DOC VEILLE

Veille bibliographique en économie de la santé / Watch on Health Economics Literature

3 juillet 2015 / July the 3rd 2015

Réalisée par le centre de documentation de l'Irdes, Doc Veille, publication bi-mensuelle, 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 françaises) :
http://ejournals.ebsco.com/Home.asp **(Accès réservé à l'Irdes)**

Les autres documents sont soit accessibles en ligne, soit consultables à la documentation (voir mention à la fin de la notice). Aucune photocopie ne sera délivrée par courrier.
Un historique des Doc Veille se trouve sur le web de l'Irdes :
http://www.irdes.fr/documentation/veille-bibliographique-en-economie-de-la-sante.html

Produced by the Irdes documentation centre, Doc Veille, a bimonthly publication, presents by theme the latest articles and reports in health economics: both peer-reviewed and grey literature.

You can access to the electronic version of articles on our EJS portal (except for the French journals):
http://ejournals.ebsco.com/Home.asp **(Access limited to Irdes team).**

Other documents are accessible online, either available for consultation at the documentation center (see mention at the end of the notice). Requests for photocopies or scans of documents will not be answered. Doc Veille's archives are located on the Irdes website:
http://www.irdes.fr/english/documentation/watch-on-health-economics-literature.html

Contacts

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

Sommaire

Assurance maladie / Health Insurance

Barkowski S. (2015). Does Government Health Insurance Reduce Job Lock and Job Push? Münich : MRPA

Abstract: I study job lock and job push, the twin phenomena believed to be caused by employment contingent health insurance (ECHI). Using variation in Medicaid eligibility among household members of male workers as a proxy for shifts in workers dependence on employment for health insurance, I estimate large job lock and job push effects. For married workers, Medicaid eligibility for one household member results in an increase in the likelihood of a voluntary job exit over a four-month period by approximately 34%. For job push, the transition rate into jobs with ECHI among all workers falls on average by 26%.
http://www.mpra.ub.uni-muenchen.de/63991/

Dave D.M., Kaestner D.R., Wehby G.L. (2015). Does Medicaid Coverage for Pregnant Women Affect Prenatal Health Behaviors? Cambridge : NBER

Abstract: Despite plausible mechanisms, little research has evaluated potential changes in health behaviors as a result of the Medicaid expansions of the 1980s and 1990s for pregnant women. Accordingly, we provide the first national study of the effects of Medicaid on health behaviors for pregnant women. We exploit exogenous variation from the Medicaid income eligibility expansions for pregnant women and children during late-1980s through mid-1990s to examine effects on several prenatal health behaviors and health outcomes using U.S. vital statistics data. We find that increases in Medicaid eligibility were associated with increases in smoking and decreases in weight gain during pregnancy. Raising Medicaid eligibility by 12 percentage-points increased rates of any prenatal smoking and smoking more than five cigarettes daily by 0.7-0.8 percentage point. Medicaid expansions were associated with a reduction in pregnancy weight-gain by about 0.6%. These effects diminish at higher levels of eligibility, which is consistent with crowd-out from private to public insurance. Importantly, our evidence is consistent with ex-ante moral hazard although income effects are also at play. The worsening of health behaviors may partly explain why Medicaid expansions have not been associated with substantial improvement in infant health.
http://www.nber.org/papers/w21049

Stapleton D.C., Ann D.R., Song J. (2015). Firm-Level Early Intervention Incentives: Which Recent Employers of Disability Program Entrants Would Pay More? Washington DC : Mathematica Policy Research.

Abstract: We used linked Social Security (SS) administrative data to analyze SS Disability Insurance (DI) program reform proposals that would hold firms partially responsible for a portion of the DI benefits paid to their recent employees. One proposal would require employers to carry short-term disability insurance; the second proposal would apply an experience rating to the DI portion of the Federal Insurance Contributions Act premium. Our analysis creates baseline firm-level benefit liability measures, simulates firm liabilities under the proposals, and compares the simulated liabilities to the baseline measures. We found that the proposals would place a relatively large burden on low-wage firms with fewer than 500 workers. The policy implications of the findings are: Firms with high potential liabilities face competing incentives to accommodate and retain or reduce hiring and retaining workers at high risk for medical problems. Although these proposals would likely reduce DI expenditures, they might have less desirable unintended consequences.

(2015). Le fonds de financement de la protection complémentaire de la couverture universelle du risque maladie. Paris : Cour des Comptes .

Abstract: La Cour des comptes rend public, le 3 juin 2015, un rapport sur le fonds de financement de la protection complémentaire de la couverture universelle du risque maladie, demandé par la commission des finances du Sénat en application de l'article 58-2° de la loi organique relatives aux lois de finances. L'enquête porte sur la couverture maladie universelle complémentaire (CMU-C), créée en 1999, et l'aide au paiement d'une complémentaire santé (ACS), instituée en 2004. La Cour examine l'évolution des règles d'éligibilité et du recours effectif à ces dispositifs qui visent à assurer l'accès aux soins des ménages défavorisés, le niveau de la protection qu'ils procurent, ainsi que les risques qui affectent leur gestion et leur soutenabilité financière. Elle formule douze recommandations.
http://www.ccomptes.fr/Publications/Publications/Le-fonds-de-financement-de-la-protection-complementaire-de-la-couverture-universelle-du-risque-maladie

Lange R., Schiller J., Steinorth P. (2015). Demand and Selection Effects in Supplemental Health Insurance in Germany. Berlin : DIW

Abstract: This paper empirically assesses the selection effects and determinants of the demand for supplemental health insurance that covers hospital and dental benefits in Germany. Our representative dataset provides doctor-diagnosed indicators of the individual's health status, risk attitude, demand for medical services and insurance purchases in other lines of insurance as well as rich demographic and socioeconomic information. Controlling for a wide range of individual preferences, we find evidence of adverse selection for individuals aged 65 and younger for hospital coverage despite initial individual underwriting by insurers. The reverse is true for individuals older than 65; individuals with supplemental hospital coverage are healthier on average. In addition, insurance affinity and income are the most important drivers of the demand for both types of coverage.
http://www.diw.de/documents/publikationen/73/diw_01.c.505648.de/diw_sp0757.pdf

Economie de la santé / Health Economics

Trusheim M.R., Berndt E.R. (2015). An Overview of the Stratified Economics of Stratified Medicine. Cambridge : NBER

Abstract: The economics of stratified medicine depend critically on setting the cut-off score of the companion diagnostic (CDx). This action integrates scientific, clinical, ethical and commercial considerations, and simultaneously determines the value of the stratified medicine to developers, providers, payers and patient. Setting a high cut-off ensures a larger response by excluding more non-responders but also denies treatment to patients who would respond. This creates ethical and clinical concerns, and limits market size. Setting a low cut-off includes more patients who can benefit but includes more non-responders with commensurate costs, side effects and lost time. CDx's capture little value under current reimbursement and exclusivity protections. Combined with low CDx investment incentives for generic drug manufacturers, little CDx development occurs for older legacy drugs. Therefore payers face an asymmetric situation of novel stratified medicines raising public health and payers' costs, but no CDx's for legacy treatments to reduce costs. It would be in payers' interests to rediscover their heritage of direct investment in diagnostic development.
http://www.nber.org/papers/w21233

Galizzi M.M., Tammi T., Godager G., et al. (2015). Provider altruism in health economics : Helsinki : University of Helsinki

Abstract: We propose a first comprehensive overview of the main theoretical notions and

empirical findings on altruism among physicians and other healthcare providers. While altruism in the behavioral and experimental economics literature is typically defined as a deviation from purely self-interested behavior, the theoretical health economics literature embeds the notion of physician altruism within the doctor– patient relationship. The altruism of physicians is typically defined as the weight in the doctor's utility function attached to patient's health benefits, besides the self-interested monetary considerations. We broadly group the empirical evidence into five main categories of evidence, gradually moving from low to high control in the settings and empirical strategies: evidence from i) survey and interview data, ii) discrete choice experiments, iii) prescriptions records, iv) field experiments, and, finally, v) laboratory experiments. Across each of those groups of studies and different methods, the evidence generally supports the theoretical notion that physicians largely behave 'altruistically' in their healthcare decisions. Some studies indicate, however, considerable heterogeneity in physicians' altruistic preferences.
http://urn.fi/URN:ISBN:978-952-302-429-8

Dunn A., Shapiro H.A. (2015). Physician Competition and the Provision of Care: Evidence from Heart Attacks. San Francisco : Federal Reserve Bank of San Franscico
Abstract: We study the impact of competition among physicians on service provision and patients' health outcomes. We focus on cardiologists treating patients with a first time heart attack treated in the emergency room. Physician concentration has a small, but statistically significant effect on service utilization. A one-standard deviation increase in cardiologist concentration causes a 5 percent increase in cardiologist service provision. Cardiologists in more concentrated markets perform more intensive procedures, particularly, diagnostic procedures-services in which the procedure choice is more discretionary. Higher concentration also leads to fewer readmissions, implying potential health benefits. These findings are potentially important for antitrust analysis and suggest that changes in organizational structure in a market, such as a merger of physician groups, not only influences the negotiated prices of services, but also service provision.
http://www.frbsf.org/economic-research/files/wp2015-07.pdf

Handicap / Disability

Penneau A., Pichetti S., Sermet C. (2015). L'hébergement en institution favorise l'accès aux soins des personnes de moins de 60 ans en situation de handicap en France. Une exploitation de l'enquête Handicap-Santé Ménages et Institutions (2008-2009). *Questions d'Economie de la Santé (Irdes),* (207)
Abstract: L'accès aux soins des personnes en situation de handicap a jusqu'à maintenant surtout été étudié par rapport à celui des personnes sans handicap. La littérature montre que les problèmes d'accès physiques aux soins et la situation socio-économique plus défavorable des personnes handicapées sont parmi les principaux éléments d'explication de leur moindre recours aux soins. Par ailleurs, si l'accès aux soins des personnes en situation de handicap est bien documenté pour les personnes vivant à domicile, en revanche, il l'est moins pour celles résidant en institution. Les rares études comparant l'accès aux soins de ces deux populations se sont concentrées sur les soins dentaires montrant que la vie en institution semble augmenter la probabilité d'accéder à ces soins. Ce résultat sur les soins dentaires est-il généralisable aux autres soins ? L'enquête Handicap-Santé Ménages (HSM, 2008) et Institutions (HSI, 2009), utilisée ici, a permis de comparer le recours aux soins des personnes en situation de handicap résidant en ménages avec celui des personnes résidant en institution pour trois soins courants (les soins dentaires, ophtalmologiques et

gynécologiques) et quatre actes de prévention et de dépistage (dépistage des cancers du sein, du col de l'utérus, colorectal et vaccination contre l'hépatite B). Elle permet ainsi d'apporter une réponse documentée à la question posée précédemment. Pour comparer ces deux populations, la définition du handicap retenue se fonde sur les restrictions d'activité pour la réalisation de soins personnels (Activities of Daily Living – ADL) ou de la vie domestique (Instrumental Activities of Daily Living – IADL) que les personnes ont déclarées.
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/207-l-hebergement-en-institution-favorise-l-acces-aux-soins-des-personnes-de-moins-de-60-ans-en-situation-de-handicap-en-france.pdf

Penneau A., Pichetti S., Sermet C. (2015). Les personnes en situation de handicap vivant à domicile ont un moindre accès aux soins de prévention que celles sans handicap. Une exploitation de l'enquête Handicap-Santé volet Ménages (2008). *Questions d'Economie de la Santeé(Irdes),* (208)
Abstract: Avec une espérance de vie qui a progressé, les personnes en situation de handicap sont confrontées aux mêmes pathologies du vieillissement que le reste de la population. L'accès à la prévention et au dépistage doit ainsi permettre d'éviter une dégradation prématurée de leur état de santé. Or la littérature montre qu'elles rencontrent de nombreux obstacles pour accéder à la prévention et aux soins courants : une expression des besoins parfois difficile, une situation socio-économique plus défavorisée ayant pour conséquence un moindre recours aux soins, une accessibilité physique aux cabinets médicaux ou aux matériels de consultation inadaptée, une méconnaissance du handicap par le personnel soignant… Cette étude sur le recours aux soins et à la prévention des personnes en situation de handicap résidant à domicile explore avec les données de l'enquête Handicap-Santé Ménages (HSM), réalisée par la Drees et l'Insee en 2008, quatre actes de dépistage ou de prévention : les dépistages des cancers du col de l'utérus, du sein, du côlon et la vaccination contre l'hépatite B. L'objectif est d'évaluer les écarts de recours à ces actes selon la situation de ces personnes face au handicap. Deux indicateurs de handicap ont été retenus pour l'analyse, les limitations fonctionnelles (limitations motrices, cognitives, visuelles ou auditives) et la reconnaissance administrative du handicap.
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/208-les-personnes-en-situation-de-handicap-vivant-a-domicile-ont-unmoindre-acces-aux-soins-de-prevention-que-celles-sans-handicap.pdf

Hôpital / Hospitals

Currie J. Macleod B., Van Parys J., (2015). Physician Practice Style and Patient Health Outcomes: The Case of Heart Attacks. Cambridge : NBER
Abstract: When a patient arrives at the Emergency Room with acute myocardial infarction (AMI), doctors must quickly decide whether the patient should be treated with clot-busting drugs, or with invasive surgery. Using Florida data on all such patients from 1992-2011, we decompose physician practice style into two components: The physician's probability of conducting invasive surgery on the average patient, and the responsiveness of the physician's choice of procedure to the patient's condition. We show that practice style is persistent over time and that physicians whose responsiveness deviates significantly from the norm in teaching hospitals have significantly worse patient outcomes, including a 7% higher probability of death in hospitals among the patients who are least appropriate for the procedure. Our results suggest that a reallocation of invasive procedures from less appropriate to more appropriate patients could improve patient outcomes without

increasing costs. Developing protocols to identify more and less appropriate patients could be a first step towards realizing this improvement.
http://www.nber.org/papers/w21218

Senot C., Chandrasekaran A., Ward P.T.,et al. (2014). The Impact of Combining Conformance and Experiential Quality on Hospitals' Readmissions and Cost Performance. **Management Science : Ahead of pub**
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2600667&download=yes
Abstract: To investigate the opportunity for hospitals to achieve better care at lower cost, we examine two key process quality measures – Conformance quality and experiential quality – and two measures of performance –readmission rate and cost per discharge. Conformance quality represents hospital's level of adherence to evidence-based standards of care, while experiential quality represents the level of interaction between hospital's caregivers and patients. Analyzing six years of data from 3,474 U.S. acute care hospitals, we find that combining conformance and experiential quality results in lower readmission rates. However, conformance quality and experiential quality each independently increase cost per discharge which suggests that a readmissions-costs tradeoff is unavoidable. To investigate this further, we conduct post-hoc analyses by distinguishing between the granular elements of experiential quality (EQ) based on task type: response focused EQ and communication-focused EQ. Response-focused EQ measures caregivers' ability to respond to patient's explicit needs, while communication-focused EQ measures caregivers' ability to engage in meaningful conversations with the patient. We find that combining communication-focused EQ with conformance quality reduces readmission rates. Moreover, as conformance quality increases, the cost of improving communication-focused EQ decreases, indicating complementarity. Response-focused EQ in combination with conformance quality also results in reduced readmission rates. However, as conformance quality increases, the cost of improving response-focused EQ also increases, suggesting that these dimensions might compete for resources. Taken together, our results suggest that hospital administrators can mitigate the tradeoff between reducing readmissions and controlling costs by prioritizing communication-focused EQ over response-focused EQ.

Gutacker N., Moscelli G., Gravelle H. (2015). Do patients choose hospitals that improve their health? York : University of York
Abstract: Patients in the English NHS can choose which hospital to attend for planned surgery. Among other things, their choice depends on the quality of care that each hospital provides. But the existing information on hospital quality is often limited and focuses only on the negative experience of patients, for example how many patients died after surgery or were readmitted for unplanned care. Patients increasingly have access to better information on hospital quality. The NHS has recently begun to publish information on improvements in health as reported by patients themselves. In this paper we test whether hip replacement patients in England are more likely to attend a hospital that achieves larger improvements in their patients' health. To do so, we study the choices made by NHS-funded patients treated during the period 2010 to 2012. We find that health improvements are more important for the choice of hospital than readmission or mortality rates. However, patients' reaction to quality information is generally limited: even for large changes in quality patients would only be willing to travel few kilometres more. But because the market for hip replacement surgery is large, individual hospitals can attract a substantial number of extra patients if they can improve their quality.
http://www.york.ac.uk/che/news/2015/che-research-paper-111/

Inégalités de santé / Health Inequalities

Raynaud J. (2015). Inégalités d'accès aux soins : acteurs de santé et territoires. Paris : FBMF ; Paris : Economica

Abstract: L'accès aux soins est devenu l'une des priorités majeures des Français. Souvent étudié à travers la distance géographique ou les difficultés financières, ce concept relève pourtant de multiples dimensions. La prise en compte des perceptions des acteurs de santé est essentielle pour que les décisions politiques soient en adéquation avec le vécu des acteurs. Ainsi, l'ouvrage présente les concepts et les outils nécessaires pour analyser les perceptions des patients (difficultés pour obtenir une consultation) et des médecins (conditions de travail et solutions pour améliorer l'accès aux soins) afin d'identifier les territoires sur lesquels l'offre de soins est insuffisante. D'autre part, le regroupement pluriprofessionnel et la télémédecine sont étudiés pour déterminer les conditions favorables pour le développement d'une offre de soins durable et de qualité sur les territoires grâce à la coopération entre professionnels de santé. L'auteur replace ainsi la géographie au centre d'une réflexion globale et pluridisciplinaire, intégrant l'aménagement du territoire, la sociologie, l'analyse des politiques de santé et l'organisation des professionnels de santé.
http://www.economica.fr/livre-inegalites-d-acces-aux-soins,fr,4,9782717867954.cfm

Moscelli G., Siciliani L., Gutacker N., et al. (2015). Socioeconomic Inequality of Access to Healthcare: Does Patients' Choice Explain the Gradient? Evidence from the English NHS. York : University of York

Abstract: Equity of access is a key policy objective in publicly-funded healthcare systems. Using data on patients undergoing non-emergency heart revascularization procedures in the English National Health Service, we find evidence of significant differences in waiting times within public hospitals between patients with different socioeconomic status (up to 35% difference between the most and least deprived population quintiles). We employ selection models to test whether such differences are explained by patients exercising choice over hospital or type of treatment. Selection bias due to choice has a limited effect on the gradient suggesting the presence of substantial inequities within the public system.
http://www.york.ac.uk/che/news/2015/che-research-paper-112

Aerts A.T., Chirazi S., Cros L. (2015). Une pauvreté très présente dans les villes-centres des grands pôles urbains. Insee Première, (1552) :

Abstract: En France métropolitaine, en 2012, le taux de pauvreté est le plus élevé dans le Nord et le Sud-Est, ainsi qu'en Seine-Saint-Denis. Le taux de pauvreté est le plus important dans les villes-centres des grandes aires urbaines, où la pauvreté touche particulièrement les familles monoparentales, les familles nombreuses et les ménages jeunes, ainsi qu'en dehors de l'influence des villes. Les inégalités de niveaux de vie à l'intérieur des régions et des départements sont souvent fortes ; elles sont les plus prononcées à Paris, dans les Hauts-de-Seine, et en Haute-Savoie, du fait d'un niveau de vie particulièrement élevé de la partie aisée de la population qui y habite. Le niveau de vie médian est généralement plus élevé dans l'espace urbain, en particulier dans les couronnes des grands pôles urbains. Pour les personnes les plus pauvres, la part des prestations sociales dans le revenu disponible est importante et varie fortement selon les régions ; elle est la plus élevée dans les villes-centres où elle représente en moyenne 46 % du revenu disponible pour les 10 % de personnes les plus modestes. À l'inverse, pour les personnes les plus aisées, la part des revenus du patrimoine est alors prédominante : dans les villes-centres, qui concentrent souvent les plus fortes inégalités, elle représente en moyenne 30 % du revenu disponible pour les 10 % de personnes les plus aisées.

http://www.insee.fr/fr/ffc/ipweb/ip1552/ip1552.pdf

Médicaments / Pharmaceuticals

Andrade L.F., Pichetti S., Sermet C. (2014). Entry time effects and follow-on drugs competition.
European Journal of Health Economics : Ahead of pub
Abstract: Les critiques auxquelles fait face l'industrie pharmaceutique sont axées notamment sur sa capacité à innover. La concentration des efforts de recherche et développement sur la production et dissémination des médicaments du type me-too ou follow-on est une préoccupation majeure des institutions responsables de la régulation du marché pharmaceutique. Le débat autour de cette problématique s'est considérablement répandu ces dernières années mais très peu d'études empiriques sur le sujet ont vu le jour, probablement en raison de la difficulté à établir un consensus sur la « vraie » définition de ces produits. Cet article propose une analyse empirique de l'impact du délai d'entrée sur la concurrence des médicaments follow-on en France entre 2001 et 2007. Plus précisément, nous cherchons à mettre en évidence la relation entre ordre d'entrée dans une classe thérapeutique et parts de marché et comment l'avantage compétitif des premiers entrants évolue dans le temps (résumé d'auteur).

Williams H.L. (2015). Intellectual Property Rights and Innovation: Evidence from Health Care Markets. Cambridge : NBER
Abstract: A long theoretical literature has analyzed optimal patent policy design, yet there is very little empirical evidence on a key parameter needed to apply these models in practice: the relationship between patent strength and research investments. I argue that the dearth of empirical evidence on this question reflects two key challenges: the difficulty of measuring specific research investments, and the fact that finding variation in patent protection is difficult. I then summarize the findings of two recent studies which have made progress in starting to overcome these empirical challenges by combining new datasets measuring biomedical research investments with novel sources of variation in the effective intellectual property protection provided to different inventions. The first study, Budish, Roin, and Williams (forthcoming), documents evidence consistent with patents affecting the rate and direction of research investments in the context of cancer drug development. The second study, Williams (2013), documents evidence that one form of intellectual property rights on the human genome had quantitatively important impacts on follow-on scientific research and commercial development. I discuss the relevance of both studies for patent policy, and discuss directions for future research.
http://www.nber.org/papers/w21246

Sinkinson M., Stark A. (2015). Ask Your Doctor? Direct-to-Consumer Advertising of Pharmaceuticals. Cambridge : NBER
Abstract: We measure the impact of direct-to-consumer television advertising (DTCA) by drug manufacturers. Our identification strategy exploits shocks to local advertising markets generated by idiosyncrasies of the political advertising cycle as well as a regulatory intervention affecting a single product. We find that a 10% increase in the number of a firm's ads leads to a 0.76% increase in revenue, while the same increase in rival advertising leads to a 0.55% decrease in firm revenue. Results also indicate that a 10% increase in category advertising produces a 0.2% revenue increase for non-advertised drugs. Both the business-stealing and spillover effects would not be detected through OLS. Decomposition using micro data confirms that the effect is due mostly to new customers as opposed to switching among

current customers. Simulations show that an outright ban on DTCA would have modest effects on the sales of advertised drugs as well as on non-advertised drugs.
http://www.nber.org/papers/w21045

Le Deaut J.Y., Touraine J.L., Le Dain A.Y.(2015). Les médicaments biosimilaires. Rapport du Sénat ; 239 , Rapport de l'Assemblée nationale ; 2760. Paris : Sénat, Paris : Assemblée nationale
Abstract: Au cours des cinq prochaines années, un grand nombre de brevets de médicaments biologiques, issus des biotechnologies, tombera dans le domaine public. D'ores et déjà, de nombreux laboratoires pharmaceutiques développent et mettent sur le marché des médicaments « biosimilaires », sur le même schéma que les génériques pour les médicaments chimiques. Les régimes d'assurance maladie attendent des économies substantielles de cette interchangeabilité. Or les médicaments biologiques diffèrent des médicaments chimiques car leur structure moléculaire est beaucoup plus complexe et leurs effets dépendent du processus de fabrication. Il reste encore à établir les modalités selon lesquelles un médicament biosimilaire pourra être amené à remplacer un médicament biologique de référence, avec les mêmes exigences en termes d'efficacité, de qualité et de sécurité. Ce rapport rend compte des débats sur cette problématique lors deux tables rondes, successivement intitulés "jusqu'où l'analogie des médicaments biosimilaires avec les médicaments génériques ?" et "les enjeux économiques, sociaux et juridiques des médicaments biosimilaires". Sont abordés : le point de vue scientifique, Le point de vue scientifique sur les effets des médicaments biosimilaires, l'insertion des médicaments biosimilaires dans notre système de santé ; les enjeux économiques : faut-il développer le marché des biosimilaires ? Les enjeux juridiques : quel encadrement ?
http://www.assemblee-nationale.fr/14/rap-off/i2760.asp

(2015). L'accès aux nouveaux médicaments dans les régimes publics d'assurance médicaments : au Canada et dans des pays comparables. Ottawa : Compagnies de recherche pharmaceutique du Canada (Les).
Abstract: Ce rapport présente une évaluation détaillée de l'accès aux nouveaux médicaments dans les régimes publics d'assurance médicaments de 18 pays comparables de l'OCDE. La proportion de nouveaux médicaments qui sont remboursés par des fonds publics, ainsi que le niveau de remboursement et le temps de remboursement ont été évalués et comparés avec un accent sur la façon dont le Canada se compare à ses homologues internationaux.

Dalen D.M., Locatelli M., Strom S. (2015). An equilibrium model estimated on pharmaceutical data. Working paper series; 18/15. Turin : Université de Turin
Abstract: The purpose of this paper is to estimate to what extent patients/doctors respond to prices when making a choice between a brand name product and its generics, and also how pharmacies respond to government regulation and to prices set by brand name producers. Data is unique in the sense that we observe prices set by pharmacies as well as by producers. We have estimated the demand side, but also jointly the demand side and the price setting by retailers/wholesalers and producers. Results confirm that estimating only the demand side yields biased estimates. Taking the whole data generating process into account we find much stronger price responses

Busch A.M. (2015). Drug Prices and Pressure Group Activities in the German Health Care Market: An Application of the Becker Model. Lünebourg : University of Lüneboourg
Abstract: This article analyzes the shifts of power relation and influence between pharmaceutical industry (producers), pharmacies, and social health insurers (SHI) in Germany based on drug prices. Since the health care reform of 2004, these interest groups have negotiated fees and discounts among each other without any intervention from the

government. These negotiations and resulting amendments to the original law express the shift of power of the involved groups, which can be explained with the Becker (1983) model. As a result, a trend becomes apparent, which shows a slight increase in political pressure on the part of SHI and a big decrease of political pressure on the part of pharmacies and producers. This reflects the cost control trend in combination with the empowerment incentives for SHI. The last years have shown increased competition between the interest groups, resulting in more balanced power relations. Nevertheless, the most powerful group is still the producer group and the influence of SHI is still very low.
http://www.leuphana.de/fileadmin/user_upload/Forschungseinrichtungen/ifvwl/WorkingPapers/wp_338_Upload.pdf

Lichtenberg F.R. (2015). The Impact of Pharmaceutical Innovation on Premature Cancer Mortality in Canada, 2000-2011. Cambridge : NBER
Abstract: The premature cancer mortality rate has been declining in Canada, but there has been considerable variation in the rate of decline across cancer sites. I analyze the effect that pharmaceutical innovation had on premature cancer mortality in Canada during the period 2000-2011, by investigating whether the cancer sites that experienced more pharmaceutical innovation had larger declines in the premature mortality rate, controlling for changes in the incidence rate. The estimates imply that pharmaceutical innovation during the period 1985-1996 reduced the number of years of potential life lost to cancer before age 75 in 2011 by 105,366. The cost per life-year before age 75 gained from previous pharmaceutical innovation is estimated to have been 2730 USD. The evidence suggests that, even if these drugs had been sold at branded rather than generic prices, the cost per life-year gained would have been below 11,000 USD, a figure well below even the lowest estimates of the value of a life-year gained.
http://www.nber.org/papers/w21239

Godman B, Wettermark B. , Sermet C.; et al. (2014). Multiple policies to enhance prescribing efficiency for established medicines in Europe with a particular focus on demand-side measures : findings and future implications. Frontiers in Pharmacology, **5** (106)
Abstract: The appreciable growth in pharmaceutical expenditure has resulted in multiple initiatives across Europe to lower generic prices and enhance their utilization. However, considerable variation in their use and prices. Assess the influence of multiple supply and demand-side initiatives across Europe for established medicines to enhance prescribing efficiency before a decision to prescribe a particular medicine. Subsequently utilize the findings to suggest potential future initiatives that countries could consider. An analysis of different methodologies involving cross national and single country retrospective observational studies on reimbursed use and expenditure of PPIs, statins, and renin-angiotensin inhibitor drugs among European countries.
http://journal.frontiersin.org/article/10.3389/fphar.2014.00106/abstracT

Politique de santé / Health Policy

Pikhart H., Pikhartova J. (2015). Promoting better integration of health information systems: best practices and challenges. Health Evidence Network (HEN) synthesis report. Copenhague : Office des Publications du Bureau Régional de l'Europe
Abstract: Ce rapport aborde les tendances actuellement observées dans les États membres de l'Union européenne (UE) et de l'Association européenne de libre-échange (AELE) quant à

la manière de promouvoir une meilleure intégration des systèmes d'information sanitaire. Afin d'en sonder les aspects pragmatiques, des experts de 13 États membres de l'UE ont été soumis à un entretien, dont les résultats ont été combinés aux conclusions d'une recherche documentaire. Le rapport de synthèse identifie les options stratégiques et les besoins suivants pour un examen plus approfondi, à savoir : continuer le travail sur certaines notions de base (tels que la disponibilité et la qualité des données, les inventaires de données et les registres, la normalisation, la législation, les infrastructures physiques et les capacités de la main-d'œuvre) et sur des ensembles d'indicateurs davantage axés sur des concepts ; définir la notion de meilleure intégration et en démontrer les avantages concrets ; développer le leadership en matière de renforcement des capacités en vue de poursuivre l'intégration des systèmes d'information sanitaire ;poursuivre les échanges internationaux concernant les activités en cours dans ce domaine.(résumé de l'éditeur).
http://www.euro.who.int/fr/publications/abstracts/promoting-better-integration-of-health-information-systems-best-practices-and-challenges

(2015). Assessing chronic disease management in European health systems : country reports. Observatory Studies Series ; 39. Copenhague : OMS Bureau régional de l'Europe

Abstract: Many countries are exploring innovative approaches to redesign delivery systems to provide appropriate support to people with long-standing health problems. Central to these efforts to enhance chronic care are approaches that seek to better bridge the boundaries between professions, providers and institutions, but, as this study clearly demonstrates, countries have adopted differing strategies to design and implement such approaches. This book systematically examines experiences of 12 countries in Europe, using an explicit comparative approach and a unified framework for assessment to better understand the diverse range of contexts in which new approaches to chronic care are being implemented, and to evaluate the outcomes of these initiatives. The study focuses in on the content of these new models, which are frequently applied from different disciplinary and professional perspectives and associated with different goals and does so through analyzing approaches to self-management support, service delivery design and decision-support strategies, financing, availability and access. Significantly, it also illustrates the challenges faced by individual patients as they pass through the system.(résumé des éditeurs).
http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/assessing-chronic-disease-management-in-european-health-systems-country-reports

Maresso A. 2015). Economic crisis, health systems and health in Europe: impact and implications for policy. Observatories Studies Series ; 41. Copenhague : OMS - Bureau Régional de l'Europe

Abstract: The financial and economic crisis has had a visible but varied impact on many health systems in Europe, eliciting a wide range of responses from governments faced with increased financial and other pressures. This book maps health system responses by country, providing a detailed analysis of policy changes in nine countries and shorter overviews of policy responses in 47 countries. It draws on a large study involving over one hundred health system experts and academic researchers across Europe. Focusing on policy responses in three areas – public funding of the health system, health coverage and health service planning, purchasing and delivery – this book gives policymakers, researchers and others valuable, systematic information about national contexts of particular interest to them, ranging from countries operating under the fiscal and structural conditions of international bailout agreements to those that, while less severely affected by the crisis, still have had to operate in a climate of diminished public sector spending since 2008. Along with a companion volume that analyses the impact of the crisis across countries, this book is part of a wider initiative to monitor the effects of the crisis on health systems and health, to identify those policies most likely to sustain the performance of health systems facing fiscal pressure

and to gain insight into the political economy of implementing reforms in a crisis.
http://www.euro.who.int/__data/assets/pdf_file/0010/279820/Economic-crisis-country-experiences.pdf

Ahlert M., Pfarr C. (2015). The acceptance of priority criteria in health care: international evidence. Munich : MRPA

Abstract: Social health care systems around the world are inevitably confronted with the scarcity of resources and the resulting distributional challenges. Prioritization is applied in almost all countries, implicitly or explicitly, and shapes access to health services. We analyze and compare attitudes towards prioritization of medical treatments in a group of countries. The focus is on the criteria of age, the fact that a patient has or does not have young children or the fact that a patient is a strong smoker or a non-smoker. We use representative data from the International Social Survey Program (ISSP) of the year 2011 for nine countries (DE, US, GB, CH, NL, SE, NO, DK, AU). The empirical analysis reveals strong effects of socio-demographic factors and attitudes towards aspects of the health care system on individual's acceptance of priority criteria. Among countries, Germans exhibit the highest aversion against priority setting whereas individuals from the US or GB are more in favor to prioritize according to the criteria smoking and age. However, a priority for patients with young children only receives support in Switzerland. Finally, we find evidence of egoistic motives for respondents' acceptance of priority criteria.
http://mpra.ub.uni-muenchen.de/64760/

Psychiatrie / Psychiatry

Bharadwaj P., Pai M.M., Suziedelyte A. (2015). Mental Health Stigma. Cambridge : NBER

Abstract: Comparing self-reports to administrative data records on diagnosis and prescription drug use, we find that survey respondents under-report mental health conditions 36% of the time when asked about diagnosis and about 20% of the time when asked about prescription drug use. Survey respondents are significantly less likely to under-report other conditions such as diabetes or hypertension. This behavior is consistent with a model in which mental health illnesses are stigmatized and agents have incentives to hide such traits from others. We show that differential under-reporting of depression is correlated with age, gender, and ethnicity and that these characteristics also predict a lower probability of mental health treatment, suggesting that stigma can play an important role in determining health-seeking behavior.
http://www.nber.org/papers/w21240

Soins de santé primaire / Primary Health Care

Kalb G., Kuehnle D., Scott A. (2015). What Factors Affect Doctors' Hours Decisions: Comparing Structural Discrete Choice and Reduced-Form Approaches. Bonn : IZA

Abstract: Few papers examine the pecuniary and non-pecuniary determinants of doctors' labour supply despite substantial predicted shortages in many OECD countries. We contribute to the literature by applying both a structural discrete choice and a reduced-form approach. Using detailed survey data for Australian physicians, we examine how these different modelling approaches affect estimated wage elasticities at the intensive margin.

We show that all modelling approaches predict small negative wage elasticities for male and female General Practitioners (GPs) and specialists. Our detailed subgroup analysis does not reveal particularly strong responses to wage increases by any specific group. We show that the translog and Box-Cox utility functions outperform the quadratic utility function. Exploiting the advantages of the structural discrete choice model, we examine short-term effects at the intensive margin by calculating labour supply changes in response to 5 and 10% wage increases. The results show that such wage increases substantially reduce the full-time equivalent supply of male GPs, and to a lesser extent of male specialists and female GPs, but not of female specialists.
http://ftp.iza.org/dp9054.pdf

(2015). Les conditions d'installation des médecins de ville en France et dans cinq pays européens. 2 volumes. Paris : ONDPS.
Abstract: En France, le système de santé est fondé historiquement sur une gestion différenciée de l'offre de soins : planificatrice et étatisée dans le secteur des établissements de santé (par exemple carte sanitaire et autorisation de lits et d'équipements lourds après 1970, SROS après 1991, etc.), de tradition libérale et conventionnelle dans le secteur de ville. Ainsi, l'essentiel de la régulation de la médecine de ville est réalisée, en amont de l'installation, par le biais des dispositifs qui s'appliquent aux flux d'étudiants (places ouvertes au numerus clausus par UFR à l'issue du concours de fin de première année - PACES - et épreuves classantes nationales - ECN - qui déterminent pour tous les étudiants ayant validé leur second cycle d'études, les postes d'internat ouverts par spécialité et UFR). Les dispositifs qui tendent à organiser l'offre de ville sont beaucoup plus récents et conservent le statut de correctifs incitatifs : il s'agit en particulier de la loi HPST de juillet 2009 qui impose aux nouvelles ARS de définir le maillage pertinent de leur région (les territoires de santé) et d'y organiser les soins de premier recours en ville ou encore le Pacte Santé Territoire de décembre 2012 qui crée les praticiens territoriaux de médecine générale (PTMG). Cette situation a conduit l'Observatoire national de la démographie des professions de santé à s'interroger sur les dispositifs qui, dans quelques pays européens proches, sont destinés à orienter l'installation des médecins en ville. L'étude est complétée, dans un second volume, par des monographies par pays : Allemagne, Belgique, Espagne, Pays-Bas et Royaume-Uni (résumé de l'éditeur).
http://www.sante.gouv.fr/les-conditions-d-installation-des-medecins-en-ville-dans-5-pays-europeens.html

Kringos D.S., Boerma W.G.W., Hutchinson A., Bourgueil Y., Cartier T. (2015). Building primary care in a changing Europe. Case studies. Copenhague : Office des Publications du Bureau Régional de l'Europe
Abstract: Ce nouveau volume est constitué d'études de cas structurées résumant la situation des soins de santé primaires dans 31 pays européens. Il sert de complément à l'étude réalisée précédemment et intitulée « Building primary care in a changing Europe » (Assurer les soins primaires dans une Europe en mutation), qui donne un aperçu de la situation des soins primaires sur le continent, notamment les aspects liés à la gouvernance, au financement et aux ressources humaines ainsi qu'une présentation détaillée des profils de service. Ces études de cas déterminent le contexte des soins de santé primaires dans chaque pays ; les conditions économiques et de gouvernance essentielles ; le développement du personnel des soins de santé primaires ; le mode de prestation des services de soins primaires ; et une évaluation de la qualité et de l'efficacité du système de soins primaires. Les études illustrent les importantes variations nationales en termes d'accessibilité, de continuité et de coordination des soins primaires dans l'Europe d'aujourd'hui, ce qui complique l'évaluation du rôle de ces soins dans la performance globale du système de santé même s'il

est de plus en plus prouvé qu'un secteur des soins primaires solide apporte de la valeur ajoutée.
http://www.euro.who.int/fr/about-us/partners/observatory/publications/studies/building-primary-care-in-a-changing-europe-case-studies

Jelovac I. (2015). Incentives to patients versus incentives to health care providers: The users' perspective. Ecully : Groupe d'Analyse et de Théorie Economique
Abstract: In theory, health care providers may adapt their professional behavior to the financial incentives driven by their remuneration. Our research question is whether the users of health care services anticipate such a behavior from their general practitioner (GP) and, if they do, what are the consequences of such an anticipation on their preferences regarding financial incentives. We propose a theoretical model to identify potential determinants of such preferences. We empirically test our theoretical predictions using the data from a survey that elicits individual preferences for either patients' or providers' hypothetical incentives in France. The empirical results confirm the theoretical ones by establishing that users tend to prefer to pay a copayment themselves when the amount of GPs' incentives is high, the one of the patients' copayment is low, they anticipate that their GP's medical decisions are affected by financial incentives and their wealth is high. Otherwise, they prefer their GP to face financial incentives.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2594743

Systèmes de santé / Health Systems

(2015). Bridging the worlds of research and policy in European health systems. Observatory Studies Series ; 36. Copenhague : Copenhague : Office des Publications du Bureau Régional de l'Europe
Abstract: Policy makers need to access up-to-date and high-quality health system information. Stakeholders may try to influence health policy as well as make decisions within their own area of work. Both groups want easily obtainable and clear evidence based on systematic and transparent research methods. Knowledge brokers (including researchers) want to know how to best communicate to decision-makers and need information about policy priorities in order to inform policy processes and share health system information effectively. The purpose of this book is to spark innovation in knowledge brokering and to encourage debate on how information is prepared and how it will be understood and used. Part I looks at knowledge brokering from different vantage points and part II describes knowledge brokering in action. It is hoped that this book will give health system policy-makers, stakeholders and researchers a clear understanding of knowledge brokering and its implications for the organization and management of health information systems. This book results from a study on knowledge-brokering practices in Europe that was undertaken between 2009 and 2011, called BRIDGE (Scoping study of approaches to Brokering knowledge and Research Information to support the Development and Governance of health systems in Europe).
http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/bridging-the-worlds-of-research-and-policy-in-european-health-systems

(2015). OECD Reviews of Health Care Quality: Portugal 2015: Raising Standards. Paris : OCDE.
Abstract: This report reviews the quality of health care in Portugal, seeks to highlight best practices, and provides a series of targeted assessments and recommendations for further improvements to quality of care. The Portuguese National Health Service has responded well

to financial pressure, successfully balancing the twin priorities of financial consolidation and continuous quality improvement. Even in the post-crisis years when GDP fell and health spending declined, improvements in quality of care continued. The need to reduce health spending has been met through a combination of structural reforms, and a well-designed suite of quality initiatives. Reforms around the purchasing and use of pharmaceuticals and medical devices have helped drive down costs, and Portugal has been innovative in how public funds are used to pay providers, increasingly basing payments on quality and efficiency. Important priorities for further work in the Portuguese health system do remain. Portugal will need to improve clinical processes and pathways, particularly in the acute sector. There is still room to improve efficiency, for instance increasing the share of generic drug consumption, and using the Portuguese health workforce more effectively, especially through expanded roles for nurses. Further structural reform is needed with an emphasis on shifting care out of hospitals into less-expensive community settings, and Portugal will also need to reflect on the strategic direction of the primary care system which, following an impressive reform, now risks developing into a two-tiered system with increasingly divergent levels of care quality.
http://www.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-care-quality-portugal-2015_9789264225985-en

(2015). Strengthening health system accountability: a WHO European Region multi-country study.
Copenhague : Office des Publications du Bureau Régional de l'Europe
Abstract: This report takes stock of the measures that countries in the WHO European Region have put in place to strengthen their health systems' accountability since the adoption of the Tallinn Charter: Health Systems for Health and Wealth (2008) and the Health 2020 policy framework (2012). Recent years have undoubtedly brought significant challenges to the health systems in the Region, including international and national environments affected by an economic crisis, increased health needs and scarcity of resources. Nevertheless, countries across the Region have taken abundant and significant steps to improve health-system accountability. This report summarizes countries' experiences with strengthening health-system accountability in the context of the momentum created by the Tallinn Charter and Health 2020, by setting rigorous goals and measuring and reviewing health systems' performance.
http://www.euro.who.int/en/publications/abstracts/strengthening-health-system-accountability-a-who-european-region-multi-country-study

Madovsky P., Thomson S., et al. (2015). Economic crisis, health systems and health in Europe : country experience. Observatory Studies Series ; 41. Copenhague : Office des Publications du Bureau Régional de l'Europe
Abstract: The financial and economic crisis has had a visible but varied impact on many health systems in Europe, eliciting a wide range of responses from governments faced with increased financial and other pressures. This book maps health system responses by country, providing a detailed analysis of policy changes in nine countries and shorter overviews of policy responses in 47 countries. It draws on a large study involving over one hundred health system experts and academic researchers across Europe. Focusing on policy responses in three areas – public funding of the health system, health coverage and health service planning, purchasing and delivery – this book gives policymakers, researchers and others valuable, systematic information about national contexts of particular interest to them, ranging from countries operating under the fiscal and structural conditions of international bailout agreements to those that, while less severely affected by the crisis, still have had to operate in a climate of diminished public sector spending since 2008. Along with a companion volume that analyses the impact of the crisis across countries, this book is part of

a wider initiative to monitor the effects of the crisis on health systems and health, to identify those policies most likely to sustain the performance of health systems facing fiscal pressure and to gain insight into the political economy of implementing reforms in a crisis (résumé des éditeurs).
http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/economic-crisis,-health-systems-and-health-in-europe-country-experiences

Vieillissement / Ageing

Nyqvist T.éd., Forsman A.K./ éd. (2015). Social capital as a health resource in later life: the relevance of context. International Perspectives on Aging ; 11. Dordrecht : Springer Verlag
Abstract: This book examines the social aspects of healthy ageing for older individuals. It features more than 15 papers that explore the relevance of the social environment for health on the micro, meso, and macro level. Overall, the book applies a comprehensive contextual approach that includes discussion of how family and friends, neighborhoods, nations, and welfare regimes influence health. The book first explores the issue on the individual level. It looks at the importance of social capital for health among older people, examines types of social networks and health among older Americans, as well as discusses dynamic social capital and mental health in late life. Next, the book looks at the issue through a neighborhood and societal context, which takes into account day-to-day interaction in the immediate environment as well as the social, health, and economic policies in place in different regions in the world, including America, Europe, Asia, and Africa. From there, the book goes on to offer implications and recommendations for research and practice, including the management of related concepts of research on well-being and health. It also offers a psychosocial approach to promoting social capital and mental health among older adults. This book provides health professionals as well as researchers and students in gerontology, sociology, social policy, psychology, and social work with vital insights into the social factors that increase healthy life years and promote well-being.
http://www.springer.com/us/book/9789401796149