements. As a result, prescription costs may shift to patients if the necessary medications are not part of such agreements, thereby requiring higher co-payments, or forcing patients to cover the entire cost of these drugs — or even go without. Finally, there can be an impact on innovation. Price pressure on the innovative pharmaceutical industry will reduce the incentives for pharmaceutical research and development, stifling innovation and reducing the number of breakthrough therapies in the pipeline.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2317532

Kaiser B., Schmid C. (2013). Does Physician Dispensing Increase Drug Expenditures?
Berne : Bern Universität //
Abstract: This study analyzes whether the possibility for physicians to dispense drugs increases health care expenditures due to the incentives created by the markup on drugs sold. Using comprehensive physician-level data from Switzerland, it exploits the fact that there is regional variation in the dispensing regime to estimate policy effects. The empirical strategy consists of doubly-robust estimation which combines inverse-probability weighting with regression. Our main finding suggests that if dispensing is permitted, physicians produce significantly higher drug costs in the order of 30% per patient.
http://www.vwl.unibe.ch/papers/dp/dp1303.pdf

Méthodologie – Statistique / Methodology – Statistics

Penta M., Arnould C., Decruynaere C. (2005). Développer et interpréter une échelle de mesure : applications du modèle de Rasch. Pratiques et psychologiques : évaluation et diagnostic. Bruxelles

Abstract: Les questionnaires d'évaluation sont les instruments les plus utilisés aujourd'hui dans le domaine de la médecine et des sciences humaines pour évaluer des variables telles que l'incapacité physique, l'altruisme ou la douleur. Pourtant les praticiens connaissent souvent mal ces instruments. Que mesurent-ils vraiment ? Comment les résultats doivent-ils être interprétés ? Le présent ouvrage s'efforce de répondre à ces questions. Il ne s'agit pas d'un simple mode d'emploi des questionnaires d'évaluation. Son objectif principal est de fournir à tous, chercheurs et praticiens, les bases méthodologiques nécessaires pour développer un tel instrument et pour en interpréter les résultats. Après avoir exposé les fondements d'une mesure objective formulés par le modèle de Rasch, les auteurs adressent une série de questions fréquemment posées dans leur contexte d'application. Quels sont les critères d'une mesure objective ? Les résultats peuvent-ils être interprétés de manière quantitative ? Comment valider un tel instrument de mesure ? Peut-on comparer les réponses observées chez différents groupes de sujets ? Six chapitres, agrémentés de nombreux exemples pratiques et d'exercices résolus, exposent les bases méthodologiques de l'évaluation quantitative à l'aide du modèle de Rasch. Le septième chapitre décrit, pas à pas, les étapes du développement et de la validation d'une échelle de mesure de l'habileté manuelle (4e de couverture).

Setz M. (2012). La représentativité en statistique. Méthodes et Savoirs. Paris : Ined éditions
Abstract: En quelques décennies, être interrogé dans le cadre d'un sondage est devenu un événement courant. Dans l'univers des enquêtes quantitatives, la notion de représentativité ouvre en effet la voie d'une légitimité du chiffre dans le débat public. En statistique, le terme de représentativité est lié à la possibilité de passer d'une partie (échantillon) au tout (population de référence). Mais qu'est-ce qui représente une population ? L'échantillon représentatif est-il un concept fiable et accepté par tous ? Aujourd'hui encore, certains statisticiens hésitent à l'employer. L'ouvrage propose un riche éventail de réflexions autour de cette notion plurielle, voire controversée. En commençant par un bilan historique, on constate que cette notion a soulevé d'importants débats dans les milieux statisticiens dès le milieu du XIXe siècle et qu'elle a véritablement connu son essor durant les années 1930, lors des élections américaines. En s'interrogeant sur ce concept, fondamental dans une institution comme l'Insee ou pour les instituts de sondage, plusieurs auteurs proposent un tour d'horizon des différentes méthodes utilisées tant dans la constitution des échantillons et des panels, que dans les différents modes de recueil et d'interviews. Un chapitre est plus spécifiquement consacré à la représentativité des populations difficiles à atteindre, en particulier les sans-domiciles, et un autre se penche sur la question délicate des enquêtes en épidémiologie mises en œuvre pour étudier des problèmes de santé d'une population et en identifier les facteurs. Enfin les interrogations soulevées par la question de la représentativité trouvent toute leur place dans des comparaisons internationales, et notamment les grandes enquêtes de population impliquant plusieurs pays, qui se sont développées ces dernières années (4e de couverture).
http://www.ined.fr/fr/publications/methodes_savoir/bdd/publication/1619/

Caspar S., Cooke H.A., O'Rourke N., Macdonald S.W. (2013). Influence of individual and contextual characteristics on the provision of individualized care in long-term care facilities. *Gerontologist,* 53 (5) : 790-800.
Abstract: PURPOSE: Previous research examining improved provision of individualized care (I-Care) in long-term care (LTC) facilities has primarily considered contextual influences. Using Kanter's theory of structural empowerment, this study explored the relationship among contextual-level characteristics, individual-level characteristics, and access to empowerment structures on LTC staffs' perceived ability to provide I-Care. Methods: Multilevel models were used to examine 567 staffs' (registered nurse [RN], licensed practical nurses [LPN], care aides) reported ability to provide I-Care, nested within 41 LTC facilities. I-Care was first modeled as a function of within-person (e.g., age, job classification, experience) and

between-context (e.g., facility ownership status, culture change models) variables. Independent of these predictors, we then assessed the influence of staffs' access to empowerment structures (information, support, opportunities, resources, informal power, and formal power) on reported ability to provide I-Care. RESULTS: The intraclass correlation coefficient indicated that 91.7% of the total variance in perceived ability to provide I-Care reflected within- versus between-person differences, with the 6 empowerment variables accounting for 31% of this within-person variance independent of the other context- and person-level covariates. In the final model, only informal power (i.e., quality of interprofessional relationships) and resources (i.e., adequate time and supplies) uniquely predicted I-Care. Notably, access to resources also attenuated the significant effect of support, suggesting a possible mediating effect. IMPLICATIONS: These findings suggest that both contextual- and individual-level factors exert considerably less influence on I-Care than factors associated to staffs' perceptions of empowerment. Consequently, interventions aimed at increasing I-Care in LTC settings should carefully consider staffs' access to structural empowerment.

Prévention / Prevention

Thomas F., Eschwege E., Bean K., Pannier B., Danchin N. (2013). Prevalence of treatment for diabetes during 1997-2007, and trends in cardiovascular risk factors between 2001 and 2007 according to diabetic treatment, in the IPC (Investigations Préventives et Cliniques; Preventive and Clinical Investigations) cohort. *Diabetes Metab.,* 39 (4) : 343-348.
Abstract: AIM: This study aimed to evaluate changes in the prevalence of glucose-lowering agents in a large, unselected general French population from 1997 to 2007, with specific focus on changes in other cardiovascular risk factors in relation to diabetic status during 2001-2002 and 2006-2007. METHODS: The prevalence of treated diabetes was assessed in a large population who had a health check-up at the "Investigations Preventives et Cliniques" Center between 1997-2007. Baseline characteristics and risk profiles of individuals with and without treatment for diabetes were assessed and compared with data for 2001-2002 and 2006-2007. RESULTS: From 1997 to 2007, the prevalence of treatment for diabetes increased from 0.75% to 1.73% in men and from 0.7% to 2.28% in women. In 2006-2007 compared with 2001-2002, the odds ratios for receiving glucose-lowering agents, adjusted for age, body mass index (BMI) and educational level, were 1.54 (95% CI: 1.28-1.86) in men and 1.59 (95% CI: 1.26-2.03) in women. In those treated for diabetes compared with untreated subjects, greater decreases in blood pressure, cholesterol and glycaemia were found, stress and depression scores improved, and a greater increase in BMI was found. Smoking decreased in both treated and untreated individuals. Physical activity decreased in treated individuals, but remained unchanged in the general population. CONCLUSION: The prevalence of people treated with diabetes increased in the Paris area. Although most concomitant risk factors decreased more in treated individuals than in the general population, physical activity and BMI worsened, thus, emphasizing the need for improving patient education.

Psychiatrie / Psychiatry

Mcinerney M., Mellor J., Nicolas L.H. (2013). Recession Depression: Mental Health Effects of the 2008 Stock Market Crash : Munich : Center for Economic Studies
Abstract: How do sudden, large wealth losses affect mental health? Most prior studies of the causal effects of material well-being on health use identification strategies involving income increases; these studies as well as prior research on stock market accumulations may not inform this question if the effect of wealth on health is asymmetric. We use exogenous variation in the interview dates of the 2008 Health and Retirement Study to assess the impact of large wealth losses on mental health among older U.S. adults. We compare cross-wave changes in wealth and health for respondents interviewed before and after the October 2008 stock market crash. We find that the crash reduced wealth and increased depressive symptoms and the use of anti-depressants. These results suggest that sudden wealth losses cause immediate declines in mental health; for example, a loss of $50,000 of non-housing wealth increases the likelihood of feeling depressed by 1.35 percentage points, or by 8%.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2277438

Mcinerney M., Mellor J., Nicolas L.H. (2013). Effects of Psychiatric Disorders on Labor Market Outcomes: A Latent Variable Approach Using Multiple Clinical Indicators : Munich : Center for Economic Studies
Abstract: This paper estimates the effect of psychiatric disorders on labor market outcomes using a structural equation model with a latent index for mental illness, an approach that acknowledges the continuous nature of psychiatric disability. We also address the potential endogeneity of mental illness using covariance instruments as suggested in Lewbel (2012), thus not requiring questionable exclusion restrictions for identification. Data come from the US National Comorbidity Survey – Replication (NCS-R) and the National Latino and Asian American Study (NLAAS). We find that depression and generalized anxiety disorder detract from the employment and labor force participation of males and females; however, we do not find evidence of adverse effects of panic attack or social phobia on any work outcomes of either males or females. After addressing the potential endogeneity of mental illness, we continue to find that mental illness adversely affects employment and labor force participation for both males and females, but the effect on weeks worked and days missed at work are significant for males only. Using our structural model we assess the policy implications of some of the recommendations in the Affordable Care Act, relating to expansion of benefits for mental health and substance use disorder benefits. We find potential gains in employment for 3.2 million individuals and reduction in workplace cost of absenteeism of $18.9 billion due to improved mental health of individuals who are in most need of treatment.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2277421

Maitre E., Debien C., Nicaise P., Wyngaerden F., Le G.M., Genest P., Ducrocq F., Delamillieure P., Lavoisy B., Walter M., Dubois V., Vaiva G. (2013). [Advanced directives in psychiatry: A review of the qualitative literature, a state-of-the-art and viewpoints]. *Encephale,* 39 (4) : 244-251.
Abstract: BACKGROUND: Advance Directives are written documents, which are used for people to notify their preference for a future situation when they are unable to give their consent. In psychiatry, psychiatric advance directives (PADs) can be used for patients with chronic psychotic disorders such as schizophrenia, or a bipolar disorder. PADs give the patient an opportunity to state wishes in advance about his/her treatment when he/she is in an acute state of illness. PADs were initially developed as a way for patients to defend themselves against the power of the psychiatrists, but are likely to become a useful tool in psychiatric care. PADs may contain information about medication, non pharmaceutical devices, and the name of a proxy decision maker. The main objective is to reduce the number of compulsory hospitalisations. OBJECTIVE: This article is a qualitative review which carries out a state-of-the-art on the use of PADs for people with chronic psychotic disorders and defines suggestions to include this intervention in the French psychiatric context. METHOD: We used the keywords psychiatric advance directives, crisis card, Ulysse

directives, joint crisis plan (JCP) in the MEDLINE database to propose a qualitative review. We selected original clinical studies about the use of PADs for people with psychotic disorders. RESULTS: We included 36 articles. The qualitative analysis identified seven main themes: different types of PADs, effectiveness of PADs, practical use of PADs, patient's views, clinician's views, economical aspects, and legal aspects. The content of the PADs is consistent with psychiatric standard care in nearly all cases, regarding medical instructions, pre-emergency interventions, non-hospital alternatives and non-medical personal care. Patients use their PADs to describe prodromal symptoms of relapse and to suggest a treatment and a hospitalisation in advance. PADs are not used to refuse all treatments. Patients show a strong interest in creating a directive and a high level of satisfaction when using it. They feel they have more control over their mental health problem and are more respected and valued as a person. Thirty-six to fifty-three percent of clinicians had positive opinions regarding PADs. They valued the increase of the patient's autonomy and the prevention of relapse, but were concerned about difficulties for accessing the documents, and about the lack of training of the medical teams. Clinicians also feared the pressure of relatives or partners on treatment decisions. The qualitative analysis revealed the specific benefit of the JCP, a particular type of PADs negotiated with the medical team, on the reduction of the general number of admissions. We can identify practical problems such as the lack of accessibility to PADs in emergency situations, and the clinician's reluctance to use PADs. The only economical evaluation showed a non-significant decrease in total costs. DISCUSSION: PADs are used in a few countries, although their benefits in terms of patient's perceptions and compulsory admissions are promising. The JCP proposes a specific clinical approach based on therapeutic alliance. Its creation also involves the clinician, family members and a neutral mediator in a negotiated process. The JCP is likely to be the most efficient PAD model in reducing compulsory admissions. The use of the JCP appears to be relevant in the context of the new French legislation, establishing outpatient commitment orders and could be an effective way to improve the relationships with patients.

Soins de santé primaires / Primary Health Care

Vayssette P. (2013). Des matrices qui arrivent à maturité. *Réseaux, Santé & Territoire,* 51, pp. 12-17.
Abstract : Le concept de matrices de maturité a fait des avancées notables en France au cours des derniers mois. Tour à tour, la Haute Autorité de santé (HAS), la Fédération française des maisons professionnelles de santé (FFMPS)...ont mené des travaux sur le sujet. La HAS a réuni les différents intervenants au sein d'un groupe de travail "Interface" et souhaite valider un outil qualité adapté aux soins de premiers recours avant la fin de l'année 2013. La grille aura un objectif d'autoévaluation en vue de progresser dans la coordination des équipes de soins de proximité. En parallèle, les autres organismes réfléchissent à d'autres outils qui pourraient servir à construire une rémunération d'équipe coordonnée.

Vayssette P. (2013). Pôles de santé, plus que maisons : Pierre-Jean Lancry, DG de l'ARS Basse-Normandie. *Réseaux, Santé & Territoire,* 51, pp. 18-21.
Abstract : La Basse-Normandie est une petite région de 1,5 millions d'habitants. Pour soutenir l'offre de soins dans les territoires fragiles, la région mise sur le développement des pôles de santé libéraux et ambulatoires (PSLA). Pierre-Jean Lancry, directeur général de l'Agence régionale de santé, livre dans cet entretien les clefs des grandes lignes d'action des ARS.

Vayssette P. (2013). Observatoire des recompositions de l'offre de soins. *Réseaux, Santé & Territoire,* 51, pp. 24-25-21.
Abstract : La Direction générale de l'offre de soins (DGOS) a entamé le déploiement d'un Observatoire des recompositions de l'offre de soins depuis 2012. Le dispositif permet des remontées d'informations automatisées et des suivis systématiques des structures (maisons de santé, groupements de coopération sanitaire, etc) qui se développent ou se créent depuis la loi Hôpital Patients Santé et Territoires de 2009. La maîtrise d'oeuvre a été confiée à l'Agence technique de l'information sur l'hospitalisation (ATIH).

Luc K.de. (2001). Developing care pathways : the handbook and the tool kit : Abingdon : Radcliffe Medical Press
Abstract: There is increasing development and use of care pathways, and a growing demand for guidance and advice on how to develop them. This practical guide meets this demand. It reflects the latest experience and incorporates best practice with contributions from highly experienced members of the National Pathways Association. Developing Care Pathways is in two parts. The handbook which defines and describes pathways and the roles of healthcare professionals involved with them, and the tool kit which provides a detailed step-by-step guide to developing a care pathway. This work is essential reading for managers and clinicians in organisations developing care pathways throughout secondary and primary care (4e de couverture).

Parchman M., Noel P., Culler S., Lanham H., Leykum L., Romero R., Palmer R. (2013). A randomized trial of practice facilitation to improve the delivery of chronic illness care in primary care: initial and sustained effects. *Implementation Science,* 8 (1) : 93.
Abstract: BACKGROUND: Practice facilitation (PF) is an implementation strategy now commonly used in primary care settings for improvement initiatives. PF occurs when a trained external facilitator engages and supports the practice in its change efforts. The purpose of this group-randomized trial is to assess PF as an intervention to improve the delivery of chronic illness care in primary care. METHODS:A randomized trial of 40 small primary care practices who were randomized to an initial or a delayed intervention (control) group. Trained practice facilitators worked with each practice for one year to implement tailored changes to improve delivery of diabetes care within the Chronic Care Model framework. The Assessment of Chronic Illness Care (ACIC) survey was administered at baseline and at one-year intervals to clinicians and staff in both groups of practices. Repeated-measures analyses of variance were used to assess the main effects (mean differences between groups) and the within-group change over time. RESULTS: There was significant improvement in ACIC scores ($p<0.05$) within initial intervention practices, from 5.58 (SD 1.89) to 6.33 (SD 1.50), compared to the delayed intervention (control) practices where there was a small decline, from 5.56 (SD 1.54) to 5.27 (SD 1.62). The increase in ACIC scores was sustained one year after withdrawal of the PF intervention in the initial intervention group, from 6.33 (SD 1.50) to 6.60 (SD 1.94), and improved in the delayed intervention (control) practices during their one year of PF intervention, from 5.27 (SD 1.62) to 5.99 (SD 1.75).CONCLUSIONS: Practice facilitation resulted in a significant and sustained improvement in delivery of care consistent with the CCM as reported by those involved in direct patient care in small primary care practices. The impact of the observed change on clinical outcomes remains uncertain. TRIAL REGISTRATION: This protocol followed the CONSORT guidelines and is registered per ICMJE guidelines: Clinical Trial Registration Number: NCT00482768.
http://www.implementationscience.com/content/8/1/93

Ono T., Lafortune G., Schoenstein M. (2013). Health Workforce Planning in OECD Countries. A review of 26 projections Models from 18 Countries : Paris : OCDE
Abstract: La planification de la main-d'œuvre dans le domaine de la santé vise à atteindre un juste équilibre entre l'offre et la demande pour les différentes catégories de professionnels de

santé, à court et à long terme. La planification de la main-d'œuvre dans le secteur de la santé s'avère particulièrement importante compte tenu du temps et des coûts investis dans la formation de nouveaux médecins et autres professionnels. Dans un contexte de fortes contraintes budgétaires, une planification appropriée du personnel de santé est nécessaire non seulement pour guider les décisions en matière d'admission aux études de formation médicale et infirmière, mais aussi pour évaluer l'impact d'éventuelles réorganisations dans la prestation des services de santé afin de mieux répondre aux nouveaux besoins. Ce document passe en revue les principales caractéristiques et les résultats de 26 modèles de projection de la main-d'œuvre dans le domaine de la santé dans 18 pays de l'OCDE. Il se concentre principalement sur des modèles s'intéressant aux médecins, mais comprend également certains modèles pour les autres professionnels

Santos R., Gravelle H., Propper C. (2013). Does Quality Affect Patients' Choice of Doctor ? Evidence from the UK : York : University of York
Abstract: Provider competition is a currently popular healthcare reform model. A necessary condition for greater competition to improve quality is that providers will face higher demand if they improve their quality. We test this crucial assumption in an important part of the health care market using data on the choices made by 3.4 million English patients from amongst nearly 1000 family doctor practices. We find that patients do respond to quality: a one standard deviation increase in a publicly available measure of clinical quality would increase the number of patients a practice would attract by around 15%.
http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP88_quality_choice_GP.pdf

Bruen B.K., Ku L., Lu X., Shin P. (2013). No evidence that primary care physicians offer less care to medicaid, community health center, or uninsured patients. *Health Aff.(Millwood.),* 32 (9) : 1624-1630.
Abstract: The Affordable Care Act increases US investment in Medicaid and community health centers, yet many people believe that care in such safety-net programs is substandard. Using data from more than 31,000 visits to primary care physicians in the period 2006-10, we examined whether the length or content of a visit was different for safety-net patients-those insured by Medicaid, those who are uninsured, and those seen in a community health center-compared to patients with private insurance. We found no significant differences in the average length of a primary care visit or in the likelihood of a patient's receiving preventive health counseling. Medicaid patients received more diagnostic and treatment services, and uninsured patients received fewer services, compared to privately insured patients, but the differences were small. This analysis indicates that length and content of primary care visits are comparable for safety-net and other patients. The main factors that contribute to differences in visit length and content are patients' health needs and the type of visit involved.

Welch W.P., Cuellar A.E., Stearns S.C., Bindman A.B. (2013). Proportion of physicians in large group practices continued to grow in 2009-11. *Health Aff.(Millwood.),* 32 (9) : 1659-1666.
Abstract: Payers and advocates for improved health care quality are raising expectations for greater care coordination and accountability for care delivery, and physician groups may be responding by becoming larger. We used Medicare claims from the period 2009-11, merged with information from the Medicare provider enrollment database, to measure whether physician group sizes have been increasing over time and in association with physician characteristics. All US physicians serving Medicare fee-for-service patients in any practice setting were included. The percentage of physicians in groups of more than fifty increased from 30.9 percent in 2009 to 35.6 percent in 2011. This shift occurred across all specialty categories, both sexes, and all age groups, although it was more prominent among physicians under age forty than those age sixty or older. The movement of physicians into

groups is not a new phenomenon, but our data suggest that the groups are larger than surveys have previously indicated. Questions for future studies include whether there are significant cost savings or quality improvements associated with increased practice size.

Travail et santé / Occupational Health

Pestieau P., Racionero M. (2013). Harsh occupations, health status and social security : Louvain-la-Neuve : CORE
Abstract: We study the optimal design of a social security system when individuals differ in health status and occupation. Health status is private information but is imperfectly correlated with occupation: individuals in harsh occupations are more likely to be in poor health. We explore the desirability of letting the social security policy differ by occupation and compare the results with those obtained when disability tests are used instead. We show that tagging by occupation is preferable to testing when the audit technology is relatively expensive and/or the proportion of disabled workers differs markedly across occupations. We also study the implications of imposing horizontal equity among disabled workers and show that those in the harsh occupation may be induced to retire late.r
http://uclouvain.be/cps/ucl/doc/core/documents/coredp2013_1web.pdf

Silva J.I., Vall C.J. (2013). Partial Disability System and Labor Market Adjustment: The Case of Spain. Kalamazoo : W.E. Upjohn Institute for Employment Research
Abstract: Although partially disabled individuals in Spain are allowed to combine the receipt of disability benefits with a job, the empirical evidence shows that employment rates for this group of individuals are very low. Therefore, in this paper we construct labor market model with search intensity and matching frictions in order to identify the incentives and disincentives to work provided by the partial disability system in Spain from the point of view of both disabled individuals and employers. According to the model, the high employment rate gap observed between nondisabled and disabled workers can be partially explained by the presence of a lower level of productivity and higher searching costs among disabled individuals that discourage them from looking for jobs. Moreover, the design of the Spanish Disability System also contributes in explaining this gap. We also analyze the role of business cycle conditions in shaping the labor market transitions of disabled individuals.
http://d.repec.org/n?u=RePEc:upj:weupjo:13-201&r=lab

Tekin E., Mclellan C., Minyard K.J. (2013). Health and Health Behaviors during the Worst of Times : Evidence from the Great Recession. Health and Health Behaviors during the Worst of Times : Evidence from the Great Recession. Cambridge : NBER
Abstract: While previous studies have shown that recessions are associated with better health outcomes and behaviors, the focus of these studies has been on the relatively milder recessions of the late 20th century. This paper examines if the previously established counter-cyclical pattern in health and heath behaviors is held during the Great Recession. Using data from the Behavioral Risk Factor Surveillance System (BRFSS) between 2005 and 2011 and focusing on a wide range of outcomes capturing health and health behaviors, we show that the association between economic deterioration and these outcomes has weakened considerably during the recent recession. In fact, majority of the estimates indicate that the relationship has practically become zero, though subtle differences exist among various sub-populations. The results are consistent with the evidence emerging from several recent studies that suggests that the relationship between economic activity and health and health behaviors has become less noticeable in the recent years.
http://papers.nber.org/papers/W19234

Vieillissement / Ageing

Van Hal L., Meershoek A., Nijhuis F., Horstman K. (2013). Disembodied abilities: Sick role and participation in activating return-to-work practices. *Social Science & Medicine,* 96 (0) : 9-16.
Abstract: In “active welfare states”, labour participation is regarded essential for being part of and contributing to society. In the striving for an increase in labour participation of people who were considered (partly) disabled for work, not “disabilities”, but “abilities”are put centre stage in vocational rehabilitation programmes. In this article we explore what this change in focus means in practice. We do this by investigating tensions experienced by participants of vocational rehabilitation practices that aim at facilitating return-to-work for people with disabilities. Our analysis derives from stories that clients and professionals told about daily experiences with disability, vocational rehabilitation and (labour) participation. These stories illustrate the logic embedded in vocational rehabilitation practices. Our analysis demonstrates that this logic, that focuses on will power, stable abilities and employability, hampers the realization of labour participation for a part of the population. We conclude that a logic of embodiment in which lived experiences of clients are acknowledged and in which it is explored what clients are concretely able to do in a specific context may be better equipped to facilitate return-to-work.

Schneider U., Trukeschitz B., Muhlmann R., Ponocny I. (2013). "Do I stay or do I go?"-job change and labor market exit intentions of employees providing informal care to older adults. *Health Econ,* 22 (10) : 1230-1249.
Abstract: This article examines whether providing informal eldercare to an older dependent person predicts employees' intentions to change jobs or exit the labor market and, if so, which particular aspects of both caregiving (e.g. time demands, physical/cognitive care burden) and their current work environment shape these intentions. We used data from a sample of 471 caring and 431 noncaring employees in Austria and split the analyses by gender. We found different aspects of informal caregiving to be associated with the intention to change jobs and with the anticipated labor market withdrawal of male and female workers. A time-based conflict between informal eldercare and paid work was significantly and positively related to the intended job change of female workers but not of their male counterparts. Flexible work arrangements were found to facilitate the attachment of female workers to their jobs and the labor market. Intentions to exit the labor market of male workers appeared to be triggered by a physical care burden rather than time demands.

Georgiou A., Marks A., Braithwaite J., Westbrook J.I. (2013). Gaps, disconnections, and discontinuities--the role of information exchange in the delivery of quality long-term care. *Gerontologist,* 53 (5) : 770-779.
Abstract: Purpose of the Study: The smart use of information and communication technologies (ICT) is widely seen as a means of enhancing the quality of aged care services. One of the barriers to ICT diffusion in aged care is the failure to cater for the complex and interdisciplinary requirements of the aged care environment. The aim of this qualitative study was to identify the layers of information exchange and communication and produce a conceptual model that can help to inform decisions related to the design, implementation, and sustainability of ICT. Design and Methods : A qualitative study conducted in 2010 within seven Australian residential aged care facilities. It included 11 focus groups involving 47 staff and 54 individual interviews and observation sessions. Results : The analysis of work processes identified key information exchange components related to the type of information (residential, clinical, and administrative) that is collected, stored, and communicated. This

information relies on a diverse number of internal and external communication channels that are important for the organization of care. Implications : The findings highlight potential areas of communication dysfunction as a consequence of structural holes, fragmentation, or disconnections that can adversely affect the continuity and coordination of care, its safety, and quality.

Zijlstra G.A., van Haastregt J.C., Du Moulin M.F., de Jonge M.C., Van der Poel A., Kempen G.I. (2013). Effects of the implementation of an evidence-based program to manage concerns about falls in older adults. *Gerontologist,* 53 (5) : 839-849.
Abstract: Purpose of the study: Concerns about falls and related activity avoidance are common in older people. A multicomponent program reduced these concerns and increased daily activity among older people in a randomized controlled trial. This study explored whether the effects and acceptability of the program maintain after its implementation into home care organizations. DESIGN AND METHODS: In a pretest-post-test study, the effects and acceptability of the 8-week cognitive behavioral program was evaluated in 125 community-living older adults. Data on concerns about falls, related avoidance behavior, falls, fall-related medical attention, feelings of loneliness and anxiety, and symptoms of depression were collected prior to the start of the program and at 2 and 4 months. RESULTS: Pretest-post-test analyses showed significant improvements at 4 months for concerns about falls, activity avoidance, number of falls in the past 2 months, feelings of anxiety, and symptoms of depression. No significant differences were shown for daily activity, feelings of loneliness, and fall-related medical attention. IMPLICATIONS: After implementation in home care organizations, the program reduced concerns about falls, avoidance behavior, and falls in community-living older adults. These findings are highly consistent with the outcomes of a previously performed randomized controlled trial, indicating that the program can be successfully implemented in practice. Further dissemination of the program is recommended to reduce concerns about falls and related activity avoidance in community-living older people.