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Sommaire

Assurance maladie / Health Insurance

(2016). La dépense de CMU complémentaire par bénéficiaire 2014-2015. Paris Fonds CMU
http://www.cmu.fr/fichier-utilisateur/fichiers/2016-Rapport_Cout_Moyen_2014-2015.pdf

Le Fonds CMU établit chaque année le coût moyen définitif de la CMU-C par bénéficiaire pour l'année N-2 et réalise une estimation pour l'année N-1. Ce travail s'effectue à partir des données fournies par les différents régimes obligatoires et organismes complémentaires. En 2015, 5,3 millions1 de personnes bénéficient de la CMU-C pour l'ensemble des régimes et du territoire. Ces effectifs ont augmenté de 4,4 % en un an, en net ralentissement par rapport à 2014 (+ 8,5 %), en raison de la fin de la montée en charge de la mesure de revalorisation exceptionnelle des plafonds de juillet 2013.

Abaluck, J. et Gruber, J. (2016). Improving the Quality of Choices in Health Insurance Markets. NBER Working Paper Series ; n° 22917. Cambridge NBER
http://www.nber.org/papers/w22917

Insurance product choice is a central feature of health insurance markets in the United States, yet there is ongoing concern over whether consumers choose appropriately in such markets – and little evidence on solutions to any choice inconsistencies. This paper addresses these omissions from the literature using novel data and a series of policy interventions across school districts in the state of Oregon. Using data on enrollment and medical claims for school district employees, we first document large choice inconsistencies, with the typical employee foregoing savings of more than $600 in their insurance plan choice. We then consider three types of interventions designed to improve choice quality. We first show that interventions to promote more active choice are unlikely to improve choice quality based on existing patterns of plan switching. We then implement a randomized trial of decision support software to illustrate that it has little impact on plan choices, largely because of consumer avoidance of the recommendations. Finally, we show that restricting the choice set size facing individuals does significantly reduce their foregone saving and total costs. This is not because individuals choose worse with larger choice sets, but rather because larger choice sets feature worse choices on average that are not offset by individual re-optimization.

Decarolis, F. et Guglielmo, L. (2016). Insurers' Response to Selection Risk: Evidence from Medicare Enrollment Reforms. NBER Working Paper Series ; n° 22876. Cambridge NBER
www.nber.org/papers/w22876

Evidence on insurers behavior in environments with both risk selection and market power is largely missing. We fill this gap by providing one of the first empirical accounts of how insurers adjust plan features when faced with potential changes in selection. Our strategy exploits a 2012 reform allowing Medicare enrollees to switch to 5-star contracts at anytime. This policy increased enrollment into 5-star contracts, but without risk selection worsening. Our findings show that this is due to 5-star plans lowering both premiums and generosity, thus becoming more appealing for most beneficiaries, but less so for those in worse health conditions.

Gruber, J., et al. (2016). The Impact of Increased Cost-sharing on Utilization of Low Value Services: Evidence from the State of Oregon. NBER Working Paper Series ; n° 22875. Cambridge NBER
http://www.nber.org/papers/w22875

In this study we examine the impact of a value-based insurance design (V-BID) program implemented between 2010 and 2013 at a large public employer in the state of Oregon. The program substantially increased cost-sharing, specifically copayments and coinsurance, for several healthcare services believed to be of low value and overused (sleep studies, endoscopies, advanced imaging, and surgeries). Using a differences-in-differences design coupled with granular, administrative health insurance claims data, we estimate the change in low value healthcare service utilization among beneficiaries before and after program implementation relative to a comparison group of beneficiaries

who were not exposed to the V-BID. Our findings suggest that the V-BID significantly reduced utilization of targeted services. These findings have important implications for both public and private healthcare policies as V-BID principles are rapidly proliferating in healthcare markets.

Martin, P. et Bec, C. p. (2016). Les métamorphoses de l'assurance maladie : conversion managériale et nouveau gouvernement des pauvres, Rennes : Presses universitaires de Rennes

À partir d'une enquête ethnographique réalisée dans une caisse primaire d'assurance maladie (CPAM) de la région parisienne, cet ouvrage décrit minutieusement la mise en œuvre de la réforme managériale de l'assurance maladie. L'évaluation de la « qualité de service » et des compétences des agents se réduit à une norme strictement quantitative, au mépris de la satisfaction des besoins des usagers les plus précaires. De là sourd une véritable souffrance chez les agents les plus attachés à l'« utilité sociale » de leur mission.

Economie de la santé / Health Economics

(2017). Tackling Wasteful Spending on Health. Paris OCDE**:** 304
www.oecd.org/health/health-systems/Primary-Care-Review-of-Denmark-OECD-report-December-2016.pdf

Following a brief pause after the economic crisis, health expenditure is rising again in most OECD countries. Yet, a considerable part of this health expenditure makes little or no contribution to improving people's health. In some cases, it even results in worse health outcomes. Countries could potentially spend significantly less on health care with no impact on health system performance, or on health outcomes. This report systematically reviews strategies put in place by countries to limit ineffective spending and waste. On the clinical front, preventable errors and low-value care are discussed. The operational waste discussion reviews strategies to obtain lower prices for medical goods and to better target the use of expensive inputs. Finally, the report reviews countries experiences in containing administrative costs and integrity violations in health (résumé de l'éditeur).

Bessou, A. (2016). "Le marché de l'audioprothèse en 2015." Points De Repère(47)

En 2015, près de 630 000 audioprothèses ont été vendues à plus de 360 000 patients. De fait, avec un marché représentant environ un milliard d'euros, le secteur de l'audioprothèse constitue une dépense de santé significative mais dont la prise en charge collective est relativement limitée (134 millions d'euros à la charge de l'assurance maladie obligatoire). De plus, le secteur connait une dynamique forte avec une croissance moyenne de 6,6 % par an depuis 2006, liée à une augmentation du taux de recours ainsi qu'à des facteurs démographiques d'autant plus importants que ce sont les personnes âgées qui ont naturellement un recours plus élevé à ce type d'appareil, la prévalence des limitations auditives augmentant avec l'âge.

Safon, M. O. (2016). Projections des dépenses de santé dans les pays de l'OCDE, Paris : Irdes
http://www.irdes.fr/documentation/syntheses/projections-des-depenses-de-sante-dans-les-pays-de-l-ocde.pdf

Les projections à moyen et long termes des dépenses publiques, notamment des dépenses de santé, jouent un rôle important dans la conduite des politiques publiques mais également dans la surveillance budgétaire internationale. Élaborer des perspectives d'évolution des dépenses de santé à long terme constitue donc un enjeu important afin de définir les mesures nécessaires pour assurer la soutenabilité des finances publiques. Après une présentation des modèles de projection des dépenses de santé en usage dans les pays de l'OCDE, cette bibliographie recense les principales études portant sur les modèles macroéconomiques pour la période s'étendant de 2008 à octobre 2016. Quelques publications antérieures à la crise économique de 2008 sont néanmoins signalées pour leur méthodologie, ainsi que des études relatives à l'impact du vieillissement sur les dépenses de santé.

Tian, F., et al. (2016). A Quantile Regression Approach to Panel Data Analysis of Health Care

Expenditure in OECD Countries. Working paper; 20/16. Melbourne Monash University
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2865062

This article investigates the variation in the effects of various determinants on the per capita health care expenditure. A total of 28 OECD countries are studied over the period 1990-2012, employing an instrumental variable quantile regression method for a dynamic panel model with fixed effects. The results show that the determinants of per capita health care expenditure do vary with the distribution of the health care expenditure growth, while the change patterns are dissimilar. Specifically, the lagged health spending growth has a significantly positive effect, with an effect that decreases towards the higher quantiles of growth of per capita health care expenditure. Per capita GDP has a significantly positive effect, both the short and long run income elasticities are smaller than one, and health care is a necessity. The density of physicians only has a significant negative effect at the lower tail of the distribution. The elderly population has the reverse effect at the lower and upper tails, and this shows an upward trend with the increase in health expenditure growth. Life expectancy has an effect similar to the proportion of the old. Variable representing Baumol's model of "unbalanced growth" theory has a significantly positive effect, and the change pattern of its influence shows a marked upward trend. However, one component of "Baumol variable", labor productivity, only shows significant effect in the low half of the distribution. More attention needs to be paid to the influence of determinants in health expenditure study.

Handicap / Handicap

Campion, C. L. et Mouiller, P. (2016). Rapport d´information sur la prise en charge de personnes handicapées en dehors du territoire français. Paris Sénat
https://www.senat.fr/notice-rapport/2016/r16-218-notice.html

Près de 6 800 personnes handicapées, dont 1 451 enfants, sont actuellement prises en charge dans un établissement sis en-dehors du territoire national, en Belgique pour la très grande majorité. La commission des affaires sociales du Sénat a souhaité apporter des éléments de réponse aux multiples questions posées par ce phénomène. Au-delà de la dimension financière de la prise en charge, intégralement assumée par les pouvoirs publics français, les deux rapporteurs de la mission d'information se sont penchés sur les modalités de suivi et sur le contrôle de la qualité des établissements wallons accueillant des personnes françaises. Interpellés par les raisons qui motivent ces départs à l'étranger (qui peuvent être choisis ou subis), ils ont également souhaité tracer quelques perspectives d'amélioration de l'offre médico-sociale destinée aux personnes handicapées en France. Parmi ces dernières, plusieurs portent des réformes ambitieuses de la politique du handicap : développement du pluri-agrément des établissements accueillant des personnes handicapées, décloisonnement des secteurs sanitaire et médico-social, engagement d'une stratégie de désinstitutionalisation en fonction de la complexité des profils, concentration des efforts sur les personnes atteintes d'autisme (résumé de l'éditeur).

Zribi, G. d. et Ceccotto, R. d. (2016). Le droit à la santé des personnes handicapées mentales et psychiques, Rennes : Presses de l'Ehesp
http://www.presses.ehesp.fr/produit/le-droit-a-la-sante-des-personnes-handicapees-mentales-et-psychiques

Depuis la récente restructuration globale du système de santé, une réforme de l'articulation des actions de santé et de l'accompagnement social s'est imposée, entraînant un basculement de la prise en charge des patients chroniques du secteur sanitaire, notamment psychiatrique, vers le secteur médico-social. Les questions de santé, somatiques et psychiques, sont ainsi devenues prégnantes dans les établissements et services destinés aux enfants, adolescents, adultes et personnes âgées handicapées, qu'il s'agisse d'autisme, de handicaps mentaux et psychiques, de handicaps graves à expression multiple ou encore rares. Dans cette nouvelle édition, qui réunit les contributions françaises et européennes de pédiatres, psychiatres, psychologues, paramédicaux, directeurs, chercheurs et juristes, les auteurs abordent les grandes problématiques populationnelles dans

lesquelles les soins somatiques et psychiques ont une place importante (les troubles psychiques, les troubles du spectre autistique, le vieillissement, les épilepsies sévères, les polyhandicaps,?etc.). En présentant ici des réponses concrètes, au sein de dispositifs territoriaux ou d'établissements et services sociaux et médico-sociaux (EMP, IME, ESAT, FAM, foyers, MAS, SAMSAH, CAMSP,?etc.), ils contribuent ainsi à combler le fossé entre les droits formels et leur application concrète en matière de santé.

Hôpital / Hospitals

Cavalieri, M., et al. (2015). Does the Extent of Per-Case Payment System Affect Hospital Efficiency? Evidence from the Italian NHS. HEDG Working Paper 15/29. York HEDG
http://www.york.ac.uk/media/economics/documents/hedg/workingpapers/1529.pdf

Recently increasing public pressure to contain costs in the healthcare sector has led many national governments to introduce some type of prospective payment system and reduce the scope of global budgeting. This study investigates the extent to which the reimbursement systems of the Italian hospital sector have an impact on hospitals' technical efficiency. Because of high variation in the financing and provision of healthcare services among regions and hospitals, Italy represents an interesting case study to test these effects. A two-stage Data Envelopment Analysis was employed, in which the efficiency scores of all Italian hospitals were first calculated and then regressed on different environmental variables to capture the role of reimbursement systems. The results found a significant impact of the use of Diagnostic-Related Group-based prospective payment systems on hospitals' efficiency.

Dor, A., et al. (2016). Do Good Reports Mean Higher Prices? The Impact of Hospital Compare Ratings on Cardiac Pricing. NBER Working Paper Series ; n° 22858. Cambridge NBER
http://www.nber.org/papers/w22858

Previous research found that the initiation of Hospital Compare (HC) quality reporting had little impact on patient outcomes. However little is known about its impact on hospital prices, which may be significant since insurers are positioned to respond to quality information when engaging hospitals in price negotiations. To explore this issue we estimate variants of difference-in-difference models allowing HC impacts to vary by levels of quality scores. We separately examine the effects of the three main scores (heart attack, heart failure, and combined mortalities) on transaction prices of two related cardiac procedures: bypass surgery and angioplasty. States which had mandated reporting systems preceding HC form the control group. Analyzing claims data of privately insured patients, we find that HC exerted downward pressure on prices, which we attribute to competitive pressures. However, hospitals ranked "above average" captured higher prices, thereby offsetting the overall policy effect. We conclude that HC was effective at constraining prices without penalizing high performers.

Schwierz, C. (2016). Cost-Containment Policies in Hospital Expenditure in the European Union. Discussion Paper; 37. Bruxelles European commission
http://ec.europa.eu/economy_finance/publications/eedp/dp037_en.htm

As hospital inpatient care accounts for 30% of total health expenditure, and as health expenditure will continue rising, due to ageing populations and costly technological innovations, it is necessary to examine how to address the twin objectives of containing costs and ensuring high access and quality of services. Bed capacity has been reduced in all EU countries in the past decade, but cross-country variation in bed capacity and inpatient hospitalisations is considerable. Apart from being a cost factor, this impacts negatively on quality of care, as countries with more hospitalisations per capita tend to have also higher shares of preventable hospitalisations. This suggests that the reorganisation and rationalisation of hospital care particularly in countries with a high bed density is an important factor towards cost containment and possibly increasing quality of care. There are well tested options for cost containment at least in the short-term. Among these, the application of hard global budgets in

combination with activity-based payments seems useful. Reducing operational costs has also been widely applied and proven to contribute to cost control in the short term. The impact of the many tools aiming at improving hospital performance via structural changes of the hospital and health care sector is more difficult to gauge. It depends among others on the role of the policy reform within the specific health system, whether it was applied at the same time with other health policy reforms and the time needed to see its effects. This applies to virtually all tools reviewed in this paper. The EU can play a supportive and active role in helping to identify the right tools for hospital reform by using its tools of economic governance, policy advice, evidence building and exchange of best practices and providing funding for investments in the sector

Shen, Y. C. et Hsia, R. Y. (2016). Geographical Distribution of Emergency Department Closures and Consequences on Heart Attack Patients. NBER Working Paper series : n° 22861. Cambridge NBER
www.nber.org/papers/w22861

We develop a conceptual framework and empirically investigate how a permanent emergency department (ED) closure affects patients with acute myocardial infarction (AMI). We first document that large increases in driving time to closest ED are more likely to happen in low-income communities and communities that had fewer medical resources at baseline. Then using a difference-in-differences design, we estimate the effect of an ED closure on access to cardiac care technology, treatment, and health outcomes among Medicare patients with AMI who lived in 24,567 ZIP codes that experienced no change, an increase of <10 minutes, 10 to <30 minutes, and =30 minutes in driving time to their closest ED. Overall, access to cardiac care declined in all communities experiencing a closure, with access to a coronary care unit decreasing by 18.64 percentage points (95% CI -30.15, -7.12) for those experiencing =30-minute increase in driving time. Even after controlling for access to technology and treatment, patients with the longest delays experienced a 6.58 (95% CI 2.49, 10.68) and 6.52 (95% CI 1.69, 11.35) percentage point increase in 90-day and 1-year mortality, respectively, compared with those not experiencing changes in distance. Our results also suggest that the predominant mechanism behind the mortality increase appeared to be time delay as opposed to availability of specialized cardiac treatment.

Youn, S., et al. (2016). Hospital Quality, Medical Charge Variation, and Patient Care Effciency: Implications for Bundled Payment Reform Models. College Station Texas A&M University

Patient-centric healthcare reform models pursue lower healthcare costs, improved care quality, and better patient population health outcomes. Many patient-centric reform models focus on standardizing treatment protocols and reducing care delivery variability. Yet the structure of reform models themselves may lead to unintended process variability, the implications of which researchers should analyze. Prior research has not determined whether the reform models can potentially drive better patient-centric outcomes. A distinct challenge in analyzing their potential impact concerns a lack of publicly available historical data on reform models. We circumvent this challenge by recasting available data into relevant metrics, and examining how variation in hospital medical charges relates to patient-centric reform model goals. To do so, we develop a hospital-condition level measure called weighted average coefficient of variation (WACV) to identify the degree of variation in hospital medical charges resulting from underlying care process variability. WACV contributes by capturing unwarranted process variation in medical care protocols after controlling for warranted variation due to patient distributions of illness severity. Using Medicare data from New York state, we find evidence that higher charge variation (WACV) levels are indeed associated with lower hospital technical efficiency. Secondly, we show that prior-period process quality (that measures how well a hospital adheres to evidence-based medical guidelines) has a significant negative association with WACV. In contrast, the prior-period outcome quality measures are not associated with WACV. For policy-makers, the results imply that managerial incentives and interventions based on process quality may be more effective for changing operational behaviors, compared to basing incentives and interventions solely on outcome quality. Further, the results imply that WACV should play a role in the design of healthcare reform models. We examine these implications for bundled payment programs, which fix the amount of reimbursement for hospitals within a predefined boundary of patient care

episode. Empirical results suggest that the current bundled payment provider selection mechanism does not consider the degree of unwarranted variation in charges, which we claim to be the improvement opportunity for each participating provider. In doing so, our results contribute by demonstrating that existing bundled payment program policies may not achieve intended goals.

Inégalités de santé / Health Inequalities

Hollander, A.-C., et al. (2016). "Refugee migration and risk of schizophrenia and other non-affective psychoses: cohort study of 1.3 million people in Sweden." BMJ **352**.

http://www.bmj.com/content/bmj/352/bmj.i1030.full.pdf

Objective To determine whether refugees are at elevated risk of schizophrenia and other non-affective psychotic disorders, relative to non-refugee migrants from similar regions of origin and the Swedish-born population. Design Cohort study of people living in Sweden, born after 1 January 1984 and followed from their 14th birthday or arrival in Sweden, if later, until diagnosis of a non-affective psychotic disorder, emigration, death, or 31 December 2011. Setting Linked Swedish national register data. Participants 1 347 790 people, including people born in Sweden to two Swedish-born parents (1 191 004; 88.4%), refugees (24 123; 1.8%), and non-refugee migrants (132 663; 9.8%) from four major refugee generating regions: the Middle East and North Africa, sub-Saharan Africa, Asia, and Eastern Europe and Russia. Main outcome measures Cox regression analysis was used to estimate adjusted hazard ratios for non-affective psychotic disorders by refugee status and region of origin, controlling for age at risk, sex, disposable income, and population density. Results 3704 cases of non-affective psychotic disorder were identified during 8.9 million person years of follow-up. The crude incidence rate was 38.5 (95% confidence interval 37.2 to 39.9) per 100 000 person years in the Swedish-born population, 80.4 (72.7 to 88.9) per 100 000 person years in non-refugee migrants, and 126.4 (103.1 to 154.8) per 100 000 person years in refugees. Refugees were at increased risk of psychosis compared with both the Swedish-born population (adjusted hazard ratio 2.9, 95% confidence interval 2.3 to 3.6) and non-refugee migrants (1.7, 1.3 to 2.1) after adjustment for confounders. The increased rate in refugees compared with non-refugee migrants was more pronounced in men (likelihood ratio test for interaction $\chi 2$ (df=2) z=13.5; P=0.001) and was present for refugees from all regions except sub-Saharan Africa. Both refugees and non-refugee migrants from sub-Saharan Africa had similarly high rates relative to the Swedish-born population. Conclusions Refugees face an increased risk of schizophrenia and other non-affective psychotic disorders compared with non-refugee migrants from similar regions of origin and the native-born Swedish population. Clinicians and health service planners in refugee receiving countries should be aware of a raised risk of psychosis in addition to other mental and physical health inequalities experienced by refugees.

2016). L'offre de soins dans les quartiers prioritaires de la politique de la ville, en 2014. In : Rapport 2015 de l'Observatoire national de la politique de la ville, Saint Denis : ONZUS/ONPV

http://i.ville.gouv.fr/index.php/download_file/7376/12537/l-offre-de-soins-dans-les-quartiers-prioritaires-de-la-politique-de-la-ville-en-2014

Les quartiers prioritaires présentent un déficit généralisé d'offre de soins ambulatoire et hospitalière en comparaison de ce qui est observé dans leurs agglomérations. Ce déficit est marqué pour les médecins spécialistes et la plupart des auxiliaires libéraux, mais plus modéré pour les médecins généralistes et les infirmiers. Toutefois, l'accessibilité aux soins dans les quartiers prioritaires ne peut pas se résumer à la seule présence d'une offre à l'intérieur même de ces périmètres. Cette question de l'offre de soins nécessitera ainsi des analyses plus approfondies, en termes notamment de disponibilité de l'offre ou de distance. Par exemple, 98 % des habitants des quartiers prioritaires ont un médecin généraliste dans le quartier ou à moins de 500 mètres de la limite du quartier.

Ancelot, L., et al. (2016). Déclarations de renoncement aux soins et non-recours aux services de santé : mesures comparatives et déterminants, Paris : Collège des économistes de la santé

http://www.ces-asso.org/sites/default/files/Ancelot_Bonnal_Depret.pdf

Dans un contexte socio-économique difficile, le renoncement aux soins des patients progresse depuis quelques années en France. Si cette question est aujourd'hui bien étudiée pour les soins d'optique, dentaires, ambulatoires et de ville, elle l'est beaucoup moins pour la médecine périnatale dans la mesure où il n'existe pas d'études sur le renoncement aux soins des femmes durant leur grossesse. Or, d'après la vague 2010 de l'Enquête Nationale Périnatale du Ministère français de la Santé, 4,1 % des femmes déclarent avoir renoncé à des soins durant leur grossesse pour des raisons financières. Cet article s'appuie sur cette base de données pour tenter de comprendre les raisons pour lesquelles les femmes renoncent à des soins durant leur grossesse malgré une prise en charge par la Sécurité Sociale parmi les plus complètes au monde. L'originalité de l'article porte également sur une comparaison entre deux types de renoncement: le renoncement «subjectif» (i.e.déclaratif) et le renoncement « objectif".

Bernard, C. A. et Teissier, O. (2016). La précarité énergétique à la lumière de l'enquête Nationale Logement 2013. Paris ONPE
http://onpe.org/rapports_de_lonpe/la_precarite_energetique_et_ses_outils

La loi Grenelle 2 a défini comme étant en précarité énergétique « une personne qui éprouve dans son logement des difficultés particulières à disposer de la fourniture d'énergie nécessaire à la satisfaction de ses besoins élémentaires en raison de l'inadaptation de ses ressources ou de ses conditions d'habitat ». Cette définition recoupe des situations diverses qu'il convient d'éclairer. Cette étude a pour objet de caractériser les ménages en situation de précarité énergétique, au regard des différents indicateurs retenus par l'ONPE, et d'évaluer leurs conditions de logement. Elle vise à renouveler et approfondir la connaissance des différentes facettes du phénomène de précarité énergétique. Elle détaille les caractéristiques des ménages ciblés par les différents indicateurs de la précarité énergétique retenus par l'Observatoire National de la Précarité Énergétique (ONPE) et leurs évolutions sur la période 1996-2013, sur la base de l'analyse des vagues 1996, 2002, 2006 et 2013 de l'Enquête Nationale Logement (ENL) (tiré de l'intro.)

Constant, A., et al. (2016). A 'healthy immigrant effect' or a 'sick immigrant effect'? Selection and policies matter. Maastricht UNU-MERIT
http://d.repec.org/n?u=RePEc:unm:unumer:2016051&r=hea

Previous literature in a variety of countries has documented a "healthy immigrant effect" (HIE). Accordingly, immigrants arriving in the host country are, on average, healthier than comparable natives. However, their health status dissipates with additional years in the country. HIE is explained through the positive self-selection of the healthy immigrants as well as the positive selection, screening and discrimination applied by host countries. In this paper we study the health of immigrants within the context of selection and migration policies. Using SHARE data we examine the HIE comparing Israel and sixteen countries in Europe that have fundamentally different migration policies. Israel has virtually unrestricted open gates for Jewish people around the world, who in turn have ideological rather than economic considerations to move. European countries have selective policies with regards to the health, education and wealth of migrants, who also self-select themselves. Our results provide evidence that a) immigrants to Israel have compromised health and suffer from many health ailments, making them less healthy than comparable natives. Their health does not improve for up to 20 years of living in Israel, after which they become similar to natives; b) immigrants to Europe have better health than natives and their health advantage persists up to six years from their arrival, after which they are not significantly different than natives except in one case in which the health of immigrants became worse than that of natives after 21 years. Our results are important for migration policy and relevant for domestic health policy.

Costa, F., J. et Cowell, F. (2016). The Measurement of Health Inequalities: Does Status Matter? CESifo working paper ; n° 6117- Category 3 : Social Protection. Munich CESifo
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2871127

The measurement of health inequalities usually involves either estimating the concentration of health

outcomes using an income-based measure of status or applying conventional inequality measurement tools to a health variable that is non-continuous or, in many cases, categorical. However, these approaches are problematic as they ignore less restrictive approaches to status. The approach in this paper is based on measuring inequality conditional on an individual's position in the distribution of health outcomes: this enables us to deal consistently with categorical data. We examine several status concepts to examine self-assessed health inequality using the sample of world countries contained in the World Health Survey. We also perform correlation and regression analysis on the determinants of inequality estimates assuming an arbitrary cardinalisation. Our findings indicate major heterogeneity in health inequality estimates depending on the status approach, distributional-sensitivity parameter and measure adopted. We find evidence that pure health inequalities vary with median health status alongside measures of government quality.

Garcia, J. L., et al. (2016). The Life-cycle Benefits of an Influential Early Childhood Program. NBER Working Paper Series ; n° 22993. Cambridge NBER
http://www.nber.org/papers/w22993

This paper estimates the long-term benefits from an influential early childhood program targeting disadvantaged families. The program was evaluated by random assignment and followed participants through their mid-30s. It has substantial beneficial impacts on health, children's future labor incomes, crime, education, and mothers' labor incomes, with greater monetized benefits for males. Lifetime returns are estimated by pooling multiple data sets using testable economic models. The overall rate of return is 13.7% per annum, and the benefit/cost ratio is 7.3. These estimates are robust to numerous sensitivity analyses.

Goodman-Bacon, A. (2016). The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcomes. NBER Working Paper Series ; n° 22899. Cambridge NBER
www.nber.org/papers/w22899

This paper exploits the original introduction of Medicaid (1966-1970) and the federal mandate that states cover all cash welfare recipients to estimate the effect of childhood Medicaid eligibility on adult health, labor supply, program participation, and income. Cohorts born closer to Medicaid implementation and in states with higher pre-existing welfare-based eligibility accumulated more Medicaid eligibility in childhood but did not differ on a range of other health, socioeconomic, and policy characteristics. Early childhood Medicaid eligibility reduces mortality and disability and, for whites, increases extensive margin labor supply, and reduces receipt of disability transfer programs and public health insurance up to 50 years later. Total income does not change because earnings replace disability benefits. The government earns a discounted annual return of between 2 and 7 percent on the original cost of childhood coverage for these cohorts, most of which comes from lower cash transfer payments.

Médicaments / Pharmaceuticals

(2017). Comité économique des produits de santé (CEPS) : Rapport d'activité 2015. Paris Comité Economique des Produits de Santé:
http://social-sante.gouv.fr/IMG/pdf/rapport_annuel_2015.pdf

Le présent rapport décrit les principales activités du Comité au cours de l'année 2015. La première partie est consacrée à la description du marché (ventes et dépenses de médicaments remboursables, fixation des prix et autres modes de régulation). La deuxième partie est consacrée aux dispositifs médicaux. La troisième partie rassemble les statistiques d'activité du CEPS en 2015 : nombre de dossiers déposés par les entreprises et traités, délais de traitement des dossiers (médicaments et dispositifs médicaux).

(2017). L'évolution des consommations d'antibiotiques en France entre 2000 et 2015. St Denis ANSM
http://ansm.sante.fr/content/download/100401/1274505/version/1/file/ANSM-rapport-antibio_2016_bd2.pdf

L'Agence nationale de sécurité du médicament et des produits de santé (ANSM) analyse chaque année les données relatives à la consommation des antibiotiques en France. Les résultats présentés dans la nouvelle édition de son rapport montrent notamment que la consommation des antibiotiques repart à la hausse depuis 2010, et que la France reste parmi les pays européens où celle-ci est la plus élevée. Ce niveau élevé est très préoccupant car une utilisation non maîtrisée des antibiotiques est responsable du développement des résistances bactériennes. De surcroît, l'éventail des solutions de recours que constituent les antibiotiques dits « de réserve » s'appauvrit en raison de la diminution du nombre de substances antibiotiques disponibles et d'une innovation thérapeutique trop modeste.

Panteli, D., et al. (2016). Pharmaceutical regulation in 15 European countries : review 2016. Health Systems in transition ; vol 18 ; n° 5. Paris OMS Bureau régional de l'Europe
http://www.euro.who.int/__data/assets/pdf_file/0019/322444/HiT-pharmaceutical-regulation-15-European-countries.pdf

Pharmaceutical care accounts for a very significant proportion of health expenditures and policy-makers repeatedly face the challenge of balancing patient access to effective medicines against affordability, particularly as costs rise. This review investigates a broad range of regulatory measures, spanning marketing authorization to generic substitution to understand their impact on price and utilization and to guide the health policy debate towards those questions that are important to actual and potential patients. It examines the situation in 16 European health systems (Austria, Belgium, Denmark, England, Finland, France, Germany, Greece, Ireland, Italy, the Netherlands, Poland, Portugal, Scotland, Spain and Sweden) as a way of understanding the range of practice and finds that: All countries employ a mix of regulatory mechanisms to contain pharmaceutical expenditure and ensure quality and efficiency, but with widely varying configurations and rigour.; Pharmaceutical prices are more or less directly controlled across the sample but, despite their widespread use, current pricing policies have real limitations; Prices in Europe have not converged as could be expected, at least for originator products, although the comparative studies that show this should be interpreted with caution as they are plagued by a number of inherent, methodological limitations (outlined in the review); There are very substantial differences between countries in terms of what their priorities are and the challenges they face. While for some timely and/or equitable access to new medicines may be the main issue, others may be primarily concerned with quality of care or containing public pharmaceutical expenditure; There is as yet no definitive evidence on the effects of different cost-containment measures on patient outcomes. However, it is clear that different levers will have to be used to enable the delivery of appropriate care at affordable prices in different settings and in line with countries' specific policy concerns.

Pareek, B. et Liua, Q. (2016). Ask Your Doctor If this Product is Right for You: A Bayesian Zero-Inflated Multinomial Joint Model for Patient Drug Requests and PhysicianPrescriptions. IIM Bangalore Working Paper; 526
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2866334

The goal of this research is to study physicians' prescription decisions and patients' drug request behaviors jointly. We have developed a new zero-inflated multinomial (ZiMNL) choice model to study patient drug request data with excessive zero requests and a standard multinomial logit (MNL) model to capture physician prescriptions decisions. The two models are joined by a flexible nonparametric multivariate distribution for their random effects. We also adopt an analytically consistent expression for the interaction effect in our non-linear and joint modeling framework. We apply our model to a unique physician panel data set from the Erectile Dysfunction category. Our key empirical findings include the following: (1) the triggering of drug requests by DTCA is complicated with category level DTCA reducing patients' probability of making drug requests and drug specific DTCA driving drug requests for the advertised drug; (2) patient characteristics may play a role in the impact of DTCA on drug requests and the impact of patient requests on physicians' prescription decisions; (3) patient drug requests have a significant impact on physicians' prescription decisions and patients can be consistent with physicians in choosing a drug based on patient diagnosis level and some unobserved

factors; (4) there are significant correlations among physician-level random effects that drive both patients' drug requests and physicians' prescription decisions, which validates the joint modeling approach.

Stomberg, C. (2016). Drug Shortages, Pricing, and Regulatory Activity. NBER Working Paper Series ; n° 22912. Cambridge NBER
http://www.nber.org/papers/w22912

This study examines the patterns and causes of shortages in generic non-injectable drugs (e.g., tablets and topicals) in the United States. While shortages for injectable drugs have garnered more attention, shortages of other forms of prescription drugs have also been on the increase. In fact, they follow a strikingly similar trend with a number of important tablet drugs having recently been affected by shortage. This poses important questions about the root causes of these trends since most explanations found in the literature are specific to generic injectable drugs. Using a simple heuristic framework, three contributing factors are explored: regulatory oversight, potential market failures in pricing/reimbursement, and competition. This paper features an empirical examination of the contribution of changes in regulatory oversight to drug shortages. A pooled dynamic regression model using FDA data on inspections and citations reveals a statistically significant relationship between FDA regulatory activity (inspections and citations) and drug shortage rates. This result cuts across both injectable and non-injectable drugs, and could reveal a transition in equilibrium quality that should be transitory in nature, but it should also be interpreted with care given the other factors likely affecting shortage rates.

Méthodologie – Statistique / Methodology - Statistics

Fleischer, L., et al. (2016). A Review of General Social Surveys. OECD Statistics Working Papers; 2016/09. Paris OCDE:
http://www.oecd-ilibrary.org/fr/social-issues-migration-health/a-review-of-general-social-surveys_bb54d16f-en

Le progrès des sociétés passe par une amélioration du bien-être des individus et des ménages. Pour évaluer ces progrès, il convient d'examiner le vécu et les conditions de vie des personnes, dans toute leur diversité et leur multi-dimensionnalité. Mesurer le bien-être et le progrès des sociétés est l'un des principaux objectifs visé par l'OCDE dans le cadre de l'Initiative du vivre mieux et de la série de rapports « Comment va la vie ? », publiés tous les deux ans depuis 2011. En outre, les objectifs de développement durable des Nations Unies créent un fort besoin d'indicateurs plus précis sur des problématiques pluridimensionnelles. Cependant, à l'heure actuelle, il n'existe pas de cadre statistique faisant le lien entre les cadres conceptuels relatifs au bien-être, les instruments de mesure spécifiques et les résultats. En outre, le manque de données harmonisées comparables au niveau international est un frein majeur au suivi des progrès d'un pays à l'autre. Cette étude ouvre la voie à un système de statistiques du bien-être. Les enquêtes sociales générales, conduites par la majorité des offices statistiques nationaux dans le cadre de leurs programmes d'enquêtes périodiques, constituent une source de données utiles à l'évaluation du caractère multidimensionnel du bien-être et de la distribution conjointe des résultats observés dans ce domaine, source qui a été sous-utilisée jusqu'à présent. En s'appuyant sur le cadre d'évaluation du bien-être de l'OCDE, cette étude examine de manière systématique les différents domaines couverts par le rapport « Comment va la vie ? », en faisant le point sur les méthodes d'évaluation appliquées pour chacun de ces domaines dans les enquêtes sociales générales menées dans les pays de l'OCDE et sur la façon dont elles pourraient être mises à profit dans des analyses comparables du bien-être, comme celle de « Comment va la vie ? ». Ce rapport met en évidence les incohérences entre les enquêtes sociales générales menées dans les différents pays, et formule des recommandations en vue d'une meilleure harmonisation (résumé de l'éditeur).

Mouillet, E. (2016). Les essentiels de la recherche bibliographique en santé : chercher, organiser,

publier, Paris : John Libbey Eurotext

Pour réaliser une bibliographie, il faut successivement rechercher des informations, les rassembler, les sélectionner, les stocker et les organiser afin de les présenter dans une publication. Ces actions, synthétisées dans les trois verbes mis en exergue dans le titre de cet ouvrage, sont expliquées et illustrées en détail avec pour chacune d'entre elles « l'outil essentiel » s'y rapportant et une série d'exercices et leurs corrigés (en annexe) pour une mise en pratique immédiate et une auto évaluation. Chaque chapitre se termine par la rubrique « L'essentiel à retenir » avec les points importants et les conseils pratiques qui ont été présentés. La première partie expose la démarche rationnelle et la méthode à adopter pour une recherche documentaire. Une sélection d'outils bibliographiques, accessibles via Internet, adaptés au domaine des sciences biomédicales sont clairement présentés ainsi qu'un mode d'emploi de la base de données internationale PubMed/MEDLINE. La deuxième partie est consacrée à la sélection et l'évaluation des données bibliographiques précédemment recueillies. Les pratiques bibliométriques classiques mais aussi les plus récentes seront présentées pour faciliter la mise en place des veilles bibliographiques pertinentes. Le mode d'emploi de deux logiciels de gestion bibliographique, outils essentiels (un gratuit, l'autre payant) termine cette deuxième partie. La troisième et dernière partie porte sur la rédaction bibliographique, les systèmes de référence et la présentation des bibliographies. Les règles de Vancouver sont devenues un référentiel incontournable pour publier correctement mémoire, thèse ou articles scientifiques. Leur maniement est expliqué dans ses moindres détails. En annexe, les corrigés des exercices et un glossaire français/anglais des termes spécifiques de la recherche bibliographique sont proposés.

Politique de santé / Health Policy

Warin, P. et Catrice-Lorey, A. p. (2016). Le non-recours aux prestations, Grenoble : Presses Universitaires de Grenoble

La question du non-recours aux prestations sociales figure sur de nombreux agendas politiques. En France, ce sont jusqu'à 60 % de personnes qui n'ont pas recours à certaines prestations sociales. Il en va de même dans d'autres pays. Peu connu, ce phénomène touche pourtant les politiques sociales et les autres composantes de la protection sociale (Sécurité sociale, assurances privées et organismes de prévoyance, aide et action sociale). Dans cet ouvrage, l'auteur établit un état des lieux de la question, à la fois sur le plan scientifique et sur le plan des politiques publiques. Il développe une synthèse des modèles d'analyse, et met en lumière l'importance du chiffrage du non-recours pour l'évaluation des facteurs d'échec et de réussite de l'action publique. Il en propose des explications, et questionne les ressorts du phénomène. Il interroge en particulier le ciblage des politiques de lutte contre la pauvreté et la précarité. Ce dernier, en entraînant une stigmatisation des personnes ciblées, pourrait-il conduire à un refus de recourir à l'aide publique ? Enfin, l'auteur explore une dernière piste, selon laquelle le non-recours manifesterait l'expression d'un désintérêt ou d'un désaccord pour l'offre publique. Le non-recours, un comportement politique ?

Soins de santé primaires / Primary Health Care

Brosig-Koch, J., et al. (2016). Physician Performance Pay: Evidence from a Laboratory Experiment. Ruhr Economic Papers ; 658. Essen Universität Duisbourg - Essen
http://econpapers.repec.org/paper/zbwrwirep/658.htm

We present causal evidence from a controlled experiment on the effect of pay for performance on physicians' behavior and patients' health benefits. At a within-subject level, we introduce performance pay to complement either fee-for-service or capitation. Performance pay is granted if a health care quality threshold is reached, and varies with the patients' severity of illness. We find that performance pay significantly reduces overprovision of medical services due to fee-for-service incentives, and underprovision due to capitation; on average, it increases the patients' health benefit. The magnitude

of these effects depends, however, on the patients' characteristics. We also find evidence for a crowding-out of patient-regarding behavior due to performance pay. Health policy implications are discussed.

Dietrichson, J., et al. (2016). Effects of increased competition on quality of primary care in Sweden. Lund Lund University
https://ideas.repec.org/p/hhs/lunewp/2016_036.html

In the last decades, many health systems have implemented policies to make care providers engage in quality competition. But care quality is a multi-dimensional concept, and competition may have different impacts on different dimensions of quality. The empirical evidence on competition and care quality is scarce, in particular regarding primary care. This paper adds evidence from recent reforms of Swedish primary care that affected competition in municipal markets differently depending on the pre- reform market structure. Using a difference-in-differences strategy, we demonstrate that the reforms led to substantially more entry of private care providers in municipalities where there were many patients per provider before the reforms. The effects on primary care quality in these municipalities are modest: we find small improvements in subjective measures of overall care quality, but no significant effects on the rate of avoidable hospitalizations or patients' satisfaction with access to care. We find no indications of quality reductions.

Forde, I., et al. (2016). Primary Care Review of Denmark. Paris OCDE
www.oecd.org/health/health-systems/Primary-Care-Review-of-Denmark-OECD-report-December-2016.pdf

In many ways, primary care in Denmark performs well. Danish primary care is trusted and valued by patients, and is relatively inexpensive. But there are important areas where it needs to be strengthened. Most critically, Danish primary care is relatively opaque in terms of the performance data available at local level. Greater transparency is vital in the next phase of reform and sector strengthening. Robust information on quality and outcomes empowers patients and gives them choice. It can support GPs to benchmark themselves, and engage in continuous quality improvement. It also allows the authorities to better understand where they should direct additional resources. This Paper draws on evidence and best practice from across OECD health systems to support Denmark in agreeing the steps that will strengthen its primary care sector, support it to deliver high quality, patient-centred care and put it on a sustainable footing as the foundation for a high-performing health system (résumé de l'éditeur).

Hofmann, S. et Muhlenweg, A. M. (2016). Gatekeeping in German Primary Health Care : Impacts on Coordination of Care, Quality Indicators and Ambulatory Costs. CINCH Working Paper; 1605. Essen Universität Duisbourg - Essen
http://econpapers.repec.org/paper/duhwpaper/1605.htm

Evaluation studies on gatekeeping in primary care exist for a variety of countries but provide mixed evidence on utilization and quality of care as well as costs. Our study evaluates the German gatekeeping program, based on claims data of a major statutory health insurance company. The panel structure of the data allows controlling for patients' characteristics in the year before opting (or not opting) for a GP contract. In contrast to previous studies we are able to draw on multiple identification strategies. We exploit variation in the regional provision of gatekeeping in an instrumental variable (IV) framework. We also analyze GP fixed effects based on the observation of patients opting for one of two different contracts within the same GP office. We find that the gatekeeping contract yields a somewhat higher coordination of care, improved quality (regarding prevention and avoidance of hospitalization) but also higher ambulatory costs. The effects are largely robust between our identification strategies.

Mispelblom Beyer, F. (2016). Encadrer les parcours de soins : vers des alliances thérapeutiques élargies ?, Paris : Dunod

Faire le lien entre hiérarchie, médecins, équipes et métiers support, s'investir dans des projets transversaux et encadrer les parcours de patients entre intérieur et extérieur de l'hôpital, telles sont les tâches des cadres hospitaliers. Mais les médecins et les autres soignants, s'intéressant aux conditions de vie des malades, savent également que sans leur participation active il n'y a pas de soin qui vaille – sans oublier les acteurs des politiques de santé territoriales et les partenariats avec le secteur social et associatif. Par leurs paroles, actes et gestes tous produisent des effets sur le sens des soins. L'auteur souligne les traits saillants des spécificités des uns et des autres, et les valeurs, logiques et orientations communes qui font passerelle entre métiers différents. Il en décrit l'art et la manière.

Schafer, W. (2016). Primary care in 34 countries: perspectives of general practitioners and their patients. Utrecht NIVEL
http://www.nivel.nl/sites/default/files/bestanden/Proefschrift_Primary_care_34_countries_Schafer.pdf

This thesis aims to evaluate primary care service delivery in Europe and in other parts of the world . Strong primary care is expected to meet the current challenges of healthcare systems which are facing increasing numbers of people with chronic diseases and rising healthcare costs. The thesis is written in the context of the international study 'Quality and Costs of Primary Care in Europe' (QUALICOPC). The countries studied include 26 EU member states as well as Australia, Canada, Iceland, FYR Macedonia, New Zealand, Norway, Switzerland and Turkey. As primary care is the point where many patients enter the professional healthcare system, easy access and a generalist approach to the health problems people present are important features.

Systèmes de santé / Health Systems

Cylus, J. éd., et al. (2016). Health system efficiency: How to make measurement matter for policy and management. Paris OMS Bureau régional de l'Europe
http://www.euro.who.int/fr/about-us/partners/observatory/publications/studies/health-system-efficiency-how-to-make-measurement-matter-for-policy-and-management

Efficiency is one of the central preoccupations of health policy-makers and managers, and justifiably so. Inefficient care can lead to unnecessarily poor outcomes for patients, either in terms of their health, or in their experience of the health system. What is more, inefficiency anywhere in the system is likely to deny health improvement to patients who might have been treated if resources had been used better. Improving efficiency is therefore a compelling policy goal, especially in systems facing serious resource constraints. The desire for greater efficiency motivates a great deal of decision-making, but the routine use of efficiency metrics to guide decisions is severely lacking. To improve efficiency in the health system we must first be able to measure it and must therefore ensure that our metrics are relevant and useful for policy-makers and managers. In this book the authors explore the state of the art on efficiency measurement in health systems and international experts offer insights into the pitfalls and potential associated with various measurement techniques

Technologies médicales – E-santé / Medical Technologies –E-Health

Gowrisankaran, G., et al. (2016). Does Health IT Adoption Lead to Better Information or Worse Incentives? NBER Working Paper Series ; n° 22873. Cambridge NBER
www.nber.org/papers/w22873

We evaluate whether hospital adoption of electronic medical records (EMRs) leads to increases in billing where financial gains are large or where hassle costs of complete coding are low. The 2007 Medicare payment reform varied both financial incentives and hassle costs of coding. We find no significant impact of financial incentives on billing levels, inconsistent with bill inflation. However, the reform led to increases in reported severity for medical relative to surgical patients at EMR hospitals,

consistent with EMRs decreasing coding costs for medical patients. Greater post-reform completeness of coding with EMRs may increase Medicare costs by $689.6 million annually.

Hult, K., et al. (2016). How Does Technological Change Affect Quality-Adjusted Prices in Health Care? Systematic Evidence from Thousands of Innovations. NBER Working Paper ; 22986. Cambridge NBER
http://www.nber.org/papers/w22986.pdf

Medical innovations have improved survival and treatment for many diseases but have simultaneously raised spending on health care. Many health economists believe that technological change is the major factor driving the growth of the heath care sector. Whether quality has increased as much as spending is a central question for both positive and normative analysis of this sector. This is a question of the impact of new innovations on quality-adjusted prices in health care. We perform a systematic analysis of the impact of technological change on quality-adjusted prices, with over six thousand comparisons of innovations to incumbent technologies. For each innovation in our dataset, we observe its price and quality, as well as the price and quality of an incumbent technology treating the same disease. Our main finding is that an innovation's quality-adjusted prices is higher than the incumbent's for about two-thirds (68%) of innovations. Despite this finding, we argue that quality-adjusted prices may fall or rise over time depending on how fast prices decline for a given treatment over time. We calibrate that price declines of 4% between the time when a treatment is a new innovation and the time when it has become the incumbent would be sufficient to offset the observed price difference between innovators and incumbents for a majority of indications. Using standard duopoly models of price competition for differentiated products, we analyze and assess empirically the conditions under which quality-adjusted prices will be higher for innovators than incumbents. We conclude by discussing the conditions particular to the health care industry that may result in less rapid declines, or even increases, in quality-adjusted prices over time.

Welfens, P. J. L. (2016). E-Health: Grundlagen der Digitalen Gesundheitswirtschaft und Leitmarktperspektiven. EIIW Discussion Papers ; 227. Wuppertal University of Wuppertal
http://eiiw.eu/fileadmin/eiiw/Daten/Publikationen/Gelbe_Reihe/disbei227.pdf

The expansion of the digital health economy represents a strategic challenge for both the wider economy and society of the Federal Republic of Germany. In this context, economic policy actors need to set adequate framework conditions, such that competition in the health system, i.e. the interaction of statutory and private health insurance providers, will lead to optimal innovation dynamics and efficiency gains. Statutory and private health insurance funds each follow their own strategies. Amongst other strategies, private insurance providers make use of the possibility that firms are also involved in the area of occupational health management. There are, however, considerable obstacles to a digital modernization of the health sector, while Germany was also relatively late in introducing a digital health card. Among the significant benefits, for patients, insurers and care providers, are innovations in the area of digital check-ups and preventative care, telemedicine, digitalized after-care and an optimization of billing processes. Germany – in an EU context – ranks mid-table with regard to eHealth applications in the hospital industry, however, on the basis of a good positioning in terms of ICT and the large domestic market, Germany has the potential to become both a leading actor and a leading market in the medium term. From an economic perspective, eHealth progress can help to curb the rise of insurance contributions – digital advances have cost dampening effects, patient benefits and positive effects in the competitive process. Non-uniform health economy standards in EU countries largely prevent national software solutions and other eHealth concepts from easily being scaled-up, i.e. exported. Here, action by the EU is clearly required; including in the promotion and support of cooperation projects.

Travail et santé / Occupational Health

(2016). "Chiffres clés sur les conditions de travail et la santé au travail." Synthèse Stat' (Dares)(22)

http://dares.travail-emploi.gouv.fr/dares-etudes-et-statistiques/etudes-et-syntheses/synthese-stat-synthese-eval/article/chiffres-cles-sur-les-conditions-de-travail-et-la-sante-au-travail

Les conditions de travail d'un emploi renvoient aux aspects matériels (contraintes physiques, moyens de travail, conditions sanitaires, exposition à des substances dangereuses, etc.), organisationnels (organisation du temps de travail, rythme de travail, autonomie et marge de manœuvre, etc.) et psychosociaux (relations avec les clients, la hiérarchie et les collègues, conflits de valeurs, satisfaction et difficultés au travail, etc.) dans lesquels le travailleur exerce son activité. Les conditions de travail peuvent avoir des conséquences sur les risques d'accidents, mais aussi sur le développement de maladies professionnelles ; de façon plus générale, la qualité de vie au travail favorise la construction de la santé physique et mentale des personnes en emploi. Deux approches sont possibles pour examiner les liens entre travail et santé. La première examine les conditions de travail, les expositions professionnelles (pénibilité, risques psychosociaux) et les atteintes liées au travail (accidents du travail, maladies professionnelles reconnues ou limitations perçues par les salariés). La seconde appréhende les conséquences des troubles de santé et des handicaps sur l'insertion professionnelle des personnes. Ce fascicule regroupe les chiffres clés sur les conditions de travail et la santé au travail en France, ainsi que des éléments sur l'activité des personnes handicapées ou en situation de handicap.

(2016). Le compte personnel de prévention de la pénibilité et l'état de santé des seniors. Dossier du 23 novembre 2016, Paris : COR
http://www.cor-retraites.fr/article478.html

La première partie du dossier présente un point d'information sur le compte personnel de prévention de la pénibilité, à l'heure où les premières statistiques sur les droits acquis en 2015 sont disponibles. Deux autres sujets connexes sont également traités dans les deuxième et troisième partie du dossier : respectivement les liens entre pénibilité du travail et état de santé des seniors et ceux entre état de santé des seniors et âge de départ à la retraite. L'enjeu est important. Il s'agit de savoir si les conditions de travail actuelles en France nuisent à l'état de santé des seniors et constituent un frein au maintien en emploi à des âges plus élevés. Il s'agit également de déterminer jusqu'à quel point un relèvement de l'âge de la retraite est envisageable, compte tenu de l'état de santé actuel des seniors et des conséquences, nocives ou au contraire bénéfiques, d'un relèvement de l'âge sur cet état de santé.

(2016). Stratégie nationale d'amélioration de la qualité de vie au travail. Paris Ministère chargé de la Santé
http://social-sante.gouv.fr/IMG/pdf/strategie_qvt_05122016.pdf

Les réformes du système de santé ont modifié l'organisation territoriale de l'offre de soins, l'organisation du travail et les modes d'exercice. Dans ce contexte, les professionnels de santé subissent davantage de pression et éprouvent souvent un certain malaise. Afin de soutenir et aider tous les professionnels de santé, le ministère des Affaires sociales et de la Santé vient de lancer une stratégie nationale pour améliorer leur qualité de vie au travail. Cette stratégie s'articule autour de trois axes. Premièrement, il s'agit de porter la qualité de vie au travail comme une priorité politique dont les enjeux sont majeurs. Deuxièmement, il s'agit d'améliorer l'environnement et les conditions de travail au quotidien, en donnant plus de place à l'écoute et aux initiatives individuelles, mais aussi en favorisant la conciliation entre vie professionnelle et vie privée. Troisièmement, un ensemble de mesures visent à accompagner les professionnels face aux changements et à améliorer la détection des risques psychosociaux.

Barnay, T., et al. (2016). The effects of breast cancer on individual labour market outcomes: an evaluation from an administrative panel. TEPP working paper ; 2016-05. Paris TEPP - CNRS TEPP working paper, n°2016-05
https://halshs.archives-ouvertes.fr/halshs-01374467/document

Using an administrative data set (Hygie), we apply a difference-in differences with dynamic matching estimation method to the onset of breast cancer. The employment probability decreases by 10

percentage points (pp) one year after the onset of cancer compared to the not-treated group. The detrimental effect of breast cancer on employment increases significantly over time, by up to 12 pp after five years. Another aim of our study is to identify some socio-demographic and work-related protective factors against the adverse effects of breast cancer on labour market outcomes. We stress four potential protective factors related to the negative effect of breast cancer. First, a young age at occurrence reduces this deleterious effect. Second, a high first job wage also appears to be a protective factor. Third, having faced less unemployment in the past is associated with a weaker negative effect of breast cancer on employment in the short run. Finally, we find a moderate "generational effect" after stratification by year of cancer onset.

Blundell, R., et al. (2016). The Dynamic Effects of Health on the Employment of Older Workers. Working Paper; 2016-348. Ann Arbor Michigan Retirement Research Center
http://www.mrrc.isr.umich.edu/publications/papers/pdf/wp348.pdf

Using data from the Health and Retirement Study (HRS) and the English Longitudinal Study of Ageing (ELSA), we estimate a dynamic model of health and employment. We estimate how transitory and persistent health shocks affect employment over time. In a first step, we formulate and estimate a dynamic model of health. The procedure accounts for measurement error and the possibility that people might justify their employment status by reporting bad health. We find that health is well represented by the sum of a transitory white noise process and a persistent AR(1) process. Next, we use the method of simulated moments to estimate the employment response to these shocks. We find that persistent shocks have much bigger effects on employment than transitory shocks, and that these persistent shocks are long lived. For this reason employment is strongly correlated with lagged health, a fact that the usual cross-sectional estimates do not account for. We also show that accounting for the dynamics of health and employment leads to larger estimates of health's effects on employment than what simple OLS

Bonnand, G., et al. (2016). Améliorer la santé au travail : l'apport du dispositif pénibilité. Paris Premier ministre:
http://www.gouvernement.fr/sites/default/files/document/document/2016/11/20161121rapportpenibilitepreventionrajout.pdf

Ce document constitue la première partie du rapport "Améliorer la santé au travail : l'apport du dispositif pénibilité". Il rappelle qu'avant d'être un dispositif de réparation permettant à ceux qui ont eu des métiers pénibles de partir plus tôt à la retraite, le compte personnel de prévention de la pénibilité (C3P) poursuit d'abord un objectif de prévention de la pénibilité. Le rapport souligne les atouts de ce dispositif pour renforcer cet effort de prévention mais identifie également des points de vigilance et formule des recommandations pour que cet objectif soit pleinement atteint. Les auteurs poursuivent leurs travaux en se consacrant désormais à l'étude de l'insertion du dispositif pénibilité dans les dispositifs existants de transition entre emploi et retraite.

Coile, C., et al. (2016). To Work for Yourself, for Others, or Not At All? How Disability Benefits Affect the Employment Decisions of Older Veterans. NBER Working Paper Series ; n° 23006. Cambridge NBER
http://www.nber.org/papers/w23006

The U.S. Department of Veterans Affairs Disability Compensation (DC) program provides disability benefits to nearly one in five military veterans in the US and its annual expenditures exceed $60 billion. We examine how the receipt of DC benefits affects the employment decisions of older veterans. We make use of variation in program eligibility resulting from a 2001 policy change that increased access to the program for Vietnam veterans who served with "boots on the ground" in the Vietnam theater but not for other veterans of that same era. We find that the policy-induced increase in program enrollment decreased labor force participation and induced a substantially larger switch from wage employment to self-employment. This latter finding suggests that an exogenous increase in income spurred many older veterans to start their own businesses. Additionally, we estimate that one in four veterans who entered the DC program due to this policy change left the labor force, estimates

in the same range as those from recent studies of the Social Security Disability Insurance (SSDI) program.

De Quidt, J. et Haushofer, J. (2016). Depression for Economists. NBER Working Paper Series ; n° 22973. Cambridge NBER
http://www.nber.org/papers/w22973

Major depressive disorder (MDD) is one of the most prevalent mental illnesses worldwide. Existing evidence suggests that it has both economic causes and consequences, such as unemployment. However, depression has not received significant attention in the economics literature. In this paper, we present a simple model which predicts the core symptoms of depression from economic primitives, i.e. beliefs. Specifically, we show that when exogenous shocks cause an agent to have pessimistic beliefs about the returns to her effort, this agent will exhibit depressive symptoms such undereating or overeating, insomnia or hypersomnia, and a decrease in labor supply. When these effects are strong enough, they can generate a poverty trap. We present descriptive evidence that illustrates the predicted relationships.

Knebelmann, J. et Prinz, C. (2016). The Impact of Depression on Employment of Older Workers in Europe. OECD Social - Employment and Migration Working Papers ; 170. Paris OCDE
http://www.oecd-ilibrary.org/social-issues-migration-health/a-descriptive-analysis-of-immigration-to-and-emigration-from-the-eu_5jlwxbxvb35j-en

According to the World Health Organization, depression is the highest ranking cause of disease in middle- and high income countries; it costs Europe around EUR 118 billion a year, mostly through lost productivity on the labour market, i.e. labour supply loss, sickness absence, and poor performance at the workplace. Using data from waves 1, 2 and 4 of the Survey of Health, Ageing and Retirement in Europe (SHARE), this paper seeks to assess the magnitude of the impact of depression on labour market outcomes of older workers, a population sub-group whose participation in the labour market is ever more crucial in view of rapid population ageing. For each of the studied outcomes, analyses show a substantial impact of depression, measured with the European Depression Scale. Using different methods to address endogeneity this paper finds that depression decreases the probability of being employed by 22 to 51 percentage points among the 50 to 64 year old age group. Older workers with the most symptoms are more than twice as likely as others to exit employment before retirement age. Finally, depression increases annual sickness absence duration by 7.2 days on average. These figures show the necessity for national and firm-level employment policies and programmes targeting the 50 and over population to include prevention of depression, increased awareness of depression and adequate medical support.

Vieillissement / Ageing

Bronshtein, G., et al. (2016). Leaving Big Money on the Table: Arbitrage Opportunities in Delaying Social Security. NBER Working Paper Series ; n° 22853. Cambridge NBER

Recent research has documented that delaying the commencement of Social Security benefits increases the expected present value of retirement income for most people. Despite this research, the vast majority of individuals claim Social Security at or before full retirement age. Claiming Social Security early is not necessarily a mistake, as delaying Social Security commencement requires forgoing current income in exchange for future income. The decision to claim early could therefore rationally be driven by liquidity constraints, mortality concerns, bequest motives, a high time discount rate, or a variety of other preference related factors. However, for some individuals, delaying Social Security offers a significant arbitrage opportunity because they can defer Social Security and have higher income in all future years. Arbitrage exists for most primary earners who either purchase a retail-priced annuity or opt for a defined benefit annuity when a lump sum payout is offered, while forgoing the opportunity to defer Social Security. These individuals are essentially buying an expensive

annuity when a cheaper one is available, and their decision to claim Social Security early is almost certainly a mistake. The magnitude of the mistake can reach up to approximately $250,000.

Grand, A., et al. (2016). Les défis du vieillissement : construction d'une politique sociale. Toulouse : Erès

Du rapport Laroque (1962) à la loi sur l'adaptation de la société au vieillissement (2015), ce numéro interroge la construction des politiques sociales du vieillissement et analyse le bienfondé des textes législatifs et des dispositifs mis en place au cours du demi-siècle qui vient de s'écouler. Il met en évidence les défis que représentent le vieillissement de la France du point de vue démographique, économique, sanitaire et de l'adaptation des politiques sociales aux évolutions prévues, notamment au regard de la dépendance.

Issindou, M. et Jacquat, D. (2016). Rapport d'information sur la mise en application de la loi n° 2014-40 du 20 janvier 2014 garantissant l'avenir et la justice du système de retraites. Paris Assemblée Nationale
http://www.assemblee-nationale.fr/14/pdf/rap-info/i4074.pdf

Ce rapport est un bilan aussi objectif et précis que possible de l'état d'application de la Loi n° 2014-40 du 20 janvier 2014 garantissant l'avenir et la justice du système de retraites en retraçant le contenu des soixante textes réglementaires pris en application des cinquante-deux articles de la loi. Il s'agit en particulier de préciser les modalités de mise en oeuvre et d'accès aux principaux dispositifs prévus par le législateur en articulant l'analyse autour de trois objectifs principaux : la pérennité financière, l'équité et la simplification du système de retraites.