Reproduction sur d'autres sites interdite mais lien vers le document accepté :
http://www.irdes.fr/EspaceDoc/Veille.html

DOC VEILLE : veille bibliographique en économie de la santé

14 juin 2013

Réalisée par les documentalistes de l'Irdes, Doc Veille rassemble de façon thématique les résultats de la veille documentaire en économie de la santé : articles, littérature grise, rapports…

Vous pouvez accéder à la version électronique des articles sur notre portail EJS (à l'exception des revues éditées par Elsevier et des revues françaises) :
http://ejournals.ebsco.com/Home.asp **(Accès réservé à l'Irdes)**

Les autres documents sont soit accessibles en ligne, soit consultables à la doc (voir mention à la fin de la notice). Aucune photocopie ne sera délivrée par courrier.

Un historique des Doc Veille (parution bi-mensuelle) se trouve sur le web de l'Irdes

(http://www.irdes.fr/EspaceDoc/DocVeille.html).

Sommaire

Economie de la santé 6

Bates L.J., Santerre R.E. (2013). Does the U.S. health care sector suffer from Baumol's cost disease? Evidence from the 50 states........ 6

Simoens S., Kutten B., Keirse E., Berghe P.V., Beguin C., Desmedt M., Deveugele M., Leonard C., Paulus D., Menten J. (2013). Terminal patients in Belgian nursing homes: a cost analysis........ 6

Heijink R., Koolman X., Westert G.P. (2013). Spending more money, saving more lives? The relationship between avoidable mortality and healthcare spending in 14 countries.. 6

Etat de santé 7

Bellanger B., Tourbe C. (2013). Espérance de vie en bonne santé : elle baisse !........ 7

Géographie de la santé 7

Marshall A., Norman P. (2013). Geographies of the impact of retirement on health in the United Kingdom........ 7

Ngamini N.A., Cohen A.A., Courteau J., Lesage A., Fleury M.J., Gregoire J.P., Moisan J., Vanasse A. (2013). Does elapsed time between first diagnosis of schizophrenia and migration between health territories vary by place of residence? A survival analysis approach 7

Green M.A. (2013). The equalisation hypothesis and changes in geographical inequalities of age based mortality in England, 2002-2004 to 2008-2010 7

Cavalieri M. (2013). Geographical variation of unmet medical needs in Italy: a multivariate logistic regression analysis........ 7

Hôpital........ 8

Karnon J., Caffrey O., Pham C., Grieve R., Ben-Tovim D., Hakendorf P., Crotty M. (2013). Applying risk adjusted cost-effectiveness (race) analysis to hospitals: estimating the costs and consequences of variation in clinical practice 8

Johar M., Jones G.S., Savage E. (2013). 8

Cookson R., Laudicella M., Li D.P. (2013). Does hospital competition harm equity? Evidence from the English National Health Service 9

Perotin V., Zamora B., Reeves R., Bartlett W., Allen P. (2013). Does hospital ownership affect patient experience? An investigation into public-private sector differences in England........ 9

DePalma G., Xu H., Covinsky K.E., Craig B.A., Stallard E., Thomas J., Sands L.P. (2013). Hospital Readmission Among Older Adults Who Return Home With Unmet Need for ADL Disability 9

Palangkaraya A., Yong J. (2013). Effects of competition on hospital quality: an examination using hospital administrative data 10

Inégalités de santé 10

(2013). Penser l'assistance : 8e rapport de l'Onpes 10

Bois C., Guillemot G. (2013). [Social inequalities in health in 4 year-old children in the Hauts-de-Seine (France)]. 10

Berchet C. (2013). [Health care utilisation in France: An analysis of the main drivers of health care use inequalities related to migration]. 11

Levesque J.F., Pineault R., Robert L., Hamel M., Roberge D., Kapetanakis C., Simard B., Laugraud A. (2008). Unmet health care needs: a reflection of the accessibility of primary care services? 11

Echazu L., Nocetti D. (2013). Priority setting in health care: disentangling risk aversion from inequality aversion 11

Flouri E., Mavroveli S., Midouhas E. (2013). Residential mobility, neighbourhood deprivation and children's behaviour in the UK 11

Lalloue B., Monnez J.M., Padilla C., Kihal W., Le Meur N., Zmirou-Navier D., Deguen S. (2013). A statistical procedure to create a neighborhood socioeconomic index for health inequalities analysis 12

Médicaments 12

King M., Essick C. (2013). The geography of antidepressant, antipsychotic, and stimulant utilization in the United States 12

Brekke K.R., Dalen S.M., Holmas T.H. (2013). Diffusion of Pharmaceuticals: Cross-Country Evidence of Anti-TNF drugs 12

Pombo-Romero J., Varela L.M., Ricoy C.J. (2013). Diffusion of innovations in social interaction systems. An agent-based model for the introduction of new drugs in markets 12

Saastamoinen L.K., Verho J. (2013). Drug expenditure of high-cost patients and their characteristics in Finland 13

Méthodologie – Statistique 13

Kohn J.L., Liu J.S. (2013). The dynamics of medical care use in the British household panel survey 13

Wouterse B., Huisman M., Meijboom B.R., Deeg D.J., Polder J.J. (2013). Modeling the relationship between health and health care expenditures using a latent Markov model 13

Bradley R. (2013). Feasible methods to estimate disease based price indexes............14

Wang T.C., Yue C.S. (2013). Spatial clusters in a global-dependence model................14

Borah B.J., Basu A. (2013). Highliting differences between conditional and unconditional quantile regression approaches through an application to assess medication adherence 14

Politique de santé...14

Monstad K., Engesaeter L.B., Espehaug B. (2013). Waiting time and socioeconomic status - An individual-level analysis 15

Prévention santé 15

Brown H.S., Karson S. (2013). Cigarette quitlines, taxes, and other tobacco control policies: a state-level analysis. 15

Prévision – Evaluation 15

Fleurbaey M., Luchini S., Muller C., Schokkaert E. (2013). Equivalent income and fair evaluation of health care 15

Psychiatrie 15

Fone D., Greene G., Farewell D., White J., Kelly M., Dunstan F. (2013). Common mental disorders, neighbourhood income inequality and income deprivation: small-area multilevel analysis 15

Curtis S., Pain R., Fuller S., Khatib Y., Rothon C., Stansfeld S.A., Daya S. (2013). Neighbourhood risk factors for Common Mental Disorders among young people aged 10-20 years: a structured review of quantitative research...16

Soins de santé primaires 16

Gay B. (2013). [Rethinking the place of primary healthcare in France - Role of general practice 16

Andreassen L., Di Tommaso M.L., Strom S. (2013). Do medical doctors respond to economic incentives? 16

Agrawal S., Brennan N., Budetti P. (2013). The Sunshine Act - Effects on Physicians ..17

Naylor C., Imison C., Addicott R. (2003). Transforming our health care system: ten priorities for commissioners...17

Systèmes de santé 17

(2013). OECD Reviews of Health Systems...17

(2013). Health system performance comparison : an agenda for policy, information and research 17

Travail et santé 18

Volker D., Vlasveld M.C., Anema J.R. (2013). Blended E-health module on return to work embedded in collaborative occupational health care for common mental disorders: Design of a cluster randomized controlled trial 18

Vieillissement 18

Moulaert T., Henrard J.C., Leider B, et al. (2013). Le vieillissement actif : à quelles conditions ? 18

Mielck A., Kiess R., Von Dem Knesebeck O., Stirbu I., Kunst A.E. (2007). Association between access to health care and household income among the elderly in 10 western European countries. 18

Batyra A., De La Croix D., Pierrard O. et al. (2013). Declining bargaining power of workers and the rise of early retirement in Europe.....18

Romero-Ortuno R., O'Shea D. (2013). Fitness and frailty: opposite ends of a challenging continuum! Will the end of age discrimination make frailty assessments an imperative? 19

Bennett S., Song X., Mitnitski A., Rockwood K. (2013). A limit to frailty in very old, community-dwelling people: a secondary analysis of the Chinese longitudinal health and longevity study 19

Moorman S.M., Macdonald C. (2013). Medically Complex Home Care and Caregiver Strain.....19

Hernaes E., Markussen S., Piggott J., Vestad O.L. (2013). Does retirement age impact mortality? 19

Economie de la santé

Bates L.J., Santerre R.E. (2013). Does the U.S. health care sector suffer from Baumol's cost disease? Evidence from the 50 states. *J Health Econ,* 32 (2) : 386-391.
Abstract: This study examines if health care costs in the United States are affected by Baumol's cost disease. It relies on an empirical test proposed by Hartwig (2008) and extended by Colombier (2010) and uses a panel data set of 50 states over the 1980-2009 period. The results suggest that health care costs grow more rapidly when economy-wide wage increases exceed productivity gains. The findings are fairly robust with respect to time- and state-fixed effects, individual state time trends, and two-stage least square estimation. Consequently, this study suggests that the U.S. health care sector suffers from Baumol's cost disease.

Simoens S., Kutten B., Keirse E., Berghe P.V., Beguin C., Desmedt M., Deveugele M., Leonard C., Paulus D., Menten J. (2013). Terminal patients in Belgian nursing homes: a cost analysis. *Eur J Health Econ,* 14 (3) : 407-413.
Abstract: Policy makers and health care payers are concerned about the costs of treating terminal patients. This study was done to measure the costs of treating terminal patients during the final month of life in a sample of Belgian nursing homes from the health care payer perspective. Also, this study compares the costs of palliative care with those of usual care. This multicenter, retrospective cohort study enrolled terminal patients from a representative sample of nursing homes. Health care costs included fixed nursing home costs, medical fees, pharmacy charges, other charges, and eventual hospitalization costs. Data sources consisted of accountancy and invoice data. The analysis calculated costs per patient during the final month of life at 2007/2008 prices. Nineteen nursing homes participated in the study, generating a total of 181 patients. Total mean nursing home costs amounted to 3,243 <euro> per patient during the final month of life. Total mean nursing home costs per patient of 3,822 <euro> for patients receiving usual care were higher than costs of 2,456 <euro> for patients receiving palliative care ($p = 0.068$). Higher costs of usual care were driven by higher hospitalization costs ($p < 0.001$). This study suggests that palliative care models in nursing homes need to be supported because such care models appear to be less expensive than usual care and because such care models are likely to better reflect the needs of terminal patients.

Heijink R., Koolman X., Westert G.P. (2013). Spending more money, saving more lives? The relationship between avoidable mortality and healthcare spending in 14 countries. *Eur J Health Econ,* 14 (3) : 527-538.
Abstract: Healthcare expenditures rise as a share of GDP in most countries, raising questions regarding the value of further spending increases. Against this backdrop, we assessed the value of healthcare spending growth in 14 western countries between 1996 and 2006. We estimated macro-level health production functions using avoidable mortality as outcome measure. Avoidable mortality comprises deaths from certain conditions "that should not occur in the presence of timely and effective healthcare". We investigated the relationship between total avoidable mortality and healthcare spending using descriptive analyses and multiple regression models, focusing on within-country variation and growth rates. We aimed to take into account the role of potential confounders and dynamic effects such as time lags. Additionally, we explored a method to estimate macro-level cost-effectiveness. We found an average yearly avoidable mortality decline of 2.6-5.3 % across countries. Simultaneously, healthcare spending rose between 1.9 and 5.9 % per year. Most countries with above-average spending growth demonstrated above-average reductions in avoidable mortality. The regression models showed a significant association between contemporaneous and lagged healthcare spending and avoidable mortality. The time-trend, representing an exogenous shift of the health production function, reduced the impact of healthcare spending. After controlling for this time-trend and other confounders, i.e. demographic and socioeconomic variables, a statistically significant relationship between healthcare spending and avoidable mortality remained. We tentatively conclude that macro-level healthcare spending increases provided value for money, at least for the disease groups, countries and years included in this study.

Etat de santé

Bellanger B., Tourbe C. (2013). Espérance de vie en bonne santé : elle baisse !

Sciences & Vie, 52-67.

Abstract: L'espérance de vie a connu, en France, entre 2004 et 2011, une augmentation de près de deux ans pour les hommes comme pour les femmes. Désormais, elle atteint une moyenne cumulée de 81, 4 années. Mais l'espérance de vie en bonne santé amorcerait en France comme dans le monde un déclin. Cet article analyse ce phénomène

Cote Irdes : c, Dossier de presse : Mortalité/Morbidité - Généralités

Géographie de la santé

Marshall A., Norman P. (2013). Geographies of the impact of retirement on health in the United Kingdom.

Health & Place, 20 1-12.

Abstract: This paper explores how the impact of retirement on self-assessed illness varies spatially across the UK. Curves of age-specific limiting long term illness rates reveal a 'retirement kink'-where the rise in illness rates with age slows or declines at retirement age indicating possible health improvement after retirement. The kink is negligible in the affluent South East and most prominent in the coalfield and former industrial districts. It is likely that the kink is attributable to hidden unemployment and health-related selective migration but additionally that in certain areas retirement is associated with improvements in self-assessed health.

Ngamini N.A., Cohen A.A., Courteau J., Lesage A., Fleury M.J., Gregoire J.P., Moisan J., Vanasse A. (2013). Does elapsed time between first diagnosis of schizophrenia and migration between health territories vary by place of residence? A survival analysis approach.

Health & Place, 20 66-74.

Abstract: Migration of patients with schizophrenia might influence health care access and utilization. However, the time between diagnosis and migration of these patients has not yet been explored. We studied the first migration between health territories of 6873 patients newly diagnosed with schizophrenia in Quebec in 2001, aiming to describe the pattern of migration and assess the influence of the place of residence on migration. Between 2001 and 2007, 34.5% of patients migrated between health territories; those living in metropolitan areas were more likely to migrate than others but tended to remain in metropolitan areas. Migrant patients were also more likely to stay in or migrate to the most socially or materially deprived territories.

Green M.A. (2013). The equalisation hypothesis and changes in geographical inequalities of age based mortality in England, 2002-2004 to 2008-2010.

Soc Sci.& Med, 87 93-98.

Abstract: The equalisation hypothesis argues that during adolescence and early adulthood, inequality in mortality declines and begins to even out. However the evidence for this phenomenon is contested and mainly based on old data. This study proposes to examine how age-specific inequalities in mortality rates have changed over the past decade, during a time of widening health inequalities. To test this, mortality rates were calculated for deprivation quintiles in England, split by individual ages and sex for three time periods (2002-2004, 2005-2007 and 2008-2010). The results showed evidence for equalisation, with a clear decline in the ratio of mortality rates during late adolescence. However this decline was not accounted for by traditional explanations of the hypothesis. Overall, geographical inequalities were shown to be widening for the majority of ages, although there was some narrowing of patterns observed.

Cavalieri M. (2013). Geographical variation of unmet medical needs in Italy: a multivariate logistic regression analysis.

International Journal of Health Geographics, 12 (1) : 27.

Abstract: BACKGROUND:Unmet health needs should be, in theory, a minor issue in Italy where a

publicly funded and universally accessible health system exists. This, however, does not seem to be the case. Moreover, in the last two decades responsibilities for health care have been progressively decentralized to regional governments, which have differently organized health service delivery within their territories. Regional decision-making has affected the use of health care services, further increasing the existing geographical disparities in the access to care across the country. This study aims at comparing self-perceived unmet needs across Italian regions and assessing how the reported reasons - grouped into the categories of availability, accessibility and acceptability - vary geographically. METHODS:Data from the 2006 Italian component of the European Union Statistics on Income and Living Conditions are employed to explore reasons and predictors of self-reported unmet medical needs among 45,175 Italian respondents aged 18 and over. Multivariate logistic regression models are used to determine adjusted rates for overall unmet medical needs and for each of the three categories of reasons. RESULTS: Results show that, overall, 6.9% of the Italian population stated having experienced at least one unmet medical need during the last 12 months. The unadjusted rates vary markedly across regions, thus resulting in a clear-cut north-south divide (4.6% in the North-East vs. 10.6% in the South). Among those reporting unmet medical needs, the leading reason was problems of accessibility related to cost or transportation (45.5%), followed by acceptability (26.4%) and availability due to the presence of too long waiting lists (21.4%). In the South, more than one out of two individuals with an unmet need refrained from seeing a physician due to economic reasons. In the northern regions, working and family responsibilities contribute relatively more to the underutilization of medical services. Logistic regression results suggest that some population groups are more vulnerable than others to experiencing unmet health needs and to reporting some categories of reasons. Adjusting for the predictors resulted in very few changes in the rank order of macro-area rates. CONCLUSIONS: Policies to address unmet health care needs should adopt a multidimensional approach and be tailored so as to consider such geographical heterogeneities.
http://www.ij-healthgeographics.com/content/12/1/27

Hôpital

Karnon J., Caffrey O., Pham C., Grieve R., Ben-Tovim D., Hakendorf P., Crotty M. (2013). Applying risk adjusted cost-effectiveness (race) analysis to hospitals: estimating the costs and consequences of variation in clinical practice. *Health Econ,* 22 (6) : 631-642.

Abstract: Cost-effectiveness analysis is well established for pharmaceuticals and medical technologies but not for evaluating variations in clinical practice. This paper describes a novel methodology-risk adjusted cost-effectiveness (RAC-E)-that facilitates the comparative evaluation of applied clinical practice processes. In this application, risk adjustment is undertaken with a multivariate matching algorithm that balances the baseline characteristics of patients attending different settings (e.g. hospitals). Linked, routinely collected data are used to analyse patient-level costs and outcomes over a 2-year period, as well as to extrapolate costs and survival over patient lifetimes. The study reports the relative cost-effectiveness of alternative forms of clinical practice, including a full representation of the statistical uncertainty around the mean estimates. The methodology is illustrated by a case study that evaluates the relative cost-effectiveness of services for patients presenting with acute chest pain across the four main public hospitals in South Australia. The evaluation finds that services provided at two hospitals were dominated, and of the remaining services, the more effective hospital gained life years at a low mean additional cost and had an 80% probability of being the most cost-effective hospital at realistic cost-effectiveness thresholds. Potential determinants of the estimated variation in costs and effects were identified, although more detailed analyses to identify specific areas of variation in clinical practice are required to inform improvements at the less cost-effective institutions. Copyright (c) 2012 John Wiley & Sons, Ltd

Johar M., Jones G.S., Savage E. (2013). Emergency admissions and elective surgery waiting times. *Health Econ,* 22 (6) : 749-756.

Abstract: An average patient waits between 2 and 3 months for an elective procedure in Australian

public hospitals. Approximately 60% of all admissions occur through an emergency department, and bed competition from emergency admission provides one path by which waiting times for elective procedures may be lengthened. In this article, we investigated the extent to which public hospital waiting times are affected by the volume of emergency admissions and whether there is a differential impact by elective patient payment status. The latter has equity implications if the potential health cost associated with delayed treatment falls on public patients with lower ability to pay. Using annual data from public hospitals in the state of New South Wales, we found that, for a given available bed capacity, a one standard deviation increase in a hospital's emergency admissions lengthens waiting times by 19 days on average. However, paying (private) patients experience no delay overall. In fact, for some procedures, higher levels of emergency admissions are associated with lower private patient waiting times.

Cookson R., Laudicella M., Li D.P. (2013). Does hospital competition harm equity? Evidence from the English National Health Service. *J Health Econ,* 32 (2) : 410-422.
Abstract: Increasing evidence shows that hospital competition under fixed prices can improve quality and reduce cost. Concerns remain, however, that competition may undermine socio-economic equity in the utilisation of care. We test this hypothesis in the context of the pro-competition reforms of the English National Health Service progressively introduced from 2004 to 2006. We use a panel of 32,482 English small areas followed from 2003 to 2008 and a difference in differences approach. The effect of competition on equity is identified by the interaction between market structure, small area income deprivation and year. We find a negative association between market competition and elective admissions in deprived areas. The effect of pro-competition reform was to reduce this negative association slightly, suggesting that competition did not undermine equity.

Perotin V., Zamora B., Reeves R., Bartlett W., Allen P. (2013). Does hospital ownership affect patient experience? An investigation into public-private sector differences in England. *J Health Econ,* 32 (3) : 633-646.
Abstract: Using patient experience survey data, the paper investigates whether hospital ownership affects the level of quality reported by patients whose care is funded by the National Health Service in areas other than clinical quality. We estimate a switching regression model that accounts for (i) some observable characteristics of the patient and the hospital episode; (ii) selection into private hospitals; and (iii) unmeasured hospital characteristics captured by hospital fixed effects. We find that the experience reported by patients in public and private hospitals is different, i.e. most dimensions of quality are delivered differently by the two types of hospitals, with each sector offering greater quality in certain specialties or to certain groups of patients. However, the sum of all ownership effects is not statistically different from zero at sample means. In other words, hospital ownership in and of itself does not affect the level of quality of the average patient's reported experience. Differences in mean reported quality levels between the private and public sectors are entirely attributable to patient characteristics, the selection of patients into public or private hospitals and unobserved characteristics specific to individual hospitals, rather than to hospital ownership.

DePalma G., Xu H., Covinsky K.E., Craig B.A., Stallard E., Thomas J., Sands L.P. (2013). Hospital Readmission Among Older Adults Who Return Home With Unmet Need for ADL Disability. *The Gerontologist,* 53 (3) : 454-461.
Abstract: Purpose: This study determined whether returning to the community from a recent hospitalization with unmet activities of daily living (ADL) need was associated with probability of readmission. Methods: A total of 584 respondents to the 1994, 1999, and/or 2004 National Long-Term Care Surveys (NLTCS) who were hospitalized within 90 days prior to the interview and reported ADL disability at the time of the interview were considered for analysis. Medicare claims linked to the NLTCS provided information about hospital episodes, so those enrolled in Health Maintenance Organizations or Veterans Affairs Medical Centers were not included (n = 62), resulting in a total sample size of 522. ADL disability was defined as needing human help or equipment to complete the task. Unmet ADL need was defined as receiving inadequate or no help for one or more ADL disabilities. Disability that began within 90 days of the interview was considered new disability. Results: After adjusting for demographic, health, and functioning characteristics, unmet ADL need was associated with increased risk for hospital readmission (HR: 1.37, 95% CI: 1.031.82). Risk of readmission was greater for those with unmet need for new disabilities than those with unmet need for disabilities that were present before the index hospitalization (HR: 1.66, 95% CI: 1.01-2.73). Implications: Many older patients are discharged from the hospital with ADL disability. Those who

report unmet need for new ADL disabilities after they return home from the hospital are particularly vulnerable to readmission. Patients' functional needs after discharge should be carefully evaluated and addressed
http://gerontologist.oxfordjournals.org/content/53/3/454.abstract

Palangkaraya A., Yong J. (2013). Effects of competition on hospital quality: an examination using hospital administrative data. *Eur J Health Econ,* 14 (3) : 415-429.
Abstract: This paper investigates the effects of competition on hospital quality using hospital administration data from the State of Victoria, Australia. Hospital quality is measured by 30-day mortality rates and 30-day unplanned readmission rates. Competition is measured by Herfindahl-Hirschman index and the numbers of competing public and private hospitals. The paper finds that hospitals facing higher competition have lower unplanned admission rates. However, competition is related negatively to hospital quality when measured by mortality, albeit the effects are weak and barely statistically significant. The paper also finds that the positive effect of competition on quality as measured by unplanned readmission differs greatly depending on whether the hospital is publicly or privately owned.

Inégalités de santé

(2013). Penser l'assistance : 8e rapport de l'Onpes : Paris : ONPES.
Abstract: Ce huitième rapport de l'Observatoire national de la pauvreté et de l'exclusion sociale (ONPES) porte sur la thématique de l'Assistance. Les dépenses d'assistance, terme utilisé dans le milieu des années 1950, avant que ne prévalent les termes d'aide sociale et/ou d'action sociale, doivent être considérées comme des "investissements sociaux", estime l'observatoire, dans la lignée des recommandations de la Commission européenne. "Une réalité qui s'impose lorsque l'on considère l'effet à long terme sur les finances publiques des coûts du mal-logement, d'une prévention insuffisante en matière de santé, de l'échec scolaire et du chômage de longue durée". Le rapport conteste des "idées reçues" selon lesquelles les bénéficiaires de minima sociaux s'installeraient délibérément dans la dépendance. "Les situations d'abus existent, on ne peut le nier", reconnaît ce rapport, mais il estime, au vu de diverses données, que "prévaut dans les populations précaires et/ou aidées une immense aspiration à s'en sortir". En témoigne l'ampleur des « non-recours », ces personnes qui ne réclament pas les aides auxquelles elles auraient droit, en partie par crainte d'être stigmatisées. Deux tiers des allocataires potentiels du RSA activité ne font pas valoir leurs droits, comme 68 % des ménages éligibles aux tarifs sociaux du gaz et de l'électricité, ou encore et 53 à 67% des personnes éligibles à l'aide à l'ACS. "Pour une prestation donnée, le non-recours engendre des non-dépenses bien supérieures au montant estimé de la fraude pour ces mêmes prestations", rappelle le rapport. L'organisme d'observation sociale suggère plusieurs pistes de travail comme automatiser davantage notre système de versement de droits, afin d'éviter le sentiment de stigmatisation éprouvé par les allocataires, repenser et revaloriser le travail social pour mieux accompagner les bénéficiaires vers l'autonomie, et mieux évaluer les effets des politiques de solidarité pour en améliorer l'efficacité et la compréhension par les citoyens.
Cote Irdes : En ligne
http://www.onpes.gouv.fr/IMG/pdf/Penser_l_assistance_web.pdf

Bois C., Guillemot G. (2013). [Social inequalities in health in 4 year-old children in the Hauts-de-Seine (France)]. *Rev Epidemiol Santé Publique,* 61 Suppl 2 S47-S59.
Abstract: The social effects on health described in France on newborn and 5- to 6-year-old children suggest the existence of a social gradient among the youngest children. The favoured, though unequal, social situation of the department of the Hauts-de-Seine (France), makes it particularly adapted to this study. A survey, conducted in 2010 by the departmental service of maternal and infantile protection (PMI) on a representative sample of 1227 children, who received check-ups in their first or second year of nursery school, reveals a significant increase of overweight (from 4.6 to 16.5%), of language disorders (from 8.3 to 25.3%), of the orientations to specialized consultations (from 20.6 to 36.6%), according to the socioprofessional category of the father or the social affiliation of the children in the following subgroups: children speaking or understanding a foreign language (36.6% of the

sample), children schooled in priority educational zones (equivalent to education achievement zones in UK, 13.6%), children with limited social health coverage (13.4%). In contrast, the BCG and hepatitis B vaccinal coverage is systematically higher in these various groups. The multivariate analysis investigates for each health problem its links with these various subgroups, and with previous child care experiences, and PMI medical consultations. This study suggests therefore further prospects for different actions according to health problems or regarding vaccinal strategy. The development of such routine indicators of disadvantage should allow territorial health services to target their actions towards the decrease of social disparities in health and to check a posteriori the efficiency of the public systems, which have been implemented.

Berchet C. (2013). [Health care utilisation in France: An analysis of the main drivers of health care use inequalities related to migration]. *Rev Epidemiol santé Publique,* 61 Suppl 2 S69-S79.
Abstract: In using a general health survey representative of the French population, the 2006 and 2008 French Health, health care and insurance survey, this study explores inequalities in health care utilization between immigrants and natives. Our objective is to highlight the most important factors generating health care use inequalities relating to immigration in using non-linear decomposition. Estimation results reveal that for equivalent health care needs, immigrants present a lower demand for GP and specialist care than the French population. The implementation of non-linear decompositions suggests that health care use inequalities between French and immigrant populations are for the most part attributable to differences in the distribution of observable characteristics between both populations. In particular, immigrant lower health coverage represents the first factor generating inequalities in the propensity to contact a GP while education and income are the most important drivers of inequalities in the propensity to contact a specialist.

Levesque J.F., Pineault R., Robert L., Hamel M., Roberge D., Kapetanakis C., Simard B., Laugraud A. (2008). Unmet health care needs: a reflection of the accessibility of primary care services? Montréal: Direction de Santé Publique de l'Agence de La Santé et des Services Sociaux de Montréal. Institut National de Sante Publique du Québec et Centre de Recherche de l'Hôpital Charles Lemoyne.
http://www.greas.ca/evolution/pdf/UnmetHealthCareNeeds.pdf

Echazu L., Nocetti D. (2013). Priority setting in health care: disentangling risk aversion from inequality aversion. *Health Econ,* 22 (6) : 730-740.
Abstract: In this paper, we introduce a tractable social welfare function that is rich enough to disentangle attitudes towards risk in health outcomes from attitudes towards health inequalities across individuals. Given this preference specification, we evaluate how the introduction of uncertainty over the severity of illness and over the effectiveness of treatments affects the optimal allocation of healthcare resources. We show that the way in which uncertainty affects the optimal allocation within our proposed specification may differ sharply from that in the standard expected utility framework. Copyright (c) 2012 John Wiley & Sons, Ltd.

Flouri E., Mavroveli S., Midouhas E. (2013). Residential mobility, neighbourhood deprivation and children's behaviour in the UK. *Health &Place,* 20 25-31.
Abstract: Using data from the first two waves (in 2001/02 and 2004) of the UK's Millennium Cohort Study (MCS), we attempted to separate the effect of residential mobility from the effect of neighbourhood deprivation on children's emotional and behavioural problems. Our sample was 23,162 children (aged 3-16 years) clustered in 12,692 families. We measured neighbourhood deprivation with the Index of Multiple Deprivation, a measure of neighbourhood-level socio-economic disadvantage, and residential mobility as household move between waves. Being in a lower deprivation neighbourhood at Wave 1 was related to lower scores of both emotional and behavioural problems 2 years later, even after adjustment for child's age and sex, family adversity, family structure and maternal psychological distress. However, children whose families subsequently moved-even within or between lower deprivation neighbourhoods-were at higher risk of emotional and behavioural problems. Adjusting for family socio-economic disadvantage at Wave 1 explained the association of residential mobility with emotional but not with behavioural problems, which remained significant even after accounting for change in family's socio-economic disadvantage between waves.

Lalloue B., Monnez J.M., Padilla C., Kihal W., Le Meur N., Zmirou-Navier D., Deguen S. (2013). A statistical procedure to create a neighborhood socioeconomic index for health inequalities analysis. *International Journal for Equity in Health,* 12 (1) : 21.
Abstract: INTRODUCTION: In order to study social health inequalities, contextual (or ecologic) data may constitute an appropriate alternative to individual socioeconomic characteristics. Indices can be used to summarize the multiple dimensions of the neighborhood socioeconomic status. This work proposes a statistical procedure to create a neighborhood socioeconomic index. METHODS: The study setting is composed of three French urban areas. Socioeconomic data at the census block scale come from the 1999 census. Successive principal components analyses are used to select variables and create the index. Both metropolitan area-specific and global indices are tested and compared. Socioeconomic categories are drawn with hierarchical clustering as a reference to determine "optimal" thresholds able to create categories along a one-dimensional index. RESULTS: Among the twenty variables finally selected in the index, 15 are common to the three metropolitan areas. The index explains at least 57% of the variance of these variables in each metropolitan area, with a contribution of more than 80% of the 15 common variables. CONCLUSIONS: The proposed procedure is statistically justified and robust. It can be applied to multiple geographical areas or socioeconomic variables and provides meaningful information to public health bodies. We highlight the importance of the classification method. We propose an R package in order to use this procedure.
http://www.equityhealthj.com/content/12/1/21

Médicaments

King M., Essick C. (2013). The geography of antidepressant, antipsychotic, and stimulant utilization in the United States. *Health & Place,* 20 32-38.
Abstract: This paper analyzes local and regional geographic variability in the use of antidepressant, antipsychotic and stimulant medications in the United States. Using a data set that covers 60% of prescriptions written in the United States, we find that use of antidepressants in three digit postal codes ranged from less than 1% of residents to more than 40% residents. Stimulant and antipsychotic use exhibited similar levels of local geographic variability. A Kulldorf Spatial Scan identified clusters of elevated use of antidepressants (RR 1.46; $p<0.001$), antipsychotics (RR 1.42; $p<0.001$), and stimulants (RR 1.77; $p<0.001$). Using a multilevel model, we find that access to health care, insurance coverage and pharmaceutical marketing efforts explain much of the geographic variation in use.

Brekke K.R., Dalen S.M., Holmas T.H. (2013). Diffusion of Pharmaceuticals: Cross-Country Evidence of Anti-TNF drugs : Bergen : Norvegian Business School
Abstract: This paper studies the diffusion of biopharmaceuticals across European countries, focusing on anti-TNF drugs, which are used to treat autoimmune diseases (e.g., rheumatism, psoriasis). We use detailed sales information on the three brands Remicade, Enbrel and Humira for nine European countries covering the period from the first launch in 2000 until becoming blockbusters in 2009. Descriptive statistics reveal large variations across countries in per-capita consumption and price levels both overall and at brand level. We explore potential sources for the cross-country consumption differences by estimating several multivariate regression models. Our results show that large parts of the cross-country variation are explained by time-invariant country-specific factors (e.g., disease prevalence, demographics, health care system). We also find that differences in income (GDP per capita) and health spending (share of GDP) ex plain the cross-country variation in consumption, while relative price difference- s seem to have limited impact.
Cote Irdes : En ligne
http://www.nhh.no/Files/Filer/institutter/sam/Discussion%20papers/2013/07.pdf

Pombo-Romero J., Varela L.M., Ricoy C.J. (2013). Diffusion of innovations in social interaction systems. An agent-based model for the introduction of new drugs in markets. *Eur J Health Econ,* 14 (3) : 443-455.
Abstract: The existence of imitative behavior among consumers is a well-known phenomenon in the field of Economics. This behavior is especially common in markets determined by a high degree of innovation, asymmetric information and/or price-inelastic demand, features that exist in the

pharmaceutical market. This paper presents evidence of the existence of imitative behavior among primary care physicians in Galicia (Spain) when choosing treatments for their patients. From this and other evidence, we propose a dynamic model for determining the entry of new drugs into the market. To do this, we introduce the structure of the organization of primary health care centers and the presence of groups of doctors who are specially interrelated, as well as the existence of commercial pressure on doctors. For modeling purposes, physicians are treated as spins connected in an exponentially distributed complex network of the Watts-Strogatz type. The proposed model provides an explanation for the differences observed in the patterns of the introduction of technological innovations in different regions. The main cause of these differences is the different structure of relationships among consumers, where the existence of small groups that show a higher degree of coordination over the average is particularly influential. The evidence presented, together with the proposed model, might be useful for the design of optimal strategies for the introduction of new drugs, as well as for planning policies to manage pharmaceutical expenditure.

Saastamoinen L.K., Verho J. (2013). Drug expenditure of high-cost patients and their characteristics in Finland. *Eur J Health Econ,* 14 (3) : 495-502.
Abstract: BACKGROUND: Little information exists on how constantly growing pharmaceutical expenditures are distributed in large representative samples of national populations in Western countries. OBJECTIVE: This study analyzes the distribution of pharmaceutical expenditures in ambulatory care and explores the basic characteristics of the high-cost drug users. METHOD: Reimbursed prescription drug purchases in 2009 were derived from the National Prescription Register for a 50 % sample of the adult Finnish population. The high-cost users who were among the top 5 % in terms of drug expenditures were identified based on annual drug costs. RESULTS: The distribution of pharmaceutical costs is strongly skewed in Finland; only 5 % of the population accounts for about half of the costs. These high-cost drug users were older than the low-cost drug users, with more than one-fourth of them being over 75 years old. The high-cost drug users used, on average, more drugs than the low-cost drug users, but approximately 15 % of them used only 1-5 drugs. Almost 50 % of the high-cost drug users used more than 10 drugs per year. They had chronic diseases more often than the low-cost drug users, especially uremia requiring dialysis, post-transplant conditions, severe anemia associated with chronic renal failure and multiple sclerosis were common among the high-cost users. CONCLUSION: The skewness of the cost distribution indicates a need for more patient-specific cost-containment methods, and the high number of drugs in the high-cost group calls for exploring the possibilities of disease management and patient monitoring techniques in cost containment.

Méthodologie – Statistique

Kohn J.L., Liu J.S. (2013). The dynamics of medical care use in the British household panel survey. *Health Econ,* 22 (6) : 687-710.
Abstract: We explore whether medical care use is persistent over a long panel using 18 waves of the British Household Panel Survey. Of particular interest is high medical care use because a few high users account for a disproportionate amount of use while many individuals use no medical care in a given year. If health is a primary driver of medical care demand, and we control for health, then past medical care use should be uninformative for future use. However, we find that conditional on health, other covariates and unobservable heterogeneity, medical care use remains significantly persistent. "No use" and "high use" are more strongly persistent, and persistence is generally stronger for women, those in poor health, and at older ages. We find that unobservable heterogeneity explains between 10% and 25% of the variation in medical care use. This heterogeneity is significantly correlated with both medical care use and health over our long panel. These findings have implications for the econometric modeling of medical care demand and suggest that policies aimed to reduce aggregate medical care spending by improving health, particularly the health of seniors, may be less effective than projected using static models.

Wouterse B., Huisman M., Meijboom B.R., Deeg D.J., Polder J.J. (2013). Modeling the relationship between health and health care expenditures using a latent Markov

model. *J Health Econ,* 32 (2) : 423-439.

Abstract: We investigate the dynamic relationship between several dimensions of health and health care expenditures for older individuals. Health data from the Longitudinal Aging Survey Amsterdam is combined with data on hospital and long term care use. We estimate a latent variable based jointly on observed health indicators and expenditures. Annual transition probabilities between states of the latent variable are estimated using a Markov model. States associated with good current health and low annual health care expenditures are not associated with lower cumulative health care expenditures over remaining lifetime. We conclude that, although the direct health care cost saving effect is limited, the considerable gain in healthy life years can make investing in the improvement of health of the older population worthwhile.

Bradley R. (2013). Feasible methods to estimate disease based price indexes. *J Health Econ,* 32 (3) : 504-514.

Abstract: There is a consensus that statistical agencies should report medical data by disease rather than by service. This study computes price indexes that are necessary to deflate nominal disease expenditures and to decompose their growth into price, treated prevalence and output per patient growth. Unlike previous studies, it uses methods that can be implemented by the Bureau of Labor Statistics (BLS). For the calendar years 2005-2010, I find that these feasible disease based indexes are approximately 1% lower on an annual basis than indexes computed by current methods at BLS. This gives evidence that traditional medical price indexes have not accounted for the more efficient use of medical inputs in treating most diseases.

Wang T.C., Yue C.S. (2013). Spatial clusters in a global-dependence model. *Spatial and Spatio-temporal Epidemiology,* 5 (0) : 39-50.

Abstract: Abstract Spatial data often possess multiple components, such as local clusters and global clustering, and these effects are not easy to be separated. In this study, we propose an approach to deal with the cases where both global clustering and local clusters exist simultaneously. The proposed method is a two-stage approach, estimating the autocorrelation by an EM algorithm and detecting the clusters by a generalized least square method. It reduces the influence of global dependence on detecting local clusters and has lower false alarms. Simulations and the sudden infant disease syndrome data of North Carolina are used to illustrate the difference between the proposed method and the spatial scan statistic.
http://www.sciencedirect.com/science/article/pii/S1877584513000129

Borah B.J., Basu A. (2013). Highliting differences between conditional and unconditional quantile regression approaches through an application to assess medication adherence. *Health Econ,*

Abstract: The quantile regression (QR) framework provides a pragmatic approach in understanding the differential impacts of covariates along the distribution of an outcome. However, the QR framework that has pervaded the applied economics literature is based on the conditional quantile regression method. It is used to assess the impact of a covariate on a quantile of the outcome conditional on specific values of other covariates. In most cases, conditional quantile regression may generate results that are often not generalizable or interpretable in a policy or population context. In contrast, the unconditional quantile regression method provides more interpretable results as it marginalizes the effect over the distributions of other covariates in the model. In this paper, the differences between these two regression frameworks are highlighted, both conceptually and econometrically. Additionally, using real-world claims data from a large US health insurer, alternative QR frameworks are implemented to assess the differential impacts of covariates along the distribution of medication adherence among elderly patients with Alzheimer's disease. Copyright (c) 2013 John Wiley & Sons, Ltd.

Politique de santé

Monstad K., Engesaeter L.B., Espehaug B. (2013). Waiting time and socioeconomic status - An individual-level analysis. *Health Economics,* (ahead of print)
Abstract: Waiting time is a rationing mechanism that is used in publicly funded healthcare systems. From an equity viewpoint, it is regarded as preferable to co-payments. However, long waits are an indication of poor quality of service. To our knowledge, this analysis is the first to benefit from individual-level data from administrative registers to investigate the relationship between waiting time, income, and education. Furthermore, it makes use of an extensive set of medical information that serves as indicators of patient need. Differences in waiting time by socioeconomic status are detected. For men, there is a statistically highly significant negative association between income and waiting time, driven by men in the highest income group, which constitutes 12% of all men. More educated women, that is, those having an education above compulsory schooling, experience lower waiting time than their fellow sisters with the lowest level of education.

Prévention santé

Brown H.S., Karson S. (2013). Cigarette quitlines, taxes, and other tobacco control policies: a state-level analysis. *Health Econ,* 22 (6) : 741-748.
Abstract: This paper estimates monthly quitline calls using panel data at the state level from January 2005 to June 2010. Calls to state quitline numbers (or 1-800-QUITNOW) were measured per million adult smokers in each state. The policies considered include excise taxes, workplace and public smoking bans, and a Peter Jennings television-based program warning of the health risks of smoking. We found that people anticipating increases in prices begin attempting to quit by calling quitlines. Finally, the Peter Jennings media campaign was highly correlated with quitline calls.

Prévision – Evaluation

Fleurbaey M., Luchini S., Muller C., Schokkaert E. (2013). Equivalent income and fair evaluation of health care. *Health Econ,* 22 (6) : 711-729.
Abstract: We argue that the economic evaluation of health care (cost-benefit analysis) should respect individual preferences and should incorporate distributional considerations. Relying on individual preferences does not imply subjective welfarism. We propose a particular non-welfarist approach, based on the concept of equivalent income, and show how it helps to define distributional weights. We illustrate the feasibility of our approach with empirical results from a pilot survey.

Psychiatrie

Fone D., Greene G., Farewell D., White J., Kelly M., Dunstan F. (2013). Common mental disorders, neighbourhood income inequality and income deprivation: small-area multilevel analysis. *Br J Psychiatry,* 202 (4) : 286-293.
Abstract: BACKGROUND: Common mental disorders are more prevalent in areas of high neighbourhood socioeconomic deprivation but whether the prevalence varies with neighbourhood income inequality is not known. AIMS: To investigate the hypothesis that the interaction between small-area income deprivation and income inequality was associated with individual mental health. METHOD: Multilevel analysis of population data from the Welsh Health Survey, 2003/04-2010. A total of 88,623 respondents aged 18-74 years were nested within 50,587 households within 1887 lower super output areas (neighbourhoods) and 22 unitary authorities (regions), linked to the Gini coefficient (income inequality) and the per cent of households living in poverty (income deprivation). Mental health was measured using the Mental Health Inventory MHI-5 as a discrete variable and as a 'case' of common mental disorder. RESULTS: High neighbourhood income inequality was associated with better mental health in low-deprivation neighbourhoods after adjusting for individual and household

risk factors (parameter estimate +0.70 (s.e. = 0.33), P = 0.036; odds ratio (OR) for common mental disorder case 0.92, 95% CI 0.88-0.97). Income inequality at regional level was significantly associated with poorer mental health (parameter estimate -1.35 (s.e. = 0.54), P = 0.012; OR = 1.13, 95% CI 1.04-1.22). CONCLUSIONS: The associations between common mental disorders, income inequality and income deprivation are complex. Income inequality at neighbourhood level is less important than income deprivation as a risk factor for common mental disorders. The adverse effect of income inequality starts to operate at the larger regional level.

Curtis S., Pain R., Fuller S., Khatib Y., Rothon C., Stansfeld S.A., Daya S. (2013). Neighbourhood risk factors for Common Mental Disorders among young people aged 10-20 years: a structured review of quantitative research. *Health Place,* 20 81-90.
Abstract: We present a critical review of research concerning the vulnerability of mental health of young people in the 10-20 year age range to neighbourhood factors that are theoretically associated with increased risk of Common Mental Disorders (CMDs). We interpreted 'neighbourhood factors' as attributes and processes in the local social and physical environment that young people inhabit, beyond the immediate household. We conducted an extensive search, and a structured method of assessment of the research papers that met our search criteria. We draw conclusions about the research evidence on this topic and identify issues needing further discussion and investigation. We focus particularly on quantitative research that aims to measure these relationships. We note that parallel to this research, a significant body of qualitative research on the geographical experiences of young people (though not specifically on their mental health) offers a rich source of background information to illuminate the statistical findings. We conclude with some reflections on the future challenges for research in this field.

Soins de santé primaires

Gay B. (2013). [Rethinking the place of primary healthcare in France - Role of general practice.]. *Rev Epidemiol santé Publique,* 61 (3) : 193-198.
Abstract: Primary healthcare is poorly structured in France while it is well defined at the international level: it is the point of first medical contact of the population with the healthcare system. General practice is the clinical specialty oriented to primary healthcare. Data in the scientific literature highlight the need of refocusing the health system on primary care known to improve both morbi-mortality and care efficiency. In France, health authorities acknowledge general practitioners as playing a key role in the health care system: its time to move from intention to action. Structural changes are needed to achieve this reinforcement of primary healthcare: to re-orientate medical studies towards primary care; to develop research in primary care; to promote cooperation between care providers; to ease the daily workload of practitioners; to diversify methods of payment; to propose a guide for patient's use of primary care. The transformation of the healthcare system in France requires a real strategy of primary healthcare implementation. Regardless of financial constraints, it is possible to redistribute the resources towards ambulatory care. Strengthening the role of general practice and favoring its societal recognition will be the major stages of this change.

Andreassen L., Di Tommaso M.L., Strom S. (2013). Do medical doctors respond to economic incentives? *J Health Econ,* 32 (2) : 392-409.
Abstract: A longitudinal analysis of married physicians labor supply is carried out on Norwegian data from 1997 to 1999. The model utilized for estimation implies that physicians can choose among 10 different job packages which are a combination of part time/full time, hospital/primary care, private/public sector, and not working. Their current choice is influenced by past available options due to a habit persistence parameter in the utility function. In the estimation we take into account the budget constraint, including all features of the tax system. Our results imply that an overall wage increase or less progressive taxation moves married physicians toward full time job packages, in particular to full time jobs in the private sector. But the overall and aggregate labor supply elasticities in the population of employed doctors are rather low compared to previous estimates.

Agrawal S., Brennan N., Budetti P. (2013). The Sunshine Act - Effects on Physicians.
New England Journal of Medicine, 368 (22) : 2054-2057.
http://dx.doi.org/10.1056/NEJMp1303523

Naylor C., Imison C., Addicott R. (2003). Transforming our health care system: ten priorities for commissioners : Londres : King's Fund
Abstract: As of 1 April 2013, clinical commissioning groups (CCGs) are responsible for the majority of the NHS budget – more than £65 billion of public money. At the same time, public health budgets of £2.7 billion are transferring to local authorities, while NHS England (formerly the NHS Commissioning Board), through its 27 area teams, takes responsibility for commissioning primary care (£13 billion) and specialised services (£12 billion). It is hoped that the new health and wellbeing boards, convened by local authorities, will play a key role in coordinating the activities of these different groups of commissioners, while commissioning support units – also new – will provide a range of services to clinical commissioning groups and NHS England to help them to perform their functions effectively. The new commissioning landscape is summarised in the figure below. Collectively, the task of this new set of commissioner- s is to deliver a sustainable health care system in the face of one of the most challenging financial and organisational environments the NHS has ever experienced. The task is especially daunting in the context of a population in which the burden of disease is growing and medical advances offer increasing opportunities to treat disease, but at a cost. The result, if nothing else changes in the NHS, will be significant unmet need and threats to the quality of care
Cote Irdes : En ligne
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf

Systèmes de santé

(2013). OECD Reviews of Health Systems: Denmark : Paris : OCDE.
Abstract: This report is the third of a new series of publications reviewing the quality of health care. Among OECD countries, Denmark has led the way in monitoring and policy development for quality of care. As several sophisticated quality assurance mechanisms have been implemented over several decades, particularly in the secondary care sector, the next priority for Denmark is to ensure overarching linkages across institutions. Efforts ought especially to focus on creating a unified vision, and extending quality monitoring and improvement initiatives to primary care, particularly in light of the increasing number of people living with multiple chronic conditions and needing good continuity of care in the community sector. Another important area will be to support the hospital specialisation reform by encouraging inter-hospital comparison- s based on quality.

(2013). Health system performance comparison : an agenda for policy, information and research. Observatory Studies Series. Berkshire : Open University Press
Abstract: International comparison of health system performance has become increasing- ly popular, made possible by the rapidly expanding availability of health data. It has become one of the most important levers for prompting health system reform. Yet, as the demand for transparency and accountability in healthcare increases, so too does the need to compare data from different health systems both accurately and meaningfully. This timely and authoritative book offers an important summary of the current developments in health system performance comparison. It summarises the current state of efforts to compare systems, and identifies and explores the practical and conceptual challenges that occur. It discusses data and methodological challenges, as well as broader issues such as the interface between evidence and practice. The book draws out the priorities for future work on performance comparison, in the development of data sources and measurement instruments, analytic methodology, and assessment of evidence on performance. It concludes by presenting the key lessons and future priorities, and in doing so offers a rich source of material for policy-makers, their analytic advisors, international agencies, academics and students of health systems (Résumé de l'éditeur).
Cote Irdes : A4456
http://www.euro.who.int/__data/assets/pdf_file/0010/162568/e96456.pdf - http://mcgraw-hill.co.uk/html/0335247261.html

Travail et santé

Volker D., Vlasveld M.C., Anema J.R. (2013). Blended E-health module on return to work embedded in collaborative occupational health care for common mental disorders: Design of a cluster randomized controlled trial. *Neuropsychiatric Disease and Treatment,* 9 529-537.
Abstract: Background: Common mental disorders (CMD) have a major impact on both society and individual workers, so return to work (RTW) is an important issue. In The Netherlands, the occupational physician plays a central role in the guidance of sick-listed workers with respect to RTW. Evidence-based guidelines are available, but seem not to be effective in improving RTW in people with CMD. An intervention supporting the occupational physician in guidance of sicklisted workers combined with specific guidance regarding RTW is needed. A blended E-health module embedded in collaborative occupational health care is now available, and comprises a decision aid supporting the occupational physician and an E-health module, Return@Work, to support sick-listed workers in the RTW process. The cost-effectiveness of this intervention will be evaluated in this study and compared with that of care as usual. Methods: This study is a two-armed cluster randomized controlled trial, with randomization done at the level of occupational physicians. Two hundred workers with CMD on sickness absence for 4–26 weeks will be included in the study. Workers whose occupational physician is allocated to the intervention group will receive the collaborative occupational health care intervention. Occupational physicians allocated to the care as usual group will give conventional sickness guidance. Follow-up assessments will be done at 3, 6, 9, and 12 months after baseline. The primary outcome is duration until RTW. The secondary outcome is severity of symptoms of CMD. An economic evaluation will be performed as part of this trial. Conclusion: It is hypothesized that collaborative occupational health care intervention will be more (cost)-effective than care as usual. This intervention is innovative in its combination of a decision aid by email sent to the occupational physician and an E-health module aimed at RTW for the sick-listed worker.
Cote Irdes : En ligne
http://arno.uvt.nl/show.cgi?fid=129665

Vieillissement

Moulaert T., Henrard J.C., Leider B, et al. (2013). Le vieillissement actif : à quelles conditions ? *Observatoire (L'),* (45) : 5-73.
Abstract: Le vieillissement actif et la solidarité intergénérationnelle était le thème de l'Année européenne 2012; Mais que signifie vieillir actif ? Est-ce un souhait, un idéal exprimé par la majorité des personnes au-delà de l'âge de la retraite ou est-ce une injonction sociale et surtout socio-économique pour pallier au renversement de la pyramide des âges et réduire les coûts de la dépendance ? La réponse se trouve en partie dans nos représentations de la vieillesse et de ce qui est ou fait "activité".
Cote Irdes : B7155

Mielck A., Kiess R., Von Dem Knesebeck O., Stirbu I., Kunst A.E. (2007). Association between access to health care and household income among the elderly in 10 western European countries. *Tackling Health Inequalities in Europe: An Integrated Approach.EUROTHINE.Final Report,* 471-482.

Batyra A., De La Croix D., Pierrard O. et al. (2013). Declining bargaining power of workers and the rise of early retirement in Europe : Istanbul : Galatasaray University Economic Research Center
Abstract: We offer an alternative explanation for the decline in labor force participation of senior

workers. Typically, tax and transfer explanations have been proposed. On the contrary, a model with imperfectly competitive labor market allows to consider as well the effects of a drop in bargaining power, which would not be possible in a purely neoclassical framework. We find that a decline in the bargaining power of workers, which has taken place in the last four decades, has largely contributed to the rise in inactivity in Europe. However, we need a combination of these two explanations, along with population aging and a fall in the matching efficiency, in order to correctly reproduce the joint evolutions of other labor market variables such as the employment and unemployment rates.
Cote Irdes : En ligne
http://gsu-giam.net/eng/images/haberler/7890980928.pdf

Romero-Ortuno R., O'Shea D. (2013). Fitness and frailty: opposite ends of a challenging continuum! Will the end of age discrimination make frailty assessments an imperative? *Age and Ageing,* 42 (3) : 279-280.

Bennett S., Song X., Mitnitski A., Rockwood K. (2013). A limit to frailty in very old, community-dwelling people: a secondary analysis of the Chinese longitudinal health and longevity study. *Age and Ageing,* 42 (3) : 372-377.
Abstract: Background: it has been observed that a frailty index (FI) is limited by the value of 0.7. Whether this holds in countries with higher mortality rates is not known. Objectives: to test for and quantify a limit in very old Chinese adults and to relate mortality risk to the FI. Design: secondary analysis of four waves (1998, 2000, 2002 and 2005) of the Chinese Longitudinal Health and Longevity Study (CLHLS).Subjects: a total of 6,300 people from 22 of 31 provinces in China, aged 80â€“99 years at baseline and followed up to 7 years. Methods: an FI was calculated as the ratio of actual to 38 possible health deficits. Frequency distributions were used to evaluate the limit to the FI. Logistic regression and survival analysis were used to evaluate the relationship between the FI and mortality. Results: at each wave, a 99% submaximal limit to frailty was observed at FI = 0.7, despite consecutive losses to death. The death rate for those who were healthiest at baseline (i.e. those in whom the baseline FI = 0) increased from 0.18 at the 2-year follow-up to 0.69 by 7 years. At each wave, 100% mortality at 2 years was observed at FI close to 0.67. A baseline FI >0.45 was associated with 100% 7-year mortality. Conclusions: a limit to frailty occurred with FI = 0.7 which was not exceeded at any age or in any wave. There appears to be a demonstrable limit to the number of health problems that people can tolerate.

Moorman S.M., Macdonald C. (2013). Medically Complex Home Care and Caregiver Strain. *The Gerontologist,* 53 (3) : 407-417.
Abstract: Purpose of the study: To examine (a) whether the content of caregiving tasks (i.e., nursing vs. personal care) contributes to variation in caregivers strain and (b) whether the level of complexity of nursing tasks contributes to variation in strain among caregivers providing help with such tasks. Design and methods: The data came from the Cash and Counseling Demonstration and Evaluation study conducted in Arkansas, Florida, and New Jersey. The paper analyzes the physical and emotional strain of 1,926 paid American caregivers who helped adult Medicaid recipients with personal and nursing care in the home. Results: Over 80% of home caregivers were providing assistance with nursing care, and over 50% of those were providing help with moderate or high complexity tasks. Caregivers who were providing any type of nursing care reported significantly more strain than caregivers who were providing only personal care. Those providing highly or moderately complex nursing care exhibited more caregiver strain than did those providing low-complexity nursing care. Implications: Medical complexity is an important contributor to caregiver strain. Policymakers should consider medical complexity in the development of practices to assist the caregivers of Medicaid long-term care recipients, especially through consumer-directed supportive service programs.
http://gerontologist.oxfordjournals.org/content/53/3/407.abstract

Hernaes E., Markussen S., Piggott J., Vestad O.L. (2013). Does retirement age impact mortality? *J Health Econ,* 32 (3) : 586-598.
Abstract: The relationship between retirement and mortality is studied with a unique administrative data set covering the full population of Norway. A series of retirement policy changes in Norway reduced the retirement age for a group of workers but not for others. Difference-in-differences estimation based on monthly birth cohorts and treatment group status show that the early retirement programme significantly reduced the retirement age; this holds true also when we account for

programme substitution, for example into the disability pension. Instrumental variables estimation results show no effect on mortality of retirement age; neither do estimation results from a hazard rate model.