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

Sommaire

Assurance maladie / Health Insurance

Dourgnon P., Evrard P., Guillaume S. (2014). Vers un système d'information sur le coût des soins, les remboursements des couvertures obligatoire et complémentaire, et les restes à charge réels des ménages. Bilan et perspectives du projet Monaco. *Questions d'Economie de la Santé (Irdes),* (194) :

Abstract: Le projet Monaco (Méthodes, outils et normes pour la mise en commun des données des assurances complémentaire et obligatoire) représente une première étape visant à mettre en place un système d'information qui permette d'améliorer la connaissance des restes à charge des assurés après remboursements par l'Assurance maladie obligatoire (AMO) et l'Assurance maladie complémentaire (AMC). Il s'agit d'un test sur la possibilité technique d'associer des données individuelles issues de l'Assurance maladie et des organismes de couverture complémentaire s'appuyant sur le dispositif de l'Enquête santé et protection sociale (ESPS). Monaco rassemble les principales caisses d'assurance maladie et dix organismes de couverture complémentaire sous l'égide de l'Institut des données de santé (IDS). Après avoir décrit la méthodologie de cet appariement, nous présentons un premier bilan technique et les perspectives de recherche qui pourraient s'ouvrir grâce à ce nouvel outil.
http:www.irdes.fr/recherche/questions-d-economie-de-la-sante/194-vers-un-systeme-d-information-sur-le-cout-des-soins-les-remboursements-des-couvertures-obligatoire-et-complementaire-et-les-restes-a-charge-reels-des-menages.pdf

Powell D. (2013). Moral Hazard and Adverse Selection in Private Health Insurance. Santa Monica : The Rand

Abstract: Moral hazard and adverse selection create inefficiencies in private health insurance markets. We use claims data from a large firm to study the independent roles of both moral hazard and adverse selection. Previous studies have attempted to estimate moral hazard in private health insurance by assuming that individuals respond only to the spot price, end-of-year price, average price, or a related metric. There is little economic justification for such assumptions and, in fact, economic intuition suggests that the nonlinear budget constraints generated by health insurance plans make these assumptions especially poor. We study the differential impact of the health insurance plans offered by the firm on the entire distribution of medical expenditures without parameterizing the plans by a specific metric. We use a new instrumental variable quantile estimation technique introduced in Powell [2013b] that provides the quantile treatment effects for each plan, while conditioning on a set of covariates for identification purposes. This technique allows us to map the resulting estimated medical expenditure distributions to the nonlinear budget sets generated by each plan. Our method also allows us to separate moral hazard from adverse selection and estimate their relative importance. We estimate that 77% of the additional medical spending observed in the most generous plan in our data relative to the least generous is due to adverse selection. The remainder can be attributed to moral hazard. A policy which resulted in each person enrolling in the least generous plan would cause the annual premium of that plan to rise by over $1,500.
http:papers.ssrn.com/sol3/papers.cfm?abstract_id=2411219

Glazer J., McGuire T.G. (2014). Risk Adjustment of Health Plan Payments to Correct Inefficient Plan Choice from Adverse Selection. Cambridge : NBER

Abstract: This paper develops and implements a statistical methodology to account for the equilibrium effects (aka adverse selection) in design of risk adjustment formula in health insurance markets. Our setting is modeled on the situation in Medicare and the new state Exchanges where individuals sort themselves between a discrete set of plan types (here, two). Our "Silver" and "Gold" plans have fixed characteristics, as in the well-known research on selection and efficiency by Einav and Finkelstein (EF). We build on the EF model in several respects, including by showing that risk adjustment can be used to achieve the premiums that will lead to efficient sorting. The target risk adjustment weights can be found by use of constrained regressions, where the constraints in the estimation are conditions on premiums that should be satisfied in equilibrium. We illustrate implementation of the method with data from seven years of the Medical Expenditure Panel Survey.
http:papers.nber.org/papers/w19998

Economie de la santé / Health Economics

Barcellos S.H., Jacobson M. (2014). The Effects of Medicare on Medical Expenditure Risk and Financial Strain. Cambridge : NBER

Abstract: We estimate the current impact of Medicare on medical expenditure risk and financial strain. At age 65, out-of-pocket expenditures drop by 33% at the mean and 53% among the top 5% of spenders. The fraction of the population with out- of-pocket medical expenditures above income drops by more than half. Medical- related financial strain, such as problems paying bills, is dramatically reduced. Using a stylized expected utility framework, the gain from reducing out-of-pocket expenditures alone accounts for 18% of the social costs of financing Medicare. This calculation ignores the benefits of reduced financial strain and direct health improvements due to Medicare.
http:papers.nber.org/papers/w19954

Zhao K. (2014). Social Security and the rise in Health Spending. Storrs : University of Connecticut

Abstract: In a quantitative model of Social Security with endogenous health, this paper argues that Social Security increases the aggregate health spending of the economy because it redistributes resources to the elderly whose marginal propensity to spend on health is high. It shows by using computational experiments that the expansion of US Social Security can account for over a third of the dramatic rise in US health spending from 1950 to 2000. In addition, Social Security has a spill-over e effect on Medicare. As Social Security increases health spending, it also increases the payments from Medicare, thus raising its financial burden.
http:www.econ.uconn.edu/working/2014-04.pdf

Kristensen S.R., Siciliani L., Sutton M. (2014). Optimal Price-Setting in Pay for Performance Schemes in Health Care. York : University of York

Abstract: The increased availability of process measures implies that quality of care is in some areas de facto verifiable. Optimal price-setting for verifiable quality is well-described in the incentive-design literature. We seek to narrow the large gap between actual price-setting behaviour in Pay-For-Performance schemes and the incentive literature. We present a model for setting prices for process measures of quality and show that optimal prices should reflect the marginal benefit of health gains, providers' altruism and the opportunity cost of public funds. We derive optimal prices for processes incentivised in the Best Practice Tariffs for emergency stroke care in the English National Health Service. Based on published estimates, we compare these to the prices set by the English Department of Health. We find that actual tariffs were lower than optimal, relied on an implausibly high level of altruism, or implied a lower social value of health gains than previously used.
http:www.york.ac.uk/media/economics/documents/discussionpapers/2014/1403.pdf

Haussler J. (2014). Effects of Obesity and Physical Activity on Health Care Utilization and Costs. Konstanz : University of Konstanz

Abstract: The study analyses the combined influence of obesity and lifestyle behaviors on health care utilization and health care costs. Therefore I analyze the interaction of obesity, nutrition and physical activity based on a community level dataset from a German city. In addition to the expected convex effects of age and chronic diseases for utilization, the results indicate that BMI and physical inactivity have an independent influence on G.P. visits as well as for hospitalization. The key finding of the cost analysis is that health care costs increase in consequence of a completely sedentary lifestyle by 505 € independent of the individual's BMI level. The results also confirm that compared to individuals of normal weight, the medical costs of the group of overweight people (by 377 €) and the group of obese people (by 565 €) are significantly increased. Even without significant weight reductions public programs against a sedentary lifestyle can be a way to reduce health care spending, and thus a sole

focus on weight reduction might underestimate the additional benefits of changes in lifestyle behaviors.
http:www.uni-konstanz.de/FuF/wiwi/workingpaperseries/WP_07_Haussler_2014.pdf

Morgan D., Astolfi R. (2014). Health Spending Continues to Stagnate in Many OECD Countries. Paris : OCDE

Abstract: The global economic crisis which began in 2008 has had a dramatic effect on health spending across OECD countries. Estimates of expenditure on health released back in 2012 showed that, for the first time, health spending had slowed markedly or fallen across many OECD countries after years of continuous growth. As a result, close to zero growth in health expenditure was recorded on average in 2010. Preliminary estimates suggested that the low or negative growth in health spending was set to continue in many OECD countries in following years.
http://www.oecd-ilibrary.org/social-issues-migration-health/health-spending-continues-to-stagnate-in-many-oecd-countries_5jz5sq5qnwf5-en

Géographie de la santé / Geography of Health

Geronimus A.T., Bound J. (2014). Residential mobility across local areas in the United States and the geographic distribution of the healthy population. Washington : U.S Census Bureau

Abstract: Determining whether population dynamics provide competing explanations to place effects for observed geographic patterns of population health is critical for understanding health inequality. We focus on the working-age population where health disparities are greatest and analyze detailed data on residential mobility collected for the first time in the 2000 US census. Residential mobility over a 5-year period is frequent and selective, with some variation by race and gender. Even so, we find little evidence that mobility biases cross-sectional snapshots of local population health. Areas undergoing large or rapid population growth or decline may be exceptions. Overall, place of residence is an important health indicator; yet, the frequency of residential mobility raises questions of interpretation from etiological or policy perspectives, complicating simple understandings that residential exposures alone explain the association between place and health. Psychosocial stressors related to contingencies of social identity associated with being black, urban, or poor in the U.S. may also have adverse health impacts that track with structural location even with movement across residential areas.
ftp:ftp2.census.gov/ces/wp/2014/CES-WP-14-14.pdf

(2014). Inégalités territoriales, environnementales et sociales de santé : Regards croisés en régions : de l'observation à l'action. Paris : Ministère chargé de l'Ecologie.

Abstract: En 2012, le Secrétariat général en charge des ministères sociaux (SGMAS) et le Commissariat général au développement durable (CGDD) ont partagé le constat d'un besoin de coordination et d'échange d'outils et de pratiques entre les services qui, dans les territoires, travaillent à la réduction des inégalités de santé, en agissant sur leurs déterminants sociaux et environnementaux. Pour répondre à ce besoin, le SGMAS et le CGDD ont constitué un comité de pilotage interministériel associant les représentants des principales administrations concernées : Direction générale de la santé (DGS), Direction générale de la prévention des risques (DGPR), Direction générale de la cohésion sociale, (DGCS), Délégation interministérielle à l'aménagement du territoire et à l'attractivité régionale (Datar), Agences régionales de santé (ARS), Directions régionales de l'environnement, l'aménagement, du logement (Dreal), ainsi que divers experts. Début 2013, ce comité a lancé une enquête, pilotée par la Fédération nationale des observatoires régionaux de la santé (Fnors), auprès des ARS, des Dreal et des directions régionales de la jeunesse, de la santé et de la cohésion sociale (DRJSCS). Ce travail a permis de repérer les démarches les plus probantes, en termes de méthodes et outils de diagnostic et d'élaboration de politiques conjointes par les services et opérateurs de l'État en région. Cette démarche permet aujourd'hui de mieux connaître et

faire connaître les initiatives régionales ou locales, encore peu nombreuses, qui s'attachent à croiser les dimensions sociales, environnementales et territoriales de la santé. À travers une série d'exemples dans des territoires divers, cette publication révèle les facteurs de succès et les limites rencontrées pour élaborer des diagnostics multidimensionnels complexes, et des coopérations exemplaires entre institutions. Elle ouvre la voie d'une meilleure gouvernance au niveau des régions, et entre les régions au plan national.
http:www.developpement-durable.gouv.fr/IMG/pdf/140221_Inegalites_territoriales_environnementales_sociales_de_sante.pdf

Inégalités de santé / Health Inequalities

Pampalon R., Hamel D., Gamache P., et al. (2014). Valider un indice de défavorisation en santé publique : un exercice complexe, illustré par l'indice québécois. *Maladies Chroniques et Blessures Au Canada,* 34 (1) :

Abstract: Malgré l'usage répandu d'indices de défavorisation en santé publique, leur validation est rarement abordée de manière explicite ou élaborée, car il s'agit là d'un exercice complexe. En nous fondant sur les propositions de chercheurs britanniques, nous avons cherché à valider l'indice québécois de défavorisation matérielle et sociale en utilisant des critères de validité (validité de contenu, validité sur critère et validité de construit), de fiabilité, de sensibilité et d'autres propriétés pertinentes en santé publique (intelligibilité, objectivité et praticabilité). Nous avons passé en revue la littérature internationale sur les indices de défavorisation ainsi que les publications et les utilisations de l'indice québécois et nous avons ajouté des données factuelles. Après examen, il apparait que l'indice québécois répond favorablement aux critères et propriétés de validation proposés. Des validations additionnelles s'imposent toutefois afin de mieux cerner les facteurs contextuels associés à cet indice.
http://www.phac-aspc.gc.ca/publicat/cdic-mcbc/34-1/assets/pdf/CDIC_MCC_Vol34_1_3_Pampalon_F.pdf

Benzeval M., Bond L., Campbell M., et al. (2014). How does money influence health ? York : Joseph Rowntree Foundation .

Abstract: This report explores the association between income and health throughout the life course and Improving the income of the poorest members of society is often proposed as a way of improving their health, and hence reducing health inequalities. However, for this policy to be effective, it is important to understand how money influences health. Effective policy responses must take all the factors that link income and health into account. The report identifies key theories that explain how money influences health, including: materialist arguments: for example, money buys health-promoting goods and the ability to engage in a social life in ways that enable people to be healthy; psychosocial mechanisms: for example, the stress of not having enough money may affect health; behavioural factors: people living in disadvantaged circumstances may be more likely to have unhealthy behaviours; being in poor health may affect education and employment opportunities in ways that affect subsequent health.
http:www.jrf.org.uk/sites/files/jrf/income-health-poverty-full.pdf

Ndumbe-Eyoh S. Moffat H. (2014). Intersectoral action for health equity: a rapid systematic review. *Bmc Public Health,* 13 (1056)

Abstract: Background: Action on the social determinants of health is considered a necessary approach to improving health equity. Most of the social determinants of health lie outside the sphere of the health sector and thus collaboration with governmental and non-governmental sectors outside of health are required to develop policies and programs to improve health equity. Case studies of intersectoral action are available, however there is limited information about the impact of intersectoral action on the social determinants of health and health equity. Methods: Search and retrieval of literature published between 2001 and 2011 was conducted in 6 databases. A staged screening of titles and abstracts, and later full-text, was conducted by two independent reviewers. Reviewers independently assessed the quality of the articles deemed relevant for inclusion. Data were extracted

and synthesized in narrative format for all included studies, conducted by one reviewer and checked by another. Results: 17 articles of varied methodological quality met the inclusion criteria. One systematic review investigating partnership interventions found mixed and limited impacts on health outcomes. Primary studies evaluating the impact of upstream and midstream interventions showed mixed effects. Downstream interventions were generally moderately effective in increasing the availability and use of services by marginalized communities. Conclusions: The literature evaluating the impact of intersectoral action on health equity is limited. The included studies identified reveal a moderate to no effect on the social determinants of health. The evidence on the impact of intersectoral action on health equity is even more limited. The lack of evidence should not be interpreted as a lack of effect. Rigorous evaluations of intersectoral action are needed to strengthen the evidence base of this public health practice.
http:www.biomedcentral.com/1471-2458/13/1056

Ottersen O.O., Dasgupta J., Blouin C., et al. (2014). The political origins of health inequity: prospects for change. *The Lancet,* 383 (9917)

Abstract: The unacceptable health inequities within and between countries cannot be addressed within the health sector, by technical measures, or at the national level alone, but require global political solutions. Norms, policies, and practices that arise from transnational interaction should be understood as political determinants of health that cause and maintain health inequities. Power asymmetry and global social norms limit the range of choice and constrain action on health inequity; these limitations are reinforced by systemic global governance dysfunctions and require vigilance across all policy arenas. There should be independent monitoring of progress made in redressing health inequities, and in countering the global political forces that are detrimental to health. State and non-state stakeholders across global policy arenas must be better connected for transparent policy dialogue in decision-making processes that affect health. Global governance for health must be rooted in commitments to global solidarity and shared responsibility; sustainable and healthy development for all requires a global economic and political system that serves a global community of healthy people on a healthy planet.
http:download.thelancet.com/pdfs/journals/lancet/PIIS0140673613624071.pdf?id=aaaxcUHp78_bYhrMSTqtu

Garcia-Gomez P., Hernandez-Quevedo C., Jimenez-Rubio D. (2014). Inequity in long-term care use and unmet need: two sides of the same coin. York : HEDG

Abstract: International studies have shown evidence on inequity in use of health services of different kinds, depending on the type of health care service analysed. However, equity in the access to long-term care (LTC) services has received much less attention. We investigate the determinants of several LTC services and the existence of unmet need by the disabled population using unique data from a survey conducted on the disabled population in Spain in 2008. We further measure the level of horizontal inequity using methods based on the Concentration Index, a widely used indicator of income-related inequality in health. At the time of the analysis, only those respondents with the highest dependency level were covered by the recently introduced universal LTC system, which allows us to explore whether inequities remain for this subgroup of the population. In addition, we compare results using self-reported versus a more objective indicator of unmet needs. Evidence suggests that after controlling for a wide set of need variables, there is not an equitable distribution of use and unmet need of LTC services in Spain, with socioeconomic status being an important factor in access to LTC. We find that individuals at the higher end of the income distribution utilize a relatively larger share of formal services (provided by a professional), while intensive informal care (provided by friends and family) is concentrated among the worst-off. In terms of unmet needs for LTC services, their distribution depends on the service considered as well as on whether we focus on subjective or objective measures. Interestingly, for the population covered by the new universal LTC system, inequities in most LTC services and unmet needs remain statistically significant and even increase for certain services, in particular, formal services provided by professionals.
http:eprints.lse.ac.uk/55429

Heckmann J.J., Humphries J.E., Veramendi G. (2014). Education, Health and Wages. Cambridge : NBER

Abstract: This paper develops and estimates a model with multiple schooling choices that identifies the causal effect of different levels of schooling on health, health-related behaviors, and labor market outcomes. We develop an approach that is a halfway house between a reduced form treatment effect model and a fully formulated dynamic discrete choice model. It is computationally tractable and identifies the causal effects of educational choices at different margins. We estimate distributions of responses to education and find evidence for substantial heterogeneity in unobserved variables on which agents make choices. The estimated treatment effects of education are decomposed into the direct benefits of attaining a given level of schooling and indirect benefits from the option to continue on to further schooling. Continuation values are an important component of our estimated treatment effects. While the estimated causal effects of education are substantial for most outcomes, we also estimate a quantitatively important effect of unobservables on outcomes. Both cognitive and socioemotional factors contribute to shaping educational choices and labor market and health outcomes. We improve on LATE by identifying the groups affected by variations in the instruments. We find benefits of cognition on most outcomes apart from its effect on schooling attainment. The benefits of socioemotional skills on outcomes beyond their effects on schooling attainment are less precisely estimated.
http:papers.nber.org/papers/w19971

Médicaments / Pharmaceuticals

Toumi M., Remuzat C., Vataire A. L., et al. (2013). External reference pricing of medicinal products: simulation-based considerations for cross-country coordination. Bruxelles : Commission Européenne .

Abstract: This project aimed to build a theoretical external reference pricing (ERP) model including the main ERP characteristics, based on 28 EU Member States, as well as Iceland, Norway, and Switzerland. This model was used to assess the price dynamics through ERP-based systems and the impact of changes in ERP policies using several scenarios.
http:ec.europa.eu/health/healthcare/docs/erp_reimbursement_medicinal_products_en.pdf

Vogler S., Zimmerman N., Habimana K. (2014). Study of the policy mix for the reimbursement of medicinal products. **Proposal for a best practice-based approach based on stakeholder assessment.** Bruxelles : Commission Européenne .

Abstract: The objective of this study was to investigate which policy mix related to the reimbursement of medicines the consulted stakeholders would consider as ideal and, based on their assessments investigated in a Multi-Criteria Decision Analysis (MCDA), to develop a proposal for the best practice-based approach for such a policy mix, by reconciling the different – often conflicting – policy objectives.
http:ec.europa.eu/health/healthcare/docs/policymix_final_report_excl_annexes_cleared.pdf

Maes E. Daemens.R. (2014). Global Pharmaceutical Management: Building a Fair Pricing Policy. Maastricht : Maastricht school of Management

Abstract: Improving access to healthcare globally represents a pressing societal challenge requiring a comprehensive approach. Stakeholders will need to work together in their quest to finding sustainable solutions that promote universal access to care. In addition, there is a need to better define the distinctive roles of the different stakeholders in the area of global access to pharmaceuticals. While the main task of innovation-driven pharmaceutical companies is to develop high quality, innovative medicines that address unmet needs, they can through their pricing policies influence the affordability of these medicines. Given this responsibility and the impact this will have on society and public health, companies have to be conscious about designing affordable pricing strategies. Since pricing is an important factor in the mix of activities to enhance access, the role of industry in the wider public domain is to be a trustworthy partner. Yet, industry cannot be held solely responsible for securing 'health for all' which is considered the prerogative of government. To maximize industry's contribution, we recommend using a differentiated, equitable pricing policy aimed at enhancing access. We

developed a number of pricing scenarios to establish an optimal balance that would allow stimulating both innovation and access.
http:web2.msm.nl/RePEc/msm/wpaper/MSM-WP2014-05.pdf

Hellander E.L.D., Malani A., et al. (2014). Unintended Consequences of Products Liability: Evidence from the Pharmaceutical Market. Cambridge : NBER

Abstract: In a complex economy, production is vertical and crosses jurisdictional lines. Goods are often produced by an upstream national or global firm and improved or distributed by local firms downstream. In this context, heightened products liability may have unintended consequences on product sales and consumer safety. Conventional wisdom holds that an increase in tort liability on the upstream firm will cause that firm to (weakly) increase investment in safety or disclosure. However, this may fail in the real-world, where upstream firms operate in many jurisdictions, so that the actions of a single jurisdiction may not be significant enough to influence upstream firm behavior. Even worse, if liability is shared between upstream and downstream firms, higher upstream liability may mechanically decrease liability of the downstream distributor and encourage more reckless behavior by the downstream firm. In this manner, higher upstream liability may perversely increase the sales of a risky good. We demonstrate this phenomenon in the context of the pharmaceutical market. We show that higher products liability on upstream pharmaceutical manufacturers reduces the liability faced by downstream doctors, who respond by prescribing more drugs than before.
http:papers.nber.org/papers/w20005

Conti R.M., Berndt E.R. (2014). Specialty Drug Prices and Utilization After Loss of U.S. Patent Exclusivity 2001-2007. Cambridge : NBER

Abstract: We examine the impact of loss of U.S. patent exclusivity (LOE) on the prices and utilization of specialty drugs between 2001 and 2007. We limit our empirical cohort to drugs commonly used to treat cancer and base our analyses on nationally representative data from IMS Health. We begin by describing the average number of manufacturers entering specialty drugs following LOE. We observe the number of firms entering the production of newly generic specialty drugs ranges between two and five per molecule in the years following LOE. However, the existence of time-varying and unobservable contract manufacturing practices complicates the definition of "manufacturers" entering the market. We use pooled data methods to examine whether the neoclassical relationship between price declines and volume increases upon LOE holds among these drugs. First, we examine the extent to which estimated prices of these drugs undergoing LOE fall with generic entry. Second, we estimate reduced form random effect models of utilization subsequent to LOE. We observe substantial price erosion after generic entry; average monthly price declines appear to be larger among physician-administered drugs (38-46.4%) compared to oral drugs (25-26%). Additionally, we find average prices for drugs produced by branded firms rise and prices for drugs produced by generic firms fall upon LOE; the latter effect is particularly large among oral drugs. In pooled models, volume appears to increase following generic entry, but this result appears to be largely driven by oral drugs. Molecule characteristics, number of manufacturers and 2007Q4 revenues are significant predictors of post-2007 drug shortages. We discuss second best welfare consequences of these results.
http:papers.nber.org/papers/w20016

Méthodologie – Statistique / Methodology - Statistics

Imbes G.W. (2014). Matching Methods in Practice: Three Examples. Cambridge : NBER

Abstract: There is a large theoretical literature on methods for estimating causal effects under unconfoundedness, exogeneity, or selection--on--observables type assumptions using matching or propensity score methods. Much of this literature is highly technical and has not made inroads into empirical practice where many researchers continue to use simple methods such as ordinary least squares regression even in settings where those methods do not have attractive properties. In this paper I discuss some of the lessons for practice from the theoretical literature, and provide detailed recommendations on what to do. I illustrate the recommendations with three detailed applications.
http:papers.nber.org/papers/w19959

Imbes G.W. (2014). Instrumental Variables: An Econometrician's Perspective. Cambridge : NBER

Abstract: I review recent work in the statistics literature on instrumental variables methods from an econometrics perspective. I discuss some of the older, economic, applications including supply and demand models and relate them to the recent applications in settings of randomized experiments with noncompliance. I discuss the assumptions underlying instrumental variables methods and in what settings these may be plausible. By providing context to the current applications a better understanding of the applicability of these methods may arise.
http:papers.nber.org/papers/w19983

Politique de santé / Health Policy

Mckee M., Busse R., Baeten R., et al. (2013). EU Crossborder health care collaboration. *Eurohealth,* 19 (4)

Abstract: This issue of Eurohealth explores various topics related to the European Directive on the application of patients' rights in cross-border health care. Ten case studies look at specific aspects of EU cross-border health care collaboration, particularly at potential obstacles not fully covered by the Directive. Other articles look at dispensing prescriptions across EU Member States, European public health strategies, oral health in Europe, reporting health care waste in the Netherlands, the chronic care system in Spain, scaling-up e-health in Catalonia and dental health services for migrants in Cyprus.
http:www.euro.who.int/__data/assets/pdf_file/0003/236811/Eurohealth_v19-n4.pdf

(2014). Health in all policies (HIAP) ; framework for country action. Paris : OMS
Abstract: La 8e Conférence Internationale sur la Promotion de la Santé s'est tenue en juin 2013, à Helsinki. Cette conférence avait pour thème : « Health in all policies ». L'Organisation Mondiale de la Santé (OMS), publie, à la suite de cette conférence, un guide rapide d'intégration des questions de santé dans toutes les décisions politiques. Le guide rappelle la constitution de l'OMS selon laquelle les Gouvernements ont la responsabilité de la santé de leur peuple, ce but ne pouvant être atteint que par l'établissement de décisions de santé et de mesures sociales adéquates. Le concept de « santé dans toutes les politiques » reflète les principes de comptabilité et de transparence des gouvernants et de leurs décisions. Pourquoi ce concept est-il important ? Selon l'OMS, la santé et l'égalité à la santé sont des droits mais aussi des pré-requis à d'autres objectifs sociétaux.
http:www.who.int/cardiovascular_diseases/140120HPRHiAPFramework.pdf?ua=1

Brekke K., Levaggi R., Siciliani L. (2014). Patient Mobility - Health Care Quality and Welfare. Munich : CESifo.

Abstract: Patient mobility is a key issue in the EU who recently passed a new law on patients' right to EU-wide provider choice. In this paper we use a Hotelling model with two regions that differ in technology to study the impact of patient mobility on health care quality, health care financing and welfare. We show that without patient mobility quality is too low (high) and too few (many) patients are treated in the high-skill (low-skill) region. The effects of patient mobility depend on the transfer payment. If the payment is below marginal cost, mobility leads to a 'race-to-the-bottom' in quality and lower welfare in both regions. If the payment is equal to marginal cost, quality and welfare remain unchanged in the high-skill region, but the low-skill region benefits. For a socially optimal payment, which is higher than marginal cost, quality levels in the two regions are closer to (but not at) the first best, but welfare is lower in the low-skill region. Thus, patient mobility can have adverse effects on quality provision and welfare unless an appropriate transfer payment scheme is implemented.
https:www.cesifo-group.de/DocDL/cesifo1_wp4576.pdf

Wolfe I., Mckee M., Thompson M., et al. (2014). Strengthening child health and health services. *Eurohealth,* 20 (1)

Abstract: Ce numéro traite de la santé des enfants en Europe. L'article principal examine l'état actuel de la santé des enfants et propose des recommandations pour le renforcement des services et des systèmes de santé pour enfants. Le numéro comprend aussi des articles sur les soins primaires destinés aux enfants, la santé publique, la santé mentale et la prescription à l'intention des enfants.
http:www.euro.who.int/__data/assets/pdf_file/0009/244863/EuroHealth-v20-n1.pdf

Domin J.P., Malone A., Abecassis P., et al (2014). Pour une élaboration démocratique des priorités de santé. *Sève : les Tribunes de la Santé,* n° HS.

Abstract: La question des priorités de santé se pose avec insistance dans une période de tensions économiques où les régimes d'assurance maladie connaissent des déficits récurrents. Mais les priorités peuvent se penser autrement que dans la pensée restrictive de la dépense de santé comme un coût. Comment alors élaborer des politiques qui garantissent l'égal accès aux soins et respectent les exigences de justice et de solidarité ? Comment parvenir à une définition des priorités de santé avec les citoyens, les représentants d'associations d'usagers et l'ensemble des autres acteurs du système de santé ? Ces questions ont été au cœur du colloque scientifique international dont les textes ont été rassemblés dans ce numéro spécial.

(2014). Santé, l'état d'urgence. *Alternatives Economiques - Poche,* (66

Abstract: Le titre de ce fascicule peut paraître excessif. Au début des années 2000, l'Organisation mondiale de la santé (OMS) considérait le système de santé français comme le meilleur du monde. Mais en quinze ans, le visage sanitaire de la France a changé. Ce numéro spécial rassemble de nombreuses contributions réalisées par des spécialistes du secteur (comme Brigitte Dormont, Didier Tabuteau, Etienne Caniard...), articulées autour des thématiques suivantes : Pourquoi nous sommes de plus en plus malades ? la fin d'un système et à la recherche d'un nouveau modèle.
http:www.alternatives-economiques.fr/sante--l-etat-d-urgence_fr_pub_1284.html

Soins de santé primaires / Primary Health Care

Samson M.L., Dormont B. (2014). Does it pay to be a doctor in France? Paris : Univerité Paris Dauphine

Abstract: This paper examines whether general practitioners(GPs) earnings are high enough to keep this profession attractive. It sets up two samples, with longitudinal data relative to GPs and executives. Those two professions have similar abilities but GPs have chosen a longer education. To measure if they get returns that compensate for their higher investment, this study analyses their career profiles and construct a measure of wealth for each individual that takes into account all earnings accumulated from the age of 24 (including zero income years when they start their career after 24). The stochastic dominance analysis shows that wealth distributions do not differ significantly between male GPs and executives but that GP wealth distribution dominates executive wealth distribution at the first order for women. Hence, while there is no monetary advantage or disadvantage to be a GP for men, it is more profitable for women to be a self-employed GP than a salaried executive.
http:basepub.dauphine.fr/xmlui/bitstream/handle/123456789/12810/samsondormont.pdf

Castonguay J. (2014). Le financement des soins chroniques. Montréal : CIRANO

Abstract: Ce rapport décrit les réformes et les mécanismes de financement des soins chroniques en Allemagne, Danemark, Pays-Bas et Royaume-Uni. Il présente ensuite des recommandations pour le Québec. Les incitatifs (financiers ou autres) et un soutien continu à la transformation sont essentiels. Il propose un financement par capitation ajusté au risque pour le suivi des patients présentant des maladies chroniques.

http:www.cirano.qc.ca/pdf/publication/2014RP-03.pdf

Mumford V., Haas M. (2014).Nurse Practitioners and Physician Assistants: Adapting models of care to changing demographics.sl: RefinedFact

Abstract: In order to combat predicted shortages in health workers and to adapt to a changing patterns of health care in Australia a number of programs have been introduced or piloted. Some of these are aimed at retaining existing health workers through recognizing advanced training and skill attainment. Other programs are aimed at introducing new roles to both complement and substitute existing practices of care. This paper discusses two of these roles: Nurse Practitioners (NP) and Physician Assistants (PA). Both of these professions are part of accepted practice in a number of countries; Table 1 summarises a comparison with other English speaking OECD countries (United Kingdom, United States, Canada and New Zealand).
http:refinephc.org.au/wp-content/uploads/2013/06/Refine-Factsheet-No-5-.pdf

Dinh T., Stonebridge C., Theriault L. (2014). Recommendations for Action: Getting the Most out of Interprofessional Primary Health Care Teams. Ottawa : The Conference Board of Canada .

Abstract: This is the final report in a series on primary care by the Conference Board of Canada. It uses three research approaches to arrive at recommendations for improving interprofessional primary care in Canada. The nine recommendations are designed to help government decision-makers, primary care leaders, other care providers and patients get the most out of the interprofessional team experience.
http:www.conferenceboard.ca/e-library/abstract.aspx?did=5988

Kesternich I., Schumacher H., Winter J. (2014). Professional norms and physician behavior: homo oeconomicus or homo hippocraticus ?

Abstract: Physicians' treatment decisions determine the level of health care spending to a large extent. The analysis of physician agency describes how doctors trade off their own and their patients' benefits, with a third party (such as the collective of insured individuals or the taxpayers) bearing the costs. Professional norms are viewed as restraining physicians' self-interest and as introducing altruism towards the patient. We present a controlled experiment that analyzes the impact of professional norms on prospective physicians' trade-offs between her own profits, the patients' benefits, and the payers' expenses for medical care. We find that professional norms derived from the Hippocratic tradition shift weight to the patient in the physician's decisions while decreasing his self-interest and efficiency concerns.
http:ideas.repec.org/p/trf/wpaper/456.html

Mason A., Goddard M., Weatherly H. (2014). Financial Mechanisms for Integrating Funds for Health and Social Care: An Evidence Review. York : University of York

Abstract: Integrated care is often perceived as a solution for some of the major challenges faced by health and social care systems. In these systems, 20% of the population accounts for 80% of the expenditure on care [1]. These ‘high users’ are typically people with one or more long-term conditions and who have complex needs that straddle health and social care boundaries; the population includes, but is not limited to, older people. By coordinating care at the level of the individual, decision makers should in theory identify problems earlier in the care pathway and shift care closer to home, improve the patient experience, prevent or reduce avoidable hospital admissions and delayed discharges, improve health outcomes and reduce unnecessary duplication of care. However, empirical studies of integrated care systems suggest that the reality falls far short of these high expectations. While some evaluations have identified cost savings or improved outcomes, most find no significant benefits, and in those that do identify improvements, the effects are small.
http:www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP97_Financial_mechanisms_integrating_funds_healtthcare_social_care_.pdf

Peikes D.N., Reid R.J., Day T.J., et al. (2014). Staffing Patterns of Primary Care Practices in the Comprehensive Primary Care Initiative. *Annals of Family Medicine,* 12 (2) :

Abstract: PURPOSE : Despite growing calls for team-based care, the current staff composition of primary care practices is unknown. We describe staffing patterns for primary care practices in the Centers for Medicare and Medicaid Services (CMS) Comprehensive Primary Care (CPC) initiative. METHODS We undertook a descriptive analysis of CPC initiative practices' baseline staffing using data from initial applications and a practice survey. CMS selected 502 primary care practices (from 987 applicants) in 7 regions based on their health information technology, number of patients covered by participating payers, and other factors; 496 practices were included in this analysis. RESULTS Consistent with the national distribution, most of the CPC initiative practices included in this study were small: 44% reported 2 or fewer full-time equivalent (FTE) physicians; 27% reported more than 4. Nearly all reported administrative staff (98%) and medical assistants (89%). Fifty-three percent reported having nurse practitioners or physician assistants; 47%, licensed practical or vocational nurses; 36%, registered nurses; and 24%, care managers/coordinators—all of these positions are more common in larger practices. Other clinical staff were reported infrequently regardless of practice size. Compared with other CPC initiative practices, designated patient-centered medical homes were more likely to have care managers/coordinators but otherwise had similar staff types. Larger practices had fewer FTE staff per physician. CONCLUSIONS At baseline, most CPC initiative practices used traditional staffing models and did not report having dedicated staff who may be integral to new primary care models, such as care coordinators, health educators, behavioral health specialists, and pharmacists. Without such staff and payment for their services, practices are unlikely to deliver comprehensive, coordinated, and accessible care to patients at a sustainable cost.
http:annfammed.org/content/12/2/142.full.pdf

Ono T., Schoestein M., Buchan J. (2014). Geographic Imbalances in Doctor Supply and Policy Responses. Paris : OCDE

Abstract: Doctors are distributed unequally across different regions in virtually all OECD countries, and this causes concern about how to continue to ensure access to health services everywhere. In particular access to services in rural regions is the focus of attention of policymakers, although in some countries, poor urban and sub-urban regions pose a challenge as well. Despite numerous efforts this mal-distribution of physician supply persists. This working paper first examines the drivers of the location choice of physicians, and second, it examines policy responses in a number of OECD countries.
http:dx.doi.org/10.1787/5jz5sq5ls1wl-en

Systèmes de santé / Health Systems

Van Den Bosh K, Willeme P. (2014). La signification sociale des soins de santé. Bruxelles : Bureau Fédéral du Plan.
Abstract: Le présent rapport tente de rendre compte de la signification sociale des soins de santé et de l'assurance publique soins de santé en Belgique. Pour ce faire, nous abordons trois questions plus spécifiques. La première question est la suivante : de quelle manière les soins de santé ont-ils contribué à améliorer l'état de santé de la population ? Cette question sort en quelque sorte du cadre strict de l'assurance publique soins de santé gérée par l'INAMI. En effet, l'amélioration de la santé n'a pas explicitement été citée comme objectif de la sécurité sociale, ni en 1944/5 ni en 1963. Dans un même temps, il paraît évident que les partenaires sociaux n'ont organisé la protection sociale contre le coût des soins de santé que parce qu'ils partaient (implicitement) du principe que cette protection serait au bénéfice de la santé de la population. Compte tenu de la formidable expansion des soins de santé et des dépenses découlant de l'assurance obligatoire soins de santé après 1963 (voir ci-après), l'on peut légitimement se demander dans quelle mesure les soins de santé ont effectivement contribué à améliorer l'état de santé de la population. Ce rapport montre qu'il n'est pas si évident de répondre à cette question. La deuxième question a trait à la signification économique de la branche des soins de santé. Trop souvent, les soins de santé publics sont considérés comme un coût et un poids économique, alors qu'ils représentent aussi une branche qui propose des services de valeur et qui emploie de nombreux travailleurs. En outre, les soins de santé peuvent être considérés comme un investissement en capital humain qui profite à la fois au bien-être individuel et national. La troisième

question qui est posée est de savoir si les soins de santé et l'assurance maladie publique ont contribué à une distribution égalitaire de la santé, une égalité d'accès aux soins de santé et plus généralement une distribution plus égalitaire des ressources et opportunités. En effet, les objectifs explicites du système public de soins de santé et de l'assurance maladie obligatoire étaient l'accès universel aux soins de santé, avec une répartition solidaire des coûts. Un chapitre distinct est consacré aux indemnités de maladie ou d'invalidité. Enfin, le dernier chapitre rassemble les conclusions des différents chapitres. (Tiré de l'introduction).
http://www.plan.be/publications/publication_det.php?lang=fr&KeyPub=1300

Holahan J., Blumberg M.J., Goughlin T. (2014). The launch of health reform in eight states : state flexibility is leading to very different outcomes. Washington : The Urban Institute .

Abstract: Ce document présente les résultats d'une série d'études qui se sont penchées sur la mise en œuvre de l'Affordable Care Act dans huit États américains. Ces États – l'Alabama, le Colorado, le Maryland, le Michigan, le Minnesota, New York, l'Oregon et la Virginie – ont fait des choix très variés quant à la conception et à l'application de la loi, allant des systèmes informatiques à l'aide à l'inscription. Les auteurs concluent que la loi fonctionne très différemment pour les résidents des divers États et qu'on peut s'attendre à des résultats dissemblables en matière de couverture et d'impact économique.
http:www.urban.org/UploadedPDF/413035-The-Launch-of-Health-Reform-in-Eight-States-State-Flexibility-Is-Leading-to-Very-Different-Outcomes.pdf

Travail et santé / Occupational Health

Daysal N.M., Orsini C. (2014). The Miracle Drugs: Hormone Replacement Therapy and Labor Market Behavior of Middle-Aged Women. Bonn : IZA

Abstract: In an aging society, determining which factors contribute to the employment of older individuals is increasingly important. We examine the impact of medical innovations on the employment of middle-aged women focusing on the specific case of Hormone Replacement Therapy (HRT), a common treatment for the alleviation of negative menopausal symptoms. HRT medications were among the most popular prescriptions in the United States until 2002 when the Women's Health Initiative Study - the largest randomized control trial on women ever undertaken - documented the health risks associated with their long term use. We exploit the release of these findings within a Fixed Effect Instrumental Variable framework to address the endogeneity in HRT use. Our results indicate substantial benefits of HRT use to the short-term employment of middle-aged women.
http:ftp.iza.org/dp7993.pdf

Caliendo M., Gehrsitz M. (2014). Obesity and the Labor Market: A Fresh Look at the Weight Penalty. Berlin : DIW

Abstract: This paper applies semiparametric regression models to shed light on the relationship between body weight and labor market outcomes in Germany. We find conclusive evidence that these relationships are poorly described by linear or quadratic OLS specifications, which have been the main approaches in previous studies. Women's wages and employment probabilities do not follow a linear relationship and are highest at a body weight far below the clinical threshold of obesity. This indicates that looks, rather than health, is the driving force behind the adverse labor market outcomes to which overweight women are subject. Further support is lent to this notion by the fact that wage penalties for overweight and obese women are only observable in white-collar occupations. On the other hand, bigger appears to be better in the case of men, for whom employment prospects increase with weight, albeit with diminishing returns. However, underweight men in blue-collar jobs earn lower wages because they lack the muscular strength required in such occupations.

St-Arnaud L., Pelletier M., Vezina M., et al. (2014). Santé mentale au travail - Projet-pilote pour passer d'une approche individuelle de réadaptation à une approche organisationnelle de prévention : Montréal : IRSST .

Abstract: Cette étude analyse le parcours des personnes absentes du travail pour des raisons de santé mentale et qui avaient identifié le travail comme facteur ayant contribué à la détérioration de leur santé et à leur arrêt de travail. Les problèmes de santé mentale au travail représentent actuellement l'une des plus importantes causes d'absence du travail, et ce phénomène a connu une croissance marquée au cours des dernières années. Des recherches antérieures ont révélé que la majorité des travailleurs qui se sont absentés en raison d'un problème de santé mentale font référence aux difficultés vécues dans le cadre de leur activité professionnelle comme facteur ayant contribué à la détérioration de leur état de santé et de leur arrêt de travail. Cette recherche essaie de tracer le passage d'une démarche individuelle de soutien au retour au travail et au maintien en emploi des travailleurs qui se sont absentés en raison d'un problème de santé mentale à une démarche organisationnelle visant la prévention des problèmes de santé mentale dans le milieu de travail. Les chercheurs ont développé une stratégie de soutien au retour au travail axée sur les activités de travail et sur la mise en place, à partir de situations réelles et en collaboration avec le supérieur immédiat, d'interventions en prévention tertiaire (s'adressant directement aux travailleurs affectés). De plus, les interventions réalisées sont susceptibles de toucher les travailleurs qui ne se sont pas encore absentés, mais qui pourraient être visés par les situations de travail à l'origine de l'absence d'autres travailleurs.
http:www.irsst.qc.ca/media/documents/PubIRSST/R-807.pdf

Kropfhausser F., Sunder M. (2014). A weighty issue revisited: the dynamic effect of body weight on earnings and satisfaction in Germany. Berlin : DIW

Abstract: This paper estimates the relationship between changes in the body mass index (bmi) and wages or satisfaction, respectively, in a panel of German employees. In contrast to previous literature, the dynamic models indicate that there is an inverse u-shaped association between bmi and wages among young workers. Among young male workers, work satisfaction is affected beyond the effect on earnings. Our finding of an implied optimum bmi in the overweight range could indicate that the recent rise in weight does not yet constitute a major limitation to productivity.
http:www.diw.de/documents/publikationen/73/diw_01.c.439709.de/diw_sp0635.pdf

Chappert F. (2014). Photographie statistique des accidents de travail, des accidents de trajet et des maladies professionnelles en France selon le sexe entre 2001 et 2002 : Lyon : ANACT.

Abstract: Ce rapport de l'Anact met à jour l'analyse de données de santé au travail (accidents de travail, accidents de trajet, et maladies professionnelles reconnues) fournies par la CNAMTS au regard du genre. Cette analyse sexuée par branche d'activité renouvelle et questionne les conditions de travail des femmes et des hommes salariés en France. Il met notamment en lumière l'existence d'inégalités entre les hommes et les femmes en matière de santé au travail.
http:www.anact.fr/web/actualite/RSS?p_thingIdToShow=36977640

Meyer S.C. (2014). Do Occupational Demands Explain the Educational Gradient in Health ? Bonn : IZA

Abstract: The aim of this paper is to investigate to what extent occupation-specific demands explain the relationship between education and health. We concentrate on ergonomic, environmental, psychical, social and time demands. Merging the German Microcensus 2009 data with a dataset including detailed occupational demands (German Employment Survey 2006), we have a unique dataset to analyze the mediating role of occupational demands in the relationship between education and health status on the one hand and education and health behavior (BMI and smoking) on the other. We base our analyses on the entire working population and therefore also include those who no longer work, taking occupational demands related to their last job. First, we find that occupational demands are significantly related to subjective health and health behaviors. This holds even stronger for those who are no longer employed. Second, we find that whereas occupational demands do not explain educational differences in subjective health status, they do partially mediate the education

gradient in the considered health behaviors. Educational differences in smoking status can partly be explained by ergonomic, environmental, psychical and social demands. The educational gradient in BMI is partly attributable to social occupational demands.
http:ftp.iza.org/dp8011.pdf

Vieillissement / Ageing

Falconnet M., Morin L. (2014). La société face au vieillissement : le risque d'un «naufrage social. Série "Analyses". Paris : Observatoire National de la Fin de Vie

Abstract: Comment maintenir la participation sociale des personnes vieillissantes ? Doit-on considérer la solitude et la dépression des personnes âgées malades ou handicapées comme des phénomènes normaux et acceptables ? Pourquoi répond-on mal aux besoins des personnes handicapées vieillissantes ? Quels besoins pour les personnes vieillissantes atteintes d'un handicap psychique ? Ce document d'analyse, qui s'appuie en partie sur les réflexions d'un groupe de travail animé par l'Observatoire national de la fin de vie (ONFV), se propose de faire émerger les principaux enjeux de société autour du vieillissement et de rendre visible des réalités qui souvent ne le sont pas. Son but est aussi de mettre en lumière des initiatives locales intéressantes.
https:sites.google.com/site/fichiersonfv/home/ONFV%202014%20-%20Analyse%20-%20La%20Socie%CC%81te%CC%81%20Face%20au%20Vieillissement.pdf?attredirects=0

Santos S. (2014). Studying the Socio-Economics of Ageing using Social Accounting and Socio-Demographic Matrices. An application to Portugal. Münich : MRPA

Abstract: In looking for empirical evidence about the activity of countries, a proposal is made for studying (measuring and modelling) the activity of countries through the use of Social Accounting Matrices (SAMs) and Socio-Demographic Matrices (SDMs). SAMs and SDMs are presented as tools that have specific features for conducting studies in several different areas, particularly in the Socio-Economics of Ageing, as well as for supporting policy decision processes. Based on methodological principles that are derived mainly from the works of Richard Stone, emphasis is placed on the desirability of working in a matrix format, which includes not only people (SDM), but also, at the same time, activities, products, factors of production and institutions (SAM). This is considered to be a way of capturing the relevant network of linkages and the corresponding multiplier effects for the subsequent modelling of the activity of the countries studied. The exposition of this proposal is accompanied by an example applied to Portugal.
http:mpra.ub.uni-muenchen.de/53858/1/MPRA_paper_53858.pdf

Sugarwara S. N. (2014). Can Formal Elderly Care Stimulate Female Labor Supply? The Japanese Experience. Tokyo : University of Tokyo

Abstract: This study analyzes the impacts of the Japanese Long-Term Care Insurance (LTCI), a decade after its launch, with respect to the female labor supply in Japan. The radical program has caused the emergence of markets for various care services apart from permanent institutional care, which is only a major formal care sector in many developed countries. The availability of various formal care services can stimulate female labor supply through a reduction of the burden of informal caregiving. To investigate the impacts of the LTCI, we compare the labor market behavior of females who face requirements for elderly care in their household for three periods before the launch of the LTCI, four years after the launch, and ten years after the launch. Our empirical analysis indicates positive effects of the launch and diffusion of the LTCI on female labor supply. As a result of the LTCI, care for male elders is no longer an obstacle for female labor supply, but care for female elders is still burdensome. We also find that the care requirement reduces the probability of being a regular worker; however, regular workers are more likely to utilize formal care, whereas many non regular workers provide informal care by themselves.
http:www.cirje.e.u-tokyo.ac.jp/research/dp/2014/2014cf924.pdf

Wildman J., McMeekin P. (2014). Health care and social care: complements, substitutes and attributes. Münich : MRPA

Abstract: Ageing populations are a major challenge for most developed countries, where social security systems were developed in the post war period. It has been suggested that the costs of caring for the ageing population places a considerable strain on individuals, as well as on the public purse, and many countries are looking for ways to reduce costs. One of the major issues is the relationship between health care and social care. This paper considers health care and social care as complements and substitutes through a household production framework. We demonstrate how health care and social care are attributes that are valued by individuals and how in the presence of a perfect market individuals would choose combinations of these attributes. We highlight how, even with technical efficiency, sub-optimal combinations of health and social care may be chosen. We also show, through the introduction of a new good, how there may be opportunities to alleviate the costs of the ageing population.
http:mpra.ub.uni-muenchen.de/54425/1/MPRA_paper_54425.pdf