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http:www.irdes.fr/english/documentation/watch-on-health-economics-literature.html

Sommaire

Assurance maladie / Health Insurance

Coile C., Milligan K.S., Wise D.A. (2014). Social Security Programs and Retirement Around the World: Disability Insurance Programs and Retirement. Introduction and summary. Cambridge : NBER

Abstract: This is the introduction and summary to the sixth phase of an ongoing project on Social Security Programs and Retirement Around the World. The first phase described the retirement incentives inherent in plan provisions and documented the strong relationship across countries between social security incentives to retire and the proportion of older persons out of the labor force. The second phase documented the large effects that changing plan provisions would have on the labor force participation of older workers. The third phase demonstrated the consequent fiscal implications that extending labor force participation would have on net program costs—reducing government social security benefit payments and increasing government tax revenues. The fourth phase presented analyses of the relationship between the labor force participation of older persons and the labor force participation of younger persons in twelve countries. We found no evidence that increasing the employment of older persons will reduce the employment opportunities of youth and no evidence that increasing the employment of older persons will increase the unemployment of youth. The fifth phase on “Historical Trends in Mortality and Health, Employment, and Disability Insurance Participation and Reforms” was intended to set the stage for this current phase. This sixth phase of the ongoing ISS project is particularly related to the fifth phase (Wise, 2012) and the second phase (Gruber and Wise, 2004) of the project. This volume continues the focus of the previous volume on DI programs while extending the methodology to study retirement behavior used in the second phase to focus in particular on the effects of the DI programs. The key question this volume seeks to address is: given health status, to what extent are differences in labor force participation across countries determined by the provisions of disability insurance programs?
http:www.nber.org/papers/w20120

Avendano M., Berkman L., Brugiavini A., et al. (2014). The Long-Run Effect of Maternity Leave Benefits on Mental Health: Evidence from European Countries. Venezia : Ca’ Foscari University of Venice

Abstract: This paper examines whether maternity leave policies have a causal effect on women's mental health in old age. We link data for women aged 50 and above from eight countries in the Survey of Health, Ageing and Retirement in Europe (SHARE) to data on maternity leave legislation from 1960 to 2010. Using a difference-in-differences approach, our preferred specification suggests that moving from a maternity leave with limited coverage to one with comprehensive coverage around the birth of a first child reduces late life depression scores by 14%.
http:papers.ssrn.com/sol3/papers.cfm?abstract_id=2435850

(2014). Rapport d'activité 2013 du Fonds de financement de la protection complémentaire de la couverture universelle du risque maladie. Paris : Fonds CMU .

Abstract: Comme chaque année, le fonds CMU présente son rapport d'activité. Il reprend les données qualitatives et quantitatives de l'année 2013 relatives notamment aux effectifs des bénéficiaires de la CMU-C, de l'ACS et de la CMU de base. La réforme des modalités de remboursement des organismes gestionnaires de la CMU-C, prévue par la LFSS pour 2013 qui concerne l'ensemble des caisses de sécurité sociale et les organismes complémentaires a engendré une charge de travail conséquente pour le Fonds CMU. Pour permettre sa mise en œuvre de nombreux travaux ont été menés : refonte des conventions financières avec les régimes obligatoires d'assurance maladie, refonte du plan de contrôle du Fonds CMU, création de nouveaux outils/tableaux de bord pour suivre les dépenses de CMU-C des organismes complémentaires… Sur le deuxième semestre 2013, l'élaboration du VIème rapport d'évaluation de la loi CMU, qui sera rendu public prochainement, a fortement mobilisé le Fonds. Enfin, de nombreuses études ont été menées en collaboration avec des caisses d'assurance maladie, l'EN3S, l'UNCCAS, des CCAS, des chercheurs et de nouveaux partenariats ont été initiés notamment avec le Défenseur des droits. Ces études essentielles

permettent au Fonds CMU de constituer une véritable force de propositions pour accompagner nos concitoyens les plus défavorisés vers les soins et la santé.
http:www.cmu.fr/fichier-utilisateur/fichiers/Rapport_activite_2013.pdf

Bitler M., Zavodny M. (2014). Medicaid: A Review of the Literature. Cambridge : NBER

Abstract: We review the existing literature about the effects of the Medicaid program. We first describe the program's structure and how it has changed over time. We then discuss findings on coverage, crowd out, take-up and health. Finally, we look at effects of the program on non-health outcomes such as welfare use and labor supply, marriage and fertility, and savings.
http:www.nber.org/papers/w20169

Coe N.B., Wu A.Y. (2014). What Impact Does Social Security Have on the Use of Public Assistance Programs Among the Elderly. Chestnut Hill : Center for Retirement Research at Boston College

Abstract: Low take-up by elderly Americans in most means-tested federal programs is a persistent and puzzling phenomenon. This paper seeks to measure the causal effect of the benefit levels on elderly enrollment in two public assistance programs - the Supplemental Nutrition Assistance Program (SNAP) and the Supplemental Security Income (SSI) program - by using the variation in SNAP and SSI eligibility and benefit levels introduced by Social Security retirement benefits. Our findings are three-fold. First, the low take-up among the elderly is not driven by changes in the composition of the eligible pool: individuals who become eligible as they age exhibit average take-up patterns that are similar to those who were eligible before reaching Social Security benefit claiming ages. Second, Social Security has a significant impact on the use of public assistance programs among the elderly, because the increase in income decreases the potential benefits available from public programs. Third, we estimate different behavioral responses to SNAP and SSI programs: a $100 increase in SSI benefits leads to a 4-6-percentage-point increase in the probability of taking up SSI, but we are unable to estimate consistent results on how benefits impact the take up for SNAP. Together with the fact that eligible individuals who begin receiving Social Security benefits continue to participate in SSI more often than they maintain SNAP enrollment, we posit that the different estimated behavioral responses could be due to individual preferences for cash over in-kind transfers.
http:crr.bc.edu/wp-content/uploads/2014/05/wp_2014-5.pdf

Dafny L., Gruber J., Ody C. (2014). More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces. Cambridge : NBER

Abstract: First-year insurer participation in the Health Insurance Marketplaces (HIMs) established by the Affordable Care Act is limited in many areas of the country. There are 3.9 participants, on (population-weighted) average, in the 395 ratings areas spanning the 34 states with federally facilitated marketplaces (FFMs). Using data on the plans offered in the FFMs, together with predicted market shares for exchange participants (estimated using 2011 insurer-state market shares in the individual insurance market), we study the impact of competition on premiums. We exploit variation in ratings-area-level competition induced by United Healthcare's decision not to participate in any of the FFMs. We estimate that United's nonparticipation decision raised the second-lowest-price silver premium (which is directly linked to federal subsidies) by 5.4 percent, on average. If all insurers active in each state's individual insurance market in 2011 had participated in all ratings areas in that state's HIM, we estimate this key premium would be 11.1% lower and 2014 federal subsidies would be reduced by $1.7 billion.
http:www.nber.org/papers/w20140

Economie de la santé / Health Economics

Shishkin S., Potapchik E., Selezneva E. (2014). Out-of-Pocket Payments in the Post-Semashko Health Care System. Moscou : HSE

Abstract: This paper presents the analysis results of existing practices of out-of-pocket payments in the Russian post-Semashko health care system. It was carried out based on the data reflected in the 'Russia Longitudinal Monitoring Survey' from 1991-2012 and data of the 'Georating' survey carried out in all regions of the Russian Federation in 2010. The trends of legal and informal out-of-pocket payments for inpatient and outpatient care are revealed, and the social and economic factors which make patients pay a fee for medical services for fee are identified. The changes in out-of-pocket health expenditures in 2005-2010 are analyzed, and the assessment of total (public and private) health expenditures on different types of health care is made.
http:papers.ssrn.com/sol3/papers.cfm?abstract_id=2427217

(2014). The Cost of Air Pollution: Health Impacts of Road Transport. Paris : OCDE.

Abstract: Outdoor air pollution kills more than 3 million people across the world every year, and causes health problems from asthma to heart disease for many more. This is costing societies very large amounts in terms of the value of lives lost and ill health. Based on extensive new epidemiological evidence since the 2010 Global Burden of Disease study, and OECD estimates of the Value of Statistical Life, this report provides evidence on the health impacts from air pollution and the related economic costs.

Etat de santé / Health Status

(2014). Global Status Report on Alcohol and Health 2014. Genève : OMS

Abstract: The Global status report on alcohol and health 2014 presents a comprehensive perspective on the global, regional and country consumption of alcohol, patterns of drinking, health consequences and policy responses in Member States. It represents a continuing effort by the World Health Organization (WHO) to support Member States in collecting information in order to assist them in their efforts to reduce the harmful use of alcohol, and its health and social consequences. The report was launched in Geneva on Monday 12 May 2014 during the second meeting of the global network of WHO national counterparts for implementation of the global strategy to reduce the harmful use of alcohol.
http:apps.who.int/iris/bitstream/10665/112736/1/9789240692763_eng.pdf

(2014). Indicateurs de suivi de l'état de santé de la population : Révision 2013 - Rapport final. Paris : Drees

Abstract: L'objectif des travaux dont les résultats sont présentés dans ce rapport était de mettre à jour, pour établir un état descriptif de l'état de santé de la population, la liste des indicateurs sur la base de l'expérience acquise depuis leur définition en 2005 et sur les mêmes thématiques, de l'évolution des systèmes d'information depuis cette date, et des propositions du Haut Conseil de la santé publique. Indépendamment du choix des objectifs stratégiques de la politique de santé, qui devraient être en nombre limité pour une période donnée, il semble en effet nécessaire de poursuivre la mise en commun et la publication régulière d'un ensemble d'indicateurs de suivi des principaux déterminants

qui affectent la santé de la population, des principales pathologies et de l'état de santé de certains groupes de population (résumé d'auteur).
http:www.drees.sante.gouv.fr/IMG/pdf/serie_source_method44.pdf

Géographie de la santé / Geography of Health

Brondeel R. (2013). Use of Healthcare Services in the residence and workplace neighbourhood: the effect of spatial accessibility to Healthcare Services. Mémoire de Master 2 ; Santé Publique - Recherche Parcours Epidémiologie. Paris : Université de Paris Sud .

Abstract: Previous literature on the effects of the spatial accessibility to healthcare services on service use has exclusively focused on the residential environment of people. This study investigates the effect of spatial accessibility to healthcare services in residence and workplace neighbourhoods on the use of healthcare services. Data from the first wave of the RECORD Cohord Study were used, from questionnaires or provided by public institutions (SNIIR-AM, CNAV). The dataset contained geographical information on the participants and healthcare services, the use of the services (through the linkage of administrative data) and demographical characteristics. To process the geographic information, Geographic information system (GIS) methods were applied. A novel method was developed to examine whether and for which participants there was clustering of the visits to healthcare services around the workplace. We examined the associations between spatial accessibility indicators and the use of four healthcare services: general practitioners, gynaecologists, cardiologists and psychiatrists. Negative binomial mixed regression models were used to test the associations between spatial accessibility to services from the residence and the workplace and the use of the four healthcare services. A clustering of the use of healthcare services around the residence was found for most people. For only a small proportion of the participants (11%), we found also a clustering around the workplace. A logistic regression indicated that this use of services around the workplace was associated with commuting from the suburb to Paris, a high distance of commuting, and with a high occupational class and a high family income. No associations were found between the spatial accessibility to health care services and the use of healthcare services, neither in the residence neighbourhood nor in the workplace neighbourhood. The use of healthcare services clustered around the workplace only for a small proportion of the participants. Spatial accessibility does not seem to have an influence on the use of healthcare services in a well-served area as Ile-de-France. Future research could benefit from focusing on how an individual overcomes spatial access barriers.
http:www.record-study.org/images/record/upload/publications/Memoire_BRONDEEL_2013.pdf

Beltzer N. (2014). Le recours aux soins des femmes en Île-de-France. Exploitation régionale de l'enquête ESPS 2008-2010. Paris : ORSIF

Abstract: Ce rapport présente un panorama des Franciliennes en termes de couverture sociale et de recours aux soins. Cet état des lieux repose essentiellement sur l'exploitation régionale, des deux vagues 2008 et 2010, de l'enquête santé et protection sociale (ESPS) réalisée régulièrement par l'IRDES.
http:www.ors-idf.org/dmdocuments/2014/RecoursAuxSoinsFemmes.pdf

Hôpital / Hospitals

Gu W. (2014). Mesures expérimentales de la production et de la productivité du secteur hospitalier au Canada - 2002 à 2010. La revue canadienne de productivité; 34. Ottawa : Statistics Canada

Abstract: Récemment, les discussions au sujet des dépenses de santé ont porté essentiellement sur deux questions, à savoir : 1) la mesure dans laquelle l'augmentation des dépenses en soins de santé est due à une augmentation de la quantité plutôt qu'au prix des services de santé et 2) l'efficacité et la productivité des fournisseurs de soins de santé (p. ex. les hôpitaux, les cabinets de médecins et les établissements de soins de longue durée). La clé de la réponse à ces deux questions est une mesure directe de la production de services de santé — mesure qui n'existe pas à l'heure actuelle. Dans les comptes nationaux, la production du secteur de la santé est mesurée par le volume des entrées, qui comprennent les coûts de main-d'œuvre pour les médecins, le personnel infirmier et le personnel administratif, la consommation de capital et les entrées intermédiaires. La mesure de la production fondée sur les entrées repose sur l'hypothèse qu'il n'existe pas de gains de productivité dans le secteur de la santé. Par conséquent, elle ne fournit aucune mesure des résultats de la productivité, et ne permet pas non plus de décomposer les dépenses totales en soins de santé en une composante des prix et une composante du volume des produits. L'objectif principal du présent document est d'élaborer une mesure directe expérimentale de la production du secteur hospitalier canadien pour pouvoir aborder ces questions. De nombreux pays ont déjà construit une mesure directe de la production du secteur hospitalier et d'autres secteurs des soins de santé (résumé de l'éditeur).
http:www.statcan.gc.ca/pub/15-206-x/15-206-x2014034-fra.pdf

Or Z. (2014). La pertinence des pratiques d'hospitalisation : une analyse des écarts départementaux de prostatectomies : Paris : Irdes

Abstract: Cet article analyse les variations territoriales de pratiques de prostatectomies en France. Nous recourons à une modélisation multiniveaux permettant de distinguer la variabilité liée à deux niveaux géographiques : le département et la région. Nos résultats montrent que les taux de prostatectomies standardisés (pour 100 000 hommes) varient de manière significative entre les départements. Les écarts interdépartementaux sont expliqués notamment par la densité d'urologues libéraux dans le département ainsi que par l'offre de soins hospitaliers (disponibilité des lits de chirurgie et de personnels soignants), au niveau régional, une fois contrôlé par le revenu et les taux de mortalité par départements (résumé d'auteur).
http:www.irdes.fr/recherche/documents-de-travail/059-la-pertinence-des-pratiques-d-hospitalisation-une-analyse-des-ecarts-departementaux-de-prostatectomies.pdf

(2014). La prise en charge des personnes vulnérables. Agir ensemble à l'hôpital et dans le système de santé. Paris : Fédération Hospitalière de France .

Abstract: Notre système de santé reste marqué par de fortes inégalités. Cela est vrai tant pour l'état de santé constaté des personnes qu'en matière d'accès aux soins et aux actions de prévention. La prise en charge des publics en situation de vulnérabilité est une mission consubstantielle à l'hôpital public, pour laquelle les hospitaliers ont toujours oeuvré avec humanité, conviction et détermination. Aujourd'hui, les hôpitaux publics assument avec quelques associations dont Médecins du Monde cette mission de prise en charge des plus vulnérables. Pour les équipes hospitalières, la fragilité des moyens et des dispositifs d'accompagnement se révèle source de malaise. C'est le constat que font aujourd'hui un grand nombre de professionnels qui, face à la nécessité d'adapter le parcours de soins aux caractéristiques de ces publics, se sentent souvent démunis. Il y a donc urgence à agir alors que l'impact de la crise économique sur l'aggravation de la précarité est de plus en plus tangible. Il y a surtout urgence à agir pour inventer un nouveau modèle de prise en charge des personnes vulnérables dans les hôpitaux. L'apparition de nouvelles formes de vulnérabilité conjuguée à l'évolution des organisations hospitalières conduit les établissements et les professionnels à repenser et à réaffirmer leur vocation d'hospitalité afin d'assurer à chacun la meilleure prise en charge possible.

L'hospitalité est en effet un sujet majeur et pleinement d'actualité, recouvrant des aspects aussi bien humains, techniques, économiques, que de recherche. Conscient de la responsabilité de l'hôpital public, et dans le souci de maintenir un dispositif d'accès aux soins pour tous, la Fédération hospitalière de France et Médecins du Monde ont décidé d'unir leur force. À l'heure où se construit la future stratégie nationale de santé, la FHF et Médecins du monde n'acceptent pas la fatalité, ne se résolvent pas à l'inaction et unissent leurs voix pour améliorer concrètement la prise en charge des personnes vulnérables à l'hôpital. Les propositions portées par la FHF et Médecins du Monde visent à nourrir le débat public d'aujourd'hui et à se transformer, dès demain, en actes. Pour cela, les pouvoirs publics et tous les acteurs de la santé doivent prendre leurs responsabilités, et mettre la question de la santé des personnes les plus fragiles au cœur des politiques publiques.
http:fichiers.fhf.fr/documents/rapport-FHFMDMbd.pdf

(2013). Cliniques et hôpitaux privés au cœur du système de santé. Rapport sectoriel : édition 2013. Paris : FHP .

Abstract: Ce rapport se structure autour de six grands chapitres correspondant à six regards clés : l'hospitalisation privée en région avec pour chaque région de France les chiffres essentiels d'activité et de positionnement géographique ; l'activité sanitaire déclinée en termes d'offre, de part de marché, de capacité par grandes spécialités chirurgicales et médicales ; la situation économique et financière ; les ressources humaines, médecins et personnels soignants ; la qualité, la sécurité des soins et la relation avec les usagers.
http:flipbook.fhp.fr/rs2013/

(2014). Atlas 2014 des SIH. Etat des lieux des systèmes d'information hospitaliers. Paris : DGOS

Abstract: La Direction générale de l'offre de soins (DGOS) publie le premier atlas des systèmes d'information hospitaliers (SIH) qui rassemble à fois les données d'usage des systèmes d'information hospitalier, les données de l'offre industrielle et les charges et ressources mises en œuvre pour accompagner le déploiement des SIH par les établissements de santé. Ce document a été élaboré en collaboration avec l'ATIH à partir des données recueillies par l'Observatoire des systèmes d'informations de santé (oSIS) et l'Observatoire du Référencement des Editeurs de Logiciels et des Intégrateurs du Monde de la Santé (RELIMS). L'édition 2014 s'enrichit d'un état des lieux des indicateurs du socle commun du programme Hôpital numérique.
http:www.sante.gouv.fr/IMG/pdf/Atlas_des_SIH_2014-2.pdf

Inégalités de santé / Health Inequalities

Mcknight A. (2014). Disabled People's Financial Histories: Uncovering the disability wealth-penalty. Londres : LSE

Abstract: It is well established that on average disabled people and the households in which they live face greater financial disadvantage in terms of income than their counterparts. What is less well understood is how they fare in terms of their wealth status. In this paper we use data from two large scale social surveys to examine the relationship between disability status and household wealth holdings. We find that overall disabled people have substantially lower household wealth and all components of wealth (property, financial, pension, physical) than non-disabled people but even these average differences mask important lifecycle patterns. The incidence of disability increases with age and the effect of this is that disabled people are on average older than non-disabled people. As wealth accumulation also increases with age up to retirement the effect is that average differences understate the true disability wealth-penalty. People who experience disability later in life have been in a stronger position to accumulate assets over their working lives than people who experience disability over the crucial wealth-accumulation stage (35-64 years) of the lifecycle. The full extent of the disability wealth-penalty can only be observed by looking at age or lifecycle profiles. We find evidence of cumulative

disadvantage related to disability longevity and cumulative advantage to remaining disability free. Part of the disability wealth-penalty can be accounted for by lower average levels of education among disabled people and by their lower position in the socio-economic classification (NS-SEC) reflecting lower profiles of lifetime earnings and household income. The evidence points to a situation where disabled people have been unable to save and accumulate assets to anything like the extent of their non-disabled peers most likely through lower long term income and extra costs associated with disability. This puts them at a disadvantage in terms of being able to draw on an asset in times of need when expenditure needs exceed current levels of income, lower pension wealth on entering retirement and less likely to be in a position to benefit from the 'asset-effect' and more generally is a matter of concern in terms of equality and social mobility.
http:sticerd.lse.ac.uk/dps/case/cp/casepaper181.pdf

(2014). Inégalités sociales de santé en lien avec l'alimentation et l'activité physique. Expertise collective. Expertise collective. Paris : INSERM

Abstract: Ce rapport présente les travaux du groupe d'experts réunis par l'Inserm dans le cadre de la procédure d'expertise collective pour répondre à la demande de la Direction générale de la santé concernant les stratégies de réduction des inégalités sociales de santé en lien avec l'alimentation et l'activité physique. Ce groupe a construit sa réflexion autour des questions suivantes : Quels sont les concepts et indicateurs des inégalités sociales de santé ? Quel rôle jouent les comportements de santé dans les inégalités sociales de santé ? Quelle est la situation nutritionnelle (alimentation et activité physique) de la population générale en France ? Quelles sont les disparités nutritionnelles selon la position socioéconomique ? Quels sont les facteurs sociaux, culturels, économiques qui participent à la construction des inégalités sociales de nutrition ? Quelles sont les interactions entre les facteurs environnementaux (offre alimentaire, publicité, équipement, urbanisme…), les comportements alimentaires et la pratique d'activité physique ? Quelles sont les répercussions sur les inégalités sociales de nutrition ? Quelles sont les différentes stratégies d'intervention en prévention universelle, ciblée ? Que sait-on de l'efficacité de ces interventions ? Quelles sont les données sur l'évaluation économique des programmes de prévention ?
http:www.inserm.fr/thematiques/sante-publique/expertises-collectives

Campbell D.J.T., King-Shier K., Hemmelgarn B., et al. (2014). Obstacles financiers à l'obtention de soins déclarés chez les patients atteints de maladies chroniques d'origine cardiovasculaire. *Rapports sur la Santé,* 25 (5)

Abstract: Fondée sur les résultats d'une enquête représentative de la population réalisée dans les quatre provinces de l'Ouest, cette étude a évalué associations entre les obstacles financiers autodéclarés, d'une part, et la prise de statines, la probabilité de cesser de prendre les médicaments prescrits et les visites au service d'urgence ou les hospitalisations, d'autre part.
http:www.statcan.gc.ca/pub/82-003-x/2014005/article/14005-fra.pdf

Beffy M., Clerc M.E, Thevenot C. (2014). Inégalités, pauvreté et protection sociale en Europe : état des lieux et impact de la crise. In Ralle P./ (Ed.), *La France dans l'Union européenne. Edition 2014* : Paris : INSEE

Abstract: En 2011, le niveau de vie médian de la France la place au sein des pays de l'Union européenne à revenus élevés. En termes d'inégalités de niveaux de vie, la France se situe dans la moyenne des 28 pays européens. Les indicateurs de pauvreté et d'exclusion sociale utilisés au niveau européen - pauvreté monétaire, privation matérielle et exclusion du marché du travail - la situent cependant dans une position plutôt favorable vis-à-vis de ses voisins européens. Cette position tient au fait que notre pays fait partie des plus avancés en termes de niveau de développement économique ; elle est aussi due à l'importance relative des transferts sociaux. Toutefois, depuis le début de la crise, les inégalités de niveau de vie se sont légèrement redressées en France, tandis qu'elles sont restées relativement stables en Europe. De même, si la pauvreté monétaire reste plus basse que la moyenne européenne, elle a un peu augmenté depuis 2007. De fait, les transferts sociaux ont certes amorti le premier impact de la crise en 2008 et 2009, mais cet effet bénéfique s'est ensuite un peu atténué. En revanche, l'augmentation du risque de pauvreté et d'exclusion sociale dans son ensemble a été plus faible en France qu'en Europe. De nombreux pays européens ont été

beaucoup plus touchés par la crise (Europe du Sud, Irlande, pays baltes…) (résumé d'auteur).
http:www.insee.fr/fr/ffc/docs_ffc/FR-UE14.pdf.pdf

Domingo P., Pucci M. (2014). Impact du non-recours sur l'efficacité du RSA « activité » seul. *Economie et Statistique,* (467-468)

Abstract: La composante RSA « activité » seul du revenu de solidarité active, en soutenant financièrement de manière pérenne les foyers ayant des revenus d'activité faibles, est un instrument de lutte contre la pauvreté laborieuse. Mais cette composante, qui constitue la principale innovation du RSA, n'a pas rencontré son public : près de sept foyers sur dix éligibles au RSA « activité » seul en décembre 2010 n'y ont pas eu recours. Alors que les principaux travaux sur le non-recours au RSA ont porté sur ses causes, cet article s'intéresse à l'impact du non-recours sur les inégalités et la pauvreté. À partir de l'Enquête quantitative sur le RSA 2010-2011 de la DARES, la première partie de l'article vise à décrire les foyers non recourants au RSA « activité » seul et à estimer des probabilités de non-recours associées aux caractéristiques sociodémographiques des foyers éligibles. Le risque d'être non recourants s'avère plus important pour les foyers sans enfant, ceux éligibles à des faibles montants de RSA et dont les membres occupent un emploi stable. Mobilisant ces probabilités de non-recours dans un modèle de microsimulation des transferts sociaux et fiscaux (Myriade), la seconde partie de l'article met en évidence l'impact financier du non-recours au RSA « activité » seul. Au niveau macroéconomique, l'inefficacité qu'il génère en matière de lutte contre la pauvreté est de faible ampleur. Pour autant, au niveau individuel, les pertes financières pour les ménages non recourants ne sont pas négligeables, de l'ordre de 100 euros par mois pour les ménages du premier décile des niveaux de vie (résumé d'auteur).
http:www.insee.fr/fr/ffc/docs_ffc/ES467E.pdf

Méthodologie - Statistique / Methodology – Statistics

Viscusi W.K. (2014). The Role of Publication Selection Bias in Estimates of the Value of a Statistical Life : Cambridge : NBER

Abstract: Meta-regression estimates of the value of a statistical life (VSL) controlling for publication selection bias yield bias-corrected estimates of VSL that are higher for labor market studies using the more recent Census of Fatal Occupational Injuries (CFOI) data. These results are borne out by the findings for four meta-analysis data sets and different formulations of the variable used to capture publication bias effects. Meta-regression estimates for a large sample of VSL estimates consisting only of results of labor market studies using the CFOI fatality data indicate publication selection bias effects that are not statistically significant in either fixed effects or random effects models with clustered standard errors. The confidence intervals of the publication bias-corrected estimates of the value of a statistical life sometimes include the sample mean estimates and always include the values that are currently used by government agencies.
http:www.nber.org/papers/w20116

Baxter S.K., Blank L., Buckley-Woods H., et al. (2014). Using logic model methods in systematic review synthesis: describing complex pathways in referral management interventions. *Bmc Medical Research Methodology* , 14 (62)

Abstract: Background: There is increasing interest in innovative methods to carry out systematic reviews of complex interventions. Theory-based approaches, such as logic models, have been suggested as a means of providing additional insights beyond that obtained via conventional review methods. Methods: This paper reports the use of an innovative method which combines systematic review processes with logic model techniques to synthesise a broad range of literature. The potential value of the model produced was explored with stakeholders. Results: The review identified 295 papers that met the inclusion criteria. The papers consisted of 141 intervention studies and 154 non-intervention quantitative and qualitative articles. A logic model was systematically built from these

studies. The model outlines interventions, short term outcomes, moderating and mediating factors and long term demand management outcomes and impacts. Interventions were grouped into typologies of practitioner education, process change, system change, and patient intervention. Short-term outcomes identified that may result from these interventions were changed physician or patient knowledge, beliefs or attitudes and also interventions related to changed doctor-patient interaction. A range of factors which may influence whether these outcomes lead to long term change were detailed. Demand management outcomes and intended impacts included content of referral, rate of referral, and doctor or patient satisfaction. Conclusions: The logic model details evidence and assumptions underpinning the complex pathway from interventions to demand management impact. The method offers a useful addition to systematic review methodologies.

Médicaments / Pharmaceuticals

Moe-Byrne T., Chambers D., Harden M., et al. (2014). Behaviour change interventions to promote prescribing of generic drugs: a rapid evidence synthesis and systematic review. *Bmj Open,* 4 (e004623)

Abstract: Objective To summarise evidence on the effectiveness of behaviour change interventions to encourage prescribing of generic forms of prescription drugs where clinically appropriate in the UK National Health Service (NHS) and similar settings. Design Systematic review. Search strategy We conducted a rapid evidence synthesis in two stages: First, we searched databases, such as the Cochrane Database of Systematic Reviews (CDSR) and Database of Abstracts of Reviews of Effects (DARE), for systematic reviews of interventions that reported outcomes related to utilisation of generic drugs. In the second stage, we searched several databases including MEDLINE and EMBASE to identify primary studies of any interventions not covered by systematic reviews. Data extraction and quality assessment Data were extracted into a standardised data extraction form. Standardised quality assessment tools were used to assess study quality. Two reviewers were involved in data extraction and quality assessment. Results 10 reviews were included for the initial evidence synthesis, but most were of limited usefulness to our focused review question. One review evaluated the effect of prescribing policies using financial incentives and showed an increase in generic prescribing. Thirteen primary studies of other interventions were included for the rapid review. Two studies showed an increase in percentage of overall generic prescribing with an educational intervention; two studies showed an improvement in generic prescribing rates when physicians collaborated with pharmacists, though in one study this was not statistically significant; two US studies showed improvements in generic prescribing with electronic prescribing. Five out of seven studies showed positive results with multifaceted interventions. Conclusions The existing evidence remains insufficient to determine which behaviour change intervention or combination of interventions is most effective due to methodological weaknesses and conflicting results. Based on the evidence, financial incentives with educational intervention and audit/feedback look promising but decision-makers should take into account the practicality and costs of the interventions before implementation.
http:bmjopen.bmj.com/content/4/5/e004623.abstract

(2014). Utilisation des médicaments chez les personnes âgées adhérant à un régime public d'assurance médicaments au Canada - 2012. Ottawa : C.I.H.I.

Abstract: Même si les personnes âgées 65 ans et plus ne représentent que 15 % de la population canadienne, on estime qu'elles occasionnent 40 % de l'ensemble des dépenses liées aux médicaments prescrits et 60 % des dépenses des régimes publics d'assurance médicaments. Les personnes âgées consomment plus de médicaments que les autres Canadiens, car elles sont, en moyenne, atteintes d'un plus grand nombre d'affections chroniques. Bien que le traitement de ces affections exige souvent la prise de plusieurs médicaments, il est important d'examiner les avantages et les risques associés à chacun ainsi que les objectifs thérapeutiques du patient. Il est aussi important de surveiller l'utilisation des médicaments du point de vue des dépenses, car la hausse de l'utilisation est souvent le plus important facteur de l'augmentation des dépenses en médicaments au Canada.

https:secure.cihi.ca/free_products/Drug_Use_in_Seniors_on_Public_Drug_Programs_2012_FR_web.pdf

(2014). 2013 Annual Report on EudraVigilance for the European Parliament, the Council and the Commission. Reporting period: 1 January to 31 December 2013.
London : European Medicines Agency

Abstract: In 2013, EudraVigilance received more than one million post-marketing expedited adverse-drug-reaction (ADR) reports. The report, covering the period from 1 January to 31 December 2013, shows a 26% increase in expedited ADR reports over 2012, resulting in the highest ever annual figure. The greatest increase occurred within the European Union (EU), showing the combined effort of the EU medicines regulatory network to encourage reporting to of suspected adverse reactions to medicines. The most notable increase was in adverse reactions reported by patients within the European Economic Area, which was 52% higher than in 2012. This is due to increased awareness among the general public of the importance of adverse reaction reporting, resulting in part from the new EU pharmacovigilance legislation, which introduced direct reporting of adverse reactions by patients and consumers in all Member States. EudraVigilance is a web-based information system that collects, manages and analyses reports of suspected side effects of medicines. The data held in the database represent an important element in ensuring the continuous safety monitoring of medicines by the European Medicines Agency (EMA) and the Member States of the EU. The reports received in 2013 were processed and subsequently made available for signal detection and data analysis by the EMA and medicines regulatory authorities in the Member States, which subsequently took appropriate regulatory action when necessary. In 2013, the Agency's Pharmacovigilance Risk Assessment Committee (PRAC) prioritised and assessed 100 signals, including 43 detected and validated by the EMA and 57 by EU Member States.
http:www.ema.europa.eu/docs/en_GB/document_library/Report/2014/04/WC500165780.pdf

(2014). Medicam 2008- 2013.

Abstract: MEDIC'AM 2008-2013 présente des informations détaillées sur les médicaments remboursés au cours des années 2008 à 2013 (Régime Général - Hors Sections Locales Mutualistes - Métropole). Le tableau porte sur les soins de ville : les médicaments délivrés à des patients hospitaliers ne sont pas inclus. Il présente pour chaque médicament, par code CIP, les données sur la base de remboursement ; le montant remboursé ; le dénombrement (nombre de boites remboursées) ; la base de remboursement des prescripteurs de ville ; la base de remboursement des autres prescripteurs.
http:www.ameli.fr/l-assurance-maladie/statistiques-et-publications/donnees-statistiques/medicament/medic-am-2008-2013.php

Psychiatrie / Psychiatry

Coldefy M. (2014). Territorialité(s) et santé mentale. In : Organisation de l'offre de soins en psychiatrie et santé mentale. Actes du séminaire recherche. *Série Etudes et Recherche - Document de Travail - Drees,* (129)
http:www.drees.sante.gouv.fr/IMG/pdf/dt129.pdf

Soins de santé primaire / Primary health care

Sweetman A., Buckley G. (2014). Ontario's experiment with primary care reform.
Calgary : University of Calgary

Abstract: Over the past 15 years Ontario has been experimenting with new models for compensating physicians and formalizing their relationships with patients. The goal is to improve service quality and ease of access. A key motivation for these changes is preventive care and chronic disease management, especially given population aging. Has Ontario achieved its objectives? And, what can other provinces learn from Ontario as that province takes the lead in this aspect of health care reform? This paper outlines and evaluates the province's move away from traditional fee-for-service towards alternative payment models for primary care physicians (i.e., family physicians/general practitioners).
http:www.policyschool.ucalgary.ca/sites/default/files/research/ontario-health-care-reform.pdf

Bourgueil Y., Perlbarg J., et al. (2014). Le rapprochement de données de médecine générale et de remboursement de l'Assurance maladie : étude de faisabilité et premiers résultats. *Questions d'Economie de la Santé(Irdes),* (196)

Abstract: Les travaux présentés ici avaient pour but de tester la faisabilité et de valider l'intérêt du rapprochement de données médicales avec des données de remboursement de l'Assurance maladie. Ce chaînage de données individuelles s'inscrit dans la constitution, à terme, d'un système d'information visant à développer la recherche sur les services de santé. Un tel système d'information permettrait, à partir d'un échantillon représentatif des médecins généralistes et des patients, de mesurer la morbidité traitée en soins primaires et d'analyser les pratiques des médecins généralistes ainsi que les parcours de soins des patients afin d'améliorer l'efficacité et l'efficience du système de soins. La première étape du test a consisté en la vérification technique de cette faisabilité. La seconde a permis d'évaluer l'intérêt de l'enrichissement des données de l'Assurance maladie avec les données cliniques pour identifier les populations atteintes de maladies chroniques, en l'occurrence les patients diabétiques et les patients hypertendus (résumé d'auteur).
http:www.irdes.fr/recherche/questions-d-economie-de-la-sante/196-le-rapprochement-de-donnees-de-medecine-generale-et-de-remboursement-de-l-assurance-maladie.pdf

(2014). Family Doctor Incentives: Getting Closer to the Sweet Spot. Ottawa : The Conference Board of Canada .

Abstract: This paper adresses the question: What is the best way to pay family doctors to achieve the best patient outcomes? Instead of choosing one model, policy-makers should aim for the right "incentive blend" for each context, guided by principles that consider health care goals, experience elsewhere, and human motivation. These principles include not undermining doctors' intrinsic motivation, aligning pay with quality improvements, ensuring that incentives do not have loopholes, adjusting for different contexts, and not overplaying financial incentives.
http:www.conferenceboard.ca/e-library/abstract.aspx?did=6224

Systèmes de santé / Health Systems

Cumming J. (2013). New Zealand Health System Review. Health systems in transition ; vol. 3, n°4.

Abstract: The second HiT for New Zealand updates the 2001 review produced by the European Observatory on Health Systems and Policies, and shows a health system in continual evolution. New Zealand has a predominantly tax-funded health system, providing universal coverage. The population enjoys high health status overall, but with significant inequalities in Maori and Pacific health. Since the 1980s, there have been five major health system reforms. Currently, a central Ministry of Health (MOH) oversees the health system, while 20 District Health Boards are responsible for planning and funding health services for their geographical areas. There are no user charges for inpatient or outpatient services in publicly owned hospitals. Primary health care (PHC) is provided through Primary Health Organisations (presently 36) that receive capitation funding for their enrolled populations, and work with general practices and other providers to deliver comprehensive PHC in the community.

Patients may pay user fees for PHC services, although most children under six years of age pay no fees. The Pharmaceutical Management Agency (PHARMAC) manages the New Zealand Pharmaceutical Schedule and negotiates the purchase of drugs from suppliers, successfully controlling supply-side expenditure. A recently reformed National Health Committee is now responsible for strengthening assessment of new technologies and services to promote the delivery of a cost-effective mix of services in New Zealand. The Accident Compensation Corporation (ACC) is a comprehensive, social insurance, no-fault, personal injury scheme which funds treatment, rehabilitation and compensation for people who are injured in New Zealand. It sits alongside the tax-funded health system, and can fund a wider range of services, raising concerns over equity of access between those whose health condition is due to illness and those receiving services because of accidents. Current challenges for the health system include reducing inequalities in health, managing noncommunicable diseases and chronic conditions, reducing waiting times, improving productivity, and ensuring greater integration and coordination of services within and between primary and secondary care, and intersectorally with other social services.
http:www.wpro.who.int/asia_pacific_observatory/hits/series/Nez_Health_Systems_Review.pdf

Miani C., Robin E., Horvath V., et al. (2014). Health and Healthcare: Assessing the Real-World Data Policy Landscape in Europe. Santa-Monica : Rand Corporation .

Abstract: Real-world data (RWD) is an umbrella term for different types of data that are not collected in conventional randomised controlled trials. RWD in the healthcare sector comes from various sources and includes patient data, data from clinicians, hospital data, data from payers and social data. There are already examples of ways in which research has contributed to the provision, construction and capture of RWD to improve health outcomes. However, to maximise the potential of these new pools of data in the healthcare sector, stakeholders need to identify pathways and processes which will allow them to efficiently access and use RWD in order to achieve better research outcomes and improved healthcare delivery. Current efforts to improve access to RWD and facilitate its use take place in a context of resource scarcity. Based on a literature review, case studies, a small set of interviews of experts from public and private organisations and a scenario based workshop, the study outlined possible strategies to illustrate how RWD standards development could facilitate RWD-based research. By investigating the current forms and uses of RWD in Europe, this study has highlighted their significant potential for assessing the (short- or long-term) impact of different drugs or medical treatments and for informing and improving healthcare service delivery. Although the potential of RWD use seems quite clear, this research reveals barriers that restrict further development towards its full exploitation: the absence of common standards for defining the content and quality of RWD; methodological barriers that may limit the potential benefits of RWD analysis; governance issues underlying the absence of standards for collaboration between stakeholders; privacy concerns and binding data protection legislation which can be seen to restrict access and use of data.
http:www.rand.org/content/dam/rand/pubs/research_reports/RR500/RR544/RAND_RR544.pdf

Esmail N. (2014). Health Care Lessons from Germany. Vancouver : The Fraser Institute .

Abstract: The German health care system has been recognized as one that provides good quality care with attentive service in which wait times are not considered to be a problem, as well as a system that rapidly adopts new medical innovations. A careful examination of the German health care system may provide insights and information to inform the Canadian debate over the future of Medicare. Health care expenditures in Germany are considerably lower than in Canada. In 2009, Germany's health expenditures, as an age-adjusted share of GDP, were 22% lower than Canada's, and 1% lower than in the average nation with universal access to medical care. On health care inputs, the Canadian system has higher ratios of nurses to population, MRI machines to population, and CT scanners to population than the German health care system. On the other hand, Germany has higher ratios of physicians to population and hospital beds to population. Germans experience shorter wait times for emergency care, primary care, specialist care, and elective surgery than Canadians. Looking at factors such as the health care systems' ability to successfully manage and treat chronic and critical illnesses, and provide protection from medically avoidable mortality, it seems that the German health care system broadly performs at a level similar to that in Canada, with a stronger performance in measures of patient safety. The German health care system provides universal coverage through two insurance premium-funded systems: a Social Health Insurance system for all Germans and a Private Health Insurance system that is an option for high-income and self-employed Germans. Though

important in terms of funding, regulation, and oversight, governments play little role in the direct delivery of health care.
http:www.fraserinstitute.org/research-news/display.aspx?id=21166

(2014). Health professional mobility in a changing Europe. New dynamics -mobile individuals and diverse responses. Observatory Studies Series ; 32. Copenhague : OMS Bureau régional de l'Europe

Abstract: Pour les responsables politiques, la mobilité des professionnels de santé en Europe est devenue une cible mouvante, dont la direction et l'importance évoluent rapidement en raison d'une profonde transformation liée à l'élargissement de l'Union européenne (UE) et à la crise économique et financière. Cette mobilité entraîne une modification de l'effectif des professionnels de santé dans les pays ainsi que de l'éventail des compétences disponibles, avec des répercussions sur la performance des systèmes de santé. Pour prévoir et planifier leurs besoins en personnel, les pays doivent tenir compte de ce phénomène. Il leur faut pour cela disposer d'informations claires sur les tendances en matière de mobilité et sur les personnes concernées, ainsi que sur les mesures qui contribuent de manière efficace à retenir les agents de santé nationaux et à intégrer ceux formés à l'étranger. La question de la mobilité des professionnels de santé n'a pas encore été réglée en Europe, alors que l'impact de la crise financière se fait toujours sentir sur les personnels européens et sur leur mobilité. Cet ouvrage apporte un éclairage nouveau sur la mobilité des professionnels de santé dans cette Europe en mutation. Il s'agit du deuxième volume réalisé dans le cadre du projet PROMeTHEUS, après une première publication qui présentait des études de cas portant sur différents pays. Ses 14 chapitres thématiques sont regroupés en trois sections : la nouvelle dynamique de la mobilité des professionnels de santé ; l'individu mobile ; les mesures à prendre dans une Europe en mutation. Loin d'être une simple analyse de la situation, cet ouvrage propose des outils pratiques, notamment des critères de référence pour la tenue des registres professionnels, une typologie des individus mobiles, des instruments qualitatifs afin d'étudier la motivation du personnel et un ensemble de mesures concrètes aux niveaux de l'UE, des pays et des organisations, parmi lesquelles des accords bilatéraux, des codes et des initiatives sur les lieux de travail (résumé de l'éditeur).
http:www.euro.who.int/__data/assets/pdf_file/0006/248343/Health-Professional-Mobility-in-a-Changing-Europe.pdf

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

Abstract: This report reviews the quality of health care in Norway. It begins by providing an overview of policies and practices aimed at supporting quality of care in Norway (Chapter 1). The report then focuses on three areas that are of particular importance for Norway's health system at present: the role of primary care physicians (Chapter 2), the shifting of care towards primary care settings and away from the hospital sector (Chapter 3), and mental health care (Chapter 4). In examining these areas, this report examines the quality of care currently provided, seeks to highlight best practices, and provides a series of targeted assessments and recommendations for further improvements to quality of care.
http:www.oecd.org/health/health-systems/ReviewofHealthCareQualityNORWAY_ExecutiveSummary.pdf

Travail et santé / Occupational Health

Mann D.R., Wittenburg D. (2014). Explaining Differentials in Employment and Wages Between Young Adults with and Without Disabilities. Princeton : Mathematica Policy Research

Abstract: We use data from the National Longitudinal Survey of Youth 1997 to estimate and decompose the employment and offered wages of young adults with and without disabilities. Those with functional limitations that are severe or mental have the lowest relative employment rates and

wage offers. The employment rate gaps between the "no limitations" group and the "severe limitations" and "mental limitations" groups are 20.0 and 15.0 percentage points, respectively. These large gaps in employment provide quantitative evidence that many young adults with disabilities decide not to enter the labor force because they receive wage offers that are below their reservation wage. The wage offer differential between those without limitations and those with severe limitations or mental limitations are 10.9 and 52.1 percentage points, respectively. We attribute most of the employment rate gaps to observed factors, whereas most of the wage offer gaps are the result of unobserved factors. Removing the proportion of the wage offer gap attributable to unexplained differences increases the employment rate among those with mental functional limitations by 1.4 percent. http:mathematica-mpr.com/publications/pdfs/disability/explaining_differentials_wp.pdf

Otterbach S. Sousa-Posa A. (2014). Job insecurity, employability, and health: An analysis for Germany across generations. Stuttgart : University of Hohenheim.

Abstract: In this paper, we use 12 waves of the German Socio-Economic Panel to examine the relationship between job insecurity, employability and health-related well-being. Our results indicate that being unemployed has a strong negative effect on life satisfaction and health. They also, however, highlight the fact that this effect is most prominent among individuals over the age of 40. A second observation is that job insecurity is also associated with lower levels of life satisfaction and health, and this association is quite strong. This negative effect of job insecurity is, in many cases, exacerbated by poor employability.
http:econstor.eu/bitstream/10419/96151/1/783546017.pdf

Sanwald A. (2014). Atypical employment and health: A meta-analysis. Innsbruck : University of Innsbruck

Abstract: In this meta-analysis we provide new quantitative evidence on the relationship between the characteristics of working contracts and worker's health. We examine 52 studies covering 26 countries in the time period 1984 - 2010 with a combined sample size of 192. We apply a random effects model using odds ratios and their 95\% confidence intervals as measures for the effect size. We distinguish between six types of employment contracts with decreasing security levels (fixed-term, temporary, casual, on-call, daily, no formal contract) and classify the health outcomes into five subgroups (sickness absence, occupational injuries, health-related behavior, mental health and physical health). Furthermore, we control for selected dimensions of the socioeconomic environment of the studies, e.g. the unemployment rate and GDP growth rate. Summary findings show a higher risk of occupational injuries for atypical employees compared to the reference group. Atypical employment increases complaints about mental and physical health and has a negative impact on health-related behavior. Sickness absence works in the opposite direction and permanent employees are more likely to be absent from work. The heterogeneity of the effect sizes between different contracts of atypical employment is low. Effect sizes are country specific and depend on the health outcome indicators. The macroeconomic surrounding - unemployment rate and GDP growth rate - don't cause variation in study results. The 'healthy worker effect' may lead to an overestimation of the impact of workers' atypical employment contract on the health status. More research work which explicitly focuses on the problems of endogeneity, reverse causality and the selection bias is necessary. Furthermore, additional control groups and the employment biography of workers have to be taken into account.
http:eeecon.uibk.ac.at/wopec2/repec/inn/wpaper/2014-15.pdf

Liu X. (2014). Will knowing diabetes affect labor income? Evidence from a natural experiment. *Economics Letters*

Abstract: This paper analyzes the impact of diabetes awareness on labor income using data from a natural experiment in China. We find that diabetes in general leads to a 16.3% decrease in annual income after respondents being diagnosed, and the adverse impact is heterogeneous across different populations. Males and individuals with lower income are affected more, suggesting that social support may be necessary. The estimated income losses are primarily due to the psychosocial consequences of diabetes, such as reduced productivity, diabetes-related distress, or discrimination in the workplace.
http:papers.ssrn.com/sol3/papers.cfm?abstract_id=2424576

Candon D. (2014). The effects of cancer in the English labour market. Beldfield : University College Dublin

Abstract: The continued rise in overall cancer survival rates has ignited a field of research which examines the effect that cancer has on survivors' employment. Previous estimates of the effect of cancer on labour market outcomes, using U.S. data, show a significant reduction in employment and hours of work in the first 6 months after diagnosis. However, this impact has been found to dissipate after 2 years. I use data from the English Longitudinal Study of Ageing (ELSA) and find that, not only does cancer have a negative impact in the first 6-month period following diagnosis, but also in the second 6-month period. I estimate that, in the second 6-month period after diagnosis, respondents with cancer are 20.7 percentage points less likely to work and work 24% less hours a week when compared to matched, healthy controls. This suggests that the negative effects from cancer can persist for longer than the 6 months identified in previous studies. Results are significant at the 1% level. These results have implications for government policy and employers, because it increases both the length of time that survivors may be on government supported sick pay and the expected time that workers will be absent from work due to illness.
http:www.ucd.ie/geary/static/publications/workingpapers/gearywp201408.pdf

Vieillissement / Ageing

Smith C. (2014). Did the Intergenerational Solidarity Pact increase the employment of the elderly in Belgium? A macro-econometric evaluation. Louvain-la-Neuve : CORE

Abstract: In December 2005, the Belgian government adopted the law on the Intergenerational Solidarity Pact (ISP) with the objective to increase the employment rate of the elderly. In order to meet that objective, several active ageing policies and reforms were taken. The aim of this paper is to investigate the overall effectiveness of the ISP in rising the elderly employment rate by gender. Two methods are used. Both rely on a macro-econometric model which explains the evolution of the elderly employment rate by the economic conditions. The first method uses forecasts of the macro-econometric model as an indicator of the value the employment rate would have taken in the absence of the policies. The second method tests for the presence of structural breaks after the introduction of the main policies of the ISP. The results of the first method suggest a positive impact of the policies on elderly employment rate which is slightly larger for men, and a negative impact on younger men's employment rate, suggesting a substitution effect. These effects are however too small to be statistically significant. Using the second method, no structural break is found.
http:sites.uclouvain.be/econ/DP/IRES/2014009.pdf

Rallu J.L. (2014). Projections of Ageing Migrant populations in France: 2008-2028. Paris : Ined

Abstract: As migrant populations are ageing, migration is becoming less a factor of demographic rejuvenation than in the past. Ageing migrant projections provide data for social and health services that will have to serve linguistically and culturally diverse populations. Although migrants tend to return less than they planned, return migration is the main component of old age migration, but migrants will engage more and more in back and forth moves in the future, due to easier and cheaper travel. Old age immigration is also significant, mostly for females: late family reunification, zero generation (migrants' parents coming to help in child care), etc. These flows will tend to rebalance the sex ratios of migrants - who were mostly males - from labour sending countries. However, the main determinant of migrant ageing is the shape of their age pyramids that vary according to origin, following migration history: pre- and post-independence migration, economic booms and crisis. Migration policies, like the closed border policy following the first oil shock in 1974 and subsequent family reunification will also impact on trends in migrant ageing.
http:www.ined.fr/en/resources_documentation/publications/working_papers/bdd/publication/1684/

Arnault L., Goltz A. (2014). Can formal home care reduce the burden of informal care for elderly dependents? Evidence from France. Paris : Université Paris Dauphine

Abstract: This paper focuses on the trade-off between formal and informal care for elderly dependents living at home in France. Using the French 2008 household Disability - Healthcare data and a newly built indicator of formal home-care prices in each French Council District, we wonder if financial incentives to use more formal home care could relieve informal caregivers. We estimate a bivariate Tobit model to account for both the censor and the endogeneity of our formal home-care variable. Our results con firm that the volume of informal care provided would decrease if the elderly dependents were faced with lower formal home-care prices. Moreover, informal caregivers are shown to be much more sensitive to public subsidizes for skilled formal home care than for the low-skilled one. Subsidizing for skilled formal home care would make informal caregivers more efficient to perform lighter low-skilled tasks. Eventually, acting on formal home care prices could help French public administrators sustain the well-being of both care receivers and informal caregivers.

(2014). Observatoire des EHPAD 2014. Paris : KPGM .

Abstract: L'objectif de l'observatoire EHPAD 2014 est de restituer et d'analyser les principaux ratios économiques et financiers caractéristiques de la gestion de ces structures : taux d'occupation, coût par résident, coût moyen du personnel par fonction, coût des locaux, coût de la restauration, etc. L'observatoire EHPAD 2014 a été conçu à partir de données portant sur l'exercice 2012, auprès de 324 établissements publics et Privés Non Lucratifs (PNL).
http:www.kpmg.com/FR/fr/IssuesAndInsights/ArticlesPublications/Documents/Observatoire-EHPAD-2014.pdf

Dorin L., Turner S.C., Beckmann L., et al. (2014). Which need characteristics influence healthcare service utilization in home care arrangements in Germany? *Bmc Health Services Research,* 14 (233)

Abstract: Background : We see a growing number of older adults receiving long-term care in industrialized countries. The Healthcare Utilization Model by Andersen suggests that individual need characteristics influence utilization. The purpose of this study is to analyze correlations between need characteristics and service utilization in home care arrangements. Methods : 1,152 respondents answered the questionnaire regarding their integration of services in their current and future care arrangements. Care recipients with high long-term care needs answered the questionnaire on their own, the family caregiver assisted the care recipient in answering the questions, or the family caregiver responded to the questionnaire on behalf of the care recipient. They were asked to rank specific needs according to their situation. We used descriptive statistics and regression analysis. Results : Respondents are widely informed about services. Nursing services and counseling are the most used services. Short-term care and guidance and training have a high potential for future use. Day care, self-help groups, and mobile services were the most frequently rejected services in our survey. Women use more services than men and with rising age utilization increases. Long waiting times and bad health of the primary caregiver increases the chance of integrating services into the home care arrangements. Conclusion : The primary family caregiver has a high impact on service utilization. This indicates that the whole family should be approached when offering services. Professionals should react upon the specific needs of care dependents and their families.
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