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18 octobre 2013 / October the 18th, 2013

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Assurance maladie / Health Insurance

Blanchet N. (2013). Etude auprès d'assurés de la CPAM du Gard sollicitant une aide financière pour des soins dentaires : Grenoble : ODENORE

Abstract: En 2012, 576 assurés ont sollicité la CPAM pour obtenir une aide financière individuelle, devant leur permettre de faire face à des frais dentaires importants. Cette même année, 333 aides ont été accordées et versées à des assurés ; 62 autres ont été annulées en 2012 faute d'utilisation dans les six mois de délai imparti (il peut donc s'agir de demandes déposées et traitées en 2011). Au total, environ 395 demandeurs étaient éligibles parmi les 576, soit une estimation de 68%. Cette aide financière peut intervenir pour des frais liés à la réalisation de prothèses dentaires, de traitements orthodontiques pour des enfants ou des adultes, d'actes hors nomenclature après avis d'un dentiste conseil. Cette aide est attribuée en fonction des ressources de l'assuré et est calculée sur la base des tarifs plafond mutualistes pratiqués. Elle est limitée à 1000 euros par an et par bénéficiaire. Cette étude vise à analyser les motifs qui conduisent certains assurés à ne pas utiliser l'aide qui leur est attribuée par la CPAM. Il s'agit de comprendre aussi ce qui peut les conduire à reporter ou annuler leurs soins dentaires et, plus globalement, à renoncer à des soins, au-delà de leur seul problème dentaire. C'est également l'occasion de mieux connaître « l'histoire » des personnes sollicitant un secours dentaire (leur trajectoire sociale, leur parcours de soins, leur relation avec la CPAM...). Enfin, ce travail doit aussi permettre d'évaluer l'efficacité de l'action de la CPAM en matière d'attribution de prestations de secours dentaires et sa capacité à accompagner les publics qui en ont le plus besoin.
http://odenore.msh-alpes.fr/documents/rapport_definitif_aides_soins_dentaires_cpam_gard.pdf

Bontout O., Hazouard S., Lasserre R., Zaidman C. (2013). Les réformes de la protection sociale en Allemagne : état des lieux et dialogue avec des experts français. Travaux et Documents du Cirac. Cergy-Pontoise : Editions du Cirac

Abstract: Dans le cadre des réflexions et des débats publics menés en France depuis 2011 sur la convergence des politiques de compétitivité entre la France et l'Allemagne, la Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques (DREES) et le Centre d'Information et de Recherche sur l'Allemagne contemporaine (CIRAC) ont développé conjointement un programme pour la promotion d'un dialogue franco-allemand sur la protection sociale ayant pour objectif de comparer les politiques de réforme des régimes de sécurité sociale menées de part et d'autre du Rhin. Ce dialogue, mené de novembre 2011 à juin 2012, a pris la forme d'un cycle de huit conférences-débats mensuelles tenues à la Maison Heinrich Heine au cours desquelles des experts allemands et français ont présenté et confronté leurs analyses sur les dossiers clés de la protection sociale dans les deux pays. Le présent ouvrage offre une synthèse des travaux et des réflexions développés au cours de ce programme. A travers les huit contributions rédigées dans leur version définitive par les experts allemands à partir des exposés et des données qu'ils avaient présentés lors de leur conférence initiale, l'ouvrage dresse en premier lieu un tableau d'ensemble approfondi et richement documenté du système allemand de protection sociale et des réformes qui lui ont été apportées au cours des dix dernières années avec la mise en œuvre de l'Agenda 2010. Dans l'étude des principaux régimes de protection, les différentes contributions ne se contentent pas d'analyser précisément les modifications apportées au mode de financement et au niveau des garanties offertes. Elles montrent également comment les réformes s'inscrivent dans une perspective systémique commune qui vise à restaurer les conditions d'une protection sociale soutenable et réponde aux défis de la compétitivité industrielle globale, du déclin démographique et de l'allongement de l'espérance de vie, tout en assurant l'équité et la cohésion sociales. Cette approche structurelle et transversale sert également de grille de référence pour l'analyse et la réflexion comparatives, principalement franco-allemandes, mais également européennes, qui constituent le second volet de l'ouvrage. Elle fournit un point d'appui aux différentes contributions des intervenants français qui, sur chacun des huit thèmes choisis, permettent de faire ressortir, pour chacun des deux pays, leurs variables structurelles significatives et leurs différences d'approches conceptuelles, ainsi que leurs performances relatives et leurs points forts respectifs (4e de couverture).
http://www.ciera.fr/ciera/spip.php?article2252

Abaluck J., Gruber J. (2013). Evolving Choice Inconsistencies in Choice of Prescription Drug Insurance : Cambridge : NBER

Abstract: We explore choice inconsistency over time within the Medicare Part D Prescription Drug Program. Using the full universe of Part D claims data, we revisit our earlier work on partial data to replicate our results showing large "foregone savings" among Part D enrollees. We also document that this foregone savings increases over time during the first four years of the Part D program. We then develop a rich dynamic structural framework that allows us to mathematically decompose the "foregone welfare" from inconsistent plan choices into components due to demand side factors, supply side factors, and changes in preferences over time. We find that the welfare cost of choice inconsistencies increases over time. Most importantly, we find that there is little improvement in the ability of consumers to choose plans over time; we identify and estimate little learning at either the individual or cohort level over the years of our analysis. Inertia does reduce welfare, but even in a world with no inertia we estimate that substantial welfare losses would remain. We conclude that the increased choice inconsistencies over time are driven by changes on the supply side that are not offset both because of inertia and because non-inertial consumers still make inconsistent choices.
http://www.nber.org/papers/w19163

Einav L. (2013). The Response of Drug Expenditures to Non-Linear Contract Design: Evidence from Medicare Part D : Cambridge : NBER

Abstract: We study the demand response to non-linear price schedules using data on insurance contracts and prescription drug purchases in Medicare Part D. Consistent with a static response of drug use to price, we document bunching of annual drug spending as individuals enter the famous "donut hole," where insurance becomes discontinuously much less generous on the margin. Consistent with a dynamic response to price, we document a response of drug use to the future out-of-pocket price by using variation in beneficiary birth month which generates variation in contract duration during the first year of eligibility. Motivated by these two facts, we develop and estimate a dynamic model of drug use during the coverage year that allows us to quantify and explore the effects of alternative contract designs on drug expenditures. For example, our estimates suggest that "filling" the donut hole, as required under the Affordable Care Act, will increase annual drug spending by $180 per beneficiary, or about 10%. Moreover, almost half of this increase is "anticipatory," coming from beneficiaries whose spending prior to the policy change would leave them short of reaching the donut hole. We also describe the nature of the utilization response and its heterogeneity across individuals and types of drugs.
http://www.nber.org/papers/w19393

Economie de la santé / Health Economics

Chandra A., Finkelstein A., Syverson C. (2013). Healthcare Exceptionalism? Productivity and Allocation in the U.S. Healthcare Sector : Cambridge : NBER

Abstract: The conventional wisdom in health economics is that large differences in average productivity across hospitals are the result of idiosyncratic, institutional features of the healthcare sector which dull the role of market forces. Strikingly, however, we find that productivity dispersion in heart attack treatment across hospitals is, if anything, smaller than in narrowly defined manufacturing industries such as ready-mixed concrete. While this fact admits multiple interpretations, we also find evidence against the conventional wisdom that the healthcare sector does not operate like an industry subject to standard market forces. In particular, we find that hospitals that are more productive at treating heart attacks have higher market shares at a point in time and are more likely to expand over time. For example, a 10 percent increase in hospital productivity today is associated with about 4 percent more patients in 5 years. Taken together, these facts suggest that the healthcare sector may have more in common with "traditional" sectors than is often assumed.
http://papers.nber.org/papers/W19200

De La Maisonneuve C., Oliveira M.J. (2013). Public Spending on Health and Long-term Care: A new set of projections : Paris : OCDE

Abstract: This paper proposes a new set of public health and long-term care expenditure projections till 2060, following up on the previous set of projections published in 2006. It disentangles health from long term care expenditure as well as the demographic from the non-demographic drivers, and refines the previous methodology, in particular by better identifying the underlying determinants of health and long-term care spending and by extending the country coverage to include BRIICS countries. A cost containment and a cost-pressure scenario are provided together with sensitivity analysis. On average across OECD countries, total health and long-term care expenditure is projected to increase by 3.3 and 7.7 percentage points of GDP between 2010 and 2060 in the cost-containment and the cost-pressure scenarios respectively. For the BRIICS over the same period, it is projected to increase by 2.8 and 7.3 percentage points of GDP in the co st-containment and the cost-pressure scenarios respectively.

http://www.oecd-ilibrary.org/docserver/download/5k44t7jwwr9x.pdf?expires=1381223981&id=id&accname=guest&checksum=755024B413AB8739EFDFA6096C08801B

Egan M., Philipson T.J. (2013). International Health Economics : Cambridge : NBER

Abstract: Perhaps because health care is a local service sector, health economists have paid little attention to international linkages between domestic health care economies. However, the growth in domestic health care sectors is often attributed to medical innovations whose returns are earned worldwide. Because world returns drive innovation and innovation is central to spending growth, spending growth in a given country is thereby highly affected by health care economies and policies of other countries. This paper analyzes the unique positive and normative implications of these innovation-induced linkages across countries when governments centrally price health care. Providing world returns to medical innovation under such central pricing involves a public-goods problem; the taxation to fund reimbursements involves a private domestic cost with an international benefit of medical innovation. This has the direct normative implication that medical innovations have inefficiently low world returns. It also has the positive implication that reimbursements in one country depend negatively on those of others; reimbursements are “strategic substitutes” through free riding. Because reimbursements are strategic substitutes, world concentration of health care is a significant issue. A small European country has no access-innovation trade-off in its pricing; it will have low reimbursements because it does not affect world returns and sees the same innovations regardless of its reimbursement policy. The public-goods problem of innovation thereby implies that the United States, despite being the world's largest buyer, will pay the highest reimbursements. This problem also implies that free riding counteracts the standard positive impact of larger world markets on innovation when health care concentration falls. Indeed, currently, health care is highly concentrated; about half of world health care spending occurs in the United States, despite that fact that it makes up only about one-fifth of the world economy. We assess the effect that emerging markets will have on this concentration and thus world returns. We use pharmaceutical reimbursement data from 1996–2010 to provide IV estimates of the degree to which domestic reimbursements are strategic substitutes. We find that these estimates imply that world returns from innovation may actually fall from a growth in “market size” of BRICS countries as a result of increased free riding in non-BRICS countries. The overall analysis has important positive implications for spending patterns across countries as well as normative implications for evaluating domestic or regional health care reforms.

http://papers.nber.org/papers/W19280

Géographie de la santé / Geography of Health

Blondin S. (2012). Zones rurales, à votre santé. Idées fixes. Paris : Ginkgo Editions

Abstract: La désertification médicale est une réalité qui n'est plus niée par personne. Certaines régions manquent cruellement de médecins alors que d'autres sont saturées; certaines spécialités sont désertées, alors que d'autres sont encombrées. Comment aborder la problématique des désertifications médicales ? Quelles solutions rapides apporter ? Cet ouvrage rend public un rapport

présenté au Sénat, analyse les causes, dénonce les dysfonctionnements et propose des solutions rapides et efficaces à mettre en place (d'après la 4è de couv.)

Cutler D., Skinner J., Stern A.D. (2013). Physician Beliefs and Patient Preferences: A New Look at Regional Variation in Health Care Spending : Cambridge : NBER
Abstract: There is considerable controversy about the causes of regional variations in healthcare expenditures. We use vignettes from patient and physician surveys, linked to Medicare expenditures at the level of the Hospital Referral Region, to test whether patient demand-side factors, or physician supply-side factors, explains regional variations in Medicare spending. We find patient demand is relatively unimportant in explaining variations. Physician organizational factors (such as peer effects) matter, but the single most important factor is physician beliefs about treatment: 36 percent of end-of-life spending, and 17 percent of U.S. health care spending, are associated with physician beliefs unsupported by clinical evidence.
http://papers.nber.org/papers/W19320

Elliott P. /éd., Cuzick J. / éd., English D. (1996). Geographical and environmental epidemiology. Methods for small-areas studies. Oxford : Oxford University Press
Abstract: This book addresses both the theoretical and practical issues which arise when describing the geographical distribution of disease and investigating apparent disease clusters. Requirements in terms of population data, disease incidence, and mortality are considered and related to the scale at which a study is being carried out. Statistical methods are reviewed for large scale correlation studies, intermediate scale map smoothing exercises, and small scale clustering investigations. Problems of measuring environmental exposures at different scales are also reviewed. These issues are then related to current practice via a comprehensive set of case studies which include a large correlation study in China, clustering of asthma attacks, the Sellafield-leukaemia cluster, environmental clusters of mesothelioma in Turkey, and a multi-source study of cancer incidence around an incinerator (Résumé éditeur).

Hôpital / Hospitals

Angele-Halgand N., Garrot T. (2013). Réconcilier performance et valeurs à l'hôpital: une approche par les biens communs : Nantes : LEMMA
Abstract: Dans le champ des valeurs publiques, la santé apparaît un peu particulière. En effet, s'il est admis en France que la santé devrait bénéficier à tous, il se trouve que la valeur de cette dernière est propre à chaque individu. Comme le note Bozeman (2007) les valeurs privées sont simples à exprimer et n'ont pas besoin de légitimation alors que les valeurs publiques requièrent une agrégation fondée notamment sur des droits sociaux communs. Dans ce contexte, la production des services publics s'avère complexe et la création de valeur est difficilement mesurable avec la nécessité d'arbitrages souvent complexes : quand un établissement public cherche à satisfaire une partie des bénéficiaires, il crée bien souvent de l'insatisfaction pour une autre partie des usagers (Kelly J., 2005). Il y a donc au-delà de la recherche de la performance de l'organisation publique, qui consiste à assumer non seulement la définition des besoins auxquels elle doit répondre, mais aussi à mettre en œuvre le couple 'valeur-coût' jusque dans les plus fins rouages de son organisation (Lorino, 1999), à envisager la santé comme un élément dépassant la seule fonction de production des soins et à rechercher la meilleure performance du système de santé. La performance hospitalière est aujourd'hui une question brûlante car les réformes financières et organisationnelles véhiculées par le Nouveau Management Public viennent percuter les valeurs médicales et soignantes au cœur même de l'activité professionnelle. Cet aspect est notamment clairement mis en évidence par Francis Fellinger, président de la Conférence des présidents de commissions médicales d'établissement de centres hospitaliers de l'époque dans son audition par la mission d'évaluation et de contrôle de la Sécurité Sociale (MECSS) du Sénat, le 7 mars 2012 : " La T2A présente l'avantage d'obliger les établissements à examiner leurs coûts de production. Les responsables médicaux, à la différence sans doute des médecins de base, ont appris très vite, trop vite même, puisqu'ils ont parfois adopté des conduites d'opportunité et d'optimisation. Dans les centres hospitaliers, on raisonne désormais en

termes médico-économiques, ce qui n'était pas du tout le cas il y a dix ans et rarement il y a cinq ans. Il n'y pas eu d'étude précise sur le sujet, mais une concurrence s'est établie entre pôles. " (Le Menn J. et Milon A. (2012), p. 206) La réforme de financement des établissements hospitaliers, dit de la T2A (tarification à l'activité) met au cœur du fonctionnement des services le contrôle de l'efficience, au sens où les résultats obtenus sont jaugés à l'aune des moyens employés pour les obtenir. Cette démarche est intégrée par les équipes de direction et se diffuse au sein de l'organisation par l'intermédiaire des équipes de pôle, au premier rang desquels se trouvent les " chefs de pôles ", les acteurs que Francis Fellinger désigne sous le vocable de " responsables médicaux ". Les pôles issus de la réforme de la " Nouvelle Gouvernance " (NG) conduisent à une restructuration de l'hôpital public sous forme de centres de responsabilité pour lesquels les données produites par la T2A permet un contrôle par les résultats avec tous les attributs techniques connus dans l'entreprise privée et directement transposés aux établissements de santé publics. Le chef de pôle, médecin hospitalier, voit sa responsabilité engagée sur la production d'un résultat comptable dans le centre dont il assume la direction. Chacun des centres étant soumis à la même démarche de comparaison entre pôles, des mises en concurrence tirent le médical vers l'économique remettant en cause du même coup des valeurs fondatrices du service public hospitalier. Commençant par une illustration approfondie des différents conflits existant entre la performance économique et les valeurs publiques dans les hôpitaux, nous proposons de reverser complètement le paradigme actuellement porté par la T2A et la NG en exploitant les travaux d'Elinor Ostrom (2010) sur les biens communs et leurs prolongements.
http://hal.archives-ouvertes.fr/view_by_stamp.php?&halsid=n13am0q0fl1tjtrv49tn6lvif2&label=LEMNA&langue=fr&action_todo=view&id=hal-00829936&version=1

Besstremyannaya G. (2013). Heterogeneous hospital response to a per diem prospective payment system. Moscou : NES - CEFIR //

Abstract: The paper provides the empirical support for heterogeneity in hospital response to changeover from the fee-for-service (FFS) system to a per diem prospective payment system (PPS). Using a recent administrative database for the universe of Japanese hospitals, it conducts estimations with dynamic panel data and shows that hospitals with shorter (longer) average length of stay under FFS have longer (shorter) average length of stay under per diem PPS. The planned readmission rate increases under per diem PPS for FFS hospitals with longer average length of stay.
http://www.cefir.ru/papers/WP193.pdf

Eldridge D.S., Onur L., Velamuri M.R. (2013). The Impact of Private Hospital Insurance on the Utilization of Hospital Care In Australia : La Trobe University

Abstract: We use the 2004-'05 wave of the Australian National Health Survey to estimate the impact of private hospital insurance on the propensity for hospitalization as a private patient. We employ instrumental-variable methods to account for the endogeneity of supplementary private hospital insurance purchases. We calculate moral hazard based on a difference-of-means estimator. We decompose the moral hazard estimate into a diversion component that is due to an insurance-induced substitution away from public patient care towards private patient care, and an expansion component that measures a pure insurance-induced increase in the propensity to seek private patient care. We find some evidence of self-selection into insurance but this finding is not robust to alternative specifications. Our results suggest that on average, private hospital insurance causes a sizable and significant increase in the likelihood of hospital admission as a private patient. However, there is little evidence of moral hazard; the treatment effect of private hospital insurance on private patient care is driven almost entirely by the substitution away from public patient care towards private patient care.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1741682

Gaughan J., Gravelle H., Santos R., Siciliani L. (2013). Long term care provision, hospital length of stay and discharge destination for hip fracture and stroke patients : York : University of York

Abstract: Expenditure on long term care is expected to rise, driven by an ageing population. Coordination between health and long term care is increasingly a priority for policymakers. Elderly individuals living at home who suffer trauma, such as hip fracture or stroke, generally require immediate acute hospital care, followed by long term care and assistance which can be provided either in their home or in a residential or nursing home. However, little is known about the effects of one sector on the other. This study examines the association between formal long term care supply and the probability of being discharged to a long-term care institution (a nursing home or a care home)

and length of stay in hospital for patients admitted for hip fracture or stroke.
http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP86_longterm_care_provision_hospital_length_of_stay_discharge_destination_hip_fracture_stroke.pdf

Hansen X.B., Bech M., Jacobsen M.L., Lauridsen J. (2013). Do Mixed Reimbursement Schemes Affect Hospital Productivity? An Analysis of the Case of Denmark : Odense : University of Southern Denmark

Abstract: The majority of public hospitals in Scandinavia are reimbursed through a mixture of two prospective reimbursement schemes, block grants (a fixed amount independent of the number of patients treated) and activity-based financing (ABF). This article contributes theoretically to the existing literature with a deeper understanding of such mixed reimbursement systems as well as empirically by identifying key design factors that determines the incentives embedded in such a mixed model. Furthermore, we describe how incentives vary in different designs of the mixed reimbursement scheme and assess whether different incentives affects the performance of hospitals regarding activity and productivity differently. Information on Danish reimbursement schemes has been collected from documents provided by the regional governments and through interviews with regional administrations. The data cover the period from 2007-2010. A theoretical framework identified the key factors in an ABF/block grant model to be the proportion of the national Diagnosis-Related Group (DRG) tariff above and below a predefined production target (i.e. the baseline); baseline calculations; the presence of kinks/ceilings; and productivity requirements. A comparative case study across the five regions in Denmark demonstrated presence of inter-regional variation in the design of reimbursement schemes. This variation creates different incentives regarding activity and productivity. Using gender-age standardized rates across year and region we show that there have not been any significant changes in the number of hospital discharges for any of the regions from 2007 to 2010 within any of the treatment groups.
http://static.sdu.dk/mediafiles//3/B/4/%7B3B48D0FF-E60B-467F-B63D-2AD2AA5E0B0B%7D20132.pdf

Ho K., Pakes A. (2013). Hospital Choices, Hospital Prices and Financial Incentives to Physicians : Cambridge : NBER

Abstract: We estimate a preference function which rationalizes hospital referrals for privately-insured birth episodes in California. The function varies across insurers and is additively separable in: a hospital price paid by the insurer, the distance traveled, and plan and severity-specific hospital fixed effects (capturing various dimensions of hospital quality). We use an inequality estimator that allows for errors in price and detailed hospital-severity interactions and obtain markedly different results than those from a logit. The inequality estimator indicates that insurers with more capitated physicians are more responsive to hospital prices. Capitated plans are willing to send patients further to utilize similar-quality lower-priced hospitals; but the trade-off between quality and costs does not vary with capitation rates.
http://papers.nber.org/papers/W19333

Inégalités de santé/ Health Inequalities

(2013). Indicateurs de suivi de l'évolution des inégalités sociales de santé dans les systèmes d'information en santé : Paris : HCSP

Abstract: Ce rapport répond à deux saisines de la Direction générale de la santé (DGS) et la Direction de la recherche - des études de l'évaluation et des statistiques (Drees), portant d'une part sur « la pertinence et les possibilités de prise en compte des caractéristiques sociales dans les indicateurs transversaux et spécifiques » associés aux objectifs de la loi de santé publique, et sur la hiérarchisation des indices écologiques de défavorisation sociale ; d'autre part sur la proposition d'indicateurs permettant « d'assurer le suivi des inégalités de santé dans le domaine du cancer, de ses facteurs de risque et de ses conséquences, notamment en termes de mortalité ». Le HCSP analyse les éléments disponibles pour rendre compte de l'évolution des inégalités sociales de santé et propose des indicateurs à insérer dans les systèmes d'information en santé, ainsi que des évolutions à apporter dans ces systèmes d'information, de façon à prendre en compte ces inégalités sociales de

santé dans les différents types d'usages des données de santé : systèmes de recueil de données en routine (mortalité, morbidité, institutions de soins) ; enquêtes, études et travaux de recherche ; bilans des politiques de santé. La première partie est générale et concerne l'ensemble des états de santé et pathologies. Dans la seconde partie, qui concerne le domaine du cancer, les objectifs généraux sont plus spécifiquement appliqués aux systèmes d'information ou sources de données mobilisables sur le cancer, afin de pouvoir disposer de données suffisantes à la conduite des politiques de réduction des inégalités.
http://www.hcsp.fr/Explore.cgi/Telecharger?NomFichier=hcspr20130619_indicateurinegalitesocialesante.pdf

Adena M. (2013). Poverty and Transitions in Health : Bonn : IZA
Abstract: Using a sample of Europeans aged 50+ from twelve countries in the Survey of Health, Ageing and Retirement in Europe (SHARE) we analyse the role of poor material conditions as a determinant of changes in health over a four-year period. We find that poverty defined with respect to relative incomes has no effect on changes in health. However, broader measures of poor material conditions such as subjective poverty or low relative value of wealth significantly increase the probability of transition to poor health among the healthy and reduce the chance of recovery from poor health over the time interval analysed. In addition to this the subjective measure of poverty has a significant effect on mortality, increasing it by 40.3% among men and by 58.3% among those aged 50–64. Material conditions matter for health among older people. We suggest that if monitoring of poverty in old age and corresponding policy targets are to focus on the relevant measures, they should take into account broader definitions of poverty than those based only on relative incomes.
http://ftp.iza.org/dp7532.pdf

Appouey B., Silber J. (2013). Inequality and bi-polarization in socioeconomic status and health: Ordinal approaches : Paris : Paris School of economics
Abstract: Traditional indices of bi-dimensional inequality and polarization were developed for cardinal variables and cannot be used to quantify dispersion in ordinal measures of socioeconomic status and health. This paper develops two approaches to the measurement of inequality and bi-polarization using only ordinal information. An empirical illustration is given for 24 European Union countries in 2004-2006 and 2011. Results suggest that inequalities and bi-polarization in income and health are especially large in Estonia and Portugal, and that inequalities have significantly increased in recent years in Austria, Belgium, Finland, Germany, and the Netherlands, whereas bi-polarization significantly decreased in France, Portugal, and the UK.
http://halshs.archives-ouvertes.fr/docs/00/85/00/14/PDF/wp_201330.pdf

Crespo L., Lopez-Noval B., Mira P. (2013). Compulsory schooling, education and mental health : new evidence from SHARELIFE : Madrid : Centro de Estudios de Monetarios y Financieros
Abstract: This paper provides new evidence on the causal effect of education on adult depression and cognition. Using SHARE data, we use schooling reforms in several European countries as instruments for educational attainment. We find that an extra year of education has a large and significant protective effect on mental health: the probability of suffering depression decreases by 6.5 percent. We find a large and significant protective effect on cognition as measured by word recall. We also explore whether heterogeneity and selection play a part in the large discrepancy between OLS and IV (LATE) estimates of the effect of education on depression and cognition. Using the data available in SHARELIFE on early life conditions of the respondents such as the individuals' socioeconomic status, health, and performance at school, we identify subgroups particularly affected by the reforms and with high marginal health returns to education.
http://www.cemfi.es/ftp/wp/1304.pdf

Christopoulou R., Jaber A., Lillard D.R. (2013). The Inter-generational and Social Transmission of Cultural Traits: Theory and Evidence from Smoking Behavior : Cambridge : NBER
Abstract: The extant literature on cultural transmission takes competing cultures in society as given and parental cultural preferences as fixed. We relax these assumptions by endogenizing both societal and parental preferences. We use smoking as a case-study of a cultural trait which did not always exist, and which over time has switched from being perceived as socially acceptable to being perceived as undesirable. In our model, parents' preferred cultural traits depend on the perceived

health costs of smoking, and societal preferences depend on the behavior of a tobacco industry that aims to maximize smoking prevalence. We derive conditions for the emergence and persistence of the smoking habit, and find new implications for the relationship between parental and societal influences. We then test explicitly for the validity of our theoretical framework using novel US data. We find that our framework is able to capture features of smoking behavior which existing models are unable to explain.
http://papers.nber.org/papers/W19304

Galama T.J., Van K.H. (2013). Health Inequalities through the Lens of Health Capital Theory: Issues, Solutions, and Future Directions : Tinbergen : Tinbergen Institute
Abstract: We explore what health-capital theory has to offer in terms of informing and directing research into health inequality. We argue that economic theory can help in identifying mechanisms through which specific socioeconomic indicators and health interact. Our reading of the literature, and our own work, leads us to conclude that non-degenerate versions of the Grossman model (1972a;b) and its extensions can explain many salient stylized facts on health inequalities. Yet, further development is required in at least two directions. First, a childhood phase needs to be incorporated, in recognition of the importance of childhood endowments and investments in the determination of later-life socioeconomic and health outcomes. Second, a unified theory of joint investment in skill (or human) capital and in health capital could provide a basis for a theory of the relationship between education and health

Lawrence D., Hafekost J., Hull P., Mitrou F., Zubrick S.R. (2013). Smoking, mental illness and socioeconomic disadvantage: analysis of the Australian National Survey of Mental Health and Wellbeing. *BMC Public Health,* 13 462.
Abstract: BACKGROUND: High rates of smoking and lower rates of smoking cessation are known to be associated with common mental disorders such as anxiety and depression, and with individual and community measures of socioeconomic status. It is not known to what extent mental illness and socioeconomic status might be jointly associated with smoking behaviour. We set out to examine the relationship between mental illness, measures of socioeconomic disadvantage and both current smoking and smoking cessation rates. METHODS: We used data from the 2007 Australian National Survey of Mental Health and Wellbeing to examine the relationship between mental illness, socioeconomic status and both current smoking and smoking cessation. We used cross-classified tables and logistic regression to examine the relationship between psychosocial and sociodemographic predictors and current smoking. We also used proportional hazards regression to examine the relationship between the factors and smoking cessation. RESULTS: Both mental illness and socioeconomic status were independently associated with current smoking and with lower likelihood of smoking cessation, with gradients in smoking by mental health status being observed within levels of socioeconomic indicators and vice versa. Having a mental illness in the past 12 months was the most prevalent factor strongly associated with smoking, affecting 20.0% of the population, associated with increased current smoking (OR 2.43; 95% CI: 1.97-3.01) and reduced likelihood of smoking cessation (HR: 0.77; 95% CI: 0.65-0.91). CONCLUSIONS: The association between mental illness and smoking is not explained by the association between mental illness and socioeconomic status. There are strong socioeconomic and psychosocial gradients in both current smoking and smoking cessation. Incorporating knowledge of the other adverse factors in smokers' lives may increase the penetration of tobacco control interventions in population groups that have historically benefited less from these activities.
http://www.biomedcentral.com/1471-2458/13/462

Médicaments / Pharmaceuticals

Alpert A. (2013). Perverse Reverse Price Competition: Average Wholesale Prices and Medicaid Pharmaceutical Spending : Cambridge : NBER
Abstract: Generic drugs comprise an increasing share of total prescriptions dispensed in the U.S., rising from nearly 50 percent in 1999 to 75 percent in 2009. The generic drug market has typically

been viewed at the wholesale level as a competitive market with price approaching marginal costs. However, the large presence of third party payers as final purchasers may distort prices at the retail level relative to what a standard model of price competition would predict. In this paper, we investigate how generic drug producers compete in the presence of the procurement rules of the Medicaid program. Medicaid reimbursement to pharmacies, like that of other payers, is based on a benchmark price called the average wholesale price (AWP). The AWP is reported by generic producers themselves, and until recently has been subject to essentially no independent verification. As a result, generic producers have had an incentive to compete for pharmacy market share by reporting AWPs that exceed actual average wholesale prices, as this “spread” leads to larger pharmacy profits. In 2000, after a federal government audit of actual wholesale prices of generic products, states were advised to reduce Medicaid reimbursement by as much as 95% for about 400 generic and off-patent drug products. We use variation induced by the timing of this policy along with its differential impact on drug products' Medicaid reimbursement to estimate the impact of this exogenous price change on the market share of targeted products. Our findings indicate that pharmacies did respond to the perverse incentives of the Medicaid program by dispensing products with the highest AWPs. Overall, the Medicaid market share fell by about 45% for targeted drug products as a result of the policy.
http://papers.nber.org/papers/W19367

Carrera M., Goldman D., Joyce J. (2013). Heterogeneity in Cost-Sharing and Cost-Sensitivity, and the Role of the Prescribing Physician : Cambridge : NBER
Abstract: This paper uses individual level data on purchases of one of the most prescribed categories of drugs (cholesterol-lowering statins) to study the responses of physicians and patients to variation in the cost of drugs. In a sample of first-time statin prescriptions to employees from a group of Fortune 500 firms, we find that copay variation across plans has a relatively small effect on the choice of drug, and this effect does not vary with patient income. After the highly-publicized expiration of the patent for Zocor (simvastatin), however, prescriptions for this drug increased substantially, especially for lower-income patients. Our analysis suggests that physicians can perceive the adherence elasticity of their patients and adjust their initial prescriptions accordingly, but only in response to a large and universal price change. Using prescriber identifiers, we present suggestive evidence that physicians learn about a patient's price sensitivity through their own experience of prescribing to that patient.
http://www.nber.org/papers/w19186

Herrmann M., Nkuiya B., Dussault A.R. (2013). Innovation and Antibiotic Use within Antibiotic Classes: Market Incentives and Economic Instruments : Québec : CREATE
Abstract: We analyze a monopolist's incentive to innovate a new antibiotic which is connected to the same pool of antibiotic treatment efficacy as is another drug produced by a generic industry. We outline the differences of antibiotic use under market conditions and in the social optimum. A time and state-dependent tax-subsidy mechanism is proposed to induce the monopolist and generic industry to exploit antibiotic efficacy optimally.
http://www.create.ulaval.ca/uploads/tx_centrerecherche/CREATE2013-3.pdf

Méthodologie – Statistique / Methodology / Statistics

Givord P., D’Haultfoeuille X. (2013). La régression quantile en pratique : Paris : INSEE //
Abstract: Les régressions quantiles sont des outils statistiques dont l'objet est de décrire l'impact de variables explicatives sur une variable d'intérêt. Elles permettent une description plus riche que les régressions linéaires classiques, puisqu'elles s'intéressent à l'ensemble de la distribution conditionnelle de la variable d'intérêt et non seulement à la moyenne de celle-ci. En outre, elles peuvent être plus adaptées pour certains types de données (variables censurées ou tronquées, présence de valeurs extrêmes, modèles non linéaires...). Ce document propose une introduction pratique à ces outils, en insistant sur les détails de leur implémentation pratique par les logiciels statistiques standards (Sas, R, Stata). Il peut également être utilisé comme un guide d'interprétation d'études mobilisant ces méthodes, en s'appuyant sur les deux applications concrètes exposées en détail. Enfin, il présente, pour un public plus averti, des extensions récentes traitant en particulier du

traitement de l'endogénéité (variables instrumentales, données de panel...)
http://www.insee.fr/fr/publications-et-services/docs_doc_travail/doc_regression_quantile.pdf

(2013). European Health Interview Survey (EHIS wave 2). Methodological manual. Methodologies & Working papers. Luxembourg: Publications Office of the European Union //
Abstract: The manual should serve as a handbook for planning and implementing the EHIS wave 2 in EU member states. Conducting the survey according to the rules and recommendations described in these guidelines is crucial for ensuring harmonized and high quality data on health in EU. The manual is split into two main parts. The first part includes conceptual guidelines and translation and interview instructions for all health modules, sub-modules and variables (including model questions) and provides also an overview on Core social variables. The second part deals with statistical survey guidelines. Instructions on data processing (including a codebook and validation rules) and its transmission to Eurostat as well the format for quality reporting (a quality report template) will be provided in separate documents (tiré de l'introduction).
http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-RA-13-018/EN/KS-RA-13-018-EN.PDF

Boeckenhoff A., Sassenroth D., Kroh M. (2013). The Socio-Economic Module of the Berlin Aging Study II (SOEP-BASE): Description, Structure, and Questionnaire : Berlin : DIW //
Abstract: The Berlin Aging Study II (BASE-II) is a multidisciplinary study that allows for the investigation of how a multitude of health status factors as well as many other social and economic outcomes interplay. The sample consists of 1,600 participants aged 60 to 80, and 600 participants aged 20 to 35. The socio-economic part of BASE-II, the so called SOEP-BASE, is conducted by the SOEP Group at the DIW Berlin. The surveyed socio-economic variables are fully comparable with the variables of the long running German Socio-Economic Panel Study (SOEP), which increases the analytical power of BASE-II. The socio-economic data collected on the individual and on the household level are enriched with geo-referenced context data (“neighbourhood data”) in order to disentangle the interplay between individual, societal and regional determinants on individuals' health status and other outcome variables. Furthermore, as the BASE-II study is based on a convenience sample, the SOEP Group at the DIW provides weights for the BASE-II dataset that correct for selectivity bias
.http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2304056

Gourieroux C., Lu Y. (2013). Love and Death : A Freund Model with Frailty : Toronto : CREST
Abstract: This study introduces new models for analyzing the mortality dependence between individuals in a couple. The mortality risk dependence is usually taken into account in the actuarial literature by introducing an Archimedean copula. This practice implies symmetric effects on the remaining lifetime of the surviving spouse. The new model allows for both asymmetric reactions by means of a Freund model, and risk dependence by means of an unobservable common risk factor (or frailty). These models allow for distinguishing in the lifetime dependence the component due to common lifetime (frailty) from the broken-heart syndrome (Freund model). The model is applied to insurance products such as joint life policy, last survivor insurance, or contracts with reversionary annuities.
http://d.repec.org/n?u=RePEc:crs:wpaper:2013-09&r=hea

Watkins S., Jonsson-Funk M., Brookhart M.A., Rosenberg S.A., O'Shea T.M., Daniels J. (2013). An Empirical Comparison of Tree-Based Methods for Propensity Score Estimation. *Health Services Research,* 48 (5) : 1798-1817.
Abstract: Objective To illustrate the use of ensemble tree-based methods (random forest classification [RFC] and bagging) for propensity score estimation and to compare these methods with logistic regression, in the context of evaluating the effect of physical and occupational therapy on preschool motor ability among very low birth weight (VLBW) children. Data Source We used secondary data from the Early Childhood Longitudinal Study Birth Cohort (ECLS-B) between 2001 and 2006. Study Design We estimated the predicted probability of treatment using tree-based methods and logistic regression (LR). We then modeled the exposure-outcome relation using weighted LR models while considering covariate balance and precision for each propensity score estimation method. Principal Findings Among approximately 500 VLBW children, therapy receipt was associated with moderately improved preschool motor ability. Overall, ensemble methods produced the best covariate balance (Mean

Squared Difference: 0.03–0.07) and the most precise effect estimates compared to LR (Mean Squared Difference: 0.11). The overall magnitude of the effect estimates was similar between RFC and LR estimation methods. Conclusion Propensity score estimation using RFC and bagging produced better covariate balance with increased precision compared to LR. Ensemble methods are a useful alterative to logistic regression to control confounding in observational studies.
http://dx.doi.org/10.1111/1475-6773.12068

Politique de santé / Health Policy

(2013). Successes and failures of Health Policy in Europe : Four decades of divergent trends and converging challenges. European Observatory on Health Systems and Policies Series. Madenhead : Open University Press

Abstract: In the last 40 years, the health of Europeans overall has improved markedly, yet progress has been very uneven from country to country. This new study draws on decades of research to examine the impact health policy has had on population health in Europe. It asks key and incisive questions about mortality trends and health policy activity and seeks to evaluate the most effective policy for the kinds of challenges Europe has faced (4e de couverture).
http://www.euro.who.int/en/who-we-are/partners/observatory/news/news/2013/04/just-published-successes-and-failures-of-health-policy-in-europe-four-decades-of-divergent-trends-and-converging-challenges

Prévention / Prevention

Bouckaert N., Schokkaert E. (2013). Differing types of medical prevention appeal to different individuals : Leuven : Leuven KU

Abstract: We analyse participation in medical prevention with an expected utility model that is sufficiently rich to capture diverging features of different prevention procedures. We distinguish primary and secondary prevention (with one or two rounds) for both fatal or non-fatal diseases. Moreover, we introduce a flexible relationship between the specific disease for which the prevention procedure is set up and the general background health of the individual. We show how these various possibilities change the comparative statics of the prevention decision and we test the differential predictions with data from SHARE (Survey of Health, Ageing and Retirement in Europe) about participation in mammography, dental caries screening and flu vaccination.
http://www.econ.kuleuven.be/drc/CES/research/dps-papers/dps-13/dps1311.pdf

Prévision – Evaluation / Prevision – Evaluation

Miller C.J., Grogan-Kaylor A., Perron B.E., Kilbourne A.M., Woltmann E., Bauer M.S. (2013). Collaborative Chronic Care Models for Mental Health Conditions: Cumulative Meta-analysis and Metaregression to Guide Future Research and Implementation. *Med Care,* 51 (10) : 922-930.

Abstract: OBJECTIVE: Prior meta-analysis indicates that collaborative chronic care models (CCMs) improve mental and physical health outcomes for individuals with mental disorders. This study aimed to investigate the stability of evidence over time and identify patient and intervention factors associated with CCM effects to facilitate implementation and sustainability of CCMs in clinical practice. METHODS: We reviewed 53 CCM trials that analyzed depression, mental quality of life (QOL), or

physical QOL outcomes. Cumulative meta-analysis and metaregression were supplemented by descriptive investigations across and within trials. RESULTS: Most trials targeted depression in the primary care setting, and cumulative meta-analysis indicated that effect sizes favoring CCM quickly achieved significance for depression outcomes, and more recently achieved significance for mental and physical QOL. Four of 6 CCM elements (patient self-management support, clinical information systems, system redesign, and provider decision support) were common among reviewed trials, whereas 2 elements (health care organization support and linkages to community resources) were rare. No single CCM element was statistically associated with the success of the model. Similarly, metaregression did not identify specific factors associated with CCM effectiveness. Nonetheless, results within individual trials suggest that increased illness severity predicts CCM outcomes. CONCLUSIONS: Significant CCM trials have been derived primarily from 4 original CCM elements. Nonetheless, implementing and sustaining this established model will require health care organization support. Although CCMs have typically been tested as population-based interventions, evidence supports stepped care application to more severely ill individuals. Future priorities include developing implementation strategies to support adoption and sustainability of the model in clinical settings while maximizing fit of this multicomponent framework to local contextual factors.

Psychiatrie / Psychiatry

Briffault X. (2010). La fabrique de la dépression : observer, comprendre, agir : Paris : Armand Colin
Abstract: La dépression concerne chaque année plusieurs centaines de milliers de personnes en France, et elle peut avoir des conséquences désastreuses. Les connaissances sur ses mécanismes et sur les stratégies thérapeutiques efficaces se sont développées de façon exponentielle au cours de la dernière décennie. Elles montrent que, si les solutions à la souffrance dépressive existent, elles sont le plus souvent complexes, et qu'une compréhension fine de leurs fondements est indispensable à une efficacité réelle et durable. C'est à une telle compréhension que vise cet ouvrage, en s'appuyant sur une analyse critique approfondie des études scientifiques les plus récentes. Comment la dépression « se fabrique-t-elle » ? Comment s'en sortir et éviter de rechuter ? Quelle est l'efficacité des multiples propositions de solutions disponibles ? Comment les articuler de façon cohérente et adaptée à la spécificité de chaque situation ? Quels sont les intérêts et les limites de l'approche « evidence-based » en santé mentale ? (4e de couverture).

Guelfi J.D., Rouillon F. (2012). Manuel de psychiatrie : Paris : Elsevier Masson
Abstract: Quatre années après la première édition de ce Manuel de psychiatrie, il a paru nécessaire d'en proposer une nouvelle version, mise à jour et assez largement enrichie. Nombre de données nouvelles en matière d'épidémiologie, de biologie, de génétique, de psychologie cognitive, d'imagerie et de thérapeutique ont ainsi été actualisées, rédigées par des auteurs référents francophones reconnus. Un chapitre a été entièrement refondu, celui sur la législation en psychiatrie avec la présentation des lois nouvelles appliquées en France depuis l'été 2011, notamment celle encadrant les soins sous contrainte. Enfin, en matière de classification, la parution de la cinquième révision de la classification américaine des troubles mentaux, le DSM-5, est prévue courant 2013. Plusieurs tendances sont déjà accessibles depuis la mise en ligne en février 2010 des recommandations et propositions des différents groupes de travail qui ont synthétisé les principales revues générales de la littérature internationale sur l'ensemble des troubles mentaux. Nous avons mentionné aussi souvent que possible les grandes orientations de cette classification dont certaines font encore l'objet de débats et d'enjeux importants. Les auteurs du Manuel ne croient pas à la mort parfois annoncée de la psychiatrie dont la spécificité aurait été dénaturée par l'émergence du concept de santé mentale. La diversification du champ d'intervention et l'hétérogénéité des références théoriques ont certes pu fragiliser la psychiatrie mais cette évolution ne doit pas être un motif de découragement mais plutôt le signe de son renouveau. Cet ouvrage en témoigne, destiné principalement aux étudiants en médecine, aux psychiatres en formation ainsi qu'à l'ensemble des spécialistes des sciences humaines dont l'objectif principal sinon exclusif pour certains est de soulager la souffrance psychique (4e de

couverture).

Soins de santé primaires / Primary Health Care

Brosig-Koch J., Hening-Schmidt H., Kairies N., Wiesen D. (2013). How Effective are Pay-for-Performance Incentives for Physicians? A Laboratory Experiment : Essen : Universität Duisbourg - Essen

Abstract: Recent reforms in health care have introduced a variety of pay-for-performance programs using financial incentives for physicians to improve the quality of care. Their effectiveness is, however, ambiguous as it is often difficult to disentangle the effect of financial incentives from the ones of various other simultaneous changes in the system. In this study we investigate the effects of introducing financial pay-for-performance incentives with the help of controlled laboratory experiments. In particular, we use fee-for-service and capitation as baseline payment schemes and test how additional pay-for-performance incentives affect the medical treatment of different patient types. Our results reveal that, on average, patients significantly benefit from introducing pay-for performance, independently of whether it is combined with capitation or fee-for-service incentives. The magnitude of this effect is significantly influenced by the patient type, though. These results hold for medical and non-medical students. A cost-benefit analysis further demonstrates that, overall, the increase in patient benefits cannot overcompensate the additional costs associated with pay-for-performance. Moreover, our analysis of individual data reveals different types of responses to pay-for-performance incentives. We find some indication that pay-for performance might crowd out the intrinsic motivation to care for patients. These insights help to understand the effects caused by introducing pay-for-performance schemes.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2278863

Brosig-Koch J., Henning-Schmidt H., Kairies N. (2013). How to Improve Patient Care? – An Analysis of Capitation, Fee-for-Service, and Mixed Payment Schemes for Physicians : Bochum : Ruhr-Universität Bochum

Abstract: In recent health care reforms, several countries have replaced pure payment schemes for physicians (fee-for-service, capitation) by so-called mixed payment schemes. Until now it is still an unresolved issue whether patients are really better off after these reforms. In this study we compare the effects resulting from pure and mixed incentives for physicians under controlled laboratory conditions. Subjects in the role of physicians choose the quantity of medical services for different patient types. Real patients gain a monetary benefit from subjects' decisions. Our results reveal that overprovision observed in fee-for-service schemes and underprovision observed in capitation schemes can, in fact, be reduced by mixed incentives. Interestingly, even the presentation of pure incentives as mixed incentives already significantly affects physicians' behavior. Moreover, the mixed payment schemes generally provide a higher benefit-remuneration ratio than the respective pure payment schemes. Our findings provide some valuable insights for designing health care reforms.
http://repec.rwi-essen.de/files/REP_13_412.pdf

Gravelle H., Scott A., Sivey P. (2013). Competition, Prices and Quality in the Market for Physician Consultations : York : University of York //

Abstract: Prices for consultations with General Practitioners (GPs) in Australia are unregulated, and patients pay the difference between the price set by the GP and a fixed reimbursement from the national tax-funded Medicare insurance scheme. We construct a Vickrey-Salop model of GP price and quality competition and test its predictions using a dataset with individual GP-level data on prices, the proportion of patients who are charged no out-of-pocket fee, average consultation length, and characteristics of the GPs, their practices and their local areas. We measure the competition to which the GP is exposed by the distance to other GPs and allow for the endogeneity of GP location decisions with measures of area characteristics and area fixed-effects. Within areas, GPs with more distant competitors charge higher prices and a smaller proportion of their patients make no out-of-pocket payment. GPs with more distant competitors also have shorter consultations, though the effect is small and statistically insignificant.
http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP89_competition_prices_quality_physician_consultations.pdf

Parchman M., Noel P., Culler S., Lanham H., Leykum L., Romero R., Palmer R. (2013). A randomized trial of practice facilitation to improve the delivery of chronic illness care in primary care: initial and sustained effects. *Implementation Science,* 8 (1) : 93.

Abstract: BACKGROUND: Practice facilitation (PF) is an implementation strategy now commonly used in primary care settings for improvement initiatives. PF occurs when a trained external facilitator engages and supports the practice in its change efforts. The purpose of this group-randomized trial is to assess PF as an intervention to improve the delivery of chronic illness care in primary care. METHODS:A randomized trial of 40 small primary care practices who were randomized to an initial or a delayed intervention (control) group. Trained practice facilitators worked with each practice for one year to implement tailored changes to improve delivery of diabetes care within the Chronic Care Model framework. The Assessment of Chronic Illness Care (ACIC) survey was administered at baseline and at one-year intervals to clinicians and staff in both groups of practices. Repeated-measures analyses of variance were used to assess the main effects (mean differences between groups) and the within-group change over time. RESULTS:There was significant improvement in ACIC scores ($p<0.05$) within initial intervention practices, from 5.58 (SD 1.89) to 6.33 (SD 1.50), compared to the delayed intervention (control) practices where there was a small decline, from 5.56 (SD 1.54) to 5.27 (SD 1.62). The increase in ACIC scores was sustained one year after withdrawal of the PF intervention in the initial intervention group, from 6.33 (SD 1.50) to 6.60 (SD 1.94), and improved in the delayed intervention (control) practices during their one year of PF intervention, from 5.27 (SD 1.62) to 5.99 (SD 1.75).CONCLUSIONS: Practice facilitation resulted in a significant and sustained improvement in delivery of care consistent with the CCM as reported by those involved in direct patient care in small primary care practices. The impact of the observed change on clinical outcomes remains uncertain. TRIAL REGISTRATION: This protocol followed the CONSORT guidelines and is registered per ICMJE guidelines: Clinical Trial Registration Number: NCT00482768.
http://www.implementationscience.com/content/8/1/93

Travail et santé / Occupational Health

Avdic D., Johansson P. (2013). Gender differences in preferences for health-related absences from work

Abstract: Women are on average more absent from work for health reasons than men. At the same time, they live longer. This conflicting pattern suggests that part of the gender difference in health-related absenteeism arises from differences between the genders unrelated to actual health. An overlooked explanation could be that men an women's preferences for absenteeism differ, for example because of gender differences in risk preferences. These differences may originate from the utility-maximizing of households in which women's traditional dual roles influence household decisions to invest primarily in women's health. Using detailed administrative data on sick leave, hospital visits and objective health measures we first investigate the existence of gender-specific preferences for abstenteeism and subsequently test for the household investment hypothesis. We find evidence for the existence of gender differences in preferences for absence from work, and that a non-trivial part of these preference differences can be attributed to household investments in women's health.
http://www.ifau.se/Upload/pdf/se/2013/wp2013-13-Gender-differences-in-preferences-for-health-related-absences-from-work.pdf

Vieillissement / Ageing

Beland F. / dir., Michel H. (2013). La fragilité des personnes âgées : définitions, controverses et perspectives d'action : Rennes : Presses de l'Ehesp

Abstract: La fragilité est un processus latent, fluctuant et potentiellement réversible. Développée par les gériatres, cette notion ouvre la voie à des actions de prévention qui permettraient aux personnes âgées de maintenir un vieillissement actif et de récupérer leurs capacités physiques. L'enjeu est donc d'intervenir en amont du processus de fragilisation, avant même la manifestation des premiers signes de fragilité, pour permettre aux personnes âgées de conserver leur autonomie le plus longtemps

possible et aux pouvoirs publics de réduire les dépenses liées au vieillissement. S'il y a globalement consensus sur l'intérêt et la nécessité d'agir, les divergences persistent sur la définition et la mesure de la fragilité. La fragilité est-elle un syndrome gériatrique ou une simple accumulation de risques ? Quels liens entre fragilité, maladies chroniques et dépendance ? Doit-on simplement parler de fragilité ou aussi de vulnérabilité ? Façonnée par les travaux de recherche essentiellement gériatrique, la fragilité émerge aussi comme une catégorie d'action publique qui interroge l'évolution du système de protection sociale du moins les politiques du vieillissement. Par son approche pluridisciplinaire et internationale, cet ouvrage apporte un éclairage précis et inédit sur la fragilité, mais aussi sur la vulnérabilité des personnes âgées (4e de couverture).

Balia S., Brau R. (2013). A Country for old men? Long-term home care utilization in Europe. *Health Econ,*

Abstract: This paper investigates long-term home care utilization in Europe. Data from the first wave of the Survey on Health, Ageing and Retirement (SHARE) on formal (nursing care and paid domestic help) and informal care (support provided by relatives) are used to study the probability and the quantity of both types of care. The overall process is framed in a fully simultaneous equation system that takes the form of a bivariate two-part model where the reciprocal interaction between formal and informal care is estimated. Endogeneity and unobservable heterogeneity are addressed using a common latent factor approach. The analysis of the relative impact of age and disability on home care utilization is enriched by the use of a proximity to death (PtD) indicator built using the second wave of SHARE. All these indicators are important predictors of home care utilization. In particular, a strong significant effect of PtD is found in the paid domestic help and informal care models. The relationship between formal and informal care moves from substitutability to complementarity depending on the type of care considered, and the estimated effects are small in absolute size. This might call for a reconsideration of the effectiveness of incentives for informal care as instruments to reduce public expenditure for home care services. Copyright (c) 2013 John Wiley & Sons, Ltd;

Bernal N., Vermeulen F. (2013). The impact of an increase in the legal retirement age on the effective retirement age : Leuven : Leuven KU //

Abstract: We analyze the impact of an increase in the legal retirement age on the effective retirement age in the Netherlands. We do this by means of a dynamic programming model for the retirement behavior of singles. The model is applied to new administrative data that contain very accurate and detailed information on individual incomes and occupational pension entitlements. Our model is able to capture the main patterns observed in the data. We observe that as individuals get older their labor supply declines considerably and this varies by health status. We simulate a soon to be implemented pension reform which aims at gradually increasing the legal retirement age from 65 to 67. The simulation results show a rather small impact on the effective retirement age. Individuals postpone their retirement by only 3 months on average, while differences across individuals mainly depend on their health status.
http://www.econ.kuleuven.be/drc/CES/research/dps-papers/dps-13/dps1303.pdf

Do Y.K., Norton E.C., Stearns S. (2013). Informal Care and Caregiver's Health : Cambridge : NBER //

Abstract: This study aims to measure the causal effect of informal caregiving on the health and health care use of women who are caregivers, using instrumental variables. We use data from South Korea, where daughters and daughters-in-law are the prevalent source of caregivers for frail elderly parents and parents-in-law. A key insight of our instrumental variable approach is that having a parent-in-law with functional limitations increases the probability of providing informal care to that parent-in-law, but a parent-in-law's functional limitation does not directly affect the daughter-in-law's health. We compare results for the daughter-in-law and daughter samples to check the assumption of the excludability of the instruments for the daughter sample. Our results show that providing informal care has significant adverse effects along multiple dimensions of health for daughter-in-law and daughter caregivers in South Korea.
http://www.nber.org/papers/w19142