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Assurance maladie / Health Insurance

Johanet G. (2014). Réponse à la note du Conseil d'analyse économique, "Refonder l'assurance maladie". In : Les inégalités de santé. *Sève : les Tribunes de la Santé,* (43) :

Abstract: Cet article est un commentaire critique de la note du Conseil d'analyse économique intitulé "Refonder l'assurance maladie", de Dormont, Geoffard et Triole.
http:www.cairn.info/revue-les-tribunes-de-la-sante-2014-2.html

Jusot F. (2014). La complémentaire santé : une source d'inégalités face à la santé ? In : Les inégalités de santé. *Sève : les Tribunes de la Santé,* (43) :

Abstract: La généralisation de l'accès à la complémentaire santé est vue aujourd'hui comme une condition nécessaire pour accéder aux soins et réduire les inégalités de santé. Le système français a en effet la particularité de laisser une partie du coût de tous les soins à la charge des patients, ce qui rend nécessaire la possession d'un contrat d'assurance complémentaire pour s'assurer contre le risque financier lié à la maladie. De nombreuses inégalités existent pourtant face à l'assurance complémentaire santé en France. Cet article propose un état des lieux des connaissances sur les inégalités face à l'accès à la complémentaire santé et les inégalités dans la qualité des couvertures et dans le coût des contrats, avant de discuter des politiques envisageables pour les réduire.
http:www.cairn.info/resume.php?ID_ARTICLE=SEVE_043_0069

Huang F., Gan L. (2015). Impact of China's Urban Employee Basic Medical Insurance on Health Care Expenditure and Health Outcomes. Cambridge : NBER

Abstract: At the end of 1998, China launched a government-run mandatory insurance program, the Urban Employee Basic Medical Insurance (UEBMI), to replace the previous medical insurance system. Using the UEBMI reform in China as a natural experiment, this study identify variations in patient cost sharing that were imposed by the UEBMI reform and examine their effects on the demand for health-care services. Using data from the 1991-2006 waves of the China Health and Nutrition Survey, we find that the increased cost sharing is associated with decreased outpatient medical care utilization and expenditures but not with decreased inpatient care utilization and expenditures. Patients from low- and middle-income households or in less-serious medical situations are found to be more sensitive to prices. We observe little impact on patient health, as measured by self-reported poor health status.
http:www.nber.org/papers/w20873

Kowalski A.E. (2015). What Do Longitudinal Data on Millions of Hospital Visits Tell us About The Value of Public Health Insurance as a Safety Net for the Young and Privately Insured? Cambridge : NBER

Abstract: Young people with private health insurance sometimes transition to the public health insurance safety net after they get sick, but popular sources of cross-sectional data obscure how frequently these transitions occur. We use longitudinal data on almost all hospital visits in New York from 1995 to 2011. We show that young privately insured individuals with diagnoses that require more hospital visits in subsequent years are more likely to transition to public insurance. If we ignore the longitudinal transitions in our data, we obscure over 80% of the value of public health insurance to the young and privately insured.

http:www.nber.org/papers/w20887

Démographie / Demography

Bellamy V., Beaumel C.(2015). Bilan démographique 2014. Des décès moins nombreux. *Insee Première*, (1532) :

Abstract: Au 1er janvier 2015, la France compte 66,3 millions d'habitants : 64,2 millions en France métropolitaine et 2,1 millions dans les cinq départements d'outre-mer. C'est environ 300 000 personnes de plus qu'un an auparavant, soit une hausse de 0,4 %. Cette progression est principalement due au solde naturel, différence entre les nombres de naissances et de décès. L'année 2014 est marquée par une natalité stable mais toujours dynamique (813 000 naissances hors Mayotte), et par des décès moins nombreux qu'en 2012 et 2013 (555 000 décès hors Mayotte). De ce fait, le solde naturel est plus élevé que les deux années précédentes. L'espérance de vie, qui avait marqué le pas, repart à la hausse. L'indicateur conjoncturel de fécondité, toujours un des plus élevés d'Europe, reste stable. En 2014, 241 000 mariages ont été célébrés en France : 231 000 entre personnes de sexe différent, 10 000 entre personnes de même sexe. La légère augmentation des mariages entre 2013 et 2014 (+ 2 400) est portée par les mariages de personnes de même sexe. Le nombre de Pacs, après avoir fortement baissé en 2011, augmente de nouveau dès 2012 pour atteindre 168 000 déclarations en 2013. Conséquence probable de l'adoption de la loi sur le mariage pour tous, le nombre de déclarations de Pacs de personnes de même sexe a diminué entre 2012 et 2013, passant de 7 000 à 6 000 déclarations (résumé d'auteur).
http:www.insee.fr/fr/ffc/ipweb/ip1532/ip1532.pdf

Economie de la santé / Health Economics

Gestsson M.H., Zoega G. (2014). A Golden Rule of Health Care. Londres : Birkbeck College

Abstract: We derive a golden rule for the level of health care expenditures and find that the optimal level of life-extending health care expenditures should increase with rising productivity and retirement age, while the effects of improvement in medical technology are ambiguous.

Géographie de la santé / Geography of Health

Elek P., Varadi V., Varga M. (2014). Effects of geographical accessibility on the use of outpatient care services: quasi-experimental evidence from administrative panel data. York : HEDG
Abstract: Between 2008 and 2012 new outpatient service locations were established in Hungarian micro-regions, which had lacked outpatient capacities before. We exploit this quasi experiment to estimate the effect of geographical accessibility on outpatient case numbers using both semi-aggregate and individual-level panel data from administrative sources. Based on propensity score matching methods, fixed-effect linear models and fixed-effect Poisson regression techniques, we find a substantial, 24-28 per cent increase of case numbers as a result of the establishments. Our causal estimates imply that a one-minute reduction of travel time to the nearest outpatient care provider increases case numbers e.g. by 0.8 per cent in internal medicine and 2.8 per cent in rheumatology. We also find that the size of the new outpatient capacities has a separate positive effect

on case numbers, possibly caused by supplier-induced demand. By combining a fixed effect logit model and a fixed effect truncated Poisson model, we decompose the effects into increases in the probability of ever visiting a doctor on the one hand and an increase of the frequency of visits on the other. We find that new visits were the main source of the increase in internal care, surgery and gynaecology, whereas both margins were important in rheumatology. Finally, as a methodological note, we examine the robustness of the fixed effect truncated Poisson estimator to some forms of misspecification by simulation methods.
http:www.york.ac.uk/media/economics/documents/hedg/workingpapers/1417.pdf

Avdic D. (2014). A matter of life and death? Hospital distance and quality of care: evidence from emergency room closures and myocardial infarctions. York : HEDG

Abstract: Recent health care centralization trends raise the important question of the extent to which the quality of emergency medical services may offset effects from decreased access to emergency health care. This article analyzes whether residential proximity from an emergency room affects the probability of surviving an acute myocardial infarction (AMI). The critical time aspect in AMI treatment provides an ideal application for evaluating this proximity-outcome hypothesis. Previous studies have encountered empirical difficulties relating to potential endogenous health-based spatial sorting of involved agents and data limitations on out-of-hospital mortality. Using policy-induced variation in hospital distance arising from emergency room closures in the highly regulated Swedish health care sector and data on all AMI deaths in Sweden over two decades, estimation results show a clear and gradually declining probability of surviving an AMI as residential distance from an emergency room increases. The results further show that spatial sorting is likely to significantly attenuate the distance effect unless accounted for.
http:www.york.ac.uk/media/economics/documents/hedg/workingpapers/1418.pdf

Atella V., Belotti F., Depalo D. ,et al (2014). Measuring spatial effects in presence of institutional constraints: the case of Italian Local Health Authority expenditure. Rome : Bank of Italy

Abstract: Spatial econometric models are now an established tool for measuring spillover effects between geographical entities. Unfortunately, however, when entities share common borders but are subject to different institutional frameworks, unless this is taken into account the conclusions may be misleading. In fact, under these circumstances, where institutional arrangements play a role, we should expect to find spatial effects mainly in entities within the same institutional setting, while the effect across different institutional settings should be small or nil even where the entities share a common border. In this case, factoring in only geographical proximity will produce biased estimates, due to the combination of two distinct effects. To avoid these problems, we derive a methodology that partitions the standard contiguity matrix into within-contiguity and between-contiguity matrices, allowing separate estimation of these spatial correlation coefficients and simple tests for the existence of institutional constraints. We then apply this methodology to Italian Local Health Authority expenditures, using spatial panel techniques. We find a high and significant spatial coefficient only for the within-contiguity effect, confirming the validity of our approach.
http:papers.ssrn.com/sol3/papers.cfm?abstract_id=2526138

Hôpital / Hospitals

Gravelle H., Moscelli G., Santos R., et al. (2014). Patient Choice and the Effects of Hospital Market Structure on Mortality for AMI, Hip Fracture and Stroke Patients. York : University of York

Abstract: We examine (a) the effect of market structure on the level of mortality for AMI, hip fracture, and stroke between 2002/3 and 2010/11 and (b) whether this effect changed after the introduction of Choice policy in 2006 which gave patients the right to a wider choice of hospital. For AMI and hip fracture, hospitals with more rivals had higher mortality at the beginning of the period but this effect became smaller over the period. We find that the decline in the detrimental effect of market structure predated the introduction of Choice. Market structure had no effect on stroke mortality.

http:www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP106_patient_choice_hospital_mortality.pdf

Pilny A., Mennicken. (2014). Does Hospital Reputation Influence the Choice of Hospital? Bochum : Ruhr-Universität Bochum

Abstract: A number of recent empirical studies document significant effects of in-patient care quality indicators on the choice of hospital. These studies use either objective quality indicators based on quantitative figures, or if subjective reputation scores are used, scores based on the opinion of hospital market insiders. We contribute to the current debate by using a subjective reputation score resorting to patient perceptions and examine its impact on the choice of hospital of patients undergoing a coronary artery bypass graft (CABG) in Germany. Our results show that 76% of the patients value hospital reputation positively when choosing a hospital. Moreover, we find evidence for a trade-off between hospital reputation and travel time, i.e. a significant share of patients is willing to accept additional travel time to get a treatment in a hospital with better reputation. The average marginal effect for hospital reputation confirms this finding, since the magnitude of the effect strengthens for higher thresholds of travel time. The results are robust for different degrees of co-morbidities and admission status.
http:repec.rwi-essen.de/files/REP_14_516.pdf

(2015). Le patient traceur en établissement de santé : méthode d'amélioration de la qualité et de la sécurité des soins. Guide méthodologique. Saint-Denis: HAS.

Abstract: Avec la méthode du patient traceur, la Haute Autorité de Santé a positionné le parcours du patient au centre de la certification des établissements de santé. Suite à l'expérimentation menée dans 13 établissements volontaires, la HAS met à disposition à l'ensemble des établissements de santé le guide «Le patient traceur en établissement de santé : méthode d'amélioration de la qualité et de la sécurité des soins » afin que les équipes qui le souhaitent puissent l'utiliser dans leur démarche d'amélioration et se préparer à la visite de certification. La méthode du patient traceur est une analyse rétrospective de la prise en charge d'un patient depuis son entrée à l'hôpital jusqu'à sa sortie. Plusieurs critères sont évalués : accueil du patient, prise en compte des droits du patients, vécu du patient, prise en charge de la douleur, prise en charge médicamenteuse, préparation à la sortie, organisation au sein de l'équipe, collaboration interprofessionnelle. Elle vient compléter les autres méthodes d'amélioration de la qualité des soins existants telles que la RMM (Revue de mortalité et de morbidité), l'audit clinique ou le chemin clinique. Elle est également une nouvelle méthode de visite de la certification dans le cadre de la procédure de certification V2014 (résumé d'auteur).
http:www.has-sante.fr/portail/upload/docs/application/pdf/2015-01/guide_methodo_patient_traceur.pdf

Inégalités de santé / Health Inequalities

Afrite A., Mousques J. (2014). Une estimation de la précarité des patients recourant à la médecine générale en centres de santé. Le cas des centres de santé du projet Epidaure-CDS. Document de travail Irdes ; 63. Paris : IRDES

Abstract: Le projet exploratoire Epidaure-CDS a pour objectif principal d'analyser la spécificité des centres de santé (CDS) dans l'offre de soins et de déterminer s'ils jouent un rôle particulier dans la réduction des inégalités sociales de santé, notamment en facilitant l'accès aux soins primaires pour les personnes en situation de précarité ou de vulnérabilité sociale, ce qui n'a été que peu exploré jusqu'à présent. Il s'agit ici d'estimer en quoi la population recourant à la médecine générale dans un échantillon de CDS volontaires se distingue de la population recourant généralement à la médecine générale, en termes socio-économiques, démographiques, d'état de santé et de précarité sociale. La précarité sociale est mesurée au moyen du score Epices. Mais il s'agit également de mesurer la propension des CDS à accueillir des populations précaires et vulnérables et d'évaluer le lien entre précarité et niveau de couverture en termes d'assurance maladie complémentaire (AMC).
http://www.irdes.fr/recherche/documents-de-travail/063-une-estimation-de-la-precarite-des-patients-recourant-a-la-medecine-generale-en-centres-de-sante.pdf

(2015). Six parcours pour mieux connaître la réalité et comprendre les enjeux de la fin de vie des personnes en situation de précarité en France. Rapport 2014. Paris : Observatoire National de la Fin de Vie .

Abstract: En 2014, l'Observatoire National de la Fin de Vie a consacré ses travaux à la précarité et à la fin de vie. L'idée d'associer ces deux notions est intéressante car elles l'ont rarement été. Ainsi, si des travaux ont été menés sur la santé des plus précaires, la question de leur fin de vie n'a jamais véritablement été abordée, tandis que les travaux sur la fin de vie ne se sont jamais focalisés sur celle des plus précaires. En présentant ce quatrième rapport, l'Observatoire souhaite une fois de plus élargir le champ de la réflexion qui se rattache à la fin de vie et montrer que les débats qui s'y rattachent ne se réduisent pas dans notre société à la question de l'accompagnement des mourants et à celle de l'euthanasie ou du suicide assisté. Comme dans son précédent rapport, l'Observatoire National de la Fin de Vie a pris le parti de présenter les résultats de ses enquêtes sous la forme de trajectoires de fin de vie et de parcours de santé fictifs. Ceci permet de voir et de comprendre les difficultés que rencontrent les personnes en situations de précarité, mais aussi les difficultés d'adaptation de notre société et de notre système de santé à ces situations souvent « hors norme ». Ainsi en 2014 l'Observatoire s'est intéressé aux personnes en fin de vie en situation de précarités : dont la vie quotidienne est impactée par les conséquences d'une précarité ou d'un cumul de précarités ; dont le parcours de santé est marqué par des besoins spécifiques d'accompagnement de fin de vie ; qui sont hébergés à leur domicile propre, dans des logements sociaux accompagnés (pension de famille), dans un établissement social (centre d'hébergement et de réinsertion sociale), dans un établissement médico-social (appartement de coordination thérapeutique, lits d'accueil médicalisé, Etablissement d'hébergement pour personnes âgées dépendantes accueillant spécifiquement des personnes sans-abris) ou dans un établissement de santé. L'enjeu est une fois encore de quantifier et de qualifier cette réalité (tiré de l'intro.).
http:www.onfv.org/wp-content/uploads/2015/01/ONFV-Rapport-2014-Fin-de-vie-et-pr%C3%A9carit%C3%A9s.pdf

Williams G., Noori T., Falla A., et al. (2014). Migrants and health. *Eurohealth,* 20 (4) :

Abstract: The last Eurohealth for 2014 throws the spotlight on migrants and health. In the Observer section, the overview article describes the infectious disease burden in migrant populations in Europe. Three migrant-focused articles follow on chronic viral hepatitis, health care access, and service entitlements in Spain and Sweden. Other articles include: Politics of health workforce planning; EU competence in health security policy; Commercialisation of public hospitals in Poland; Perceptions about affordability of care in the Netherlands; Financial crisis and health service reform in Cyprus; Reducing avoidable mortality in England; and Eurohealth Monitor.
http:www.euro.who.int/en/about-us/partners/observatory/publications/eurohealth/migrants-and-health

Marmot M, Allen J., Lang T., et al.. (2014). Les inégalités de santé. In : Les inégalités de santé. *Sève : les Tribunes de la Santé,* (43) :

Abstract: Les inégalités de santé sont protéiformes. Inégalités sociales mais aussi inégalités géographiques, même si bien souvent disparités territoriales et fractures sociales se superposent. Inégalités socio-culturelles également qui, par leurs conséquences sur l'éducation à la santé et à l'accès à l'information, influent directement sur les comportements à risque, les conduites addictives, l'orientation dans le système de santé et l'efficacité de la prise en charge médicale. Enfin inégalités au regard de la protection sociale, notamment complémentaire, qui se traduisent par des renoncements aux soins ou des retards de prise en charge. Ce numéro invite à s'interroger sur différentes facettes de ces inégalités de santé, réalités douloureuses et cruciales pour l'élaboration et la conduite de la politique de santé mais aussi des autres politiques publiques. Avec le souci de mobiliser les différentes disciplines et d'examiner au prisme de leurs méthodologies les ressorts et les effets des inégalités de santé (tiré du 4ème de couv.).
http:www.cairn.info/revue-les-tribunes-de-la-sante-2014-2.html

Constant A., Garcia-Munos T., Neuman S., et al. (2014). Micro and Macro Determinants of Health: Older Immigrants in Europe. Bonn : IZA

Abstract: We study the health determinants of immigrant men and women over the age of fifty, in Europe, and compare them to natives. We utilize the unique Survey of Health Aging and Retirement (SHARE) and augmented it with macroeconomic information on the 22 home countries and 16 host countries. Using Multilevel Analysis we can best capture the within and between countries variation and produce reliable results. We find that during the first decade after arrival, immigrants report higher levels of subjective health compared to natives and to previous cohorts of immigrants. As time since migration passes by, reported subjective health decreases; immigrants' health becomes the same as that of comparable natives or it even decreases. The level of economic development of both the origin and the host country positively affect the individual's health, but the effect of the host country is much more pronounced. It appears that positive and negative deviations (of the host from the origin country) have different impacts on individual health: an increase in a positive deviation (the country of origin is more developed compared to the host country - a 'loss' for the immigrating individual) leads to a decrease in the immigrant's subjective health, while an increase in the absolute negative deviation (a 'gain' for the immigrating person) leads to an increase in the immigrant's subjective health. These differential effects can be explained as some variant of the Loss-Aversion Theory.
http:ftp.iza.org/dp8754.pdf

Bricard D., Jusot F., Trannoy A., Tubeuf S. (2014). Inequality of Opportunity in Health and the Principle of Natural Reward: evidence from European Countries. *Cahiers de la Chaire Santé,* 18

Abstract: This paper aims to quantify inequalities of opportunities in health in Europe and to assess whether the way the correlation between effort towards health and circumstances empirically matters for the magnitude of inequalities of opportunities. Methodology: This paper considers two alternative normative ways of treating the correlation between effort and circumstances championed by Barry and Roemer, and combine regression analysis with inequality measures to compare inequality of opportunities in health within Europe. This paper uses the Retrospective Survey of SHARELIFE focusing on life histories of European people aged 50 and over. Findings: Our results show considerable inequalities of opportunity in health in Germany, Spain, Italy, Denmark, Greece and Belgium whereas Sweden and Switzerland show low inequalities of opportunities in health. The normative principle considered makes little difference in Austria, France, Czech Republic, Sweden and Switzerland whereas it appears to matter in the Netherlands, Poland, Germany, Spain, Italy, Denmark, Greece and Belgium. Research implications: Our results suggest a strong social and family determinism of lifestyles in the Netherlands, Poland, Germany, Denmark, Belgium and the Mediterranean which emphasized the importance of inequalities of opportunities in health within those countries. In terms of public health and social policies, it appears that reducing social and unhealthy lifestyles reproduction across generations would provide important benefits on health. On the other hand Austria, France, and Czech Republic show high inequalities of opportunities in health mainly driven by social and family background affecting adult health directly, and so would require policies compensating for poorer initial conditions.
http:d.repec.org/n?u=RePEc:dau:papers:123456789/14339&r=hea

Médicaments / Pharmaceuticals

Schaumans C. (2014). Prescribing Behavior of General Practitioners : Competition Matters! Le Tilburg : Center for Economic Research.

Abstract: Background: General Practitioners have limited means to compete. As quality is hard to observe by patients, GPs have incentives to signal quality by using instruments patients perceive as quality. Ob jectives: We investigate whether GPs exhibit different prescribing behavior (volume and value of prescriptions) when confronted with more competition. As there is no monetary benefit in doing so, this type of (perceived) quality competition originates from GPs satisfying patients' expectations. Method: We look at market level data on per capita and per contact number of items prescribed by GPs and the value of prescriptions for the Belgian market of General Practitioners. We test to which extent different types of variables explain the observed variation. We consider patient characteristics, GP characteristics, number and type of GP contacts and the level of competition. The level of competition is measured by GP density, after controlling for the number of GPs and a

HHI. Results: We find that a higher number of GPs per capita results in a higher number of units prescribed by GPs, both per capita and per contact. We argue that this is consistent with quality competition in the GP market. Our findings reject alternative explanations of GP scarcity, availability effect in GP care consumption and GP dispersing prescription in time due to competition.
http:papers.ssrn.com/sol3/papers.cfm?abstract_id=2422330

Hume E. (2014). Tell me the whole story: the role of product labelling in building user confidence in biosimilars in Europe. *Gabi Journals : Generics and Biosimilars Initiative Journal,* 3 (4) :

Abstract: The European Medicines Agency (EMA) has led the development of biosimilar regulatory pathways globally, tailoring their approach to meet the specific and scientifically determined needs of biosimilar development. However, the information-driven stepwise approach encouraged by this pathway leading to approval of biosimilar products is only reflected in a single section of the product labelling for healthcare professionals and patients, which so far has followed a generic approach in Europe.This paper reviews the need for sufficiently detailed and transparent labelling and product information (PI) regarding biosimilars to enable informed decision making by physicians and patients and therefore ensure appropriate safe and effective use of the medicine. The authors, representing the European Biopharmaceutical Enterprises (EBE), argue that it is necessary to ensure that the evidentiary basis and terms of approval for each biosimilar and its reference product are clear, and so they set out a proposal for transparency concerning evidence generated for these respective products. Approaches to labelling of biosimilars will be examined to highlight potential ways forward in ensuring more informed clinical use and to generate trust in these important medicines. A consideration of these various aspects will illustrate the value to have detailed specific guidance on biosimilar labelling, which could be developed based on open dialogue with key stakeholders.
http:gabi-journal.net/tell-me-the-whole-story-the-role-of-product-labelling-in-building-user-confidence-in-biosimilars-in-europe.html

White C., Eguchi M. (2014). Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle. *Research Brief,* (18) :

Abstract: Reference pricing, or capping payment for a particular medical service, has been gaining interest as a strategy to reduce health care costs. Using private insurance data as a measure, reference pricing applied to a narrow scope of inpatient services was shown to produce limited savings only a few tenths of a percentage of total spending; reference pricing applied to a much broader set of "shoppable" inpatient and ambulatory services was shown to potentially save about 5 percent of total spending. When considering reference pricing, employers and health plans would need to weigh the potential savings against the additional resources needed to implement and manage a more complex program.
http:www.nihcr.org/Reference-Pricing2

Agha L. Molitor D. (2015). The Local Influence of Pioneer Investigators on Technology Adoption: Evidence from New Cancer Drugs. Cambridge : NBER

Abstract: Local opinion leaders may play a key role in easing information frictions associated with technology adoption. This paper analyzes the influence of physician investigators who lead pivotal clinical trials for new cancer drugs. By comparing diffusion patterns across many drugs, we separate correlated regional demand for new technology from information spillovers. Using original data on clinical trial study authors for 21 new cancer drugs along with Medicare claims data from 1998-2008, we find that patients in the lead investigator's region are initially 36% more likely to receive the new drug, but utilization converges within four years. We further demonstrate that "superstar" physicians, identified by trial role or citation history, have substantially broader influence than less prominent physicians.
http:www.nber.org/papers/w20878

O'Neill P., Sussex J. (2014). International Comparison of Medicines Usage: Quantitative Analysis.
Londres : OHE

Abstract: This report updates to 2012/13 the quantitative analysis of UK usage of medicines per head of total population compared to that in other countries in 2008/09 which was published in the 2010 Richards Report: In the absence of internationally comparable data on the quantities of medicines actually used bypatients, we have proxied usage by IMS sales volume data. On the basis of the same classes of medicines as in the Richards Report and the same group of comparator countries (excluding Denmark for which up to date data were not available): In 2012/13 the UK's overall ranking across all of the medicines studied for usage per person remains ninth highest of 13 high income countries. UK usage per person is below the international average in 2012/13 for 11 out of 16 classes of medicines and above average for five. The UK's relative usage of medicines is slightly higher when compared to the other five largest EU economies (France, Germany, Italy, Spain and UK): UK usage per person in 2012/13 was below the EU5 average for nine out of 16 classes of medicines and above for seven.
http:www.abpi.org.uk/our-work/library/industry/Pages/261014.aspx

Van Bull L.W., Van Der Steen J.T., Doncker S.M. (2014). Factors influencing antibiotic prescribing in long-term care facilities: a qualitative in-depth study. *Bmc Geriatrics,* 14 (136) :

Abstract: BACKGROUND: Insight into factors that influence antibiotic prescribing is crucial when developing interventions aimed at a more rational use of antibiotics. We examined factors that influence antibiotic prescribing in long-term care facilities, and present a conceptual model that integrates these factors. METHODS: Semi-structured qualitative interviews were conducted with physicians (n?=?13) and nursing staff (n?=?13) in five nursing homes and two residential care homes in the central-west region of the Netherlands. An iterative analysis was applied to interviews with physicians to identify and categorize factors that influence antibiotic prescribing, and to integrate these into a conceptual model. This conceptual model was triangulated with the perspectives of nursing staff. RESULTS: The analysis resulted in the identification of six categories of factors that can influence the antibiotic prescribing decision: the clinical situation, advance care plans, utilization of diagnostic resources, physicians' perceived risks, influence of others, and influence of the environment. Each category comprises several factors that may influence the decision to prescribe or not prescribe antibiotics directly (e.g. pressure of patients' family leading to antibiotic prescribing) or indirectly via influence on other factors (e.g. unfamiliarity with patients resulting in a higher physician perceived risk of non-treatment, in turn resulting in a higher tendency to prescribe antibiotics). CONCLUSIONS: Our interview study shows that several non-rational factors may affect antibiotic prescribing decision making in long-term care facilities, suggesting opportunities to reduce inappropriate antibiotic use. We developed a conceptual model that integrates the identified categories of influencing factors and shows the relationships between those categories. This model may be used as a practical tool in long-term care facilities to identify local factors potentially leading to inappropriate prescribing, and to subsequently intervene at the level of those factors to promote appropriate antibiotic prescribing.
http:www.biomedcentral.com/1471-2318/14/136

Howard D.H., Bach P.B., Berndt E.R. (2015). Pricing in the Market for Anticancer Drugs. Cambridge : NBER

Abstract: Drugs like bevacizumab ($50,000 per treatment episode) and ipilimumab ($120,000 per episode) have fueled the perception that the launch prices of anticancer drugs are increasing over time. Using an original dataset of 58 anticancer drugs approved between 1995 and 2013, we find that launch prices, adjusted for inflation and drugs' survival benefits, increased by 10%, or about $8,500, per year. Although physicians are not penalized for prescribing costly drugs, they may be reluctant to prescribe drugs with prices that exceed subjective standards of fairness. Manufacturers may set higher launch prices over time as standards evolve. Pricing trends may also reflect manufacturers' response to expansions in the 340B Drug Pricing Program, which requires manufacturers to provide steep discounts to eligible providers.
http:papers.nber.org/papers/w20867

Méthodologie – Statistique / Methodology – Statistics

(2014). Rapport au Parlement 2014. Progrès, enjeux, solutions. Charenton-Le-Pont : Institut des données de santé

Abstract: Le rapport 2014 de l'Institut des données de santé traduit des progrès dans l'ouverture des données de santé. Ils ont permis des avancées significatives, par exemple : La création d'une base pour mieux connaitre le parcours de soins des personnes atteintes d'un cancer afin d'optimiser leur traitement, la création d'une base permettant de mesurer l'impact des habitudes alimentaires des personnes sur leur santé afin de développer la prévention, le développement de l'expertise en matière de sécurité sanitaire, notamment celle de l'Agence Nationale de Sécurité du Médicament et des produits de santé, qui a constitué une équipe pour développer l'analyse des données auxquelles elle a désormais accès, et qui a fait émerger des relais dans des organismes de recherches afin d'accroitre ses possibilités d'analyse au service de la sécurité des patients, la possibilité pour des acteurs de la société civile d'utiliser les données pour réaliser des études, en particulier celles du Collectif Inter associatif Sur la Santé portant sur l'évolution du reste à charge des patients en cas de consultation d'un professionnel de santé ou de séjour hospitalier, la possibilité pour certaines professions de santé d'avoir accès aux données leur permettant d'éclairer leur dialogue avec l'assurance maladie. Compte tenu de l'actualité, ce rapport traite également des enjeux liés au nécessaire élargissement de l'ouverture de ces données dans l'intérêt des patients, et analyse les solutions proposées par les différents acteurs. Il vise ainsi à éclairer les débats, comme c'est aussi le rôle de l'Institut (d'après l'éditorial).
http:www.institut-des-donnees-de-sante.fr/site-download-process/609-jkkv8m.html

Safon M.O. (2015). Sources d'information et méthodologie de recherche documentaire. Paris : Irdes

Abstract: Ce document présente les principales sources d'information en santé et économie de la santé : bases de données, littérature grise, agences gouvernementales, espaces de médecine factuelle, moteurs de recherche… et donne quelques élément sur la manière de conduire une recherche documentaire. Il est accompagné d'une bibliographie détaillée, notamment sur les méthodes de revue de la littérature, la communication médicale et la gestion des références bibliographiques.
http:www.irdes.fr/documentation/documents/sources-d-information-et-methodologie-de-recherche-documentaire.pdf

Politique de santé / Health Policy

Mcguire A. /éd., Costa-Font J/ /éd.. (2012). The LSE Companion to Health Policy. LSE Health. Cheltenham : Edward Elgar

Abstract: The LSE Companion to Health Policy covers a wide range of conceptual and practical issues from a number of different perspectives introducing the reader to, and summarising, the vast literature that analyses the complexities of health policy. The Companion also assesses the current state of the art.
http:www.e-elgar.co.uk/bookentry_main.lasso?id=14876

Sanfourche C., Cardin H., Pianezza P. ,et al. (2014). Un ministre, une loi. *Sève : les Tribunes de la Santé,* (42) :

Abstract: "Un ministre, une loi". Le titre du cycle de conférence organisé en 2013 par la Chaire santé de Sciences Po invitait à s'interroger sur le rôle des ministres de la santé et sur la place de la loi dans un système de santé, qui a pendant longtemps échappé à la régulation de l'Etat. Les articles proposés par ce numéro procèdent au même exercice mais avec un regard différent, celui des témoins privilégiés de l'action ministérielle et législative que sont les journalistes. Cinq grandes lois, attachées à l'action de cinq ministres de la santé, sont soumises à cet examen rétrospectif : la loi Evin du 10 janvier 1991 de lutte contre le tabagisme et l'alcoolisme, la loi Kouchner du 4 mars 2002 sur les droits des malades, la loi Mattéi du 6 août 2004 sur la bioéthique, la loi Bachelot su 21 juillet 2009, dite "HPST" (hôpital, patients, santé, territoires), et enfin la loi Bertrand du 29 décembre 2011 sur la sécurité sanitaire du médicaments et des produits de santé (tiré de la 4è de couv.).

http:www.cairn.info/revue-les-tribunes-de-la-sante-2014-1.htm

Elias J.J., Lacetera N, Macis M. (2015). Sacred Values? The Effect of Information on Attitudes toward Payments for Human Organs. Cambridge : NBER

Abstract: Many economic transactions are prohibited-even in the absence of health or safety concerns or negative externalities-because of ethical concerns that cause these exchanges to be perceived as "repugnant" if conducted through a market. Establishing a system of payments for human organs is a particularly relevant example given its implications for public health; in almost all countries, these payments are prohibited because they are considered morally unacceptable-a prohibition that societies seem to accept despite the long waitlists and high death rates for people needing a transplant. We investigate how deeply rooted these attitudes are and, in particular, whether providing information on how a price mechanism can help alleviate the organ shortage changes people's opinions about the legalization of these transactions. We conducted a survey experiment with 3,417 subjects in the U.S. and found that providing information significantly increased support for payments for organs from a baseline of 52% to 72%, and this increase applied to most of the relevant subgroups of the analyzed sample. Additional analyses on the support for other morally controversial activities show that attitude changes in response to information depend on the type of activity under consideration and interactions with other beliefs.
http:papers.nber.org/papers/w20866

Politique sociale / Social Policy

Immervoll H., Jenkins S.P., Konigs S. (2015). Are Recipients of Social Assistance 'Benefit Dependent'?: Concepts, Measurement and Results for Selected Countries. Paris : OCDE

Abstract: Means-tested Social Assistance (SA) benefits play an important role as social protection floors supporting households in financial difficulties. This paper presents evidence on the patterns of SA benefit receipt in a selection of OECD and EU countries. It provides an overview of the role of SA benefits in social protection systems and assesses the generosity of benefit payments. It then studies the dynamics of SA benefit receipt based on micro-level data describing trends in aggregate receipt and transition rates and presenting new evidence on spell durations and repeat spells. The final part of the paper summarizes recent empirical evidence on state dependence (or 'scarring effects') in benefit receipt and discusses its possible sources and policy implications.
http://www.oecd-ilibrary.org/social-issues-migration-health/are-recipients-of-social-assistance-benefit-dependent_5jxrcmgpc6mn-en

Psychiatrie / Psychiatry

Coldefy M., Le Neindre C. (2014). Les disparités territoriales d'offre et d'organisation des soins en psychiatrie en France : d'une vision segmentée à une approche systémique. Les rapports de l'Irdes ; 558. Paris : IRDES .

Abstract: Priorités de santé publique en France, la psychiatrie et la santé mentale relèvent des grandes orientations de la stratégie nationale de santé à travers, notamment, le plan Psychiatrie et santé mentale 2011-2015. Elles représentent le deuxième poste de dépenses de santé (Cnamts, 2013). En raison de leur faible létalité, la charge des troubles psychiques a été longtemps sous-estimée, or, ils sont responsables d'un peu plus de 1 % des décès et de près de 11 % de la charge globale de morbidité (exprimée en années de vie perdues en bonne santé) en 2012. De plus, même si la situation de la France est favorable en termes de capacités d'hospitalisation et de densité de psychiatres comparativement aux autres pays de l'OCDE, elle est marquée par de fortes disparités territoriales. Cette étude propose, d'une part, une photographie actualisée des

disparités d'offre et d'organisation des soins en psychiatrie à partir de nombreuses sources d'information, surtout dans le secteur sanitaire mais également dans le secteur médicosocial, et, d'autre part, une approche de ces disparités d'abord segmentée, puis systémique. A partir d'une typologie des territoires de santé, il s'agissait d'aller au-delà des clivages entre territoires quantitativement bien et sous dotés afin de qualifier plus finement les disparités d'offre et d'organisation des soins en psychiatrie. Ces disparités traduisent aussi des besoins différents des populations entre territoires urbains et ruraux, notamment, et reflètent également une histoire du développement inégal de la psychiatrie sur ces espaces en termes de sectorisation et d'implantation du secteur privé ou médicosocial. Elles questionnent enfin l'équité d'accès à des soins de qualité et diversifiés des populations concernées.
www.irdes.fr/recherche/rapports/558-les-disparites-territoriales-d-offre-et-d-organisation-des-soins-en-psychiatrie-en-france.pdf

(2014). La responsabilité médicale depuis la loi du 5 juillet 2011. Lyon : Ascodocpsy

Abstract: La loi n° 2011-803 du 5 juillet 2011 relative aux droits et à la protection des personnes faisant l'objet de soins psychiatriques et aux modalités de leur prise en charge vient réformer la loi n° 90-527 du 27 juin 1990 relative aux droits et à la protection des personnes hospitalisées en raison de troubles mentaux et à leur conditions d'hospitalisation. Elle modifie en effet en profondeur les conditions de prise en charge de ces personnes. Ce dossier bibliographique contient un rappel des textes législatifs et juridiques, la jurisprudence et des références bibliographiques.
http:www.ascodocpsy.org/la-responsabilite-medicale-depuis-la-loi-du-5-juillet-2011

Soins de santé primaires / Primary Health Care

Correia I., Norwood P. ,Veiga P., et al (2014). Patients' views on primary care: A focus group analysis. Braga : NIMA

Abstract: This study aims to identify Portuguese patients' views and preferences on Primary Care (PC) services by exploring patients' experiences of receiving primary care.
https:ideas.repec.org/p/nim/nimawp/58-2014.html

(2014). Intégration d'infirmiers au sein de cabinets de médecine générale : l'opinion des médecins généralistes des Pays de la Loire. Nantes : ORS Pays de la Loire .

Abstract: Cette étude a été réalisée par l'Observatoire régional de la santé et l'Union régionale des professionnels de santé-médecins libéraux des Pays de la Loire, en partenariat avec le Ministère chargé de la santé (Drees) et cofinancé par l'ARS, la Drees et l'URPS-ml. Elle analyse l'opinion des médecins généralistes des Pays de la Loire concernant l'intégration d'infirmiers au sein de cabinets médicaux pour des missions spécifiques de suivi de certains patients à risque ou atteints de pathologies chroniques. Ces résultats proviennent du Panel d'observation des pratiques et des conditions d'exercice en médecine générale. L'intégration d'infirmiers au sein de cabinets médicaux pour des missions spécifiques de suivi de certains patients à risque ou atteints de pathologies chroniques est expérimentée depuis plusieurs années, en particulier dans le cadre du protocole ASALÉE. Ce protocole, qui peut concerner les diabétiques de type 2, les patients à risque cardiovasculaire, les fumeurs à risque de broncho-pneumopathie chronique obstructive (BPCO), les personnes âgées, s'étend aujourd'hui dans plusieurs régions, dont les Pays de la Loire.
http:www.santepaysdelaloire.com/fileadmin/documents/ORS/ORS_pdf/panelMG/2014_10_Integration_d_infirmiers_Panel2MGpdl.pdf

Afrite A., Mousques J. (2014). Formes du regroupement pluriprofessionnel en soins de premiers recours. Une typologie des maisons, pôles et centres de santé participant aux Expérimentations des nouveaux modes de rémunération (ENMR). Document de travail Irdes ; 62. Paris : IRDES

Abstract: Ce travail s'appuie sur une enquête spécifique réalisée auprès de 147 sites participant aux ENMR sur la période 2008-2012. Cette enquête a été réalisée en deux vagues, à partir de questionnaires standardisés et administrés par Internet en 2011-2012 et en 2013. Elle décrit l'organisation de la délivrance des soins, le fonctionnement des sites et leur équipement ainsi que les processus de travail. Elle explore aussi la collaboration entre les professionnels, l'existence de pratiques innovantes ainsi que les caractéristiques et usages des systèmes d'information. Dans un premier temps, des analyses descriptives caractérisent les sites selon leurs principales dimensions structurelles, organisationnelles et fonctionnelles. Dans un second temps, afin de s'affranchir de la dimension statutaire des sites (maisons, pôles et centres de santé) et de tenir compte des dimensions considérées comme déterminantes de la performance, des méthodes factorielles d'analyses de données sont mobilisées sur un sous-échantillon de 128 sites afin d'en réaliser une typologie.
www.irdes.fr/recherche/documents-de-travail/062-formes-du-regroupement-pluriprofessionnel-en-soins-depremiers-recours.pdf

Mousques J., Bourgueil Y. (2014). L'évaluation de la performance des maisons, pôles et centres de santé dans le cadre des Expérimentations des nouveaux modes de rémunération (ENMR) sur la période 2009-2012. Les rapports de l'Irdes ; 559. Paris : IRDES .

Abstract: L'exercice pluriprofessionnel en soins primaires se développe en France sous les formes nouvelles de maisons et pôles de santé et, celle, plus ancienne de centres de santé. Souvent à l'initiative de professionnels, ces nouvelles organisations rencontrent l'intérêt des pouvoirs publics dans la mesure où elles permettraient de maintenir une offre de soins dans les zones déficitaires mais également le déploiement d'activités de soins plus cordonnées et plus efficientes. Parmi les incitations au renforcement de ces organisations innovantes, des Expérimentations de nouveaux modes de rémunération (ENMR) à destination de groupes pluriprofessionnels en soins de premiers recours ont été mises en œuvre en 2010 et ont récemment été étendues jusqu'à fin 2014. Elles visent à financer des activités de coordination de nouveaux services aux patients. Ces nouveaux services se déclinent en programmes d'éducation thérapeutique collective et de coopération entre généralistes et infirmiers au sein des maisons, pôles et centres de santé, sur la base de paiements forfaitaires complémentaires de la rémunération à l'acte des individus ou des structures. Ces innovations organisationnelles posent deux questions principales au regard des attentes qu'elles suscitent : l'exercice collectif interprofessionnel permet-il de maintenir une offre de soins dans les zones moins bien dotées ? Est-il plus performant en termes d'activité et de productivité des professionnels, de consommation de soins des bénéficiaires, et de qualité des soins et services rendus ? Ce rapport tente de répondre à ces questions au moyen d'une évaluation de l'impact du regroupement pluriprofessionnel tel qu'observé pour les sites participant aux ENMR. Cette évaluation n'a donc pas pour principal objectif de mesurer l'impact des financements reçus par les ENMR même si certaines analyses permettent de s'en faire une idée.
www.irdes.fr/recherche/rapports/559-l-evaluation-de-la-performance-des-maisons-poles-et-centres-de-sante-dans-le-cadre-des-enmr.pdf

Schieber A.C., Delpierre C., Lepage B., Afrite A., et al. (2014). Do gender differences affect the doctor–patient interaction during consultations in general practice? Results from the INTERMEDE study. *Family Practice,* 31 (6)

Abstract: The aim of the study was to ascertain whether disagreement between GPs and patients on advice given on nutrition, exercise and weight loss is related to patient-doctor gender discordance. Our hypothesis is that a patient interacting with a physician of the same gender may perceive more social proximity, notably on health care beliefs and may be more inclined to trust them.
http:fampra.oxfordjournals.org/content/31/6/706.abstract

Zaman R.U, Gemmell I., Lievens T.. (2014). Factors affecting health worker density: evidence from a quantitative crosscountry analysis. Rochester : Social Science Electronic Publishing

Abstract: In 2006 the World Health Organization identified 57 countries with critical shortage of health workforce. A number of cross-country studies have explored the effect of the health workforce density on countries' health outcomes. However, little is known about the factors driving health workforce density. The objective of this study was to identify the factors affecting the density of health workforce, which would

provide broader understanding of the underlying causes of this crisis and help formulate appropriate policies in order to mitigate the challenge. This study analysed data from 183 UN member countries to assess the association between the various demographic, economic and political factors and the health workforce density. Out of 183 countries, 66 (36%) had a heath workforce density below the WHO recommended threshold of 2.3 per 1,000 people. The adult literacy rate (p-value<0.01), total health expenditure (p-value<0.01) and social stability (p-value=0.04) are statistically significant. Total health expenditure had the greatest (33%) effect on the density of health workforce, followed by literacy rates (25%) and social stability (11%). This cross-country study provides a snapshot of the potential factors affecting health workforce density. Two of the three significant factors (adult literacy rate and social stability) are not directly related to countries' health system, which indicates that a holistic and integrated approach is required in order to alleviate the health workforce crisis. Further studies triangulating various quantitative and qualitative data would extend the understanding of the topic.
http:papers.ssrn.com/sol3/papers.cfm?abstract_id=2541690

Zuckerman S. M., Merrell K., Berenson R.A., et al. (2015). Realign Physician Payment Incentives in Medicare to Achieve Payment Equity among Specialties, Expand the Supply of Primary Care Physicians, and Improve the Value of Care for Beneficiaries. Washington : The Urban Institute .

Abstract: This report includes a number of studies related to promoting primary care access, addressing rising health care costs and improving value in the Medicare Physician Fee Schedule. One study showed that alternative methods for allocating Relative Value Units (RVUs) related to practice expenses would not result in a major payment shift to primary care providers. A second study examined the introduction of new codes and the effects of physician productivity changes on the distribution of work RVUs across services. The final study examined approaches promoting primary care services through payment reform, outside of the Medicare Resource Based Relative Value Scale.
http:www.urban.org/publications/2000059.html

Systèmes de santé / Health Care Systems

(2014). Portugal: assessing health-system capacity to manage sudden large influxes of migrants.
Copenhague: OMS - Bureau régional de l'Europe .

Abstract: The area of migration and health is one of the topics to which the new WHO European health policy framework - Health 2020 - has drawn particular attention, along with other issues related to population vulnerability and human rights. Health 2020 provides a comprehensive framework for, as well as values and approaches to action that are much needed in public health work in the field of migration and health. A sudden influx of migrants has occurred on several occasions in the countries of the WHO European Region over recent years, posing significant challenges to the health systems of the recipient countries and requiring basic services to be scaled up to facilitate the appropriate response to the essential needs of the migrants and to fulfil their fundamental human rights. The unpredictable nature of the migration phenomenon calls Member States to strengthen the preparedness of their health systems to manage a potential large influx of displaced populations and to invest in emergency management capabilities and effective multisectoral coordination mechanisms. With this in mind, an assessment of Portugal's health system capacity to manage large influxes of migrants was jointly conducted by the country's Ministry of Health and WHO. Influxes in the southern European countries in particular underlined the need to identify best practices, share experiences and enter into an efficient policy dialogue between stakeholders. Portugal is implementing measures consistent with World Health Assembly resolution WHA 61.17 of 2008 and the Global Consultation on Migrant Health of 2010 in Madrid, Spain. In several aspects, Portugal could be seen as model for migrant integration practices, although in terms of preparedness there is scope to strengthen planning and surge capacity. Activities were conducted within the framework of WHO's Public Health Aspects of Migration in Europe project, which, sustained by a direct contribution from the Italian Ministry of Health, supports the ongoing work of the WHO

European Region to strengthen national and local capacities of Member States in order to address migrants' health needs, with a focus on public health aspects.
http://www.euro.who.int/en/publications/abstracts/portugal-assessing-health-system-capacity-to-manage-sudden-large-influxes-of-migrants.-joint-report-on-a-mission-of-the-ministry-of-health-of-portugal,-the-international-centre-for-migration,-health-and-development-and-the-who-regional-office-for-europe

(2015). OECD Reviews of Health Care Quality: Italy 2014: Raising Standards. Paris : OCDE .

Abstract: This report reviews the quality of health care in Italy, seeks to highlight best practices, and provides a series of targeted assessments and recommendations for further improvements to quality of care. Italy's indicators of health system outcomes, quality and efficiency are uniformly impressive. Life expectancy is the fifth highest in the OECD. Avoidable admission rates are amongst the very best in the OECD, and case-fatality after stroke or heart attack are also well below OECD averages. These figures, however, mask profound regional differences. Five times as many children in Sicily are admitted to hospital with an asthma attack than in Tuscany, for example. Despite this, quality improvement and service redesign have taken a back-seat as the fiscal crisis has hit. Fiscal consolidation has become an over-riding priority, even as health needs rapidly evolve. Italy must urgently prioritise quality of its health care services alongside fiscal sustainability. Regional differences must be lessened, in part by giving central authorities a greater role in supporting regional monitoring of local performance. Proactive, coordinated care for people with complex needs must be delivered by a strengthened primary care sector. Fundamental to each of these steps will be ensuring that the knowledge and skills of the health care workforce are best matched to needs.
http://www.oecd.org/fr/italie/oecd-reviews-of-health-care-quality-italy-2014-9789264225428-en.htm

Joumard I., Kumar A. (2015). Improving Health Outcomes and Health Care in India. Paris : OCDE

Abstract: With India's low life expectancy largely reflecting deaths from preventable diseases, the most significant gains in health would come from population-wide preventive measures. Access to public health care services varies substantially, resulting in many people turning to private-sector providers who mainly serve those who can pay. While government has scaled up public health services, more health professionals and public health care spending will be needed to ensure broad and adequate health-care coverage. Priority should be given to high impact primary health care services. For more resources to translate into better services, the management of public health care services needs to improve. The private sector can be drawn upon more extensively, but should also be obliged to meet basic quality standards.
http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=ECO/WKP(2015)2&docLanguage=En

Travail / Occupational Health

Angelov N., Eliason M. The effects of targeted labour market programs for job seekers with occupational disabilities. Uppsala : IFAU

Abstract: In this study, we estimate the effects of three targeted labour market programmes (LMPs) on the labour market outcomes of occupationally disabled job seekers. Using propensity score matching, we estimate the average treatment effect on the treated of wage subsidies, sheltered public employment, and employment at Samhall, a Swedish state-owned company whose aim is to provide employment for persons with disabilites. The control group consists of individuals who are eligible for the targeted LMPs, but have not (yet) received treatment. Using a rich panel data set, containing demographics as well as health and sickness absence measures, we are able to estimate short- to medium-term effects. Our results show large positive effects of all LMPs on labour income, disposable income and employment, and the effects are relatively persistent. However, consistant with the previous empirical literature, we find considerable locking-in effects, measured by a decrease in un-subsidized employment. Furthermore, the yearly amounts of disability insurance paid decrease as a result of program participation, and the decrease becomes more pronounced with time since

treatment start. Finally, the effects on disability insurance prevalence are heterogenous, both with respect to the different LMPs and gender.
http:www.ifau.se/Upload/pdf/se/2013/wp2013-19-Intergenerational-transmission-of-long-term-sick-leave.pdf

Autor D.H., Duggan M., Greenberg K., et al. (2014). The Impact of Disability Benefits on Labor Supply: Evidence for the VA's Disability Compensation Program. Standford : Stanford Institute for Economic Policy Research

Abstract: We analyze the labor market effects of the U.S. Department of Veterans Affairs' Disability Compensation (DC) program. The largely unstudied DC program currently provides income and health insurance to approximately four million veterans of military service who have serviceconnected disabilities. We study a unique policy change, the 2001 Agent Orange decision, which expanded eligibility for DC benefits to a broader set of covered conditions-in particular, type II diabetes-to Vietnam veterans who had served in-theater (with 'Boots on the Ground' or BOG). Notably, the Agent Orange policy excluded Vietnam era veterans who did not serve in-theatre ('Not on Ground' or NOG), thus allowing us to assess the causal effects of DC eligibility by contrasting the outcomes of BOG and NOG veterans. Our results indicate that the policy-induced increase in DC enrollment reduced labor force participation by 18 percentage points among BOG veterans who enrolled in the DC program as a result of the policy change. We also find evidence of program spillovers, with DC recipients significantly more likely to qualify for Social Security Disability Insurance benefits.
http:siepr.stanford.edu/publicationsprofile/2835

Ceren I. (2014). Les facteurs de risques psychosociaux en France et en Europe. Une comparaison à travers l'enquête européenne sur les conditions de travail. *Dares Analyses ,* (100)

Abstract: En 2010, les salariés en France déclarent une intensité du travail équivalente à la moyenne des 27 pays de l'Union européenne ; près des trois quarts respectent des normes de qualité précise, plus de la moitié réalisent des tâches complexes et plus d'un tiers travaillent dans des délais très courts. Toutefois, ils déclarent plus souvent être exposés, dans le cadre de leur travail, à un manque d'autonomie, à des exigences émotionnelles et à des conflits de valeurs. En France, les salariés font une distinction plus nette qu'ailleurs entre le temps professionnel et le temps extra-professionnel. Ils déclarent plus souvent que leurs horaires de travail s'accordent mal avec leurs engagements sociaux et familiaux (21 %), contrairement aux salariés au Danemark, aux Pays-Bas ou en Grande-Bretagne (respectivement 6 %, 9 % et 13 %). De même, 45 % des salariés en France parviennent difficilement à prendre une ou deux heures sur leur temps de travail afin de traiter des problèmes personnels ou familiaux, contre 15 % en Suède ou aux Pays-Bas. Relativement à la plupart des autres pays de l'Union, les rapports sociaux au travail, notamment avec la hiérarchie, apparaissent de moins bonne qualité en France. Près de 20 % des salariés déclarent n'être jamais ou rarement soutenus par leur supérieur contre 6 % en Irlande, mais 30 % en Allemagne ; 3 % signalent subir des discriminations au travail, soit autant qu'en Belgique ou au Luxembourg, mais bien plus qu'en Italie, Lituanie ou Roumanie. Le sentiment d'insécurité de l'emploi et du revenu est un peu moins fort en France que dans l'ensemble de l'Union européenne, mais les salariés pensent beaucoup plus souvent qu'ils ne pourront pas faire le même travail lorsqu'ils auront 60 ans (résumé de l'éditeur).
http://travail-emploi.gouv.fr/IMG/pdf/2014-100.pdf

Rottmann H. (2014). Do unemployment benefits and employment protection influence suicide mortality? An international panel data analysis. Amberg-Weiden : University of Applied Sciences Amberg-Weiden

Abstract: We examine the economic and social determinants of suicide mortality in a panel of 25 OECD countries over the period 1970 - 2011 and explicitly analyze the effects of unemployment and labor market institutions on suicide rates. In line with a large body of literature, our results suggest that unemployment and social factors are important determinants of suicide mortality. The results also indicate that unemployment benefits decrease suicides of males, while relatively strict employment protection regulations increase suicide mortality. These findings indicate that labor market institutions may influence job satisfaction and the quality of life in industrial countries. We suggest taking into account the role of labor market institutions when analyzing the effects of institutional and economic determinants on health.
https:ideas.repec.org/p/zbw/hawdps/42.html

Guertzen N., Hank K. (2014). Maternity Leave and Mothers' Long-Term Sickness Absence - Evidence from Germany. Mannheim. : Centre for European Economic Research (Z.E.W.).

Abstract: Exploiting unique German administrative data, we estimate the association between an expansion in maternity leave duration from two to six months in 1979 and mothers' post-birth long-term sickness absence over a period of three decades after childbirth. Using a regression discontinuity design, we first show that the leave extension caused mothers to significantly delay their return to work within the first year after childbirth. We then compare the number and length of spells of long-term sickness absence of returned mothers who gave birth before and after the change in leave legislation. Our findings suggest that among those returned, mothers subject to the leave extension exhibit a higher incidence of long-term sickness absence as compared to control mothers. This also holds true after controlling for observable differences in pre-birth illness histories. At the same time, there are no pronounced effects on mothers' medium-run labor market attachment following the short-run delay in return to work, which might rationalize a negative causal health effect. Breaking down the results by mothers' pre-birth health status suggests that the higher incidence of long-term sickness absence among the treated may be explained by the fact that the reform has facilitated re-entry of a negative health selection into the labor market.
http://ftp.zew.de/pub/zew-docs/dp/dp14109.pdf

Drydakis N. (2014). The Effect of Unemployment on Self-Reported Health and Mental Health in Greece from 2008 to 2013: A Longitudinal Study Before and During the Financial Crisis. Bonn : IZA

Abstract: The current study uses six annual waves of the Longitudinal Labor Market Study (LLMS) covering the 2008-2013 period to obtain longitudinal estimations suggesting statistically significant negative effects from unemployment on self-reported health and mental health in Greece. The specifications suggest that unemployment results in lower health and the deterioration of mental health during the 2008-2009 period compared with the 2010-2013 period, i.e., a period in which the country's unemployment doubled as a consequence of the financial crisis. Unemployment seems to be more detrimental to health/mental health in periods of high unemployment, suggesting that the unemployment crisis in Greece is more devastating as it concerns more people. Importantly, in all specifications, comparable qualitative patterns are found by controlling for unemployment due to firm closure, which allows us to minimize potential bias due to unemployment-health related reverse causality. Moreover, in all cases, women are more negatively affected by unemployment in relation to their health and mental health statuses than are men. Greece has been more deeply affected by the financial crisis than any other EU country, and this study contributes by offering estimates for before and during the financial crisis and considering causality issues. Because health and mental health indicators increase more rapidly in a context of higher surrounding unemployment, policy action must place greater emphasis on unemployment reduction and supporting women's employment.
http:ftp.iza.org/dp8742.pdf

Lis M., Magda I. (2014). Health - productivity and ageing. Warsaw : Institute for structural research.

Abstract: We provide a comparative cross-country analysis of individual age-wage profiles for different health statuses. Using semi-parametric regressions run on EU-SILC data we aim at answering the question on the relationship between individual health and productivity and its changes in the life cycle, separating the impact of health from traditional wage determinants. We found that although the age- productivity profiles vary much among countries, these differences are not influenced by the self-perceived health status.
https:ideas.repec.org/p/ibt/wpaper/wp022014.html

Lengagne P. (2014). Workers Compensation Insurance: Incentive Effects of Experience Rating on Work-related Health and Safety. Document de travail Irdes ; 64. Paris : IRDES
Abstract: L'assurance des risques professionnels couvrant les salariés du Régime général est financée sur la base de cotisations patronales dépendantes de la sinistralité passée de l'entreprise. Ce système de tarification peut, ainsi, contribuer à sensibiliser les employeurs à l'intérêt de développer des démarches préventives. Cet article propose une synthèse de la littérature empirique étudiant cet effet incitatif, puis présente une mesure de la relation entre les taux de cotisation et l'effort de prévention des entreprises, les conditions de travail et

les accidents du travail, à partir de données françaises au niveau sectoriel, dans l'industrie et la construction. Selon nos résultats, l'augmentation des taux de cotisation est associée à une amélioration des conditions de travail et un moindre taux d'accidents du travail, toutes choses égales par ailleurs.
http://www.irdes.fr/english/working-papers/064-workers-compensation-insurance-incentive-effects-of-experience-rating-on-work-related-health-and-safety.pdf

Angelov N., Eliason M. (2014). The differential earnings and income effects of involuntary job loss on workers with disabilities. Uppsala : IFAU

Abstract: People with disabilities, both in Sweden and elsewhere, are consistently found to face considerable difficulties on the labour market. In this study we have investigated the differential impact of involuntary job loss, on earnings and income, if being disabled. Our main findings are that earnings of those with and without disabilities began to diverge already several years prior to job loss because of a much larger incidence of longer periods of absence due to either sickness or rehabilitation. The seemingly permanent earnings differential following job loss seems to have been a consequence of much more of the job losers with disabilities not returning to employment but instead becoming disability retirees. Although the earnings differential experienced by the job seekers with disabilities was considerable during the post-job loss period, a majority of the difference was replaced by public social insurances.
http:www.ifau.se/Upload/pdf/se/2014/wp2014-26-The-differential-earnings-and-income-effects-of-involuntary-job-loss-on-workers-with-disabilitiespdf.pdf

Vieillissement / Ageing

Hurd M.D., Rohwedder S. (2014). Predicting labor force participation of the older population.
Standford : Stanford Institute for Economic Policy Research

Abstract: Labor force participation (LFP) rates are changing-and, at least for some groups, changing dramatically. These trends have important societal implications. For the most part, they indicate longer stays in the labor force and later retirement. Such trends may allow for the accumulation of greater wealth by the time an individual reaches retirement age, allowing for higher levels of income replacement and less pressure for increases in Social Security benefits. These trends may also reduce the financial stress borne by the working generation in supporting the retiring generation. Given the importance of these and other potential effects of changing LFP rates, the ability to predict the future of such rate s could be helpful to decision-makers. While LFP trends to date have been well documented, there have been few projections of trend lines that have instilled confidence. The purpose of this paper is to report on new LFP projections based on novel but rigorous methods taking advantage of panel data from the Health and Retirement Study. We begin with LFP rates based on the Current Population Survey, then move to two-year labor force retention rates and retirement hazards from HRS data. We then introduce the prediction tool, the HRS respondent's subjective probability of retention in the labor force at age 62 (or 65). We show the trends in this measure over the course of the past two decades and demonstrate its favorable comparability with actual retention behavior. We present individual - and population - level predictions of LFP rates based on subjective probabilities. We conclude with some data about possible cause of the increased LFP rates.
http://siepr.stanford.edu/?q=/system/files/shared/pubs/papers/14-011.pdf.

Gosh A., Orfield C., Schmitz R. (2014). Evaluating PACE: A Review of The Literature. Washington : D.A.L.T.C.P.

Abstract: The Program of All-Inclusive Care for the Elderly (PACE) provides coordinated acute and long-term care services to nursing home (NH) eligible seniors in the community. PACE is a Medicare managed care program and a Medicaid state plan option. Individuals who are 55 or older, certified by their state of residence as being eligible for NH level of care, and live in the service area of a PACE program are eligible to enroll in PACE. The underlying premise for Medicare and Medicaid financing of PACE is that these programs enable

some frail elderly enrollees to remain in the community, increase enrollees' satisfaction with health care services and quality of care, and save money for both the Medicare and Medicaid programs. Based on a comprehensive review of existing evaluations of PACE, this paper brings together available evidence on the effect of PACE on several key outcomes of interest--Medicare and Medicaid costs; hospital and NH utilization; quality of care, satisfaction and quality of life; and mortality. We summarize findings from past studies and assess their methodological approach. We include both published articles as well as research reports in this review and identify key themes that emerge from past findings when viewed in the light of their underlying strength of evidence. This review improves upon an earlier literature review (Galantowicz 2011) by utilizing stricter inclusion criteria and conducting a more detailed review of the studies, as well as a more rigorous assessment of the quality of evidence presented in each study.
http:aspe.hhs.gov/daltcp/reports/2014/PACELitRev.pdf

Gosh A., Schmitz R., Brown R. (2014). Effect of PACE on Costs, Nursing Home Admissions, and Mortality: 2006-2011. Washington : D.A.L.T.C.P. .

Abstract: This study examines the effects of the Program of All-Inclusive Care for the Elderly (PACE) on Medicare and Medicaid expenditures, use of nursing home services, and mortality. It was conducted as part of the Center of Excellence on Disability Research project. PACE plans provide coordinated acute and long-term care services to nursing home-eligible older adults in the community. Two separate components constituted the study: (1) a comprehensive review of existing evaluations of PACE, and (2) an empirical analysis of costs and outcomes for PACE enrollees relative to a matched comparison group. This report presents findings from the empirical evaluation.
http:aspe.hhs.gov/daltcp/reports/2014/PACEeffect.pdf