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Assurance maladie / Health Insurance

(2016). Les données personnelles de santé gérées par l'assurance maladie. Une utilisation à développer, une sécurité à renforcer. Paris : Cour des Comptes
https://www.ccomptes.fr/Accueil/Publications/Publications/Les-donnees-personnelles-de-sante-gerees-par-l-assurance-maladie
La Cour des comptes rend public, le 3 mai 2016, un rapport sur les données personnelles de santé gérées par l'assurance maladie, demandé par la commission des affaires sociales et la mission d'évaluation et de contrôle des lois de financement de la sécurité sociale de l'Assemblée nationale, en application de l'article LO. 132-3-1 du code des juridictions financières. Le système national d'information interrégimes de l'assurance maladie (SNIIRAM) constitue une base de données médico-administratives sans équivalent en Europe. Mise en service depuis 2004, elle a été progressivement enrichie et structurée, mais son potentiel, très important, demeure à parfaire. La qualité de la base peut être améliorée en réduisant les fragilités de codage et les remontées d'informations incomplètes. Les efforts doivent être poursuivis afin de réduire les risques pouvant affecter la confidentialité et la sécurité des données. Par ailleurs, les utilisations du SNIIRAM restent très limitées par rapport aux enjeux sanitaires et financiers. La Caisse nationale d'assurance maladie devrait notamment davantage y avoir recours, en particulier pour lutter contre les abus et la fraude des professionnels de santé. Devant être intégré au nouveau système national des données de santé institué en janvier 2016, le Sniiram demeure pour longtemps le cœur du système des données de santé. Pour encourager leur utilisation à des fins d'intérêt général, sécuriser l'existant, améliorer la gouvernance et assurer la fluidité des accès selon une approche à la fois rigoureuse et ouverte est prioritaire. La Cour formule 13 recommandations.

Courtemanche, C., et al. (2016). Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States. NBER Working Paper Series ; n° 22182. Cambridge : NBER
http://www.nber.org/papers/w22182
The Affordable Care Act (ACA) aimed to achieve nearly universal health insurance coverage in the United States through a combination of insurance market reforms, mandates, subsidies, health insurance exchanges, and Medicaid expansions, most of which took effect in 2014. This paper estimates the causal effects of the ACA on health insurance coverage using data from the American Community Survey. We utilize difference-in-difference-in-differences models that exploit cross-sectional variation in the intensity of treatment arising from state participation in the Medicaid expansion and local area pre-ACA uninsured rates. This strategy allows us to identify the effects of the ACA in both Medicaid expansion and non-expansion states. Our preferred specification suggests that, at the average pre-treatment uninsured rate, the full ACA increased the proportion of residents with insurance by 5.9 percentage points compared to 3.0 percentage points in states that did not expand Medicaid. Private insurance expansions from the ACA were due to increases in both employer-provided and non-group coverage. The coverage gains from the full ACA were largest for those with incomes below the Medicaid eligibility threshold, non-whites, young adults, and unmarried individuals. We find some evidence that the Medicaid expansion partially crowded out private coverage among low-income individuals.

Einav, L., et al. (2016). Private Provision of Social Insurance: Drug-specific Price Elasticities and Cost Sharing in Medicare Part D. NBER Working Paper Series ; n° 22277. Cambridge : NBER
http://www.nber.org/papers/w22277
Standard theory suggests that optimal consumer cost-sharing in health insurance increases with the price elasticity of demand, yet publicly-provided drug coverage typically involves

uniform cost-sharing across drugs. We investigate how private drug plans set cost-sharing in the context of Medicare Part D. We document substantial heterogeneity in the price elasticities of demand across more than 150 drugs and across more than 100 therapeutic classes, as well as substantial heterogeneity in the cost-sharing for different drugs within privately-provided plans. We find that private plans set higher consumer cost-sharing for drugs or classes with more elastic demand. Our findings suggest that benefit design may be more efficient in privately rather than publicly provided insurance.

Frean, M., et al. (2016). Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act. NBER Working Paper Series ; n° 22213. Cambridge : NBER
http://www.nber.org/papers/w22213
Using a combination of subsidized premiums for Marketplace coverage, an individual mandate, and expanded Medicaid eligibility, the Affordable Care Act (ACA) has significantly increased insurance coverage rates. We assessed the relative contributions to insurance changes of these different ACA provisions in the law's first full year, using rating-area level premium data for all 50 states and microdata from the 2012-2014 American Community Survey. We employ a difference-in-difference-in-difference estimation strategy that relies on variation across income groups, areas, and years to causally identify the role of the ACA policy levers. We have four key findings. First, insurance coverage was only moderately responsive to price subsidies, but the subsidies were still large enough to raise coverage by almost one percent of the population; the coverage gains were larger in states that operated their own health insurance exchanges (as opposed to using the federal exchange). Second, the exemptions and tax penalty structure of the individual mandate had little impact on coverage decisions. Third, the law increased Medicaid coverage both among newly eligible populations and those who were previously eligible for Medicaid (the "woodwork" effect), with the latter driven predominantly by states that expanded their programs prior to 2014. Finally, there was no "crowdout" effect of expanded Medicaid on private insurance. Overall, we conclude that exchange premium subsidies produced roughly 40% of the ACA's 2014 coverage gains, and Medicaid the other 60%, of which 2/3 occurred among previously-eligible individuals.

Laporte, A. et Ferguson, B. (2016). How does Insurance affect the Price of Drugs: A Graphical Analysis. Working Paper No: 160006. Toronto : Canadian Centre for Health Economics.
https://ideas.repec.org/p/cch/wpaper/160006.html
Prices of drugs differ greatly across countries and to a certain degree across payment agencies within countries (OECD (2015)). It is well known among health economists that the presence of insurance creates a separation between the consumer of pharmaceuticals and the payer. This separation can result in the price of drugs being driven up simply because somebody other than the consumer is responsible for paying for them. The precise impact of insurance on drug prices however, will depend critically on the structure of the insurance, a fact that has tended to get lost in health policy debate. The purpose of this paper is to use diagrammatic analysis of three types of insurance: co-insurance, reference pricing and co-payment, to investigate how each affects the price of prescription drugs. In addition, we analyze the role of a new pricing tool, which has recently been increasingly used by pharmaceutical companies in North America: co-Payment waiver coupons. Among other policy implications, we suggest that the use of co-pay waivers turns the co-payment insurance constraint into something similar to the reference pricing constraint, from the supplier's perspective, but with greater transactions costs.

Simon, K., et al. (2016). The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence from the 2014 ACA Medicaid Expansions. NBER Working Paper Series ; n° 22265.

Cambridge : NBER
http://www.nber.org/papers/w22265
The U.S. population receives suboptimal levels of preventive care and has a high prevalence of risky health behaviors. One goal of the Affordable Care Act (ACA) was to increase preventive care and improve health behaviors by expanding access to health insurance. This paper estimates how the ACA's state-level expansions of Medicaid in 2014 affected these outcomes. Using data from the Behavioral Risk Factor Surveillance System, and a difference-in-differences model that compares states that did and did not expand Medicaid, we examine the impact of the expansions on preventive care (e.g. dental visits, immunizations, mammograms, cancer screenings) and risky health behaviors (e.g. smoking, heavy drinking, lack of exercise, obesity). We find evidence consistent with increased use of certain forms of preventive care such as dental visits and cancer screenings but little evidence of changes in health behaviors and in particular no evidence of ex ante moral hazard (i.e., no evidence that risky health behaviors increased in response to health insurance coverage). The Medicaid expansions also resulted in modest improvements in self-assessed health and decreases in the number of work days missed due to poor health.

Economie de la santé / Health Economics

Hege, R. (2016). La demande d'aide à domicile est-elle sensible au reste-à-charge : une analyse multi-niveaux sur données françaises. CES Working Paper; 2016.22. Paris : Centre d'économie de la Sorbonne:
https://ideas.repec.org/p/mse/cesdoc/16022.html
This article focuses on the price-elasticity of demand for formal home-care received by disabled elderly. In France a public financing system of long-term care for disabled elderly – aged 60 and over – called APA (Allocation Personnalisée d'Autonomie) has been set up in 2001. This policy is based on a partial subsidization of demand for formal home-care so that an out-of-pocket cost remains. It rests on three variables: the department policy, the provider chosen by the recipient and the income level of the recipient. The induced heterogeneity of the out-of-pocket cost allows price-elasticity estimations but compels me to employ two databases. I use the HSM survey – an individual database on disability and health that is representative of the French population – and the Territoire survey which provides information in each region on the APA policy parameters. The combination of these two databases enables me to approximate the out-of-pocket cost for each individual that is the one-hour formal home-care price. I estimate a multi-level model with random effects and find that the price-elasticity of demand for formal home-care has a value of -0.15 at my average point

Etat de santé / Health Status

(2015). Rapport sur la santé en Europe 2015 : Les cibles et au-delà. Atteindre les nouvelles frontières des bases factuelles. Copenhague : Bureau régional de l'Europe
http://www.euro.who.int/__data/assets/pdf_file/0005/293738/European-health-report-2015-full-book-fr.pdf
Tous les trois ans, la publication du Rapport sur la santé en Europe est l'occasion de se pencher sur les progrès accomplis pour assurer réellement santé et bien-être à tous. Le

rapport 2015 montre que la situation sanitaire continue de s'améliorer dans toute la Région européenne, et que certaines des inégalités entre pays, notamment en matière d'espérance de vie et de mortalité infantile, ont reculé ces dernières années. En termes réels, cependant, ces différences entre les pays qui sont les plus ou les moins performants représentent toujours 11 années de vie et 20 bébés en bonne santé pour 1000 naissances vivantes. Dans l'absolu, les différences entre pays conservent une ampleur inacceptable, en particulier pour les indicateurs liés aux déterminants sociaux de la santé. En outre, ce rapport montre clairement que la Région européenne reste celle qui enregistre les plus hauts taux de consommation d'alcool et de tabac au monde. Le rapport 2015 poursuit la discussion, entamée dans le rapport 2012, sur le concept du bien-être dans le cadre de Santé 2020. Il présente les premiers résultats au sujet du bien-être subjectif et objectif dans le contexte de Santé 2020 et examine les méthodes innovatrices que les décideurs politiques peuvent employer pour le mesurer, ce qui est une tâche difficile ; étudie comment la culture pourrait influencer la santé et le bien-être ; est une réflexion sur la manière dont l'OMS pourrait exploiter des informations provenant de sources non traditionnelles (par exemple, en recourant à l'histoire et à l'anthropologie) pour obtenir un tableau plus complet du bien-être en Europe. Santé 2020 englobe des notions telles que la résilience des communautés et le sentiment d'appartenance et d'autonomie, et nécessite de jeter un regard neuf sur les informations sanitaires pour veiller à ce que les bases factuelles compilées répondent aux besoins de cette politique. Tout au long de la chaîne d'information, depuis le recueil, l'analyse et l'interprétation des données jusqu'à leur communication et l'emploi de ces informations dans le processus d'élaboration de politiques, les difficultés sont nombreuses. Ce rapport est un appel à une vaste collaboration internationale afin de concentrer l'attention et les efforts sur l'harmonisation, la fixation de normes pour le XXIe siècle et la création de bases factuelles adaptées à notre époque. Les utilisateurs peuvent travailler avec les données présentées dans cette publication sur le portail européen d'information sanitaire de l'OMS/Europe.

Barbieri, P. N. (2016). The heterogeneity in immigrants unhealthy assimilation. Munich : MRPA
https://mpra.ub.uni-muenchen.de/71560/
Immigrants upon their arrival in the United States are in better health condition with respect to their American counterpart however such advantage erodes over time. In this paper, we study the heterogeneity of such unhealthy behaviours assimilation among different arrival cohorts. We focus our analysis on binge drinking and cigarette consumption as a proxy for unhealthy behaviour assimilation by immigrants. Regarding binge drinking we show that more recent immigrant cohorts arrive with a higher probability of being binge drinker and experience a faster "unhealthy assimilation" in terms of increased consumption of alcohol and an increase in the probability of starting to drink over guideline on a daily basis. Such assimilation is less pronounced for smoking habits, in fact both earlier and later arrival cohorts report lower smoking rates. However, such health advantage is decreasing with time spent in the US.

Chernew, M., et al. (2016). Understanding the Improvement in Disability Free Life Expectancy In the U.S. Elderly Population. NBER Working Paper Series ; n° 22306. Cambridge : NBER
Understanding how healthy lifespans are changing is essential for public policy. This paper explores changes in healthy lifespan in the U.S. over time and considers reasons for the changes. We reach three fundamental conclusions. First, we show that healthy life increased measurably in the US between 1992 and 2008. Years of healthy life expectancy at age 65 increased by 1.8 years over that time period, while disabled life expectancy fell by 0.5 years. Second, we identify the medical conditions that contribute the most to changes in healthy life expectancy. The largest improvements in healthy life expectancy come from reduced

incidence and improved functioning for those with cardiovascular disease and vision problems. Together, these conditions account for 63 percent of the improvement in disability-free life expectancy. Third and more speculatively, we explore the role of medical treatments in the improvements for these two conditions. We estimate that improved medical care is likely responsible for a significant part of the cardiovascular and vision-related extension of healthy life.

Chzhen, Y., et al. (2016). Family Affluence and Inequality in Adolescent Health and Life Satisfaction: Evidence from the HBSC study 2002-2014. Florence : Centre de recherche Innocenti de l'UNICEF
https://www.unicef-irc.org/publications/pdf/IWP_2016_10.pdf
A large body of literature has established socio-economic gradients in adolescent health, but few studies have investigated the extent to which these gradients are associated with very poor health outcomes. The current analysis examined the extent to which the socio-economic background of adolescents relates to very poor self-reported health and well-being (the so-called 'bottom end'). We examined the following as indicators of adolescent health: psychosomatic health complaints; physical activity; healthy eating; unhealthy eating; and life satisfaction. Adolescents who scored below the mean of the lower half of the distribution of a given indicator fall in the "bottom group" on this indicator. The largest, most persistent and widespread socio-economic gradients are in life satisfaction, physical activity and healthy eating, while the findings are mixed for unhealthy eating and psychosomatic health. Socio-economic inequalities were largely stable, but in a sizeable minority of the countries, socio-economic inequalities in physical activity and healthy eating have widened between 2001/02 and 2013/14, while inequalities in unhealthy eating and life satisfaction have narrowed in several countries.

Gil, J. (2016). Is Marriage Protecting your Health in Recession Times? Madrid : FEDEA:
http://documentos.fedea.net/pubs/eee/eee2016-19.pdf
This paper aims to contribute to the literature on the protective effects of marriage on individuals' health by examining whether this advantage is still valid in recession times. A two stage empirical strategy is followed based on individual-level cross-section data for Spain. Using propensity score matching techniques we firstly estimate the causal impact of divorce and legal separation (marital dissolution) on mental health and binge drinking in two different points in time: before and during the economic crisis. Secondly, we examine whether there exists an incremental or detrimental effect on these health outcomes implied by the economic recession using difference in-difference (DiD) regression methods, upon conditioning on a proxy of innate health status. The results confirm that divorce and separation cause a large and significant deterioration of mental health and a raise in heavy drinking both before the economic recession and after (during) the crisis. Strikingly, we find that this detrimental effect on psychological health is actually lowered because of the recession, although this amelioration on mental health is observed for male individuals. However, heavy drinking does not seem to worsen more with divorce/separation during the economic downturn. These findings, which appear robust to the sensitivity analysis, would then suggest that the marriage institution, contrary to what is generally believed, would not be protecting mental health status, mainly in male individuals, under a period of economic crisis. We speculate that divorce/separation may act as an escape mechanism to confront the usual financial constraints and other stress-related issues which are strengthened during a prolonged period of recession.

Persico, C., et al. (2016). Inequality Before Birth: The Developmental Consequences of Environmental Toxicants. NBER Working Paper Series ; n° 22263. Cambridge : NBER

http://www.nber.org/papers/w22263
Millions of tons of hazardous wastes have been produced in the United States in the last 60 years which have been dispersed into the air, into water, and on and under the ground. Using new population-level data that follows cohorts of children born in the state of Florida between 1994 and 2002, this paper examines the short and long-term effects of prenatal exposure to environmental toxicants on children living within two miles of a Superfund site, toxic waste sites identified by the Environmental Protection Agency as being particularly severe. We compare siblings living within two miles from a Superfund site at birth where at least one sibling was conceived before or during cleanup of the site, and the other(s) was conceived after the site cleanup was completed using a family fixed effects model. Children conceived to mothers living within 2 miles of a Superfund site before it was cleaned are 7.4 percentage points more likely to repeat a grade, have 0.06 of a standard deviation lower test scores, and are 6.6 percentage points more likely to be suspended from school than their siblings who were conceived after the site was cleaned. Children conceived to mothers living within one mile of a Superfund site before it was cleaned are 10 percentage points more likely to be diagnosed with a cognitive disability than their later born siblings as well. These results tend to be larger and are more statistically significant than the estimated effects of proximity to a Superfund site on birth outcomes. This study suggests that the cleanup of severe toxic waste sites has significant positive effects on a variety of long-term cognitive and developmental outcomes for children.

Persson, P. et Rossin-Slater, M. (2016). Family Ruptures, Stress, and the Mental Health of the Next Generation. NBER Working Paper Series ; n° 22229. Cambridge : NBER
http://www.nber.org/papers/w22229
This paper studies how in utero exposure to maternal stress from family ruptures affects later mental health. We find that prenatal exposure to the death of a maternal relative increases take-up of ADHD medications during childhood and anti-anxiety and depression medications in adulthood. Further, family ruptures during pregnancy depress birth outcomes and raise the risk of perinatal complications necessitating hospitalization. Our results suggest large welfare gains from preventing fetal stress from family ruptures and possibly from economically induced stressors such as unemployment. They further suggest that greater stress exposure among the poor may partially explain the intergenerational persistence of poverty.

Pruss-Ustin, A., et al. (2016). Preventing disease through healthy environments. A global assessment of the burden of disease from environmental risks. Genève : OMS
http://apps.who.int/iris/bitstream/10665/204585/1/9789241565196_eng.pdf
Ce rapport a pour objectif d'estimer la charge de morbidité liée aux facteurs environnementaux. Le rapport indique, pathologie par pathologie, le nombre de décès, pathologies et incapacités qui pourraient être évités chaque année en réduisant l'exposition humaine aux risques environnementaux. Il s'intéresse en particulier aux facteurs environnementaux modifiables, qui comprennent les dangers physiques, chimiques et biologiques qui nuisent directement à la santé, mais aussi les facteurs environnementaux qui favorisent des comportements malsains tels que la sédentarité.

Vang, Z., et al. (2015). The Healthy Immigrant Effect in Canada: A Systematic Review. Document de travail ; Vol. 3: Iss. 1, Article 4. Montréal : McGill University
http://socserv.mcmaster.ca/sedap/p/sedap164.pdf
Many studies show that immigrants are typically healthier than the native -born population, at least initially upon arrival in their new country. Immigrants are also heal thier than non -migrants in the countries of origin. This foreign -born health advantage (also known as the

"healthy immigrant effect") has been documented among immigrants in Europe (Bollini & Siem, 1995), the United States (Cunningham, Ruben, & Narayan, 2008) and Canada (Beiser, 2005). In Canada, much of what we know about the healthy immigrant effect is based on studies of adult migrants. Thus, it remains unclear whether immigrants' health advantage extends to foreign -born children and older adults. Moreover, with the exception of a few publications (Beiser, 2005; Hyman & Jackson, 2010; Ng, 2010), there has not been an attempt to systematically document the extent of the healthy immigrant effect in Canada across multiple health indicators and life -course stages. The current report fills this lacuna.

Géographie de la santé / Geography of Health

(2016). Inégalités environnementales : identification des points noirs environnementaux en Île-de-France. Paris : ORSIF
http://www.ors-idf.org/dmdocuments/2016/Rapport_etude_PNE.pdf
Le plan régional Santé Environnement 2 (PRSE 2) de la région Île-de-France (2011-2015) a consacré l'un de ses principaux axes structurants à la réduction des inégalités environnementales. Parmi les différentes actions que comporte ce plan, l'action n° 6 concernait précisément l'identification de « points noirs environnementaux » entendus comme des zones géographiques surexposées, cumulant plusieurs problèmes environnementaux. Dans le cadre de cette action sous le pilotage de l'ORS Île-de-France, de la DRIEE Île-de-France et de la région Île-de-France, une méthodologie pour révéler ces situations territoriales critiques de multi-exposition a été développée. 864 secteurs cumulant au moins 3 nuisances environnementales ont ainsi pu être recensés. Cinq indicateurs de nuisances et pollutions ont été retenus pour établir cette première géographie des points noirs environnementaux à l'échelle régionale : la pollution de l'air ; le bruit ; la pollution des sols ; la pollution de l'eau distribuée ; les pollutions chroniques diffuses liées à l'activité industrielle. L'objet de ce rapport d'étude est de présenter les différentes étapes et choix méthodologiques et les principaux résultats et enseignements qui peuvent en être tirés.

Ferruccio, P. (éd),. et Ponzo, I. éd. (2016). Inter-group Relations and Migrant Integration in European Cities, sl : Springer Open
http://link.springer.com/book/10.1007/978-3-319-23096-2
This book presents a comparative analysis of intergroup relations and migrant integration at the neighbourhood level in Europe. Featuring a unique collection of portraits of urban relations between the majority population and immigrant minorities, it examines how relations are structured and evolve in different and increasingly diverse local societies. Inside, readers will find a coordinated set of ethnographic studies conducted in eleven neighbourhoods of five European cities: London, Barcelona, Budapest, Nuremberg, and Turin. The wide-ranging coverage encompasses post-industrial districts struggling to counter decline, vibrant super-diverse areas, and everything in between. Featuring highly contextualised, cross-disciplinary explorations presented within a solid comparative framework, this book considers such questions as: Why does the native-immigrant split become a tense boundary in some neighbourhoods of some European cities but not in others? To what extent are ethnically framed conflicts driven by site-specific factors or instead by broader, exogenous ones? How much does the structure of urban spaces count in fuelling inter-ethnic tensions and what can local policy communities do to prevent this? The answers it provides are based on a multi-layer approach which combines in-depth analysis of intergroup relations with a strong attention towards everyday categorization processes, media representations, and narratives on which local policies are based. Even though the relations between the majority and migrant minorities are a central topic, the volume also

offers readers a broader perspective of social and urban transformation in contemporary urban settings. It provides insightful research on migration and urban studies as well as social dynamics that scholars and students around the world will find relevant. In addition, policy makers will find evidence-based and practically relevant lessons for the governance of increasingly diverse and mobile societies (résumé de l'éditeur).

Hôpital / Hospitals

(2016). Discharging older patients from hospital. Londres : NAO
https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf
There are currently far too many older people in hospitals who do not need to be there. Without radical action, this problem will worsen and add further financial strain to the NHS and local government. This report examines how effectively the health and social care system is managing the discharge of older patients from hospital, in particular: the scale of delays that older patients experience in hospital ; the extent to which health and social care providers are adopting good practice in discharging older patients and barriers to local health and social care systems working effectively.

Dobkin, C., et al. (2016). The Economic Consequences of Hospital Admissions. NBER Working Paper Series ; n° 22288. Cambridge : NBER
http://www.nber.org/papers/w22288
We examine some economic impacts of hospital admissions using an event study approach in two datasets: survey data from the Health and Retirement Study, and hospital admissions data linked to consumer credit reports. We report estimates of the impact of hospital admissions on out-of-pocket medical spending, unpaid medical bills, bankruptcy, earnings, income (and its components), access to credit, and consumer borrowing. The results point to three primary conclusions: non-elderly adults with health insurance still face considerable exposure to uninsured earnings risk; a large share of the incremental risk exposure for uninsured non-elderly adults is borne by third parties who absorb their unpaid medical bills; the elderly face very little economic risk from adverse health shocks.

Georges-Tarragano, C., et al. (2015). Soigner (l')humain. Manifeste pour un juste soin au juste coût, Rennes : Presses de l'Ehesp
http://www.presses.ehesp.fr/produit/soigner-lhumain-manifeste-pour-un-juste-soin-au-juste-cout/
Le système de santé français est confronté à une crise multiforme : contraintes financières sans précédent, spécialisation et pression à la productivité des équipes… À cette approche quantitative s'ajoutent les exigences croissantes des patients en matière de qualité et de sécurité des soins et une montée en puissance des aspirations à plus de démocratie sanitaire. Tels sont les défis auxquels doit faire face l'offre de soins. Loin des discours incantatoires ou d'une vision « hors-sol » du sujet, médecins, travailleurs sociaux, économistes de la santé, directeurs d'hôpital, personnalités de la santé publique et de l'éthique et chercheurs en sciences sociales livrent leur réflexion et explorent une nouvelle voie pour tenter de relever ces défis : l'humain. Ils proposent des solutions concrètes tirées des expériences de terrain de professionnels œuvrant auprès des plus démunis dans les permanences d'accès aux soins de santé (PASS). Dans ces dispositifs, l'approche du soin s'adapte aux situations complexes et se révèle à la fois qualitative, performante et complémentaire du soin technique et spécialisé (extrait 4ème de couv.)

Gravelle, H. et Schroyen, F. (2016). Optimal Hospital Payment Rules Under Rationing By Random Waiting. CHE Research Paper Series ;130. York : University of York
https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP130_rationing_waiting_prospective_payment_queues_hospitals.pdf
We derive optimal rules for paying hospitals in a public health care system in which providers can choose quality and random patient demand is rationed by waiting time. Since waiting time imposes real costs on patients hospital payment rules should take account of their effect on waiting time as well as on quality and the number of patients treated. We develop a general stochastic model of rationing by waiting and use it to derive welfare maximising payment to hospitals linked to output, expected waiting times, quality, hospital capacity and length of stay. We show that, although prospective output pricing gives hospitals an incentive to attract patients by raising quality and reducing waiting times, it must be supplemented by prices attached to other hospital decisions and outcomes except under very strong assumptions about the welfare function, patient preferences, and whether patients lose income whilst waiting.

Nestrigue, C. et Or, Z. (2016). "Le surcoût des événements indésirables associés aux soins à l'hôpital." Soins **61**(804): 23-25.
http://www.em-consulte.com/en/article/1048292
La qualité et la sécurité des soins fournis à l'hôpital font l'objet d'une attention croissante dans nombre de pays. Le célèbre rapport de l'Institut de médecine américain précisant que près de 100 000 Américains meurent chaque année à cause d'événements indésirables associés aux soins (EIS) – pour lesquels le coût est estimé à près de 29 milliards de dollars par an – a suscité la volonté de mieux comprendre ces EIS afin d'en réduire l'occurrence.

Veran, O. (2016). Mission sur l'évolution du mode de financement des établissements de santé. Rapport d'étape. sl sn
http://www.olivier-veran.fr/rapport-detape-sur-le-mode-de-financement-des-etablissements-de-sante/rapport-detape-t2a/
Ce rapport intermédiaire est le résultat d'une mission sur l'évolution du mode de financement des établissements de santé, établi par un comité des experts. Il dresse un premier bilan de la tarification à l'activité (T2A) près de 10 ans après sa mise en œuvre. Il fait le constat que la T2A, pensé comme un outil de cotation, efficace pour les activités standardisées, peine à rendre compte de l'activité médicale, notamment les maladies chroniques, les urgences, les soins critiques, les soins palliatifs,… mais aussi les activités hospitalières dites de proximité. Par ailleurs, la T2A a pris dans certains cas une place prépondérante dans l'organisation même de l'hôpital alors que ce n'est pas son rôle. La T2A peine enfin à rendre compte de la pertinence et de la qualité des soins. Le comité émet des propositions applicables à court terme visant à faire évoluer le financement hospitalier lorsque le modèle actuel n'est pas le plus adapté. Il ouvre par ailleurs la voie à des réformes structurelles couvrant l'ensemble des enjeux liés à la question générale du financement des établissements de santé, et qui feront l'objet d'un rapport complémentaire.

Inégalités de santé / Health Inequalities

(2016). Inégalités sociales de santé en lien avec l'alimentation et l'activité physique : une expertise collective. Paris : Inserm
http://www.inserm.fr/espace-journalistes/inegalites-sociales-de-sante-en-lien-avec-l-alimentation-et-l-activite-physique-une-expertise-collective-de-l-inserm
L'un des nouveaux axes de la 3ème période du Programme national nutrition-santé (PNNS)

(2011-2015) vise à réduire les inégalités sociales de santé en lien avec la nutrition (alimentation et activité physique). Dans ce cadre, la Direction générale de la santé (DGS) a sollicité l'Inserm pour établir un bilan des connaissances scientifiques sur les déterminants de la différenciation sociale dans le champ de la nutrition et sur les différentes stratégies d'interventions qui pourraient être utilisées pour réduire ces inégalités. L'analyse par des experts pluridisciplinaires des données issues de la littérature scientifique internationale récente a permis d'évaluer les disparités nutritionnelles selon la position socioéconomique des individus. Les facteurs sociaux, culturels, économiques et environnementaux qui participent à la construction des inégalités sociales de nutrition ont été analysés. Les experts ont également étudié l'impact des interventions et des politiques de prévention en fonction de la position socioéconomique et identifié les stratégies les plus à même de réduire les inégalités sociales dans le domaine de l'alimentation et de l'activité physique. En conclusion, ils proposent de concevoir et promouvoir des programmes qui apportent des bénéfices à la fois à l'ensemble de la population mais aussi des actions qui s'adressent aux différents groupes sociaux en fonction des risques et besoins auxquels ils sont confrontés.

(2016). Les droits fondamentaux des étrangers en France. Paris : Le Défenseur des Droits
http://www.defenseurdesdroits.fr/fr/publications/rapports/rapports-thematiques/les-droits-fondamentaux-des-etrangers-en-france
Ce rapport pointe l'ensemble des obstacles qui entravent l'accès des étrangers aux droits fondamentaux, en prenant appui sur les décisions de l'Institution mais en identifiant aussi de nouveaux problèmes juridiques et les pratiques illégales. Une partie est notamment consacrée aux droits à la protection de la santé (AME, PUMa, refus de soins discriminatoires), à la protection sociale (discriminations légales à l'accès aux prestations sociales des étrangers en situation régulière, accès aux prestations familiales, aux minima sociaux), au droit du travail, au droit au séjour des étrangers pour soins.

(2016). Pacte pour la santé globale des plus vulnérables : rapport 2016. Paris : Croix Rouge Française
http://www.croix-rouge.fr/
Rendu public à l'occasion de ses Journées Nationales, ce document de la Croix Rouge française présente le premier opus d'un rapport annuel autour de la thématique de la santé, telle que définie par l'OMS, à savoir un état de bien-être physique, mental et social et ne consistant pas seulement en une absence d'infirmité ou de maladie : le « Pacte pour la santé globale des plus vulnérables ».

Leopold, L. et Leopold, T. (2016). Education and Health Across Lives and Cohorts: A Study of Cumulative Advantage in Germany. SOEPpapers on Multidisciplinary Panel Data Research ; 835. Berlin : DIW
Research from the United States has supported two hypotheses about health inequality. First, educational gaps in health widen with age – the cumulative advantage hypothesis. Second, this relationship has intensified across cohorts – the rising importance hypothesis. In this article, we estimate hierarchical linear models using 22 waves of panel data (SOEP, 1992–2013) to test both hypotheses in the German context, which contrasts sharply with the U.S. in the structural forces shaping health inequality. We consider individual and contextual influences on the core association between education and health, and assess gender differences in the process of cumulative advantage. Our overall results support the cumulative advantage hypothesis, as health gaps between higher and lower educated people widen with age. Further analyses reveal that this process is gender specific. Among women, educational gaps in health are small and remain stable. Among men, these gaps not only widen rapidly with age, but also increasingly across cohorts, supporting the rising importance

hypothesis.

Sole-Auro, A. et Alcaniz, M. (2015). Is the educational health gap increasing for women? Results from Catalonia (Spain). UB Riskcenter Working Paper; 2015/06. Barcelone : Université de Barcelone
http://www.ub.edu/riskcenter/research/WP/UBriskcenterWP201506.pdf
Background: Health expectancies vary worldwide according to socioeconomic status (SES). The lower SES usually show health disadvantage and the higher SES a health advantage compared to the average. The educational level of individuals is strongly linked to their SES. Objective: We propose to identify the evolution of SES differentials in health by gender, paying special attention to the trends for the least advantaged - low educated females. We focus on the adult Catalan population (Spain) aged 55 or older. Methods: We measured SES through education. We used individual cross-sectional data obtained in 1994 and in 2012 from the Catalan Health Survey. We examined three comprehensive health indicators to disentangle the health and disability statuses in order to document social differences in health. We applied logistic models for each indicator, controlling for sociodemographic characteristics, health coverage and lifestyle. Results: Low educated males and females experienced an increase in the prevalence of functional and ADL limitations. We found an increment in the likelihood of bad health and functional limitations for the low educated between 1994 and 2012. The prevalence of smoking increased for low and middle educated females, whereas low educated males suffered a 4.1% increment of sedentarism. Having smoked in the past and leading a sedentary lifestyle increased the likelihood of bad and functional limitations. In general, double health coverage reduced the effect on reporting more health problems. Our predicted probabilities show that low educated women were more likely to self-perceive their health as bad and report functional limitations than any other group in both periods. Conclusions: Lower educated females are the most disfavored group in terms of health and personal autonomy. The gender gap between low educated men and women has reduced for self-perceiving bad health and for functional limitations between 1994 and 2012. Adopting a healthy lifestyle promotes well-being and personal autonomy. Health policies should continue to take into account that the population with lower SES is more likely to suffer from poor health and disability as they age, being the females a particularly fragile group.

Médicaments / Pharmaceuticals

(2016). Guidelines for ATC index with DDDs assigment 2016. Oslo : OMS - Collaborating Centre for Drug Statistics Methodology.
www.whocc.no
L'objectif de ce guide est de mettre à la disposition de l'utilisateur des recommandations concernant la classification anatomique, thérapeutique et chimique (ATC) et la notion de DDD (Dose définie par jour) pour les médicaments.

(2016). "Les dispositifs médicaux inscrits à la LPP : situation et évolution 2010-2014." Points De Repère(45): 11
http://www.ameli.fr/l-assurance-maladie/statistiques-et-publications/rapports-et-periodiques/points-de-repere/n-44-antiviraux-a-action-directe-et-hepatite-c.php
Avec 5,1 milliards d'euros présentés au remboursement et une croissance annuelle moyenne de l'ordre de 6 % entre 2010 et 2014, les dispositifs médicaux inscrits sur la liste des produits et prestations (LPP), hors dispositifs implantables constituent un poste de dépense important, très hétérogène et souvent mal connu (encadré 2). Aussi, ce fascicule est

l'occasion de se pencher sur les catégories qui composent la LPP, de décrire les postes présentant les dépenses les plus importantes ou des dynamiques particulières. Dans la lignée de l'analyse faite en 2008, il a pour objet de donner un éclairage sur ces prestations : description de celles-ci et évolution des montants associés. La décomposition des différents facteurs de croissance met par ailleurs en exergue un effet volume prédominant dans ce secteur où les effets prix (à la baisse) sont paradoxalement relativement limités.

Hawlik, K. et Devaliere, A. (2016). Access to High-priced Medicines in Hospital Settings in Europe. Amsterdam : HAI
http://haiweb.org/wp-content/uploads/2016/04/Access-to-High-priced-Medicines-in-the-Hospital-Sector.pdf
The demand for new medicines is constantly rising—and alongside that demand are increasing prices on patented pharmaceuticals. Significant disparities regarding access to medicines are emerging across the European Union (EU). However, only limited data is available on the price difference of medicines used in hospitals across the EU. The aim of this paper is to assess access to patented, high-priced medicines used in hospitals in different EU Member States

Schwabe, U. et Paffrath, D. (2016). Arzneiverordnungsreport 2015. Heidelberg : Springer Medizin Verlag
Publiée annuellement, cette brochure rassemble toute une série d'informations sur les médicaments en Allemagne, pour l'année 2015. Ces données proviennent des remboursements effectués par la GKV (l'ensemble des caisses d'Assurance maladie obligatoire allemande). Cet ouvrage contient à la fois : des données chiffrées très détaillées - conditionnement par conditionnement, en termes de dépenses et de quantités évaluées en DDD ; des analyses du marché pharmaceutique de l'année, arrivée de nouveaux produits, analyse générale du marché de l'année et analyse détaillée par classe thérapeutique ; des analyses de 'évolution du marché en mettant en regard tous les événements institutionnels de l'année écoulée. Cet ouvrage constitue l'ouvrage de référence du marché pharmaceutique allemand ; l'analyse de chaque classe thérapeutique est confiée à une personne spécialiste de la classe concernée.

Yeung, K., et al. (2016). Price Elasticities of Pharmaceuticals in a Value-Based-Formulary Setting. NBER Working Paper Series; n° 22308. Cambridge : NBER
http://www.nber.org/papers/w22308
Ever since the seminal RAND Health insurance experiment (HIE) was conducted, most health care services, including pharmaceuticals, are deemed to be price inelastic with price elasticities of demand (PED) close to -0.20. However, most studies of PED exploit natural experiments that change demand prices for multiple components of health care. Consequently, these experiments usually do not produce estimates for the true own-price elasticities of demand but rather composite own-price elasticities that are driven by concomitant price changes to their substitutes and complements. Hence, an estimate of price elasticity is expected to vary based on the setting in which it was estimated, and likely not be applicable to other settings. In this work, exploiting a natural experiment of exogenous policy implementation of a value-based formulary (VBF) that was designed based on drug-specific incremental cost-effectiveness ratios, we estimate price elasticities of pharmaceuticals within a VBF design, formally accounting for the nature of composite elasticities that such a setting would generate. We also calculate welfare effects of such a policy using a consumer surplus approach. We show theoretically that VBF designs can increase dispersion of price elasticities of demand among pharmaceutical products compared to their true own-price elasticities and affect their magnitude based on direction

of price change. Aligning these PEDs with value VBF is also likely to produce positive welfare effects. We estimate an overall PED for pharmaceuticals to be -0.16, close to the estimate of RAND HIE. However, we see substantial dispersion of PED across the VBF tiers ranging from -0.09 to -0.87 with trends aligned with the levels of value as reflected by the cost-effectiveness ratio (p<0.001). The net welfare increase was $147,000 for the cohort or $28 per member over the post-policy year. Further experimentations of VBF designs with alternative cost-effectiveness thresholds, copayment levels and value-definitions could be quite promising for improving welfare.

Méthodologie – Statistique / Methodology - Statistics

(2016). "Classification internationale des maladies et des problèmes de santé connexes (CIM-10 FR) 2016 à usage PMSI : Volume 1." Bulletin Officiel(2016-9bis)
http://social-sante.gouv.fr/IMG/pdf/sts_20160009_0001_p000.pdf
La Classification statistique internationale des maladies et des problèmes de santé connexes (CIM) a pour but de permettre l'analyse systématique, l'interprétation et la comparaison des données de mortalité et de morbidité recueillies dans différents pays ou régions et à des époques différentes. La CIM est utilisée pour transposer les diagnostics de maladies ou autres problèmes de santé, en codes alphanumériques, ce qui facilite le stockage, la recherche et l'analyse des données et son utilisation en épidémiologie, en planification et gestion sanitaire ou encore à des fins cliniques. La CIM est gérée par l'Organisation mondiale de la santé (OMS) qui en a publié la dixième révision (CIM–10) en 1993. La CIM–10 fait l'objet de mises à jour annuelles qui sont publiées en anglais sur le site www.who.int/classifications/icd/icd10updates. Dans le cadre du Programme de médicalisation du système d'information (PMSI) des établissements hospitaliers français, la CIM–10 est utilisée pour le codage des diagnostics et des motifs de recours aux services de santé. Pour répondre aux exigences descriptives et administratives du PMSI, l'ATIH crée chaque année des extensions nationales qui enrichissent la CIM–10. La présente CIM–10 à usage PMSI (CIM–10–FR 2016) constitue une version actualisée et enrichie du volume 1 (Table analytique) de la CIM–10. Elle intègre : - l'ensemble des mises à jour de l'OMS jusqu'en janvier 20151 ; - l'intégralité des mises à jour réalisées par l'ATIH. Cette publication est uniquement destinée au PMSI et est applicable pour le recueil d'information des champs MCO (Etablissement de court séjour de médecine, chirurgie et obstétrique), SSR (Établissements de soins de suite et de réadaptation), HAD (Hospitalisation à domicile) et psychiatrie à compter de l'année 2016.

Heckmann, J. J., et al. (2016). Returns to Education: The Causal Effects of Education on Earnings, Health and Smoking. NBER Working Paper Series ; n° 22291. Cambridge : NBER
http://www.nber.org/papers/w22291
This paper estimates returns to education using a dynamic model of educational choice that synthesizes approaches in the structural dynamic discrete choice literature with approaches used in the reduced form treatment effect literature. It is an empirically robust middle ground between the two approaches which estimates economically interpretable and policy-relevant dynamic treatment effects that account for heterogeneity in cognitive and non-cognitive skills and the continuation values of educational choices. Graduating college is not a wise choice for all. Ability bias is a major component of observed educational differentials. For some, there are substantial causal effects of education at all stages of schooling.

Politique de santé- Politique sociale/ Health Policy- Social Policy

Chevalier, T. L'Etat social et les jeunes en Europe : analyse comparée des politiques de citoyenneté socioéconomique des jeunes. Paris IEPS. Doctorat en Sciences politiques - Sociologie politique et en action publique.
http://www.en3s.fr/recherche-publications/contributions-exterieures/
Ce doctorant en science politique a bénéficié d'un soutien financier de l'EN3S. Un double questionnement est à l'origine de cette thèse. Le premier relève de la grande diversité d'accès des jeunes à la protection sociale dans les pays Européens, et le second des difficultés d'appréhension de ces différences par la littérature et les typologies existantes

Farache, J. (2016). L'impact du chômage sur les personnes et leur entourage : mieux prévenir et accompagner. Les Avis du Conseil Economique - Social et Environnemental. Paris : CESE
http://www.lecese.fr/travaux-publies/limpact-du-chomage-sur-les-personnes-et-leur-entourage-mieux-prevenir-et-accompagner
Le chômage touche 10,6 % de la population active. 40 % des chômeur(euse)s ne sont pas indemnisé(e)s. Pourtant, l'impact du chômage sur les personnes et leur entourage reste méconnu. 14 000 décès par an lui sont imputables, il augmente le risque de séparation des couples, compromet l'avenir des enfants. Le chômage est un « facteur de risque » qui doit être appréhendé comme tel : organisation d'un suivi sanitaire et psychologique précoce ; accompagnement renforcé en termes d'accueil par Pôle emploi et d'insertion sociale et professionnelle… Mais c'est aussi le regard sur les personnes au chômage qu'il faut changer. La lutte contre les discriminations fondées sur la précarité sociale, la médiatisation de leur vécu, leur participation aux politiques publiques qui les concernent poursuivent cet objectif.

Rubin, J., et al. (2016). Are better health outcomes related to social expenditure? A cross-national empirical analysis of social expenditure and population health measures. Santa-Monica : Rand Corporation
http://www.rand.org/pubs/research_reports/RR1252.html

Previous studies have shown that social spending and the ratio of social to health spending are associated with better health outcomes in OECD countries. This exploratory study builds on this finding by widening the scope of the analysis, by incorporating other societal factors — namely, social capital and income inequality — and by assessing these relationships not only at the cross-national level but also at the cross-state level within the United States. The findings of the study are based on analyses of large longitudinal cross-national data sets on social spending, health outcomes and wider societal factors. The study confirmed earlier findings of a positive association between higher social spending and improved health outcomes, even when this is tested in many different ways. Public social expenditure by governments seems to have a particularly strong relationship with health outcomes. Disaggregating social spending by type of programme, some areas of social expenditure, such as old-age spending, appear more strongly positively related to better health outcomes than others. In addition, better health outcomes seem to be even more evident when the data are looked at over a longer time period from when the social expenditure occurs — perhaps because social expenditure can take time to translate into better health outcomes. Wider contextual factors also appear to matter. Countries with higher levels of trust in others tend to have both higher levels of social spending and better health outcomes. Also, higher inequality is associated with an even stronger association between social spending and health outcomes.

Prévention / Prevention

(2016). La réduction des risques et des dommages liés aux conduites addictives : rapport d'orientation et les recommandations de la commission d'audition. Paris : Fédération Française d'Addictologie
http://www.addictologie.org/dist/telecharges/FFA2016_RapportOrientation&Recos.pdf
Une audition publique sur la réduction des risques et des dommages (RdRD) liés aux conduites addictive a été organisée les 7 et 8 avril 2016 par la Fédération Française d'Addictologie. Un rapport d'orientation et de recommandations a été publié à l'issu de cette audition. Le rapport revient sur le concept de RdRD, sur son histoire et sur sa philosophie. Il décrit ensuite sa mise en œuvre en termes de politique de santé publique, en termes d'outils, en termes de pertinence, en termes de plus-value pour les personnes présentant des conduites addictives et pour les intervenants en addictologie, en termes de freins, à travers les exemples de l'alcool, du tabac, des opiacés et des nouveaux produits de synthèse (NPS), en termes d'évolutions sur Internet.

Davies, A., et al. (2016). Focus on: public health and prevention : has the quality of services changed over recent years? QualityWatch. Londres : Health Foundation, Londres The Nuffield Trust: 60.
This report provides an overview of public health outcomes in recent years. The report also considers the opportunities and challenges presented as efforts are made to maintain the quality of services in the light of these recent reforms and financial pressures. It examines trends in 20 indicators across sexual and reproductive health (SRH) and HIV, substance misuse, smoking, childhood obesity and immunisations. In order to provide a more nuanced view it also gathered reflections from senior public health professionals (37 responses to a survey and 11 interviews), and other provider and advocacy organisations (11 interviews)..

Fournier, C. et Murphy, M. (2016). "L'autogestion des maladies chroniques, l'état de santé et l'utilisation des services hospitaliers : exploration de données d'enquêtes populationnelles." Zoom Santé (55)
http://www.stat.gouv.qc.ca/statistiques/sante/bulletins/zoom-sante-201602.pdf
Ce numéro du bulletin Zoom santé de l'Institut de la statistique du Québec (ISQ) s'intéresse à l'autogestion des maladies chroniques d'après l'expérience vécue de personnes aux prises avec l'une des cinq maladies chroniques faisant l'objet d'une surveillance particulière par le ministère de la Santé et des Services sociaux, soit : l'arthrite, le diabète, la bronchite chronique, l'hypertension et les maladies cardiaques. Les éléments d'autogestion examinés par l'étude concernent : l'acquisition d'informations et de compétences pour maintenir un bon état de santé, le renforcement de l'autonomie de la personne afin qu'elle reconnaisse les signes avant-coureurs de la maladie et agisse adéquatement et le soutien à l'adoption de saines habitudes.

Richardson, E., et al. (2016). National Diabetes Plans in Europe - What lessons are there for the prevention and control of chronic diseases in Europe? Copenhague : OMS Bureau régional de l'Europe
http://www.euro.who.int/en/about-us/partners/observatory/publications/policy-briefs-and-summaries/national-diabetes-plans-in-europe-what-lessons-are-there-for-the-prevention-and-control-of-chronic-diseases-in-europe
The rising burden of diabetes poses important public health challenges to health systems today. Although countries in Europe have made progress towards developing a systematic

policy response, there is still variation in the investment in and implementation of comprehensive strategies for the prevention and treatment of diabetes. Drawing on a mapping of national diabetes plans (NDPs) in Europe that was undertaken as part of the EU Joint Action on Chronic Diseases and Promoting Healthy Ageing across the Life Cycle (JA-CHRODIS), this policy brief identifies a range of factors that appear to facilitate the development, implementation and sustainability of national diabetes plans. Making diabetes a political priority – either specifically or as part of broader non-communicable disease (NCD) strategies more broadly - has proven critical for the development and implementation of NDPs.

Saout, C. et Voiturier, J. (2016). Cap santé : Rapport en vue du cahier des charges des expérimentations des projets d'accompagnement à l'autonomie prévues par le projet de loi de modernisation de notre système de santé. Paris : CISS
http://www.leciss.org/sites/default/files/150720_CAP-Sante_RapportAccompagnementAutonomie-ChristianSaout.pdf
L'accompagnement est une notion reconnue dans de nombreuses politiques publiques : dans l'emploi, dans la formation professionnelle, dans les actions en faveur des personnes handicapées. L'accompagnement à l'autonomie en santé, tel qu'il est revendiqué par la loi de modernisation de notre système de santé, dispose de références doctrinales et pratiques, en raison de travaux conduits par les chercheurs en sciences humaines, en sciences politiques ou économiques, d'une part, et des expériences menées par les associations de patients ou parfois même d'organismes médico-sociaux, d'autre part. Ces apports permettent de singulariser l'accompagnement à l'autonomie en le reconnaissant comme un processus d'empowerment des personnes concernées par une vulnérabilité en santé. Il est donc possible d'adosser les expérimentations aux notions suivantes - capabilités, empowerment, éducation thérapeutique, réhabilitation, care, engagement et Health Literacy – bien documentées. Le Collectif Interassociatif sur la santé s'est vue confié la mission d'élaborer des propositions en vue du cahier des charges national de cette expérimentation. L'objectif de ce rapport est donc de définir et d'analyser les conditions de mise en oeuvre.

Prévision – Evaluation / Prevision - Evaluation

(2016). Évaluation de la politique de lutte contre le cancer. Paris : HCSP
http://www.hcsp.fr/explore.cgi/avisrapportsdomaine?clefr=557
À partir de l'analyse des 6 axes clés de la politique de lutte contre le cancer (Recherche, Observation, Prévention, Dépistage, Soins, Qualité de vie), le HCSP s'est, plus particulièrement, attaché à répondre aux 4 questions principales suivantes : Quel a été l'impact des deux premiers Plans cancer en termes de réduction des inégalités de santé ? Dans quelle mesure un plan thématique et un opérateur dédié (Institut national du Cancer – INCa) ont-ils constitué un progrès ? L'expérience acquise dans ce champ est-elle extrapolable à d'autres maladies chroniques ? Quels enseignements peut-on tirer d'une comparaison avec les expériences étrangères, notamment sur l'organisation des dépistages ? Cette évaluation a conduit à formuler 60 recommandations visant à améliorer la prévention, le dépistage et la prise en charge des cancers, à garantir des soins personnalisés et efficaces, à améliorer la qualité de vie des patients pendant et après le cancer, et à réduire les inégalités sociales et territoriales de santé face au cancer. Il s'agit aussi de renforcer la recherche et le recueil des données en cancérologie et d'optimiser le pilotage et la gouvernance concernant cette maladie.

(2016). Évaluation du plan national maladies rares 2, 2011-2016. Paris : HCSP
http://www.hcsp.fr/explore.cgi/avisrapportsdomaine?clefr=558
Ce plan prévu pour la période de 2011 à 2014 puis prolongé jusqu'à fin 2016, comprend 3 axes déclinés en mesures, actions et focus visant à améliorer la qualité de la prise en charge du patient, développer la recherche sur les maladies rares, et amplifier les coopérations européennes et internationales. Le HCSP dresse les constats suivants : les 2 plans successifs ont permis des avancées importantes dans la prise en charge des patients. L'errance diagnostique semble avoir diminué : l'effort d'information, la mise en place d'une plateforme d'appels (Maladies Rares Info Services), le développement du site Orphanet, l'effort de formation des professionnels à la prise en charge des maladies rares ont certainement contribué à cette amélioration. Toutefois, tous les objectifs du PNMR2 n'ont pas été atteints : seuls quelques protocoles nationaux de diagnostics et de soins ont été élaborés, l'accès pour les patients aux plateformes de séquençage est difficile. Une enquête qualitative sur 24 parcours de patients ayant une sclérose latérale amyotrophique, une drépanocytose, des troubles rares du rythme cardiaque ou des maladies héréditaires du métabolisme, complète cette évaluation. Le HCSP présente 9 recommandations transversales autour de la gouvernance, la pertinence d'un nouveau plan, les systèmes d'information, les inégalités sociales et territoriales de santé… ainsi que 54 recommandations spécifiques par thème, par exemple clarifier les missions respectives des filières, centres de référence, de compétence…

(2016). Pertinence du dépistage du cancer broncho-pulmonaire en France.Point de situation sur les données disponibles. Analyse critique des études contrôlées randomisées. Saint-Denis : HAS
http://www.has-sante.fr/portail/plugins/ModuleXitiKLEE/types/FileDocument/doXiti.jsp?id=c_2632197
Le rapport présente l'analyse critique et la synthèse des informations issues des publications sur les essais contrôlés de dépistage de ce cancer par imagerie tomodensitométrique du thorax (scanner thoracique) chez des individus fumeurs, réalisées, à sa demande, par un groupe externe d'experts indépendants en évaluation de programmes de dépistage. A l'issue de ce travail et au regard des critères définis par l'OMS et actualisés par l'ANAES/HAS justifiant la mise en place d'un dépistage, la HAS considère que les conditions de qualité, d'efficacité et de sécurité nécessaires à la réalisation du dépistage du cancer broncho-pulmonaire par tomodensitométrie thoracique à dose de rayons X qualifiée de faible chez des personnes fortement exposées au tabac ou l'ayant été ne sont pas réunies en France en 2016. La HAS rappelle, par ailleurs, les difficultés à identifier de façon précise et fiable la population la plus à risque de cancer broncho-pulmonaire et souligne donc l'intérêt d'orienter les recherches autour de cette question. Elle rappelle également la nécessité d'une maitrise de l'irradiation, la répétition d'examens radiologiques entrainant un cumul de doses de rayons X au niveau des organes du thorax (dont poumons, seins) et souligne l'importance de recherches complémentaires afin d'améliorer les connaissances sur les conséquences de l'exposition répétée à des doses de rayons X qualifiées de faibles.

Brockis, E., et al. (2016). A review of NICE methods across health technology assessment programmes : differences, justifications and implications. Research Paper ; 16/03. Londres OHE
https://www.ohe.org/system/files/private/publications/NICE%20HTA%20methods%20RP%20FINAL.pdf
Background: All NICE decisions exert an influence on the allocation of fixed NHS budgets, but decisions for different types of health interventions (for example drugs and devices) are handled via different 'programmes' within NICE. These different programmes use different

methods and decision processes. To date there has been no systematic comparison of methods across these programmes. Objectives: To carry out a systematic comparison of five of NICE's health technology assessment programmes (Technology Appraisal Programme, Medical Technologies Guidance, Diagnostic Assessment Programme, Highly Specialised Technologies Programme, and Clinical Guidelines) with the aim of establishing how differences in methods and processes between the programmes may impact on allocative efficiency within the NHS. Such a comparison has not been undertaken previously. Methods: Data were extracted from the NICE programme manuals to allow for a systematic comparison between the programmes. Eight qualitative interviews were carried out with NICE members of staff and committee members to explore the reasons for the differences found. Results: The processes overall were broadly similar. However, there were differences in the required review period (the amount of time after which the evidence must be reviewed to see if the guidance needs updating), and methods of evaluation, specifically the provision of a reference case, the requirement for and type of economic analysis, and the decision making criteria used for appraisal. Conclusion: All NICE programmes affect the allocation of resources from the same fixed NHS budget. Differences in approaches between the programmes could therefore lead to the misallocation of resources. Many of the differences found can be justified on grounds of practicality and relevance to the health technologies under assessment. However, from a strict utilitarian view there are several potential areas of inefficiency, although many of these are eliminated or reduced if an egalitarian view is taken. The challenge is finding the optimal balance within the equity-efficiency trade-off, and determining where society is willing trade health gains between different people.

Calver, M. (2016). Measuring the Appropriate Outcomes for Better Decision-Making: A Framework to Guide the Analysis of Health Policy. CSLS Research Report 2016-03. Ottawa : CSLS
http://www.csls.ca/reports/csls2016-03.pdf
Many existing economic evaluations of health policy recognize multidimensional outcomes and the importance of equally distributing the benefits, but do not to incorporate all relevant outcomes into a single comprehensive metric for cost-benefit analysis. The Organization for Economic Co-operation and Development's (OECD's) inclusive growth framework offers a novel approach for improved evaluation of policies which can address these concerns by aggregating societal outcomes in terms of income, life expectancy, unemployment rates and inequality into a single measure of living standards. We discuss the inclusive growth framework in the context of health policy and how it can be utilized by business leaders and policymakers to make superior policy decisions. Using an inclusive growth index of living standards developed by the OECD, we decompose growth in living standards (as defined by the OECD) due to increased life expectancy in Canada between 2000 and 2011 by cause of death and estimate the equivalent value of these reductions in mortality in terms of billions of dollars of income. We discuss factors underlying these reductions in mortality and suggest how they have been linked to policy. This exercise illustrates one way in which the inclusive growth framework can be used to evaluate the impacts of health policy.

Raine, R., et al. (2016). "Challenges, solutions and future directions in the evaluation of service innovations in health care and public health." Health Services and Delivery Research 4(16)
http://www.journalslibrary.nihr.ac.uk/hsdr/volume-4/issue-16#abstract
This collection of essays offers insights from world-leading researchers on important methodological issues in health care and public health evaluation. The authors have stimulated debate as to how these issues might be addressed and proposed thoughtful approaches to tackle often competing priorities such as rigour and the need for prompt results. In doing so, the case for plurality in methodological approaches and for sustained

investment in new and diverse methods is well made. Other commonly occurring themes can be drawn out from these essays. Contents : Integrating multiple sources of evidence: a Bayesian perspective; Randomised controlled trials of complex interventions and large-scale transformation of services; Advancing quantitative methods for the evaluation of complex interventions; Patient-reported outcome measures and the evaluation of services; Major system change: a management and organisational research perspectiveEvaluating health-care equity; Contextual issues and qualitative research.

Roumegegas, J. L. et Saddier, M. (2016). Politiques publiques de lutte contre la pollution de l'air - le coût de l'inaction : Rapport d'information. Paris : Assemblée Nationale.
http://www.assemblee-nationale.fr/14/rap-info/i3772.asp
Ce rapport d'information sur l'évaluation des politiques publiques de lutte contre la pollution de l'air aborde, dans une première partie, l'évaluation du coût de la pollution de l'air et clarifient les compétences des différents acteurs. Puis il souligne combien l'évaluation du coût de l'inaction et des bénéfices de la lutte contre la pollution sont des éléments d'aide à la décision des politiques publiques. Néanmoins, cette évaluation est complexe et nécessite d'approfondir les connaissances économiques et épidémiologiques. Dans une seconde partie, le rapport traite de l'efficacité des mesures de mitigation des sources de pollution fixes et mobiles. Il s'agit notamment d'améliorer le score encore médiocre du secteur routier en matière de pollution atmosphérique. Enfin, dans une troisième partie, ce sont les problématiques relatives à la pollution de l'air intérieur qui sont détaillées.

Soins de santé primaires / Primary Health Care

(2016). Rapport sur la dialyse chronique en France en 2016. Avignon : Société Francophone de Néphrologie Dialyse et transplantation
http://www.sfndt.org/sn/PDF/actualites/2016/05/rapport_dialyse_chronique_France_2016_SFNDT.pdf
Ce rapport de la Société Francophone de Néphrologie Dialyse et Transplantation (SFNDT) dresse un état des lieux le plus exhaustif et le plus documenté possible sur la dialyse en France. Il a pour but de préciser les organisations qui sont importantes en 2016 pour maintenir une dialyse de haute qualité. Il comprend également des propositions pour faire évoluer la prise en charge des malades.

Baird, B., et al. (2016). Understanding pressures in general practice. Londres : King's Fund Institute
http://www.kingsfund.org.uk/publications/pressures-in-general-practice
Increasing demands on general practice over the past five years – not just a heavier workload but the increasing complexity and intensity of work – have led to a feeling of crisis. The NHS is finding it difficult to recruit and retain sufficient GPs who want to do full-time, patient-facing work. Moving care closer to home means that many activities previously undertaken in secondary care are now done in primary care, but funding has not followed the patients. At the same time, more people report difficulty in accessing care and are less satisfied with their experience of using GP services. This report looks at patient factors, system factors and supply-side issues to see what lies behind this increasing pressure on general practice. It finds that despite GPs being at the heart of the health care system, a lack of nationally available, real-time data has made their changing workload largely invisible to commissioners and policy-makers.

Bienkowska-Gibbs, T., et al. (2015). New organisational models of primary care to meet the future needs of the NHS. A brief overview of recent reports. Santa-Monica : Rand Corporation

http://www.rand.org/pubs/research_reports/RR1181.html

The NHS in England faces several future challenges for primary care, including an ageing population, increasing numbers of patients with multiple long-term conditions and a limited workforce. The Health Education England Primary Care Workforce Commission has set out to identify innovative models of primary care that will meet these future challenges. As part of this work, RAND Europe was commissioned to present a brief overview of reports from professional bodies and policy-focused organisations — from England and internationally — that describe new models for delivering primary care. These models include: Models that introduce new roles, or change existing roles, in general practice (e.g. introducing physician associates and pharmacists into general practice, extending roles for allied health professionals and primary care nurses); Models of collaboration among professionals and among the primary care, secondary care and social care sectors (e.g. 'micro-teams', GPs and specialists working together and/or specialists working in the community, extended roles for community pharmacists); and New organisational forms for general practice (e.g. primary care federations or networks, super-practices, regional multipractice organisations, community health organisations, polyclinics and multispecialty community providers). In addition, we present some examples of communication/information technology used in primary care and discuss recruitment and retention challenges facing health professionals in general practice. Most reports included in this overview are descriptive, and they include recommendations regarding how new models of care could be implemented. From these reports, it was evident that there is no 'one size fits all' model for delivering primary care and that the way in which new models are implemented may be as important as the models themselves.

Fournier, C. (2015). Les maisons de santé pluriprofessionnelles, une opportunité pour transformer les pratiques de soins de premier recours : place et rôle des pratiques préventives et éducatives dans des organisations innovantes. Paris Université Paris 11, Université de Paris 11. Orsay. FRA. Thèse de doctorat Santé Publique - sociologie

https://tel.archives-ouvertes.fr/tel-01149605/

L'exercice des soins de premier recours en maisons et pôles de santé pluriprofessionnels (MSP) connaît depuis quelques années un développement croissant. Ces modalités d'exercice sont présentées comme une solution aux défis que représentent le vieillissement de la population, l'augmentation de la prévalence des maladies chroniques, l'accentuation des inégalités sociales de santé et l'irrésistible croissance des dépenses de santé. Elles s'inscrivent dans une remise en cause du système de santé français, construit historiquement sur un modèle curatif hospitalo-centré et sur une médecine de ville d'exercice libéral et isolé. L'impératif d'un recentrage du système sur les soins de premier recours devient un objectif partagé par l'Etat et certains professionnels libéraux, associé à celui de leur réorganisation pour en accroître la dimension préventive et éducative, dans une approche de santé publique collective, populationnelle et mieux coordonnée au niveau d'un territoire. Comment les soins primaires se transforment-ils dans les MSP ? Dans les dynamiques observées, quels places et rôles jouent les pratiques préventives et éducatives ? Ces questions sont abordées avec une posture de recherche engagée, inscrite dans une réflexion méthodologique et politique, articulant des approches médicale, de santé publique et sociologique (extrait du résumé de l'auteur).

Goodyear-Smith, F. et al. (2016). International Perspectives on Primary Care Research. Londres : CRC Press: 255

https://www.crcpress.com/International-Perspectives-on-Primary-Care-Research/Goodyear-Smith-Mash/p/book/9781785230127

This book examines how the evidence base from primary care research can strengthen

health care services and delivery, tackle the growing burden of disease, improve quality and safety, and increase a person-centred focus to health care. Demonstrating the inter-professional nature of the discipline, the book also features a section on cross-nation organisations and primary care networks supporting research. National perspectives are offered from researchers in 20 countries that form part of the World Organization of Family Doctors, providing case histories from research-rich to resource-poor nations that illustrate the range of research development and capacity building. This book argues the importance of primary care research, especially to policy makers, decision makers and funders in informing best practice, training primary health care providers and achieving equitable distribution of care.

Le Breton-Lerouvillois, G. et Rault, J. F. (2016). Atlas de la démographie médicale en France. Situation au 1er janvier 2016. Paris : Conseil National de l'Ordre des médecins
https://www.conseil-national.medecin.fr/sites/default/files/atlas_de_la_demographie_medicale_2016_0.pdf
Au 1 er janvier 2016, la France comptait 88886 généralistes en activité, contre 97012 dix ans plus tôt. L'exercice libéral recule particulièrement. La plus grande partie de la France est concernée par cette diminution des effectifs généralistes à l'exception de départements côtiers ou frontaliers. Leur nombre a diminué de 8,4 % entre 2007 et 2016.

Winpenny, E., et al. (2016). "Outpatient services and primary care: scoping review, substudies and international comparisons." Health Services and Delivery Research 4(15)
http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0008/165491/FullReport-hsdr04150.pdf
This study updates a 2006 literature review on ways of improving the effectiveness and efficiency of hospital outpatient services. We undertook a new review of the current literature on the subject and found that, with appropriate safeguards and support, substantial areas of care traditionally given in hospitals can be transferred to primary care. For example, relocating specialists to work in the community is popular with patients, and joint working between specialists and general practitioners (GPs) can be of substantial educational value. As there is limited information on whether new schemes increase or reduce demand and cost more or less than traditional approaches, we also conducted a number of substudies. Our substudies investigated five areas: referral management centres (organisations established to review referrals and potentially divert them away from hospitals), in-house review of referrals by GPs, financial incentives to reduce referrals, consultants contracted to community organisations and, last, international experiences of moving care from hospital into the community. We concluded that: High-quality care in the community can be provided for many conditions and is popular with patients. It may not be cheaper to move care into the community, and more evidence is required on cost-effectiveness. Moves towards care in the community can be justified if high value is given to patient convenience in relation to NHS costs or if community care can be provided in a way that reduces overall health-care costs.

Systèmes de santé / Health Systems

(2016). So What? Strategies across Europe to assess quality of care. Luxembourg : Publications Office of the European Union
http://ec.europa.eu/health/systems_performance_assessment/docs/sowhat_en.pdf

Today, the expert group on health systems performance assessment (HSPA) composed of European countries health authorities and international organisations, and co-chaired by Sweden and the Commission, publishes its first report. The HSPA expert group, set up in 2014, provides participating countries with a forum to exchange experience on the use of HSPA at national level. It also aims to support national policy-makers by identifying tools and methodologies for developing HSPA. The overarching aim of this work is to build better health systems that help people remain healthy and ensure access to good quality healthcare for those in need. This first report focuses on quality of care. It is based on the exchange of experiences and knowledge among countries and with international organisations between 2014 and 2015. It sets out a selection of country cases, analyses them and draws general conclusions. The aim is to provide useful recommendations for policy makers who want to design, set up, run and evaluate a system to assess quality of care.

(2016). World Health Statistics 2016: Monitoring health for the SDGs. Genève : OMS
http://apps.who.int/iris/bitstream/10665/206498/1/9789241565264_eng.pdf

The World Health Statistics series is WHO's annual compilation of health statistics for its 194 Member States. This report 2016 focuses on the proposed health and health-related Sustainable Development Goals (SDGs) and associated targets. It represents an initial effort to bring together available data on SDG health and health-related indicators. In the current absence of official goal-level indicators, summary measures of health such as (healthy) life expectancy are used to provide a general assessment of the situation.

Paris, V., et al. (2016). Health care coverage in OECD countries in 2012. OECD Health Working Papers ; 88. Paris : OCDE
http://www.oecd-ilibrary.org/fr/social-issues-migration-health/health-care-coverage-in-oecd-countries-in-2012_5jlz3kbf7pzv-en

This paper provides a detailed description of health coverage in OECD countries in 2012. It includes information on the organisation of health coverage (residence-based vs contributory systems), on the range of benefits covered by basic health coverage and on cost-sharing requirements. It also describes policies implemented to ensure universal health coverage –in most countries- and to limit user charges for vulnerable populations or people exposed to high health spending. The paper then describes the role played by voluntary health insurance as a secondary source of coverage. Combining qualitative information collected through a survey of OECD countries on benefits covered and cost-sharing requirements with spending data collected through the system of health accounts for 2012, this paper provides valuable information on health care coverage in OECD countries at a time universal health coverage is high on the policy agenda of many countrie

Travail et santé / Occupational Health

(2016). Stress au travail : un défi collectif. Genève : Organisation Internationale du Travail
http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/publication/wcms_466548.pdf

Ce rapport a pour objet de présenter la situation du stress lié au travail dans les pays développés et en développement afin de sensibiliser à l'ampleur du problème et à ses répercussions dans le nouveau contexte du monde du travail. À cette fin, il propose un aperçu interrégional de la prévalence et de l'impact du stress lié au travail, et examine la législation, les politiques et les interventions visant à gérer ce phénomène à l'échelle internationale, régionale, nationale et des lieux de travail. Au moyen d'une enquête Delphi, il

identifie et évalue des scénarios pour le futur et les facteurs contributifs.

Blanchet, D., et al. (2015). Health capacity to work at older ages in France. G2015/15. Paris : INSEE
http://www.insee.fr/fr/themes/document.asp?reg_id=0&ref_id=G201604

Health status is one potentially limiting barrier to policies that aim at increasing retirement ages. This paper examines the application to France of two methods that have been proposed in the literature for evaluating how strong is this constraint. Both methods provide measures of a so-called « health-related additional work capacity », i.e. the gap between effective employment rates and the ones that would prevail according to some conventional reference relationship between employment and health status. The first method is based on historical changes in employment rates at given mortality levels, under the strong hypothesis that changes in mortality rates are an adequate proxy of changes in health conditions (Milligan and Wise, 2012). The second one is based on the employment-health relationship observed at a given reference age, using both subjective and objective measures of health status : this relationship is used for inferring the health-related work capacity at other ages, for the same time period (Cutler, Meara and Richards-Shubik, 2013). Both methods suggest that health would not be constraining on the average, but under assumptions whose limits

Bockerman, P., et al. (2016). The Effect of Weight on Labor Market Outcomes: an Application of Genetic Instrumental Variables. NBER Working Paper Series ; n° 22200. Cambridge : NBER
http://www.nber.org/papers/w22200

The increase in the prevalence of obesity worldwide has led to great interest in the economic consequences of obesity, but valid and powerful instruments for obesity, which are needed to estimate its causal effects, are rare. This paper contributes to the literature by using a novel instrument: genetic risk score, which reflects the predisposition to higher body mass index across many genetic loci. We estimate IV models of the effect of BMI on labor market outcomes using Finnish data that have many strengths: genetic information, measured body mass index, and administrative earnings records that are free of the problems associated with non-response, self-reporting error or top-coding. The first stage of the IV models indicate that genetic risk score is a powerful instrument, and the available evidence from the genetics literature is consistent with instrument validity. The results of the IV models indicate weight reduces earnings and employment and increases social income transfers, although we caution that the results are based on small samples, and are sensitive to specification and subsample.

Bubonya, M., et al. (2016). Mental Health and Productivity at Work: Does What You Do Matter? Melbourne Institute Working Paper No. 16/16. Victoria : Melbourne Institute of Applied Economic and Social Research
https://www.melbourneinstitute.com/downloads/working_paper_series/wp2016n16.pdf

Much of the economic cost of mental illness stems from workers' reduced productivity. We analyze the links between mental health and two alternative workplace productivity measures – absenteeism and presenteeism (i.e., lower productivity while attending work) – explicitly allowing these relationships to be moderated by the nature of the job itself. We find that absence rates are approximately five percent higher among workers who report being in poor mental health. Moreover, job conditions are related to both presenteeism and absenteeism even after accounting for workers' self-reported mental health status. Job conditions are relatively more important in understanding diminished productivity at work if workers are in good rather than poor mental health. The effects of job complexity and stress on absenteeism do not depend on workers' mental health, while job security and control moderate the effect of mental illness on absence days.

Cahuc, P., et al. (2016). "L'emploi des seniors : un choix à éclairer et à personnaliser." Notes D'analyse Du Cae (Les)(32): 12 ,
http://www.cae-eco.fr/IMG/pdf/cae-note032.pdf
Le taux d'emploi des seniors a fortement augmenté ces 15 dernières années en France : pour les 55-64 ans, il est passé de 37,9 % au début de 2008 à 48,9 % à la fin de 2015. La montée de l'emploi des seniors s'est accompagnée d'un accroissement de leur taux de chômage, un phénomène souvent mis en avant pour s'interroger sur la pertinence du recul de l'âge de la retraite. L'objectif affiché de cette note du Conseil d'analyse économique (Pierre Cahuc, J-Olivier Hairault, Corinne Prost), présentée au cabinet du Premier ministre le 23 mai 2016, est de relancer l'emploi des plus de 50 ans afin que la France se rapproche des moyennes de l'OCDE (supérieures de 10 points). La mesure principale est d'aligner la durée d'indemnisation par l'assurance chômage des seniors sur celle du régime général (passage de trois à deux ans maximum). Les auteurs proposent en outre de supprimer l'extension de la période d'indemnisation à partir de l'âge légal jusqu'à l'âge de la retraite à taux plein et de mettre en place un plan spécifique d'accompagnement et de formation pour les chômeurs de plus de 50 ans. Pour le CAE, le sous-emploi des seniors n'est pas une fatalité. "Mobiliser cette force de travail expérimentée est un enjeu essentiel pour la prospérité du pays et la soutenabilité de sa couverture sociale".

Chatterji, P., et al. (2016). Diabetes and Labor Market Exits: Evidence from the Health & Retirement Study (HRS). Cesinfo Working Paper; 5832. Munich : Center for Economic Studies
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2768057
The objective of this paper is to estimate the effect of diabetes on labor market exit using longitudinal data from the 1992-2010 Health and Retirement Study (HRS). We estimate a discrete time hazard model to test whether diabetes affects the hazard of leaving employment among individuals who were working for pay at the age of 55-56. Using a probit model, we also estimate the effect of having undiagnosed or poorly controlled diabetes on the probability of labor market exit two years later. Our results indicate that diabetes is associated with an increased hazard of exiting the labor market for both males, but not for females. This effect persists when we include controls for onset of other health conditions, two of which are documented complications due to diabetes (stroke and heart conditions). We also find diagnosed diabetes with medication use, regardless of whether it is under control, is associated with large negative effects on the likelihood of employment two years later.

Colombo, E., et al. (2016). Macroeconomic Conditions and Health: Inspecting the Transmission Mechanism. Working Paper No. 337. Milan : Université de Milan
http://www.ecostat.unical.it/RePEc/WorkingPapers/WP04_2016.pdf
This paper studies the effects of labor market conditions on individual-level health, investigating the factors that moderate and mediate this relationship. Using a large and representative sample of individuals in Italy between 1993 and 2012, we shed light on the transmission mechanism, focusing on the role played by health behaviors (smoking, alcohol consumption, physical activity, eating habits) and economic stress. We find that, overall, higher local unemployment negatively affects health, with a dynamic response that differs across health conditions. Employment status and educational level play a significant role as moderators of these effects. Eating habits, in addition to economic stress, are found to play a key role in the transmission mechanism, while physical activity acts as a buffer against the adverse health effects of unemployment shocks.

Lengagne, P. et Afrite, A. (2016). "Tarification à l’expérience, incidence des troubles musculo-squelettiques et arrêts de travail." Questions d'Economie de la Santé (Irdes)(215): 1-6.

http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/215-tarification-a-l-experience-incidence-des-troubles-musculo-squelettiques-et-arrets-de-travail.pdf
L’assurance des risques professionnels des travailleurs salariés du Régime général est financée par les entreprises sur la base de cotisations modulées selon leur sinistralité passée. En théorie, ce mode de tarification devrait contribuer à inciter les employeurs à développer des démarches de prévention des risques professionnels et à minimiser ainsi le coût des mauvaises conditions de travail. À partir d’une expérience naturelle observée en région Nord – Pas-de-Calais – Picardie en 2007, cette étude mesure l’influence d’une augmentation de la contribution des entreprises au coût des troubles musculo-squelettiques (TMS) sur l’incidence de ces maladies et les arrêts de travail associés. Cette étude s’appuie sur les données administratives de tarification des risques professionnels. La méthode repose sur une estimation en différence de différences. Les résultats indiquent que l'augmentation de la contribution des entreprises au coût des TMS a eu pour effet de limiter l’incidence de ces maladies. Cela s'est traduit par une baisse significative du nombre de jours d’arrêts de travail liés à ces pathologies.

Muller, T. et Boes, J. L. (2016). Disability Insurance Benefits and Labor Supply Choices: Evidence from a Discontinuity in Benefit Awards. MPRA Paper ; 70957. Münich : MPRA: 39 , fig.
This paper explores the effects of disability insurance (DI) benefits on the labor market decision of existing DI beneficiaries using a fuzzy regression discontinuity (RD) design. We identify the effect of DI benefits on the decision of working full-time, part-time or staying out of the labor force by exploiting a discontinuity in the DI benefit award rate above the age of 55. Overall, our results suggest that the Swiss DI system creates substantial lock-in effects which heavily influence the labor supply decision of existing beneficiaries: the benefit receipt increases the probability of working part-time by about 41%-points, decreases the probability of working full-time by about 42%-points but has little or no effects on the probability of staying out of the labor force for the average beneficiary. Therefore, DI benefits induce a shift in the labor supply of existing beneficiaries in the sense that they reduce their work intensity from working full-time to part-time which adds a possible explanation for the low DI outflow observed all across the OECD.

Vieillissement / Ageing

Coe, N. B., et al. (2016). What is the Marginal Benefit of Payment-Induced Family Care? NBER Working Paper Series ; n° 22249. Cambridge : NBER
http://www.nber.org/papers/w22249
Research on informal and formal long-term care has centered almost solely on costs; to date, there has been very little attention paid to the benefits. This study exploits the randomization in the Cash and Counseling Demonstration and Evaluation program and instrumental variable techniques to gain causal estimates of the effect of family involvement in home-based care on health care utilization and health outcomes. We find that family involvement significantly decreases Medicaid utilization. Importantly, we find family involvement significantly lowers the likelihood of urinary tract infections, respiratory infections, and bedsores, suggesting that the lower utilization is due to better health outcomes.

Colombier, C. (2016). Population aging in healthcare - a minor issue? Evidence from Switzerland. FiFo Discussion Papers, No. 16-3. Cologne : University of Cologne

http://econstor.eu/bitstream/10419/121476/1/837692121.pdf

Our study shows that population aging substantially affects healthcare expenditure (HCE). This conclusion supports the popular, but recently strongly contested, view that the coming population aging will threaten the fiscal sustainability of health systems. We contribute to this debate, first by estimating the determinants of Swiss healthcare expenditure (HCE) with outlier-robust dynamic regressions, and second, by projecting Swiss HCE based on the estimates produced and new population scenarios. Medical advances and GDP per capita also play a decisive role. Governments can mitigate HCE growth by improving the health status of the population and by stimulating cost-effective and productive medical advances.

Horioka, C. Y., et al. (2016). Why Do Children Take Care of Their Elderly Parents? Are the Japanese Any Different? NBER Working Paper Series ; n° 22245. Cambridge : NBER

http://www.nber.org/papers/w22245

In this paper, we conduct a theoretical analysis of why individuals provide care and attention to their elderly parents using a two-period overlapping generations model with endogenous saving and a “contest success function” and test this model using micro data from a Japanese household survey, the Osaka University Preference Parameter Study. To summarize our main findings, we find that the Japanese are more likely to live with (or near) their elderly parents and/or to provide care and attention to them if they expect to receive a bequest from them, which constitutes strong support for the selfish bequest motive or the exchange motive (much stronger than in the United States), but we find that their caregiving behavior is also heavily influenced by the strength of their altruism toward their parents and social norms.

Lee, R. (2016). Macroeconomics, Aging and Growth. NBER Working Paper Series ; n° 22310. Cambridge : NBER

http://www.nber.org/papers/w22310

Inevitable population aging and slower population growth will affect the economies of all nations in ways influenced by cultural values, institutional arrangements, and economic incentives. One outcome will be a tendency toward increased capital intensity, higher wages, and lower returns on capital, a tendency partially offset when the elderly are supported by public or private transfers rather than assets, and when economies are open, in which case aging will lead to increased flows of capital and labor. Rising human capital investment per child accompanies the falling fertility that drives population aging, and partially offsets slower labor force growth. Research to date finds little effect on technological progress or labor productivity. National differences in labor supply at older ages, per capita consumption of the elderly relative to younger ages, strength of public pension and health care systems, and health and vitality of the elderly all condition the impact of population aging on the economy. Policy responses include increasing the size of the labor force, mainly by raising the retirement age; reducing benefits and/or raising taxes for public transfer programs for the elderly, with concern for dead-weight loss and the fair distribution of costs across socioeconomic classes; investing more in children to increase the quality and productivity of the future labor force; and public programs that promote fertility by facilitating market work for women with children.

Riffe, T., et al. (2015). Time-to-death patterns in markers of age and dependency. Rostock Max Planck Institute for Demographic Research

http://www.demogr.mpg.de/papers/working/wp-2015-003.pdf

We aim to determine the extent to which variables commonly used to describe health, wellbeing, and disability in old-age vary primarily as a function of years lived (chronological

age), years left (thanatological age), or as a function of both. We analyze data from the US Health and Retirement Study to estimate chronological age and time-to-death patterns in 78 such variables. We describe results from the birth cohort born 1915-1919 in the final 12 years of life. Our results show that most markers used to study well-being in old-age vary along both the age and time-to-death dimensions, but some markers are exclusively a function of either time to death or chronological age, and others display different patterns between the sexes.

Roller, C. et Stroka-Wetsch, M. A. (2016). Informal Care Provision and Work Disability Days. Ruhr Economic Papers; 616. Bochum : Ruhr-Universität Bochum

http://en.rwi-essen.de/publikationen/ruhr-economic-papers/766/

Due to the demographic change and the concomitant ageing of society, the labor force will reduce in Germany in the following decades. Simultaneously, the demand for informal care will increase as a result of the ageing society. Informal care is assumed being the least expensive form of care and is the most common form of care in Germany. However, the literature conveys the impression that informal care is not easily compatible with a range of situations in life. This is especially confirmed by findings of negative health effects of informal caregiving. Based on these findings, it could be suspected that there have to be large effects on employment, as individuals with health restrictions are supposed to work less. Indeed, findings on effects of informal care provision on employment indicate a rather small or even an insignificant effect. We think that health problems become manifest in some form or another. Thus, the effects of informal care provision on labor supply are possibly larger than it has been assumed so far. To verify our hypothesis, we examine the effects of informal caregiving on a health related labor market outcome in the form of work disability days using administrative data of Germany's largest sickness fund, the Techniker Krankenkasse with more than 5 million observations. In order to identify the effects of informal care on work disability days, linear regression models are estimated in which is controlled for time invariant heterogeneity. The results illustrate a significant positive relationship between informal caregiving and the number of work disability days.

Roquebert, Q., et al. (2016). L'aide à un parent âgé, seul et dépendant : déterminants structurels et interactions. CES Working Paper; 2016.30. Paris : Centre d'économie de la Sorbonne

https://ideas.repec.org/p/mse/cesdoc/16030.html

Cet article étudie les déterminants des décisions d'aide de la part des membres d'une fratrie de deux enfants à l'égard d'un parent âgé, seul et dépendant. L'application d'une méthodologie semistructurelle, déjà utilisée sur données européennes (enquête SHARE), permet de distinguer les déterminants structurels (individuels et familiaux) et les interactions (influence de la décision d'un membre de la fratrie sur la décision de l'autre). Les résultats obtenus sur les données françaises de l'enquête Handicap-Santé de 2008 confirment l'importance du rang dans la fratrie pour comprendre les comportements d'aide. En effet, deux logiques de comportements distinctes apparaissent, aussi bien dans les déterminants structurels que dans les interactions. D'une part, si l'aide des enfants est influencée par les caractéristiques du parent quel que soit leur rang, les aînés semblent par ailleurs réagir principalement à la composition de la fratrie, tandis que les cadets adaptent leurs comportements à leurs contraintes personnelles. D'autre part, l'implication de l'autre membre de la fratrie augmente l'utilité d'être aidant pour les aînés, alors qu'elle la diminue pour les cadets. L'aide des aînés se comprendrait alors comme l'acceptation d'une assignation sociale, tandis que celle des cadets répondrait à une logique d'arbitrage, fondée sur la comparaison des coûts et des avantages associés à l'aide.