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Les restes à charge ou les dépenses de santé catastrophiques en France et à l'étranger

Bibliographie thématique

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Sommaire

En guise d'introduction

Le système public d'assurance-maladie obligatoire français se caractérise par des restes à charge sur la plupart des soins qu'il couvre, soit près d'un quart de la consommation de soins et de biens médicaux (CSBM) en 2015[1] Cependant cette part restant à la charge des ménages continue de reculer pour s'établir à 6,9 % en 2019[2]. Avec une part de sa richesse nationale consacrée à la santé un peu supérieure à la moyenne des pays de l'UE-15, la France est le pays de l'OCDE où les ménages sont le moins mis à contribution financièrement. Ces restes à charge publics sont payés par une assurance-maladie complémentaire privée ou par les ménages. Ils sont composés d'une superposition de participations financières introduites au fil du temps : tickets modérateurs, forfaits journaliers, franchises médicales, dépassements d'honoraires… Ces participations financières varient en fonction du type de soins consommés. Elles peuvent être élevées et constituer un frein à l'accès aux soins des

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[1] Beffy M et al. (2016). Les dépenses de santé en 2015 (Comptes de la santé)

[2] Marc, C., Heam, J. C., Mikou, M., et al. (2020). Les dépenses de santé en 2019 - Résultats des comptes de la santé - Édition 2020

populations précaires[3][4]. Dans son rapport 2016 sur l'application des lois de financement de la Sécurité sociale, la Cour des comptes a par ailleurs constaté que la participation des assurés dans le financement des dépenses de santé avait de nouveau augmenté depuis 2012 et tendait à retrouver le niveau qui était le sien à la fin des années 1990[5]

Même si la plupart des pays de l'OCDE tendent à développer des dispositifs de couverture maladie universelle à destination des usagers vulnérables ou exposés à des dépenses de santé élevées, nombre de ces pays connaissent néanmoins des restes à charge ou dépenses de santé catastrophiques. Telles sont les conclusions d'études récemment conduites par l'European Hospital Healthcare Foundation (HOPE)[6] ou par l'Organisation de coopération et de développement économiques (OCDE)[7]. Deux tendances ont été par ailleurs observées : une baisse des restes à charge sur la période 2000-2009, puis une hausse à partir de l'année 2009 sans doute imputable à la récession économique.

Ces restes à charge demeurent inégaux parmi les pays de l'OCDE. Les pays nordiques, le Luxembourg, la Belgique… ont un taux d'usagers exposés à des dépenses élevées de 0 %, tandis que ceux d'autres pays avoisinent 2 % (les États-Unis), voire dépassent 3 % (Estonie, Corée)[8]. Ces chiffres sont à interpréter avec précaution, car les définitions des restes à charge diffèrent d'un pays à l'autre et si on se réfère à un autre indicateur (la part des dépenses de santé non couvertes dans la consommation finale des ménages), on obtient d'autres chiffres : le Luxembourg, la France, le Royaume-Uni ont un taux inférieur à 1,5 %, tandis que la Bulgarie, Malte, Chypre ou la Grèce ont un taux dépassant 4 %[9]. Si l'on s'appuie sur deux autres études de l'OCDE[10]et de la Drees[11], les ménages paient environ un cinquième des dépenses de santé et les taux de RAC oscillent entre 9 % et10 % en France, 12 % en Allemagne, 15 % au Royaume-Uni et 28 % au Portugal, 34 % et 35 % en Grèce.

Parmi les nombreux obstacles à l'accès aux soins invoqués par les usagers (distance d'accès, listes d'attente…), les restes à charge demeurent l'élément le plus déterminant du renoncement aux soins[12]. En se basant sur les soins dentaires souvent partiellement couverts par les assurances santé, la Latvie accuse, en 2014[13], le taux le plus élevé de renoncement aux soins (18 %). Le Portugal, l'Italie et l'Espagne connaissent aussi un taux important. L'Autriche, le Luxembourg, l'Allemagne et les Pays-Bas réalisent les taux les plus bas (entre 0 et 4 %). La France se situe à un taux intermédiaire, entre 6 et 7 %. Enfin, si l'on compare les chiffres obtenus en 2008 avec ceux de 2014, on se rend compte que les taux de renoncement aux soins se sont significativement accrus chez les populations vulnérables consécutivement à la crise économique de 2008. Les conclusions demeurent sensiblement identiques dans le Panorama de santé 2020 de l'OCDE. L'impact de la crise sanitaire liée à l'épidémie de la convid-19 n'est pas encore connu.[14]

L'objectif de cette bibliographie est donc de recenser des sources d'information (ouvrages, rapports, articles scientifiques, littérature grise, sites institutionnels…) sur les restes à charge dans les dépenses de santé pour la période s'étendant de 2006 à décembre2019.

Le périmètre géographique retenu est celui des pays industrialisés.

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[3] Perronnin M. (2016). Restes à charge public en ville et à l'hôpital (Irdes)

[4] Franc K. et Pierre A. (2016)

[5] Cour des comptes (2016). Rapport sur l'application des lois de financement de la Sécurité sociale

[6] HOPE (2015). Out-of-pocket payments in Health Care Systems in the European Union

[7] Paris (2016) et al. Health Care Coverage in OECD countries in 2012

[8] Paris (2016) et al. Health Care Coverage in OECD countries in 2012 – page 56

[9] 9 HOPE (2015). Out-of-pocket payments in Health Care Systems in the European Union (voir Country profiles)

[10] (2019). "Out-of-pocket spending: Access to care and financial protection." Focus On: 4

[11] Heam, J. C., Mikou, M., Ferreti, C., et al. (2019). Comparaisons internationales du reste à charge des ménages. Les dépenses de santé en 2018 : Résultats des comptes de la santé. Edition 2018., Paris : Drees

[12] OCDE (2016). Health at glance Europe :out-of-pocket medical expenditure and unmet health care needs – pages 154-157

[13] Enquête EU-SILC 2014

[14] OCDE (2020). Health at a glance : Europe 2020, state of health in the EU cycle. Paris OCDE.

Les recherches bibliographiques ont été réalisées sur les bases suivantes : Base bibliographique de l'Irdes, Banque de données santé publique (BDSP), Cairn, Medline et Econlit.

Les aspects ciblés sont les suivants :

- Le poids des restes à charge dans les dépenses de santé ;
- Leur rôle dans l'accès et le renoncement aux soins ;
- L'impact de la crise économique de 2008 sur l'évolution du RAC et de l'accès aux soins.
- Les effets de la crise sanitaire due à la Covid-19 sur les inégalités d'accès aux soins

Les références bibliographiques sont présentées par année de publications, puis par ordre alphabétique d'auteurs et/ou de titres.

Les restes à charge dans les dépenses de santé : une part en augmentation depuis 2009

FOCUS : DEFINITIONS DES RESTES A CHARGE

Définitions

Les définitions des restes à charge, débours ou participations financières diffèrent selon les pays. On peut néanmoins se baser sur celles de l'Organisation mondiale de la santé (OMS).
Ce sont globalement les dépenses pour frais de santé qui ne sont remboursées ni par les assurances obligatoires, ni par les assurances privées (complémentaires ou supplémentaires). Les participations financières ou « *cost-sharing* » incluent les tickets modérateurs (*co-payments*, *co-insurance*), les franchises (*deductibles*), payés directement par les ménages et les paiements informels ou dessous-de-table (*informal payments*), versés aux professionnels de santé.
En France, les participations financières des assurés sont constituées du ticket modérateur (1930), du forfait hospitalier (1983), des franchises médicales (2008) et des dépassements d'honoraires des professionnels de santé (Voir le site d'Ameli).
Les terminologies les plus couramment utilisées dans les bases de données anglo-saxonnes sont les suivantes : out-of-pocket, catastrophic health care expenditures, cost sharing, copayment, coinsurance, fees and deductibles, user fees.

ÉTUDES FRANÇAISES

2021

Adjerad, R. et Courtejoie, N. (2021). "Des restes à charge après assurance maladie obligatoire comparables entre patients âgés avec et sans affection de longue durée, malgré des dépenses de santé 3 fois supérieures." Etudes et Resultats (Drees)(1180): 7 , fig., graph.
https://drees.solidarites-sante.gouv.fr/

> En 2017, la dépense de santé des assurés bénéficiant du dispositif d'affection de longue durée (ALD) s'élève à 8 900 euros en moyenne, soit presque sept fois plus que pour le reste des patients. Ces assurés, qui représentent 18 % des patients, concentrent près de 60 % des dépenses de santé présentées au remboursement. Le dispositif ALD permet une redistribution horizontale envers les plus malades : plus de 90 % de la dépense des assurés en ALD est prise en charge par l'assurance maladie obligatoire (AMO), contre 67 % pour le reste des assurés. Chez les patients âgés, le montant du reste à charge moyen après AMO des assurés en ALD est comparable à celui des autres patients. Or, plus de la moitié des assurés en ALD ont plus de 65 ans et ont donc davantage de dépenses de santé, qu'elles soient relatives à leur(s) affection(s) ou non. De fait, les assurés en ALD ont aussi des prestations sans lien avec leur(s) affection(s). Ces dernières ne correspondent qu'à hauteur de 30 % à leurs dépenses de santé, mais elles représentent presque 80 % de leur reste à charge après assurance maladie

obligatoire (RAC AMO). Elles se composent notamment de dépenses en soins dentaires, d'optique et d'aides auditives. Malgré le dispositif ALD, pour près de 1 % de ses bénéficiaires, les RAC AMO sont encore supérieurs à 4 900 euros annuels et composés en moyenne à 70 % de dépenses sans lien avec leur(s) affection(s).

Gueniau, J. (2021). Osons une nouvelle complémentarité entre la sécurité sociale et les complémentaires santé, Paris : Institut Sapiens
https://www.institutsapiens.fr/osons-une-nouvelle-complementarite-entre-la-securite-sociale-et-les-complementaires-sante/

Cette note s'inscrit dans le prolongement direct dans l'étude Sécuriser et améliorer notre système de santé publiée par l'Institut Sapiens en septembre 2020, et vise à en prolonger l'analyse sur un aspect particulier : celui du rôle des complémentaires santé, dans le cadre du Contrat responsable. Elle s'inscrit également dans l'actualité des travaux du Haut Comité pour l'Avenir de l'Assurance Maladie (HCAAM), qui portent actuellement sur la place de la complémentaire santé et prévoyance en France. En effet, les garanties de couverture des contrats de complémentaires santé, souscrites à titre individuel et surtout à titre collectif, dans le cadre de l'entreprise, ne sont pas libres. Un cadre a été défini par la loi de réforme de l'assurance maladie de 2004 : le Contrat responsable, qui fixe aux complémentaires santé des obligations, comme celle de rembourser un montant minimum en optique, et des interdictions, comme celle de ne pas rembourser certains dépassements d'honoraires au-dessus d'un montant déterminé. En définitive, le Contrat responsable a progressivement conduit les complémentaires santé à devenir les hyper-spécialistes du financement de ces trois domaines (optique, dentaire et aides auditives). Ce mouvement s'est opéré au détriment d'une différenciation souhaitable du rapport garanties / prix des couvertures proposées, suivant les besoins et les moyens des assurés, mais surtout au détriment du financement du reste à charge (RAC) des assurés en cas de gros incident de santé, comme l'hospitalisation et les Affections de Longue Durée (ALD). Cette logique a finalement abouti à la séparation du petit et du gros risque : l'Assurance maladie a vu croître sa part (78,2% en 2019) dans la Consommation de Soins et de Biens Médicaux (CSBM) puisqu'elle prend en charge à 100 % les frais de soins hors dépassements d'honoraires et soins non-remboursables pour les ALD ; tandis que les OC ont pris une place croissante dans le « petit risque ». Cette répartition avait pourtant été très largement rejetée lors de la dernière campagne présidentielle, car elle ne répond à aucune logique médicale ou médico-économique.

2020

Adjerad, R. et Courtejoie, N. (2020). "Pour 1 % des patients, le reste à charge après assurance maladie obligatoire dépasse 3 700 euros annuels." Etudes et Resultats (Drees)(1171): 7 , Tab., graph.
https://drees.solidarites-sante.gouv.fr/

En 2017, le reste à charge des dépenses de santé après assurance maladie obligatoire est inférieur à 240 euros par an pour la moitié des patients ayant consommé des soins remboursables. L'âge est le principal déterminant du reste à charge après assurance maladie obligatoire, qui atteint 1 000 euros annuels en moyenne chez les plus de 85 ans, soit presque trois fois plus que pour les 36-40 ans. Cependant, grâce à l'Assurance maladie, l'augmentation du reste à charge avec l'âge est plus modérée que celle des dépenses de santé : celles-ci sont cinq fois plus élevées pour les plus de 85 ans que pour les 36-40 ans. 1 % des personnes ayant consommé des soins remboursables ont un reste à charge supérieur à 3 700 euros, pour une moyenne de 5 400 euros, dont près de 3 000 euros de liberté tarifaire. Le millième supérieur des personnes exposées aux restes à charge les plus élevés, dépassant 7 600 euros, regroupe plusieurs profils de patients : patients occasionnels de soins de ville confrontés à de forts dépassements, malades ayant une consommation continue de soins en ville et à l'hôpital et personnes âgées en fin de vie.

Arnault, L. et Roy, D. (2020). Allocation personnalisée d'autonomie : en 2017, un bénéficiaire sur deux n'utilise pas l'intégralité du montant d'aide humaine notifié. Paris Drees**:** 6 , Tab., graph.

https://drees.solidarites-sante.gouv.fr/

> Fin 2017, 93 % des bénéficiaires de l'allocation personnalisée d'autonomie (APA) à domicile se voient notifier des aides humaines pour accomplir les activités de la vie quotidienne, d'après les remontées individuelles sur l'APA réalisées par la DREES. Elles représentent 87 % des montants totaux notifiés d'APA à domicile. Lorsque le plan d'aide notifié inclut de l'aide humaine, le montant moyen de cette aide est de 500 euros par mois. À caractéristiques identiques, le montant notifié aux hommes en couple est 54 euros moins élevé que celui proposé aux femmes en couple, et il est inférieur d'environ 130 euros à celui notifié aux bénéficiaires vivant seuls. Près d'un bénéficiaire sur deux (47 %) ne consomme pas l'intégralité du montant d'aide humaine qui lui a été notifiée. Cette proportion est plus élevée de 10 points pour les moins dépendants (GIR 4) que pour les plus dépendants (GIR 1). Parmi ceux qui ne consomment pas la totalité du montant d'aide notifié, un tiers du montant notifié d'aide humaine n'est pas dépensé, en moyenne. Les bénéficiaires aux ressources intermédiaires, pour qui le reste à charge constitue une part importante des ressources, sous-consomment davantage que les autres. C'est également le cas des hommes en couple qui, lorsqu'ils ne consomment pas tout le montant d'aide humaine qui leur est notifié, renoncent aussi à une part plus importante du montant notifié.

Bec, C., Gombert, F., Paris, V., et al. (2020). "Les transformations de l'Assurance maladie." Seve : Les Tribunes De La Sante(65): 27-102.
https://www.cairn.info/revue-les-tribunes-de-la-sante-2020-3.htm

> Un siècle d'épopée sociale ! Ce pourrait être le titre d'une histoire de l'Assurance maladie. Au coeur du pacte social, l'Assurance maladie est également le terrain de vives oppositions d'intérêts. Système social exceptionnel par la garantie qu'elle apporte d'une prise en charge des frais de santé, elle est également un système social paradoxal dès lors qu'en dépit de sa dénomination, elle n'est pas une assurance. Elle a vocation à protéger l'ensemble de la population de manière égalitaire, c'est-à-dire en fonction du seul état de santé de ses bénéficiaires et indépendamment de leur état de fortune. Malgré son histoire séculaire, l'Assurance maladie connaît en France de profondes transformations depuis un quart de siècle. D'importantes mutations sont également observées dans de nombreux systèmes étrangers de protection maladie. Ces réformes constituent le plus souvent des enjeux politiques et sociaux cruciaux. Le débat sur l'Obamacare et le Trumpcare est évidemment emblématique des tensions exacerbées qu'elles peuvent provoquer. C'est à ces différentes problématiques que ce numéro des Tribunes de la santé est consacré. Avec l'ambition de mettre en lumière les inquiétudes et les espoirs que suscitent et nourrissent les projets visant à adapter les systèmes d'assurance maladie aux défis du XXIe siècle. Nul doute que la pandémie de la Covid-19 donne aux questions ainsi abordées une résonance sans précédent (4ème de couv.)

Bensadon, A. C., Nuytten, B., Ott, M. O., et al. (2020). Evaluation du 3ème Plan cancer (2014-2019). 2 tomes. Paris IGAS**:** 2 vol. (273;265).
www.igas.gouv.fr/spip.php?article801

> Avec 382.000 nouveaux cas et 157.000 décès annuels (chiffres de 2018), le cancer est la première cause de mortalité chez l'homme, et la deuxième chez la femme.Afin de préparer les orientations de la prochaine stratégie décennale de lutte contre les cancers, les inspections générales des affaires sociales et de la recherche ont été chargées d'évaluer le troisième plan cancer couvrant la période 2014-2019. Ce plan comportait quatre axes : Guérir ; - Préserver la qualité de vie des patients ; Investir dans la prévention et dans la recherche ; Conforter les organisations. Les besoins des enfants, adolescents et jeunes adultes atteints de cancer devaient recevoir une attention prioritaire, de même que la réduction des inégalités devant la maladie et des pertes de chance. La mission a mené des travaux très approfondis et rencontré près de 200 personnes (représentants des patients, professionnels de santé, sociétés savantes, conseils professionnels, collège de médecine générale, fédérations d'établissements, institutions de recherche, etc.), tout en parcourant plusieurs régions. Ses constats et ses recommandations tournent autour de 11 thèmes : Recherche - Observation – Prévention – Dépistage – Soins – Vie pendant et après le cancer – Démocratie en santé – Besoins des

enfants, adolescents et jeunes adultes – Réduction des inégalités – Ressources - Gouvernance.Ces thèmes sont développés de manière détaillée dans le rapport complet, qu'accompagne un rapport de synthèse pour connaître l'essentiel.

Carrere, A. (2020). "Vivre à domicile ou en institution : quels sont les déterminants de la prise en charge de la perte d'autonomie des personnes âgées ?" Regards **57**: 127-139.
https://www.cairn.info/revue-regards-2020-1-page-127.htm

Sous l'effet des dynamiques démographiques, sociales et sanitaires, les besoins de prise en charge des personnes âgées en perte d'autonomie progressent, se complexifient et se diversifient. Ces évolutions invitent à s'interroger sur les réponses apportées à la fois par la sphère privée et publique pour prendre en charge ces besoins complexes dans un contexte marqué par une politique affichée en faveur du « vieillir à domicile » et une décentralisation de la politique gérontologique. Cet article mobilise différents articles scientifiques pour identifier à la fois les facteurs de la demande de prise en charge et les contraintes d'offre pour comprendre les décisions des personnes âgées dépendantes quant à leur lieu de prise en charge.

Denormandie, P. et Chevalier, C. (2020). Des aides techniques pour l'autonomie des personnes en situation de handicap ou âgées : Une réforme structurelle indispensable. Paris Secrétariat d'Etat aux Personnes Handicapées.**:** 255 , annexes.

Ce rapport émet des recommandations pour améliorer le recours aux aides techniques, à travers un accompagnement renforcé des personnes âgées ou handicapées. Il dresse un diagnostic très étayé du système actuel et des difficultés trop souvent rencontrées par les personnes, et formule de nombreuses propositions concrètes, pour mieux évaluer les besoins des personnes et accompagner la prise en main des aides techniques, pour améliorer leur financement et baisser les restes à charge, pour renforcer la qualité du service rendu par les fabricants et les distributeurs, pour faire évoluer la gouvernance de ces politiques publiques, et enfin pour stimuler la recherche et l'innovation.

Feral-Pierssens, A.-L., Rives-Lange, C., Matta, J., et al. (2020). "Forgoing health care under universal health insurance: the case of France." Int J Public Health **65**(5): 617-625.
https://doi.org/10.1007/s00038-020-01395-2

We investigate the reliability of a survey question on forgone healthcare services for financial reasons, based on analysis of actual healthcare use over the 3-year period preceding response to the question. We compare the actual use of different health services by patients who report having forgone health care to those who do not.

Heinzlef, O., Molinier, G., Van Hille, B., et al. (2020). "Economic Burden of the Out-of-Pocket Expenses for People with Multiple Sclerosis in France." Pharmacoeconomics(On line): 1-11.
https://link.springer.com/content/pdf/10.1007/s41669-020-00199-7.pdf

People with chronic diseases in France frequently incur out-of-pocket expenses (OOPE) related to their medical care. The objective of this study was to evaluate OOPE incurred by people with multiple sclerosis (MS) with respect to direct non-medical and medical expenditure.

FNMF (2020). Accès territorial aux soins : les inégalités ne sont pas définitives. Paris FNMF**:** 46.
https://placedelasante.mutualite.fr/observatoire2020-acces-territorial-aux-soins-les-inegalites-ne-sont-pas-definitives/

La quatrième édition de l'Observatoire-Place de la Santé est consacrée à l'accès territorial aux soins. Cette étude comporte une analyse à partir de différentes sources de données permettant une mise en perspective ainsi qu'une enquête réalisée auprès du grand public et des entretiens avec des professionnels de santé. Elle vise à démontrer que, sans mesures fortes sur l'organisation des soins, des pouvoirs publics ou par les professions de santé, l'accroissement des inégalités est inéluctable.

HCFEA (2020). L'incidence des Réformes du « 100 % santé » et de la complémentaire santé solidaire pour les personnes âgées. Avis-note et synthèse. Paris HCFEA**:** 3 vol. (1;75;16).
http://www.hcfea.fr/spip.php?rubrique11

> La note adoptée par le Conseil de l'Age présente des incidences pour les personnes âgées des dernières réformes relatives au 100 % santé ou « Zéro reste à charge », d'une part, et d'autre part à la Complémentaire santé solidaire (qui intègre les acquis du 100 % santé pour les publics plus modestes).

Loiseau, R. (2020). "Aide au paiement d'une complémentaire santé : un niveau de couverture équivalent à celui des contrats du marché individuel en 2018." Etudes et Resultats (Drees)(1142): 5.
https://drees.solidarites-sante.gouv.fr/

> Depuis le 1er novembre 2019, la complémentaire santé solidaire (CSS) remplace par un contrat unique les deux anciens dispositifs de la couverture maladie universelle complémentaire (CMU-C) et de l'aide au paiement d'une complémentaire santé (ACS). L'instauration de la CSS poursuit les mêmes objectifs que l'ACS. Elle vise à réduire les dépenses de santé en offrant un panier de soins sans reste à charge à tarif modéré. Sa mise en place est l'occasion d'un bilan des réformes successives de l'ACS. En 2018, 1,24 million de personnes sont couvertes par un contrat ACS et bénéficient d'un niveau théorique de prise en charge comparable en moyenne à celui des autres contrats individuels des complémentaires santé. Alors qu'en 2013, les contrats ACS faisaient partie des moins couvrants du marché, plusieurs changements de réglementation ont permis d'améliorer le recours au dispositif, l'accessibilité financière aux soins et le niveau de qualité de la couverture. Ainsi en 2018, le contrat ACS le plus couvrant, choisi par 4 bénéficiaires de l'ACS sur 10, donne accès à un niveau de prise en charge supérieur à celui dont disposent 90 % de l'ensemble des personnes couvertes en individuel. Cependant, le taux de recours au dispositif reste nettement plus faible que celui à la CMU-C. De plus, les restes à charge demeurent élevés sur des postes de soins tels que l'optique, les soins prothétiques dentaires et les audioprothèses. En simplifiant le dispositif par un contrat unique, dont le panier de soins accessible sans reste à charge est élargi, la CSS vise précisément à corriger ces défauts.

Mazevet, M. E., Garyga, V., Mayne, C., et al. (2020). "2018 French dental contracts: On the road to achieving universal dental health coverage?" Health Policy **124**(8): 781-786.
https://doi.org/10.1016/j.healthpol.2020.04.016

> Following the failure of earlier negotiations, the new French Government decided not to go ahead with a unilateral decision to define fees in the dental contracts, and to reopen the negotiations. This in a bid to satisfy the providers' requests, as well as to negotiate Emmanuel Macron's presidential campaign promise of no out-of-pocket expenses on dental prosthetics. The three stakeholders, the National Health Insurance System, Dental Trade Unions and Complementary Health Insurers, started another round of negotiations which lead to an agreement. This new convention, which will be phased in from the 1 st of April 2019, will exclude 90 % of dental procedures from out-of pocket payments for patients. Though economic models were controversial between the stakeholders, this reform is likely to engage France in a system where the dental medical divide is narrowing, quasi-universal dental coverage is achieved and policy making processes are adaptable to the evolution of evidence-based medicine and economic realities. This reform, supported by more than 95 % of the French population, is likely to serve as an example for its impact on: political campaigns; the role of comprehensive data collection systems; economic models; and adaptive policies in order to overcome barriers to reforms.

Or, Z., Pierre, A., Flood, C. M. e., et al. (2020). The Public-Private Mix in France: A Case for Two-Tier Health Care. Is Two-Tier Health Care the Future?, Ottawa : University of Ottawa Press**:** 237-266.
https://http://press.uottawa.ca/is-two-tier-health-care-the-future.html

> France has an employment-based statutory health insurance (SHI) system that guarantees universal access to a large basket of health care. While the SHI system imposes significant copayments, patients rely on a mix of public SHI and private complementary health insurance (CHI) schemes to defray these

costs, leaving France with some of the lowest out-of-pocket expenditures in the OECD. Patients can choose from a mix of public and private providers without severe wait time problems, and the health status of the population ranks among the best in the world. At the same time, the French system is complex, with some apparent contradictions that raise concerns for solidarity, redistribution, and efficiency.

Pelen, F. et Bouzou, N. (2020). Point vision : l'avenir de la filière visuelle et évaluation des recommandations de l'Igas. Paris Asterès**:** 2 vol. (65 +12).
https://www.groupepointvision.com/rapports-asteres-2020/

Ce rapport réalisé par le cabinet Asterès Etudes & Conseil sur la demande du groupe Point vision rassemble les résultats de son étude économique sur la filière visuelle en France consacrée à l'analyse de l'impact de la technologie sur les besoins en ophtalmologues. Le constat est clair : les besoins des Français en soins ophtalmologiques ne cessent d'augmenter dans un contexte de stagnation du nombre d'ophtalmologistes et de fortes inégalités de leur densité à l'échelle du territoire. Menée en partenariat avec Point Vision, cette étude aboutit à la proposition d'un modèle économique selon lequel il est possible de faire face à la demande en consultation d'ophtalmologie dans les années à venir. Parallèlement à cette étude, Asteres a publié un autre rapport analysant les recommandations contenues dans le récent rapport de l'Igas sur la filière visuelle.

Raynaud, D. (2020). Quels restes à charge en France ?, Paris : France Assos Santé
https://www.france-assos-sante.org/wp-content/uploads/2020/08/Actes-journee-AM-25-nov-2019.pdf

La France affiche le reste à charge le plus bas de l'OCDE, notamment grâce à l'articulation entre régime obligatoire et régime complémentaire. Cela étant, pour qu'il y ait un reste à charge, il faut une consommation de soins. Cet indicateur, s'il est intéressant, ne suffit donc pas pour appréhender la problématique du non-recours aux soins...(Résumé d'auteur).

Tison, E., Calmels, D. et Kyrylesku, A. (2020). Sécuriser et améliorer notre système de santé : capitaliser sur nos points forts pour corriger nos faiblesses. Paris Institut Sapiens**:** 98.
https://www.institutsapiens.fr/observatoire_category/sante-et-innovation/page/2/

Chaque pays a pu mesurer la résilience et les limites de son propre système. Les mesures adoptées face à la pandémie, au prix de lourdes conséquences économiques, ont surtout rappelé une évidence : la santé passe avant tout. Si cette actualité a démontré la primauté du sanitaire sur toute autre préoccupation, elle a aussi remis sur le devant de la scène, en France, une question maintenant ancienne : comment améliorer notre système de santé ? Attention aux mots, cependant : améliorer ne veut pas dire tout balayer. Si des réformes structurelles profondes sont requises dans notre système de santé, il est aussi crucial de bien identifier les spécificités qui font sa force. Avant de chercher à perfectionner le système de santé français, il faut déjà bien le comprendre et mettre en regard le pays avec ses voisins pour déterminer ses atouts et les aspects sur lesquels il est le plus performants. C'est tout l'objet de la présente étude. Pour évaluer les performances du système de santé français, cette étude mesure ainsi son efficacité par rapport à un ensemble de pays de l'OCDE, à travers cinq critères objectifs. Dans un second temps, elle examine de plus près les caractéristiques structurelles qui font la force et la faiblesse de notre modèle sanitaire. Savoir réformer, c'est certes savoir améliorer des points faibles ; mais c'est aussi savoir capitaliser sur des spécificités essentielles. En France, cela implique notamment de s'appuyer sur un acteur qui a fait ses preuves et qui joue un rôle capital, au bénéfice de nos concitoyens : le secteur des complémentaires santé.

2019

Acker, D. et Bonnet, C. (2019). Politique de soutien à l'autonomie des personnes âgées : quelques comparaisons internationales. Note du Conseil de l'Age. Paris HCFEA**:** 26.
http://www.hcfea.fr/spip.php?rubrique11

Cette note porte sur 9 pays : l'Allemagne, le Danemark, l'Espagne, l'Italie, la Suède et le Québec, ainsi que sur la Belgique, les Pays-Bas et le Japon. Tous les pays étudiés sont confrontés aux enjeux du vieillissement et de la perte d'autonomie. Les stratégies développées et les grandes orientations sont similaires : priorité au soutien à domicile, diversification des réponses en termes de lieux de vie et des choix offerts aux familles, tendance à l'extension des prestations en espèces plutôt qu'en nature, soutien aux aidants et attention portée à la question de la qualification des professionnels du secteur.

Bonne, B. et Meunier, M. (2019). Rapport d'information sur le financement de la dépendance. Paris Sénat**:** 115.
http://www.senat.fr/notice-rapport/2018/r18-428-notice.html

Ce rapport rend compte de travaux sur le financement de la perte d'autonomie des personnes âgées, alors que s'engageait parallèlement une concertation plus large pilotée par M. Dominique Libault, à la demande du Gouvernement, sur le grand âge et l'autonomie. Les rapporteurs se sont attachés à définir la notion de « reste à charge », dont les composantes sont multiples, et à en donner des estimations chiffrées. Ils ont ainsi distingué, au sein du reste à charge, la part des aides apportées au titre de la perte d'autonomie et qui obéissent à une logique de compensation, et celle des frais d'hébergement en établissement, dont la couverture est en partie assurée par la solidarité nationale. Ces deux composantes forment un reste à charge global de 7 milliards d'euros par année, très inégalement réparti entre personnes âgées à domicile et personnes âgées accueillies en établissement. Ce niveau élevé est fréquemment reproché au conseil départemental, attributaire de la compétence de droit commun en matière de dépendance. Les rapporteurs souhaitent à cet égard rappeler tout l'intérêt de confier la prise en charge de la perte d'autonomie aux acteurs publics de proximité, qui restent les mieux à même de la mener. Sur la question financière, les rapporteurs soulignent que les recettes actuellement affectées au remboursement de la dette sociale ne suffiront pas, une fois cette dernière éteinte, à couvrir les dépenses de la dépendance à ce jour non financées. C'est pourquoi ils préconisent la mise en place d'une assurance dépendance obligatoire, dont le présent rapport offre les premiers contours. Dans le prolongement des débats engagés en 2007-2008 autour du « cinquième risque », et malgré la conjoncture budgétaire et sociale complexe qui s'impose aux pouvoirs publics, il leur paraît essentiel que le sujet du financement fasse l'objet d'une réforme systémique, au vu des enjeux qui s'annoncent.

FNMF (2019). Hôpital : des restes à charge inégalitaires. L'Observatoire de la Mutualité française, Paris : FNMF
https://www.mutualite.fr/presse/hopital-des-restes-a-charge-inegalitaires/

Dans l'édition 2019 de son Observatoire, la Mutualité Française décrypte les restes à charge encore supportés par les Français, alors que se met en place la réforme du 100 % Santé. Ces restes à charge peuvent s'avérer élevés et très variables en fonction de l'âge et du lieu d'habitation, en particulier pour les dépenses hospitalières. L'intervention des mutuelles est alors déterminante pour réduire la facture et les inégalités. L'Observatoire confirme les préoccupations des Français liées au grand âge et révèle également leur inquiétude pour l'hôpital dont ils considèrent la réforme comme une priorité.

Heam, J. C., Mikou, M., Ferreti, C., et al. (2019). Comparaisons internationales du reste à charge des ménages. Les dépenses de santé en 2018 : Résultats des comptes de la santé. Edition 2018., Paris : Drees**:** 118-119.
https://drees.solidarites-sante.gouv.fr/

Les comptes de la santé 2018 mettent en évidence que la consommation de soins et de biens médicaux (CSBM) est évaluée à titre provisoire à 203,5 milliards d'euros. Elle progresse moins vite en 2018 qu'en 2017 (+1,5 % après +1,7 %), du fait du net ralentissement des soins hospitaliers. La Sécurité sociale finance 78,1 % de la CSBM, et les organismes complémentaires (mutuelles, sociétés d'assurances et institutions de prévoyance), 13,4 %. La part restant à la charge des ménages continue de reculer pour s'établir à 7,0 % en 2018. Avec une part de sa richesse nationale consacrée à la santé un peu supérieure à la moyenne des pays de l'UE-15, la France est le pays de l'OCDE où les ménages sont le moins mis à contribution financièrement.

Heam, J. C., Mikou, M., Ferreti, C., et al. (2019). Les dépenses de santé en 2018 : Résultats des comptes de la santé. Edition 2018. Panoramas de la DREES. Paris Drees**:** 158.
https://drees.solidarites-sante.gouv.fr/

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Kervasdoue, J. d. et Bazzocchi, D. (2019). La santé rationnée : un mal qui se soigne, Paris : Economica

> L'économie de la santé est une économie du rationnement. La raison en est simple : comme, en France, 92 % du coût des soins médicaux ne sont pas supportés par le patient au moment de ses soins, puisqu'ils sont presque toujours gratuits, la demande du patient est potentiellement infinie, elle doit donc être régulée. Si elle ne peut pas l'être par des mécanismes de marché, l'État est contraint de contrôler de façon autoritaire le montant et/ou les quantités de ressources financières, de biens ou de services affectés aux soins médicaux. La vérité est donc qu'il rationne, même si l'euphémisme utilisé est de dire qu'il « régule ». Tout ou presque est rationné : le nombre de médecins (numerus clausus), les lits hospitaliers, les pharmacies, les équipements lourds, les actes médicaux (nomenclatures), les médicaments remboursés par l'assurance maladie. Il n'y a de prix que pour les médecins du secteur 2 et pour quelques services (chambres particulières) ou biens médicaux ; la règle est le tarif basé sur des nomenclatures et les tarifs ne sont pas des prix. Si, dans le domaine des soins médicaux, les mécanismes de marché sont inégalitaires et inflationnistes, si l'on est éthiquement contraint de recourir à des mécanismes de rationnement, comment les penser et les gérer ? Peut-on dans certaines circonstances, grâce au marché, ne plus sentir peser la chape du rationnement ? Tel est l'objet de cet ouvrage qui traite de la question centrale en économie : l'accès et la répartition des biens rares.

Libault, D. (2019). Grand âge et autonomie : concertation. Paris Ministère chargé de la santé**:** 228.

> Ce rapport sur la prise en charge de la dépendance et le maintien de l'autonomie est issu des réflexions de dix groupes de travail thématiques et de cinq forums régionaux, mais aussi des résultats d'une vaste concertation de quatre mois. Alors que d'ici à 2050, la France comptera près de 5 millions de plus de 85 ans, contre 1,5 aujourd'hui, avec un doublement du nombre de personnes dépendantes, l'enjeu du vieillissement de la population et de la prise en charge de la dépendance fait partie des priorités du gouvernement. Ce rapport formule 175 propositions pour prévenir et prendre en charge la dépendance et favoriser l'autonomie et le maintien à domicile, avec notamment 10 propositions clés pour « passer de la gestion de la dépendance au soutien à l'autonomie » : créer un guichet unique pour les personnes âgées et les aidants dans chaque département, avec la mise en place des "Maisons des aînés et des aidants", copilotées entre le département et l'ARS, qui se substitueraient aux CLIC, MAIA, Paerpa, PTA et autres plates-formes de répit ; renforcer l'attractivité des métiers du grand âge qui peinent à recruter ; revaloriser l'aide à domicile (pour un coût de 550 millions d'euros) ; augmenter de 25% le taux d'encadrement en Ehpad d'ici 2024, soit 80 000 postes supplémentaires (1,2 milliard) ; rénover les maisons de retraite publiques devenues vétustes (3 milliards d'euros sur 10 ans) ; faciliter l'intégration entre domicile et Ehpad (300 millions); réduire le reste à charge mensuel de 300 euros en établissement pour les personnes modestes gagnant entre 1000 et 1600 euros par mois (création d'une « prestation autonomie » dégressive) pour un coût de 2,7 milliards ; indemniser le congé de proche aidant (53 euros par jour) par la Sécurité sociale avec une négociation obligatoire dans les branches professionnelles pour faciliter sa mise en place en entreprise ; lancer une mobilisation nationale pour la prévention de la perte d'autonomie et enfin, renforcer la mobilisation du service civique et du service universel pour rompre l'isolement des personnes âgées et favoriser les liens

intergénérationnels. Le coût annuel des 175 propositions du rapport « Grand âge et autonomie », par rapport à 2018, est estimé à 4,8 Md€ en 2024 et à 6,1 Md€ en 2030. Cumulée aux conséquences de l'évolution démographique, et nette des mesures d'économies proposées, la dépense publique globale consacrée à l'autonomie augmenterait, par rapport à 2018, de 6,2 Md€ en 2024 et de 9,2 Md€ en 2030, à rapporter aux 23,7 milliards actuels (départements et Sécurité sociale). Les pistes d'économie suggérées par la mission (1,2 milliard en 2030) portent notamment sur une prévention active de la perte d'autonomie, une coordination des acteurs forte, limitant les hospitalisations évitables, la mise en emploi de personnes en parcours d'insertion ou de demandeurs d'emploi. La mission compte aussi sur des gains d'efficience par une réorganisation de l'offre médico-sociale, une baisse de l'absentéisme et des dépenses d'indemnités journalières maladie, résultant des mesures en faveur des professionnels et des proches aidants. Concernant le financement, le rapport préconise de dégager un financement uniquement public reposant sur la solidarité nationale. Il pose les bases d'un cinquième risque de sécurité sociale. Le financement privé a une vocation complémentaire et facultative (en instaurant pour l'assurance dépendance le même dispositif du contrat responsable en vigueur dans la santé). Il recommande également la mobilisation de prélèvements obligatoires existants, plutôt que la création de nouveaux prélèvements, notamment en lien avec la fin de la dette sociale et la priorisation des dépenses publiques affectées au grand âge au sein de la protection sociale, autrement dit en arbitrant au sein des 720 milliards d'euros de dépenses annuelles allouées à la protection sociale en faisant des économies ailleurs. Un projet de loi devrait être prés

Malone, A. (2019). "Reste à charge après remboursement par l'assurance maladie obligatoire." Lettre Du College (La)(1): 5-7.

Cet article présente les positions de la Fédération hospitalière de France sur l'article 51 de la loi de financement de la sécurité sociale pour 2018 relatif à l'encadrement et au financement des innovations en santé.

Penneau, A., Pichetti, S. et Espagnacq, M. (2019). Dépenses et restes à charge sanitaires des personnes en situation de handicap avant et après 60 ans. Les rapports de l'Irdes ; 571. Paris IRDES**:** 165.
https://www.irdes.fr/recherche/rapports/571-depenses-de-sante-et-restes-a-charge-sanitaires-des-personnes-en-situation-de-handicap-avant-et-apres-60-ans.pdf

Les situations de handicap entraînent des coûts supplémentaires pour les ménages concernés. Les coûts sanitaires - soins médicaux et une partie des aides techniques - représentent l'un des principaux postes de dépense des personnes en situation de handicap. L'objectif de ce rapport est de dresser un état des lieux de la prise en charge sanitaire de ces personnes avant et après 60 ans. Deux populations se distinguent, les personnes handicapées reconnues inaptes au travail et les personnes ayant besoin d'aide pour réaliser les activités de la vie quotidienne.

Tenand, M. et Gramain, A. (2019). "Quels effets attendre de la réforme de l'APA à domicile de 2016 ?"
https://hal.archives-ouvertes.fr/hal-02149712/document

La loi relative à l'adaptation de la société au vieillissement (loi ASV), entrée en vigueur le 1er janvier 2016, comporte une réforme de l'allocation personnalisée d'autonomie (APA) pour les personnes dépendantes qui vivent à domicile. Cette réforme vise principalement à réduire le reste-à-charge supporté par les bénéficiaires de l'APA, en particulier les plus dépendants et ceux appartenant aux « classes moyennes ». Trois ans après l'adoption de la loi ASV, son impact sur les reste-à-charge à domicile n'a cependant été que peu documenté, faute de données individuelles permettant une évaluation ex post. Compte tenu des différentes modifications qui ont été apportées au barème de l'APA, quel impact la réforme peut-elle avoir sur le reste-à-charge supporté par les personnes âgées dépendantes à domicile ? Quelles catégories de bénéficiaires, en termes de revenu et de niveau de dépendance, devraient bénéficier le plus de cette réforme ? Cette note propose des éléments d'évaluation de la réforme de l'APA à partir de données sur la clientèle d'un service d'aide et d'accompagnement à domicile (SAAD). La simulation de la réforme sur cette population particulière permet d'illustrer les différents canaux par lesquels une modification de la prestation APA peut affecter le reste-à-charge des bénéficiaires.

2018

(2018). "L'Observatoire citoyen des restes à charge en santé : enquêter pour comprendre, sensibiliser, améliorer." Actualite Et Dossier En Sante Publique(102): 45-47.
https://www.hcsp.fr/explore.cgi/Adsp?clef=159

[BDSP. Notice produite par EHESP R0x9BH7t. Diffusion soumise à autorisation]. Pour les représentants des usagers, la priorité est de définir, de façon concertée, un cadre clair afin de réguler les tarifs : "prix limites de vente" des prothèses et des dispositifs médicaux, plafond pour des actes médicaux et dentaires, et forfaitisation systématique des tickets modérateurs à l'hôpital.

Carre, B. et Perronnin, M. (2018). Évolution de la dépense en part de complémentaire santé des bénéficiaires de la CMU-C : analyse et prévision. Paris Irdes**:** 82 , tabl., fig.
https://www.irdes.fr/recherche/rapports/569-evolution-de-la-depense-en-part-de-complementaire-sante-des-beneficiaires-de-la-cmu-c.pdf

Mise en place au 1er janvier 2000, la Couverture maladie universelle complémentaire (CMU-C) est gratuite et accessible sous conditions de ressources. Elle vise à lever les barrières financières à l'accès aux soins des plus pauvres, comme l'avance de frais et les restes à charge laissés par l'assurance maladie obligatoire. L'effectif des bénéficiaires de la CMU-C, stable entre 2000 et 2009, a fortement augmenté ensuite, passant de 4,15 millions en 2009 à 5,3 millions en 2015 et 5,6 millions au 31 juillet 2018, en raison d'une conjoncture économique défavorable et de la revalorisation en 2013 des seuils de ressources ouvrant droit au dispositif. Pour autant, les coûts moyens par bénéficiaire liés aux remboursements de la CMU-C, qui évoluaient à la hausse jusqu'en 2012, décroissent ensuite de façon persistante. Comment expliquer cette évolution ? Comprendre et prévoir la dynamique d'évolution de la dépense en part de complémentaire CMU-C sont les objectifs de cette étude. Ainsi, en s'appuyant sur une revue de littérature qui rappelle les spécificités et déterminants des dépenses de santé des bénéficiaires de la CMU-C, différentes hypothèses sont testées sur les causes de rupture dans l'évolution de cette dépense à partir de données micro-économiques : le Système national des données de santé (SNDS) des individus appartenant à l'échantillon-maître de l'Enquête santé et protection sociale (ESPS) et l'Échantillon généraliste de bénéficiaires (EGB). Les résultats montrent que ce sont les différences d'évolution entre la composition des bénéficiaires de la CMU-C - arrivée après 2013 de bénéficiaires ayant un plus faible recours aux soins - et celle de la population générale - dont le vieillissement est plus marqué - qui expliquent l'écart croissant entre ces deux populations. Enfin, un modèle de prévision est estimé sur données macro-économiques.

Charpy, C. R. (2018). La dépense moyenne par bénéficiaire de la couverture maladie universelle complémentaire. Les comptes de la sécurité sociale : résultats 2017, prévisions 2018 et 2019., Paris : Ministère chargé de la santé**:** 124-127, tab., graph., fig.

La couverture maladie universelle complémentaire (CMU-C) est un dispositif de prise en charge gratuite de la part complémentaire des dépenses de santé destiné aux personnes avec de faibles ressources (moins de 734 € par mois pour une personne seule). Les dépenses au titre de la CMU-C ont augmenté de 4% entre 2014 et 2017, passant de 2,1 Md€ à 2,2 Md€. Cette croissance résulte de deux évolutions en sens contraires : d'une part, le nombre de patients ayant été pris en charge au moins une fois par le dispositif a augmenté de 6% sur la période, passant de 5,6 millions à 5,9 millions ; d'autre part, la moyenne de la dépense par consommant couvert par la CMU-C a baissé de 3% durant la même période, de 362 € à 353 €, soit une diminution de près de 1% par an. Durant cette période, plusieurs facteurs ont tiré à la hausse les dépenses moyennes de CMU-C, comme le vieillissement de la population couverte et la prévalence en hausse des affections de longue durée parmi les bénéficiaires. Toutefois, ces facteurs haussiers ont été plus que compensés par des mécanismes jouant en sens contraire, tels que la diminution des prix des médicaments non innovants, et un moindre recours aux médicaments, aux soins des médecins généralistes, et aux séjours en hospitalisation complète.

Cornu, Pauchet, M., Gissot, C. et De Lagasnerie, G. (2018). "Quelle complémentarité entre AMO ET AMC ? Actes de la 13e Matinée thématique du 19 octobre 2017." Lette Du College (La)(2): 22 , tab., graph., fig.

La place de l'assurance privée dans le financement des dépenses de santé en France apparaît relativement élevée au regard des comparaisons internationales, et sur longue période, cette part a tendance à augmenter. Au-delà de cette place croissante, ce qui en fait sa singularité est sa nature : il s'agit pour l'essentiel d'une assurance dite complémentaire, c'est-à-dire qui intervient en complément des remboursements de la Sécurité sociale, pour prendre en charge les co-paiements laissés par le système public pour les consommations de soins à tarif réglementé et pour les dépenses excédant les tarifs de responsabilité quand les tarifs sont libres. Cette Lettre rassemble les communications données lors de la 13e Matinée thématique du 19 octobre 2017 du Collège des économistes de la santé. Elle dresse tout d'abord une état des lieux sur le partage entre l'AMO et l'AMC et sur les dynamiques actuelles ; puis s'interroge sur les solutions futures : ajustements à la marge ou réinterrogation du modèle.

Czenichow, P. et Com Ruelle, L. (2018). ""Reste à charge : entre souhaitable et possible. Editorial." Actualite Et Dossier En Sante Publique(102): 2-2.
www.hcsp.fr/explore.cgi/Adsp?clef=159

Définir un niveau de "reste à charge" pour les soins sur l'échiquier de notre système de santé, c'est positionner aujourd'hui en parallèle de multiples curseurs (financier privé, sanitaire, technique et social). Cet éditorial introduit un dossier spécial sur le reste à charge en santé en France avec quelques éclairages internationaux.

FNMF (2018). Santé, perte d'autonomie : impacts financiers du vieillissement. 2e édition de l'Observatoire Place de la santé. Paris FNMF**:** 36 , tab., graph., fig.
www.mutualite.fr/actualites/perte-dautonomie-des-restes-a-charge-trop-eleves/

La Mutualité Française consacre la 2e édition de son Observatoire au sujet des impacts financiers du vieillissement de la population. En France, la prise en charge de la perte d'autonomie coûte 30 milliards d'euros. Cette somme est financée à hauteur de 23,7 milliards d'euros par les pouvoirs publics et la solidarité nationale, tandis que 6,3 milliards d'euros sont à la charge des ménages. Comment se répartissent ces 30 milliards d'euros ? Les dépenses de santé représentent 12,2 milliards d'euros, dont 99% sont prises en charge par les financeurs publics, tout particulièrement l'assurance maladie. Les ménages règlent 2,4 milliards d'euros sur les 10,7 milliards consacrés directement à la perte d'autonomie, via l'allocation personnalisée d'autonomie (Apa), la prestation de compensation du handicap (PCH) ou encore l'allocation compensatrice pour tierce personne (ACTP).

Fonds CMU (2018). Rapport annuel sur l'aide au paiement d'une complémentaire santé. Bénéficiaires, prix et contenu des contrats ayant ouvert droit à l'aide. Paris Fonds CMU**:** 63 , tabl., fig.
http://www.cmu.fr/fichier-utilisateur/fichiers/2018-11-29_RapportAnnuel_ACS_2017_Internet.pdf

Le Fonds CMU-C rend compte annuellement au gouvernement de l'évolution du prix et du contenu des contrats ayant ouvert droit à l'aide au paiement d'une complémentaire santé (ACS). Le dispositif créé en 2005 a été réformé le 1er juillet 2015. Le gouvernement a souhaité faciliter l'accès à l'ACS au plus grand nombre par un processus de mise en concurrence visant à offrir une plus grande lisibilité des offres de complémentaire santé et de meilleures garanties à des prix plus bas. Désormais, seuls les contrats sélectionnés par l'État pour leur bon rapport qualité-prix peuvent bénéficier de l'ACS sur la base de trois garanties type : un contrat A d'entrée de gamme, un contrat B de niveau intermédiaire, un contrat C, de niveau supérieur. Alors que le gouvernement vient d'annoncer l'extension de la couverture CMU-C aux personnes éligibles à l'ACS à compter de novembre 2019 (dans le cadre du PLFSS), ce nouveau rapport du Fonds dresse un panorama complet du dispositif ACS, trois ans après la réforme de 2015. Ce panorama fait état de l'évolution du nombre de bénéficiaires (progression à un rythme annuel de 7 %, soit une augmentation de 25 % depuis la réforme), du taux de recours et du taux d'utilisation du chèque ACS (un chèque ACS sur cinq n'est pas utilisé). Depuis la mise en place de la réforme, le niveau de garantie des contrats souscrits par les bénéficiaires de l'ACS s'est amélioré significativement, alors que le prix moyen des contrats a baissé de 10 %. Le rapport apporte aussi un éclairage sur les dépenses de santé des bénéficiaires, sur leurs restes à charge en santé après intervention de l'assurance maladie obligatoire et complémentaire (environ 5 % de la dépense) et sur leurs restes à payer sur le prix du contrat (en moyenne, 62 % du prix des contrats est pris en charge par l'ACS). Si ce rapport fait, comme les années précédentes, un bilan positif de la réforme de 2015, il analyse également les difficultés qui demeurent pour l'accès aux soins des bénéficiaires de l'ACS et qui justifient la transformation à venir du dispositif

Fontaine, R. (2018). "Le financement de l'aide à l'autonomie : comment adapter notre système de protection sociale au défi du vieillissement ?" Recherche Sur Le Vieillissement(13): 1-3, fig.

Les dépenses d'aide à l'autonomie des personnes âgées représentaient au total près de 30 m milliards d'euros en 2014. Environ 79 % de ces dépenses sont aujourd'hui couvertes par des financements publics, le reste étant laissé à la charge des ménages confrontés à une situation de perte d'autonomie.

HCFEA (2018). Avis sur les notes « Contribution du Conseil de l'âge à la concertation Grand Age et autonomie. Paris HCFA**:** 6 + (11; 36; 65; 33).
http://www.hcfea.fr/spip.php?rubrique11

Dans cet avis, le Conseil de l'âge pose d'abord la question de l'unification des statuts des personnes âgées et des personnes en situation de handicap, et de la suppression de la barrière d'âge à 60 ans pour l'accès à la prestation de compensation du handicap (PCH). Si cette option est soutenue par une grande majorité des membres du Conseil dans la perspective de constitution d'un cinquième risque (note 1), les études disponibles ne permettent pas d'apprécier les conséquences d'un tel changement, susceptible d'engager des financements publics conséquents. Ils demandent que des études soient engagées sans délai de façon à être disponibles pour la préparation de la loi annoncée par le Président de la République pour 2019. Si la loi ne retenait pas cette option, le Conseil considère qu'elle devrait en tous les cas rapprocher sensiblement les statuts actuels des personnes âgées et des personnes en situation de handicap (note 2). Le Conseil souhaite une loi ambitieuse avec un socle de base minimum à atteindre au plus tard en 2024. Les priorités de ce socle sont définies dans un cadre conservateur, plus crédible à court terme (note 3) : consolider le maintien à domicile pour un effort financier d'environ 1,9 milliards d'euros et de revoir le statut des aidants. Une politique renforcée de soutien à domicile devrait faire baisser le taux d'institutionnalisation et répondre au souhait majoritaire des personnes de rester à domicile ; privilégier l'amélioration de la qualité des établissements (conditions de vie des résidents et conditions de travail et valorisation du personnel). Le Conseil juge qu'un accroissement des moyens de fonctionnement de l'ordre de 4 milliards d'euros à l'horizon 2024 est une référence pertinente de l'effort minimal à consentir ; diminuer les restes à charge dans les établissements. Si le Conseil évoque des schémas de réforme ambitieux comme la suppression de l'obligation alimentaire et du recours sur succession dans la gestion de l'aide sociale à l'hébergement (ASH), il envisage également des projets moins coûteux, notamment des schémas de bouclier protégeant les résidents qui vivent de longues années en établissement. Le Conseil estime qu'on doit faire un progrès significatif en prévoyant d'y affecter une enveloppe de 1 à 1,5 milliard d'euros. L'augmentation conséquente des dépenses publiques brutes proposée dans l'avis du Conseil de l'âge peut être partiellement compensée par une meilleure gestion des politiques de soutien à l'autonomie. Si bien que le solde net se situerait à un niveau sensiblement inférieur. Le Conseil analyse ensuite les recettes envisageables pour le financement de ces mesures et le calendrier de leur mise en place.

Jager, W. (2018). La santé en réseaux : qualité des soins, entreprise à mission et contrats dérogatoires. Paris Terra Nova**:** 389.
http://tnova.fr/notes/la-sante-en-reseaux-qualite-des-soins-entreprise-a-mission-et-contrats-derogatoires

> Dans notre pays, chaque patient peut choisir librement son professionnel de santé. Sans accès à une information de qualité, cette liberté risque cependant de se retourner contre son titulaire, d'être facteur de surcoûts, voire de risques. Comment allier autonomie des parties prenantes, qualité des soins, accès à l'information et maîtrise de la dépense ? Les « réseaux de soins » développés par les assureurs privés tentent de répondre à cette question en mettant des patients en relation avec des professionnels répertoriés. Ces réseaux de professionnels agréés ont vocation à proposer de meilleurs rapports qualité-prix aux assurés, à l'instar d'une centrale de référencement ou d'un courtier. L'adhésion des professionnels, établissements ou services à ces réseaux s'effectue sur la base de critères objectifs, transparents et non discriminatoires. En dépit des fortes résistances qu'ils rencontrent en particulier chez les opticiens, les audioprothésistes ou les chirurgiens-dentistes, cette note plaide pour une plus large reconnaissance des vertus et bénéfices des réseaux de soins. Elle propose également différentes pistes de réflexion pour permettre leur développement dans une plus grande sérénité. Enfin, au moment où les pouvoirs publics pourraient être tentés de les contourner dans le cadre de la réforme en faveur d'un « reste à charge zéro », elle recommande au contraire de s'appuyer sur leur expérience.

Jusot, F. et Perronnin, M. (2018). "Le reste à charge comme instrument de régulation des dépenses de santé." Actualite Et Dossier En Sante Publique(102): 19-23.

> Alors que le système d'assurance maladie français exige depuis sa création une participation financière des assurés aux coûts des soins médicaux, la suppression du reste à charge s'est retrouvée au cœur des débats lors des élections présidentielles de 2017, que ce soit au travers de la proposition de plusieurs candidats de créer une «Grande Sécu» prenant en charge l'intégralité du coût des soins, ou de la promesse du « reste à charge zéro» d'Emmanuel Macron, visant cette fois à une prise en charge complète de la partie des soins non financée par la Sécurité sociale par les organismes d'assurance complémentaires santé. Pourquoi notre système de Sécurité sociale a-t-il instauré dès son origine un ticket modérateur à hauteur de 20 % du coût de l'ensemble de soins (art. 24, ordonnance du 19 octobre 1945)? Et pourquoi vouloir supprimer aujourd'hui ce reste à charge, c'est-à-dire la part des dépenses de soins non prise en charge par le système d'assurance public ou par les assurances privées ? Pour répondre à ces questions, il est nécessaire de s'interroger sur les justifications économiques du reste à charge.

Ministère chargé de la Santé (2018). 100% santé. Des soins pour tous, 100 % pris en charge, Paris : Ministère chargé de la santé

> Donner à tous les Français un accès à des soins de qualité pris en charge à 100%, dans le domaine de l'optique, de l'audiologie et du dentaire constitue un des engagements du Président pendant la campagne. Après négociation avec les différents acteurs de la santé et professionnels des secteurs concernés, cette réforme majeure pour le quotidien des Français va pouvoir se mettre en place progressivement au cours des trois prochaines années. Les principes retenus sont les mêmes quel que soit le secteur concerné : il s'agit de proposer un ensemble de prestations de soins identifiées (panier) qui répond aux besoins de santé nécessaires –

Ministère chargé de la Santé (2018). Améliorer l'accès aux soins "Reste-à-charge zéro" : optique, audioprothèse, dentaire, Paris : Ministère chargé de la santé
http://solidarites-sante.gouv.fr/IMG/pdf/dp_rac0-2.pdf

> Les différents acteurs du système de santé (professionnels de santé, Assurance Maladie, organismes complémentaires, Haute Autorité de santé, usagers du système de soins)) présentent les objectifs du gouvernement, le calendrier ainsi que la méthode de travail pour réduire le renoncement aux soins et améliorer l'accès aux dispositifs médicaux dans le domaine de l'optique, du dentaire et des audioprothèses. On note, par exemple, que seules 30% des 6 millions de personnes malentendantes sont aujourd'hui appareillées ; l'objectif serait d'améliorer le taux d'équipement, avec un objectif à moyen terme entre 40 et 45 % de personnes appareillées. Le syndicat national des audioprothésistes a, quant à lui, proposé une amélioration de la prise en charge par une hausse de la base des

remboursements et suggère d'inscrire un plancher et un plafond de remboursement des audioprothèses dans les contrats responsables au sein des complémentaires.

Ministère chargé de la Santé (2018). Comparaisons internationales du reste à charge des ménages. Les dépenses de santé en 2017 : résultats des Comptes de la santé. Edition 2018., Paris : Ministère chargé de la Santé**:** 132-133.
https://drees.solidarites-sante.gouv.fr/

Penneau, A., Pichetti, S. et Espagnacq, M. (2018). "Le système de protection sociale limite les restes à charge liés aux soins des personnes qui recourent à l'aide humaine." Questions D'Economie de la Sante (Irdes)(233): 1-8.
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/233-le-systeme-de-protection-sociale-limite-les-restes-a-charge-lies-aux-soins-des-personnes-qui-recourent-a-l-aide-humaine.pdf

Les personnes qui recourent à l'aide humaine pour réaliser les activités du quotidien ont souvent des dépenses de santé élevées. Cette aide est en effet fréquemment associée à des pathologies nécessitant une prise en charge sanitaire lourde et à l'achat de dispositifs médicaux coûteux qui peuvent s'accompagner de restes à charge après remboursement par l'assurance maladie obligatoire importants. Pour autant, on ne connaît pas la capacité du système de protection sociale à limiter le niveau de reste à charge pour cette population. A partir des données de l'enquête Handicap Santé Ménages, les profils des personnes âgées de 20 ans et plus recourant à l'aide humaine et qui vivent à domicile sont analysés en termes de caractéristiques sociodémographiques, d'état de santé, de dépenses de santé, d'accès aux dispositifs de protection sociale et de restes à charge. Deux populations sont distinguées, les personnes âgées de plus ou de moins de 60 ans dont les caractéristiques et accès aux droits diffèrent. Les personnes âgées de plus de 20 ans sont 4,4 millions à recourir à cette aide, soit 9 % des plus de 20 ans, et leurs dépenses de santé croissent avec l'intensité de leur recours. Leur reste à charge est le double de celui de la population générale mais ne croît pas avec le degré de recours à l'aide humaine. Et si l'Assurance maladie parvient à lisser les restes à charge moyens liés aux dépenses de santé grâce aux exonérations du ticket modérateur, des restes à charge élevés persistent pour des personnes recourant à l'aide humaine avec des consommations de soins spécifiques tels les orthèses et prothèses ou les hospitalisations en psychiatrie.

Perronnin, M. (2018). "Pour quels soins et quels patients ? Iniquités des restes à charge selon la santé et le niveau de vie. Enseignements de travaux récents de l'Irdes." Actualite Et Dossier En Sante Publique(102): 24-35.
www.hcsp.fr/explore.cgi/Adsp?clef=159

[BDSP. Notice produite par EHESP 7qR0x9GG. Diffusion soumise à autorisation]. Les restes à charges sont inéquitablement répartis selon l'état de santé, le niveau de vie et le lieu de résidence. Des dispositifs existent pour les patients atteints de maladies chroniques ou les personnes à faible revenu, mais ils ne compensent pas la totalité des dépenses engagées.

Raymond, G. et et al. (2018). "Le reste à charge : définitions et comparaisons." Actualite Et Dossier En Sante Publique(102): 11-23.
https://www.hcsp.fr/explore.cgi/Adsp?clef=159

[BDSP. Notice produite par EHESP R0xlr9Cm. Diffusion soumise à autorisation]. Dès son origine, le système d'assurance maladie français a prévu une participation financière des assurés aux soins médicaux. Conçue comme un élément de régulation des dépenses de santé, la part directement à la charge des patients varie selon les pays : de 42% en Lettonie à 7% en France.

Revil, H. (2018). "Quelles conséquences ? Quelles prises en charge ?" Actualite Et Dossier En Sante Publique(102): 36-44.
https://www.hcsp.fr/explore.cgi/Adsp?clef=159

[BDSP. Notice produite par EHESP kR0xnHGk. Diffusion soumise à autorisation]. Les restes à charge peuvent induire des difficultés d'accès aux soins, voire des renoncements pour contraintes financières. Outre sanitaires, les conséquences peuvent être professionnelles et sociales.

Roussel, R., Heam, J.-C., et al., et al. (2018). Les dépenses de santé en 2017 : Résultats des comptes de la santé. Edition 2018. Panoramas de la DREES. Paris Drees**:** 224.
https://drees.solidarites-sante.gouv.fr/

[BDSP. Notice produite par MSSH-EHESP GnFDR0xj. Diffusion soumise à autorisation]. En 2017, la consommation de soins et de biens médicaux (CSBM) est évaluée à titre provisoire à 199,3 milliards d'euros. Sa croissance s'infléchit nettement à +1,3 % en 2017 (après 2,0% en 2016), du fait du fort ralentissement des soins hospitaliers. La France consacre au total 11,5 % de son PIB à la santé, soit 1,1 point de plus que la moyenne de l'Union Européenne à 15. La Sécurité sociale finance 77,8 % de la CSBM, et les organismes complémentaires 13,2 %. La part restant à la charge des ménages continue de reculer pour s'établir à 7, % en 2017. Les dépenses de santé en 2017 présentent également un dossier sur les dépenses de prévention sanitaire en France qui actualise, et complète, celui publié dans la même collection deux ans auparavant, ainsi qu'un dossier sur les principaux résultats du Baromètre d'opinion de la Drees sur l'accès aux soins et l'Assurance maladie.

2017

Celant, N. et Rochereau, T. (2017). L'Enquête santé européenne - Enquête santé et protection sociale (EHIS-ESPS) 2014. Les rapports de l'Irdes ; 566. Paris IRDES**:** 282 , tabl.
http://www.irdes.fr/recherche/rapports/566-enquete-sante-europeenne-ehis-enquete-sante-et-protection-sociale-esps-2014.pdf

Conduite par l'Irdes depuis 1988, l'Enquête santé protection sociale (ESPS) est un outil pluridisciplinaire qui explore les relations entre l'état de santé, l'accès aux services de santé, l'accès à l'assurance publique et privée et le statut économique et social des individus enquêtés. En 2014, en collaboration avec la Direction de la recherche, des études, de l'évaluation et des statistiques (Drees), l'enquête ESPS a été le support de l'Enquête santé européenne (European Health Interview Survey-EHIS) qui devient, pour la France, la seule enquête généraliste sur le sujet représentative en population générale. L'année 2014 constitue ainsi la dernière vague du terrain de l'enquête ESPS dont les données de consommation de soins seront collectées et appariées aux données de l'Assurance maladie jusqu'en 2016. Pour la vague 2019 et les suivantes, prévues tous les six ans, la version française d'EHIS intégrera, en plus des questions européennes inscrites dans un règlement Eurostat, des questions spécifiques à la France sur la couverture complémentaire santé. En 2014, ESPS est représentative d'environ 95 % de la population vivant en ménage ordinaire en France. Selon les résultats de l'enquête, près d'une personne sur trois âgée de 15 ans ou plus déclare un état de santé assez bon, mauvais ou très mauvais. Près de 40 % évoquent un problème de santé chronique et un quart une limitation dans les activités du quotidien. Les catégories sociales les plus défavorisées déclarent globalement être en moins bonne santé que les autres. Environ 9 % des femmes et 5 % des hommes souffrent de symptômes dépressifs, ce qui place la France au huitième rang des 26 pays pour lesquels ces données sont disponibles. Concernant la couverture complémentaire santé, près de 5 % des personnes déclarent ne pas en avoir. L'absence de complémentaire santé concerne avant tout les populations les plus précaires, comme les personnes au chômage et celles disposant de faibles revenus. Malgré des dispositifs d'aide existants (Couverture maladie universelle complémentaire (CMU-C) et Aide au paiement d'une complémentaire santé (ACS)), le premier motif de non-recours demeure le coût trop élevé des contrats.

Cnam (2017). Rapport sur les charges et produits de l'assurance maladie pour 2018 : Améliorer la qualité du système de santé et maîtriser les dépenses : propositions de l'Assurance Maladie pour 2018. Paris Cnamts**:** 206 , tabl.

https://www.ameli.fr/l-assurance-maladie/statistiques-et-publications/rapports-et-periodiques/rapports-charges-produits-de-l-assurance-maladie/index.php

Chaque année, l'Assurance Maladie présente au Gouvernement et au Parlement ses propositions relatives à l'évolution des charges et produits au titre de l'année suivante et aux mesures nécessaires pour atteindre l'équilibre prévu par le cadrage financier pluriannuel des dépenses d'assurance maladie. À partir d'analyses réalisées sur l'évolution des dépenses et des pratiques, et en s'appuyant sur les recommandations françaises et internationales, le rapport Charges et produits pour l'année 2018 présente des propositions et des pistes de réflexion visant à améliorer la qualité et l'efficience des soins, et à optimiser les dépenses de santé.

Drees (2017). "En 2016, les dépenses de santé retrouvent leur dynamisme." Etudes et Resultats (Drees)(1024): 4.
https://drees.solidarites-sante.gouv.fr/

[BDSP. Notice produite par MIN-SANTE E8JAoR0x. Diffusion soumise à autorisation]. La consommation de soins et de biens médicaux (CSBM) progresse en valeur de 2,3% en 2016, contre 1,5% un an plus tôt, pour atteindre 198,5 milliards d'euros. Après un léger ralentissement en 2015, la CSBM croît à nouveau à un rythme proche de celui des années précédentes. Cette croissance est principalement portée par les soins hospitaliers, les soins de ville, notamment les auxiliaires médicaux et les médecins, et les autres biens médicaux. Les prix continuent de reculer : - 0,6% en 2016.

Drees (2017). Les dépenses de santé en 2016 : résultats des Comptes de la santé. Edition 2017. Panorama de la Drees Santé. Paris Ministère chargé de la Santé**:** 213, tab., graph., fig.
https://drees.solidarites-sante.gouv.fr/

Élaborés par la DREES, les comptes de la santé constituent l'un des satellites des comptes nationaux de l'INSEE, dont ils adoptent la méthodologie. Ils servent également de base à l'élaboration des comptes de la santé présentés dans les instances internationales (système SHA de l'OCDE, d'Eurostat et de l'OMS) et permettent ainsi d'établir des comparaisons internationales sur des bases fiables et harmonisées. Cet ouvrage est composé d'une vue d'ensemble, synthétisant les éléments marquants de 2016, et de trois chapitres de fiches. Le premier traite de la consommation de soins et de biens médicaux (CSBM), qu'il examine en détail pour chaque volet de dépense et de son financement. Le deuxième est centré sur l'agrégat comptable le plus englobant du système de soins, la dépense courante de santé (DCS), sur les acteurs associés et l'opinion des ménages en matière de santé. Enfin, le dernier est consacré aux comparaisons internationales des dépenses de santé et du reste à charge des ménages. Cet ouvrage comprend également un éclairage consacré aux indices de prix de la santé.

Fonds CMU (2017). Rapport annuel sur l'aide au paiement d'une complémentaire santé. Bénéficiaires, prix et contenu des contrats ayant ouvert droit à l'aide. Paris Fonds CMU**:** 68, tabl., fig.
http://www.cmu.fr/fichier-utilisateur/fichiers/Rapport_ACS_2016-2017.pdf

Le gouvernement a réformé le dispositif d'aide au paiement d'une complémentaire santé (ACS) afin d'en faciliter l'accès au plus grand nombre par un processus de mise en concurrence visant à offrir une plus grande lisibilité des offres de contrats et de meilleures garanties à des prix plus bas. Alors que l'étude précédente dressait un premier bilan positif de la réforme, le présent rapport confirme ce constat après deux ans de mise en œuvre. Il apporte aussi de nombreux éléments inédits sur les dépenses de santé des bénéficiaires et leurs restes à charge, qui constituent des enseignements précieux pour la préparation de la prochaine mise en concurrence des contrats ACS.

Jusot, F., Legal, R., Louvel, A., et al. (2017). "Assurance maladie et complémentaires santé : comment contribuent-elles à la solidarité entre hauts et bas revenus ?" Questions D'Economie de la Sante (Irdes)(225): 1-6.
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/225-assurance-maladie-et-complementaires-sante.pdf

La solidarité assurée par un système d'assurance maladie provient des transferts qu'il opère entre individus de classes de revenus différentes. Cette solidarité dépend des structures de consommations de soins et de cotisations à l'assurance maladie par niveau de vie. La solidarité du système français relève essentiellement du financement progressif de l'assurance maladie obligatoire : les plus aisés contribuent plus que les plus pauvres. Mais en dépit de fortes inégalités sociales de santé, qui impliquent des besoins de soins plus importants chez les plus pauvres, les prestations sont relativement homogènes entre classes de revenus. Elles n'augmentent donc que très faiblement la solidarité du système en raison des barrières à l'accès à certains soins. Au contraire de l'assurance maladie obligatoire, l'assurance maladie complémentaire et les restes à charge induisent très peu de transferts entre groupes de revenu. La mixité du système d'assurance maladie français est donc également un facteur limitant de sa solidarité entre classes de revenus.

Lafon, A. et Louvel, A., Montaut, A. (2017). "La place de l'assurance maladie privée dans six pays européens - La France, l'Allemagne, l'Espagne, les Pays-Bas, le Royaume-Uni et la Suisse." Dossiers De La Drees (Les)(19): 32 , tab., graph., fig.
https://drees.solidarites-sante.gouv.fr/

Ce dossier décrit la place des organismes privés d'assurance maladie en Europe, à travers l'exemple de six pays. Au sein de ces pays existe une couverture de base et obligatoire instaurée par les pouvoirs publics. Toutefois, en Suisse, aux Pays-Bas et dans une moindre mesure en Allemagne, la gestion de cette couverture de base est confiée aux assureurs privés, mis en concurrence. Dans l'ensemble des pays étudiés, des organismes privés proposent aussi en sus une offre d'assurance maladie facultative qui vient améliorer la couverture de base. À l'exception de la France, les marchés de l'assurance privée sont principalement le fait d'un nombre réduit d'acteurs. Ces marchés sont généralement en phase de concentration, en raison notamment des évolutions de la réglementation européenne. Des organismes d'assurances à but lucratif y exercent à côté d'autres organismes à but non lucratifs, parfois appelés « mutuelles ». La couverture de base, lorsqu'elle est gérée par des assureurs privés, est très contrainte par les pouvoirs publics. La couverture facultative d'assurance maladie, en revanche, l'est très peu, sauf en France. Autres évolutions notables du secteur, les contrats collectifs gagnent du terrain dans plusieurs pays de même que la contractualisation entre assureurs privés et fournisseurs de soins, via l'émergence de réseaux de soins.

Legal, R., Louvel, A., Pollak, C., et al. (2017). "Assurance maladie et complémentaires santé : comment contribuent-elles à la solidarité entre hauts et bas revenus ?" Etudes et Resultats (Drees)(1005): 6.
https://drees.solidarites-sante.gouv.fr/

[BDSP. Notice produite par MIN-SANTE R0xm8sA8. Diffusion soumise à autorisation]. La solidarité du système français relève essentiellement du financement progressif de l'assurance maladie obligatoire : les plus aisés contribuent plus que les plus pauvres. Mais, en dépit de fortes inégalités sociales de santé qui impliquent des besoins de soins plus importants chez les plus pauvres, les prestations sont relativement homogènes entre classes de revenus. Elles n'augmentent donc que très faiblement la solidarité du système, en partie en raison des barrières à l'accès à certains soins. Au contraire de l'assurance maladie obligatoire, l'assurance maladie complémentaire et les restes à charges induisent très peu de transferts entre groupes de revenus. La mixité du système d'assurance maladie français est donc également un facteur limitant de sa solidarité entre classes de revenus.

Soual, H. (2017). "Les dépenses de santé depuis 1950." Etudes et Resultats (Drees)(1017): 6.
https://drees.solidarites-sante.gouv.fr/

[BDSP. Notice produite par MIN-SANTE nR0xAHmo. Diffusion soumise à autorisation]. La part de la Sécurité sociale dans le financement des dépenses de santé a crû fortement jusqu'à atteindre un pic en 1980. Symétriquement, la participation financière des ménages et celle des administrations centrales et locales ont diminué jusqu'au début des années 1980, tandis que le développement des organismes complémentaires s'est amorcé dès les années 1970. La part de la CSBM financée par la

Sécurité sociale, proche de 77% en 2015, est globalement stable depuis 1990. Entre 1990 et 2015, les organismes complémentaires (mutuelles, sociétés d'assurances et institutions de prévoyance) ont vu leur prise en charge s'accroître, notamment sur les biens médicaux et les soins de ville.

Unsaf (2017). Déficit auditif en France : livre blanc. Paris UNSAF**:** 70 , tab., graph., fig.
www.unsaf.org/doc/Deficits_auditifs_en_France_-_Livre_blanc_-_Mars_2017.pdf

Ce livre blanc dresse le bilan du secteur de l'audioprothèse. Il présente tout d'abord par un panorama statistique du déficit auditif en France : étiologie, épidémiologie et conséquences. Il s'intéresse ensuite aue parcours vécu du déficit auditif et de la place et rôle de l'audioprothésiste dans le parcours de soins. Enfin, il aborde les aspects économique : reste à charge et couverture maladie et compare la situation française à d'autres pays européens.

Yeni, I., Eslous, L., Simon-Delavelle, F., et al. (2017). "Le remboursement des frais dentaires." Seve : Les Tribunes De La Sante(57): 63-70, tabl.

Bien que les soins dentaires soient des soins médicaux, leur prise en charge par la sécurité sociale reste à l'écart des principes de cette dernière. Les patients financent 63% de la dépense totale de soins dentaires à travers de ce qui reste leur charge ou leur cotisation à une complémentaire. Il en sont les premiers financeurs. Du fait du renoncement aux soins, dû notamment aux dépassements d'honoraires perçus par les chirurgiens-dentistes, cette charge réagit sur l'état de santé bucco-dentaire. Ces conditions de prise en charge sont antiredistributives et favorisent les inégalités territoriales et sociales. Elles sont en outre inefficaces au regard de la santé publique puisque l'état de santé bucco-dentaire en France est considéré comme médiocre. Ainsi, serait-il souhaitable que les soins bucco-dentaires bénéficient, comme les soins médicaux, à nouveau du régime de droit commun de la sécurité sociale contre le risque maladie pour qu'un meilleur état de santé bucco-dentaire de la population puisse concourir à l'amélioration de l'état de santé général (résumé de l'éditeur).

Voir aussi :

Selon une étude du cabinet de conseil Actense, les restes à charge explosent à l'hôpital

L'étude d"Actence porte sur les remboursements de 10 contrats de complémentaire santé couvrant 60 000 personnes mis en conformité le 1er janvier 2016. Les résultats montrent que l'immense majorité des interventions chirurgicales remboursées génèrent un RAC compris entre quelques centaines d'euros et plus de 1 000 € par acte. Cette hausse s'explique par le faible nombre de signature de contrats d'accès aux soins (CAS). Toutefois, il est à noter que ces RAC sont concentrés sur un nombre très limité de salarié.
> Protection Sociale Informations, 26 avril 2017

2016

Beffy, M., et al. (2016). Les dépenses de santé en 2015 : résultats des Comptes de la santé. Edition 2016. Panorama de la Drees Santé. Paris Ministère chargé de la Santé**:** 213, tab., graph., fig.
https://drees.solidarites-sante.gouv.fr/

En 2015, la consommation de soins et de biens médicaux (CSBM) est de 194,6 milliards d'euros. Elle progresse de 1,8 %, soit légèrement moins rapidement que le PIB en valeur (+1,9 %), contrairement à la période 2012-2014 où sa croissance était supérieure à celle du PIB. La France consacre, au total, 11 % de son PIB à la santé, tout comme la Suède, l'Allemagne et les Pays-Bas. La Sécurité sociale finance plus des trois quarts de la CSBM et les organismes complémentaires 13,3 %. La part restant à la charge des ménages recule pour la quatrième année consécutive et atteint 8,4 % en 2015. Les ménages consacrent ainsi un peu moins de 250 euros par habitant à leur consommation de santé, soit moins que la plupart de leurs voisins européens. Les dépenses de santé en 2015 – édition 2016 présentent également un éclairage sur les dépenses de prévention sanitaire, qui représenteraient plus de 4,8 % de la CSBM, en 2014.

Cour des Comptes (2016). La participation des assurés au financement de leurs dépenses de santé : une charge croissante, une protection maladie à redéfinir. Sécurité sociale : Rapport 2016 sur l'application des lois de financement de la Sécurité sociale., Paris : Cour des Comptes**:** 155-203., tabl., fig.
https://www.ccomptes.fr › files › 20160920-rapport-securite-sociale-2016

La Cour a constaté que si la part globale de financement des dépenses de santé par l'assurance maladie, après avoir diminué avant 2012, revenait depuis lors vers le niveau qui était le sien à la fin des années 1990, ce retour, en grande partie lié à l'effet de structure induit par la progression rapide des effectifs de patients en affection de longue durée, s'était accompagné d'une érosion progressive des niveaux individuels de prise en charge des autres dépenses de santé (I). Elle a aussi examiné les modalités d'intervention des organismes complémentaires, qui jouent un rôle progressivement croissant dans le financement des restes à charge après intervention de l'assurance maladie, en constatant qu'elles s'accompagnaient de coûts élevés pour les assurés comme pour la collectivité et d'inégalités dans les niveaux de prise en charge des dépenses de santé entre assurés (II). Devant le double constat, sur longue période, d'une dégradation des conditions de prise en charge par l'assurance maladie et d'un report croissant et coûteux vers les organismes complémentaires, un réexamen d'ensemble des modalités de couverture des dépenses de santé apparaît nécessaire (III) (tiré de l'intro).

Cour des Comptes (2016). La prise en charge des affections de longue durée : une dynamique non maîtrisée, une gestion médicalisée de la dépense à mettre en oeuvre. Sécurité sociale : Rapport 2016 sur l'application des lois de financement de la Sécurité sociale., Paris : Cour des Comptes**:** 207-244., tabl.,

Ce chapitre analyse les causes de ces évolutions et à apprécier la cohérence de ce dispositif dans un contexte qui s'est ainsi profondément transformé depuis son instauration sans que ses objectifs n'aient été redéfinis. Elle a constaté que le dispositif des affections de longue durée connaît une forte dynamique et représente une part prépondérante et croissante des dépenses d'assurance-maladie (I). Pour autant, les facteurs de ces évolutions sont encore insuffisamment analysés et les modalités de régulation des dépenses présentent des faiblesses persistantes (II). Mieux maîtriser ces dépenses appelle une gestion médicalisée plus construite, qui s'appuie en particulier sur une modernisation des modes de tarification et de rémunération des prises en charge des patients en affection de longue durée (III) (tiré de l'intro).

Cour des Comptes (2016). Les soins bucco-dentaires : une action publique à restaurer, une prise en charge à refonder. Sécurité sociale : Rapport 2016 sur l'application des lois de financement de la Sécurité
https://www.ccomptes.fr/fr/publications/securite-sociale-2016

La prise en charge des soins bucco-dentaires par l'assurance maladie continue à se dégrader, non sans conséquences fortes en termes d'accès aux soins et de situation sanitaire d'une partie de la population (I). Les acteurs publics demeurent en effet dans une relation de faiblesse avec les professionnels (II). L'organisation des soins bucco-dentaires et leurs modalités de financement doivent ainsi être repensées en profondeur (III). (tiré de l'intro).

Drees (2016). Dépenses de santé : une nouvelle baisse des restes en charge des ménages en 2015. Etudes & Résultats (Drees)(971) : 1-4
https://drees.solidarites-sante.gouv.fr/

En 2015, la consommation de soins et de biens médicaux (CSBM) est évaluée à 194,6 milliards d'euros, soit 8,9 % du PIB. Cette part est stable entre 2014 et 2015 (-0,04 point) alors qu'elle progressait depuis 2012. Le rythme de croissance de la CSBM, inférieur à 3,0 % depuis 2010, est moins dynamique en 2015 (+1,8 %, après +2,7 % en 2014). La CSBM est financée à 76,8 % par la Sécurité sociale. La hausse de ce taux de prise en charge (+0,2 point par rapport à 2014) est à rapprocher du dynamisme des postes de dépenses les mieux remboursés par la Sécurité sociale et de la progression du nombre d'assurés exonérés du ticket modérateur. À l'inverse, la part des organismes complémentaires, qui représente 13,3 % de la CSBM en 2015, diminue légèrement pour la deuxième année consécutive (-0,3 point sur deux ans). La part du reste à charge des ménages dans la CSBM diminue pour la quatrième année consécutive (-0,8 point sur quatre ans) pour s'établir à 8,4 % en 2015. Au sein de l'Union européenne des 15, la France est le pays où le reste à charge des ménages est le plus limité. Le montant dévolu à la prévention sanitaire est évalué à 15,1 milliards d'euros pour l'exercice 2014.

Franc, C. et Pierre, A. (2016). "Restes à charge élevés : profils d'assurés et persistance dans le temps." Questions D'Economie de la Sante (Irdes)(217): 1-6
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/217-restes-a-charge-eleves-profils-assures-et-persistance-dans-le-temps.pdf

En France, les restes à charge des assurés après remboursements de l'Assurance maladie obligatoire représentent en moyenne un quart de la dépense de santé. Ils peuvent cependant s'avérer très élevés pour certains individus et constituer une véritable barrière à l'accès aux soins, a fortiori s'ils se répètent dans le temps. A partir de l'Enquête santé et protection sociale (ESPS) appariée aux données de consommations de soins sont construits, à l'aide d'une typologie, les profils des 10 % d'individus qui supportent les restes à charge les plus élevés en 2010. Quatre profils sont identifiés en fonction des divers postes de soins consommés, puis décrits selon leurs caractéristiques socio-économiques et leur état de santé. Un premier profil concerne des patients principalement traités en ambulatoire pour des maladies chroniques ; un second regroupe les individus plutôt précaires et hospitalisés dans un établissement public ; un troisième concerne majoritairement des actifs consommant des soins dentaires et un quatrième profil rassemble plutôt des seniors non hospitalisés. Les résultats montrent enfin que les individus appartenant au premier profil ont le plus de risques de supporter des restes à charges élevés en 2012.

Grangier, J. et Guibert, G. (2016). Une estimation partielle des dépenses de prévention sanitaire. Les dépenses de santé en 2015 : résultats des Comptes de la santé. Edition 2016., Paris : Ministère chargé de la Santé**:** 10 , tab., graph., fig.
https://drees.solidarites-sante.gouv.fr/

Les comptes de la santé comptabilisent chaque année la prévention dite « institutionnelle » dans la dépense courante de santé (DCS). Celle-ci est financée ou organisée par des fonds et des programmes de prévention nationaux ou départementaux et ne représente qu'une partie des dépenses de santé à visée préventive. Les autres actes de prévention sanitaire financés par l'assurance maladie et les ménages, comme ceux effectués par les médecins traitants lors de consultations médicales ordinaires, sont intégrés dans la consommation de soins et de biens médicaux (CSBM), avec la consommation de soins de médecins généralistes, mais n'y sont pas distingués. La prise en charge des facteurs de risque (prise en charge de la dépendance alcoolique, sevrage tabagique, traitement médicamenteux et suivi de l'hypertension artérielle…) n'est pas non plus comptabilisée dans la prévention institutionnelle ; les soins concernés sont en revanche inclus dans la CSBM. Par exemple, les patchs anti-tabac font partie de la consommation de médicaments et les conseils du médecin pour arrêter de fumer sont comptabilisés dans la consommation de soins de médecins généralistes. Parvenir à cartographier l'ensemble des dépenses de prévention sanitaire suppose donc d'identifier, d'isoler et de comptabiliser également les soins préventifs disséminés au sein de la CSBM. Une telle estimation est délicate, pour deux raisons : • d'une part, elle doit s'appuyer sur une définition précise de la prévention, dont la délimitation peut être discutable ; • d'autre part, les informations disponibles au sein du système d'information ne sont pas toujours suffisantes pour identifier finement ces actions de prévention. En 2016, un groupe de travail, piloté par la DREES et la DGS, a été mis en place afin d'améliorer la méthodologie utilisée pour estimer les dépenses de prévention (encadré 1). Dans l'attente des conclusions de ce groupe, le champ retenu pour la prévention et la méthodologie adoptée ici sont issues des travaux de l'IRDES de 2008.

Hege, R. (2016). La demande d'aide à domicile est-elle sensible au reste-à-charge : une analyse multi-niveaux sur données françaises. CES Working Paper; 2016.22. Paris Centre d'économie de la Sorbonne**:** 34 , tabl.
https://ideas.repec.org/p/mse/cesdoc/16022.html

This article focuses on the price-elasticity of demand for formal home-care received by disabled elderly. In France a public financing system of long-term care for disabled elderly – aged 60 and over – called APA (Allocation Personnalisée d'Autonomie) has been set up in 2001. This policy is based on a partial subsidization of demand for formal home-care so that an out-of-pocket cost remains. It rests on three variables: the department policy, the provider chosen by the recipient and the income level of the recipient. The induced heterogeneity of the out-of-pocket cost allows price-elasticity estimations but compels me to employ two databases. I use the HSM survey – an individual database on disability and health that is representative of the French population – and the Territoire survey which provides information in each region on the APA policy parameters. The combination of these two databases enables me to approximate the out-of-pocket cost for each individual that is the one-hour formal home-care price. I estimate a multi-level model with random effects and find that the price-elasticity of demand for formal home-care has a value of -0.15 at my average point

Legendre, B. et Le, Duguet, S. (2016). Retraite et vulnérabilité aux dépenses de santé. Noisy-le-Grand IRES**:** 66, tabl., fig.

Ce projet de recherche propose d'évaluer l'impact du passage à la retraite sur la vulnérabilité des ménages français face au poids que représentent les dépenses de santé dans leur budget. Les ménages connaissent en effet lors de leur passage à la retraite une rupture de couverture complémentaire qui a un impact direct sur le montant de leurs dépenses de santé. Nous caractériserons la vulnérabilité et mobiliserons les données de l'enquête européenne SHARE pour la mesurer. Une analyse toutes choses égales par ailleurs nous permettra d'analyser l'impact du départ en retraite et d'un certain nombre d'autres déterminants sur cette vulnérabilité. Notre contribution sera double et répondra à de grands enjeux économiques et sociaux actuels. Elle permettra de questionner le caractère équitable du système d'assurance maladie dans sa forme actuelle, et de proposer des orientations de politiques publiques en matière de financement de la santé, dans un contexte où la nécessité de réformer le système de protection sociale pour assurer sa soutenabilité financière ne fait plus débat.

Paris, V. et Polton, D. (2016). "L'articulation entre assurance maladie obligatoire et complémentaire, une spécificité française ?" Regards(49): 69-79.

L'analyse comparative des dépenses de santé menée par l'OCDE depuis de nombreuses années montre que coexistent dans tous les pays, à des degrés divers, des financements publics (qu'ils soient apportés dans le cadre d'assurances sociales ou de systèmes nationaux de santé financés par l'impôt), des dépenses payées directement par les patients et des financements par des assurances privées. Cette intervention combinée de couvertures publiques et privées s'opère-telle selon le schéma que nous connaissons en France, retrouve-t-on le même modèle dans d'autres pays ? Ou au contraire, cette configuration est-elle assez spécifique à notre système de santé ? Un examen approfondi montre que la situation de la France est effectivement particulière, tant par le niveau d'intervention de l'assurance privée que par le rôle qu'elle joue dans le système. Dès lors on peut s'interroger sur les avantages et les inconvénients d'un tel schéma de financement, au regard d'autres modèles possibles que l'on trouve chez nos voisins. La question se pose également, dans un contexte général de tension sur les finances publiques, de la dynamique d'évolution de ces différents modèles.

Perronnin, M. (2016). "Restes à charge publics en ville et à l'hôpital : des taux d'effort inégalement répartis." Questions D'Economie de la Sante (Irdes)(218): 1-8.
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/218-restes-a-charge-publics-en-ville-et-a-l-hopital.pdf

Le système public d'Assurance maladie obligatoire français se caractérise par des restes à charge sur la plupart des soins qu'il couvre, soit près d'un quart de la Consommation de soins et de biens médicaux (CSBM) en 2015 (Beffy et al., 2016). Ces restes à charge publics sont payés par une assurance maladie complémentaire privée ou par les ménages. Ils sont composés d'une superposition de participations financières introduites au fil du temps : tickets modérateurs, forfaits journaliers, participations forfaitaires, dépassements d'honoraires… Ces participations financières varient en fonction du type de soins consommés, peuvent être élevées et constituer un frein à l'accès aux soins des plus démunis. Dans cette étude, chaque participation financière est étudiée selon sa contribution aux inégalités de restes à charge en fonction du revenu et en distinguant soins de ville et soins hospitaliers de court séjour. Les participations financières à l'hôpital, ticket modérateur et forfait journalier, apparaissent les plus inéquitables. Elles sont en général prises en charge intégralement par les assurances complémentaires, mais 5 % de personnes restent non couvertes par une telle assurance et donc exposées à l'intégralité des restes à charge.

Santéclair (2016). Les frais cachés des affections longue durée (ALD), Paris : CISS Boulogne-Billancourt : Santéclair

Malgré le dispositif de prise en charge à 100 % de la sécurité sociale, des frais substantiels restent à la charge des patients en ALD. C'est ce sur quoi porte cette enquête de l'Observatoire citoyen des restes-à-charge en santé, qui s'est ici associé au cabinet Cemka Eval afin d'étudier les chiffres issus des bases de données de l'Assurance maladie et plus spécifiquement de l'échantillon généraliste des bénéficiaires. L'Observatoire a également fait appel à des témoignages d'usagers du système de santé recueillis par des associations de patients : Aides, la Fédération française des diabétiques, la Ligue contre le cancer, La Note rose et Renaloo. Cette étude a donc pour objet d'aider à comprendre en quoi consistent le restes-à-charge, le type de frais de santé qui les composent en particulier pour les personnes en ALD, afin de permettre aux personnes de mettre en place la meilleure stratégie pour les contenir au maximum notamment en ayant le plus d'éléments en main pour faire intervenir de la façon la plus pertinente une éventuelle assurance complémentaire santé.

2015

Batifoulier, P. (2015). "Aux origines de la privatisation du financement du soin : quand la théorie de l'aléa moral rencontre le capitalisme sanitaire." Revue De La Regulation(17).
http://regulation.revues.org/11063

La privatisation de la santé en Europe se traduit par le retrait de l'assurance santé publique, l'essor de l'assurance privée, le durcissement des mécanismes de partage des coûts avec les patients et l'accroissement des dépenses directes des ménages. Cet article analyse le processus de légitimation de cette privatisation qui s'appuie sur une représentation de la couverture maladie réduite à un problème d'incitation financière. Elle s'érige en convention sous l'effet de la convergence de la théorie économique mainstream et des intérêts du capitalisme sanitaire. Elle s'appuie sur la forte influence politique de la théorie orthodoxe de l'aléa moral en santé selon lequel faire payer le patient et réduire sa couverture n'a pas d'effet sur son état de santé. On montre que cette conception, qui nourrit le développement du marché, est faussement scientifique et dangereuse : elle accroît les inégalités tout en activant de nouvelles dépenses publiques et encourage la sécession sociale.

Bouvet, M. et Soual, H. (2015). Les dépenses de santé en 2014 : résultats des Comptes de la santé. Edition 2015. Collection Etudes et Statistiques. Paris Ministère chargé de la Santé**:** 247, tab., graph., fig.
https://drees.solidarites-sante.gouv.fr/

Les Comptes de la santé fournissent une estimation de la consommation finale de soins de santé et des financements correspondants, qu'ils relèvent de l'Assurance maladie, de l'État, des collectivités locales, des organismes complémentaires ou directement des ménages. Ils constituent un des comptes satellites des Comptes nationaux, dont ils adoptent la méthodologie. Les données de ce rapport correspondent aux données provisoires de l'année 2014, aux données semi-définitives de l'année 2013 et aux données définitives des années 2006 à 2012. Ils servent de base à l'élaboration des Comptes de la santé présentés dans les instances internationales (système SHA de l'OCDE, d'Eurostat et de l'OMS) et permettent ainsi d'établir des comparaisons internationales. En 2014, la consommation de soins et de biens médicaux s'élève à 190,6 milliards d'euros, soit près de 2 900 euros par habitant. Son rythme de croissance reste inférieur à 3 % depuis 2010. Les ménages supportent 8,5 % des dépenses de santé en 2014. Ce reste à charge baisse de 0,2 point par an depuis 2011. La prise en charge par les organismes complémentaires diminue légèrement en 2014 ; elle représente 13,5 % des dépenses de santé. En revanche, la part de la Sécurité sociale augmente et atteint 76,6 % en 2014. En France, la dépense courante de santé au sens international représente 10,9 % du PIB en 2013, dernière année disponible en comparaison internationale. La France est l'un des pays de l'OCDE où la prise en charge des dépenses de santé par les fonds publics est la plus importante et où le reste à charge des ménages est le plus limité.

Caby, D. et Eidelman, A. (2015). "Quel avenir pour le dispositif de prise en charge des affections de longue durée (ALD) ?" Lettre Tresor Eco(145): 8 , tabl., fig.

Face aux coûts que représente le dispositif de prise en charge des affections de longue durée, cette étude propose une réforme systémique de ce système en régulant la dépense publique et le reste à charge à partir de paramètres à définir (montant du plafond de restes à charge, niveau d'une éventuelle franchise, valeurs des tickets modérateurs...).Selon les auteurs, la prise en charge de la dépense de santé par l'assurance maladie obligatoire à partir de critères économiques rétablirait ainsi l'équité entre les malades, indépendamment de leur pathologie, tout en leur évitant des restes à charges trop élevés.

CISS (2015). Les dépassements d'honoraires des médecins toujours à la hausse, Paris : CISS Boulogne-Billancourt : Santéclair

Cohen, L. (2015). Proposition de loi de Mme Laurence COHEN et plusieurs de ses collègues, visant à supprimer les franchises médicales et participations forfaitaires. Paris Sénat**:** 32.
http://www.senat.fr/rap/l14-320/l14-3201.pdf

Le système de santé français repose sur deux piliers : permettre l'accès de tous aux soins et asseoir le financement sur la solidarité entre bien portants et malades. Or l'une des limites à l'accès aux soins est leur coût. Particulièrement visible pour l'appareillage optique ou les soins dentaires, pour lesquels le taux de prise en charge par l'assurance maladie est faible, elle existe également, sous forme de renoncement ou de retard, pour les soins courants. Préserver l'équilibre financier de la sécurité sociale constitue un objectif de valeur constitutionnelle et il importe donc de trouver des ressources correspondant aux besoins de soins. Ce rapport présente les propositions des membres du groupe communiste, républicain et citoyen, préconise une prise en charge intégrale des dépenses de santé par la sécurité sociale. Ils sont donc défavorables à un reste à charge par les malades, même couverts par l'assurance privée. Plusieurs dispositifs existent en effet tendant à faire payer les soins aux personnes auxquelles ils sont prescrits : le ticket modérateur, le forfait hospitalier (1983) et, plus récemment, une participation forfaitaire de 1 euro sur les consultations médicales (2004) et les franchises médicales (2008).Il apparaît particulièrement urgent aux auteurs de la proposition de loi de supprimer les deux derniers dispositifs mis en place pour faire financer les soins directement par les usagers.

Drees 2015). "Les dépenses de santé en 2014." Etudes et Resultats (Drees)(935): 6.
https://drees.solidarites-sante.gouv.fr/

[BDSP. Notice produite par MIN-SANTE FR0xH88l. Diffusion soumise à autorisation]. En 2014, la consommation de soins et de biens médicaux (CSBM), qui représente la valeur totale des biens et services qui concourent au traitement d'une perturbation provisoire de l'état de santé, est évalué à 190,6 milliards d'euros, soit 8,9% du produit intérieur brut. Ce pourcentage croît légèrement depuis

2012. Sa progression en valeur, qui reste inférieure à 3% depuis cinq ans est néanmoins légèrement plus élevée en 2014 (+2,5%) qu'en 2013 et 2012. La part de la CSBM financée par l'Assurance maladie, qui atteint 76,6% en 2014, a progressé de 0,7 point entre 2011 et 2014, en raison du dynamisme des dépenses de soins hospitaliers, de soins infirmiers, de transports sanitaires, de dépenses de médicaments coûteux et de la hausse continue du nombre d'assurés exonérés du ticket modérateur. A l'inverse, la part des organismes complémentaires (13,5% de la dépense) diminue légèrement. Le reste à charge des ménages s'établit à 8,5% en 2014.

Fizzala, A. (2015). Autonomix, un modèle de micro-simulation sur le champ de la dépendance des personnes âgées, Paris: INSEE

Autonomix est un modèle de micro-simulation statique développé à la DREES. Il permet d'évaluer ex ante des réformes modifiant les aides publiques destinées aux personnes âgées dépendantes, qu'elles résident à domicile ou en établissement. Il permet également d'estimer un « reste à charge hors santé » des personnes âgées dépendantes en rapprochant au niveau individuel leurs ressources et leurs dépenses. Cet article présente la nouvelle version d'Autonomix. Elle devrait produire de meilleures estimations puisque basées sur des données à la fois plus nombreuses et plus récentes que les données utilisées dans la version précédente. Côté établissement, la possibilité d'apparier les données individuelles recueillies auprès des conseils départementaux aux informations issues d'enquêtes auprès des établissements permet d'assoir le modèle sur davantage de données observées, rendant là encore les estimations probablement plus fiables.

Franc, C. et Pierre, A. (2015). "Conséquences de l'assurance publique et complémentaire sur la distribution et la concentration des restes à charge : une étude de cas." Economie et Statistique(475-476): 31-59.
http://www.insee.fr/fr/ffc/docs_ffc/ES475C.pdf

En France, le financement des soins se caractérise par la juxtaposition des remboursements de l'Assurance maladie obligatoire (AMO) et des assurances complémentaires (AMC). Les dépenses de santé restant à la charge des assurés après intervention de ces deux niveaux de couverture constituent des indicateurs incontournables de l'accès aux soins mais ont été peu étudiées à ce jour faute de sources nationales adéquates. Cet article vise à pallier ce manque en mobilisant les données administratives d'une mutuelle particulière gérant simultanément l'AMO et l'AMC, permettant ainsi une analyse des restes à charge avant et après intervention de la complémentaire (RACO et RACC). Dans un premier temps, nous étudions le niveau, la distribution et la concentration des RACO et des RACC sur l'ensemble des dépenses ambulatoires puis par poste de soins. Dans un second temps, nous analysons la concentration des RAC après intervention de l'AMO et de l'AMC en tenant compte de deux indicateurs des besoins de soins : le fait d'être exonéré ou non du ticket modérateur et le niveau des dépenses avant remboursements (résumé d'auteur).

Franc, C., et al. (2015). "Supplemental health insurance and healthcare consumption - A dynamic approach to moral hazard." Health Economics: 1-17.
http://onlinelibrary.wiley.com/doi/10.1002/hec.3271/abstract;jsessionid=368792B7DF66080C5414191DC580E7C0.f04t02?globalMessage=0

We analyze the existence and persistence of moral hazard over time to test the assumption of pent-up demand. We consider the effects of supplemental health insurance provided by a private insurer when added to compulsory public insurance that is already supplemented by private insurance. Using original panel data from a French mutuelle, we study the influence of insurance on all of the dimensions of healthcare expenditures: (1) the probability of using health care, (2) the number of uses conditional on use, and (3) the per unit cost of care. To conduct this study, we control, to the extent possible, for endogeneity because of adverse selection using the characteristics of our panel data. Our study allows us to confirm a positive and significant effect of the extra complementary health insurance on healthcare consumption, primarily in terms of the probability of using care. More interestingly, our results show that these effects are principally transitory mainly for the probability of using dental care and optical care and depend on income. Finally, we show that individuals did not postpone health care before enrollment.

Jess, N., et al. (2015). Les dépenses de santé à la charge des ménages retraités. Note de la Drees pour le COR. Paris COR**:** 30, tabl.
http://www.cor-retraites.fr/IMG/pdf/doc-3022.pdf

Cette note analyse le poids des dépenses de santé dans le budget des ménages retraités. Le taux d'effort en matière de santé des ménages est entendu comme les dépenses de santé à la charge des ménages rapportées à leur revenu disponible. Le modèle Inès-Omar de la DREES est l'outil adapté pour analyser la distribution des primes et des restes à charge des ménages après assurance maladie complémentaire (AMC) en France métropolitaine. Il permet de fournir des éléments de distribution par statut d'activité et niveau de vie (estimé ici par les quintiles de niveau de vie). Grâce à une amélioration de la prise en compte de l'âge dans l'imputation des contrats de complémentaire santé, la version 2012 du modèle mis à jour en 2015 permet désormais une déclinaison plus fine de ces indicateurs par tranche d'âge.

Jusot, F. et Pierre, A. (2015). "Quels impacts attendre de la généralisation de la complémentaire santé d'entreprise sur la non-couverture en France ? Une simulation à partir de l'Enquête santé et protection sociale (ESPS) 2012." Questions D'Economie de la Sante (Irdes)(209): 1-8.
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/209-quels-impacts-attendre-de-la-generalisation-de-la-complementaire-sante-d-entreprise-sur-la-non-couverture-en-france.pdf

En France, l'accès aux soins est très dépendant de la possession d'une complémentaire santé dont 5 % de la population ne bénéficient pas en 2012. Ainsi, l'accès pour tous à une complémentaire santé de qualité se trouve au cœur de la stratégie nationale de santé énoncée en 2013 par le gouvernement. Négociée dans le cadre de l'Accord national interprofessionnel (Ani) de janvier 2013, la première mesure consistera à généraliser la complémentaire santé d'entreprise – financée en partie par les employeurs – à l'ensemble des salariés du secteur privé au 1er janvier 2016 et à améliorer sa portabilité pour les chômeurs jusqu'à douze mois au plus après la rupture de leur contrat de travail. Il s'agit ici d'évaluer de façon ex ante les effets attendus du dispositif de l'Ani sur la non-couverture par une complémentaire santé et de discuter de ses conséquences en termes d'inégalités. A partir de l'Enquête santé et protection sociale (ESPS) 2012, l'impact de l'introduction de l'Ani sur la proportion d'individus qui resteraient non couverts par une complémentaire est simulé en population générale et, en tenant compte des potentielles dispenses d'adhésion dont certains peuvent bénéficier, au sein même des salariés du secteur privé. La non-couverture est étudiée selon plusieurs caractéristiques individuelles telles que l'état de santé, le statut socio-économique et les préférences à l'égard du temps et du risque.

Lagasnerie, G., et al. (2015). Une analyse longitudinale (2008-2013) du reste à charge des ménages après remboursement par l'assurance maladie obligatoire. Les dépenses de santé en 2014 : résultats des Comptes de la santé. Edition 2015., Paris : Ministère chargé de la Santé**:** 141-168, tab., graph., fig., ann.
https://drees.solidarites-sante.gouv.fr/

Le montant des dépenses restant à la charge des patients est un indicateur d'accessibilité financière ainsi qu'un indicateur de solidarité entre bien-portants et malades. L'objectif de l'étude est de décrire, pour la première fois, sur six années, les montants et la récurrence des restes à charge des patients du régime général après remboursement par l'assurance maladie obligatoire mais avant remboursement par les assurances complémentaires santé. Cette analyse complète les études déjà menées sur ces sujets sur des données annuelles (Geoffard et Lagasnerie, 2013), ou longitudinales mais sur trois années uniquement (HCAAM, 2013). À partir de l'échantillon généraliste de bénéficiaires (EGB), issu du système national d'information inter-régimes de l'assurance maladie (SNIIRAM), est créée une cohorte d'environ 380 000 assurés du régime général, âgés en moyenne de 40 ans en 2008, hors bénéficiaires de la couverture maladie universelle complémentaire, qui sont suivis de 2008 à 2013.

Sont étudiés sur cette période leurs restes à charge pour les soins de ville et les hospitalisations en établissements de santé privés et publics (en médecine, chirurgie, obstétrique).

Pierre, A. et Jusot, F. (2015). Une évaluation ex ante de la généralisation de la complémentaire santé d'entreprise sur les inégalités et les déterminants de la non-couverture. Document de travail Irdes ; 67. Paris Irdes**:** 56.
http://www.irdes.fr/recherche/documents-de-travail/067-une-evaluation-ex-ante-de-la-generalisation-de-lacomplementaire- sante-d-entreprise.pdf

Cet article propose d'évaluer de façon ex ante les effets attendus du dispositif de l'Accord national interprofessionnel (Ani) sur la non-couverture par une complémentaire santé en France et de discuter de ses conséquences en termes d'inégalités. A partir de l'Enquête santé et protection sociale (ESPS) 2012, il s'agit de : i/ simuler l'impact de l'introduction de l'Ani sur la proportion d'individus qui resteront non couverts par une complémentaire en population générale et, en tenant compte des potentielles dispenses d'adhésion au sein de la population salariée selon l'état de santé, le statut socio-économique, les préférences à l'égard du temps et du risque et le motif de non-couverture ; ii/ étudier l'évolution des caractéristiques des personnes non couvertes, toutes choses égales par ailleurs, avant et après l'introduction de l'Ani.

2014

Abrossimov, C. et Chereque, F. (2014). Les liens entre handicap et pauvreté : les difficultés dans l'accès aux droits et aux ressources. Rapport IGAS ; 2014-048. Paris Inspection générale des affaires sociales, Paris La documentation française**:** 253.
http://www.igas.gouv.fr/spip.php?article406

[BDSP. Notice produite par MIN-SANTE FR0xojC7. Diffusion soumise à autorisation]. Suite aux engagements du gouvernement annoncés lors du Comité interministériel du handicap (CIH) du 25 septembre 2013 afin de compléter les expertises du plan de lutte contre la pauvreté et pour l'inclusion sociale sur la situation des personnes handicapées, le Premier ministre a confié à l'IGAS le 11 mars 2014 une mission portant sur "Les liens entre handicap et pauvreté : les difficultés dans l'accès aux droits et aux ressources". Ce rapport aborde les sept thématiques du plan pauvreté : accès aux droits, accès à l'emploi, accès à l'hébergement et au logement, accès à la santé, enfance et famille, inclusion bancaire et lutte contre le surendettement, gouvernance des politiques. Il formule plusieurs préconisations, notamment la simplification des procédures et des démarches, la coordination des institutions, la mobilisation sur l'accès à l'emploi.

Bourreau-Dubois, C., et al. (2014). Impact du reste à charge sur le volume d'heures d'aide à domicile utilisé par les bénéfiçiaires de l'APA. CES Working Paper; 2014.24. Paris Centre d'économie de la Sorbonne**:** 25 , tabl.

Depuis 2001, en France, les personnes âgées dépendantes bénéficient d'une subvention publique (l'allocation personnalisée d'autonomie) pour financer l'achat d'heures d'aide à la réalisation des activités de la vie quotidienne. Cette subvention n'est que partielle et laisse à la charge des bénéficiaires un montant horaire qui varie selon plusieurs paramètres (son revenu, le prix facturé par le prestataire, les tarifs de solvabilisation fixés par l'autorité publique locale). A partir de données administratives issues d'un département, et en tenant compte des règles institutionnelles nationales et départementales, nous estimons l'élasticité de la demande à ce reste à charge, pour l'aide professionnelle à domicile fournie par des prestataires autorisés. Nous montrons que le reste à charge supporté par les personnes âgées dépendantes bénéficiaires de l'APA a bien un impact négatif sur leur consommation d'heures d'aide à domicile. Une augmentation du prix facturé de 10% induit une baisse du volume d'heures de 5.5%, soit 73 minutes pour l'allocataire qui utiliserait 22 heures d'aides, ie le volume moyen utilisé par les allocataires supportant un ticket modérateur non nul.

Le, Garrec., M.A. et Bouvet, M. (2014). "Les Comptes nationaux de la santé en 2013." Etudes et Resultats (Drees)(890): 6.
https://drees.solidarites-sante.gouv.fr/

[BDSP. Notice produite par MIN-SANTE kEn9R0x9. Diffusion soumise à autorisation]. Le montant des dépenses courantes de santé s'élève à 247,7 milliards d'euros en 2013, soit 11,7% du produit intérieur brut (PIB) en base 2010. La consommation de soins et de biens médicaux (CSBM), en représente les trois quarts et atteint 186,7 milliards d'euros. Elle s'établit à 8,8% du PIB en 2013, contre 8,7% en 2012. Sa progression en valeur reste sensiblement inférieure à 3% pour la quatrième année consécutive. En particulier, le recul de la consommation de médicaments, imputable à la faible croissance de leur volume conjuguée à la baisse des prix, contribue négativement à la croissance de la CSBM. En 2013, la part de la CSBM financée par la Sécurité sociale atteint 76,0% et celle prise en charge par les organismes complémentaires 13,8%. Quant au reste à charge des ménages, il s'établit à 8,8%, en recul de 0,2 point par rapport à 2012.

Santéclair (2014). Remboursement des dispositifs médicaux : double peine, Paris : CISS Boulogne-Billancourt : Santéclair

Ce dossier de presse présente une étude de l'Observatoire citoyen des restes à charge en santé qui dénonce les nombreux dysfonctionnements dans la prise en charge des dispositifs médicaux (lunettes, mais aussi prothèses auditives, fauteuils roulants, appareils respiratoires, pansements spécifiques, semelles orthopédiques...). L'analyse des données fait apparaître de profondes inégalités. Inégalités d'un secteur à l'autre, mais aussi inégalités aussi entre les produits. Résultat, certains produits ou prestations laissent des sommes considérables à la charge de l'assuré, notamment les audioprothèses ou les fauteuils électriques. L'étude met également en lumière des pratiques tarifaires choquantes (en l'absence de prix limite de vente), notamment dans l'audioprothèse. Les chiffres de cette 4e étude de l'Observatoire sont principalement issus du SNIIRAM, auquel le CISS a accès en tant que membre de l'Institut des données de santé (IDS). Mais avec "la menace du closed data" inscrite dans le projet de loi de santé, en dépit des déclarations officielles, il n'est pas dit que cet accès reste ouvert, dénoncent les membres de l'Observatoire.

Soulat, L. et Arrondel, L. (2014). Les dépenses de santé à la charge des ménages avant et pendant la retraite. Paris COR**:** 24 , tabl., graph.

Cette note présente quelques premiers résultats sur les modifications des dépenses de santé au moment de la retraite en se centrant sur les dépenses de santé non remboursées. Ce travail s'appuie sur l'exploitation de réponses à l'enquête de la Caisse des Dépôts Attentes et perception des Français à l'égard de la retraite. Plus particulièrement, il étudie les réponses à la question sur le budget des ménages en dix postes, et notamment celles portant sur le poste des dépenses de santé, hors dépenses remboursées. Les dépenses de santé ainsi déclarées par les enquêtés correspondent à un périmètre différent de celui des chiffrages de la DREES. Ceci peut expliquer des différences dans le niveau des dépenses de santé à la charge des ménages, les mesures présentées ici étant plus élevées que celles de la DREES.

2013

(2013). "Payer pour être mieux soigné : un poids réel pour certaines maladies en France." Revue Prescrire : **34**(363).

Les dépenses de santé restant à la charge des patients s'avèrent parfois très lourds pour certains patients à revenus modestes ou certaines pathologies. En 2013, pour agir sur la RAC, les pouvoirs publics ont décidé de généraliser l'assurance maladie complémentaire via l'employeur. Ce type d'orientation principalement financière évite une rationalisation pourtant nécessaire du système de soins, pour optimiser les dépenses de santé. Notamment en conditionnant la prise en charge des soins à une évaluation rigoureuse et transparente de leur intérêt. Sans attendre cette remise à plat hypothétique, les professionnels de santé peuvent, à leur niveau, aider les patients à accéder à des soins de qualité aux meilleurs coûts.

CISS (2013). Soins dentaires : des dérives inacceptables, Paris : Le Ciss

Ce dossier de presse présente les résultats de a seconde édition de l'observatoire citoyen des restes à charge en santé. Cette étude menée par Le Collectif interassociatif en santé (Le Ciss), 60 millions de consommateurs et Santéclair explore une nouvelle cible, celle des frais dentaires Les trois partenaires dénoncent des engagements conventionnels non tenus par les professionnels, des pratiques non conformes ou pire des soupçons de fraudes. Les soins dentaires font souvent l'objet de pratiques tarifaires excessives voire de dérives inacceptables, ce qui peut conduire à renoncer aux soins. Sur les frais pris en charge par l'Assurance maladie obligatoire, ils évaluent le reste à charge dentaire à près de 6 Mds€ sur la seule année 2012, avant intervention des complémentaires santé. Principaux soins incriminés : les prothèses, comme les couronnes, bridge, inlay ou reconstitutions. L'Observatoire citoyen accuse les dentistes de privilégier des techniques onéreuses qui ne sont pas toujours indispensables comme les inlay-cores, au détriment des reconstitutions au fauteuil. La somme qui reste à la charge du patient après remboursement par l'Assurance maladie s'élève à plus de 290 euros en moyenne par acte de prothèse, avec des variations en fonction des départements. Elle ne descend "quasiment jamais" en dessous de 200 euros et grimpe jusqu'à plus de 400 euros à Paris. Ce reste à charge peut être remboursé par les complémentaires mais il est très difficile d'avoir une estimation précise de leur niveau de prise en charge global. En revanche, les soins courants (carie, dévitalisation, détartrage, etc.), dont les tarifs sont encadrés par l'Assurance maladie, font peu l'objet de dépassements, en dehors de Paris qui représente 57 % des dépassements constatés pour ce type de soins. Toutefois, ces dépassements "illégaux" atteignent 35 millions d'euros en 2012. Autre traitement pointé du doigt, l'orthodontie dont les soins ont représenté en 2012 plus d'un milliard d'euros, dont près de 80 % constituent des dépassements d'honoraires, selon l'étude. Les trois partenaires ont alerté l'Assurance Maladie. Faute de réaction, ils demandent maintenant aux pouvoirs publics d'intervenir. Ces chiffres sont issus de 177 000 devis de prothèses et d'implants et des données de l'Assurance maladie (SNIIRAM), auquel le CISS a accès en tant que membre de l'Institut des données de santé.

Dourgnon, P. (2013). Évaluation des politiques publiques et inégalités sociales d'accès aux services de santé, Paris : Université Paris Dauphine. **Thèse de doctorat de sciences économiques.**
http://www.irdes.fr/EspaceEnseignement/ThesesMemoires/ThesePaulDourgnonPolitiquesPubliques.pdf

En dépit des objectifs énoncés de respect du principe d'équité horizontale, on observe des inégalités sociales dans la consommation de soins des pays dotés de systèmes de santé socialisés. Cette thèse se propose, au travers de quatre études, de contribuer a l'analyse des politiques publiques dans le système de santé, du point de vue de l'équité de recours aux services de santé. L'introduction propose des éléments descriptifs des inégalités sociales de recours aux soins en France ainsi que des principaux mécanismes qui, à l'intérieur du système de santé français, peuvent en être a l'origine. Le premier chapitre étudie les liens entre barrières financières à l'accès aux soins et état de santé. Il montre que le fait de renoncer à des soins pour des raisons financières est associé à un état de santé futur plus détérioré. Le deuxième chapitre propose une analyse de l'interaction médecin-patient et de son rôle dans la formation des inégalités de recours aux soins. Cette thèse étudie les catégorisations opérées par les médecins au sujet de leurs patients en fonction de leurs situations sociales. Elle montre ensuite les relations entre ces catégorisations et les pratiques observées. Un troisième chapitre collige deux études portant sur la réforme du médecin traitant. La première propose une analyse de la réforme et de son contexte, en particulier le rôle des différents acteurs. La seconde propose une étude des conséquences de la réforme sur l'accès financier aux soins de spécialistes.

Dourgnon, P., et al. (2013). "L'impact du dispositif des affections de longue durée (ALD) sur_ les inégalités de recours aux soins ambulatoires entre 1998 et 2008 ». Questions D'Economie de la Sante (Irdes)(183).
http://www.irdes.fr/Publications/Qes2013/Qes183.pdf

Le dispositif des affections de longue durée (ALD) vise à réduire la charge financière des assurés souffrant d4une maladie longue et coûteuse. Introduit dès 1945 au titre de quatre maladies (cancer, tuberculose, poliomyélite, maladie mentale), il concerne aujourd'hui 32 _groupes de pathologies. En 2009, les personnes en ALD représentent 15 % des assurés du régime général, soit 8,6 _millions de personnes. Leurs dépenses s'élèvent à 60 % du total des dépenses remboursées et croissent à un rythme annuel de 4,9 % de 2005 à 2010. Un dispositif de ce type peut-il prendre en charge de façon satisfaisante l'ensemble des problèmes d'accès financier aux services de santé ? Comment l'effet de l'ALD s'articule-t-il avec les autres dispositifs jouant sur les restes à charge (Complémentaire privée, Couverture maladie universelle complémentaire (CMU-C))? A partir des données appariées de l'Enquête santé et protection sociale de l'Irdes et de l'Echantillon permanent des assurés sociaux (Epas) des régimes d'assurance maladie, l'impact des ALD sur les inégalités de recours aux soins ambulatoires est étudié sur la période 1998-2008. Plus âgées que le reste de la population, les personnes en ALD sont aussi plus défavorisées et leurs restes à charge plus élevés. Le niveau d'inégalité de consommation de soins ambulatoires au sein de la population en ALD, en faveur des plus riches de 1998 à 2000, devient non significatif à partir de 2002 alors qu'il demeure significatif dans le reste de la population. Au total, le dispositif des ALD améliore l'accès aux soins ambulatoires des personnes qui en bénéficient et ainsi contribue à réduire le niveau d'inégalités constaté dans l'ensemble de la population. Il existe également une forme de complémentarité entre CMU-C et ALD. Néanmoins, les inégalités de recours aux spécialistes, en faveur des plus riches, perdurent tant pour les personnes en ALD que les autres.

FNMF (2013). La prise en charge des dépenses de santé : les évolutions du poids des différents acteurs depuis 2000 : analyse réalisée à partir des comptes nationaux de la santé 2012. Paris : FNMF.

Cette note reprend les principaux indicateurs présentés dans les Comptes nationaux de la santé 2012 publiés par la Direction de la Recherche, des Etudes, de l'Évaluation et des Statistiques (DREES).Elle porte sur : l'évolution des dépenses d'assurance maladie obligatoire et complémentaire de 2000 à 2012, l'évolution du reste à charge avant et après intervention des organismes complémentaires, l'évolution des dépenses de soins et de biens médicaux par financeur depuis 2000.

Geoffard, P. Y. et Lagasnerie, G. d. (2013). Réformer le système de remboursement pour les soins de ville, une analyse par microsimulation. Economie et Statistique. Systèmes de santé. Economiques. Paris : Insee http://www.insee.fr/fr/themes/document.asp?reg_id=0&id=3965

Les évolutions du système de remboursement des dépenses de soins par l'assurance publique ont progressivement diminué la couverture publique du risque maladie. Ce système laisse à la charge des assurés des sommes qui peuvent s'avérer importantes lorsque ceux-ci traversent des épisodes de maladie longs et coûteux, et parfois même lorsqu'ils bénéficient d'exonérations au titre d'une affection de longue durée. L'assurance complémentaire est de fait devenue nécessaire. Cependant, 7 % de la population ne jouit pas d'une telle assurance. Cet article étudie une réforme possible de l'assurance maladie obligatoire qui prend la forme d'un plafond annuel de la participation financière en soins de ville. Un tel plafond serait financé par l'instauration de franchises annuelles. Nous évaluons cette réforme à partir de micro-simulations appliquées aux données de l'enquête santé soins médicaux 2003, appariée avec les données de remboursement de l'assurance maladie publique (SNIIR-AM) (résumé d'auteur)

Kambia-Chopin, B. et Perronnin, M. (2013). Deductibles and the demand for prescription drugs : evidence from french data. Document de travail Irdes ; 54. Paris Irdes**:** 24. http://www.irdes.fr/EspaceAnglais/Publications/WorkingPapers/DT54DeductiblesAndDemandPrescriptionDrugs.pdf

Une franchise de 0,5 cts par boîte de médicaments prescrite a été mise en place le 1er janvier 2008. Afin d'apporter un premier éclairage sur les effets de celle-ci sur la consommation de médicaments, une analyse a été menée en ayant recours au modèle comportemental d'Andersen et à un modèle économique de demande. À partir de données déclaratives de l'enquête santé protection sociale (ESPS) 2008, nous montrons que la probabilité de modifier la demande de médicaments suite à la mise en place de la franchise est influencée par le niveau de revenu et l'état de santé : toutes choses égales par ailleurs, elle varie de manière opposée avec chacune de ces variables. Les franchises médicales représentent ainsi une charge financière pour les individus à bas revenus et ceux en mauvais état de santé, avec pour corollaire une limitation potentielle de leur accès financier aux soins (résumé d'auteur).

HCAAM (2013). La généralisation de la couverture complémentaire en santé : avis. Paris : HCAAM.
https://www.securite-sociale.fr/hcaam

Saisi en mars 2013 par le gouvernement dans le cadre de l'objectif présidentiel de généralisation de la couverture complémentaire en santé, le Haut Conseil pour l'avenir de l'assurance maladie (HCAAM) a adopté le 18 juillet un avis accompagné d'un rapport, à l'unanimité à l'exception de la CGT-FO. Ces documents portent un diagnostic sur le rôle de l'assurance maladie complémentaire, les inégalités de garanties et d'aide publique selon les contrats. Ils analysent également les conditions et les enjeux d'une extension de l'assurance complémentaire en santé à l'ensemble de la population. Le HCAAM a examiné les conditions de la généralisation d'une couverture de qualité, incluant les personnes les plus éloignées de l'emploi et les plus modestes. Cette généralisation implique une évolution du dispositif de l'ACS pour en améliorer le taux de recours, un renforcement des critères de solidarité et de responsabilité des contrats d'assurance complémentaire et une amélioration du ciblage des aides publiques bénéficiant au secteur. Le Haut Conseil s'est également penché sur la répartition des rôles entre l'assurance maladie obligatoire (AMO) et l'assurance maladie complémentaire (AMC) en matière de gestion du risque et souligne l'intérêt des réseaux de professionnels de santé pour réduire les restes à charge et améliorer l'accès aux soins.

HCAAM (2013). La généralisation de la couverture complémentaire en santé : rapport. Paris : HCAAM.
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HCAAM (2013). L'accessibilité financière des soins après assurance maladie obligatoire. Rapport du Haut Conseil pour l'avenir de l'assurance maladie 2013. Paris : HCAAM**:** 2 vol. (273;145), tabl., ann.
https://www.securite-sociale.fr/hcaam

Ce rapport annuel de l'année 2013 du HCAAM comporte des études inédites : deux d'entre elles portent sur l'origine des restes à charges les plus élevés des ménages ; un exercice de projection à long terme des dépenses de santé et des voies du retour à l'équilibre (réalisée par la Direction générale du Trésor). Figurent également dans ce rapport l'avis et l'analyse du HCAAM sur la généralisation de la complémentaire en santé.

HCAAM (2013). Les restes à charge les plus élevés. In : Rapport du Haut Conseil pour l'avenir de l'assurance maladie 2013. Rapport du Haut Conseil pour l'avenir de l'assurance maladie 2013. Paris : HCAAM**:** 2 vol. (273;145), tabl., ann.
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Le Garrec Marie-Anne, B. M. (2013). "Les comptes nationaux de la santé 2012." Serie Statistiques - Document de Travail - Drees(185).
https://drees.solidarites-sante.gouv.fr/

[BDSP. Notice produite par MIN-SANTE Hp8oR0x8. Diffusion soumise à autorisation]. Le montant des dépenses courantes de santé s'élève à 243 milliards d'euros en 2012, soit 12% du produit intérieur brut (PIB). La CSBM en représente les trois quarts et atteint 183,6 milliards d'euros. Sa progression en valeur est sensiblement inférieure à 3% pour la troisième année consécutive. Sa part dans le PIB est de 9%, comme en 2011. En volume, la CSBM a augmenté de 2,7% en 2012, comme en 2011, tandis que son prix moyen recule légèrement pour la troisième année consécutive. La diminution du prix des soins hospitaliers et de celui des médicaments a en effet compensé la hausse du prix des soins de ville. En 2012 comme en 2011, la part de la CSBM financée par la Sécurité sociale est de 75,5%, celle prise en charge par les organismes complémentaires de 13,7%. Quant au reste à charge des ménages, il est stable à 9,6% depuis 2009

Le, Garrec. M.-A., et al. (2013). "60 années de dépenses de santé. Une rétropolation des Comptes de la santé de 1950 à 2010. " Etudes et Resultats (Drees)(831).

[BDSP. Notice produite par MIN-SANTE R0x8kkBH. Diffusion soumise à autorisation]. En soixante ans, la part de la consommation de soins et de biens médicaux (CSBM) dans le PIB a crû très fortement, passant de 2,6% en 1950 à 9,1% du PIB en 2010. De 1950 à 1985, la CSBM a progressé plus rapidement que le PIB, en raison du développement de l'assurance maladie et d'une forte croissance des dépenses hospitalières. Cette période est, en effet, marquée par d'importants programmes de construction d'hôpitaux. Depuis 1985, on observe une alternance de périodes de croissance puis de stabilisation des dépenses de santé sous l'effet de mesures de régulation. Sur les quinze dernières années, la prise en charge par l'assurance complémentaire a augmenté de 1,4 point et atteint 13,5% de la dépense en 2010, tandis que celle laissée à la charge des ménages a fluctué entre 9% et 10% pour s'établir à 9,6% en 2010

Marie E., R. (2013). Rapport sur le tiers payant pour les consultations de médecine de ville. Sociales. Paris : Igas.
http://www.igas.gouv.fr/IMG/pdf/RM2013-143P_Tiers_payant_DEF.pdf

La généralisation du tiers payant d'ici à 2017 est une des principales mesures de la stratégie nationale de santé mais qui pose de sérieuses difficultés pratiques car les médecins libéraux sont majoritairement hostiles au projet. Hubert Garrigue-Guyonnaud a été nommé par Marisol Touraine directeur de ce projet. Cet inspecteur IGAS aura la lourde tâche de mettre en place la dispense totale d'avance de frais des patients lors des consultations médicales, en concertation avec les complémentaires santé et les patients. Une première étape doit être franchie avant la fin de 2014 avec les bénéficiaires de l'aide à la complémentaire santé (ACS). L'objectif du rapport ci-contre est d'évaluer les modalités de mise en place d'un dispositif de tiers-payant

2012

Andre, J. M., et al. (2012). L'articulation entre assurance maladie obligatoire et assurance maladie complémentaire : quelles implications pour la solidarité ? La dette sociale. Sociale. Saint-Etienne : EN3S.

Les perspectives d'évolution de l'Assurance Maladie Obligatoire (AMO) devraient conduire à accroître le reste à charge des assurés et, « mécaniquement », la place de l'Assurance Maladie Complémentaire (AMC). Ce contexte de privatisation croissante de l'Assurance maladie bouleverse les fondements solidaires sur lesquels repose historiquement la prise en charge du risque maladie. Il suscite de nombreuses questions dont certaines n'ont pas encore été explorées en détail alors même que nous disposons de l'éclairage d'enquêtes quanitatives menées notamment par l'Institut de Recherche et de Documentation en Économie de la Santé (IRDES) et la Direction de la Recherche, des Études, de l'Évaluation et des Statistiques (DREES). Au coeur des interrogations fortes encore trop peu explorées se trouve la question de la solidarité que notre recherche a décidé de prendre comme « clé d'entrée ». Il s'agit en substance de questionner le degré de solidarité du marché de la complémentaire Santé et ce dans deux de ses dimensions : d'une part, la dimension individuelle qui s'intéresse aux conditions d'accès, pour les populations en marge de l'emploi, à une couverture santé complémentaire dont on sait qu'elle devient de plus en plus une condition sine qua non de l'accès aux soins; d'autre part, la dimension collective qui est centrée sur la participation des Organismes Complémentaires d'Assurance Maladie (OCAM) à la régulation des dépenses de santé, participation dont le degré d'efficacité peut avoir des effets sur les restes à charge, sur le coût de l'assurance complémentaire et in fine sur l'accès aux soins des populations en marge de l'emploi.

Bérardier, M. (2012). "Allocation personnalisée d'autonomie à domicile : quels restes à charge pour les bénéficiaires ?" Revue française des affaires sociales **2-3**(2-3): 194-217.
http://www.cairn.info/revue-francaise-des-affaires-sociales-2012-2-page-194.htm

Le financement des besoins en matière de prise en charge de la dépendance des personnes âgées est réparti entre différents acteurs (l'État, l'assurance maladie, les collectivités locales, la Caisse nationale de solidarité pour l'autonomie...). L'allocation personnalisée d'autonomie (APA) est une des aides publiques les plus importantes dans ce domaine. Le conseil général évalue les besoins d'aide de la personne à domicile et notifie un plan d'aide. Le montant total de l'aide ne peut pas dépasser un certain plafond, modulé en fonction du niveau de dépendance de la personne. Le conseil général finance une partie et l'autre partie est à la charge du bénéficiaire en fonction de ses ressources (ticket modérateur). Les besoins des personnes âgées sont donc connus à travers ces plans, mais pour les personnes dont les besoins excèdent les plafonds, l'ensemble des besoins et des dépenses n'est pas observable. C'est le cas d'un quart des personnes, cette proportion augmente avec le niveau de dépendance. Cet article propose de prolonger par une méthode économétrique les montants des plans au-delà des plafonds et ainsi d'estimer les dépenses et les restes à charge des personnes âgées : les montants moyens seraient en moyenne de 400 euros par mois pour les personnes les plus dépendantes alors que le ticket modérateur est actuellement de 170 euros en moyenne et de 100 euros pour les personnes les moins dépendantes alors que le ticket modérateur est de 60 euros. Dans trois cas sur quatre, le reste à charge simulé excède 60 % des ressources des bénéficiaires.

Daudigny, Y. (2012). Rapport d'information sur l'enquête de la Cour des comptes relative aux dépenses de l'Assurance maladie hors prise en charge des soins. Rapport d'information ; 656. Sénat.Commission.
http://www.senat.fr/rap/r11-656/r11-6561.pdf

Les dépenses de l'Assurance maladie hors prise en charge des soins, de nature très disparate, représentent tout de même 6 à 7 milliards d'euros par an. Elles sont dispersées dans les comptes de l'Assurance maladie, mal identifiées, leur légitimité et leur évolution étant jusqu'ici restées peu étudiées. S'appuyant sur les conclusions de l'étude de la Cour des comptes commandée par la Mission d'évaluation et de contrôle de la Sécurité sociale, ce rapport préconise notamment de clarifier les conditions dans lesquelles l'Assurance maladie, sur décision de l'Etat, finance une vingtaine de fonds ou organismes dont le lien avec ses missions est parfois ténu. Yves Daudigny souhaite un encadrement pluriannuel systématique de ces contributions chiffrées par la Cour à 959 millions d'euros en 2010 et demande une plus grande transparence. Le sénateur recommande également une simplification des règles d'attribution des aides individuelles financées par l'action sanitaire et sociale des CPAM. Enfin, à propos de la prise en charge des cotisations sociales des praticiens et auxiliaires médicaux du secteur 1, qui représente un coût de 2 milliards d'euros par an pour l'Assurance maladie, la Cour des comptes suggérait qu'elle soit modulée selon des critères géographiques, en vue de corriger les inégalités de répartition territoriale des médecins. Le rapporteur général s'empresse d'écarter cette solution qui prise isolément pourrait réduire l'attractivité du secteur 1. Il souhaite une réponse plus globale à la question des déserts médicaux, passant par le soutien actif aux formes d'exercice en groupe et à un meilleur partage des rôles entre professionnels de santé et la lutte contre les dépassements d'honoraires. Les départements ruraux eux-mêmes sont aujourd'hui touchés par des dépassements élevés, subissant une forme de double peine de l'accès aux soins : désert médical et restes à charge importants

Duval, J. et Lardellier, R. (2012). La redistribution verticale opérée par l'assurance maladie. In : Comptes nationaux de la santé 2011. Serie Statistiques - Document de Travail - Drees
https://drees.solidarites-sante.gouv.fr/

Cette étude aborde quatre points. La première partie revient sur les modalités de financement des assurances maladie obligatoire et complémentaire, et leur effet sur le revenu des ménages en fonction de leur niveau de vie. La deuxième partie examine les remboursements de soins effectués par L'assurance maladie obligatoire et l'assurance maladie complémentaire. La troisième partie vise à présenter une mesure synthétique de la redistribution verticale opérée par L'assurance maladie, en mobilisant des indices de Gini. Enfin, une quatrième partie permet d'aborder les phénomènes connexes aux effets redistributifs que sont le reste à charge et le renoncement aux soins. Ces phénomènes, qui n'apparaissent pas dans le cadre d'une analyse portant exclusivement sur les prestations consommées, montrent que l'approche en termes de redistribution ne peut se passer d'une approche en termes d'accessibilité financière.

Fonds CMU (2012). Evaluation de la loi CMU - Rapport n° V novembre 2011 réalisé en application de l'article 34 de la loi n° 99-641 du 27 juillet 1999. Paris : Fonds CMU.

En application de l'article 34 de la loi du 27 juillet 1999 portant création de la couverture maladie universelle, le Fonds CMU a été missionné par le directeur de la sécurité sociale pour élaborer le Vème rapport d'évaluation de l'application de la loi. Le rapport présente les dernières évolutions des dispositifs de la CMU de base, de la CMU complémentaire et de l'ACS. Bien que la loi CMU demeure un facteur déterminant dans la réduction des inégalités d'accès aux soins, les populations les plus fragiles rencontrent encore des difficultés d'accès aux soins : méconnaissance des dispositifs, refus de soins, dépassements d'honoraires, restes à charge. Le rapport présente 'l'ensemble des éléments disponibles permettant d'analyser ces phénomènes. Par ailleurs, le rapport consacre une partie du rapport à l'analyse du coût des dispositifs et présente les évolutions relatives à la lutte contre la fraude. Partant de l'ensemble de ces constats, un certain nombre de préconisations et de pistes de travail sont présentées dont l'objectif est l'amélioration des dispositifs. Parmi elles, le rapport propose de réfléchir à une révision globale du panier de soins CMU-C, tant sur l'optique, afin de l'actualiser et de tenir compte de besoins non pris en charge au moment de la création du dispositif, que sur l'audioprothèse.

Gilles, L. et Lautie, S. (2012). "Garantir l'accès aux soins des catégories modestes : l'exemple de l'optique." Points de Repere(37).
http://www.ameli.fr/fileadmin/user_upload/documents/Points_de_repere_n__37.pdf

La CNAMTS a confié au CREDOC une enquête auprès des bénéficiaires de la CMU-C ayant eu un reste à charge en optique afin de caractériser et hiérarchiser les circonstances et les motifs de ces restes à charge et d'envisager des évolutions du dispositif pour diminuer leur montant

Gilles, L. et Lautier, S. (2012). "Garantir l'accès aux soins des catégories modestes : l'exemple de l'optique

Garantir l'accès aux soins des catégories modestes : l'exemple de l'optique." Consommation et Modes de Vie(247).
http://www.credoc.fr/pdf/4p/247.pdf

L'accès aux soins est devenu une préoccupation croissante pour les pouvoirs publics. Au fil des ans, de plus en plus d'individus, notamment au sein des catégories sociales les plus modestes, déclarent s'imposer des restrictions budgétaires en matière de soins médicaux. La prise en charge par la couverture maladie universelle complémentaire (CMU-C) a pour objectif de financer les dépenses de soins des personnes aux revenus modestes. Des données de la Caisse Nationale d'Assurance Maladie des Travailleurs Salariés (CNAM-TS) ont montré que, dans le cas des achats d'optique, les dépenses restant à la charge des bénéficiaires sont peu fréquentes. Cependant, l'étude de la CNAM-TS montre également que ces dépenses sont d'un montant relativement élevé et peuvent faire obstacle à l'accès aux soins des catégories modestes. Face à ces constats, la CNAM-TS a confié au CRÉDOC une enquête auprès des bénéficiaires ayant eu un reste à charge en optique afin de caractériser et hiérarchiser les circonstances et les motifs de ces restes à charge et d'envisager des évolutions du dispositif qui soient de nature à diminuer leur montant. Les résultats de cette étude montrent que l?origine des restes à charge peut être recherchée du côté de la qualité de l'offre de montures et de la capacité des opticiens à conseiller les bénéficiaires, mais aussi des niveaux de remboursement et des prix pratiqués pour les offres correspondant aux attentes standard des bénéficiaires (résumé d'auteur).

HCAAM (2012). Avenir de l'assurance maladie : les options du HCAAM. Paris : HCCAM.
https://www.securite-sociale.fr/hcaam

Le Haut Conseil pour l'avenir de l'assurance maladie (HCAAM) a été installé en octobre 2003 pour exercer une vigilance collective garantissant la pérennité du système de prise en charge solidaire des frais occasionnés par la maladie. Dans un contexte financier difficile, son premier rapport de janvier 2004 avait affirmé qu'une démarche exigeante de qualité des pratiques et des organisations était essentielle pour que le système solidaire d'assurance maladie trouve la voie d'un équilibre financier durable. Huit ans après ce premier rapport, alors que la situation financière de l'assurance maladie traverse de nouveau, après une phase de redressement, une période extrêmement critique, il lui a semblé nécessaire de s'appuyer sur l'ensemble de ses travaux pour en souligner les principaux éléments d'actualité, identifier les options décisives pour l'avenir de l'assurance maladie et dégager les principaux sujets de débat qui en découlent (résumé de l'éditeur)

HCAAM (2012). Rapport du Haut Conseil pour l'avenir de l'assurance maladie 2012. Maladie. Paris : HCAAM..
https://www.securite-sociale.fr/hcaam

Le rapport annuel 2012 du Haut Conseil pour l4avenir de l4assurance maladie présente, tout d4abord, un volet sur l4accessibilité financière aux soins et des tableaux de bord financiers. Il comprend aussi des premiers éléments de réflexion sur les inégalités sociales de santé : problématique générale, indicateurs, liens entre inégalités sociales et inégalités de santé, mesure des inégalités sociales de santé par l'accès aux soins, relations inégalités territoriales et inégalités de santé. Il termine sur des comparaisons internationales et des éléments bibliographiques.

La Mutuelle des Étudiants (2012). La santé des étudiants : 3e enquête nationale. Principaux enseignements. La Mutuelle des Etudiants.

Ce rapport de la Mutuelle des Etudiants (LMDE) rassemble les résultats de sa troisième enquête nationale sur la santé des étudiants dont les données sont issues de l'Observatoire Expertise et Prévention pour la Santé des Étudiants (EPSE). Les données proviennent de questionnaires remplis par 8400 étudiants affiliés à la LMDE. Les résultats sont présentés selon plusieurs thématiques : situation sociale, pratiques et habitudes médicales, consommation de tabac, d'alcool et de cannabis, rapport au monde extérieur, et enfin rapport au parcours universitaire et à l'insertion professionnelle. Parmi les principaux résultats, il est à noter qu'un tiers des étudiants déclarent avoir renoncé à consulter un médecin au cours de l'année écoulée, que 17% des étudiants ont réduit leur consommation de tabac suite aux différentes hausses des prix, ou encore que 38% des répondants ont ressenti un sentiment constant de tristesse ou de déprime au cours des douze derniers mois.

Lardellier, R., et al. (2012). "Dépenses de santé et restes à charge des ménages : le modèle de microsimulation Omar." Serie Sources et Methodes - Document de Travail - Drees(34).

[BDSP. Notice produite par MIN-SANTE R0x8Frok. Diffusion soumise à autorisation]. La Drees a construit un Outil de microsimulation pour l'Analyse des restes à charge (Omar). Celui-ci permet de simuler au niveau individuel le partage de la dépense entre les trois financeurs : la Sécurité sociale, l'organisme complémentaire et l'individu. En outre, Omar a désormais été rapproché de l'outil Ines, rendant ainsi possible des études plus larges de la redistribution. Cet article, de nature méthodologique, présente les différentes étapes de construction d'Omar. En fin d'article, une étude de la sensibilité des valeurs simulées à la méthode d'imputation des contrats offre un aperçu des possibilités offertes par ce nouvel outil

Lardellier, R., et al. (2012). "Un outil pour l'étude des dépenses de santé et des « restes à charge » des ménages : le modèle Omar." Economie et Statistique(450-2011).
http://www.insee.fr/fr/ffc/docs_ffc/ES450C.pdf

Les « restes à charge » des ménages correspondent à la part de leurs dépenses de santé qui n'est couverte ni par l'assurance obligatoire de base ni par la couverture complémentaire. Leur connaissance est indispensable au pilotage du système d'assurance maladie. Au niveau macroéconomique, ils sont suivis grâce aux Comptes de la santé. Mais on s'attend à ce que leur poids soit très variable d'un individu à l'autre. Or il n'y a pas de source individuelle qui permette leur observation directe à niveau fin. Cet article présente une démarche qui vise à combler cette lacune, celle du modèle Omar (Outil de Microsimulation pour l'Analyse des Restes à charge). Ce modèle reconstitue le partage de la dépense individuelle entre les trois financeurs : la Sécurité sociale, l'organisme complémentaire et l'individu. Il le fait en s'appuyant sur deux sources. La première est la source Epas-SPS qui apparie l'enquête Santé et Protection Sociale de l'Irdes et des données administratives de la Caisse nationale d'assurance maladie. La seconde est une enquête de la Drees auprès des organismes de couverture complémentaire. Cette dernière permet d'identifier les principales caractéristiques des contrats qu'ils offrent à leurs affiliés. Les informations de ces deux sources sont combinées et complétées par diverses techniques d'imputation.

Pierre, A., et al. (2012). "Impact d'une sur-assurance santé sur le reste à charge des patients." Economie Publique(28-29): 149-164, tabl., graph.
http://economiepublique.revues.org/8907?file=1

En santé, un individu averse au risque choisit de s'assurer afin de réduire le risque financier associé à la maladie. L'hypothèse naïve conduit à supposer que l'introduction d'une assurance santé réduit le risque à charge (RAC), c'est-à-dire la dépense de santé qu'il supporte in fine après les remboursements des organismes d'assurance maladie. Toutefois, sous hypothèse de sensibilité au prix de la demande de soins, la souscription d'un contrat d'assurance santé induit une modification du comportement de consommation de soins, qu'il s'agisse d'aléa moral ou d'accès aux soins. Le lien entre assurance et RAC n'est donc pas si clair. A partir d'un panel de données individuelles d'assurés auxquels une sur-complémentaire d'assurance a été offerte (SHI), cet article teste hypothèse selon laquelle l'assurance permet de réduire le RAC lié aux dépenses de santé et étudie ensuite dans quelle mesure l'évolution des RAC est susceptible de caractériser une amélioration de l'accès aux soins.

2011

Fonds CMU (2011). Analyse du reste à charge en soins de ville des assurés bénéficiaires de la CMU complémentaire. Salariés., Paris : Fonds Cmu.

L'objectif de cette étude est de mesurer les montants restant à la charge des bénéficiaires de la CMU-C (couverture maladie universelle complémentaire) sur les principaux postes de dépenses. En effet, de récents travaux, menés notamment par la Caisse nationale d'assurance maladie (CNAMTS) ont mis en évidence l'existence de participations financières supplémentaires pour des soins qui n'auraient pas dû en générer. C'est pourquoi, le Fonds CMU a sollicité la caisse des Hauts-de-Seine pour mener un état des lieux détaillé de la situation, au niveau local.

Fonds CMU (2011). Rapport du Fonds CMU au Gouvernement sur l'évolution du prix et du contenu des contrats ayant ouvert droit à l'aide pour une complémentaire santé (ACS) en 2010. Pari s: Fonds Cmu

Selon l'article L. 863-5 du code de la sécurité sociale, le Fonds CMU « rend compte annuellement au Gouvernement de l'évolution du prix et du contenu des contrats ayant ouvert droit» à l'aide complémentaire santé (ACS). Elle s'inscrit dans la continuité de l'enquête 2009 sauf sur ce qui concerne le montant moyen de déduction qui connaît un bond de 17 % grâce aux mesures de revalorisations intervenues récemment et qui conduisent à la prise en charge du prix des contrats à hauteur de 60 %, contre 50 % auparavant. Le prix moyen du contrat s'établit à 782 euros (par contrat couvrant en moyenne 1,62 personnes, soit 483 euros pour 1 personne) ; Le montant moyen de déduction ACS (aide légale) s'élève à 439 euros, le reste à charge moyen à 344 euros (il s'agit du reste à charge sur le prix du contrat) ; Ces données conduisent à un taux de reste à charge (ou pourcentage de la prime ou cotisation restant à charge) par contrat de 42 %

HCAAM (2011). L'accessibilité financière des soins : comment la mesurer ? Avis. Paris : HCAAM**:** 24 , graph., ann.
https://www.securite-sociale.fr/hcaam

L'objectif futur du Haut Conseil pour l'avenir de l'assurance maladie est de proposer un ensemble d'indicateurs d'évaluation de l'assurance maladie, sous la forme d'un « tableau de bord » qui ne se limite pas aux seuls aspects financiers, mais englobe aussi les dimensions du recours efficient au système de soins ; qui renforce les analyses et les comparaisons, notamment avec les systèmes étrangers de protection sociale ; qui - contribue à la qualité du débat public, en vue des nécessaires adaptations du système d'assurance maladie au regard du respect de ses objectifs fondamentaux. Le suivi de ces indicateurs servira de base aux considérations des « rapports annuels » du HCAAM. La première étape a porté sur l'accessibilité financière des soins » pour tous. Cet avis présente donc le premier volet de ce tableau de bord, soit un ensemble restreint d'indicateurs qui permettront de suivre cet objectif fondamental, selon trois angles d'approche :- la solidarité entre bien portants et malades, au regard du coût de la maladie et quels que soient les revenus du malade ;- la garantie d'accessibilité financière pour les revenus les plus faibles ; - le financement de l'accès optimal au système de soins.

HCAAM (2011). Mieux évaluer la dépense publique d'assurance maladie : l'ONDAM et la mesure de l'accessibilité financière des soins. Maladie. Paris : HCAAM.
https://www.securite-sociale.fr/hcaam

Ce rapport, adopté le 15 décembre 2011, comporte une prise de position sur l'Objectif national des dépenses d'assurance maladie (ONDAM), à partir d'une étude qui aborde l'ensemble des enjeux associés à cet objectif, ainsi que la question des Objectifs régionaux (ORDAM) ;une prise de position sur l'accessibilité financière des soins et la question du "reste à charge" en matière de santé, à partir de données originales produites par le Haut Conseil pour l'avenir de l'assurance maladie. les deux premiers volets du "Tableau de bord " annuel du HCAAM, portant respectivement sur l'accessibilité financière des soins et sur la situation financière de l'assurance maladie. Ce document comprend aussi une note de la Direction de recherche - de l'évaluation, des études et des Statistiques (DREES) fera l'objet de compléments.

MSA (2011). Les restes à charge supportés par les bénéficiaires de la CMU-C du régime social agricole en

Gironde en 2010. Gironde. Paris : MSA

L'objectif de cette étude est de confirmer l'existence d'un reste à charge pour les bénéficiaires de la CMU-C (couverture maladie universelle complémentaire) relevant de la Mutualité sociale agricole de Gironde et d'en analyser les caractéristiques.

Mizrahi, A. et Mizrahi, A. (2011). "Le financement individuel des dépenses médicales : un indicateur de participation individuelle aux dépenses médicales." Bibliographie Argses(50).
http://argses.free.fr/textes/50_financement_individuel_depenses_medicales.pdf

La notion d'équité en matière d'accès aux soins médicaux a été posée dès la création des premières sociétés de secours mutuel, et elles continuent de se poser4 plus d'un siècle après. En France, une part importante du coût des soins est prise en charge par l'Assurance maladie et l'Etat (76,8 % en 2009), le reste est financé en partie par les OCAM6 (13,8 %), en partie par les malades eux-mêmes (9,4 %). Le problème de l'équité se présente de manière duale : verticale, indiquant que chaque personne participe aux dépenses en fonction de ses ressources, et horizontale, indiquant que deux personnes ayant les mêmes ressources participent également aux dépenses, indépendamment de leur état de santé. Dans un premier temps, cet article présente le cadre des variables classiques d'analyse des problèmes de l'équité, dépense médicale totale (quel qu'en soit le financeur final) et reste à charge. Dans un deuxième temps, une nouvelle variable, le financement individuel des dépenses médicales, est proposée pour analyser les deux formes duales de l'équité en matière de financement des soins médicaux.

Ricci, P. (2011). "Reste à charge des personnes bénéficiant de la CMU-C en 2010. " Points de Repere(35).
http://www.ameli.fr/fileadmin/user_upload/documents/Points_de_repere_n__35.pdf

Aujourd'hui, plus de 4 millions de personnes ont, au titre de la couverture maladie universelle complémentaire (CMU-C), une protection complémentaire gratuite. Ce dispositif offre un panier de soins élargi par rapport à l'Assurance maladie obligatoire (AMO), notamment grâce à des forfaits relatifs aux prestations d'optique et de dentaire. L'ensemble de ces dispositions limite les restes à charge et doit donc permettre de faciliter l'accès aux soins des patients dont les revenus sont les plus faibles. L'objectif de cette étude est de mesurer l'ampleur et d'analyser la structure des restes à charge (RAC) des bénéficiaires de la CMU-C qui ont eu recours aux soins en 2010.

Tabuteau, D. (2011). "Santé et assurance-maladie : l'inquiétante dilution des services publics." Droit Social //(12).

Cet article dresse un historique des réformes de l'assurance maladie mises en place depuis 1988, dont l'objectif principal était la régulation des dépenses de santé en soulignant les deux principes directeurs : la responsabilisation des acteurs, notamment de l'assuré social et la mise en concurrence du système de santé.

Yilmaz, E. et Raynaud, D. (2011). Les patients en situation de précarité accueillis en court séjour restent-ils plus longtemps à l'hôpital ? Le panorama des établissements de santé., Paris : DREES**:** 14 , tabl., graph. fig.

Cette étude a pour but de mesurer l'influence de la précarité sur la durée de séjour en médecine, chirurgie et obstétrique (MCO). Elle fait suite à une enquête spécifique sur la précarité dans les établissements de santé participant à l'étude nationale de coût à méthodologie commune (ENCC) qui a été menée en novembre et décembre 2008. Quatre dimensions ont été retenues pour définir la précarité : isolement social, qualité du logement, niveau de revenu, accès aux droits.

2010

Debrand, T. et Sorasith, C. (2010). "Apports du modèle de microsimulation Arammis : une analyse des effets

redistributifs du plafonnement des restes à charge en ambulatoire." Questions D'Economie de la Sante (Irdes)(159).
http://www.irdes.fr/Publications/2010/Qes159.pdf

En France, bien qu4une grande partie des dépenses de santé soit prise en charge par le système d?Assurance maladie obligatoire, d'importants restes à charge ? différence entre les dépenses de santé et les remboursements de l'Assurance maladie peuvent persister. Dans le cadre de la réflexion engagée sur les moyens de limiter ces restes à charge « excessifs », nous avons testé deux types de plafonnement des restes à charge, à partir du modèle de microsimulation Arammis. Nous avons simulé le remplacement du dispositif actuel de remboursement à 100 % des malades en affections de longue durée (ALD) par l'instauration de deux plafonnements appliqués à l'ensemble des assurés (hors bénéficiaires de la CMU) sur les remboursements de leurs dépenses de santé en ambulatoire (hors hôpital et dépassements d'honoraires). Le premier applique un plafond identique à tous ; le deuxième établit un plafond en fonction du revenu. L'étude documente, à partir d?un modèle de microsimulation basé sur des données individuelles, deux mécanismes de plafonnements de restes à charge en ne modifiant pas les équilibres financiers de l'Assurance maladie obligatoire (résumé d'auteur).

Debrand, T. et Sorasith, C. (2010). Bouclier sanitaire : choisir entre égalité et équité ? Une analyse à partir du modèle ARAMMIS, Paris : Irdes
http://www.irdes.fr/EspaceRecherche/DocumentsDeTravail/DT32BouclierSanitaireAnalyseModeleArammis.pdf

Cet article cherche à mesurer, à l'aide du modèle d'Analyse des réformes de l'Assurance maladie par micro-simulation statique (ARAMMIS), les effets de la mise en place d'un bouclier sanitaire financé par la suppression du régime des affections de longue durée (ALD). Notre étude repose sur la comparaison des conséquences redistributives de différentes règles de boucliers sur les restes à charge des patients dans le secteur ambulatoire en France. Nous attachons une importance particulière aux indicateurs permettant de mettre en évidence les modifications des restes à charge et de mesurer l'évolution du système en termes d'équité. Nous présentons, dans une première partie, le cadre général du système de santé en France pour mieux comprendre le contexte et les enjeux d'une refonte du mode de remboursement lié à l'Assurance maladie obligatoire. Dans une deuxième partie, nous décrivons les hypothèses retenues, la base de données et le modèle de micro-simulation. Enfin, nous consacrons la dernière partie à la présentation des principaux résultats mesurant l'impact de la réforme tant au niveau des individus qu'au niveau du système (résumé d'auteur).

Debrand, T. et Sorasith, C. (2010). Out-of-pocket maximum rules under a compulsory health care insurance scheme : a choice between equality and equity, Paris : Irdes
http://www.irdes.fr/EspaceAnglais/Publications/WorkingPapers/DT34OutPocketMaxRulesCompulsoryHealthCare.pdf

Cette publication cherche à mesurer, à l'aide du modèle d'Analyse des réformes de l'Assurance maladie par microsimulation statique (ARAMMIS), les effets de la mise en place d'un bouclier sanitaire financé par la suppression du régime des affections de longue durée (ALD). Notre étude repose sur la comparaison des conséquences redistributives de différentes règles de boucliers sur les restes à charge des patients dans le secteur ambulatoire en France. Nous attachons une importance particulière aux indicateurs permettant de mettre en évidence les modifications des restes à charge et de mesurer l'évolution du système en termes d'équité. Nous présentons, dans une première partie, le cadre général du système de santé en France pour mieux comprendre le contexte et les enjeux d'une refonte du mode de remboursement lié à l'Assurance maladie obligatoire. Dans une deuxième partie, nous décrivons les hypothèses retenues, la base de données et le modèle de micro-simulation. Enfin, nous consacrons la dernière partie à la présentation des principaux résultats mesurant l'impact de la réforme tant au niveau des individus qu'au niveau du système (résumé d'auteur).

Elbaum, M. (2010). "[A new way of financing the French healthcare system?]." Sante Publique **22**(1): 91-106.

Several changes occurred lately in the regulation of the French healthcare system: the public health insurance deficit has been reduced until 2008, the ratio of health expenditure as percentage of GDP has remained fairly stable, activity-based payments have been implemented in public and private hospitals, and the government tried to promote more coordination and better prescriptions among practitioners. These changes have nevertheless limited impacts, and do not concern the "heart" of economic regulation: the system of prices, fees and reimbursement remains unchanged, and health insurance deficits have been repeatedly funded by new specific taxes and decreases in reimbursement. The part of expenses left to complementary insurances and out-of-pocket spending is increasing for ambulatory care, and government policies claiming for more "responsibility" in the use of health care mainly apply to patients. As these problems remain unsolved, the French health system has to tackle major short and medium-term challenges: the consolidation of deficits linked or not to the economic crisis, the long-term trend of health care expenditures resulting from population ageing, and the necessity to improve the efficiency of the system in a way which does not increase inequities in health care access.

Legal, R., et al. (2010). "Financement des dépenses de santé et reste à charge des ménages : une approche par micro-simulation." Serie Statistiques - Document de Travail - Drees(149).
https://drees.solidarites-sante.gouv.fr/

La présente étude offre pour la première fois une analyse micro-économique de la structure de financement des dépenses de santé des ménages. Celle-ci est loin d'être uniforme, compte tenu de l'hétérogénéité de la population face au risque maladie d'une part et face à sa prise en charge par l'assurance maladie et les organismes complémentaires d'autre part. La distribution du reste à charge au niveau des ménages est donc très variable selon leur âge et leur niveau socio-économique. Les ménages modestes, plus âgés et en moins bonne santé que les plus aisés ont ainsi en moyenne des dépenses plus élevées. Leur structure de consommation est également particulière, marquée par un recours plus important à l'hôpital mais plus faible aux spécialistes pratiquant des dépassements ainsi qu'une consommation moindre des soins les moins bien pris en charge par l'assurance maladie (optique et dentaire). La couverture complémentaire est un déterminant important de l'accès aux soins : 94 % de la population en dispose. Toutefois, le niveau de garantie offert est très variable : ce sont les actifs qui sont le plus fréquemment couverts par un contrat haut de gamme, tandis que les jeunes sont plus fréquemment couverts par des contrats d'entrée de gamme et les retraités par des contrats intermédiaires. En définitive, le niveau de remboursement au titre de l'assurance complémentaire dont dispose un individu dépend assez peu de son état de santé. La structure de financement et le reste à charge des ménages sont très sensibles à leur niveau de vie et à leur position par rapport à l'emploi. C'est pour les plus modestes, les moins bien insérés sur le marché du travail et les plus âgés que la part des dépenses prises en charge par la Sécurité sociale est la plus élevée. Ce sont eux aussi qui bénéficient le plus de la CMUC. A contrario, les plus aisés financent une part non négligeable de leur santé à partir de fonds privés. Le reste à charge moyen des ménages augmente avec leur niveau de vie, qu'on le considère uniquement après intervention de l'assurance maladie, pour mesurer l'ampleur de la solidarité que celle-ci organise, ou également après prise en compte de la prise en charge des organismes complémentaires. Toutefois, si l'on rapporte ce reste à charge au revenu disponible des ménages, pour avoir une mesure de l'effort financier qu'ils consacrent à leur santé, l?on constate a contrario que le taux d'effort des ménages est d'autant plus élevé que leur niveau de vie est faible. La couverture complémentaire, et notamment la CMU-C, joue un rôle important pour alléger la charge financière des plus modestes : elle permet de diviser leur taux d'effort par 3,5. Pour les plus aisés, l'intervention des complémentaires privées divise par 3 leur taux d'effort.

Legal, R., et al. (2010). "La prise en charge des dépenses maladie des assurés sociaux en fonction du risque constaté : quelle contribution de l'assurance maladie et des organismes complémentaires ?" Serie Statistiques - Document de Travail - Drees(149).
https://drees.solidarites-sante.gouv.fr/

La présente étude analyse la prise en charge des dépenses maladie des assurés sociaux par l'assurance maladie mais aussi par les assurances complémentaires selon la gravité de leur état de santé, appréhendée ici à travers la reconnaissance d'une affection de longue durée (ALD). La dépense des assurés ayant le risque santé le plus élevé est en moyenne 6 fois supérieure à celle des autres assurés, ce qui traduit bien la gravité des pathologies qui les affectent. L'assurance maladie contribue à améliorer significativement l'accessibilité financière aux soins pour les plus malades : après son intervention, la dépense moyenne de ces personnes est divisée par 12. Toutefois, malgré l'ampleur de la redistribution horizontale qu'elle organise, les plus malades supportent un reste à charge moyen toujours plus élevé que les autres assurés. L'assurance maladie organise également une redistribution verticale importante : en effet, les personnes les plus modestes ont plus fréquemment un risque santé élevé que les plus aisées. Toutefois, même si le système actuel constitue un filet de protection largement efficace, une frange de la population doit faire face à des dépenses de santé importantes qui ne sont pas remboursées par la sécurité sociale. Ces restes à charge « catastrophiques » sont principalement liés aux dépenses hospitalières. L'assurance maladie complémentaire contribue également à réduire le reste à charge des assurés. Logiquement, la part de la dépense qu'elle prend en charge est d'autant plus importante que celle de l'assurance maladie est faible. Les mécanismes de redistribution de l'assurance maladie obligatoire bénéficiant aux plus malades jouent un rôle régulateur important du marché de la couverture complémentaire. En concentrant les dépenses de l'assurance maladie sur les plus malades, ils permettent de réduire, du point de vue des assureurs complémentaires, le différentiel de dépenses non remboursées et donc l'écart de risque avec les moins malades et limitent donc leur intérêt pour pratiquer la sélection des risques ou la tarification en fonction de l'état de santé. Ils favorisent donc l'accès des plus malades à une couverture complémentaire en modérant le montant des primes qu'ils supportent

UFC (2010). Le coût de la couverture santé pour les ménages : enquête et propositions de l'UFC- Que Choisir ; Paris . Union Française des consommateurs
http://www.quechoisir.org/sante-bien-etre/systeme-de-sante/assurance-maladie/etude-le-cout-de-la-couverture-sante-pour-les-menages-enquete-et-propositions-de-l-ufc-que-choisir

Cette publication de l'UFC-Que Choisir présente les résultats d'une étude sur le poids des dépenses de santé dans le budget des consommateurs et particulièrement celui relatif à l'achat des assurances en santé. Ces dernières années, les pouvoirs publics accumulent les mesures visant à sortir de plus en plus de dépenses de santé du champ de l'assurance-maladie pour les transférer directement aux consommateurs. Ainsi, quand une personne consacrait 407 euros à se soigner en 2001 - reste à charge et éventuelle cotisation de complémentaire -, elle devait y consacrer 618 euros sept ans plus tard soit une progression de 52%. Cette inflation des dépenses de santé est, dans une large mesure, liée au marché des complémentaires. Mais l'effort exigé n'est pas le même d'un ménage à l'autre. Ce qui signifie que les mesures d'économie n'ont pas les mêmes conséquences d'un consommateur à l'autre. Tous ces éléments sont venus plaider pour que l'UFC-Que Choisir mène une analyse plus fine visant à connaître le poids et l'évolution des dépenses de santé sur différentes strates de la population. Très rapidement, l'analyse a démontré que, parmi les sommes qui restent à la charge des ménages, l'achat d'une assurance complémentaire constitue le premier poste. C'est pourquoi l'association a souhaité mettre l'accent sur le poste de dépense en santé relatif à l'achat d'une assurance santé. Dans ce domaine, le constat est sans appel : les complémentaires sont devenues un pré requis dans l'accès aux soins ; l'accroissement du poids des dépenses de santé pour les ménages s'est accompagné de difficultés croissantes dans le choix et l'acquisition d'une assurance santé complémentaire ; les consommateurs ont été soumis à une inflation des primes d'assurance santé déconnectées des remboursements. Les données utilisées émanent de différentes sources de la statistique publique intervenant dans le secteur de la santé (IRDES, DREES, INSEE) mais également de l'assurance (ACAM devenue ACP, Fond CMU). L'analyse se limite à la période 2001-2008, les données pour les années postérieures n'étant pas encore disponibles.

2009

(2009). "Lorsque la dépense remboursée par le régime obligatoire augmente, le reste à charge des assurés diminue-t-il ? Une étude de la Mutualité contredit les idées reçues." Revue de Presse de L'Afim //(3515).

Contrairement à une idée couramment véhiculée, lorsque le niveau des dépenses remboursées par le régime obligatoire augmente, le reste à charge pour les complémentaires et les assurés augmente également. C'est ce que démontre une étude de la Mutualité française menée au niveau départemental à partir des données du Système national d'informations inter-régimes d'assurance maladie (Sniiram)

Lagasnerie, G. (2009). Justice sociale et efficacité : pour une nouvelle régulation de la demande de soins. Regards Croises Sur L'Economie. In : Au chevet de la santé : quels diagnostics ? quelles réformes ?, Paris : Editions de le découverte.
http://www.cairn.info/revue-regards-croises-sur-l-economie-2009-1-page-112.htm

La tendance est à la baisse de la part des dépenses de santé financées par l'assurance maladie obligatoire pour les patients ne souffrant pas d'une affection de longue durée (ALD), pathologie que la Sécurité sociale prend en charge à 100 %. Dans un premier temps, ce désengagement a été assumé comme une mesure visant à rétablir l'équilibre des comptes (plans Barrot de 1979, Bérégovoy de 1982-1983). Mais depuis les années 2000, sa justification est toute autre : la baisse des remboursements vise à « responsabiliser les assurés ».

2008

Grignon, M., et al. (2008). "Does free complementary health insurance help the poor to access health care? Evidence from France." Health Econ **17**(2): 203-219.

The French government introduced a 'free complementary health insurance plan' in 2000, which covers most of the out-of-pocket payments faced by the poorest 10% of French residents. This plan was designed to help the non-elderly poor to access health care. To assess the impact of the introduction of the plan on its beneficiaries, we use a longitudinal data set to compare, for the same individual, the evolution of his/her expenditures before-and-after enrollment in the plan. This before-and-after analysis allows us to remove most of the spuriousness due to individual heterogeneity. We also use information on past coverage in a difference-in-difference analysis to evaluate the impact of specific benefits associated with the plan. We attempt at controlling for changes other than enrollment through a difference-in-difference analysis within the eligible (rather than enrolled) population. Our main result is the plan's lack of an overall effect on utilization. This result is likely attributable to the fact that those who were enrolled automatically in the free plan (the majority of enrollees), already benefited from a relatively generous plan. The significant effect among those who enrolled voluntarily in the free plan was likely driven by those with no previous complementary coverage.

2007

Bras, P. L., et al. (2007). "En finir avec les affections de longue durée (ALD), plafonner les restes à charge." Droit Social : (4).

Après avoir présenté le dispositif français de couverture des restes à charge importants et en avoir analysé les limites, cet article propose la création d'un mécanisme de plafonnement du reste à charge sur la dépense remboursable, hors dépassement. Ce bouclier contre les restes à charge importants se substituerait notamment au régime d'exonération des affections longue durée. Plus équitable, il présente l'intérêt de libérer un temps médical conséquent pour l'amélioration de la qualité des pratiques.

Ecalle, F. (2007). "Assurance-maladie : plafonner les franchises et tickets modérateurs en fonction du revenu." Societal : (56).

L'analyse proposée dans cet article repose sur un ouvrage réalisé par l'Institut de l'entreprise : « C'est possible ! Voici comment. ». Dans cet ouvrage, il est proposé de mieux prendre en compte les revenus des ménages pour rembourser leurs dépenses de santé. Le reste à charge qui leur est laissé par l'assurance maladie obligatoire est actuellement , en effet, sans aucun rapport avec leur capacité contributive. Si le reste à charge supporté par chaque ménage était limité à un certain pourcentage de son revenu, la justice sociale serait sensiblement améliorée et, en modifiant ce pourcentage, les comptes de l'assurance-maladie pourraient être équilibrés.

2005

HCAAM (2005). Le périmètre de la prise en charge intégrale par les régimes de base, Paris : HCAAM
https://www.securite-sociale.fr/hcaam

Un avis consacré au périmètre de prise en charge intégrale par les régimes de base, adopté jeudi 27 octobre à la quasi unanimité par le Haut Conseil pour l'avenir de l'assurance maladie, propose de remettre à plat les critères occasionnant une couverture intégrale des soins, afin de donner plus de cohérence à notre système, et envisage les conséquences du forfait de 18 euros sur les actes lourds. Le Haut Conseil ne conteste pas le fait que la collectivité nationale a fait le choix de couvrir aussi parfaitement que possible les soins les plus onéreux, mais il observe que, en fait, on exonère non pas sur la seule constatation d'une dépense élevée mais aussi en fonction du statut de l'individu : état de santé, situation du bénéficiaire (régime des accidents du travail, femmes enceintes...). Il en résulte des incohérences, certes à la marge mais choquantes. L'avis s'inquiète d'une telle distorsion [?] qui est de nature à diminuer l'attachement des Français à une Sécurité sociale obligatoire et solidaire. Quant au forfait de 18 euros sur les actes lourds (supérieurs à 91 euros), le Haut Conseil souligne qu'il s'agit d'une petite franchise qui représente 1 % des dépenses exonérées à ce titre. L'avis insiste aussi sur le fait que 2,3 millions d'assurés hospitalisés ne sont pas exonérés aujourd'hui (absence d'acte technique lourd), ce qui occasionne pour eux un reste à charge moyen de 500 euros. Si ce forfait de 18 euros peut apparaître comme un moyen de rééquilibrer les règles de prise en charge entre assurés hospitalisés, selon que leur séjour comporte un acte technique ou non, ce rééquilibrage reste partiel et ne résout en rien le fait que certains hospitalisés supportent des coûts très élevés. De plus, le fait d'exonérer du forfait de 18 euros les personnes en ALD, les femmes enceintes ou les titulaires d'une pension d'invalidité risque d'accroître la distorsion pointée par le Haut Conseil, entre les assurés pris en charge à 100 % et les autres

ÉTUDES INTERNATIONALES

2021

Chandra, A., Flack, E. et Obermeyer, Z. (2021). The Health Costs of Cost-Sharing. NBER Working Paper Series ;28439. Cambridge NBER**:** 55 , tabl., fig.
https://www.nber.org/papers/w28439

We use the design of Medicare's prescription drug benefit program to demonstrate three facts about the health consequences of cost-sharing. First, we show that an as-if-random increase of 33.6% in out-of-pocket price (11.0 percentage points (p.p.) change in coinsurance, or $10.40 per drug) causes a 22.6% drop in total drug consumption ($61.20), and a 32.7% increase in monthly mortality (0.048 p.p.). Second, we trace this mortality effect to cutbacks in life-saving medicines like statins and antihypertensives, for which clinical trials show large mortality benefits. We find no indication that these reductions in demand affect only 'low-value' drugs; on the contrary, those at the highest risk of heart attack and stroke, who would benefit the most from statins and antihypertensives, cut back more on these drugs than lower risk patients. Similar patterns exist for other drug–disease pairs, and irrespective of socioeconomic circumstance. Finally, we document that when faced with complex, high-dimensional choice problems, patients respond in simple, perverse ways. Specifically, price increases cause 18.0% more patients (2.8 p.p.) to fill no drugs, regardless of how many drugs they had been on previously, or their health risks. This decision mechanically results in larger absolute reductions in utilization for those on many drugs. We conclude that cost-sharing schemes should be evaluated based on their overall impact on welfare, which can be very different from the price elasticity of demand.

Karsu, Ö. et Morton, A. (2021). "Trading off health and financial protection benefits with multiobjective optimization." Health Econ **30**(1): 55-69.

Countries which are introducing a system of Universal health coverage have to make a number of key tradeoffs, of which one is the tradeoff between the level of coverage and the degree to which patients are exposed to potentially catastrophic financial risk. In this study, we first present a way in which decision makers might be supported to focus on in a particular part of the tradeoff curve and ultimately choose an efficient solution. We then introduce some multiobjective optimization models for generating the tradeoff curves given data about potential treatment numbers, costs, and benefits. Using a dataset from Malawi, we demonstrate the approach and suggest a core index metric to make specific observations on the individual treatments. Moreover, as there has been some debate about the best way to measure financial exposure, we also investigate the extent to sensitivity of our results to the precise technical choice of financial exposure metric. Specifically, we consider two metrics, which are the total number of cases protected from catastrophic expenditure and a convex penalty function that penalizes out-of-pocket expenditures in an increasingly growing way, respectively.

Liu, C., Gotanda, H., Khullar, D., et al. (2021). "The Affordable Care Act's Insurance Marketplace Subsidies Were Associated With Reduced Financial Burden For US Adults." Health Aff (Millwood) **40**(3): 496-504.

Research suggests that the Affordable Care Act (ACA) Medicaid expansions improved financial protection for the poor. However, evidence is limited on whether subsidies offered through the ACA Marketplaces, the law's other major coverage expansion, were associated with reduced financial burden. Using national survey data from the period 2008-17, we examined changes in household health care spending among low-income adults eligible for both Marketplace premium subsidies and cost-sharing reductions (139-250 percent of the federal poverty level) and middle-income adults eligible only for premium subsidies (251-400 percent of the federal poverty level), using high-income adults ineligible for subsidies (greater than 400 percent of the federal poverty level) as controls. Among low-income adults, Marketplace subsidy implementation was associated with 17 percent lower out-of-pocket spending and 30 percent lower probability of catastrophic health expenditures. In contrast, middle-income adults did not experience reduced financial burden by either measure. These findings highlight the successes and limitations of Marketplace subsidies as debate continues over the ACA's future.

López-López, S., Del Pozo-Rubio, R., Ortega-Ortega, M., et al. (2021). "Catastrophic Household Expenditure Associated with Out-of-Pocket Healthcare Payments in Spain." Int J Environ Res Public Health **18**(3).

BACKGROUND: The financial effect of households' out-of-pocket payments (OOP) on access and use of health systems has been extensively studied in the literature, especially in emerging or developing countries. However, it has been the subject of little research in European countries, and is almost nonexistent after the financial crisis of 2008. The aim of the work is to analyze the incidence and intensity of financial catastrophism derived from Spanish households' out-of-pocket payments associated with health care during the period 2008-2015. METHODS: The Household Budget Survey was used and catastrophic measures were estimated, classifying the households into those above the threshold of catastrophe versus below. Three ordered logistic regression models and margins effects were estimated. RESULTS: The results reveal that, in 2008, 4.42% of Spanish households dedicated more than 40% of their income to financing out-of-pocket payments in health, with an average annual gap of EUR 259.84 (DE: EUR 2431.55), which in overall terms amounts to EUR 3939.44 million (0.36% of GDP). CONCLUSION: The findings of this study reveal the existence of catastrophic households resulting from OOP payments associated with health care in Spain and the need to design financial protection policies against the financial risk derived from facing these types of costs.

Sabermahani, A., Sirizi, M. J., Zolala, F., et al. (2021). "Out-of-Pocket Costs and Importance of Nonmedical and Indirect Costs of Inpatients." Value Health Reg Issues **24**: 141-147.

OBJECTIVES: Out-of-pocket (OOP) costs are a major part of the expenditures for healthcare services. In most cases, patient financial protection plans cover only direct medical costs and not other expenses by patients. METHODS: This cross-sectional study was conducted on 800 patients referring medical centers of Kerman to analyse all aspects of OOP, especially after the Health Transformation Plan in Iran. Using the probability proportional to the size of the medical center, samples from each ward in each medical center were determined in accordance with the previous year's patient number. Randomly selected medical records of the last 2 weeks of patients discharged were collected, information was extracted, and telephone interviews were conducted. RESULTS: The mean total OOP costs of a one-time hospitalization in all medical centers in Kerman was equal to 7 561 977 Iranian rials. Assuming a 5% threshold, 37% of patients in public centers were faced with catastrophic health expenditures for a one-time hospitalization. Based on the results of the regression model, reduction of length of stay, elimination of the need for the presence of next of kin, and provision of healthcare services out of hospitals can greatly reduce OOP expenditures. CONCLUSION: Although direct medical costs are of special importance, and it is very necessary to protect patients against such costs, patients usually incur a variety of costs when receiving inpatient services. Inattention to direct nonmedical costs and indirect costs due to patients' and their next of kin's absenteeism may cause households to face catastrophic expenditures.

2020

Alessie, R. J. M., Angelini, V., Mierau, J. O., et al. (2020). "Moral hazard and selection for voluntary deductibles." Health Economics **29**(10): 1251-1269.
https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4134

Abstract This paper investigates whether the voluntary deductible in the Dutch health insurance system reduces moral hazard or acts only as a cost reduction tool for low-risk individuals. We use a sample of 14,089 observations, comprising 2,939 individuals over seven waves from the Longitudinal Internet Studies for the Social sciences panel for the analysis. We employ bivariate models that jointly model the choice of a deductible and health care utilization and supplement the identification with an instrumental variable strategy. The results show that the voluntary deductible reduces moral hazard, especially in the decision to visit a doctor (extensive margin) compared with the number of visits (intensive margin). In addition, a robustness test shows that selection on moral hazard is not present in this context.

Atake, E. H. (2020). "Does the type of health insurance enrollment affect provider choice, utilization and health care expenditures?" BMC Health Serv Res **20**(1): 1003.

BACKGROUND: Two of the objectives of Universal Health Coverage are equity in access to health services and protection from financial risks. This paper seeks to examine whether the type of health insurance enrollment affects the utilization of health services, choice of provider and financial protection of households in Togo. METHODS: Data were obtained from a cross-sectional, representative household survey involving 1180 insured households that had reported either illness in the household in the 4 weeks preceding the survey or hospitalization in the 12 months preceding the survey. A nested logit model was used to account for the utilization of health services and provider choice, and methods of assessing catastrophic health care expenditures were used to analyze the level of household financial protection. RESULTS: Policyholders of private health insurance use private health care facilities more than policyholders of public health insurance. The main reasons for not using health centers among households with public insurance were out-of-pocket payments (49.19%), waiting time (36.80%), and distance to the nearest health center (36.76%). Furthermore, on average, households with public insurance spent a higher proportion of their total monthly nonfood expenditures on health care than those with private insurance. We find that the type of insurance, share of expenditures allocated to food, distance to the nearest health center, and waiting time significantly impact the choice of provider. Regardless of the type of health insurance, elderly individuals avoid using private health centers and referral hospitals due to the high cost. CONCLUSION: We found that a multiple health insurance system results in a multilevel health system that is not equitable for everyone. The capacity of the health insurance system to provide equitable health care services and protect its members from catastrophic health care expenditures should be at the core of health care reform. This study recommends raising awareness of the criteria for the reimbursement of medical procedures within the framework of public insurance and promoting specific health insurance mechanisms for elderly individuals. Careful attention should be paid to ensuring universal education and literacy as a means of improving access to and the use of health care.

Bouckaert, N., Maertens Denoordhout, C., BuronVan Devoorde, C., et al. (2020). Health System Performance Assessment: how equitable is the Belgian health system? KCE Report; 334B. Bruxelles KCE**:** 99 , fig., tabl., annexes.
https://kce.fgov.be/fr/performance-du-syst%C3%A8me-de-sant%C3%A9-belge-%C3%A9valuation-de-l%E2%80%99%C3%A9quit%C3%A9

Il est bien connu que les populations les plus vulnérables présentent en moyenne davantage de problèmes de santé, et ont donc des besoins plus importants en matière de soins. Le système belge d'assurance maladie obligatoire est basé sur la solidarité et vise à atténuer autant que possible les inégalités en matière de santé. C'est ainsi que les citoyens en bonne santé contribuent aux soins des personnes en moins bonne santé. Mais une autre question est de savoir si l'accès à notre système est équitable ? En d'autres termes, nos soins de santé sont-ils accessibles de manière égale pour les personnes qui présentent les mêmes besoins de soins ? Ou bien le statut socio-économique entraîne-t-il des différences à cet égard ? Et si oui, ces différences ont-elles évolué au fil des ans ? Pour répondre à cette question, le KCE a fait appel à une méthode qui permet de tenir compte des besoins de soins dans l'évaluation du recours aux soins. Cette méthode, et les résultats qui en découlent, constituent la principale différence avec les précédentes recherches sur l'équité dans les soins en Belgique. Les données utilisées datent d'avant la crise du COVID.

Chapman, S., Paris, V. et Loperti, R. (2020). Challenges in access to oncology medicines. Policies and practices across the OECD and the EU. OECD Health Working Papers ; 120. Paris OCDE**:** 123 , tabl., fig.
https://doi.org/10.1787/4b2e9cb9-en

With rapid advancements in oncology, even the wealthiest countries around the globe find it increasingly challenging to provide – and sustain – access to new medicines. Challenges include managing the uncertainty surrounding the extent of benefit of new treatments; complexities in determining the price and place in therapy of certain products; and the need to reconcile affordable, equitable access with spending efficiency and fiscal sustainability. Differences in timing of market entry and heterogeneity of coverage processes and policies contribute to inequity in access across the OECD and EU. Future policies and practices to promote sustainable access to oncology medicines will likely focus on improving affordability for patients and value-for-money for payers. An important element will be strengthening the evidence base, drawing on both clinical trial and "real world" evidence, and enhancing international collaboration and information sharing to improve countries' collective capacity to address clinical and economic uncertainties.

Flood, C. M. et Thomas, B. (2020). Is Two-Tier Health Care the Future?, Ottawa : University of Ottawa Press
https://press.uottawa.ca/is-two-tier-health-care-the-future.html

Canadians are deeply worried about wait times for health care. Entrepreneurial doctors and private clinics are bringing Charter challenges to existing laws restrictive of a two-tier system. They argue that Canada is an outlier among developed countries in limiting options to jump the queue. This book explores whether a two-tier model is a solution. In Is Two-Tier Health Care the Future?, leading researchers explore the public and private mix in Canada, Australia, Germany, France, and Ireland. They explain the history and complexity of interactions between public and private funding of health care and the many regulations and policies found in different countries used to both inhibit and sometimes to encourage two-tier care, such as tax breaks. This edited collection provides critical evidence on the different approaches to regulating two-tier care across different countries and what could work in Canada.

Giannouchos, T. V., Vozikis, A., Koufopoulou, P., et al. (2020). "Informal out-of-pocket payments for healthcare services in Greece." Health Policy **124**(7): 758-764.
https://doi.org/10.1016/j.healthpol.2020.04.005

Background Informal out-of-pocket (OOP) payments for healthcare services are not unusual in Greece. Aim This study estimates the association between respondent and incident-level characteristics and informal payments. Methods A survey of 4218 households was conducted from November 2016 to February 2017. We analyzed healthcare incidents by all household members within the past four months. Multivariate negative binomial regression analysis was used to estimate the association between respondents and incident-level characteristics and informal OOP payments to providers. Results A total of 3494 healthcare incidents were reported by 3183 household-representatives. More-than-half (63 %) of all incidents involved informal activity (median=€150). About 30 % of those were related to provider requested payments. Using hospital, dental, diagnostic/screening, and emergency department services compared to primary care services and having oncological and surgical conditions were among the strongest predictors of higher rates for informal payments. The use of specific providers for reasons related to trust, reputation, referral, and lack of alternatives was also associated with higher rates of informal payments. Provider requested and skip the line payments were associated with larger OOP amounts compared to gratitude payments. Conclusion This survey reveals that informal payments occur for higher-need and less cost-responsive healthcare services particularly in areas where patients lack alternatives. Health policy and regulatory interventions, including stricter control of the financial reporting system are essential to limit informal payments.

Glied, S. A., Collins, S. R. et Lin, S. (2020). "Did The ACA Lower Americans' Financial Barriers To Health Care?" Health Affairs **39**(3): 379-386.
https://doi.org/10.1377/hlthaff.2019.01448

The Affordable Care Act was designed to provide financial protection to Americans in their use of the health care system. This required addressing two intertwined problems: cost barriers to accessing coverage and care, and barriers to comprehensive risk protection provided by insurance. We reviewed the evidence on whether the law was effective in achieving these goals. We found that the Affordable Care Act generated substantial, widespread improvements in protecting Americans against the financial risks of illness. The coverage expansions reduced uninsurance rates, especially relative to earlier forecasts; improved access to care; and lowered out-of-pocket spending. The insurance market reforms also made it easier for people to get and stay enrolled in coverage and ensured that those who were insured had true financial risk protection. But subsequent court decisions and congressional and executive branch actions have left millions uninsured and allowed the risk of inadequate insurance to resurface.

Glied, S. A. et Zhu, B. (2020). "Catastrophic Out-of-Pocket Health Care Costs: A Problem Mainly for Middle-Income Americans with Employer Coverage?" Issue Brief: 14.
https://www.commonwealthfund.org/publications/issue-briefs/2020/apr/catastrophic-out-of-pocket-costs-problem-middle-income

Issue: Many studies report that high out-of-pocket health spending is an increasing problem, despite expanded insurance coverage under the Affordable Care Act (ACA). Little is known about how

Americans' out-of-pocket spending has changed over time. Goals: To observe trends in high out-of-pocket spending and describe the distribution and composition of out-of-pocket spending over time, focusing on the top 5 percent and 1 percent of spenders. Methods: Analysis of Medical Expenditure Panel Survey (MEPS) data. Key findings and conclusions: Expansions in insurance coverage and in the quality of coverage through the ACA have protected most Americans from high out-of-pocket costs. Recently, however, out-of-pocket costs for the highest out-of-pocket spenders (the 99th percentile) have been increasing. In 2017, one in 100 Americans under age 64 spent $5,000 or more out of pocket for medical services, and about one in 20 spent more than $1,700. High out-of-pocket spending mostly affects those with employer coverage and those with incomes above 400 percent (and, in particular, above 600 percent) of the federal poverty level. The plurality of this spending is for physician services. High deductibles and out-of-pocket maximums in private insurance, combined with exposure to out-of-network bills for physician services, leave many Americans facing very high out-of-pocket costs.

Goryakin, Y., Thiebaut, S., Cortaredona, S., et al. (2020). "Assessing the future medical cost burden for the European health systems under alternative exposure-to-risks scenarios." PLoS One **15**(9): 15. https://dx.plos.org/10.1371/journal.pone.0238565

Background: Ageing populations and rising prevalence of non-communicable diseases (NCDs) increasingly contribute to the growing cost burden facing European healthcare systems. Few studies have attempted to quantify the future magnitude of this burden at the European level, and none of them consider the impact of potential changes in risk factor trajectories on future health expenditures. Methods: The new microsimulation model forecasts the impact of behavioural and metabolic risk factors on NCDs, longevity and direct healthcare costs, and shows how changes in epidemiological trends can modify those impacts. Economic burden of NCDs is modelled under three scenarios based on assumed future risk factors trends: business as usual (BAU); best case and worst case predictions (BCP and WCP). Findings: The direct costs of NCDs in the EU 27 countries and the UK (in constant 2014 prices) will grow under all scenarios. Between 2014 and 2050, the overall healthcare spending is expected to increase by 0.8% annually under BAU. In the all the countries, 605 billion Euros can be saved by 2050 if BCP is realized compared to the BAU, while excess spending under the WCP is forecast to be around 350 billion. Interpretation: Although the savings realised under the BCP can be substantial, population ageing is a stronger driver of rising total healthcare expenditures in Europe compared to scenario-based changes in risk factor prevalence.

Gotanda, H., Jha, A. K., Kominski, G. F., et al. (2020). "Out-of-pocket spending and financial burden among low income adults after Medicaid expansions in the United States: quasi-experimental difference-in-difference study." BMJ **368**: m40.

OBJECTIVE: To examine the association between expansion of the Medicaid program under the Affordable Care Act and changes in healthcare spending among low income adults during the first four years of the policy implementation (2014-17). DESIGN: Quasi-experimental difference-in-difference analysis to examine out-of-pocket spending and financial burden among low income adults after Medicaid expansions. SETTING: United States. PARTICIPANTS: A nationally representative sample of individuals aged 19-64 years, with family incomes below 138% of the federal poverty level, from the 2010-17 Medical Expenditure Panel Survey. MAIN OUTCOMES AND MEASURES: Four annual healthcare spending outcomes: out-of-pocket spending; premium contributions; out-of-pocket plus premium spending; and catastrophic financial burden (defined as out-of-pocket plus premium spending exceeding 40% of post-subsistence income). P values were adjusted for multiple comparisons. RESULTS: 37 819 adults were included in the study. Healthcare spending did not change in the first two years, but Medicaid expansions were associated with lower out-of-pocket spending (adjusted percentage change -28.0% (95% confidence interval -38.4% to -15.8%); adjusted absolute change -$122 (£93; €110); adjusted P<0.001), lower out-of-pocket plus premium spending (-29.0% (-40.5% to -15.3%); -$442; adjusted P<0.001), and lower probability of experiencing a catastrophic financial burden (adjusted percentage point change -4.7 (-7.9 to -1.4); adjusted P=0.01) in years three to four. No evidence was found to indicate that premium contributions changed after the Medicaid expansions. CONCLUSION: Medicaid expansions under the Affordable Care Act were associated with lower out-of-pocket spending and a lower likelihood of catastrophic financial burden for low income adults in the third and fourth years of the act's implementation. These findings suggest that the act has been successful nationally in improving financial risk protection against medical bills among low income adults.

Grépin, K. A., Irwin, B. R. et Sas Trakinsky, B. (2020). "On the Measurement of Financial Protection: An Assessment of the Usefulness of the Catastrophic Health Expenditure Indicator to Monitor Progress Towards Universal Health Coverage." Health Syst Reform **6**(1): e1744988.

Ensuring financial protection (FP) against health expenditures is a key component of Sustainable Development Goal (SDG) 3.8, which aims to achieve Universal Health Coverage (UHC). While the proportion of households with catastrophic health expenditures exceeding a proportion of their total income or consumption has been adopted as the official SDG indicator, other approaches exist and it is unclear how useful the official indicator is in tracking progress toward the FP sub-target across countries and across time. This paper evaluates the usefulness of the official SDG indicator to measure FP using the RACER framework and discusses how alternative indicators may improve upon the limitations of the official SDG indicator for global monitoring purposes. We find that while all FP indicators have some disadvantages, the official SDG indicator has some properties that severely limit its usefulness for global monitoring purposes. We recommend more research to understand how alternative indicators may enhance global monitoring, as well as improvements to the quality and quantity of underlying data to construct FP indicators in order to improve efforts to monitor progress toward UHC.

Hajizadeh, M. et Edmonds, S. (2020). "Universal Pharmacare in Canada: A Prescription for Equity in Healthcare." Int J Health Policy Manag **9**(3): 91-95.

Despite progressive universal drug coverage and pharmaceutical policies found in other countries, Canada remains the only developed nation with a publicly funded healthcare system that does not include universal coverage for prescription drugs. In the absence of a national pharmacare plan, a province may choose to cover a specific sub-population for certain drugs. Although different provinces have individually attempted to extend coverage to certain subpopulations within their jurisdictions, out-of-pocket expenses on drugs and pharmaceutical products (OPEDP) accounts for a large proportion of out-of-pocket health expenses (OPHE) that are catastrophic in nature. Pharmaceutical drug coverage is a major source of public scrutiny among politicians and policy-makers in Canada. In this editorial, we focus on social inequalities in the burden of OPEDP in Canada. Prescription drugs are inconsistently covered under patchworks of public insurance coverage, and this inconsistency represents a major source of inequity of healthcare financing. Residents of certain provinces, rural households and Canadians from poorer households are more likely to be affected by this inequity and suffer disproportionately higher proportions of catastrophic out-of-pocket expenses on drugs and pharmaceutical products (COPEDP). Universal pharmacare would reduce COPEDP and promote a more equitable healthcare system in Canada.

Heinzlef, O., Molinier, G. et van Hille, B. (2020). "Economic Burden of the Out-of-Pocket Expenses for People with Multiple Sclerosis in France." Pharmacoeconomics Open(Ahead of print).

BACKGROUND: People with chronic diseases in France frequently incur out-of-pocket expenses (OOPE) related to their medical care. OBJECTIVE: The objective of this study was to evaluate OOPE incurred by people with multiple sclerosis (MS) with respect to direct non-medical and medical expenditure. METHODS: Data were collected through a web-based survey using an online patient community platform (Carenity). The survey questionnaire contained 87 questions (numerical response or Likert scale) and took less than 30 min to complete. Participants rated their disability on a ten-point scale. RESULTS: In total, 376 patients, with a mean age of 48.3 years (95% confidence interval [CI] 47.2-49.5), participated in the survey. Participants estimated that they spent an average of euro127 each month on OOPE for their MS, principally on physician consultations (mean annual expenditure of euro75 by 183 participants), non-physician consultations (euro358 by 135 participants) and non-prescription medication (mean expense of euro67 per pharmacy visit by 234 patients). In total, 77% of participants who needed adaptations to their home or vehicle because of their MS contributed to the cost. No obvious relationship between OOPE and self-rated disability was observed. A total of 61.4% of participants reported that they had to choose between spending money on MS care or on their family and social life. CONCLUSIONS: Most patients with MS incurred significant OOPE linked to consultations, non-prescription medications or home equipment and medical equipment. These outlays could lead to dilemmas when choosing between spending on MS care or family or social life.

Ho, K. et Lee, R. S. (2020). Health Insurance Menu Design for Large Employers. NBER Working Paper Series ; 27868. Cambridge NBER**:** 59 , fig., tab., annexes.
https://www.nber.org/papers/w27868

We explore the challenges faced by a large employer designing a health insurance plan menu for its employees. Using detailed administrative data from Harvard University, we estimate a model of plan choice and utilization, and evaluate the benefits of cost sharing and plan variety. For a single plan with a generous out-of-pocket maximum, we find that a modest coinsurance rate of approximately 30% with a zero deductible maximizes average employee surplus. Gains from offering choice are limited if based solely on financial dimensions, but can be economically significant if paired with other features that appeal to sicker households.

Jilla, A. M., Johnson, C. E. et Huntington-Klein, N. (2020). "Hearing aid affordability in the United States." Disabil Rehabil Assist Technol: 1-7.

PURPOSE: Substantial out-of-pocket costs for hearing aids constitute a barrier to hearing health care accessibility for older adults among whom prevalence of hearing loss is high. This study is the first to estimate the proportion of Americans with functional hearing loss for which out-of-pocket expenditures for hearing aids would be unaffordable at current average costs and determine how affordability varies by sociodemographic factors. MATERIALS AND METHODS: We utilized data from the 2016 American Community Survey to determine the proportion of adults with functional hearing loss for whom hearing aids would constitute ≥3% of annual income or have post-purchase income below a poverty standard. Chi-square tests were used to identify differences in affordability outcomes by sociodemographic characteristics. RESULTS: Results indicated that an average bundled cost of $2500 would constitute a catastrophic expense for 77% of Americans with functional hearing loss (N = 7,872,292) and would add an additional 4% of the population into poverty for the year (N = 423,548). Affordability outcomes varied significantly by age, race, sex, educational attainment and geographic location. CONCLUSIONS: Hearing aids were unaffordable for three-fourths of Americans with functional hearing loss, and their purchase would result in impoverishment for hundreds of thousands of individuals. Reductions in out-of-pocket hearing aid costs to $500 or $1000 would alleviate affordability issues for many Americans with hearing loss. Future federal and state policy should address poor rates of insurance coverage for hearing care, specifically among Medicare and Medicaid, to reduce out-of-pocket costs for hearing care particularly for older adults. Implications for rehabilitation An average out-of-pocket hearing care cost of $2500 was unaffordable for over three quarters of Americans with functional hearing loss. Hearing care affordability varied significantly by demographic characteristics such as age, sex, gender, educational attainment and geographic region. Affordability constitutes a significant barrier to hearing care accessibility in the United States, where most costs of hearing aids and rehabilitation are statutorily excluded from insurance coverage, including the largest insurer of Americans, Medicare.

Koch, S. F. et Setshegesto, N. (2020). Progressivity of Out-of-Pocket Payments and its Determinants Decomposed Over Time. Pretoria University of Pretoria**:** 33 , fig., tabl.
http://d.repec.org/n?u=RePEc:pre:wpaper:2020112&r=hea

This study estimates progressivity of out-of-pocket (OOP) health payments and their determinants using South African Income and Expenditure Surveys. Concentration is decomposed to examine the effect of household determinants on OOP inequality, shedding light on how progressivity/regressivity is related to changes in the concentration and elasticities of the determinants over time. Our results suggest that actual OOP health expenditures are concentrated among non-poor households, although less so now than in the recent past. When OOP health payments are viewed from the perspective of affordability, which instead focuses on the share of payments relative to capacity-to-pay, they are regressive; However, they have become less concentrated amongst poor households, although still regressive, recently. These results appear to be independent of the measure of socioeconomic status employed in the analysis. The results highlight large income and education related disparities and also suggest continued gender and ethnic differences that deserve further attention in policymaking.

Kockaya, G., Oguzhan, G. et Çalşkan, Z. (2020). "Changes in Catastrophic Health Expenditures Depending on Health Policies in Turkey." Front Public Health **8**: 614449.

Without any financial protection out of pocket health expenses are essential both because their increase causes difficulties in accessing higher quality health services for households and more importantly because it complicates access to most basic health services. As a result of the Health Transformation Program in practice in the Turkish healthcare system since 2003, significant changes have been done in all layers of the health system. Turkish Statistics Institute (TurkStat) publishes the ratio of households that bear catastrophic health expenditures since 2002. According to TurkStat data, the ratio of households with catastrophic expenditure has fallen from 0.81% in 2002 to 0.17% in 2011 with the health transformation project. However, it has started to rise since 2012 and has reached 0.31% in 2014. This study aims to evaluate the expenditure items that may have caused the rise of the ratio of households with catastrophic health expenditures since 2012, which had previously dropped with the Health Transformation Program that has caused fundamental changes in health policies. Methodology and definitions presented in the article named "Distribution of health payments and catastrophic expenditures: Methodology" by Ke Xu published by the World Health Organization in 2005 have been used. Percentages of health expenditure items among the total expenditure of households with positive health expenditure and households with catastrophic health expenditure between 2007 and 2014 have been evaluated using descriptive analysis. Findings have been interpreted in light of the health policies in practice between 2007 and 2014. An overview of the impact of the health policies reveals that medicine expenditures have decreased both for household and public health expenditures. Despite the impact of policies on the pharmaceutical industry was criticized by the industry, the positive impact can be seen by the decrease in the spending on medicine for households spending on health. Hospital service with positive health expenditure is seen to decrease health expenditure. The reasons for the increase in households with catastrophic health expenditure need further research. As a result, the study strives to discuss the possible policy reasons for the observed effects.

Lee, L. K., Chien, A., Stewart, A., et al. (2020). "Women's Coverage, Utilization, Affordability, And Health After The ACA: A Review Of The Literature." Health Affairs **39**(3): 387-394.
https://doi.org/10.1377/hlthaff.2019.01361

Women of working age (ages 19?64) faced specific challenges in obtaining health insurance coverage and health care before the Affordable Care Act. Multiple factors contributed to women?s experiencing uninsurance, underinsurance, and increased financial burdens related to obtaining health care. This literature review summarizes evidence on the law?s effects on women?s health care and health and finds improvements in overall coverage, access to health care, affordability, preventive care use, mental health care, use of contraceptives, and perinatal outcomes. Despite major progress after the Affordable Care Act?s implementation, barriers to coverage, access, and affordability remain, and serious threats to women?s health still exist. Highlighting the law?s effects on women?s health is critical for informing future policies directed toward the continuing improvement of women?s health care and health.

Liu, C., Chhabra, K. R. et Scott, J. W. (2020). "Catastrophic Health Expenditures Across Insurance Types and Incomes Before and After the Patient Protection and Affordable Care Act." JAMA Netw Open **3**(9): e2017696.

This cohort study analyzes changes in financial risk protection associated with implementation of the Patient Protection and Affordable Care Act (ACA) across income strata and insurance types.

Liu, C., Maggard-Gibbons, M., Weiser, T. G., et al. (2020). "Impact of the Affordable Care Act Insurance Marketplaces on Out-of-Pocket Spending Among Surgical Patients." Ann Surg.

OBJECTIVE: To evaluate the association between the introduction of the Affordable Care Act (ACA) Health Insurance Marketplaces ("Marketplaces") and financial protection for patients undergoing surgery. BACKGROUND: The ACA established Marketplaces through which individuals could purchase subsidized insurance coverage. However, the effect of these Marketplaces on surgical patients' healthcare spending remains largely unknown. METHODS: We analyzed a nationally representative sample of adults aged 19-64 who underwent surgery in 2010-2017, using the Medical Expenditure Panel Survey. Low-income patients eligible for cost-sharing and premium subsidies in the Marketplaces [income 139%-250% federal poverty level (FPL)] and middle-income patients eligible only for premium subsidies (251%-400% FPL) were compared to high-income controls ineligible for subsidies (>400% FPL) using a quasi-experimental difference-in-differences approach. We evaluated 3 main outcomes: (1) out-of-pocket spending, (2) premium contributions, and (3) likelihood of experiencing catastrophic expenditures, defined as out-of-pocket plus premium spending exceeding 19.5% of family income. RESULTS: Our sample included 5450 patients undergoing surgery, representing approximately 69 million US adults. Among low-income patients, Marketplace implementation was associated with $601 lower [95% confidence interval (CI): -$1169 to -$33; P = 0.04) out-of-pocket spending; $968 lower (95% CI: -$1652 to -$285; P = 0.006) premium spending; and 34.6% lower probability (absolute change: -8.3 percentage points; 95% CI: -14.9 to -1.7; P = 0.01) of catastrophic expenditures. We found no evidence that health expenditures changed for middle-income surgical patients. CONCLUSIONS: The ACA's insurance Marketplaces were associated with improved financial protection among low-income surgical patients eligible for both cost-sharing and premium subsidies, but not in middle-income patients eligible for only premium subsidies.

Liu, C., Rahman, A. S. et Chao, T. E. (2020). "Catastrophic expenditures in California trauma patients after the Affordable Care Act: reduced financial risk and racial disparities." Am J Surg **220**(3): 511-517.

BACKGROUND: Hospital charges due to major injury can result in high out-of-pocket expenses for patients. We analyzed the effect of the Affordable Care Act (ACA) on catastrophic health expenditures (CHE) among trauma patients. METHODS: We identified trauma patients aged 19-64 admitted to a safety-net Level 1 trauma center in California from 2007 to 2017. Out-of-pocket expenditures and income were calculated using hospital charges, insurance status, and ZIP code. CHE was defined using the World Health Organization definition of out-of-pocket spending exceeding 40% of inflation-adjusted income minus food and housing expenditures. Multivariable logistic regression was performed to assess odds of CHE post-ACA (2014-2017) vs. pre-ACA (2007-2013). RESULTS: Of 7519 trauma patients, 20.6% experienced CHE, including 89.0% of uninsured patients. There was a 74% decrease in odds of CHE post-ACA (aOR: 0.26, 95% CI: 0.22-0.30), with greater decreases among Black (aOR: 0.09, 95% CI: 0.04-0.18) and Hispanic (aOR: 0.23, 95% CI: 0.19-0.29) patients. CONCLUSIONS: ACA implementation was associated with markedly decreased odds of catastrophic expenditures and decreased racial disparities in financial protection among trauma patients in our study.

Liu, C., Tsugawa, Y., Weiser, T. G., et al. (2020). "Association of the US Affordable Care Act With Out-of-Pocket Spending and Catastrophic Health Expenditures Among Adult Patients With Traumatic Injury." JAMA Netw Open **3**(2): e200157.

IMPORTANCE: Trauma is an expensive and unpredictable source of out-of-pocket spending for American families. The Patient Protection and Affordable Care Act (ACA) sought to improve financial protection by expanding health insurance coverage, but its association with health care spending for patients with traumatic injury remains largely unknown. OBJECTIVE: To evaluate the association of ACA implementation with out-of-pocket spending, premiums, and catastrophic health expenditures

(CHE) among adult patients with traumatic injury. DESIGN, SETTING, AND PARTICIPANTS: Data from a nationally representative sample of US adults aged 19 to 64 years who had a hospital stay or emergency department visit for a traumatic injury from January 2010 to December 2017 were analyzed using the Medical Expenditure Panel Survey. Multivariable generalized linear models were used to evaluate changes in spending after ACA implementation. Additionally, 4 income subgroups were evaluated based on ACA thresholds for program eligibility: lowest-income patients (earning 138% or less of the federal poverty level [FPL]), low-income patients (earning 139% to 250% of the FPL), middle-income patients (earning 251% to 400% of the FPL), and high-income patients (earning more than 400% of the FPL). Data were analyzed from February to December 2019. EXPOSURES: Implementation of the ACA, beginning January 1, 2014. MAIN OUTCOMES AND MEASURES: Out-of-pocket spending, premium spending, out-of-pocket plus premium spending, and likelihood of experiencing CHE, defined as out-of-pocket plus premium spending exceeding 19.5% of family income. RESULTS: Of the 6288 included patients, 2995 (weighted percentage, 51.3%) were male, and the mean (SD) age was 41.4 (12.8) years. Implementation of the ACA was associated with 31% lower odds of CHE (adjusted odds ratio, 0.69; 95% CI, 0.54 to 0.87; P = .002). Changes were greatest in lowest-income patients, who experienced 30% lower out-of-pocket spending (adjusted percentage change, -30.4%; 95% CI, -46.6% to -9.4%; P = .01), 26% lower out-of-pocket plus premium spending (adjusted percentage change, -26.3%; 95% CI, -41.0% to -8.1%; P = .01), and 39% lower odds of CHE (adjusted odds ratio, 0.61; 95% CI, 0.44 to 0.84; P = .002). Low-income patients experienced decreased out-of-pocket spending and out-of-pocket plus premium spending but no changes in CHE, while middle-income and high-income patients experienced no significant changes in any spending outcome. In the post-ACA period, 1 in 11 of all patients with traumatic injury and 1 in 5 with the lowest incomes continued to experience CHE each year. CONCLUSIONS AND RELEVANCE: Implementation of the ACA was associated with improved financial protection for US adults with traumatic injury, especially lowest-income individuals targeted by the law's Medicaid expansions. Despite these gains, injured patients remain at risk of financial strain.

Lozano, R., Fullman, N., Mumford, J. E., et al. (2020). "Measuring universal health coverage based on an index of effective coverage of health services in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019." The Lancet **396**(10258): 1250-1284.
https://doi.org/10.1016/S0140-6736(20)30750-9

BackgroundAchieving universal health coverage (UHC) involves all people receiving the health services they need, of high quality, without experiencing financial hardship. Making progress towards UHC is a policy priority for both countries and global institutions, as highlighted by the agenda of the UN Sustainable Development Goals (SDGs) and WHO's Thirteenth General Programme of Work (GPW13). Measuring effective coverage at the health-system level is important for understanding whether health services are aligned with countries' health profiles and are of sufficient quality to produce health gains for populations of all ages.

Lucarelli, C., Frean, M. et Gordon, A. S. (2020). How Does Cost-Sharing Impact Spending Growth and Cost-Effective Treatments? Evidence from Deductibles. NBER Working Paper Series ;28155. Cambridge NBER**:** 43 , fig., tab., annexes.
https://www.nber.org/papers/w28155

The growth of health care spending has been a longstanding policy concern. Over the years, several innovations have been proposed to lower levels of health care spending; however, their impact has been limited and not sustained over time. Costly new technology, while often an improvement to existing care, has been identified as a principal driver of health care spending growth. Recent literature has shown that high deductible health plans (HDHP) can have an immediate impact on levels of health care spending, but their medium- and long-run effects on spending growth remain unknown. In this paper, we use multiple-employer-group claims data from a large national insurer to (i) study whether HDHPs reduce the growth in spending over four years compared to lower deductible alternatives; and (ii) explore the mechanisms behind any reductions in growth by looking at whether HDHPs reduce the use of low- vs. high-value treatments. We find that HDHPs have a limited effect on spending growth, with a statistically significant reduction observed only for prescription drugs. HDHPs are not associated with significantly lower growth in spending on highly cost-effective medicines in a sample of drugs but do reduce spending growth for less cost-effective drugs.

Macinko, J., Cristina Drumond Andrade, F., Bof de Andrade, F., et al. (2020). "Universal Health Coverage: Are Older Adults Being Left Behind? Evidence From Aging Cohorts In Twenty-Three Countries." Health Affairs **39**(11): 1951-1960.
https://doi.org/10.1377/hlthaff.2019.01570

Countries around the world have committed to achieving universal health coverage as part of the Sustainable Development Goals agreed upon by all United Nations members, intended to be achieved by 2030. But important population groups such as older adults are rarely examined as part of Sustainable Development Goals monitoring and evaluation efforts. This study uses recent (2014?16) high-quality, individual-level data from several aging cohorts representing more than 100,000 adults ages fifty and older in twenty-three high- and middle-income countries. After individual characteristics and health needs were controlled for, national rates varied up to tenfold for poor access (no doctor visit) and threefold for potential overutilization (fifteen or more doctor visits and multiple hospitalizations) in the past year. Catastrophic expenditures (25 percent or more of household income spent out of pocket on health care) averaged 9 percent, with the highest rates observed in middle-income countries and among sicker populations in some high-income countries. Strengthening universal health coverage for older adults will require greater tailoring and targeting of benefits to meet this population?s health needs while protecting them from catastrophic health expenditures.

McGinty, B. (2020). "Medicare's Mental Health Coverage: How COVID-19 Highlights Gaps and Opportunities for Improvement." Issue Brief: 10.
https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/medicare-mental-health-coverage-covid-19-gaps-opportunities

COVID-19 has heightened the need for mental health services for Medicare beneficiaries. Policy options for helping beneficiaries' obtain needed mental health care include removing insurance barriers, improving mental health provider networks in Medicare Advantage, and expanding access to telemental health

Murphy, A., Palafox, B., Walli-Attaei, M., et al. (2020). "The household economic burden of non-communicable diseases in 18 countries." BMJ Glob Health **5**(2): e002040.

BACKGROUND: Non-communicable diseases (NCDs) are the leading cause of death globally. In 2014, the United Nations committed to reducing premature mortality from NCDs, including by reducing the burden of healthcare costs. Since 2014, the Prospective Urban and Rural Epidemiology (PURE) Study has been collecting health expenditure data from households with NCDs in 18 countries. METHODS: Using data from the PURE Study, we estimated risk of catastrophic health spending and impoverishment among households with at least one person with NCDs (cardiovascular disease, diabetes, kidney disease, cancer and respiratory diseases; n=17 435), with hypertension only (a leading risk factor for NCDs; n=11 831) or with neither (n=22 654) by country income group: high-income countries (Canada and Sweden), upper middle income countries (UMICs: Brazil, Chile, Malaysia, Poland, South Africa and Turkey), lower middle income countries (LMICs: the Philippines, Colombia, India, Iran and the Occupied Palestinian Territory) and low-income countries (LICs: Bangladesh, Pakistan, Zimbabwe and Tanzania) and China. RESULTS: The prevalence of catastrophic spending and impoverishment is highest among households with NCDs in LMICs and China. After adjusting for covariates that might drive health expenditure, the absolute risk of catastrophic spending is higher in households with NCDs compared with no NCDs in LMICs (risk difference=1.71%; 95% CI 0.75 to 2.67), UMICs (0.82%; 95% CI 0.37 to 1.27) and China (7.52%; 95% CI 5.88 to 9.16). A similar pattern is observed in UMICs and China for impoverishment. A high proportion of those with NCDs in LICs, especially women (38.7% compared with 12.6% in men), reported not taking medication due to costs. CONCLUSIONS: Our findings show that financial protection from healthcare costs for people

with NCDs is inadequate, particularly in LMICs and China. While the burden of NCD care may appear greatest in LMICs and China, the burden in LICs may be masked by care foregone due to costs. The high proportion of women reporting foregone care due to cost may in part explain gender inequality in treatment of NCDs.

O'Brien, G. L., Sinnott, S.-J., O' Flynn, B., et al. (2020). "Out of pocket or out of control: A qualitative analysis of healthcare professional stakeholder involvement in pharmaceutical policy change in Ireland." Health Policy **124**(4): 411-418.

OCDE (2020). Health at a glance : Europe 2020, state of health in the EU cycle. Paris OCDE.
https://www.keepeek.com//Digital-Asset-Management/oecd/social-issues-migration-health/health-at-a-glance-europe-2020_82129230-en#page1

The 2020 edition of Health at a Glance: Europe focuses on the impact of the COVID-19 crisis. Chapter 1 provides an initial assessment of the resilience of European health systems to the COVID-19 pandemic and their ability to contain and respond to the worst pandemic in the past century. Chapter 2 reviews the huge health and welfare burden of air pollution as another major public health issue in European countries, and highlights the need for sustained efforts to reduce air pollution to mitigate its impact on health and mortality. The five other chapters provide an overview of key indicators of health and health systems across the 27 EU member states, 5 EU candidate countries, 3 European Free Trade Association countries and the United Kingdom. Health at a Glance: Europe is the first step in the State of Health in the EU cycle.

OliveiraHashiguchi, T. et Llena-Nozal, A. (2020). The effectiveness of social protection for long-term care in old age : Is social protection reducing the risk of poverty associated with care needs ? OECD Health Working Papers ; 117. Paris OCDE**:** 117 , tabl., fig., annexes.
https://doi.org/10.1787/2592f06e-en

As people grow old and their health deteriorates, they are likely to require help with everyday activities that were once second nature; they need what is commonly termed long-term care (LTC). With demand for LTC in old age expected to grow, OECD countries face significant challenges in balancing financial sustainability with the provision of effective social protection against the financial risks associated with developing LTC needs – the cost of care can far exceed median incomes and its duration can be many years. This report provides a novel set of comprehensive and internationally comparable estimates of the adequacy, equity and efficiency of public social protection systems for LTC in old age in OECD countries and EU Member States. Using a set of "typical cases" of LTC need to ensure comparability, including different levels of severity and different ways in which needs can be met, this report shows cross-country and regional variations in the total costs of LTC services, the degree of public coverage, the out-of-pocket costs that care recipients face, and the associated poverty risks. The quantitative results are discussed in the context of how different countries design LTC benefits and schemes, including cost-sharing mechanisms. Finally, to illustrate the policy relevance of the analyses, the distributive effects of actual and hypothetical policy scenarios are simulated, including an international free personal care policy, and possible reforms in Ireland and England. Au fur et à mesure que les personnes vieillissent et leur santé décline, ils sont plus enclins à avoir besoin d'aide pour les activités de la vie quotidienne: ces besoins constituent ce que l'on définit par les soins de longue durée (SLD). Les pays de l'OCDE vont faire face à des défis importants pour trouver un équilibre entre la viabilité des finances publiques et la provision optimale de la protection sociale contre les risques financiers associés aux besoins de longue durée étant donné la demande croissante des besoins due au vieillissement de la population et les coûts importants des soins, excédant les revenus medians et s'étalant sur plusieurs années. Cette étude contient les premières estimations comparatives de l'adéquation, l'équité et l'efficacité des systèmes de protection sociale des soins de longue durée pour les personnes âgées dans les pays de l'OCDE et l'UE. L'étude montre les variations entre les pays et les régions concernant les coûts des services des SLD, le montant de la couverture sociale publique, le reste-à-charge et les risques de pauvreté associés en utilisant des « cas typiques » des besoins de SLD afin d'établir une comparabilité internationale et se basant sur différents niveaux

de sévérité des besoins et de la provision des soins. Les résultats quantitatifs illustrent également l'organisation des différentes prestations dans les pays, notamment les mécanismes de répartition des coûts. L'étude contient également des simulations des impacts distributifs de certains scénarios comme l'introduction de la gratuité des soins incluant des soins personnels et certaines réformes en Irlande et en Angleterre.

O'Neill, K. M., Jean, R. A., Gross, C. P., et al. (2020). "Financial Hardship After Traumatic Injury: Risk Factors and Drivers of Out-of-Pocket Health Expenses." J Surg Res **256**: 1-12.

BACKGROUND: Trauma-related disorders rank among the top five most costly medical conditions to the health care system. However, the impact of out-of-pocket (OOP) health expenses for traumatic conditions is not known. In this cross-sectional study, we use nationally representative data to investigate whether patients with a traumatic injury experienced financial hardship from OOP health expenses. METHODS: Using data from the Medical Expenditure Panel Survey from 2010 to 2015, we analyzed the financial burden associated with a traumatic injury. Primary outcomes were excess financial burden (OOP>20% of annual income) and catastrophic medical expenses (OOP>40% of annual income). A multivariable logistic regression analysis evaluated whether these outcomes were associated with traumatic injury, adjusting for demographic, socioeconomic, and health care factors. We then completed a descriptive analysis to elucidate drivers of total OOP expenses. RESULTS: Of the 90,964 families in the cohort, 6434 families had a traumatic injury requiring a visit to the emergency room and 668 families had a traumatic injury requiring hospitalization. Overall 1 in 8 households with an injured family member requiring hospitalization experienced financial hardship. These families were more likely to experience excess financial burden (OR: 2.04, 95% CI: 1.13-3.64) and catastrophic medical expenses (OR: 3.08, 95% CI: 1.37-6.9). The largest burden of OOP expenses was due to prescription drug costs, with inpatient costs as a major driver of OOP expenses for those requiring hospitalization. CONCLUSIONS: Households with an injured family member requiring hospitalization are significantly more vulnerable to financial hardship from OOP health expenses than the noninjured population. Prescription drug and inpatient costs were the most significant drivers of OOP health expenses.

Palm, W., Webb, E., Hernández-Quevedo, C., et al. (2020). "Gaps in coverage and access in the European Union." Health Policy.
https://doi.org/10.1016/j.healthpol.2020.12.011

This study identifies gaps in universal health coverage in the European Union, using a questionnaire sent to the Health Systems and Policy Monitor network of the European Observatory on Health Systems and Policies. The questionnaire was based on a conceptual framework with four access dimensions: population coverage, service coverage, cost coverage, and service access. With respect to population coverage, groups often excluded from statutory coverage include asylum seekers and irregular residents. Some countries exclude certain social-professional groups (e.g. civil servants) from statutory coverage but cover these groups under alternative schemes. In terms of service coverage, excluded or restricted services include optical treatments, dental care, physiotherapy, reproductive health services, and psychotherapy. Early access to new and expensive pharmaceuticals is a concern, especially for rare diseases and cancers. As to cost coverage, some countries introduced protective measures for vulnerable patients in the form of exemptions or ceilings from user chargers, especially for deprived groups or patients with accumulation of out-of-pocket spending. For service access, common issues are low perceived quality and long waiting times, which are exacerbated for rural residents who also face barriers from physical distance. Some groups may lack physical or mental ability to properly formulate their request for care. Currently, available indicators fail to capture the underlying causes of gaps in coverage and access.

Papanicolas, I., Marino, A., Lorenzoni, L., et al. (2020). "A comparison of health care spending by age in eight high-income countries." JAMA Netw Open **3**(8): 3.
http://eprints.lse.ac.uk/105109/

The United States spends more on health care than any other country. Unlike many other high-income countries, which have largely uniform financing schemes for health care, the US has different financing schemes for different populations. The degree to which this fragmentation in US financing explains higher spending is not clear. Some policy makers believe that expanding the Medicare model, which has a financing system that more closely resembles that of other high-income countries (ie, it is government run and tax financed), could reduce spending substantially. To examine whether this policy has potential, this cross-sectional study compared nominal and relative spending in the US, by 5-year age groupings, with that of other high-income countries that have more homogenous financing systems. This comparison allows us to better understand spending differentials between the US and other countries for people aged 65 years or older, as well as for other age groups.

Paris, V. (2020). "La couverture santé dans les pays de l'OCDE." Seve : Les Tribunes De La Sante(65): 47-59.

Cet article décrit les mécanismes de financement mobilisés dans les pays de l'OCDE pour assurer une couverture santé à leurs résidents. La couverture santé de base est le plus souvent garantie par le gouvernement ou l'assurance sociale. L'assurance privée facultative offre dans deux tiers des pays de l'OCDE un second niveau de couverture (duplicatif, complémentaire et/ou supplémentaire). Ces types de couverture santé et les mécanismes de financement qui les sous-tendent diffèrent dans leur capacité à collecter des ressources pour le système de santé, à mutualiser les risques et à assurer une redistribution (horizontale et verticale). La couverture de base est effectivement universelle dans deux tiers des pays de l'OCDE et offre très souvent un panier de soins homogène. On observe certaines régularités entre le type de couverture et l'organisation et la rémunération des offreurs de soins, mais il est plus compliqué d'établir un lien entre « type » de couverture et accès aux soins, état de santé et inégalités de santé et d'accès aux soins.

Park, J. et Look, K. A. (2020). "Part D coverage gap reform: trends in drug use and expenditures." Am J Manag Care **26**(8): 349-356.

OBJECTIVES: This study analyzed annual trends in the distribution of beneficiaries entering each benefit phase and the utilization of and expenditures for prescription drugs among Medicare Part D beneficiaries from 2008 to 2015. STUDY DESIGN: Retrospective, repeated cross-sectional analysis using Medicare Current Beneficiary Survey data. METHODS: The study population included elderly Part D beneficiaries without a low-income subsidy, with continuous enrollment in a Part D plan, and with at least 1 prescription fill for a given year. We assessed annual trends for 3 outcomes: (1) proportion of beneficiaries entering each benefit phase and the number of days taken to enter these phases, (2) number of 30-day prescription drug fills, and (3) total and out-of-pocket spending on prescription drugs. RESULTS: The proportion of beneficiaries reaching the catastrophic coverage phase increased after the Affordable Care Act (ACA), and they reached the threshold earlier in the year. The overall number of 30-day drug fills increased over the study period, although no statistically significant changes in utilization were seen among those reaching the catastrophic coverage phase. Total drug spending steadily increased over time, particularly after the ACA, with the largest increase seen in those reaching the catastrophic threshold; however, out-of-pocket spending significantly decreased. CONCLUSIONS: Although this study provides support for reductions in financial barriers to prescription drugs under the ACA, substantial increases in both total drug spending and the proportion of high-cost beneficiaries in the Part D program indicate a growing burden of Part D spending on the Medicare program, which is expected to continue to grow in the future.

Paul, P. (2020). "The distributive fairness of out-of-pocket healthcare expenditure in the Russian Federation." Int J Health Econ Manag **20**(1): 13-40.
https://doi.org/10.1007/s10754-019-09268-9

This article examines the effects of socioeconomic position and urban–rural settlement on the distribution of out-of-pocket expenditure (OPE) for health in the Russian Federation. Data comes from 2005 to 2016 waves of the Russian Longitudinal Monitoring Survey. Concentration index reflects changes in the distribution of OPE between the worse-off and the better-off Russians over a 12-year period. Finally, unconditional quantile regression—a recentred influence function approach estimates differential impacts of covariates along the distribution of OPE. OPE is concentrated amongst the better-off Russians in 2016. Urban settlements contribute to top end OPE distribution for the richest and town settlements, at the median for the richest and the poorest. Our model for the analysis is unique in the context of study population, as it marginalises the effect over the distributions of other covariates used in the model.

Pellet, S. (2020). "Reste à charge et équité du système de santé : le cas du Tadjikistan." Revue économique **71**(5): 865-893.
https://www.cairn.info/revue-economique-2020-5-page-865.htm

Cet article vise à mesurer les inégalités d'accès et de financement d'un système de santé à fort reste à charge. Malgré l'universalité de son système, le Tadjikistan affiche des taux de reste à charge parmi les plus hauts du monde, de 60 % à 80 % des dépenses ces dix dernières années. À partir des données issues du Tajikistan Living Standards Survey 2007 et de la méthodologie des indices de concentration, nous suggérons que l'accès aux soins n'est pas équitablement réparti dans la population et que les dépenses de santé sont régressives. Les paiements informels reconstruits après contrôle des différences de besoin sont eux aussi régressifs, ce qui invalide l'hypothèse selon laquelle les médecins redistribuent.

Piroozi, B., Mohamadi-Bolbanabad, A., Moradi, G., et al. (2020). "Incidence and Intensity of Catastrophic Health-care Expenditure for Type 2 Diabetes Mellitus Care in Iran: Determinants and Inequality." Diabetes Metab Syndr Obes **13**: 2865-2876.

BACKGROUND: The present study aimed to assess the prevalence and intensity of catastrophic health-care expenditures (CHE) relating to type 2 diabetes mellitus care and inequality in facing such expenditures in Iran. METHODS: A total of 1065 type 2 diabetes patients were included in this cross-sectional study. A multistage sampling method was used to select the samples. Data on sociodemographic characteristics, economic status, health and diabetic costs were collected using a self-constructed questionnaire. We used capacity to pay (CTP) of households to calculate the incidence of CHE due to diabetic care at four different thresholds. The mean positive overshoot (MPO) and overshoot were used to assess the intensity of CHE. The relative concentration index and slope index of inequality (SII) were used to measure socioeconomic-related inequalities in incidences of CHE. In addition, decomposition methods were used to identify the main factors affecting observed inequality in CHE. RESULTS: The incidence of CHE at the 10, 20, 30, and 40% of CTP thresholds for type 2 diabetes mellitus care was 57.5, 28.9, 16.5, and 11.4%, respectively. The results of CI and SII indices for CHE due to diabetic care indicated that the incidence of CHE was more prevalent among patients with lower socioeconomic groups. The decomposition analysis showed that the socioeconomic status, marital status and gender of patients were the main factors contributing to socioeconomic inequality in incidence of CHE among the poor. CONCLUSION: Our study demonstrated that the incidence and intensity of CHE due to diabetic care were relatively high, particularly among socioeconomically disadvantaged patients. Modification to the present health care financing strategies is recommended in order to protect lower socioeconomic groups against the financial burden of diabetic care.

Pozo-Rubio, R. D., Pardo-García, I. et Escribano-Sotos, F. (2020). "Financial Catastrophism Inherent with Out-of-Pocket Payments in Long Term Care for Households: A Latent Impoverishment." Int J Environ Res Public Health **17**(1).

Background: Out-of-pocket (OOP) payments are configured as an important source of financing long-term care (LTC). However, very few studies have analyzed the risk of impoverishment and catastrophic effects of OOP in LTC. To estimate the contribution of users to the financing of LTC and to analyze the economic consequences for households in terms of impoverishment and catastrophism after financial crisis in Spain. METHODS: The database that was used is the 2008 Spanish Disability and Dependency Survey, projected to 2012. We analyze the OOP payments effect associated to the impoverishment of households comparing volume and financial situation before and after OOP payment. At the same time, the extent to which OOP payment had led to catastrophism was analyzed using different thresholds. RESULTS: The results show that contribution of dependent people to the financing of the services they receive exceeds by 50% the costs of these services. This expenditure entails an increase in the number of households that live below the poverty. In terms of catastrophism, more than 80% of households dedicate more than 10% of their income to dependency OOP payments. In annual terms, the catastrophe gap generated by devoting more than 10% of the household income to dependent care OOP payment reached €3955, 1 million (0.38% of GDP). CONCLUSION: This article informs about consequences of OOP in LCT and supplements previous research that focus on health. Our results should serve to develop strategic for protection against the financial risk resulting from facing the costs of a situation of dependence.

Rajan, S., Ricciardi, W. et McKee, M. (2020). "The SDGs and health systems: the last step on the long and unfinished journey to universal health care?" Eur J Public Health **30**(Suppl_1): i28-i31.

In 2015, the world's governments committed, in the Sustainable Development Goals (SDGs), to achieve universal health coverage by 2030, something they will be held accountable for. We examine progress in the WHO European Region using data from several sources. We assess effective coverage using data from the Global Burden of Disease Programme, including access to 9 key interventions for maternal and child health and communicable and non-communicable diseases and mortality from 32 conditions amenable to health care. Progress is mixed; while Finland and Iceland have already achieved the 2030 target already, other countries, including in the Caucasus and Central Asia have not yet, and are unlikely to by 2030. We then examine financial protection, where progress lags in Central and South East Europe and the former Soviet Union, where high out-of-pocket healthcare payments and catastrophic spending are still common. We stress the need to consider inequalities within countries, with the most vulnerable groups, such as Roma or newly arrived migrants (from the Middle East and Africa) often underserved, while their needs are frequently undocumented. To make progress on the SDGs, governments must invest more heavily in health services research and support the infrastructure and capacity required to enable it.

Rice, D. R., Farooq, A., Hyer, J. M., et al. (2020). "Health expenditures and financial burden among patients with major gastrointestinal cancers relative to other common cancers in the United States." Surgery **167**(6): 985-990.

BACKGROUND: Gastrointestinal cancers contribute substantially to the cost of health care. We sought to quantify and compare the financial burden associated with treatment of gastrointestinal cancers versus other common nongastrointestinal cancers. METHODS: The Medical Expenditure Panel Survey from 2006 to 2015 was used to identify individuals with gastrointestinal cancer, other nongastrointestinal cancer (breast/prostate or lung), or no history of malignancy. Total and out-of-pocket medical expenditures were compared. Among each cohort, risk of high and catastrophic financial burden was determined. RESULTS: A total of 90,344 individuals were identified, which was extrapolated to a national representative sample of 95,449,062 individuals. Overall, an estimated 365,367 (0.4%) individuals had a gastrointestinal cancer while 2,015,724 (2.1%) had lung, breast, or prostate cancer. Mean adjusted total health expenditures was greater among patients with gastrointestinal cancer ($13,716; 95% confidence interval, $9,805-$17,628) versus patients with nongastrointestinal cancer ($8,665; 95% confidence interval, $8,222-$9,108) or individuals without cancer ($5,807; 95% confidence interval $5,740-$5,874). An estimated 15.8% (n = 57,898) and 7.1% (n = 25,956) of patients with gastrointestinal cancer experienced a high and catastrophic financial burden, respectively. Patients with gastrointestinal cancer had a 64% increased odds of experiencing catastrophic financial burden compared with patients without a history of cancer (odds ratio 1.64, 95% confidence interval, 1.17-2.31). Furthermore, patients with a gastrointestinal cancer had nearly 40% increased odds of high financial burden associated with their care compared with patients without cancer (odds ratio 1.37; 95% confidence interval, 1.00-1.88). CONCLUSION: The risk of experiencing catastrophic financial burden among patients with gastrointestinal cancer was considerable, as roughly 1 in 7 patients experienced high financial burden, and 1 in 13 had a catastrophic financial burden.

Rodela, T., Tasnim, S., Mazumder, H., et al. (2020). Economic Impacts of Coronavirus Disease (COVID-19) in Developing Countries. Texas Texas A&M University. College Station. School of Public Health**:** 7 , tabl., graph.
http://d.repec.org/n?u=RePEc:osf:socarx:wygpk&r=hea

The coronavirus disease (COVID-19) has critically impacted global health systems and economies, especially in developing countries. Those countries have been struggling to address the preexisting burden of diseases with limited resources, which will become even more challenging during COVID-19. The economic implications related to COVID-19 in those countries include a high cost of care, market failures in pluralistic health systems, high out-of-pocket expenses, the added burden of noncommunicable diseases, missed economic opportunities, and socioeconomic consequences like unemployment and poverty. It is essential to assess the prevalent gaps, mobilize resources, strengthen health systems financing and leadership, enhance research capacities informing evidence-based policymaking, and foster effective partnerships for addressing health and economic disparities due to COVID-19.

Sangnam, A., Seonghoon, K. et Kanghyock, K. (2020). Changes in Healthcare Utilization, Spending, and Perceived Health during COVID–19: A Longitudinal Study from Singapore. IZA Discussion Paper ; 13715. Bonn IZA**:** 33.
http://ftp.iza.org/dp13715.pdf

The COVID–19 pandemic has challenged the capacity of healthcare systems around the world and can potentially compromise healthcare utilization and health outcomes among non-COVID–19 patients. Using monthly panel data of nationally representative middle-aged and older Singaporeans, we examined the associations of the pandemic with healthcare utilization, out-of-pocket medical costs, and perceived health. At its peak, doctor visits decreased by 30% and out-of-pocket medical spending decreased by 23%, mostly driven by reductions in inpatient and outpatient care. Although there were little changes in self-reported health and sleep quality, COVID–19 increased depressive symptoms by 4%. We argue that it is imperative to monitor COVID–19's long-term health effects among non-COVID–19 patients since our findings indicated delayed healthcare and worsened mental health during the outbreak.

Tambor, M. et Pavlova, M. (2020). Can people afford to pay for health care? New evidence on financial protection in Poland. Copenhague OMS Bureau régional de l'Europe**:** xiv+89 ,tabl., fig.
http://www.euro.who.int/en/publications/abstracts/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-poland-2020

Cette analyse fait partie d'une série d'études réalisées dans les pays et apportant de nouvelles bases factuelles sur la protection financière offerte par les systèmes de santé européens. La protection financière est un élément central de la couverture sanitaire universelle et une dimension essentielle de la performance des systèmes de santé. La fréquence des dépenses de santé catastrophiques est élevée en Pologne par rapport à de nombreux pays de l'Union européenne. Les ménages pauvres sont les plus lourdement affectés, et les dépenses occasionnées afin de se procurer des médicaments pour les soins ambulatoires joue ici un rôle important. Les médicaments prescrits en ambulatoire sont soumis à un système complexe de frais à charge de l'utilisateur (participation aux frais de santé). Les mécanismes visant à protéger les ménages contre ces frais sont généralement insuffisants ; les personnes à faible revenu ou souffrant de maladies chroniques ne bénéficient explicitement d'aucune exemption, et aucun plafond n'est fixé pour la participation aux frais de santé. La couverture des soins dentaires et des produits médicaux est également limitée, en particulier pour les adultes. Les efforts visant à améliorer la protection financière devraient se concentrer davantage sur les personnes à faible revenu, par exemple en permettant aux bénéficiaires de prestations sociales de disposer d'exemptions en matière de participation aux frais. Les niveaux élevés d'utilisation des médicaments non prescrits et les dépenses directes qu'ils entraînent méritent également notre attention.

Votapkova, J. (2020). The Effect of Inpatient User Charges on Inpatient Care. IES Working Papers.; 11/2020. Prague Institute of Economic Studies**:** 25.
http://ies.fsv.cuni.cz/sci/publication/show/id/6240/lang/cs

The essay assesses the infuence of inpatient user charges in the Czech Republic on the amount of inpatient hospital care provided, namely the number of patient days. We apply the difference-indifferences approach on a panel of 76 general hospitals in 2008-2009. The introduction and subsequent partial reimbursement of user fees charged on an inpatient day in the Czech Republic satisfies the criteria of a natural experiment - the decision to reimburse patients for user charges applied to hospitals under the control of the Social Democratic (ÄŒSSD) regional governments in the year 2009, and was unrelated to other hospital characteristic. Our treatment group comprises hospitals where patients could ask for reimbursement, i.e. user charges were effectively abolished. The control group covers hospitals where it was not possible to get reimbursement. The base year is 2008 when user charges were introduced. The observed effect of user-charge abolition was small and marginally significant (between 2.7 % and 4.1 %) having controlled for exogenous hospital and regional characteristics.

Zhe, J. I. N. G., Lien, H. et Tao, X. (2020). Top-up Design and Health Care Expenditure: Evidence from Cardiac Stents. NBER Working Paper Series ;28107. Cambridge NBER**:** 43 .
https://www.nber.org/papers/w28107

Since 2006, Taiwan's National Health Insurance (NHI) covers the full cost of baseline treatment in cardiac stents (bare-metal stents, BMS), but requires patients to pay the incremental cost of more expensive treatments (drug-eluting stents, DES). Within this "top-up" design, we study how hospitals respond to a 26% cut of the NHI reimbursement rate in 2009. We find hospitals do not raise the DES prices from patients, but increase BMS usage per admission by 18%, recouping up to 30% of the revenue loss in 2009-2010. Overall, the rate cut is effective in reducing NHI expenditure despite hospitals' moral hazard adjustment.

2019

Seo, V., Baggett, T. P., Thorndike, A. N., et al. (2019). "Access to care among Medicaid and uninsured patients in community health centers after the Affordable Care Act." Bmc Health Services Research **19**(1): 291.
https://doi.org/10.1186/s12913-019-4124-z

The Affordable Care Act expanded Medicaid and increased federal funding for Community Health Centers (CHCs). To examine the role of Medicaid coverage on care patterns for those with available safety net care, we assessed differences in access to care for CHC patients with continuous Medicaid coverage vs. gaps in insurance coverage in the last year.

Wagstaff, A. (2019). "Measuring catastrophic medical expenditures: Reflections on three issues." Health Econ.

In the "basic" approach, medical expenses are catastrophic if they exceed a prespecified percentage of consumption or income; the approach tells us if expenses cause a large percentage reduction in living standards. The ability-to-pay (ATP) approach defines expenses as catastrophic if they exceed a prespecified percentage of consumption less expenses on nonmedical necessities or an allowance for them. The paper argues that the ATP approach does not tell us whether expenses are large enough to undermine a household's ability to purchase nonmedical necessities. The paper compares the income-based and consumption-based variants of the basic approach, and shows that if the individual is a borrower after a health shock, the income-based ratio will exceed the consumption-based ratio, and both will exceed the more theoretically correct Flores et al. ratio; whereas if the individual continues to be a saver after a health shock, the ordering is reversed and the income-based ratio may not overestimate Flores et al.'s ratio. Last, the paper proposes a lifetime money metric utility (LMMU) approach defining medical expenses as catastrophic in terms of their lifetime consequences. Under certain assumptions, the LMMU and Flores et al. approaches are identical, and neither requires data on how households finance their medical expenses.

2019

(2019). "Out-of-pocket spending: Access to care and financial protection." Focus On: 4 , graph.

Households are directly responsible for funding a fifth of all health spending across the OECD. Pharmaceuticals and dental services account for over half of household payments on healthcare. Households fund two-thirds of spending on dental care and medical devices. High levels of out-of-pocket payments can impact on individuals' access to care.

del Pozo-Rubio, R. et Jiménez-Rubio, D. (2019). "Catastrophic risk associated with ou-of-pocket payments for long term care in Spain." Health Policy.

Objectives This study analyses the financial burden associated with the introduction of copayment for long term care (LTC) in Spain in 2012 for dependent individuals. Material and methods We analyse and identify households for which the dependency-related out-of-pocket payment exceeds the defined catastrophic threshold (incidence), and the gap between the copayment and the threshold for the catastrophic copayment (intensity), for the full population sample and for subsamples based on the level of long-term care dependency and on regional characteristics (regional income and political ideology of party ruling the region). Results The results obtained show there is a higher risk of impoverishment due to copayment among relatively well-off dependents, although the financial burden falls more heavily on less well-off households. Our findings also reveal interesting regional patterns of inequity in financing and access to long-term care services, which appear to be explained by an uneven development of LTC services (monetary transfers versus formal services) and varying levels of copayment across regions. Conclusions The new copayment for long-term care dependency in Spain is an important factor of catastrophic risk, and more attention should be addressed to policies aimed at improving the progressivity of out-of-pocket payments for LTC services within and between regions. In addition, formal services should be prioritised in all regions in order to guarantee equal access for equal need.

del Pozo-Rubio, R., Mínguez-Salido, R., Pardo-García, I., et al. (2019). "Catastrophic long-term care expenditure: associated socio-demographic and economic factors." The European Journal of Health Economics **20**(5): 691-701.
https://doi.org/10.1007/s10198-019-01031-8

An increasing number of persons across the world require long-term care (LTC). In Spain, access to LTC involves individuals incurring out-of-pocket (OOP) expenditure. There is a large body of literature on the incidence of catastrophic OOP payments in access and participation in health systems, but not in the field of LTC nor the determinants of these expenses. Our aim was to analyse the socio-demographic and economic factors associated with different levels of catastrophic LTC expenditure in the form of private out-of-pocket payments among dependent persons in Spain.

Devaux, M., Couffinhal, A. et Mueller, M. (2019). Health for Everyone? Social Inequalities in Health and Health Systems, Paris : OCDE
https://www.oecd.org/publications/health-for-everyone-3c8385d0-en.htm

Good health is a key component of people's well-being. It is a value in itself but – through its influence on social, education and labour market outcomes – being in good or bad health has also wider implications on people's chances of leading a fulfilling and productive life. Yet, even in the OECD countries, health inequality persists with severe consequences on the goal of promoting inclusive growth. This report documents a comprehensive range of inequalities in health and health systems to the detriment of disadvantaged population groups in a large set of OECD and EU countries. It assesses the gaps in health outcomes and risk factors between different socio-economic groups. When it comes to health systems, the report measures inequalities in health care utilisation, unmet needs and the affordability of health care services. For each of these different domains, the report identifies groups of countries that display higher, intermediate, and low levels of inequality. The report makes a strong case for addressing health-related inequalities as a key component of a policy strategy to promote inclusive growth and reduce social inequalities. It also provides a framework for more in-depth analyses on how to address these inequalities at country level.

Edmonds, S. et Hajizadeh, M. (2019). "Assessing progressivity and catastrophic effect of out-of-pocket payments for healthcare in Canada: 2010–2015." The European Journal of Health Economics **20**(7): 1001-1011.
https://doi.org/10.1007/s10198-019-01074-x

Equity in healthcare is an important policy objective of the Canadian healthcare system. Out-of-pocket payments for healthcare (OPPH) by Canadian households account for a substantial share of total healthcare expenditures. Using data from Statistics Canada's Survey of Household Spending (SHS, n = 33,367), this study examined the progressivity and catastrophic effect of OPPH in Canada over the period 2010 to 2015 inclusive. The Kakwani Progressivity Index (KPI) was used to measure the progressivity of OPPH for each year of the study period. The catastrophic effect of OPPH was calculated using a threshold of 10% of total household consumption. The computed KPI indicated that OPPH are a regressive source of healthcare funding in Canada and the regressivity of OPPH has increased over the study period. This indicates that the distribution of OPPH in Canada is not equitable and the percentage contribution of households from their total consumption to healthcare as OPPH decreases as their consumption increase. The results also suggested that 7% of Canadian households face catastrophic out-of-pocket payments for healthcare (COPPH) over the study period. The proportion of households with COPPH was higher in rural areas compared with urban areas over the study period. Policies to enhance financial risk protection among low-income and rural households are required to improve equity in healthcare financing in Canada.

Fomenko, O. et Gruber, J. (2019). Reclassification to Avoid Consumer Cost-Sharing in Group Health Plans. NBER Working Paper ; 25870. Cambridge NBER**:** 41.
https://www.nber.org/papers/w25870

We examine how consumers respond to being effectively double insured under two systems: group health (GH) and workers' compensation (WC). Many GH plans have substantial consumer cost-sharing burden, while WC coverage has no cost-sharing for medical services for work-related injuries. As a result, a consumer facing a large deductible under their group health plan will have a strong financial incentive to make a claim under WC instead. We use a unique data set of claims under both GH and WC to study how "case shifting" to WC responds to GH deductibles for the most common set of injuries that are covered under both types of insurance. We identify the impact of case shifting by using interactions of deductible levels and previous spending. We find that a typical claim is about 1.4 percentage points (5.3%) more likely to be filed as a WC claim when facing an average deductible (about $630) compared to a plan with no deductible, and that total WC costs in the U.S. are more than $1.2 billion higher as a result. At the same time, we find that consumers do not appear to be forward looking, focusing on the "spot price" rather than the full "end of year price" in deciding whether to claim under WC.

Gaffney, A., McCormick, D., Bor, D., et al. (2019). "Coverage Expansions and Utilization of Physician Care: Evidence From the 2014 Affordable Care Act and 1966 Medicare/Medicaid Expansions." American Journal of Public Health **109**(12): 1694-1701.
https://doi.org/10.2105/AJPH.2019.305330

The aim of this paper is to evaluate the effects of the 2 major coverage expansions in US history - Medicare/Medicaid in 1966 and the Affordable Care Act (ACA) in 2014? - on the utilization of physician care. Using the National Health Interview Survey (1963-1969; 2011-2016), we analyzed trends in utilization of physician services society-wide and by targeted subgroups. Following

Medicare/Medicaid's implementation, society-wide utilization remained unchanged. While visits by low-income persons increased 6.2% (P<01) and surgical procedures among the elderly increased 14.7% (P<01), decreases among nontargeted groups offset these increases. After the ACA, society-wide utilization again remained unchanged. Increased utilization among targeted low-income groups (e.g., a 3.5-percentage-point increase in the proportion of persons earning less than or equal to 138% of the federal poverty level with at least 1 office visit [P<001]) was offset by small, nonsignificant reductions among the nontargeted population. Past coverage expansions in the United States have redistributed physician care, but have not increased society-wide utilization in the short term, possibly because of the limited supply of physicians. Public Health Implications. These findings suggest that future expansions may not cause unaffordable surges in utilization.

Glied, S., Black, M., Lauerman, W., et al. (2019). "Considering "Single Payer" Proposals in the U.S.: Lessons from Abroad." Issue Brief: 9.
https://www.commonwealthfund.org/publications/2019/apr/considering-single-payer-proposals-lessons-from-abroad

This issue brief uses data from the Organisation for Economic Co-operation and Development (OECD), the Commonwealth Fund, and other sources to compare key features of universal health care systems in 12 high income countries: Australia, Canada, Denmark, England, France, Germany, the Netherlands, Norway, Singapore, Sweden, Switzerland, and Taiwan. We focus on three major areas of variation between these countries that are relevant to U.S. policymakers: the distribution of responsibilities and resources between various levels of government; the breadth of benefits covered and the degree of cost-sharing under public insurance; and the role of private health insurance. There are many other areas of variation among the health care systems of other high-income countries with universal coverage — such as

Johnston, B. M., Burke, S., Barry, S., et al. (2019). "Private health expenditure in Ireland: Assessing the affordability of private financing of health care." Health Policy.
https://doi.org/10.1016/j.healthpol.2019.08.002

This paper investigates the affordability of private health expenditure among Irish households and the services contributing towards financial hardship. We use data from the Irish Household Budget Survey, a representative survey of household spending in Ireland, covering 2009-10 and 2015-16. Private health expenditure comprises out-of-pocket payments for health and social care services and private health insurance (PHI) premiums. The poverty threshold is 60% of median total equivalised consumption and households with consumption below this level were defined as poor. Households were classified as having unaffordable health expenditure if: 1) they were poor and reported any spending; 2) they were pushed below poverty threshold by health spending; or 3) their spending on health exceeded 40% of capacity to pay. Despite signs of economic recovery, the incidence of unaffordable private health spending increased over the years—from 15% in 2009-10 to 18.8% in 2015-16. People on low incomes were disproportionately affected. The largest component of unaffordable spending for poorer households is PHI and not user charges, which have actually fallen as a cause of hardship. Our findings indicate that reliance on private health expenditure as a funding mechanism undermines the fundamental goals of equity and appropriate access within the health care system.

Khandelwal, N., White, L., Curtis, J. R., et al. (2019). "Health Insurance and Out-of-Pocket Costs in the Last Year of Life Among Decedents Utilizing the ICU." Critical Care Medicine **47**(6): 749-756.
https://journals.lww.com/ccmjournal/Fulltext/2019/06000/Health_Insurance_and_Out_of_Pocket_Costs_in_the.2.aspx

Objectives: Use of intensive care is increasing in the United States and may be associated with high financial burden on patients and their families near the end of life. Our objective was to estimate out-of-pocket costs in the last year of life for individuals who required intensive care in the months prior to death and examine how these costs vary by insurance coverage. Design: Observational cohort study using seven waves of post-death interview data (2002–2014). Participants: Decedents (n = 2,909) who spent time in the ICU at some point between their last interview and death. Interventions: None. Measurements and Main Results: Two-part models were used to estimate out-of-pocket costs for direct medical care and health-related services by type of care and insurance coverage. Decedents with only traditional Medicare fee-for-service coverage have the highest out-of-pocket spending in the last year of life, estimated at $12,668 (95% CI, $9,744–15,592), second to only the uninsured. Medicare Advantage and private insurance provide slightly more comprehensive coverage. Individuals who spend-down to Medicaid coverage have 4× the out-of-pocket spending as those continuously on Medicaid. Conclusions: Across all categories of insurance coverage, out-of-pocket spending in the last 12 months of life is high and represents a significant portion of assets for many patients requiring intensive care and their families. Medicare fee-for-service alone does not insulate individuals from the financial burden of high-intensity care, due to lack of an out-of-pocket maximum and a relatively high co-payment for hospitalizations. Medicaid plays an important role in the social safety net, providing the most complete hospital coverage of all the insurance groups, as well as significantly financing long-term care.

Korenman, S., Remler, D. K. et Hyson, R. T. (2019). Accounting for the Impact of Medicaid on Child Poverty. NBER Working Paper ; 25973. Cambridge NBER**:** 59 , tab., fig.
https://www.nber.org/papers/w25973

US Census Bureau poverty measures do not include an explicit need for health care or insurance nor do they consider health insurance benefits to be resources. Consequently, they cannot measure the direct impact of health insurance benefits on poverty. This paper reviews conceptual and practical considerations in incorporating health benefits and needs into poverty measures. We analyze the advantages and disadvantages of various approaches including variants of the Official Poverty Measure (OPM); the Supplemental Poverty Measure (SPM); using a threshold with medical out-of-pocket (MOOP) expenditures; a Medical Care Expenditure Risk (MCER) Index; willingness to pay (WTP) for Medicaid; and the Health-Inclusive Poverty Measure (HIPM; Korenman and Remler 2016). We present estimates of Medicaid's impacts on child poverty, based on the HIPM. This paper was prepared as a background paper for the Committee on Building an Agenda to Reduce the Number of Children in Poverty by Half in 10 Years, of the Board of Children, Youth and Families of the National Academy of Sciences. The paper was submitted in October 2017 and embargoed until the release of the Committee's report, A Roadmap to Reducing Child Poverty, in March of 2019.

Ku, Y.-C., Chou, Y.-J., Lee, M.-C., et al. (2019). "Effects of National Health Insurance on household out-of-pocket expenditure structure." Social Science & Medicine **222**: 1-10.

Achieving universal health insurance coverage is a major objective for many countries. Taiwan implemented its National Health Insurance (NHI) program with universal coverage in 1995. This study investigates whether the NHI program affects the level and structures of out-of-pocket (OOP) health expenditures. We used data from the Taiwan Survey of Family Income and Expenditure released by the Directorate-General of Budget, Accounting and Statistics. We identified a case and a control group and then employed coarsened exact matching to match the two groups using several available variables. We then conducted a difference-in-difference analysis and determined that there was a statistically significant negative effect on OOP expenditure that was attributable to NHI (a reduction of 2.11 percentage points in total household expenditure). The largest reductions were found in health care services (−1.63%) and pharmaceuticals (−0.45%). We found a statistically significant positive effect on purchases of private insurance related to health care, which was attributable to NHI (an increase of 0.96 percentage points in household budget share). In addition, we discovered that the NHI program had a greater impact on households of a lower socioeconomic status compared with higher socioeconomic status households. The structure of OOP payments in the post-NHI period remained similar to that of the pre-NHI period in the full sample but varied slightly depending on the educational level of the head of the household.

Maclean, J. C., Tello-Trillo, S. et Webber, D. (2019). Losing Insurance and Behavioral Health Hospitalizations:

Evidence from a Large-scale Medicaid Disenrollment. NBER Working Paper ; 25936. Cambridge NBER**:** 46 , tab., fig.
https://www.nber.org/papers/w25936

We study the effects of losing insurance on behavioral health – mental health and substance use disorder (SUD) – community hospitalizations. We leverage variation in public insurance coverage eligibility offered by a large-scale and unexpected Medicaid disenrollment in Tennessee. Losing insurance decreased SUD-related hospitalizations but mental illness hospitalizations were unchanged. Use of Medicaid to pay for behavioral health, mental illness and SUD, hospitalizations declined post-disenrollment. Mental illness hospitalization financing shifted to private insurance, Medicare, and patients, while SUD treatment financing shifted entirely to patients. We also investigate the implications of reliance on data that is not representative at the level of the treatment variable and propose a possible solution.

McGrattan, E. R., Kazuaki, M. et Peralta-Alva, A. (2019). On Financing Retirement, Health Care, and Long-Term Care in Japan. Minneapolis Federal Reserve Bank of Minneapolis**:** 40.
http://d.repec.org/n?u=RePEc:fip:fedmsr:586&r=age

Japan is facing the problem of how to finance retirement, health care, and long-term care expenditures as the population ages. This paper analyzes the impact of policy options intended to address this problem by employing a dynamic general equilibrium overlapping generations model, specifically parameterized to match both the macro- and microeconomic level data of Japan. We find that financing the costs of aging through gradual increases in the consumption tax rate delivers better macroeconomic performance and higher welfare for most individuals relative to other financing options, including raising social security contributions, debt financing, and a uniform increase in health care and long-term care copayments.

Mommaerts, C., Raza, S. H. et Zheng, H. (2019). The Economic Consequences of Hospitalizations for Older Workers across Countries.
http://d.repec.org/n?u=RePEc:cpr:ceprdp:13753&r=hea

This paper estimates the effect of hospital admissions among older workers on economic outcomes across countries. We use harmonized longitudinal survey data from the United States, China, and 13 countries in Europe, and follow the event study design of Dobkin, Finkelstein, Kluender and Notowidigdo (2018) to estimate dynamic effects of a hospitalization on out-of-pocket health expenditures, labor market outcomes, social insurance payments, and household income. We find distinctly different patterns across countries. In contrast to the United States, where hospitalizations lead to large health expenditures and decreases in earnings, individuals in Northern and Southern Europe are largely protected from negative economic outcomes. Hospitalizations in China lead to even larger out-of-pocket expenditures as a percent of prior income, but do not negatively affect labor market outcomes. Our results largely align with the differences in generosity across countries in social protection institutions that include health systems, social security programs and labor market regulations.

Remmerswaal, M., Boone, J. et Douven, R. (2019). Selection and moral hazard effects in healthcare. La Hague CPB**:** 36.

In the Netherlands, average healthcare expenditures of persons with a voluntary deductible are twice as high as average healthcare expenditures of persons without a voluntary deductible. When assessing the effects of voluntary cost-sharing in healthcare on healthcare expenditures, it is important to disentangle moral hazard from selection: are healthcare expenditures low because people pay (a bigger share of) their healthcare expenditures out-of-pocket? Or are people with higher cost-sharing levels healthier? In this study, we separate selection from moral hazard for the combined mandatory and voluntary deductible in the Netherlands. We use proprietary claims data from Dutch health insurers and exploit with a panel regression discontinuity design that we can observe healthcare expenditures before and after the deductibles kick in for 18 year olds. Our study shows that selection, not moral hazard, is the main effect explaining the difference in healthcare expenditures between persons with and without a voluntary deductible. Furthermore, we find that 18 year olds who never chose a voluntary deductible reduce their healthcare spending by 26 euros (on average) in response to a 100 euro increase in the (mandatory) deductible. However, for 18 year olds who chose a voluntary deductible (on top of the mandatory) we find that this choice does not result in a further reduction in healthcare spending.

Sisira Kumara, A. et Samaratunge, R. (2019). "Relationship between healthcare utilization and household out-of-pocket healthcare expenditure: Evidence from an emerging economy with a free healthcare policy." Social Science & Medicine **235**: 112364.

Despite the free public healthcare policy in Sri Lanka, households' out-of-pocket healthcare expenditures are steadily increasing. Parallel to this, there is an emerging private healthcare sector based on a user-pays approach. This study, therefore, examines the relationship between healthcare utilization and out-of-pocket healthcare expenses at household level. Using a double-hurdle model with 42,288 household observations drawn from the household income and expenditure survey (2012/2013 and 2016 waves), we find that out- and in-patient care in public hospitals under 'free healthcare policy' is positively associated with household out-of-pocket healthcare expenses, imposing a significant financial burden on the family budget. This relationship is even greater for utilization of private out- and in-patient care. The recent regulatory and fiscal interventions of the government have favourably moderated this relationship for out-patient care but not for in-patient care. The results recommend introducing public policies to further strengthen the monitoring process for private healthcare sector while ensuring the sustainability of free healthcare policy. The paper provides policy implications for richly categorized out-of-pocket healthcare expenditure and healthcare utilization types.

Thomson, S., Cylus, J. et Evetovits, T. (2019). Can people afford to pay for health care? New evidence on financial protection in Europe. Copenhague OMS Bureau régional de l'Europe**:** xv+116 ,tabl., fig.
http://www.euro.who.int/en/publications/abstracts/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-europe-2019

Les paiements directs pour les soins de santé peuvent constituer un obstacle financier à l'accès aux soins, ce qui entraîne des besoins non satisfaits ou provoque des difficultés financières chez les usagers des services de santé. Ce rapport compile pour la première fois des données sur les besoins non satisfaits et les difficultés financières afin d'évaluer dans quelle mesure les habitants de la Région européenne peuvent se permettre les soins de santé. S'appuyant sur les contributions d'experts nationaux de 24 pays, le rapport révèle que les difficultés financières varient considérablement en Europe, et que la situation peut être améliorée, même dans les pays à revenu élevé qui garantissent à l'ensemble de leur population l'accès à des services de santé financés par des fonds publics. Les dépenses de santé catastrophiques concernent surtout les ménages les plus pauvres dans tous les pays couverts par l'étude et, là où la protection financière est relativement faible, sont principalement dues aux paiements directs à la charge du patient afin de se procurer des médicaments pour les soins ambulatoires. Out-of-pocket payments for health can create a financial barrier to access, resulting in unmet need, or lead to financial hardship for people using health services. This report brings together for the first time data on unmet need and financial hardship to assess whether people living in Europe can afford to pay for health care. Drawing on contributions from national experts in 24 countries, the report shows that financial hardship varies widely in Europe, and that there is room for improvement even in high-income countries that provide the whole population with access to publicly financed health services. Catastrophic health spending is heavily concentrated among the poorest households in all of the countries in the study. Where financial protection is relatively weak, catastrophic spending is mainly driven by out-of-pocket payments for outpatient medicines.

Wagstaff, A. (2019). "Measuring catastrophic medical expenditures: Reflections on three issues." Health Econ.

In the "basic" approach, medical expenses are catastrophic if they exceed a prespecified percentage of consumption or income; the approach tells us if expenses cause a large percentage reduction in living standards. The ability-to-pay (ATP) approach defines expenses as catastrophic if they exceed a prespecified percentage of consumption less expenses on nonmedical necessities or an allowance for them. The paper argues that the ATP approach does not tell us whether expenses are large enough to undermine a household's ability to purchase nonmedical necessities. The paper compares the income-based and consumption-based variants of the basic approach, and shows that if the individual is a borrower after a health shock, the income-based ratio will exceed the consumption-based ratio, and both will exceed the more theoretically correct Flores et al. ratio; whereas if the individual continues to be a saver after a health shock, the ordering is reversed and the income-based ratio may not overestimate Flores et al.'s ratio. Last, the paper proposes a lifetime money metric utility (LMMU) approach defining medical expenses as catastrophic in terms of their lifetime consequences. Under certain assumptions, the LMMU and Flores et al. approaches are identical, and neither requires data on how households finance their medical expenses.

2018

Baeten, R., Spasova, S., Vanhercke, B., et al. (2018). Inequalities in access to healthcare. A study of national policies 2018. Bruxelles Commission européenne**:** 74 , tab., graph., fig.
http://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=8152&furtherPubs=yes

The right of everyone to timely access to affordable, preventive and curative care of good quality is one of the key principles of the European Pillar of Social Rights. This report explores inequalities in access to healthcare in 35 European countries. It shows that important inequalities persist, both between and within countries. Large shares of the EU population, in particular vulnerable groups, face multiple hurdles and do not obtain the care they need. National reports are also available at : https://ec.europa.eu/social/main.jsp?advSearchKey=ESPNhc_2018&mode=advancedSubmit&catId=22&policyArea=0&policyAreaSub=0&country=0&year=0

Cooke, O. D. N., Kumpunen, S. et Holder, H. (2018). Can people afford to pay for health care? New evidence on financial protection in the United Kingdom. Copenhague OMS Bureau régional de l'Europe**:** xii+79 ,tabl., fig.
http://www.euro.who.int/en/publications/abstracts/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-the-united-kingdom-2018

Au Royaume-Uni, la protection financière est meilleure que dans beaucoup d'autres pays de l'Union européenne, conséquence des niveaux assez élevés de dépenses publiques en faveur de la santé ; du droit d'accès au National Health Service (NHS, système national de services médicaux) pour la population résidente ; d'une couverture de services étendue ; et du recours très limité aux frais à charge du patient pour les services couverts par le NHS. Il existe des motifs d'inquiétude quant à l'accès aux soins de santé et à la protection financière dans l'avenir. Le NHS est confronté à des pressions financières exceptionnelles en raison de niveaux de dépenses publiques inférieurs aux besoins et de coupes dans les budgets des services sociaux. Les stratégies de rationnement des soins dispensés par le NHS pourraient intensifier la nécessité de paiements directs assumés par la population. Tandis que les personnes ayant les moyens pourraient recourir au secteur privé, les ménages déjà exposés à des contraintes financières pourraient être obligés de différer le moment de se soigner ou se passer de soins. Le rôle essentiel et efficace joué par le NHS pour protéger la population des difficultés financières en cas de maladie devrait être sauvegardé en s'assurant que les dépenses publiques en faveur de la santé soient suffisantes pour satisfaire les besoins. Financial protection is stronger in the United Kingdom than in many other European Union countries, reflecting relatively high levels of public spending on health; population entitlement to National Health Service (NHS) care based on residence; comprehensive service coverage; and very limited use of patient charges for services covered by the NHS.There are reasons to be concerned about access to health care and financial protection in the future. The NHS is facing exceptional financial pressure owing to public spending levels that are lower than needed, as well as cuts to social care budgets. Strategies to ration NHS care may increase the need for people to pay out of pocket. While those who can afford to do so may pay for private treatment, households already facing financial pressure may be forced to delay or forego care.The vital and effective role the NHS plays in protecting people from financial hardship when they are ill should be safeguarded by ensuring that public spending on health is adequate to meet health needs.

Cylus, J., Roland, D. et Nolte, E. (2018). Identifying options for funding the NHS and social care in the UK: international evidence. Londres Health Foundation**:** 108 , fig., tabl.
www.health.org.uk/sites/health/files/Social%20care%20funding%20-%20international%20evidence_web.pdf

Ce document identifie les options pour le financement de la santé et des services sociaux au Royaume-Uni et explore la manière dont 16 autres pays à revenu élevé ont mis en œuvre des changements pour relever des défis systémiques. La plupart de ces pays ont des systèmes de santé publics, mais comptent davantage sur le financement privé pour les services sociaux. Sur le plan international, les réformes de financement ont tendance à être progressives et catalysées par la situation économique plutôt que par la demande de soins.

Farfan-Portet, M. I., Bouckaert, N., Devries, S., et al. (2018). Cost sharing and protection mechanisms in health. KCE Report; 309. Bruxelles KCE**:** 98 , fig., tabl.
https://kce.fgov.be/fr/impact-global-et-effet-redistributif-des-mesures-de-protection-sociale-en-mati%C3%A8re-de-co%C3%BBts-de-sant%C3%A9

Le partage des coûts entre l'assurance maladie et le patient est une des caractéristiques du système d'assurance maladie belge. Ce rapport technique utilise une modélisation par microsimulation pour évaluer les conséquences budgétaires des récentes propositions du gouvernement visant à modifier les mécanismes de partage des coûts et de protection sociale. Le rapport comprend 54 sections, chacune avec des tableaux résumant les résultats spécifiques.

Fitch, M. et Longo, C. J. (2018). "Exploring the impact of out-of-pocket costs on the quality of life of Canadian cancer patients." J Psychosoc Oncol **36**(5): 582-596.

OBJECTIVE: To explore cancer patients' perspective about the impact of financial burden on quality of life. METHODS: A qualitative descriptive approach was utilized. In-depth interview transcripts from 14 survivors were subjected to a thematic analysis. RESULTS: All participants experienced reduced income and increased out-of-pocket costs following their diagnosis. None worked during their treatment interval. They described profound impacts on the social, psychological, and spiritual domains of quality of life from the financial challenges. Many were worried about having sufficient funds to support themselves in the long term and felt this added to the burden they were carrying. Most found the financial challenges surprising and unexpected. Additionally, the impact was also experienced by their family members. IMPLICATIONS: Healthcare providers ought to be aware of the potential impact financial challenges can have and the distress they bring about. A discussion about financial concerns needs to occur at the beginning of the cancer journey, with appropriate resources made available, and monitored regularly.

Goujard, A. (2018). France: improving the efficiency of the health-care system. OECD Economics Department Working Papers ; 1455**:** 51 , tab., graph., fig.
http://d.repec.org/n?u=RePEc:oec:ecoaaa:1455-en&r=age

France's health-care system offers high-quality care. Average health outcomes are good, public satisfaction with the health-care system is high, and average household out-of-pocket expenditures are low. As in other OECD countries, technology is expanding possibilities for life extension and quality, and spending is rising steadily, while an ageing population requires substantially more and different services. The main challenges are to promote prevention and cost-efficient behaviour by care providers, tackle the high spending on pharmaceuticals, strengthen the role of health insurers as purchasing agents and secure cost containment. Good-quality information and appropriate financing schemes would ensure stronger efficiency incentives. Disparities of coverage across social groups and health services suggest paying greater attention to co-ordination between statutory and complementary insurance provision. Ongoing reforms to improve prevention and co-ordination among care providers are steps in the right direction. However, progress in the development of capitation-based payment schemes, which can reduce the incentives to increase the number of medical acts and encourage health professionals to spend more time with their patients, and performance-based payment schemes in primary care need to be stepped up to respond to the increasing prevalence of chronic diseases and curb supplier-induced demand and social disparities in access to care

Hayen, A. P., Klein, T. J. et Salm, M. (2018). Does the Framing of Patient Cost-Sharing Incentives Matter? The Effects of Deductibles vs. No-Claim Refunds. CEPR Discussion Paper ; DP12908. Tilburg Tilburg University**:** 66 , tab., graph., fig.
http://d.repec.org/n?u=RePEc:iza:izadps:dp11508&r=hea?

In light of increasing health care expenditures, patient cost-sharing schemes have emerged as one of the main policy tools to reduce medical spending. We show that the effect of patient cost-sharing schemes on health care expenditures is not only determined by the economic incentives they provide, but also by the way these economic incentives are framed. Patients react to changes in economic incentives almost twice as strongly under a deductible policy than under a no-claims refund policy. Our preferred explanation is that individuals are loss-averse and respond differently to both schemes because they perceive deductible payments as a loss and no-claim refunds as a gain.

Insicive Health (2018). An international comparison of long-term care funding and outcomes: insights for the social care green paper. Londres Age UK, Londres Incisive Health**:** 49, fig.
www.incisivehealth.com/wp-content/uploads/2018/08/international_comparison_of_social_care_funding_and_outcomes.pdf

By 2068 there will be an extra 8.6 million people aged 65 or over living in the UK, with over-65s making up 26% of the population. With more of us living longer and many people having one or more long-term conditions, more people will need access to long-term care. Incisive Health partnered with Age UK to examine what five other countries have done to respond to the question of how long-term care should be funded and delivered.

Iizuka, T. et Shigeoka, H. (2018). Free for Children? Patient Cost-sharing and Healthcare Utilization. NBER Working Paper Series ; 25306. Cambridge NBER**:** 50 ,tabl., fig.,annexes.
http://papers.nber.org/papers/W25306

This study exploits over 5,000 variations in subsidy generosity across ages and municipalities in Japan to examine how children respond to healthcare prices. We find that free care significantly increases outpatient spending, with price elasticities considerably smaller than for adults. Price responses are substantially larger when small copayments are introduced, indicating more elastic demand around a zero price. We also find that increased utilization primarily reflects low-value and costly care: increased outpatient spending neither reduces subsequent hospitalization by “avoidable” conditions nor improves short- or medium-term health outcomes. By contrast, inappropriate use of antibiotics and costly after-hours visits increase.

Kwon, E., Park, S. et McBride, T. D. (2018). "Health Insurance and Poverty in Trajectories of Out-of-Pocket Expenditure among Low-Income Middle-Aged Adults." Health Services Research **53**(6): 4332-4352.
https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12974

Objective To assess the effects of longitudinal patterns of health insurance and poverty on out-of-pocket expenditures among low-income late middle-aged adults. Data Sources/Study Setting Six waves (2002–2012) of the Health and Retirement Study, in combination with RAND Center for the

Study of Aging data, were used. Study Design A random coefficient regression analysis was conducted in a multilevel growth curve framework to estimate the impact of health insurance and poverty on out-of-pocket expenditures. Principal Findings At baseline, individuals with private insurance or unstable coverage were more likely to have out-of-pocket expenditures and financial burdens than public insurance holders. Over time, the poor who had no insurance, unstable coverage, or insurance type change had higher out-of-pocket expenditures; private coverage holders had higher odds of financial burden. Conclusions Unstable insurance coverage had a discernible effect on the long-term, out-of-pocket expenditures among low-income adults. Findings have an important policy implication to protect poor late middle-aged population; as this population enters old age, the high financial burden it faces may exacerbate persistent socioeconomic health disparity among older people with unstable insurance coverage.

Nishi, T. (2018). The impact of revision for coinsurance rate for elderly on healthcare resource utilization: a pilot study using interrupted time series analysis of employee health insurance claims data. MPRA Paper : 86329. Munich MPRA**:** 13.
https://econpapers.repec.org/paper/pramprapa/86329.htm

Cost sharing, including copayment and coinsurance, is often used as a means of containing medical expenditure by reducing unnecessary or excessive use of health-care resources. Previous studies have reported the effects of reducing the coinsurance rate in Japan from 30% to 10% on demand for medical care among people aged 70 years. However, the coinsurance rate in Japan for individuals aged 70–74 years old has recently been increased from 10% to 20%. This study aimed to estimate the economic impact of coinsurance rate revision on health-care resource utilization using interrupted time-series analysis of employee health insurance claims data. I classified those who were born in FY 1944 and whose coinsurance rates decreased to 20% into the 10%-reduction group. It was found that the 10%-reduction group showed a lower increase of health-care utilization than the 20%-reduction group. However, no significant differences were observed in the overall and inpatient settings. The results of this study suggest that increasing the coinsurance rate among elderly people would reduce outpatient health-care resource utilization; however, it would not necessarily reduce overall health-care resource utilization.

OCDE (2018). Health at a glance : Europe 2018. Paris OCDE**:** 221 , ann., graph., tabl.
https://www.oecd.org/health/health-at-a-glance-europe-23056088.htm

Health at a Glance: Europe 2018 presents comparative analyses of the health status of EU citizens and the performance of the health systems of the 28 EU Member States, 5 candidate countries and 3 EFTA countries. It is the first step in the State of Health in the EU cycle of knowledge brokering. This publication has two parts. Part I comprises two thematic chapters, the first focusing on the need for concerted efforts to promote better mental health, the second outlining possible strategies for reducing wasteful spending in health. In Part II, the most recent trends in key indicators of health status, risk factors and health spending are presented, together with a discussion of progress in improving the effectiveness, accessibility and resilience of European health systems.

Palagyi, A., Jan, S., Dodd, R., et al. (2018). "The impact of out-of-pocket costs on treatment commencement and adherence in chronic kidney disease: a systematic review." Health Policy and Planning **33**(9): 1047-1054.
https://dx.doi.org/10.1093/heapol/czy081

Chronic kidney disease (CKD) is a significant and growing driver of the global non-communicable diseases (NCD) burden, responsible for 1.2 million deaths in 2016. While previous research has estimated the out-of-pocket costs of CKD treatment and resulting levels of catastrophic health expenditures, less is known about the impact of such costs on access to, and maintenance of, care. Our study seeks to fill this gap by synthesizing available evidence on cost as a determinant of CKD treatment discontinuation. We searched for studies which considered the financial burden of treatment and medication for CKD patients and the extent to which this burden was associated with patients forgoing or discontinuing treatment. We identified 14 relevant studies, 5 from high-income countries and 9 from low-middle income countries. All suggest that cost adversely influences adherence to CKD medication and dialysis treatment. In poorer countries, those entering treatment programs were typically diagnosed late, under-dialysed and suffered very high levels of mortality. Identified studies present consistent findings regardless of study context: cost is barrier to treatment and a driver of non-adherence and discontinuation, with poorer households worst affected. This is in line with previous research. Major gaps in the literature remain, however, in relation to differential impact of the cost burden on men and women, the coping strategies of poor households and the effect of insurance coverage.

Pymont, C., McNamee, P. et Butterworth, P. (2018). "Out-of-pocket costs, primary care frequent attendance and sample selection: Estimates from a longitudinal cohort design." Health Policy **122**(6): 652-659.

Rice, T., Quentin, W., Anell, A., et al. (2018). "Revisiting out-of-pocket requirements: trends in spending, financial access barriers, and policy in ten high-income countries." Bmc Health Services Research **18**: 18 , tabl.
https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/s12913-018-3185-8

Background: Countries rely on out-of-pocket (OOP) spending to different degrees and employ varying techniques. The article examines trends in OOP spending in ten high-income countries since 2000, and analyzes their relationship to self-assessed barriers to accessing health care services. The countries are Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. Methods: Data from three sources are employed: OECD statistics, the Commonwealth Fund survey of individuals in each of ten countries, and country-specific documents on health care policies. Based on trends in OOP spending, we divide the ten countries into three groups and analyze both trends and access barriers accordingly. As part of this effort, we propose a conceptual model for understanding the key components of OOP spending. Results: There is a great deal of variation in aggregate OOP spending per capita spending but there has been convergence over time, with the lowest-spending countries continuing to show growth and the highest spending countries showing stability. Both the level of aggregate OOP spending and changes in spending affect perceived access barriers, although there is not a perfect correspondence between the two. Conclusions: There is a need for better understanding the root causes of OOP spending. This will require data collection that is broken down into OOP resulting from cost sharing and OOP resulting from direct payments (due to underinsurance and lacking benefits). Moreover, data should be disaggregated by consumer groups (e.g. income-level or health status). Only then can we better link the data to specific policies and suggest effective solutions to policy makers.

Villalobos Dintrans, P. (2018). "Out-of-pocket health expenditure differences in Chile: Insurance performance or selection?" Health Policy **122**(2): 184-191.

Vogler, S. (2018). Medicines Reimbursement Policies in Europe, Copenhague : OMS Bureau régional de l'Europe
http://www.euro.who.int/__data/assets/pdf_file/0011/376625/pharmaceutical-reimbursement-eng.pdf

This report reviews and analyses different reimbursement policies for medicines applied by countries in the WHO European region. The study used a mixed methods approach including primary data collection through a questionnaire addressing the competent authorities included in the Pharmaceutical Pricing and Reimbursement Information (PPRI) network, a literature review, qualitative interviews with authorities and researchers in selected case study countries, and a cross-country analysis of the actual financial burden for patients. The study found that while almost all countries provide full coverage for medicines in the inpatient sector, patients can be asked to co-pay for reimbursable medicines in the outpatient sector. As a commonly applied co-payment patients pay a defined share of the price of a medicine; in addition, prescription fees and/or deductibles are also in place in some countries. In the countries of the WHO European region, mechanisms have been established to protect defined population groups from excessive co-payments for medicines; key reasons for reductions of and exemptions from co-payments include low income, defined diseases or disabilities and age. The analysis of the actual financial burden suggested that co-payments may pose a substantial financial burden for patients, particularly in lower-income countries. The report identified several principles aiming to improve affordable access to medicines and protect people from excessive out-of-pocket co-payments. These include clear priority-setting processes, evidence based decision-making, transparent processes, consideration of vulnerable population groups, making use of the efficiency of lower priced medicines, regular evaluations and strategic design of policy measures.

Westerhout, E. et Folmer, K. (2018). The Effects of Capping Co-Insurance Payments. Discussion Paper; No 2018-050. Tilburg Tilburg University**:** 41 , tab., graph., fig.
https://pure.uvt.nl/ws/portalfiles/portal/28354863/2018_050.pdf

In light of increasing health care expenditures, patient cost-sharing schemes have emerged as one of the main policy tools to reduce medical spending. We show that the effect of patient cost-sharing schemes on health care expenditures is not only determined by the economic incentives they provide, but also by the way these economic incentives are framed. Patients react to changes in economic incentives almost twice as strongly under a deductible policy than under a no-claims refund policy. Our preferred explanation is that individuals are loss-averse and respond differently to both schemes because they perceive deductible payments as a loss and no-claim refunds as a gain.

Wouterse, B., Hussem, A. et Wong, A. (2018). The effect of co-payments in Long Term Care on the distribution of payments, consumption, and risk. HEDG Working Paper ; 18/24. York University of York**:** 35 ,tab., graph., fig.
www.york.ac.uk/media/economics/documents/hedg/workingpapers/1824.pdf

Population aging leads to concerns about the financial sustainability of collective long term care insurance systems. One way to keep public spending in check is by increasing the role of co-payments. An interesting feature of the copayments that have been introduced in the Netherlands is that they are income and wealth dependent. This dependency allows the fine-tuning of effects across income groups, but can also distort consumption decisions of the elderly. Modeling long term care expenditures over the lifecycle is challenging because of their very uneven distribution, with a small proportion of elderly experiencing very high costs. We use a flexible semi-parametric nearest-neighbor approach to estimate lifecycle paths of long term care spending. We apply this approach to an extensive administrative data set for the entire Dutch elderly population. The estimated paths are then used as inputs in a stochastic lifecycle decision model for singles at the retirement age. We analyze the effects of different co-payment schemes on the distribution of LTC payments, consumption and risk across income groups. We find that, compared to a flat-rate co-payment, income- and especially wealth-dependent copayments lead to much lower welfare costs for groups with low financial means. At the same time, the welfare costs of the groups with the highest means increase only slightly. Excluding a bequest motive leads to lower, and including health state dependent utility to higher welfare losses due to co-payments compared to full insurance.

Xu, K., Soucat, A. et Kutzin, J. (2018). Public Spending on Health: A Closer Look at Global Trends. Genève Office des publications de l'OMS**:** 47 , tab., graph., fig.
https://apps.who.int/iris/bitstream/handle/10665/276728/WHO-HIS-HGF-HF-WorkingPaper-18.3-eng.pdf

L'augmentation des dépenses en santé, qui représentent 10% du produit intérieur brut (PIB) mondial, est plus rapide que la croissance de l'économie mondiale. Selon un nouveau rapport de l'Organisation mondiale de la Santé (OMS) sur les dépenses en santé dans le monde, celles-ci augmentent rapidement, en particulier dans les pays à revenu faible ou intermédiaire, où l'augmentation est de 6% par an en moyenne contre 4% dans les pays à revenu élevé. Les dépenses en santé d'un pays sont assumées à 51% en moyenne par les administrations publiques et à plus de 35% par les individus sous forme de dépenses directes. L'une des conséquences de cette situation est que, chaque année, 100 millions de personnes plongent dans l'extrême pauvreté.

2017

(2017). "Evolution and patterns of global health financing 1995-2014: development assistance for health, and government, prepaid private, and out-of-pocket health spending in 184 countries." Lancet **389**(10083): 1981-2004.

BACKGROUND: An adequate amount of prepaid resources for health is important to ensure access to health services and for the pursuit of universal health coverage. Previous studies on global health financing have described the relationship between economic development and health financing. In this study, we further explore global health financing trends and examine how the sources of funds used, types of services purchased, and development assistance for health disbursed change with economic development. We also identify countries that deviate from the trends. METHODS: We estimated national health spending by type of care and by source, including development assistance for health, based on a diverse set of data including programme reports, budget data, national estimates, and 964 National Health Accounts. These data represent health spending for 184 countries from 1995 through 2014. We converted these data into a common inflation-adjusted and purchasing power-adjusted currency, and used non-linear regression methods to model the relationship between health financing, time, and economic development. FINDINGS: Between 1995 and 2014, economic development was positively associated with total health spending and a shift away from a reliance on development assistance and out-of-pocket (OOP) towards government spending. The largest absolute increase in spending was in high-income countries, which increased to purchasing power-adjusted $5221 per capita based on an annual growth rate of 3.0%. The largest health spending growth rates were in upper-middle-income (5.9) and lower-middle-income groups (5.0), which both increased spending at more than 5% per year, and spent $914 and $267 per capita in 2014, respectively. Spending in low-income countries grew nearly as fast, at 4.6%, and health spending increased from $51 to $120 per capita. In 2014, 59.2% of all health spending was financed by the government, although in low-income and lower-middle-income countries, 29.1% and 58.0% of spending was OOP spending and 35.7% and 3.0% of spending was development assistance. Recent growth in development assistance for health has been tepid; between 2010 and 2016, it grew annually at 1.8%, and reached US$37.6 billion in 2016. Nonetheless, there is a great deal of variation revolving around these averages. 29 countries spend at least 50% more than expected per capita, based on their level of economic development alone, whereas 11 countries spend less than 50% their expected amount. INTERPRETATION: Health spending remains disparate, with low-income and lower-middle-income countries increasing spending in absolute terms the least, and relying heavily on OOP spending and development assistance. Moreover, tremendous variation shows that neither time nor economic development guarantee adequate prepaid health resources, which are vital for the pursuit of universal health coverage. FUNDING: The Bill & Melinda Gates Foundation.

(2017). "Future and potential spending on health 2015-40: development assistance for health, and government, prepaid private, and out-of-pocket health spending in 184 countries." Lancet **389**(10083): 2005-2030.

BACKGROUND: The amount of resources, particularly prepaid resources, available for health can affect access to health care and health outcomes. Although health spending tends to increase with economic development, tremendous variation exists among health financing systems. Estimates of future spending can be beneficial for policy makers and planners, and can identify financing gaps. In this study, we estimate future gross domestic product (GDP), all-sector government spending, and health spending disaggregated by source, and we compare expected future spending to potential future spending. METHODS: We extracted GDP, government spending in 184 countries from 1980-2015, and health spend data from 1995-2014. We used a series of ensemble models to estimate future GDP, all-sector government spending, development assistance for health, and government, out-of-pocket, and prepaid private health spending through 2040. We used frontier analyses to identify patterns exhibited by the countries that dedicate the most funding to health, and used these frontiers to estimate potential health spending for each low-income or middle-income country. All estimates are inflation and purchasing power adjusted. FINDINGS: We estimated that global spending on health will increase from US$9.21 trillion in 2014 to $24.24 trillion (uncertainty interval [UI] 20.47-29.72) in 2040. We expect per capita health spending to increase fastest in upper-middle-income countries, at 5.3% (UI 4.1-6.8) per year. This growth is driven by continued growth in GDP, government spending, and government health spending. Lower-middle income countries are expected to grow at 4.2% (3.8-4.9). High-income countries are expected to grow at 2.1% (UI 1.8-2.4) and low-income countries are expected to grow at 1.8% (1.0-2.8). Despite this growth, health spending per capita in low-income countries is expected to remain low, at $154 (UI 133-181) per capita in 2030 and $195 (157-258) per capita in 2040. Increases in national health spending to reach the level of the countries who spend the most on health, relative to their level of economic development, would mean $321 (157-258) per capita was available for health in 2040 in low-income countries. INTERPRETATION: Health spending is associated with economic development but past trends and relationships suggest that spending will remain variable, and low in some low-resource settings. Policy change could lead to increased health spending, although for the poorest countries external support might remain essential. FUNDING: Bill & Melinda Gates Foundation.

Ali, S., Cookson, R. et Dusheiko, M. (2017). "Addressing care-seeking as well as insurance-seeking selection biases in estimating the impact of health insurance on out-of-pocket expenditure." Social Science & Medicine **177**: 127-140.

Health Insurance (HI) programmes in low-income countries aim to reduce the burden of out-of-pocket (OOP) health care expenditure. However, if the decisions to purchase insurance and to seek care when ill are correlated with the expected health care expenditure, the use of naïve regression models may produce biased estimates of the impact of insurance membership on OOP expenditure. Whilst many studies in the literature have accounted for the endogeneity of the insurance decision, the potential selection bias due to the care-seeking decision has not been taken into account. We extend the Heckman selection model to account simultaneously for both care-seeking and insurance-seeking selection biases in the health care expenditure regression model. The proposed model is illustrated in the context of a Vietnamese HI programme using data from a household survey of 1,192 individuals conducted in 1999. Results were compared with those of alternative econometric models making no or partial allowance for selection bias. In this illustrative example, the impact of insurance membership on reducing OOP expenditures was underestimated by 21 percentage points when selection biases were not taken into account. We believe this is an important methodological contribution that will be relevant to future empirical work.

Costa-Font, J. et Zigante, V. (2017). Building 'Implicit Partnerships'? Financial Long Term Care Entitlements in Europe. LSE 'Europe in Question' Discussion Paper Series;125. London London School of Economics and Political Science**:** 34.
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3052190

The public funding of long-term care (LTC) programs to support the frail elderly is still underdeveloped compared to other areas of social protection for old age. In Europe, any moves to broaden entitlements to LTC are impeded by increasing demand for care coinciding with constrained public finances. We examine a set of conditions that facilitate modifications to the financial entitlement to LTC and elaborate the concept of 'implicit partnerships': an implicit (or 'silent') agreement, encompassing the financial co-participation of public funders and the time and/or financial resources of users and their families. We argue that the successful building of 'implicit partnerships' opens the door to potential reform of financial entitlements, either through 'user partnerships' relying on users' co-payments, or 'caregiver partnerships' relying on informal care provision. We examine entitlements over time in seven European countries; the EU-5, the Netherlands and Sweden. Furthermore, we show that public attitudes towards financing and provision of LTC support the country specific financial entitlements and the type of implicit partnership we identify.

Eibner, C., Liu, J. L. et Nowak, S. A. (2017). The Effects of the American Health Care Act on Health Insurance Coverage and Federal Spending in 2020 and 2026. Santa Monica Rand Corporation**:** 36 , tabl., fig.
https://www.rand.org/pubs/research_reports/RR2003.html

In this report, the authors analyzed a version of the American Health Care Act (AHCA), a bill proposed in the U.S. House of Representatives on March 6, 2017. The bill would have repealed many of the provisions of the Affordable Care Act (ACA) and replaced them with alternative reforms. The authors used RAND's COMPARE microsimulation model to assess how the AHCA would have affected such outcomes as health insurance enrollment, consumer out-of-pocket costs, and the federal deficit relative to the ACA. This analysis relies on the version of the bill dated March 6, 2017, with several updates to account for the March 20 "Manager's Amendment."This analysis finds that the AHCA would have resulted in a reduction in health insurance enrollment of 14.2 million in 2020 and a reduction in health insurance enrollment of 19.7 million in 2026. While the magnitude of the estimated coverage reductions is smaller than those of the Congressional Budget Office (CBO), this analysis confirms CBO's general finding that the AHCA would have substantially reduced insurance enrollment relative to current law. Those without insurance under the AHCA would have tended to be older, sicker, and poorer than those currently uninsured.

Erus, B. (2017). Reforms and physicians' status in Turkey: Distribution of OOP Health Expenditures for Physicians and Hospitals. Working paper; 1088. Giza Economic Research forum**:** 8 , tabl., fig.
http://d.repec.org/n?s=http://erf.org.eg/wp-content/uploads/2017/04/1088.pdf

Turkish health care reforms brought about significant changes regarding the way physicians practice. Dual-time practice, which was very common among public hospital physicians, was gradually banned. While public insurance coverage has been extended to private hospitals, private practices have been left out. The resulting system rendered physicians more attached to the hospitals, public and private, and decreased their independence. This study explores the change in out-of-pocket payments to physicians and hospitals from 2003, the year reforms started, to 2013. We use a finite mixture model to examine changes in small and large expenditures. Our findings show a steep drop in payments to physicians both for small and large sums of payments. For hospitals, the drop in the size of the payments appear to be compensated by an increase in the number of households making a payment.

Farrel, A. et Greig, F. E. (2017). Paying Out-of-Pocket: The Healthcare Spending of 2 Million US Families. New York JPMorgan Chase Institute**:** 44 ,fig.

The JPMorgan Chase Institute set out to better understand out-of-pocket healthcare spending among US households. Building off a sample of 2.3 million de-identified core Chase customers aged 18 to 64 between 2013 and 2016, we assembled the JPMorgan Chase Institute Healthcare Out-of-pocket Spending Panel (JPMCI HOSP) data asset in order to explore the levels, concentration, and growth of out-of-pocket healthcare spending and the implications for household financial health. The JPMCI HOSP provides a first-ever look into out-of-pocket healthcare spending for households on a month-to-month basis, at the state, metro, and county level, and as recent as 2016. In this report, we describe the creation of, and initial insights gleaned from, this new data asset. We highlight six key findings. First, out-of-pocket healthcare spending grew between 2013 and 2016, but remained a relatively constant share of take-home income. Second, the financial burden of out-of-pocket healthcare spending was highest for older, lower-income, and female account holders and increased in 2016 for low-income account holders. Third, doctor, dental, and hospital payments accounted for more than half of observed healthcare spending; dental and hospital payments were less common but larger in magnitude. Fourth, out-of-pocket healthcare spending was highly concentrated among a few families—often the same families year over year. The top 10 percent of families spent roughly 9 percent of their take-home income on healthcare expenses. Fifth, families made larger healthcare payments in the months and the years when they had a higher ability to pay. Elevated dental and hospital payments primarily contributed to high healthcare spending. Finally, there was dramatic variation in out-of-pocket healthcare spending between and within the 23 states where Chase has a retail footprint. Families in Colorado spent the most on healthcare, while families in Louisiana spent the highest fraction of their gross income on healthcare.

Flores, G., Hogan, D., Stevens, G., et al. (2017). Tracking universal health coverage: 2017 Global Monitoring

Report. Copenhague OMS ; Washington Banque Mondiale**:** 73 , tab., graph., fig.

L'objectif de la Couverture sanitaire universelle est de permettre à tous d'accéder aux soins de santé sans être exposé à des dépenses catastrophiques. Dans ce nouveau rapport, l'Organisation mondiale de la Santé fait l'état des lieux de la couverture sanitaire universelle pour 2017. Le rapport estime qu'encore la moitié de la population mondiale n'a pas accès aux services de santé essentiels. Il expose également que 800 millions de personnes consacrent au moins 10 % du budget de leur ménage à des dépenses occasionnées de santé pour elles-mêmes ou un autre membre de leur famille. De plus, les dépenses de santé font basculer 100 millions de personnes dans une situation d'extrême pauvreté. Outre l'analyse des avancées de la couverture sanitaire dans les pays, le rapport examine les inégalités sociales d'accès aux services de santé essentielle à l'intérieur des pays. Il ressort notamment de cette analyse que, dans les pays à revenu faible ou intermédiaire, seulement 17 % des mères et des enfants des ménages les plus pauvres bénéficient de six au moins des sept interventions fondamentales de santé de la mère et de l'enfant, contre 74% dans les ménages les plus favorisés.

Grigorakis, N., Floros, C., Tsangari, H., et al. (2017). "Combined social and private health insurance versus catastrophic out of pocket payments for private hospital care in Greece." Int J Health Econ Manag.

The high level of out of pocket (OOP) payments constitutes a major concern for Greece and several other European and OECD countries as a result of the significant down turning of their public health finances due to the 2008 financial crisis. The basic objective of this study is to provide empirical evidence on the effect of combining social health insurance (SHI) and private health insurance (PHI) on OOP payments. Further, this study examines the catastrophic impact of OOP payments on insured's welfare using the incidence and intensity methodological approach of measuring catastrophic health care expenditures. Conducting a cross-sectional survey in Greece in 2013, we find that the combination of SHI-PHI has a strong negative influence on insured OOP payments for inpatient health care in private hospitals. Furthermore, our results indicate that SHI coverage is not sufficient by itself to manage with this issue. Moreover, we find that poor people present a greater tendency to incur catastrophic OOP expenditures for hospital health care in private providers. Drawing evidence from Greece, a country with huge fiscal problems that has suffered the consequences of the economic crisis more than any other, could be a starting point for policymakers to consider the perspective of SHI-PHI co-operation against OOP payments more seriously.

Grigorakis, N., Floros, C., Tsangari, H., et al. (2017). "Out of pocket payments and social health insurance for private hospital care: Evidence from Greece." Health Policy **120**(8): 948-959.
http://dx.doi.org/10.1016/j.healthpol.2016.06.011

We examine social health insurance's risk pooling mechanisms.?We consider the catastrophic impact that health care OOPs may have on insured's income and well-being.?Using data from Greece, we find that the OOPs for inpatient care in private hospitals have a positive relationship with SHI funding.?We show that the SHI funding is inadequate to total inpatient financing.

Homaie Rad, E., Rashidian, A., Arab, M., et al. (2017). "The Effect of Catastrophic Health Expenditure on Work After Retirement." Int J Aging Hum Dev **84**(3): 313-323.

Several factors can force retirees to go to paid work. Catastrophic health-care expenditure (CHCE) is one of the driving forces for retirees to go to paid work. This cross-sectional study was based on 6,307 Iran retirees' data. Xu method was used to calculate CHCE, and a logit model was estimated to show the association between CHCE and bridge employment. Other control variables were added to the model. The findings showed that there was positive relationship between CHCE and bridge employment. Retirement pension had negative relationship with work after retirement. Prevalence of work after retirement was higher in people who lived in rural region and increased due to increase in household size. The financial constraint was the main pushing factor for the retiree to go to paid work. Thus, covering retirees with health insurances and identifying and listing diseases that may face the retirees with CHCE are some possible efforts to decrease CHCE.

Hua, X., Erreygers, G., Chalmers, J., et al. (2017). "Using administrative data to look at changes in the level and distribution of out-of-pocket medical expenditure: An example using Medicare data from Australia." Health Policy **121**(4): 426-433.

OBJECTIVES: Australia's universal health insurance system Medicare generates very large amounts of data on out-of-pocket expenditure (OOPE), but only highly aggregated statistics are routinely published. Our primary purpose is to develop indices from the Medicare administrative data to quantify changes in the level and distribution of OOPE on out-of-hospital medical services over time. METHODS: Data were obtained from the Australian Hypertension and Absolute Risk Study, which involved patients aged 55 years and over (n=2653). Socio-economic and clinical information was collected and linked to Medicare records over a five-year period from March 2008. The Fisher price and quantity indices were used to evaluate year-to-year changes in OOPE. The relative concentration index was used to evaluate the distribution of OOPE across socio-economic strata. RESULTS: Our price index indicates that overall OOPE were not rising faster than inflation, but there was considerable variation across different types of services (e.g. OOPE on professional attendances rose by 20% over a five-year period, while all other items fell by around 14%). Concentration indices, adjusted for demographic factors and clinical need, indicate that OOPE tends to be higher among those on higher incomes. CONCLUSIONS: A major challenge in utilizing large administrative data sets is to develop reliable and easily interpretable statistics for policy makers. Price, quantity and concentration indices represent statistics that move us beyond the average.

Karter, A. J., Parker, M. M., Solomon, M. D., et al. (2018). "Effect of Out-of-Pocket Cost on Medication Initiation, Adherence, and Persistence among Patients with Type 2 Diabetes: The Diabetes Study of Northern California (DISTANCE)." Health Services Research **53**(2): 1227-1247.

OBJECTIVE: To estimate the effect of out-of-pocket (OOP) cost on nonadherence to classes of cardiometabolic medications among patients with diabetes. DATA SOURCES/SETTING: Electronic health records from a large, health care delivery system for 223,730 patients with diabetes prescribed 842,899 new cardiometabolic medications during 2006-2012. STUDY DESIGN: Observational, new prescription cohort study of the effect of OOP cost on medication initiation and adherence. DATA COLLECTION: Adherence and OOP costs were based on pharmacy dispensing records and benefits. PRINCIPAL FINDINGS: Primary nonadherence (never dispensed) increased monotonically with OOP cost after adjusting for demographics, neighborhood socioeconomic status, Medicare, medical financial assistance, OOP maximum, deductibles, mail order pharmacy incentive and use, drug type, generic or brand, day's supply, and comorbidity index; 7 percent were never dispensed the new medication when OOP cost >/=$11, 5 percent with OOP cost of $1-$10, and 3 percent when the medication was free of charge (p < .0001). Higher OOP cost was also strongly associated with inadequate secondary adherence (>/=20 percent of time without adequate medication). There was no clinically significant or consistent relationship between OOP costs and early nonpersistence (dispensed once, never refilled) or later stage nonpersistence (discontinued within 24 months). CONCLUSIONS: Cost-sharing may deter clinically vulnerable patients from initiating essential medications, undermining adherence and risk factor control.

McInerney, M., Rutledge, M. S. et King, S. E. (2017). How Much Does Out-of-Pocket Medical Spending Eat Away at Retirement Income? Working Paper; 2017-13. Ann Arbor Michigan Retirement Research Center**:** 31 , fig.
http://crr.bc.edu/working-papers/how-much-does-out-of-pocket-medical-spending-eat-away-at-retirement-income/

The adequacy of retirement income – from Social Security benefits and other sources – is substantially reduced by Medicare's high out-of-pocket (OOP) costs. This project uses the 2002-2014 Health and Retirement Study to calculate post-OOP benefit ratios, defined as the share of either Social Security benefits or total income available for non-medical spending. The project decomposes the share of income that is going toward premium payments and services delivered and examines how these post-

OOP benefit ratios differ by age, gender, income, supplemental insurance coverage, and health status. The project also updates previous studies' estimates to document how OOP spending and the post-OOP income ratios changed following the introduction of Medicare Part D prescription drug coverage in 2006 and the closing of the "donut hole" coverage gap in 2010, which decreased OOP costs under Part D for those spending moderate amounts on prescriptions.

Muir, T. (2017). Measuring social protection for long-term care. OECD Health Working Papers ; 93. Paris OCDE**:** 55 , graph.
http://www.oecd-ilibrary.org/social-issues-migration-health/measuring-social-protection-for-long-term-care_a411500a-en

This report presents the first international quantification and comparison of levels of social protection for long-term care (LTC) in 14 OECD and EU countries. Focusing on five scenarios with different LTC needs and services, it quantifies the cost of care; the level of coverage provided by social protection systems; the out-of-pocket costs that people are left facing; and whether these costs are affordable. The cost of care varies widely between countries but it is always high relative to typical incomes, meaning that LTC is often unaffordable in the absence of social protection. All countries studied have some form of social protection for LTC, but even where coverage is comprehensive, people pay some of the cost out of pocket. Coverage for home care for moderate or severe needs is often insufficient, leaving people with large out-of-pocket costs. In contrast, all countries studied ensure that institutional care is affordable. Unless family and friends can provide informal care, many people will be unable to afford LTC in their own home, leaving them with unmet needs or at risk of early institutionalisation. Benefits are usually means-tested to provide more support to those less able to afford to contribute, but it is still those with lowest incomes that are most likely to face unaffordable costs. Some countries provide financial support to informal carers, but this rarely comes close to compensating them for the time they spend providing LTC. When designing social protection systems for LTC, countries need to look systematically at the level of protection provided to people in different scenarios. Many countries aim to support people with LTC needs to remain in their own home for longer, but the results presented here suggest that gaps in social protection make this unaffordable for people with low income. Addressing these gaps should be a priority for future reforms.

Non, M. (2017). Co-payments in long-term home care: do they affect the use of care? CPB Discussion Paper; 363. La Hague CPB**:** 18.

We study the effect of a policy change in co-payments on the use of long-term home care in The Netherlands. The change increased co-payments for persons with considerable household financial assets. For identification we apply a difference-in-difference analysis with matched treatment and control groups. We find a significant effect at the extensive margin: persons affected by the policy change are less likely to take up care. The magnitude of the response increases over time, corresponding with an average annual price elasticity of demand of -0.14 and a price elasticity of -0.26 for episodes of care one year after the change. We do not find a significant effect at the intensive margin: persons who take up care do not use less hours of care.

OCDE (2017). Panorama de la santé 2017. Indicateurs de l'OCDE. Paris OCDE**:** 221 , ann., graph., tabl.
http://www.oecd-ilibrary.org/social-issues-migration-health/panorama-de-la-sante-2017_health_glance-2017-fr

Cette nouvelle édition du Panorama de la santé présente les données comparables les plus récentes pour les principaux indicateurs relatifs à la santé et à la performance des systèmes de santé dans les pays de l'OCDE. Les pays candidats et les principaux pays partenaires (Afrique du Sud, Brésil, Chine, Colombie, Costa Rica, Fédération de Russie, Inde, Indonésie et Lituanie) ont également été inclus dans la mesure du possible. Sauf indication contraire, les données présentées dans cette publication sont tirées des statistiques nationales officielles. Cette édition contient des nouveaux indicateurs, particulièrement dans le domaine des facteurs de risque pour la santé. Elle place aussi une plus grande emphase sur l'analyse des tendances temporelles. Parallèlement à l'analyse par indicateur, cette édition propose des instantanés et une série de tableaux de bord qui résument les performances comparatives des pays, ainsi qu'un chapitre spécial sur les principaux facteurs à l'origine des gains d'espérance de vie.

Orlovic, M., Marti, J. et Mossialos, E. (2017). "Analysis Of End-Of-Life Care, Out-Of-Pocket Spending, And Place Of Death In 16 European Countries And Israel." Health Aff (Millwood) **36**(7): 1201-1210.
https://www.ncbi.nlm.nih.gov/pubmed/28679806

In Europe the aging of the population will pose considerable challenges to providing high-quality end-of-life care. The complexity of providing care and the large spectrum of actors involved make it difficult to understand the care pathways and how these are influenced by financial and institutional factors. We examined a large, multicountry data set with waves of data from the period 2006-13 to determine the differences in health care usage, out-of-pocket spending, and place of death in sixteen European countries and Israel. Our results reveal the importance of the funding mechanisms of long-term care. They also illuminate the effect of patients' characteristics on end-of-life care pathways. We found that in countries where public financing and organization of long-term care are particularly strong, patients at the end of life are more likely to have reduced hospitalizations and a higher share of out-of-hospital deaths. Understanding end-of-life care patterns is crucial to developing policies to address the urgent public health priority that this aspect of health care presents.

Park, T. et Jung, J. (2017). "The Effect of Medicare Part D on Prescription Drug Spending and Health Care Use: 6 Years of Follow-up, 2007-2012." J Manag Care Spec Pharm **23**(1): 5-12.

BACKGROUND: Previous studies have shown that Medicare Part D was associated with a reduction in out-of-pocket expenditures for Medicare beneficiaries during the early years of its implementation (2006 and 2007). However, a question remains regarding the effect of Part D on out-of-pocket expenditures in the longer term. OBJECTIVE: To evaluate the effects of Part D on prescription drug expenditures and certain health care use for a longer time period using a large, nationally representative sample of Medicare beneficiaries. METHODS: Using Medical Expenditure Panel Survey (MEPS) data from 2000 through 2005 (pre-Part D period) and from 2007 through 2012 (Part D era), this study identified a cohort of elderly Medicare beneficiaries (treatment group) and a near-elderly non-Medicare population (control group). A difference-in-differences analysis was conducted to estimate the effect of Part D on prescription medication use and expenditures and outpatient visits. Propensity score weights and sampling weights were applied to obtain unbiased effect estimates accounting for complex survey designs. RESULTS: A total of 26,585 elderly Medicare beneficiaries and 20,688 near-elderly non-Medicare beneficiaries were identified. The introduction of Part D was associated with an adjusted average reduction of $105 in annual out-of-pocket spending on prescription drugs during the post-Part D period (2007 through 2012). The reduction in annual out-of-pocket spending ranged from $49 to $152 during the post-Part D period. No significant increase was found in total prescription expenditures or prescription medication use following the introduction of Part D nor were there significant changes in outpatient visits. CONCLUSIONS: A continued reduction of Part D out-of-pocket drug expenditures was found each year from 2007 to 2012. DISCLOSURES: No funding has been received to conduct this study or prepare this manuscript. The authors have no conflicts of interest to declare. Study concept and design were primarily contributed by Park with assistance from Jung. Both authors contributed equally to data analysis and interpretation. The manuscript was written primarily by Park, with assistance from Jung, and revised primarily by Jung.

Sanwald, A. et Theurl, E. (2017). "Out-of-pocket expenditures for pharmaceuticals: lessons from the Austrian household budget survey." Eur J Health Econ **18**(4): 435-447.

BACKGROUND: Paying pharmaceuticals out of pocket is an important source of financing pharmaceutical consumption. Only limited empirical knowledge is available on the determinants of these expenditures. OBJECTIVES: In this article we analyze which characteristics of private households influence out-of-pocket pharmaceutical expenditure (OOPPE) in Austria. DESIGN AND METHODS: We use cross-sectional information on OOPPE and household characteristics provided by the Austrian household budget survey 2009/10. We split pharmaceutical expenditures into the two components prescription fees and over-the-counter (OTC) expenditures. To adjust for the specific characteristics of the data, we compare different econometric approaches: a two-part model, hurdle model, generalized linear model and zero-inflated negative binomial regression model. FINDINGS: The finally selected econometric approaches give a quite consistent picture. The probability of expenditures of both types is strongly influenced by the household structure. It increases with age, doctoral visits and the presence of a female householder. The education level and income only increase the probability of OTC pharmaceuticals. The level of OTC expenditures remains widely unexplained while the household structure and age influence the expenditures for prescription fees. Insurance characteristics of private households, either private or public, play a minor role in explaining the expenditure levels in all specifications. This refers to a homogeneous and comprehensive provision of pharmaceuticals in the public part of the Austrian health care system. CONCLUSIONS: The article gives useful insights into the determinants of pharmaceutical expenditures of private households and supplements the previous research that focuses on the individual level.

Shukai, L., Zhang, D. et Chen, Z. (2017). Choice Model for Individuals' Healthcare Decisions: Endogeneity of Insurance Choice and Selection Issues Due to Utilization Choice in Insurance Study. New York University Mailman, School of Public Health**:** 27 , tab., graph., fig.
https://ssrn.com/abstract=3073434

This paper contributes to health insurance literature by taking into account the interrelationship within outpatient and inpatient decisions, the endogeneity of insurance choice, and the selection issues due to utilization when making economic evaluation of the impact of health insurance. We build a "triple decision model", which assesses the interrelationship among three healthcare decisions: the insurance choice, healthcare utilization, and expenditure level. Specially, we use this model to examine the impact of New Cooperative Medical Scheme (NCMS) enrollment on individuals' utilization and out-of-pocket expenditure for outpatient and inpatient care using a national sample from the China Health and Retirement Longitudinal Study (CHARLS) 2011. A total sample of 12,561 individuals are included in the analysis. In addition to the triple decision model, a set of multiple estimation strategies are used. The estimation results confirmed the interrelationship of the NCMS with outpatient decisions was different from that with inpatient decisions, especially in the endogeneity that insurance choice behaved. Major finding indicated that the NCMS increased medical care utilization for outpatient care among people aged 45 or older, but had no significant impacts on inpatient utilization or the out-of-pocket spending on either outpatient or inpatient care. Although we study the special case of NCMS, the model is generalizable for other health insurance that is not mandatory.

Zhang, A., Nikoloski, Z. et Mossialos, E. (2017). "Does health insurance reduce out-of-pocket expenditure? Heterogeneity among China's middle-aged and elderly." Soc Sci Med **190**: 11-19.

China's recent healthcare reforms aim to provide fair and affordable health services for its huge population. In this paper, we investigate the association between China's health insurance and out-of-pocket (OOP) healthcare expenditure. We further explore the heterogeneity in this association. Using data of 32,387 middle-aged and elderly individuals drawn from the 2011 and 2013 waves of China Health and Retirement Longitudinal Study (CHARLS), we report five findings. First, having health insurance increases the likelihood of utilizing healthcare and reduces inpatient OOP expenditure. Second, healthcare benefits are distributed unevenly: while low- and medium-income individuals are the main beneficiaries with reduced OOP expenditure, those faced with very high medical bills are still at risk, owing to limited and shallow coverage in certain aspects. Third, rural migrants hardly benefit from having health insurance, suggesting that institutional barriers are still in place. Fourth, health insurance does not increase patient visits to primary care facilities; hospitals are still the main provider of healthcare. Nonetheless, there is some evidence that patients shift from higher-tier to lower-tier hospitals. Last, OOP spending on pharmaceuticals is reduced for inpatient care but not for outpatient care, suggesting that people rely on inpatient care to obtain reimbursable drugs, putting further pressure on the already overcrowded hospitals. Our findings suggest that China's health insurance system has been effective in boosting healthcare utilization and lowering OOP hospitalization expenditure, but there still remain challenges due to the less generous rural scheme, shallow outpatient care coverage, lack of insurance portability, and an underdeveloped primary healthcare system.

2016

(2016). Improving Access to Canadian Health Care. The Role of Tax Policies. Ottawa The Conference Board of Canada**:** 71, tabl., fig.
http://www.conferenceboard.ca/e-Library/document.aspx?did=7932

Despite having a health care system that is predominately publicly funded, many Canadians face a significant financial burden when accessing health services that have to be paid for out-of-pocket or that are only partly covered by private insurance. This research describes Canadians' use of fiscal incentives related to health services and sheds light on fiscal tools that could be used to make access to private health services more equitable across income groups. As well, it assesses selected fiscal measures in health care and their role in improving access to uninsured or underinsured health care services, and it discusses the potential impact of implementing a health-related tax deduction in Canada.

Andre, C., et al. (2016). Privatisation de la santé en Europe. Un outil de classification des réformes. sl Halshs archives ouvertes**:** 74.
https://hal-univ-paris13.archives-ouvertes.fr/hal-01256505

Les systèmes de santé européens ont été soumis à de nombreuses réformes depuis une trentaine d'années. La privatisation en constitue une tendance majeure que l'on retrouve dans tous les pays. Mais le concept de privatisation revêt plusieurs dimensions qu'il convient de préciser pour effectuer une comparaison internationale. On propose dans une première partie de caractériser la privatisation selon deux critères : le champ d'application (financement et délivrance du soin) et le caractère « externe » ou « interne » de la privatisation. Dans une seconde partie est menée une analyse empirique systématique des privatisations dans les systèmes de santé de quatorze pays européens depuis 1980. Une cartographie des processus de privatisation est enfin proposée qui fait ressortir les différences dans la hiérarchisation des formes de privatisation selon les pays.

Arsenijevic, J., et al. (2016). "Catastrophic Health Care Expenditure among Older People with Chronic Diseases in 15 European Countries." PLoS One **11**(7): e0157765.

INTRODUCTION: It is well-known that the prevalence of chronic diseases is high among older people, especially those who are poor. Moreover, chronic diseases can result in catastrophic health expenditure. The relationship between chronic diseases and their financial burden on households is thus double-sided, as financial difficulties can give rise to, and result from, chronic diseases. Our aim was to examine the levels of catastrophic health expenditure imposed by private out-of-pocket payments among older people diagnosed with diabetes mellitus, cardiovascular diseases and cancer in 15 European countries. METHODS: The SHARE dataset for individuals aged 50+ and their households, collected in 2010-2012 was used. The total number of participants included in this study was N = 51,661. The sample consisted of 43.8% male and 56.2% female participants. The average age was 67 years. We applied an instrumental variable approach for binary instrumented variables known as a treatment-effect model. RESULTS: We found that being diagnosed with diabetes mellitus and cardiovascular diseases was associated with catastrophic health expenditure among older people even in comparatively wealthy countries with developed risk-pooling mechanisms. When compared to the Netherlands (the country with the lowest share of out-of-pocket payments as a percentage of total health expenditure in our study), older people diagnosed with diabetes mellitus in Portugal, Poland, Denmark, Italy, Switzerland, Belgium, the Czech Republic and Hungary were more likely to experience catastrophic health expenditure. Similar results were observed for diagnosed cardiovascular diseases.

In contrast, cancer was not associated with catastrophic health expenditure. DISCUSSION: Our study shows that older people with diagnosed chronic diseases face catastrophic health expenditure even in some of the wealthiest countries in Europe. The effect differs across chronic diseases and countries. This may be due to different socio-economic contexts, but also due to the specific characteristics of the different health systems. In view of the ageing of European populations, it will be crucial to strengthen the mechanisms for financial protection for older people with chronic diseases.

Baird, K. (2016). "High Out-of-Pocket Medical Spending among the Poor and Elderly in Nine Developed Countries." Health Serv Res **51**(4): 1467-1488.
https://www.ncbi.nlm.nih.gov/pubmed/26800220

OBJECTIVE: The design of health insurance, and the role out-of-pocket (OOP) payments play in it, is a key policy issue as rising health costs have encouraged greater cost-sharing measures. This paper compares the percentage of Americans spending large amounts OOP to meet their health needs with percentages in eight other developed countries. By disaggregating by age and income, the paper focuses on the poor and elderly populations within each. DATA SOURCE: The study uses nationally representative household survey data made available through the Luxembourg Income Study. It includes nations with high, medium, and low levels of OOP spending. STUDY DESIGN: Households have high medical spending when their OOP expenditures exceed a threshold share of income. I calculate the share of each nation's population, as well as subpopulations within it, with high OOP expenditures. PRINCIPAL FINDINGS: The United States is not alone in exposing large numbers of citizens to high OOP expenses. In six of the other eight countries, one-quarter or more of low-income citizens devoted at least 5 percent of their income to OOP expenses, and in all but two countries, more than 1 in 10 elderly citizens had high medical expenses. CONCLUSIONS: For some populations in the sample nations, health insurance does not provide adequate financial protection and likely contributes to inequities in health care delivery and outcomes.

Baird, K. (2016). Recent trends in the probability of High-ou-of-Pocket Medical Expenses in the US. lis Working Paper Study ; 675. 19 p.
http://www.lisdatacenter.org/wps/liswps/675.pdf

Objective: This paper measures large out-of-pocket expenses by health condition, income, and elderly status, and estimates changes in them between 2010 and 2013. Data Source: The paper uses nationally-representative household survey data. Study Design: Logistic regression estimates the probabilities of high expenses by demographic groups in the two study years. Households have large out-of-pocket expenses when these exceed 5% or alternatively 10% of income. Data Collection/Abstraction Method: The study uses 99.5% of the 344,000 individuals in the two samples. Principle Findings: Despite favorable conditions, the large numbers of Americans exposed to high out-of-pocket expenditures has not declined much. Conclusions: The magnitude of financial risk and trends in them underscore the need to monitor the ACA's success in reducing Americans' exposure to large medical bills.

Baird, K. E. (2016). "The financial burden of out-of-pocket expenses in the United States and Canada: How different is the United States?" SAGE Open Med **4**: 2050312115623792.

BACKGROUND: This article compares the burden that medical cost-sharing requirements place on households in the United States and Canada. It estimates the probability that individuals with similar demographic features in the two countries have large medical expenses relative to income. METHOD: The study uses 2010 nationally representative household survey data harmonized for cross-national comparisons to identify individuals with high medical expenses relative to income. Using logistic regression, it estimates the probability of high expenses occurring among 10 different demographic groups in the two countries. RESULTS: The results show the risk of large medical expenses in the United States is 1.5-4 times higher than it is in Canada, depending on the demographic group and spending threshold used. The United States compares least favorably when evaluating poorer citizens and when using a higher spending threshold. CONCLUSION: Recent health care reforms can be

expected to reduce Americans' catastrophic health expenses, but it will take very large reductions in out-of-pocket expenditures-larger than can be expected-if poorer and middle-class families are to have the financial protection from high health care costs that their counterparts in Canada have.

Banks, J., et al. (2016). Life-Cycle Consumption Patterns at Older Ages in the US and the UK: Can Medical Expenditures Explain the Difference? NBER Working Paper series : n° 22513. Cambridge NBER**:** 39 , tabl., fig., annexes.
www.nber.org/papers/w22513

In this paper we document significantly steeper declines in nondurable expenditures in the UK compared to the US, in spite of income paths being similar. We explore several possible causes, including different employment paths, housing ownership and expenses, levels and paths of health status, number of household members, and out-of -pocket medical expenditures. Among all the potential explanations considered, we find that those to do with healthcare—differences in levels and age paths in medical expenses—can fully account for the steeper declines in nondurable consumption in the UK compared to the US.

Barnes, K., et al. (2016). Financial Risk Protection from Social Health Insurance, National Bureau of Economic Research, Inc, NBER Working Papers: 22620.
http://www.nber.org/papers/w22620.pdf

This paper estimates the impact of social health insurance on financial risk reduction by utilizing data from a natural experiment created by the phased roll out of a social health insurance program for the poor in India. We estimate the impact of insurance on the distribution of out-of-pocket costs, frequency and amount of money borrowed for health reasons, and the likelihood of incurring catastrophic health expenditures. We use a stylized expected utility model to compute the welfare effects associated with changes due to insurance in the distribution of out-of-pocket costs. We adjust the standard model to account for the unique conditions of a developing country by incorporating consumption floors, informal borrowing, and selling of assets. These adjustments allow us to estimate the value of financial risk reduction from both consumption smoothing and asset protection channels. Our results show that social insurance reduces out-of-pocket costs with larger effects in the higher quantiles of the out-of-pocket cost distribution. In addition, we find a reduction in the frequency and amount of money borrowed for health reasons. Finally, we find that the value of financial risk reduction outweighs the total per household cost of the social insurance program by two to five times.

Chevreul, K., et al. (2016). France. Voluntary health insurance in Europe: country experience., Copenhague : Bureau régional de l'Europe**:** 51-56.
http://www.euro.who.int/__data/assets/pdf_file/0011/310799/Voluntary-health-insurance-Europe-country-experience.pdf

En matière d'assurance maladie volontaire, aucun marché ne ressemble à un autre. Ils diffèrent tous par certains côtés en raison de l'importante influence exercée par la nature et la performance des systèmes de santé à financement public, ainsi que par les contextes dans lesquels ils ont évolué. Cette publication présente des profils courts et structurés des marchés de l'assurance maladie volontaire de 34 pays de la Région européenne de l'OMS, à savoir des États membres de l'Union européenne ainsi que l'Arménie, la Fédération de Russie, la Géorgie, l'Islande, la Norvège, la Suisse et l'Ukraine. Ce chapitre présente le marché de l'assurance maladie volontaire en France.

Dafny, L., et al. (2016). When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization. NBER Working Paper series : n° 22745. Cambridge NBER**:** 55 , tabl., fig., annexes.
www.nber.org/papers/w22745

Branded pharmaceutical manufacturers frequently offer "copay coupons'" that insulate consumers from cost-sharing, thereby undermining insurers' ability to influence drug utilization. We study the impact of copay coupons on branded drugs first facing generic entry between 2007 and 2010. To

overcome endogeneity concerns, we exploit cross-state and cross-consumer variation in coupon legality. We find that coupons increase branded sales by 60+ percent, entirely by reducing the sales of bioequivalent generics. During the five years following generic entry, we estimate that coupons increase total spending by $30 to $120 million per drug, or $700 million to $2.7 billion for our sample alone.

Devlin, R. A. et Wang, Y. (2016). Prescription Drug Expenditure and 'Universal' Coverage: the Quebec Experience in Canada, University of Ottawa, Department of Economics, Working Papers: 1609e**:** 41 pages.
http://socialsciences.uottawa.ca/economics/sites/socialsciences.uottawa.ca.economics/files/1609e.pdf

This paper examines the relationship between public expenditures on prescription drugs and public-insurance coverage in Canada over the period 1985 to 2012 using data from the Canadian Institute for Health Information and Statistics Canada. We pay particular attention to the introduction of universal prescription drug coverage in Quebec in 1997. Employing an OLS procedure with panel-corrected standard errors (PCSE) and correcting for AR(1) disturbances, we find that universal coverage in Quebec led to an increase in per capita public expenditures on prescription drugs. It also led to a reduction in spending for over-the-counter medications, suggesting some substitutability between prescription and non-prescription drugs.

Dickey, H., et al. (2016). ""Doctor my eyes": A natural experiment on the demand for eye care services." Soc Sci Med **150**: 117-127.

Preventive health care is promoted by many organisations from the World Health Organisation (WHO) to regional and national governments. The degree of cost-sharing between individuals and the health care service affects preventive service use. For instance, out-of-pocket fees that are paid by individuals for curative services reduce preventive care demand. We examine the impact of subsidised preventive care on demand. We motivate our analysis with a theoretical model of inter-temporal substitution in which individuals decide whether to have a health examination in period one and consequently whether to be treated if required in period two. We derive four testable hypotheses. We test these using the subsidised eye care policy introduced in Scotland in 2006. This provides a natural experiment that allows us to identify the effect of the policy on the demand for eye examinations. We also explore socio-economic differences in the response to the policy. The analysis is based on a sample from the British Household Panel Survey of 52,613 observations of people, aged between 16 and 59 years, living in England and Scotland for the period 2001-2008. Using the difference-in-difference methodology, we find that on average the policy did not affect demand for eye examinations. We find that demand for eye examinations only increased among high income households, and consequently, inequalities in eye-care services demand have widened in Scotland since the introduction of the policy.

Dobkin, C., et al. (2016). The Economic Consequences of Hospital Admissions. NBER Working Paper Series ; n° 22288. Cambridge NBER**:** 42 , fig., tabl., annexes.
http://www.nber.org/papers/w22288

We examine some economic impacts of hospital admissions using an event study approach in two datasets: survey data from the Health and Retirement Study, and hospital admissions data linked to consumer credit reports. We report estimates of the impact of hospital admissions on out-of-pocket medical spending, unpaid medical bills, bankruptcy, earnings, income (and its components), access to credit, and consumer borrowing. The results point to three primary conclusions: non-elderly adults with health insurance still face considerable exposure to uninsured earnings risk; a large share of the incremental risk exposure for uninsured non-elderly adults is borne by third parties who absorb their unpaid medical bills; the elderly face very little economic risk from adverse health shocks.

Einav, L., et al. (2016). Private Provision of Social Insurance: Drug-specific Price Elasticities and Cost Sharing in Medicare Part D. NBER Working Paper Series ; n° 22277. Cambridge NBER**:** 44 , fig., tabl., annexes.
http://www.nber.org/papers/w22277

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

Flores, G. et O'Donnell, O. (2016). "Catastrophic Medical Expenditure Risk." Journal of Health Economics **46**: 1-15.

We propose a measure of household exposure to particularly onerous medical expenses. The measure can be decomposed into the probability that medical expenditure exceeds a threshold, the loss due to predictably low consumption of other goods if it does and the further loss arising from the volatility of medical expenses above the threshold. Depending on the choice of threshold, the measure is consistent with a model of reference-dependent utility with loss aversion. Unlike the risk premium, the measure is only sensitive to particularly high expenses, and can identify households that expect to incur such expenses and would benefit from subsidised, but not actuarially fair, insurance. An empirical illustration using data from seven Asian countries demonstrates the importance of taking account of informal insurance and reveals clear differences in catastrophic medical expenditure risk across and within countries. In general, risk is higher among poorer, rural and chronically ill populations.

Glied, S., et al. (2016). "How the ACA's Health Insurance Expansions Have Affected Out-of-Pocket Cost-Sharing and Spending on Premiums." Issue Brief: 14 , tabl., fig.

Issue: One important benefit gained by the millions of Americans with health insurance through the Affordable Care Act (ACA) is protection from high out-of-pocket health spending. While Medicaid unambiguously reduces out-of-pocket premium and medical costs for low-income people, it is less certain that marketplace coverage and other types of insurance purchased to comply with the law's individual mandate also protect from high health spending. Goal: To compare out-of-pocket spending in 2014 to spending in 2013; assess how this spending changed in states where many people enrolled in the marketplaces relative to states where few people enrolled; and project the decline in the percentage of people paying high amounts out-of-pocket. Methods: Linear regression models were used to estimate whether people under age 65 spent above certain thresholds. Key findings and conclusions: The probability of incurring high out-of-pocket costs and premium expenses declined as marketplace enrollment increased. The percentage reductions were greatest among those with incomes between 250 percent and 399 percent of poverty, those who were eligible for premium subsidies, and those who previously were uninsured or had very limited nongroup coverage. These effects appear largely attributable to marketplace enrollment rather than to other ACA provisions or to economic trends.

Grigorakis, N., et al. (2016). "Out of pocket payments and social health insurance for private hospital care: Evidence from Greece." Health Policy **120**(8): 948-959.
http://dx.doi.org/10.1016/j.healthpol.2016.06.011

We examine social health insurance's risk pooling mechanisms.?We consider the catastrophic impact that health care OOPs may have on insured's income and well-being. Using data from Greece, we find that the OOPs for inpatient care in private hospitals have a positive relationship with SHI funding. We show that the SHI funding is inadequate to total inpatient financing.

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**:** 51 , tabl., fig.

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.

Hayes, S. L., et al. (2016). "High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care? A Population-Based Comparison of Demographics, Health Care Use, and Expenditures." Issue Brief (Commonw Fund) **26**: 1-14.

Issue: Finding ways to improve outcomes and reduce spending for patients with complex and costly care needs requires an understanding of their unique needs and characteristics. Goal: Examine demographics and health care spending and use of services among adults with high needs, defined as people who have three or more chronic diseases and a functional limitation in their ability to care for themselves or perform routine daily tasks. Methods: Analysis of data from the 2009-2011 Medical Expenditure Panel Survey. Key findings: High-need adults differed notably from adults with multiple chronic diseases but no functional limitations. They had average annual health care expenditures that were nearly three times higher-and which were more likely to remain high over two years of observation-and out-of-pocket expenses that were more than a third higher, despite their lower incomes. Rates of hospital use for high-need adults were more than twice those for adults with multiple chronic conditions only; high-need adults also visited the doctor more frequently and used more home health care. Costs and use of services also varied widely within the high-need group. Conclusion: These findings suggest that interventions should be targeted and tailored to high-need individuals most likely to benefit.

Hennessy, D., et al. (2016). "Dépenses non remboursées en médicaments et produits pharmaceutiques et non-respect des prescriptions lié aux coûts chez les Canadiens ayant une maladie chronique." Rapports Sur La Sante **27**(6): 9 , tabl., fig.
http://www.statcan.gc.ca/pub/82-003-x/2016006/article/14634-fra.pdf

Contexte : Environ le tiers des dépenses en médicaments sur ordonnance des Canadiens ne sont pas remboursées. La présente étude essaie de déterminer s'il existe un lien entre les dépenses non remboursées en médicaments et produits pharmaceutiques qui dépassent 5 % du revenu du ménage et le non respect des prescriptions lié aux coûts chez les personnes qui ont des problèmes de santé cardiovasculaires chroniques. Méthodes : Les données sont tirées des résultats de l'enquête intitulée Entraves aux soins destinés aux personnes ayant des problèmes de santé chroniques. Les dépenses non remboursées en médicaments et produits pharmaceutiques ont été classées en trois catégories, selon le pourcentage du revenu du ménage qu'elles représentent : 0 %, plus de 0 % mais moins de 5 %, et 5 % et plus. Une régression log-binomiale a été utilisée pour examiner les associations entre la catégorie de dépenses non remboursées et le non-respect lié aux coûts. Résultats : En 2012, environ 80 % des personnes de 40 ans et plus qui habitaient en Colombie-Britannique, en Alberta, en Saskatchewan ou au Manitoba et qui avaient des problèmes de santé cardiovasculaires chroniques ont déclaré des dépenses non remboursées en médicaments et produits pharmaceutiques, ces dépenses représentant au moins 5 % du revenu du ménage pour 4,8 % d'entre elles. Ces personnes étaient considérablement plus âgées, vivaient plus souvent dans des ménages dont le revenu était inférieur à 30 000 $, et déclaraient plus souvent des morbidités multiples que celles dont les dépenses non remboursées en médicaments et produits pharmaceutiques étaient inférieures à 5 % du revenu du ménage. Une fois les résultats corrigés de l'âge et du sexe, les personnes dont les dépenses étaient supérieures ou égales à 5 % du revenu du ménage étaient près de trois fois plus susceptibles (ratio des taux de prévalence = 2,6) de déclarer un non-respect des prescriptions lié aux coûts que celles dont les dépenses étaient inférieures à 5 %. Interprétation : Un lien significatif a été observé entre les dépenses en médicaments et produits pharmaceutiques correspondant à au moins 5 % du revenu du ménage et le non-respect des prescriptions lié aux coûts. Des données supplémentaires sont requises pour déterminer si des niveaux encore plus faibles de dépenses sont associés à un risque de non-respect lié aux coûts.

Herbert- Emery, J. C. (2016). Tax-Assisted Approaches for Helping Canadians Meet Out-of-Pocket Health-Care Costs. SPP Research Papers, Vol. 9. Calgary University of Calgary**:** 32, tab., graph., fig.

Canadians are not saving for the inevitable costs of drugs and long-term care which they will have to pay for out of pocket in their old age, and these costs could potentially be financially devastating for them. Later in life, when out-of-pocket health-care costs mount, those who previously enjoyed the security of a workplace insurance plan to cover such expenses will face a grim financial reality. Many aspects of care for older Canadians aren't covered by this country's single-payer health-care system. Besides prescription drugs, these include management of chronic conditions by ancillary health professionals, home care, long-term care, and dental and vision care. Statistics show that in 2012, Canadians' private spending on health care totaled $60 billion, with private health insurance covering $24.5 billion of that amount. Coverage of health-care costs that don't fall under Medicare's purview is at present rather piecemeal. The non-refundable federal Medical Expense Tax Credit covers expenses only after the three-per-cent minimum, or first $2,171, of out-of-pocket costs have been paid by the individual. The Disability Tax Credit is available to those with a certified chronic disability, and these individuals are eligible for further support via the Registered Disability Savings Plan. A Caregiver Tax Credit is also available. The federal government has a golden opportunity to provide an incentive for Canadians to set aside money to pay not only for the often catastrophic medical and drug costs that can come with aging, but also to save so they can afford long-term care, or purchase private health insurance.

Homaie Rad, E., et al. (2016). "The Effect of Catastrophic Health Expenditure on Work After Retirement." Int J Aging Hum Dev.

Several factors can force retirees to go to paid work. Catastrophic health-care expenditure (CHCE) is one of the driving forces for retirees to go to paid work. This cross-sectional study was based on 6,307 Iran retirees' data. Xu method was used to calculate CHCE, and a logit model was estimated to show the association between CHCE and bridge employment. Other control variables were added to the model. The findings showed that there was positive relationship between CHCE and bridge employment. Retirement pension had negative relationship with work after retirement. Prevalence of work after retirement was higher in people who lived in rural region and increased due to increase in household size. The financial constraint was the main pushing factor for the retiree to go to paid work. Thus, covering retirees with health insurances and identifying and listing diseases that may face the retirees with CHCE are some possible efforts to decrease CHCE.

Kreider, A. R., et al. (2016). "Quality of Health Insurance Coverage and Access to Care for Children in Low-Income Families." JAMA Pediatr **170**(1): 43-51.

IMPORTANCE: An increasing diversity of children's health coverage options under the US Patient Protection and Affordable Care Act, together with uncertainty regarding reauthorization of the Children's Health Insurance Program (CHIP) beyond 2017, merits renewed attention on the quality of these options for children. OBJECTIVE: To compare health care access, quality, and cost outcomes by insurance type (Medicaid, CHIP, private, and uninsured) for children in households with low to moderate incomes. DESIGN, SETTING, AND PARTICIPANTS: A repeated cross-sectional analysis was conducted using data from the 2003, 2007, and 2011-2012 US National Surveys of Children's Health, comprising 80,655 children 17 years or younger, weighted to 67 million children nationally, with household incomes between 100% and 300% of the federal poverty level. Multivariable logistic regression models compared caregiver-reported outcomes across insurance types. Analysis was conducted between July 14, 2014, and May 6, 2015. EXPOSURES: Insurance type was ascertained using a caregiver-reported measure of insurance status and each household's poverty status (percentage of the federal poverty level). MAIN OUTCOMES AND MEASURES: Caregiver-reported outcomes related to access to primary and specialty care, unmet needs, out-of-pocket costs, care coordination, and satisfaction with care. RESULTS: Among the 80,655 children, 51,123 (57.3%) had private insurance, 11,853 (13.6%) had Medicaid, 9554 (18.4%) had CHIP, and 8125 (10.8%) were uninsured. In a multivariable logistic regression model (with results reported as adjusted probabilities [95% CIs]), children insured by Medicaid and CHIP were significantly more likely to receive a preventive medical (Medicaid, 88% [86%-89%]; P < .01; CHIP, 88% [87%-89%]; P < .01) and dental (Medicaid, 80% [78%-81%]; P < .01; CHIP, 77% [76%-79%]; P < .01) visits than were privately insured children (medical, 83% [82%-84%]; dental, 73% [72%-74%]). Children with all insurance types experienced challenges in access to specialty care, with caregivers of children insured by CHIP reporting the highest rates of difficulty accessing specialty care (28% [24%-32%]), problems obtaining a referral (23% [18%-29%]), and frustration obtaining health care services (26% [23%-28%]). These challenges were also magnified for privately insured children with special health care needs, whose caregivers reported significantly greater problems accessing specialty care (29% [26%-33%]) and frustration obtaining health care services (36% [32%-41%]) than did caregivers of children insured by Medicaid, and a lower likelihood of insurance always meeting the child's needs (63% [60%-67%]) than children insured by Medicaid or CHIP. Caregivers of privately insured children were also significantly more likely to experience out-of-pocket costs (77% [75%-78%]) than were caregivers of children insured by Medicaid (26% [23%-28%]; P < .01) or CHIP (38% [35%-40%]; P < .01). CONCLUSIONS AND RELEVANCE: This examination of caregiver experiences across insurance types revealed important differences that can help guide future policymaking regarding coverage for families with low to moderate incomes.

Krutilova, V. (2016). Access to Health Care and the Out-of-Pocket Burden of the European Elderly. MENDELU Working Papers in Business and Economics ; 2016/60**:** 14 , fig., tabl.
https://ideas.repec.org/p/men/wpaper/60_2016.html

Provision of access to health care is a desirable feature of health care systems. Access to health care is caused to be restricted whether out-of-pocket burden is too high. The paper focuses on the European elderly with restricted access to health care and evaluates their health care burden and determines factors affecting the burden. The data from the Survey of Health, Ageing and Retirement in Europe from the fifth wave is used. The methods of descriptive and multivariate analysis are applied. A linear regression model with a bootstrapped method is used. The results showed that inequalities in access to health care exist. Unmet need is a critical issue in Estonia and Italy. The highest burden is found in Estonia, Italy and Belgium. Chronic diseases and limitation in activities significantly contributes to health care burden. Expenditure on drugs, outpatient and nursing care have a significant effect on the burden. The effect is found to be insignificant for inpatient care. Income and the employment status is a preventing factor.

Laporte, A. et Ferguson, B. (2016). How does Insurance affect the Price of Drugs: A Graphical Analysis. Working Paper No: 160006. Toronto Canadian Centre for Health Economics.**:** 24 , tabl.
https://ideas.repec.org/p/cch/wpaper/160006.html

Prices of drugs differ greatly across countries and to a certain degree across payment agencies within countries (OECD (2015)). It is well known among health economists that the presence of insurance creates a separation between the consumer of pharmaceuticals and the payer. This separation can result in the price of drugs being driven up simply because somebody other than the consumer is responsible for paying for them. The precise impact of insurance on drug prices however, will depend critically on the structure of the insurance, a fact that has tended to get lost in health policy debate. The purpose of this paper is to use diagrammatic analysis of three types of insurance: co-insurance, reference pricing and co-payment, to investigate how each affects the price of prescription drugs. In addition, we analyze the role of a new pricing tool, which has recently been increasingly used by pharmaceutical companies in North America: co-Payment waiver coupons. Among other policy implications, we suggest that the use of co-pay waivers turns the co-payment insurance constraint into something similar to the reference pricing constraint, from the supplier's perspective, but with greater transactions costs.

Lin, H. et Sacks, D. W. (2016). Intertemporal Substitution in Health Care Demand: Evidence from the RAND Health Insurance Experiment. NBER Working Paper series : n° 22802. Cambridge NBER**:** 44 , tabl., fig., annexes.
www.nber.org/papers/w22802

Nonlinear cost-sharing in health insurance encourages intertemporal substitution be- cause patients can reduce their out-of-pocket costs by concentrating spending in years when they hit the deductible. We test for such intertemporal substitution using data from the RAND Health Insurance Experiment, where people were randomly assigned either to a free care plan or to a cost-sharing plan which had coinsurance up to a maximum dollar expenditure (MDE). Hitting the MDE—leading to an effective price of zero—has a bigger effect on monthly health care spending and utilization than does being in free care, because people who hit the MDE face high future and past prices. As a result, we estimate that sensitivity to short-lasting price changes is about twice as large as sensitivity to long-lasting changes. These findings help reconcile conflicting estimates of the price elasticity of demand for health care, and suggest that high deductible health plans may be less effective than hoped in controlling health care spending.

Mulcahy, A. W., et al. (2016). "Gaining Coverage Through Medicaid Or Private Insurance Increased Prescription Use And Lowered Out-Of-Pocket Spending." Health Affairs **35**(9): 1725-1733.
http://content.healthaffairs.org/content/35/9/1725.abstract

A growing body of literature describes how the Affordable Care Act (ACA) has expanded health insurance coverage. What is less well known is how these coverage gains have affected populations that are at risk for high health spending. To investigate this issue, we used prescription transaction data for a panel of 6.7 million prescription drug users to compare changes in coverage, prescription fills, plan spending, and out-of-pocket spending before and after the implementation of the ACA's coverage expansion. We found a 30 percent reduction in the proportion of this population that was uninsured in 2014 compared to 2013. Uninsured people who gained private coverage filled, on average, 28 percent more prescriptions and had 29 percent less out-of-pocket spending per prescription in 2014 compared to 2013. Those who gained Medicaid coverage had larger increases in fill rates (79 percent) and reductions in out-of-pocket spending per prescription (58 percent). People who gained coverage who had at least one of the chronic conditions detailed in our study saw larger decreases in out-of-pocket spending compared to those who did not have at least one condition. These results demonstrate that by reducing financial barriers to care, the ACA has increased treatment rates while reducing out-of-pocket spending, particularly for people with chronic conditions.

Nguyen, K. H. et Sommers, B. D. (2016). "Access and Quality of Care by Insurance Type for Low-Income Adults Before the Affordable Care Act." Am J Public Health **106**(8): 1409-1415.

OBJECTIVES: To compare access to care and perceived health care quality by insurance type among low-income adults in 3 southern US states, before Medicaid expansion under the Affordable Care Act. METHODS: We conducted a telephone survey in 2013 of 2765 low-income US citizens, aged 19 to 64 years, in Arkansas, Kentucky, and Texas. We compared 11 measures of access and quality of care for respondents with Medicaid, private insurance, Medicare, and no insurance with adjustment for sociodemographics and health status. RESULTS: Low-income adults with Medicaid, private insurance, and Medicare reported significantly better health care access and quality than uninsured individuals. Medicaid beneficiaries reported greater difficulty accessing specialists but less risk of high out-of-pocket spending than those with private insurance. For other outcomes, Medicaid and private coverage performed similarly. CONCLUSIONS: Low-income adults with insurance report significantly greater access and quality of care than uninsured adults, regardless of whether they have private or public insurance. Access to specialty care in Medicaid may require policy attention. PUBLIC HEALTH IMPLICATIONS: Many states are still considering whether to expand Medicaid under the Affordable Care Act and whether to pursue alternative models for coverage expansion. Our results suggest that access to quality health care will improve under the Affordable Care Act's coverage expansions, regardless of the type of coverage.

OCDE (2016). Health at a Glance 2016 : Europe. Paris OCDE**:** 204, ann., graph., tabl.
http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2016_9789264265592-en;jsessionid=3raq7b06ufflo.x-oecd-live-02

This fourth edition of Health at a Glance: Europe presents key indicators of health and health systems in the 28 EU countries, 5 candidate countries to the EU and 3 EFTA countries. This 2016 edition contains two main new features: two thematic chapters analyse the links between population health and labour market outcomes, and the important challenge of strengthening primary care systems in European countries; and a new chapter on the resilience, efficiency and sustainability of health systems in Europe, in order to align the content of this publication more closely with the 2014 European Commission Communication on effective, accessible and resilient health systems. This publication is the result of a renewed collaboration between the OECD and the European Commission under the broader "State of Health in the EU" initiative, designed to support EU member states in their evidence-based policy making.

- Voir pages 156-157 pour les dépenses catastrophiques.

Owen, R., et al. (2016). "Health services appraisal and the transition to Medicaid Managed Care from fee for service." Disabil Health J **9**(2): 239-247.

BACKGROUND: Many states are transitioning fee-for-service (FFS) Medicaid into Medicaid Managed Care (MMC) for people with disabilities. OBJECTIVE: This study examined managed care's impact on health services appraisal (HSA) and unmet medical needs of individuals with disabilities receiving Medicaid. Key questions included 1) Do participant demographics and enrollment in MMC impact unmet medical needs and HSA? 2) Within MMC, do demographics and continuity of care relate to unmet medical needs? 3) Within MMC, do demographics, unmet medical needs and continuity of care relate to HSA? METHODS: We collected cross-sectional survey data (n = 1615) from people with disabilities in MMC operated by for-profit insurance companies (n = 849) and a similar group remaining in FFS (n = 766) in one state. Regression analyses were conducted across these groups and within MMC only. RESULTS: Across Medicaid groups, MMC enrollment was not related to either HSA or unmet needs; health status, having a mental health disability and unmet transportation needs related to HSA and health status, unmet transportation needs and having a mental health or physical disability related to higher unmet medical needs. Within MMC, in addition to better health and fewer unmet medical needs, less continuity of care significantly decreased HSA. Higher unmet transportation needs, poorer health status, having a physical or mental health disability, and less continuity of care significantly decreased unmet medical needs. CONCLUSIONS: This research points to the importance of meeting unmet needs of individuals in MMC and the need for increased continuity of care as people transition from FFS.

Ozdamar, O. et Giovanis, E. (2016). The Link between Health Condition Costs and Standard of Living Through Out-of- Pocket Health Expenditures and Labour Market Outcomes in Turkey: A StructuralEquation Modelling**:** 41 , tabl., fig.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2784949

This study employs a Structural Equation Modelling (SEM) to understand the effect of the costs related to health conditions of people on their standard of living (SoL)using the data from the cross-sectional Household Budget Survey (HBS) for the period 2002-2013 and the panel Income and Living Conditions Survey (ILCS) in Turkey during the period 2009-2012. Using HBS, it is tested whether out-of-pocket health expenditures (OOPEs), which is directly affected by the health conditions of people, contribute to the standard of living in a negative way. Using ILCS, it is examined the effect of labor market outcomes (wages and hours of work loss due to bad health conditions) on SoL. A Structural Equation model allows us to investigate all these concerns simultaneously. Referring health conditions, two different health-condition indices are constructed using two different datasets since they have various questions representing health status of people. Using HBS a health condition index is created regarding questions related to the mental and physical limitations (disability) of people. The second health condition index is created using ILCS that includes questions both related to disability and chronic diseases. The study extends the previous research by several ways. First, the application of a structural equation modelling (SEM) accounts for the measurement error both in the SoL and health-condition indices and it allows for the simultaneous estimation of the link between health condition costs and SoL through out-of-pocket expenditures as well as labor market outcomes using structural equations. Second, it will contribute to existing literature by analysing not only the impact of health condition costs but also the impact of health insurance types on OOPEs and therefore SoL. Third, using a propensity score matching, it creates comparable groups. Finally, the impact of disability and relevant OOPEs on transportation expenditures is analysed and their association with SoL is investigated. The results show that OOPEs and disability have a significant and negative impact on SoL. The disability related costs consist of the 24-30 per cent of the household income corresponding to monetary values ranging between 4,200-4,600 Turkish Liras (TL) per annum, while the respective values in terms of wages range between 1,000-1,200 TL. OOPEs costs are estimated at 2.5 per cent of the household income, which are equal at 540 TL per annum and OOPEs consist of 10 per cent of the non-wage household income corresponding to 870 TL per year. Moreover, the disability leads to significant increases of transportation expenditures and the associated costs are estimated at roughly 470 TL per year. However, when the households with members that have been disabled during the survey are compared with the non-disabled households, the disability costs reach 8,500 TL.

Paris, V., et al. (2016). Health care coverage in OECD countries in 2012. OECD Health Working Papers ; 88. Paris OCDE**:** 72 , tab., graph. fig.
http://www.oecd-ilibrary.org/fr/social-issues-migration-health/health-care-coverage-in-oecd-countries-in-2012_5jlz3kbf7pzv-en

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

Quintal, C. et Lopes, J. (2016). "Equity in Health Care Financing in Portugal: Findings from the Household Budget Survey 2010/2011." Health Economics, Policy and Law **11**(3): 233-252.
http://journals.cambridge.org/action/displayBackIssues?jid=HEP

Equity in health care financing is recognised as a main goal in health policy. It implies that payments should be linked to capacity to pay and that households should be protected against catastrophic health expenditure (CHE). The risk of CHE is inversely related to the share of out-of-pocket payments (OOP) in total health expenditure. In Portugal, OOP represented 26% of total health expenditure in 2010 [one of the highest among Organisation for Economic Co-operation and Development (OECD) countries]. This study aims to identify the proportion of households with CHE in Portugal and the household factors associated with this outcome. Additionally, progressivity indices are calculated for OOP and private health insurance. Data were taken from the Portuguese Household Budget Survey 2010/2011. The prevalence of CHE is 2.1%, which is high for a developed country with a universal National Health Service. The main factor associated with CHE is the presence of at least one elderly person in households (when the risk quadruples). Payments are particularly regressive for medicines. Regarding the results by regions, the Kakwani index for total OOP is larger (negative) for the Centre and lower, not significant, for the Azores. Payments for voluntary health insurance are progressive.

Roquebert, Q. et Tenand, M. (2016). Pay less, consume more? Estimating the price elasticity of demand for home care services of the disabled elderly. Working paper ; 16/16. Londres University of York: 56 , tabl., fig.
https://www.york.ac.uk/media/economics/documents/hedg/workingpapers/1616.pdf

Although the consumption of home care is increasing with population ageing, little is known about its price sensitivity. This paper estimates the price elasticity of the demand for home care of the disabled elderly, using the French home care subsidy program (\APA"). We use an original dataset collected from a French District Council with administrative records of APA out-of-pocket payments and home care consumption. Identification primarily relies on inter-individual variations in producer prices. We use the unequal spatial distribution of producers to address the potential price endogeneity arising from non-random selection into a producer. Our results point to a price elasticity around -0.4: a 10% increase in the out-of-pocket price is predicted to lower consumption by 4%, or 37 minutes per month for the median consumer. Copayment rates thus matter for allocative and dynamic efficiencies, while the generosity of home care subsidies also entails redistributive effects.

Sagan, A. (éd.). et Thomson, S. (éd.) (2016). Voluntary health insurance in Europe: country experience, Copenhague : Bureau régional de l'Europe
http://www.euro.who.int/__data/assets/pdf_file/0011/310799/Voluntary-health-insurance-Europe-country-experience.pdf

No two markets for voluntary health insurance (VHI) are identical. All differ in some way because they are heavily shaped by the nature and performance of publicly financed health systems and by the contexts in which they have evolved. This volume contains short, structured profiles of markets for VHI in 34 countries in the WHO European Region. These are drawn from European Union Member States plus Armenia, Iceland, Georgia, Norway, the Russian Federation, Switzerland and Ukraine. The book is aimed at policy-makers and researchers interested in knowing more about how VHI works in practice in a wide range of contexts. Each profile, written by one or more local experts, identifies gaps in publicly financed health coverage, describes the role VHI plays, outlines how the market for VHI operates, summarizes public policy towards VHI, including major developments over time, and highlights national debates and challenges. The book is part of a study on VHI in Europe prepared jointly by the European Observatory on Health Systems and Policies and the WHO Regional Office for Europe. A companion volume, "An introduction to voluntary health insurance in Europe", provides an analytical overview of VHI markets across the 34 countries.

Sagan, A. (éd.), et al. (2016). Voluntary health insurance in Europe: Role and regulation, Copenhague : Bureau régional de l'Europe
http://www.euro.who.int/__data/assets/pdf_file/0005/310838/Voluntary-health-insurance-Europe-role-regulation.pdf

If public resources were unlimited, there would be no gaps in health coverage and no real need for voluntary health insurance (VHI). Most health systems face fiscal constraints, however, and VHI is often seen as a way to address these pressures. This study draws from the experiences of 34 countries to assess VHI's contribution to health spending and to understand its role in Europe and in relation to publicly financed coverage. It looks at who sells VHI, who purchases it and why. It also reviews public policy on VHI at the national and European Union (EU) levels and the related national policy debates. The analysis shows that, while the markets for VHI vary considerably in size, operation and regulation, the vast majority are small. The substantial markets tend to be the oldest, to have a tradition of non-profit insurers and to be the most heavily regulated to ensure VHI policies are accessible and affordable. The study also suggests that VHI is normally a better way of meeting the population's health needs than out-of-pocket payments, although there are notable exceptions. VHI can contribute to financial protection, especially where it plays a substitutive and complementary role covering co-payments. Nevertheless, it is a complex, challenging and highly context-specific policy instrument that may undermine other health-system goals, including equitable access, efficiency, transparency and accountability, even where markets are well regulated. Policy-makers should therefore exercise real caution before expanding VHI to fill coverage gaps. This report is accompanied by a set of country profiles. The study draws on contributions from national experts from the countries in the EU and the European Free Trade Association, and other countries in the WHO European Region.

Trish, E., et al. (2016). "Medicare Beneficiaries Face Growing Out-Of-Pocket Burden For Specialty Drugs While In Catastrophic Coverage Phase." Health Affairs **35**(9): 1564-1571.
http://content.healthaffairs.org/content/35/9/1564.abstract

The Affordable Care Act (ACA) includes provisions to reduce Medicare beneficiaries' out-of-pocket spending for prescription drugs by gradually closing the coverage gap between the initial coverage limit and the catastrophic coverage threshold (known as the doughnut hole) beginning in 2011. However, Medicare beneficiaries who take specialty pharmaceuticals could still face a large out-of-pocket burden because of uncapped cost sharing in the catastrophic coverage phase. Using 2008–12 pharmacy claims data from a 20 percent sample of Medicare beneficiaries, we analyzed trends in total and out-of-pocket spending among Medicare beneficiaries who take at least one high-cost specialty drug from the top eight specialty drug classes in terms of spending. Annual total drug spending per specialty drug user studied increased considerably during the study period, from $18,335 to $33,301, and the proportion of expenditures incurred while in the catastrophic coverage phase increased from 70 percent to 80 percent. We observed a 26 percent decrease in mean annual out-of-pocket expenditures incurred below the catastrophic coverage threshold, likely attributable to the ACA's doughnut hole cost-sharing reductions, but increases in mean annual out-of-pocket expenditures incurred while in the catastrophic coverage phase offset these reductions almost entirely. Policy makers should consider implementing limits on patients' out-of-pocket burden.

Wong, C. Y., et al. (2016). "The Rise and Fall in Out-of-Pocket Costs in Australia: An Analysis of the Strengthening Medicare Reforms." Health Econ.

After a period of steady decline, out-of-pocket (OOP) costs for general practitioner (GP) consultations in Australia began increasing in the mid-1990s. Following the rising community concerns about the increasing costs, the Australian Government introduced the Strengthening Medicare reforms in 2004 and 2005, which included a targeted incentive for GPs to charge zero OOP costs for consultations provided to children and concession cardholders (older adults and the poor), as well as an increase in the reimbursement for all GP visits. This paper examines the impact of those reforms using longitudinal survey and administrative data from a large national sample of women. The findings suggest that the reforms were effective in reducing OOP costs by an average of $A0.40 per visit. Decreases in OOP costs, however, were not evenly distributed. Those with higher pre-reform OOP costs had the biggest reductions in OOP costs, as did those with concession cards. However, results also reveal increases in OOP costs for most people without a concession card. The analysis suggests that there has been considerable heterogeneity in GP responses to the reforms, which has led to substantial changes in the fees charged by doctors and, as a result, the OOP costs incurred by different population groups. Copyright (c) 2016 John Wiley & Sons, Ltd.

Yeung, K., et al. (2016). Price Elasticities of Pharmaceuticals in a Value-Based-Formulary Setting. NBER Working Paper Series ; n° 22308. Cambridge NBER**:** C, 29 , fig., tabl., annexes.
http://www.nber.org/papers/w22308

Ever since the seminal RAND Health insurance experiment (HIE) was conducted, most health care services, including pharmaceuticals, are deemed to be price inelastic with price elasticities of demand (PED) close to -0.20. However, most studies of PED exploit natural experiments that change demand prices for multiple components of health care. Consequently, these experiments usually do not produce estimates for the true own-price elasticities of demand but rather composite own-price elasticities that are driven by concomitant price changes to their substitutes and complements. Hence, an estimate of price elasticity is expected to vary based on the setting in which it was estimated, and likely not be applicable to other settings. In this work, exploiting a natural experiment of exogenous policy implementation of a value-based formulary (VBF) that was designed based on drug-specific incremental cost-effectiveness ratios, we estimate price elasticities of pharmaceuticals within a VBF design, formally accounting for the nature of composite elasticities that such a setting would generate. We also calculate welfare effects of such a policy using a consumer surplus approach. We show theoretically that VBF designs can increase dispersion of price elasticities of demand among pharmaceutical products compared to their true own-price elasticities and affect their magnitude based on direction of price change. Aligning these PEDs with value VBF is also likely to produce positive welfare effects. We estimate an overall PED for pharmaceuticals to be -0.16, close to the estimate of RAND HIE. However, we see substantial dispersion of PED across the VBF tiers ranging from -0.09 to -0.87 with trends aligned with the levels of value as reflected by the cost-effectiveness ratio (p<0.001). The net welfare increase was $147,000 for the cohort or $28 per member over the post-policy year. Further experimentations of VBF designs with alternative cost-effectiveness thresholds, copayment levels and value-definitions could be quite promising for improving welfare.

Zweifel, P. (2016). "'Catastrophic' Healthcare Expenditure: Critique of a Problematic Concept and a Proposal: Editorial." European Journal of Health Economics **17**(5): 519-520.

2015

Akincigil, A. et Zurlo, K. (2015). The Economic Burden of Out-of-Pocket Medical Expenditures Before and After Implementation of the Medicare Prescription Drug Program. Working Paper; 2015-28. Ann Arbor Michigan Retirement Research Center**:** 21 , fig., tabl.
http://crr.bc.edu/wp-content/uploads/2015/10/wp_2015-28.pdf

Older Americans, although covered by Medicare, bear a large economic burden of medical expenses in the form of premiums for Medicare and supplemental plans, as well as the cost of uncovered or under-covered medical services. This study compares the patterns of this economic burden in 2010 with the baseline year of 2005. The period covered was marked by economic shocks, health care technology innovations and major Medicare reforms, including implementation of the prescription drug (Part D) program and changes in premium rules. Consequently, we present a description of the economic burden and do not attempt to make causal inferences. The definition of expenditures is limited to three components of out-of-pocket (OOP) medical spending: premiums, prescription drugs costs, and health services. While this definition is a limitation of the study, it also allows the researchers to focus on the costs most likely to be affected by improved access to prescription drugs and premium reforms.

Arrieta, A. et Garcia-Prado, A. (2015). "Cost sharing and hospitalizations for ambulatory care sensitive conditions." Soc Sci Med **124**: 115-120.

During the last decade, Chile's private health sector has experienced a dramatic increase in hospitalization rates, growing at four times the rate of ambulatory visits. Such evolution has raised concern among policy-makers. We studied the effect of ambulatory and hospital co-insurance rates on hospitalizations for ambulatory care sensitive conditions (ACSC) among individuals with private insurance in Chile. We used a large administrative dataset of private insurance claims for the period 2007-8 and a final sample of 2,792,662 individuals to estimate a structural model of two equations. The first equation was for ambulatory visits and the second for future hospitalizations for ACSC. We estimated the system by Two Stage Least Squares (2SLS) corrected by heteroskedasticity via Generalized Method of Moments (GMM) estimation. Results show that increased ambulatory visits reduced the probability of future hospitalizations, and increased ambulatory co-insurance decreased ambulatory visits for the adult population (19-65 years-old). Both findings indicate the need to reduce ambulatory co-insurance as a way to reduce hospitalizations for ACSC. Results also showed that increasing hospital co-insurance does have a statistically significant reduction on hospitalizations for the adult group, while it does not seem to have a significant effect on hospitalizations for the children (1-18 years-old) group. This paper's contribution is twofold: first, it shows how the level of co-insurance can be a determinant in avoiding unnecessary hospitalizations for certain conditions; second, it highlights the relevance for policy-making of using data on ACSC to improve the efficiency of health systems by promoting ambulatory care as well as population health.

Calcoen, P., et al. (2015). "Improved estimates of Belgian private health expenditure can give important lessons to other OECD countries." Health Policy **119**(3): 341-355.
http://www.healthpolicyjrnl.com/article/S0168-8510(14)00173-0/abstract

OECD Health Data are a well-known source for detailed information about health expenditure. These data enable us to analyze health policy issues over time and in comparison with other countries. However, current official Belgian estimates of private expenditure (as published in the OECD Health Data) have proven not to be reliable. We distinguish four potential major sources of problems with estimating private health spending: interpretation of definitions, formulation of assumptions, missing or incomplete data and incorrect data. Using alternative sources of billing information, we have reached more accurate estimates of private and out-of-pocket expenditure. For Belgium we found differences of more than 100% between our estimates and the official Belgian estimates of private health expenditure (as published in the OECD Health Data). For instance, according to OECD Health Data private expenditure on hospitals in Belgium amounts to euro3.1 billion, while according to our alternative calculations these expenses represent only euro1.1 billion. Total private expenditure differs only 1%, but this is a mere coincidence. This exercise may be of interest to other OECD countries looking to improve their estimates of private expenditure on health.

Caldbick, S., et al. (2015). "The Financial Burden of Out of Pocket Prescription Drug Expenses in Canada." Int J Health Econ Manag **15**(3): 329-338.
http://link.springer.com/journal/volumesAndIssues/10754

Pharmaceutical expenditures account for approximately 15.9 % of total health expenditures in Canada. Unlike hospital and physician services, in which costs are universally covered, most pharmacological therapy does not fall under the umbrella of 'medically necessary' services set out by the Canada Health Act, and therefore is funded through a mix of public and private plans. Little is known about the actual financial burden experienced by Canadians from out-of-pocket drug expenditures (OOPDE). This paper examines the burden of OOPDE in Canada. 1.1% of Canadian households exceed our catastrophic threshold (9%) of the drug budget share. Additionally, 2.6 and 8.2% of households exceed lower thresholds of 6 and 3% respectively. We find an inverse relationship between household income and the burden of OPPDE. Low-income households have the highest likelihood of being in the 'catastrophic' drug expenditure category. This finding suggests that a vulnerable population of 'working poor' are likely to be experiencing disproportionate financial burden because they are not eligible for public assistance programs. Seniors experience the highest burden of OPPDE when compared to other age groups. We also find that there is significant interprovincial variation in the burden of OOPDE, which partly reflects different provincial government drug coverage policies.

Carpenter, A., et al. (2015). "Affordability of out-of-pocket health care expenses among older Australians." Health Policy **119**(7): 907-914.

Australia has universal health insurance, and provides price concessions on health care and prescription pharmaceuticals through government subsidies. However Australia ranks among the highest OECD nations for out-of-pocket health care spending. With high prevalence of multimorbidity (27% aged 65 and over have 2 or more long-term health conditions) older Australians may face a severe financial burden from out-of-pocket health expenses. We surveyed 4574 members of National Seniors Australia aged 50 years or more on their inability to pay out-of-pocket health-related expenses across categories of medical consultations and tests, medications, dental appointments, allied health appointments (e.g. physiotherapy, podiatry) and transport to medical appointments or tests. Almost 4% of those surveyed were unable to afford out-of-pocket costs in at least one category of health care expenses in the previous 3 months. The odds of being unable to afford out-of-pocket medical costs increased with the number of chronic medical conditions (3 conditions: OR 3.05, 95% CI 1.17-6.30; 4 or more conditions: OR 3.45, 95% CI 1.34-7.28, compared with no chronic medical conditions). Despite Australia's universal health insurance, and safety nets for medical and pharmaceutical contributions, older Australians with multiple chronic conditions are at risk of being unable to afford out-of-pocket health care expenses.

Chevan, J., et al. (2015). "Out-of-Pocket Spending for Ambulatory Physical Therapy Services From 2008 to 2012: National Panel Survey." Phys Ther **95**(12): 1680-1691.

BACKGROUND: Out-of-pocket (OOP) expenditures are incurred as insurers and employers shift some of the burden of health care costs onto consumers. As cost-sharing increases, OOP expenditures could be a barrier to physical therapy care. OBJECTIVE: The purposes of this study were: (1) to identify factors associated with any OOP physical therapy spending and (2) to identify factors associated with higher spending among individuals incurring OOP costs. DESIGN: The study was a retrospective analysis using the 4 most recently available panels of data from the Medical Expenditure Panel Survey (MEPS) encompassing 2008-2012. METHODS: A data file containing episodes of physical therapy care for 2,189 people was created. Logistic regression was used to identify factors related to having an OOP expenditure. A multivariable generalized linear model was used to identify factors related to mean OOP expenditures. RESULTS: On average, an episode of care encompassed 9.9 visits, with mean total expenditures of $1,708 (median: $792). Fifty-four percent of episodes of care had an OOP expenditure. For individuals with OOP expenditures, the mean OOP expenditure for an episode of care was $351 (median: $144). Being female or non-Hispanic and having a higher income were associated with higher odds of incurring an OOP expenditure, whereas being in worse general health, >65 years of age, or nonwhite and having public funding were associated with lower odds of incurring an OOP expenditure. Amounts of OOP spending were higher in urban areas and in all census geographic regions relative to the Northeast region. LIMITATIONS: Estimates are based on household-reported survey data, limited to ambulatory care, and do not include institutionalized individuals. CONCLUSIONS: At 54%, the proportion of individuals with OOP expenditures for physical therapy is lower than for general medical care. Several predictors were found of having OOP expenditures and of the magnitude of those expenditures.

De, Nardi, M., et al. (2015). Medical Spending of the U.S. Elderly. NBER Working Paper Series ; n° 21270. Cambridge NBER**:** 36 , tabl., fig.
http://www.nber.org/papers/w21270

We use data from the Medicare Current Beneficiary Survey (MCBS) to document the medical spending of Americans aged 65 and older. We find that medical expenses more than double between ages 70 and 90 and that they are very concentrated: the top 10% of all spenders are responsible for 52% of medical spending in a given year. In addition, those currently experiencing either very low or very high medical expenses are likely to find themselves in the same position in the future. We also find that the poor consume more medical goods and services than the rich and have a much larger share of their expenses covered by the government. Overall, the government pays for 65% of the elderly's medical expenses. Despite this, the expenses that remain after government transfers are even more concentrated among a small group of people. Thus, government health insurance, while potentially very valuable, is far from complete. Finally, while medical expenses before death can be large, on average they constitute only a small fraction of total spending, both in the aggregate and over the life cycle. Hence, medical expenses before death do not appear to be an important driver of the high and increasing medical spending found in the U.S.

Fedewa, S. A., et al. (2015). "Elimination of cost-sharing and receipt of screening for colorectal and breast cancer." Cancer **121**(18): 3272-3280.

BACKGROUND: The aim of the cost-sharing provision of the Patient Protection and Affordable Care Act (ACA) was to reduce financial barriers for preventive services, including screening for colorectal cancer (CRC) and breast cancer (BC) among privately and Medicare-insured individuals. Whether the provision has affected CRC and BC screening prevalence is unknown. The current study investigated whether CRC and BC screening prevalence among privately and Medicare-insured adults by socioeconomic status (SES) changed before and after the ACA. METHODS: Data obtained from the National Health Interview Survey pertaining to privately and Medicare-insured adults from 2008 (before the ACA) and 2013 (after the ACA) were used. There were 15,786 adults aged 50 to 75 years in the CRC screening analysis and 14,530 women aged >/=40 years in the BC screening analysis. Changes in guideline-recommended screening between 2008 and 2013 by SES were expressed as the prevalence difference (PD) and 95% confidence interval (95% CI) adjusted for demographics, insurance, income, education, body mass index, and having a usual provider. RESULTS: Overall, CRC screening prevalence increased from 57.3% to 61.2% between 2008 and 2013 (P<.001). Adjusted CRC screening prevalence during the corresponding period increased in low-income (PD, 5.9; 95% CI, 1.8 to 10.2), least-educated (PD, 7.2; 95% CI, 0.9 to 13.5), and Medicare-insured (PD, 6.2; 95% CI, 1.7 to 10.7) individuals, but not in high-income, most-educated, and privately insured respondents. BC screening remained unchanged overall (70.5% in 2008 vs 70.2% in 2013) and in the low SES groups. CONCLUSIONS: Increases in CRC screening prevalence between 2008 and 2013 were confined to respondents with low SES. These findings may in part reflect the ACA's removal of financial barriers.

Gerfin, M., et al. (2015). "Healthcare Demand in the Presence of Discrete Price Changes." Health Econ **24**(9): 1164-1177.

Deductibles in health insurance generate nonlinear budget sets and dynamic incentives. Using detailed individual health expenditure data from a Swiss health insurer, we estimate the response in healthcare demand to the discrete price increase generated by resetting the deductible at the start of each calendar year. We find that for individuals with high deductibles, healthcare demand drops by 27%. The decrease is most pronounced for inpatient care and prescription drugs. By contrast, for individuals with low deductibles, there is no significant change in healthcare demand (except for prescription drugs). Overall our results suggest that healthy individuals respond much stronger to the price change.

Golberstein, E. et Gonzales, G. (2015). "The Effects of Medicaid Eligibility on Mental Health Services and Out-of-Pocket Spending for Mental Health Services." Health Serv Res.

OBJECTIVE: Millions of low-income Americans will gain health insurance through Medicaid under the Affordable Care Act. This study assesses the impact of previous Medicaid expansions on mental health services utilization and out-of-pocket spending. DATA SOURCES: Secondary data from the 1998-2011 Medical Expenditure Panel Survey Household Component merged with National Health Interview Survey and state Medicaid eligibility rules data. STUDY DESIGN: Instrumental variables regression models were used to estimate the impact of expanded Medicaid eligibility on health insurance coverage, mental health services utilization, and out-of-pocket spending for mental health services. DATA EXTRACTION METHODS: Person-year files were constructed including adults ages 21-64 under 300 percent of the Federal Poverty Level. PRINCIPAL FINDINGS: Medicaid expansions significantly increased health insurance coverage and reduced out-of-pocket spending on mental health services for low-income adults. Effects of expanded Medicaid eligibility on out-of-pocket spending were strongest for adults with psychological distress. Expanding Medicaid eligibility did not significantly increase the use of mental health services. CONCLUSIONS: Previous Medicaid eligibility expansions did not substantially increase mental health service utilization, but they did reduce out-of-pocket mental health care spending.

Grogger, J., et al. (2015). "Heterogeneity in the effect of public health insurance on catastrophic out-of-pocket health expenditures: the case of Mexico." Health Policy Plan **30**(5): 593-599.

Low- and middle-income countries increasingly provide broad-based public health coverage to their residents. One of the goals of such programmes is to reduce the extent to which beneficiaries incur catastrophic out-of-pocket expenditures on health care. A recent field experiment showed that on average Mexico's new public insurance programme reduced such expenditures in rural areas. Our reanalysis of that data, augmented with administrative data on health infrastructure, shows that this effect depends strongly on the type of health facility to which the beneficiary has access. A second analysis, based on data from Mexico's National Household Income and Expenditure Surveys (abbreviated ENIGH for its name in Spanish), substantiates those findings. It shows that catastrophic expenditures have fallen sharply for rural households with access to well-staffed facilities, but that they have fallen little if at all for rural households with access to poorly staffed facilities. Our analysis of the ENIGH also shows that Mexico's public health insurance programme has sharply reduced catastrophic spending among urban households. Considering that most Mexicans live either in urban areas or in rural areas with access to well-staffed facilities, our results show that the public health insurance programme has been largely successful in achieving one of its key goals. At the same time, our results show how difficult it can be to provide effective protection against catastrophic health expenditures for residents of remote rural areas.

Hodgkin, D., et al. (2015). "Management of Newer Antidepressant Medications in U.S. Commercial Health Plans." J Ment Health Policy Econ **18**(4): 165-173.

BACKGROUND: Private health insurance plays a large role in the U.S. health system, including for many individuals with depression. Private insurers have been actively trying to influence pharmaceutical utilization and costs, particularly for newer and costlier medications. The approaches that insurers use may have important effects on patients' access to antidepressant medications. AIMS OF THE STUDY: To report which approaches (e.g., tiered copayments, prior authorization, and step therapy) commercial health plans are employing to manage newer antidepressant medications, and how the use of these approaches has changed since 2003. METHODS: Data are from a nationally representative survey of commercial health plans in 60 market areas regarding alcohol, drug abuse and mental health services in 2010. Responses were obtained from 389 plans (89% response rate), reporting on 925 insurance products. For each of six branded antidepressant medications, respondents were asked whether the plan covered the medication and if so, on what copayment tier, and whether it was subject to prior authorization or step therapy. Measures of management approach were constructed for each medication and for the group of medications. Bivariate and multivariate analyses were used to test for association of the management approach with various health plan characteristics. RESULTS: Less than 1% of health plan products excluded any of the six antidepressants studied. Medications were more likely to be subjected to restrictions if they were newer, more expensive or were reformulations. 55% of products used placement on a high cost-sharing tier (3 or 4) as their only form of restriction for newer branded antidepressants. This proportion was lower than in 2003, when 71% of products took this approach. In addition, only 2% of products left all the newer branded medications unrestricted, down from 25% in 2003. Multivariate analysis indicated that preferred provider organizations were more likely than other product types to use tier 3 or 4 placement. DISCUSSION: We find that U.S. health plans are using a variety of strategies to manage cost and utilization of newer branded antidepressant medications. Plans appear to be finding that approaches other than exclusion are adequate to meet their cost-management goals for newer branded antidepressants, although they have increased their use of administrative restrictions since 2003. Limitations include lack of information about how administrative restrictions were applied in practice, information on only six medications, and some potential for endogeneity bias in the regression analyses. CONCLUSION: This study has documented substantial use of various restrictions on access to newer branded antidepressants in U.S. commercial health plans. Most of these medications had generic equivalents that offered at least some substitutability, reducing access concerns. At the same time, it is worth noting that high copayments and administrative requirements can nonetheless be burdensome for some patients. IMPLICATIONS FOR HEALTH POLICY: Health plans' pharmacy management approaches may concern policymakers less than in the early 2000s, due to the lesser distinctiveness of today's branded medications. This may change depending on future drug introductions. IMPLICATIONS FOR FURTHER RESEARCH: Future research should examine the impact of plans' pharmacy management approaches, using patient-level data.

HOPE (2015). Out-of-pocket payments In healthcare systems in the European Union. Bruxelles HOPE**:** 59 , tabl., annexes.
http://www.hope.be/wp-content/uploads/2015/11/99_2015_HOPE-REPORT_Out-of-pocket-payments-in-healthcare-systems-in-the-European-Union.pdf

Hospitals are by essence a field where solidarity is of utmost importance, insuring the most costly risks. In the context of the crisis, one of the main worries is that choices would be made to reduce the coverage of such risks. The scope of the present work is first to know whether it is possible to have a clear picture on what out-of-pockets payments are, and then to try to understand if and how such policies affected solidarity in the healthcare coverage.

Jelovac, I. (2015). "On the relationship between the negotiated prices of pharmaceuticals and the patients' co-payment." Economics Bulletin **35**(1): 481-485.

In this paper, we give a new insight on the relationship between the patients' co-payment for buying pharmaceuticals and the price of a patented pharmaceutical. We consider that the price of a pharmaceutical is the outcome of a negotiation between a health authority and a pharmaceutical monopoly producer. We use a model based on bargaining theory to represent this negotiation. The negotiated price is shown to be increasing in the degree of the patients' co-payment. This positive relationship is thus opposite to the negative one prevailing when the price is set by a monopoly without any negotiation. We further analyze the negotiation on the co-payment itself, and show that the optimal degree of the negotiated co-payment is the lowest one.

Jurges, H. (2015). Health insurance coverage and access to care among European elders: crossnational differences and social gradients. Ageing in Europe - Supporting Policies for an Inclusive Society., Berlin : Degruyter**:** 301-312.
http://www.degruyter.com/view/product/462442

Unmet health care needs and insufficient health insurance coverage still exist among European elders and vary widely across countries .Insufficient access and lack of insurance coverage are most prevalent in poorer countries with low health care expenditures and in countries with large income inequalities. Health insurance coverage and access to care are socially graded within almost all countries and may contribute to social inequalities in health status.

Kalousova, L. (2015). "Curing over-use by prescribing fees: an evaluation of the effect of user fees' implementation on healthcare use in the Czech Republic." Health Policy Plan **30**(4): 423-431.

In 2008, the Czech Republic instituted a new policy that requires most patients to pay a small fee for some inpatient and outpatient healthcare services. Using the Survey of Health Aging and Retirement in Europe, this article examines the changes in healthcare utilization of Czechs 50 years and older following the new fee requirement by constructing difference-in-differences regression models focusing on four outcome measures: any visits to primary care physician, any hospitalization, number of visits to the primary care physician and number of nights hospitalized. For this population, I find that the likelihood of having any primary care visit decreased after the policy was instituted. The likelihood of reporting any hospitalization was not significantly changed. The predicted number of primary care visits per person declined, but the predicted number of nights spent in a hospital did not. I find only mixed evidence of greater effect of the user fees on some subpopulations compared with others. Those 65 or older reduced their use more than those between 50 and 64, and so did those who consider their health to be good, and the less educated.

Laba, T. L., et al. (2015). "Co-payments for health care: what is their real cost?" Aust Health Rev **39**(1): 33-36.

Based on the premise that current trends in healthcare spending are unsustainable, the Australian Government has proposed in the recent Budget the introduction of a compulsory $7 co-payment to

visit a General Practitioner (GP), alongside increased medication copayments. This paper is based on a recent submission to the Senate Inquiry into the impact of out-of-pocket costs in Australia. It is based on a growing body of evidence highlighting the substantial economic burden faced by individuals and families as a result of out-of-pocket costs for health care and their flow-on effects on healthcare access, outcomes and long-term healthcare costs. It is argued that a compulsory minimum co-payment for GP consultations will exacerbate these burdens and significantly undermine the tenets of universal access in Medicare. Alternative recommendations are provided that may help harness unsustainable health spending while promoting an equitable and fair health system.

Mahmoudi, E. et Meade, M. A. (2015). "Disparities in access to health care among adults with physical disabilities: analysis of a representative national sample for a ten-year period." Disabil Health J **8**(2): 182-190.

BACKGROUND: People with physical disabilities are the largest underserved subpopulation in the U.S. However, disparities in access to health care and how these have changed over time have not been fully explored. OBJECTIVE: To examine national trends in disparities in access to health care and to identify the impact of physical disability and the personal factors that are associated with unmet health care needs, defined as self-reported ability to get medical care, dental care or prescription medications, among working age adults within the United States. METHODS: Logistic regression analysis of a nationally representative sample of adults ages 25-64 (n = 163,220) with and without physical disabilities, using pooled data from the 2002-2011 Medical Expenditure Panel Survey. RESULTS: Individuals with physical disabilities have 75% (p < 0.0001), 57% (p < 0.0001), and 85% (p < 0.000) higher odds of having unmet medical, dental, and prescription medication needs, respectively. Sociodemographic and health factors were related to unmet needs in all three measures of access to care. In particular, being female, living at or near the poverty level, and lacking health insurance increased the odds of unmet health care needs. Predicted probabilities of unmet health care needs from 2002 to 2011 show persistent gaps between individuals with and without physical disabilities, with a growing gap in unmet dental care (p = 0.004). CONCLUSION: Having physical disabilities increase the odds of unmet health care needs. This study has important policy and community program implications. The Affordable Care Act could significantly reduce unmet health care needs, especially among individuals with physical disabilities.

OCDE (2015). Evolution des dépenses pharmaceutiques et défis futurs. Panorama de la santé 2015. Indicateurs de l'OCDE., Paris : OCDE**:** 33-48, graph., tabl.
http://www.oecd-ilibrary.org/docserver/download/8115072e.pdf

Les dépenses pharmaceutiques ont atteint environ 800 milliards USD en 2013 dans les pays de l'OCDE, soit environ 20 % en moyenne des dépenses de santé totales lorsque l'on ajoute la consommation hospitalière de produits pharmaceutiques à l'achat de médicaments au détail. Ce chapitre présente les tendances récentes en matière de dépenses pharmaceutiques dans les pays de l'OCDE. Il examine les déterminants de l'évolution récente des dépenses, en soulignant les différences entre classes thérapeutiques. Il montre que, alors que la consommation de médicaments continue d'augmenter et de pousser à la hausse les dépenses pharmaceutiques, les politiques de maîtrise des coûts et l'expiration des brevets d'un certain nombre de produits les plus vendus ont mis la pression à la baisse sur les prix des médicaments au cours des dernières années. Cela a entraîné un ralentissement de la croissance des dépenses au cours de la dernière décennie. Le chapitre se penche ensuite sur les défis émergents pour les décideurs politiques en ce qui concerne la gestion des dépenses pharmaceutiques. La prolifération de médicaments de spécialité à coût élevé sera un moteur important de la croissance des dépenses de santé dans les années à venir. Alors que certains de ces médicaments apportent de grands bénéfices aux patients, d'autres ne fournissent que des améliorations marginales. Cela remet en question l'efficacité des dépenses pharmaceutiques (résumé de l'éditeur).

Ozgen Narci, H., et al. (2015). "Financial catastrophe and poverty impacts of out-of-pocket health payments in Turkey." Eur J Health Econ **16**(3): 255-270.

OBJECTIVE: To determine the prevalence of catastrophic health payments, examine the determinants of catastrophic expenditures, and assess the poverty impact of out-of-pocket (OOP) payments. METHODS: Data came from the 2004 to 2010 Household Budget Survey. Catastrophic health spending was defined by health payments as percentage of household consumption expenditures and capacity to pay at a set of thresholds. The poverty impact was evaluated by poverty head counts and poverty gaps before and after OOP health payments. RESULTS: The percentage of households that catastrophically spent their consumption expenditure and capacity to pay increased from 2004 to 2010, regardless of the threshold used. Households with a share of more than 40% health spending in both consumption expenditure and capacity to pay accounted for less than 1% across years. However, when a series of potential confounders were taken into account, the study found statistically significantly increased risk for the lowest threshold and decreased risk for the highest threshold in 2010 relative to the base year. Household income, size, education, senior and under 5-year-old members, health insurance, disabled members, payment for inpatient care and settlement were also statistically significant predictors of catastrophic health spending. Overall, poverty head counts were below 1%. Poverty gaps reached a maximum of 0.098%, with an overall increase in 2010 compared to 2004. CONCLUSIONS: Catastrophe and poverty increased from 2004 to 2010. However, given that the realization of some recent policies will affect the financial burden of OOP payments on households, the findings of this study need to be replicated.

Pauly, L., et al. (2015). The Price of Responsibility: The Impact of Health Reform on Non-Poor Uninsureds. Working Paper Series ; n° 21565. Cambridge NBER**:** 37 , tabl.,fig., annexes.
http://www.nber.org/papers/w21565

This paper estimates the change in net (of subsidy) financial burden ("the price of responsibility") and in welfare that would be experienced by a large nationally representative sample of the "non-poor" uninsured if they were to purchase Silver or Bronze plans on the ACA exchanges. The sample is the set of full-year uninsured persons represented in the Current Population Survey for the pre-ACA period with incomes above 138 percent of the federal poverty level. The estimated change in financial burden compares out-of-pocket payments by income stratum in the pre-ACA period with the sum of premiums (net of subsidy) and expected cost sharing (net of subsidy) for benchmark Silver and Bronze plans, under various assumptions about the extent of increased spending associated with obtaining coverage. In addition to changes in the financial burden, our welfare estimates incorporate the value of additional care consumed and the change in risk premiums for changes in exposure to out-of-pocket payments associated with coverage, under various assumptions about risk aversion. We find that the average financial burden will increase for all income levels once insured. Subsidy-eligible persons with incomes below 250 percent of the poverty threshold likely experience welfare improvements that offset the higher financial burden, depending on assumptions about risk aversion and the value of additional consumption of medical care. However, even under the most optimistic assumptions, close to half of the formerly uninsured (especially those with higher incomes) experience both higher financial burden and lower estimated welfare; indicating a positive "price of responsibility" for complying with the individual mandate. The percentage of the sample with estimated welfare increases is close to matching observed take-up rates by the previously uninsured in the exchanges.

Pauly, M. (2015). "Cost-effectiveness analysis and insurance coverage: solving a puzzle." Health Econ **24**(5): 506-515.

The conventional model for the use of cost-effectiveness analysis for health programs involves determining whether the cost per unit of effectiveness of the program is lower than some socially determined maximum acceptable cost per unit of effectiveness. If a program is better by this criterion, the policy implication is that it should be implemented by full coverage of its cost by insurance; if not, the program should not be implemented. This paper examines the unanswered question of how cost-effectiveness analysis should be performed and interpreted when insurance coverage may involve cost sharing. It explores the question of how cost sharing should be related to the magnitude of a cost-effectiveness ratio. A common view that cost sharing should vary inversely with program cost-effectiveness is shown to be incorrect. A key issue in correct analysis is whether there is heterogeneity in marginal effectiveness of care that cannot be perceived by the social planner but is known by the demander. It is possible that some programs that would fail the social efficiency test at full coverage will be acceptable with positive cost sharing. Combining individual and social preferences affects both the choice of programs and the extent of cost sharing.

Reitsma-Van-Rooijen, M. et De, Jonglong, J. D. (2015). "Out-of-pocket payments in the Netherlands: expected effects are high, actual effects limited." Eurohealth **21**(2): 27-30, tabl., fig.
http://www.euro.who.int/__data/assets/pdf_file/0003/280605/EuroHealth_v2n1.pdf?ua=1

Out-of-pocket (OOP) payments are often introduced to reduce health care expenditures. The assumption is that OOP payments result in less health care use, therefore lower expenditure. However, the effects of OOP payments appear to be limited and they have adverse effects. Variants of OOP payments are being considered by several governments in order to address these problems; however, in the Netherlands the current OOP payment system has limited effect. This is possibly due to a lack of knowledge, the limited influence people have on their health care use, and the fact that people rarely judge this use as unnecessary.

Sanwald, A. et Theurl, E. (2015). Out-of-pocket expenditures for pharmaceuticals: Lessons from the Austrian household budget survey. Working Papers in Economics and Statistics; 2015-01. Innsbruck University of Innsbruck**:** 19 , tabl., fig.
http://eeecon.uibk.ac.at/wopec2/repec/inn/wpaper/2015-01.pdf

BACKGROUND: Paying pharmaceuticals out-of-pocket is an important source of financing pharmaceutical consumption. Only limited empirical knowledge is available on the determinants of these expenditures. OBJECTIVES: In this paper we analyze which characteristics of private households influence out-of-pocket pharmaceutical expenditure (OOPPE) in Austria. DESIGN & METHODS: We use cross-sectional information on OOPPE and on household characteristics provided by the Austrian household budget survey 2009/10. We split pharmaceutical expenditures into the two components prescription fees and over-the-counter (OTC) expenditures. To adjust for the specific characteristics of the data we compare different econometric approaches: two-part model, hurdle model, generalized linear model, zero-inflated negative binomial regression model. FINDINGS: The finally selected econometric approaches give a quite consistent picture. The probability of expenditures of both types is strongly influenced by the household structure. It increases with age, doctoral visits and the presence of a female householder. The education level and income only increase the probability of OTC-pharmaceuticals. The level of OTC-expenditures remains widely unexplained while the household structure and age influences the expenditures for prescription fees. Insurance characteristics of private households either private or public play a minor role in explaining the expenditure levels in all specifications. This refers to a homogenous and comprehensive provision of pharmaceuticals in the public part of the Austrian health care system. CONCLUSIONS: The paper gives useful insights into the determinants of pharmaceutical expenditures of private households and supplements the previous research which focuses on the individual level.

Sanwald, A. et Theurl, E. (2015). Out-of-pocket payments in the Austrian healthcare system - a distributional analysis. Working Papers in Economics and Statistics; 2015-05. Innsbruck University of Innsbruck**:** 22 , tabl., fig.
https://ideas.repec.org/p/inn/wpaper/2015-05.html

Introduction: Out-of-pocket spending is an important source of healthcare financing even in countries with established prepaid financing of healthcare. However, out-of-pocket payments (OOPP) may have undesirable effects from an equity perspective. In this study, we analyse the distributive effects of OOPP in Austria based on cross-sectional information from the Austrian Household Budget Survey 2009/10. Methods: We combine evidence from disaggregated measures (concentration curve and Lorenz curve) and summary indices (Gini coefficient, Kakwani index, and Reynolds-Smolensky index) to demonstrate the distributive effects of total OOPP and their subcomponents. Thereby, we use different specifications of household ability to pay. We follow the Aronson-Johnson-Lampert approach and split the distributive effect into its three components: progressivity, horizontal equity, and reranking. Results: OOPP in Austria have regressive effects on income distribution. These regressive effects are especially pronounced for the OOPP category prescription fees and over-the-counter pharmaceuticals. Dis- aggregated evidence shows that the effects differ between income groups. The decomposition analysis reveals a high degree of reranking and horizontal inequity for total OOPP, and particularly, for therapeutic aids and physician services. Conclusions: The results - especially those for prescription fees and therapeutic aids - are of high relevance for the recent and on-going discussion on the reform of benefit catalogues and cost-sharing schemes in the public health insurance system in Austria.

Schaller, J. et Stevens, A. H. (2015). "Short-run effects of job loss on health conditions, health insurance, and health care utilization." J Health Econ **43**: 190-203.

Job loss in the United States is associated with reductions in income and long-term increases in mortality rates. This paper examines the short-run changes in health, health care access, and health care utilization after job loss that lead to these long-term effects. Using a sample with more than 10,000 individual job losses and longitudinal data on a wide variety of health-related outcomes, we show that job loss results in worse self-reported health, activity limitations, and worse mental health, but is not associated with statistically significant increases in a variety of specific chronic conditions. Among the full sample of workers, we see reductions in insurance coverage, but little evidence of reductions in health care utilization after job loss. Among the subset of displaced workers with chronic conditions and those for whom the lost job was their primary source of insurance we do see reductions in doctor's visits and prescription drug usage.

Scheil-Adlung, X. (2015). Long-term care protection for older persons. A review of coverage deficits in 46 countries. ESS – Working Paper No. 50. Genève Organisation Internationale du Travail**:** 99 , fig., tabl.
http://www.social-protection.org/gimi/gess/RessourcePDF.action?ressource.ressourceId=53175

This paper: (i) examines long-term care (LTC) protection in 46 developing and developed countries covering 80 per cent of the world's population; (ii) provides (data on LTC coverage for the population aged 65+; (iii) identifies access deficits for older persons due to the critical shortfall of formal LTC workers; (iv) presents the impacts of insufficient public funding, the reliance on unpaid informal LTC workers and high out-of-pocket payments (OOP); and (v) calls for recognizing LTC as a right, and mainstreaming LTC as a priority in national policy agendas given the benefits in terms of job creation and improved welfare of the population.

Scheil-Adlung, X. é. (2015). Global evidence on inequities in rural health protection: new data on rural deficits in health coverage for 174 countries. Genève OIT**:** 69 , tabl., fig., carte.
http://www.social-protection.org/gimi/gess/ShowRessource.action?ressource.ressourceId=51297

This paper presents global estimates on rural/urban disparities in access to health-care services. The report uses proxy indicators to assess key dimensions of coverage and access involving the core principles of universality and equity. Based on the results of the estimates, policy options are discussed to close the gaps in a multi-sectoral approach addressing issues and their root causes both within and beyond the health sector.

Tambor, M., et al. (2015). "Towards a stakeholders' consensus on patient payment policy: the views of health-care consumers, providers, insurers and policy makers in six Central and Eastern European countries." Health Expect **18**(4): 475-488.

BACKGROUND: Although patient charges for health-care services may contribute to a more sustainable health-care financing, they often raise public opposition, which impedes their introduction. Thus, a consensus among the main stakeholders on the presence and role of patient charges should be worked out to assure their successful implementation. AIM: To analyse the acceptability of formal patient charges for health-care services in a basic package among different health-care system stakeholders in six Central and Eastern European countries (Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine). METHODS: Qualitative data were collected in 2009 via focus group discussions and in-depth interviews with health-care consumers, providers, policy makers and insurers. The same participants were asked to fill in a self-administrative questionnaire. Qualitative and quantitative data are analysed separately to outline similarities and differences in the opinions between the stakeholder groups and across countries. RESULTS: There is a rather weak consensus on patient charges in the countries. Health policy makers and insurers strongly advocate patient charges. Health-care providers overall support charges but their financial profits from the system strongly affects their approval. Consumers are against paying for services, mostly due to poor quality and access to health-care services and inability to pay. CONCLUSIONS: To build consensus on patient charges, the payment policy should be responsive to consumers' needs with regard to quality and equity. Transparency and accountability in the health-care system should be improved to enhance public trust and acceptance of patient payments.

Zallman, L., et al. (2015). "Affordability of health care under publicly subsidized insurance after Massachusetts health care reform: a qualitative study of safety net patients." Int J Equity Health **14**: 112.

INTRODUCTION: The Affordable Care Act (ACA) and the 2006 Massachusetts (MA) health reform law, on which the ACA was based, aimed to improve the affordability of care largely by expanding publicly sponsored insurances. Both laws also aimed to promote consumer understanding of how to acquire, maintain and use these public plans. A prior study found an association between the level of cost-sharing required in these plans and the affordability of care. Preparatory to a quantitative study we conducted this qualitative study that aimed to examine (1) whether cost sharing levels built into the public insurance types that formed the backbone of the MA health reform led to unaffordability of care and if so, (2) how insurances with higher cost sharing levels led to unaffordability of care in this context. METHODS: We interviewed 12 consumers obtaining the most commonly obtained insurances under MA health reform (Medicaid and Commonwealth Care) at a safety net hospital emergency department. We purposefully interviewed a stratified sample of higher and low cost sharing recipients. We used a combination of inductive and deductive codes to analyze the data according to degree of cost-sharing required by different insurance types. RESULTS: We found that higher cost sharing plans led to unaffordability of care, as evidenced by unmet medical needs, difficulty affording basic non-medical needs due to expenditures on medical care, and reliance on non-insurance resources to pay for care. Participants described two principal mechanisms by which higher cost sharing led to unaffordability of care: (1) cost sharing above what their incomes allowed and (2) poor understanding of how to effectively acquire, maintain and utilize insurance new public plans. CONCLUSIONS: Further efforts to investigate the relationship between perceived affordability of care and understanding of insurance for the insurance types obtained under MA health reform may be warranted. A potential focus for further work may be quantitative investigation of how the level of calibration of cost-sharing to income and understanding of insurances under the MA reform was associated with perceived affordability of care.

2014

Atanasov, P. et Baker, T. (2014). "Putting Health Back Into Health Insurance Choice." Med Care Res Rev **71**(4): 337-355.

What are the barriers to voluntary take-up of high-deductible plans? We address this question using a large-scale employer survey conducted after an open-enrollment period in which a new high-deductible plan was first introduced. Only 3% of the employees chose this plan, despite the respondents' recognition of its financial advantages. Employees who believed that the high-deductible plan provided access to top physicians in the area were three times more likely to choose it than employees who did not share this belief. A framed field experiment using a similar choice menu showed that displaying additional financial information did not increase high-deductible plan take-up.

However, when plans were presented as identical except for the deductible, respondents were highly likely to choose the high-deductible plan, especially in a two-way choice. These results suggest that informing plan choosers about high-deductible plans' health access provisions may affect choice more strongly than focusing on their financial advantages.

Barcellos, S. H. et Jacobson, M. (2014). The Effects of Medicare on Medical Expenditure Risk and Financial Strain. NBER Working Paper Series ; 19954. Cambridge NBER**:** 28 +annexes, tabl., fig.
http://papers.nber.org/papers/w19954

We estimate the current impact of Medicare on medical expenditure risk and financial strain. At age 65, out-of-pocket expenditures drop by 33% at the mean and 53% among the top 5% of spenders. The fraction of the population with out- of-pocket medical expenditures above income drops by more than half. Medical- related financial strain, such as problems paying bills, is dramatically reduced. Using a stylized expected utility framework, the gain from reducing out-of-pocket expenditures alone accounts for 18% of the social costs of financing Medicare. This calculation ignores the benefits of reduced financial strain and direct health improvements due to Medicare.

Barnieh, L., et al. (2014). "A Systematic Review of Cost-Sharing Strategies Used within Publicly-Funded Drug Plans in Member Countries of the Organisation for Economic Co-Operation and Development." PLoS One **9**(3): (10), fig., tabl.
http://www.plosone.org/article/fetchObject.action?uri=info%3Adoi%2F10.1371%2Fjournal.pone.0090434&representation=PDF

Background: Publicly-funded drug plans vary in strategies used and policies employed to reduce continually increasing pharmaceutical expenditures. We systematically reviewed the utilization of cost-sharing strategies and physician-directed prescribing regulations in publicly-funded formularies within member nations of the Organization of Economic Cooperation and Development (OECD). Methods & Findings: Using the OECD nations as the sampling frame, a search for cost-sharing strategies and physician directed prescribing regulations was done using published and grey literature. Collected data was verified by a system expert within the prescription drug insurance plan in each country, to ensure the accuracy of key data elements across plans. Significant variation in the use of cost-sharing mechanisms was seen. Copayments were the most commonly used cost-containment measure, though their use and amount varied for those with certain conditions, most often chronic diseases (in 17 countries), and by socio-economic status (either income or employment status), or with age (in 15 countries). Caps and deductibles were only used by five systems. Drug cost-containment strategies targeting physicians were also identified in 24 countries, including guideline-based prescribing, prescription monitoring and incentive structures. Conclusions: There was variable use of cost-containment strategies to limit pharmaceutical expenditures in publicly funded formularies within OECD countries. Further research is needed to determine the best approach to constrain costs while maintaining access to pharmaceutical drugs.

Bourke-Taylor, H., et al. (2014). "Young children with cerebral palsy : families self-reported equipment needs and out-of-pocket expenditure." Child : Care, Health and Development **40**(5): 654-662.

Background : Costs to families raising a child with cerebral palsy and complex needs are direct and indirect. This study investigated the self-reported real-life costs, equipment needs, and associated characteristics of children who had the highest equipment and care needs. Method : The purposive sample (n = 29) were families with a child with cerebral palsy: gross motor function levels 5 (n = 20), level 4 (n = 5), level 3 (n = 4); complex communication needs (n = 21); medical needs (n = 14); hearing impairment (n = 5) and visual impairment (n = 9). Participants completed a specifically designed survey that included the Assistance to Participate Scale. Equipment and technology purchases were recorded in the areas of positioning, mobility, transport, home modifications, communication, splinting and orthoses, self-care, technology, communication devices, medical, adapted toys/leisure items and privately hired babysitters/carers. Descriptive and inferential statistics were used to analyse the data.

Brown, S., et al. (2014). "Out-of-Pocket Health Care Expenditure in Turkey: Analysis of the 2003-2008 Household Budget Surveys." Economic Modelling **41**: 211-218.

This paper analyses the prevalence of 'catastrophic' out-of-pocket health expenditure in Turkey and identifies the factors which are associated with its risk using the Turkish Household Budget Surveys from 2003 to 2008. A sample selection approach based on Sartori (2003) is adopted to allow for the potential selection problem which may arise if poor households choose not to seek health care due to concerns regarding its affordability. The results suggest that poor households are less likely to seek health care as compared to non-poor households and that a negative relationship between poverty and experiencing catastrophic health expenditure remains even after allowing for such selection bias. Our findings, which may assist policy-makers concerned with health care system reforms, also highlight factors such as insurance coverage, which may protect households from the risk of incurring catastrophic health expenditure.

Campbell, D. J. T., et al. (2014). "Obstacles financiers à l'obtention de soins déclarés chez les patients atteints de maladies chroniques d'origine cardiovasculaire." Rapports Sur La Sante **25**(5): 13 , tabl., fig.
http://www.statcan.gc.ca/pub/82-003-x/2014005/article/14005-fra.pdf

Fondée sur les résultats d'une enquête représentative de la population réalisée dans les quatre provinces de l'Ouest canadian, 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.

Cunningham, P. et Carrier, E. (2014). "Trends in the Financial Burden of Medical Care for Nonelderly Adults with Diabetes, 2001 to 2009." American Journal of Managed Care **20**(2): 135-147, tabl., fig;.

Objectives: To examine trends in out-of-pocket spending and the financial burden of care for persons with diabetes between 2001 and 2009, and to examine whether these trends are consistent with trends in access to prescription drugs and utilization of hospital services. Study Design and Methods: Data are from the 2001 to 2009 Medical Expenditure Panel Survey (MEPS). The sample includes persons aged 18 to 64 years with diagnosed diabetes. The primary outcome variable is the percent of people with out-of-pocket spending on insurance premiums and services that exceed 10% of family income. Secondary outcome measures include the percent with diabetes-related prescription drug use, perceived access to prescription drugs, hospital inpatient stays, and emergency department use in the past 12 months. Multiple regression analysis is used to control for changes in comorbid chronic conditions and other characteristics of persons with diabetes. Results: Both out-of-pocket spending and the percent with high financial burden decreased markedly for persons with diabetes between 2001 to 2003 and 2007 to 2009. The decrease in spending was driven primarily by a decrease in spending on prescription drugs, including diabetes-related prescriptions. The shift from brand name drugs to generics accounts for much of this decline, although decreases in out-of-pocket spending for both brand name and generic drugs also contributed. During the same period, utilization of and access to diabetes-related prescriptions increased, and hospital use decreased. Conclusions: Although the prevalence of diagnosed diabetes continues to increase, treatment is becoming more affordable, especially prescription drugs. This may offset some of the costs to the healthcare system of higher prevalence by reducing complications of uncontrolled diabetes that result in more costly hospital use.

Fanourgiakis, J. et Kanoupakis, E. (2014). "Greek's health, waiting for the 'deus ex machina'." Expert Rev Pharmacoecon Outcomes Res **14**(5): 637-642.

Greece from May 2010 has been following Troika's (European Commission, European Central Bank and International Monetary Fund) austere policies in all over the public finance sector. Troika's instructions which are adopted by the politicians resulted to depressed and weak citizens. The consequences in health care sector are becoming visible across the society. A big part of Greek's society is uninsured without any access to public health care system. The vulnerable social groups confront catastrophic health care expenditures and impoverishment with no social net protection.

Greeks are paying the price of their irrational way of living. The current paper has gathered from the literature the early effects of the implementation of these policies on public health and healthcare.

Fronstin, P. et Roebuck, C. (2014). "Reference Pricing for Health Care Services: A New Twist on the Defined Contribution Concept in Employment-Based Health Benefits." Issue Brief(398): 15 , tabl., fig.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2428270

This paper examines reference pricing, a form of defined contribution health benefits, where plan sponsors pay a fixed amount or limit their contributions toward the cost of a specific health care service, and health plan members must pay the difference in price if a more costly health care provider or service is selected. Reference pricing for hip and knee replacement, colonoscopy, magnetic resonance imaging (MRI) of the spine, computerized tomography (CT) scan of the head or brain, nuclear stress test of the heart, and echocardiogram were examined because these services have fairly uniform protocols, and they are less likely to experience variation in quality, both of which make price comparisons easier for patients. Potential aggregate savings could reach $9.4 billion if all employers adopted reference pricing for the health care services examined in this paper. The $9.4 billion represents 1.6 percent of all spending on health care services among the 156 million people under age 65 with employment-based health benefits in 2010. Savings from reference pricing materializes through the combination of 1) patients choosing providers at the reference price, 2) patients paying the difference between the reference price and the allowed charge through cost sharing, and 3) providers reducing their prices to the reference price. Any increase in prices among providers below the reference price would reduce the potential for savings. Reference pricing for knee and hip replacements would result in savings averaging $10,367 per knee or hip replacement among the cases that were above the reference price, and would account for about 40 percent of the aggregate savings. While the incidence rate of hip and knee replacements in the population of people with employment-based coverage is relatively low, the costs are relatively high. In contrast, stress tests of the heart accounted for only 2 percent of the aggregate potential savings. While incidence rates ranged from 14 to 20 percent between 2008 and 2010, only $87 per case would be saved from reference pricing. Colonoscopies, CT scans of the head or brain, and echocardiograms each accounted for between 15-20 percent of aggregate potential savings, while MRIs of the spine accounted for about 10 percent of the potential savings. Plan sponsors should consider a number of issues as they weigh adopting reference pricing, including how the reference price is determined and how providers may react. Communication to plan members is also key to effective use of reference pricing.

Fortier, J. (2014). Les effets des programmes universels d'assurance médicaments sur les dépenses privées en médicaments : l'expérience québécoise. Montréal UQAM. **Mémoire présenté comme exigence partielle de la maîtrise en économie:** 78 , tabl., fig.

Ce mémoire évalue les impacts de la réforme de l'assurance médicaments au Québec sur les différentes populations assurées. En utilisant des données de dépenses, soit l'Enquête sur les dépenses des familles (EDF) de 1996 et de l'Enquête sur les dépenses des ménages (EDM) de 1998, il nous a été possible d'évaluer les impacts sur différentes catégories de dépenses, qualifiés d'effets directs pour les dépenses en médicaments prescrits et assurance publique et d' effets indirects pour les médicaments non prescrits et les assurances privées en santé. La réforme a affecté de façon distincte trois sous populations, soit les prestataires de la sécurité du revenu, les personnes de plus de 65 ans et la population en général via les nouveaux adhérents.

Herr, A., et al. (2014). Reference pricing and cost-sharing: Theory and evidence on German off-patent drugs
http://hdl.handle.net/10419/100556

This paper evaluates the impact of reference pricing on prices and co-payments in the (German) market for off-patent pharmaceuticals. We present a theoretical model with price-sensitive and loyal consumers that shows that a decrease in the reference price affects the consumers' co-payments in a non-monotonic way: For high reference prices, a marginally lower reference price may lead to lower copayments. However, for low reference prices a further reduction may result into higher consumer co-payments. We use quarterly data on reference priced drugs covered by the social health insurance in Germany over the period 2007 - 2010 to analyze the empirical effects of reference price reductions. We find that, while prices decrease due to the reduction, co-payments behave non-monotonically and indeed increase if the reference price is sufficiently low.

Karaca-Mandic, P., et al. (2014). "Family out-of-pocket health care burden and children's unmet needs or delayed health care." Academic Pediatrics **14**(1): 101-108.

OBJECTIVE : To assess the relationship between family members' out-of-pocket (OOP) health care spending and unmet needs or delayed health care due to cost for children with and without special health care needs (SHCN).METHODS : Data come from the Medical Expenditure Panel Survey, 2002-2009, and include 63,462 observations representing 41,748 unique children. The primary outcome was having any unmet needs/delayed care as a result of the cost of medical care, dental care, or prescription drugs. We also examined having unmet needs/delayed care due to cost for each service separately. Key explanatory variables were OOP spending on the index child and OOP spending on other family members. We estimated multivariate instrumental variable models to adjust the results for potential bias from any unobserved factors that might influence both other family OOP costs and the outcome variable.

Kiil, A. et Houlberg, K. (2014). "How does copayment for health care services affect demand, health and redistribution? A systematic review of the empirical evidence from 1990 to 2011." Eur J Health Econ **15**(8): 813-828.

This article reviews the quantitative evidence on the behavioural effects of copayment within the health area across a wide range of countries. The review distinguishes itself from previous similar reviews by having a high degree of transparency for the search strategy used to identify the studies included in the review as well as the criteria for inclusion and by including the most recent literature. Empirical studies were identified by performing searches in EconLit. The literature search identified a total of 47 studies of the behavioural effects of copayment. Considering the demand effects, the majority of the reviewed studies found that copayment reduces the use of prescription medicine, consultations with general practitioners and specialists, and ambulatory care, respectively. The literature found no significant effects of copayment on the prevalence of hospitalisations. The empirical evidence on whether copayment for some services, but not for others, causes substitution from the services that are subject to copayment to the 'free' services rather than lower total use is sparse and mixed. Likewise, the health effects of copayment have only been analysed empirically in a limited number of studies, of which half did not find any significant effects in the short term. Finally, the empirical evidence on the distributional consequences of copayment indicates that individuals with low income and in particular need of care generally reduce their use relatively more than the remaining population in consequence of copayment. Hence, it is clear that copayment involves some important economic and political trade-offs.

Kronenberg, C. et Barros, P. P. (2014). "Catastrophic healthcare expenditure - Drivers and protection: The Portuguese case." Health Policy **115**(1): 44-51.
http://www.ncbi.nlm.nih.gov/pubmed/24210762

The objective of this paper is to assess the extent of catastrophic healthcare expenditure, which can lead to impoverishment, even in a country with a National Health Service, such as Portugal. The level of catastrophic healthcare expenditure will be identified before the determinants of these catastrophic payments are analyzed. Afterwards, the effects of existing exemptions to copayments in health care use will be tested and the relationship between catastrophe and impoverishment will be discussed. Catastrophe is calculated from the Portuguese Household Budget Surveys of 2000 and 2005, and then analyzed using logistic regression models. The results show that catastrophe due to healthcare out-of-pocket payments are a sizeable issue in Portugal. Exemptions from out-of-pocket expenses for medical care should be created to prevent vulnerable groups from facing catastrophic healthcare spending. These vulnerable groups include children, people with disabilities and individuals suffering from chronic conditions. Disability proxies offer straightforward policy options for an exemption for the elderly with recognized disabilities. An exemption of retired people with disabilities is therefore recommended to policymakers as it targets a vulnerable group with high risk of facing catastrophic healthcare expenditure

Kyriopoulos, II, et al. (2014). "Barriers in access to healthcare services for chronic patients in times of austerity: an empirical approach in Greece." Int J Equity Health **13**: 54.

OBJECTIVES: To investigate the magnitude of barriers in access to health services for chronic patients and the socioeconomic and demographic characteristics that affect them. METHODS: A cross-sectional study was conducted in 1,594 chronic patients suffering from diabetes, hypertension, COPD and Alzheimer. Logistic regression analyses were carried out in order to explore the factors related to economic and geographical barriers in access, as well as the determinants of barriers due to waiting lists. RESULTS: A total of 25% of chronic patients face geographical barriers while 63.5% and 58.5% of them are in front of economic and waiting list barriers, respectively. Unemployed, low-income and low-educated are more likely to face economic barriers in access. Moreover, women, low-income patients, and patients with lower health status are more likely to be in front of geographical barriers. In addition, the probability of waiting lists occurrence is greater for unemployed, employees and low income patients. CONCLUSIONS: Barriers in access can be mainly attributed to income decrease and unemployment. In this context, health policy measures are essential for removing barriers in access. Otherwise, inequalities may increase and chronic patients' health status will be deteriorated. These consequences imply adverse effects on health expenditure.

Li, R., et al. (2014). "Changes over time in high out-of-pocket health care burden in U.S. adults with diabetes, 2001-2011." Diabetes Care **37**(6): 1629-1635.

OBJECTIVE: High out-of-pocket (OOP) costs can be an obstacle to health care access and treatment compliance. This study investigated trends in high OOP health care burden in people with diabetes. RESEARCH DESIGN AND METHODS: Using Medical Expenditure Panel Survey 2001-2011 data, we examined trends in the proportion of people aged 18-64 years with diabetes facing a high OOP burden. We also examined whether the trend differed by insurance status (private insurance, public insurance, or no insurance) or by income level (poor and near poor, low income, middle income, or high income). RESULTS: In 2011, 23% of people with diabetes faced high OOP burden. Between 2001-2002 and 2011, the proportion of people facing high OOP burden fell by 5 percentage points ($P < 0.01$). The proportion of those who were publicly insured decreased by 22 percentage points ($P < 0.001$) and of those who were uninsured by 12 percentage points ($P = 0.01$). Among people with diabetes who were poor and near poor and those with low income, the proportion facing high OOP burden decreased by 21 ($P < 0.001$) and 13 ($P = 0.01$) percentage points, respectively; no significant change occurred in the proportion with private insurance or middle and high incomes between 2001-2002 and 2011. CONCLUSIONS: The past decade has seen a narrowing of insurance coverage and income-related disparities in high OOP burden in people with diabetes; yet, almost one-fourth of all people with diabetes still face a high OOP burden.

Maeda, A., et al. (2014). Universal coverage for inclusive and sustainable developement : a synthesis of 11 country cases studies, Washington : Banque mondiale
http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2014/07/04/000333037_20140704110435/Rendered/PDF/888620PUB0REPL00Box385245B00PUBLIC0.pdf

The goals of Universal Health Coverage (UHC) are to ensure that all people can access quality health services, to safeguard all people from public health risks, and to protect all people from impoverishment due to illness, whether from out-of-pocket payments for health care or loss of income when a household member falls sick. Countries as diverse as Brazil, France, Japan, Thailand, and Turkey that have achieved UHC are showing how these programs can serve as vital mechanisms for improving the health and welfare of their citizens, and lay the foundation for economic growth and competitiveness grounded in the principles of equity and sustainability. Ensuring universal access to affordable, quality health services will be an important contribution to ending extreme poverty by 2030 and boosting shared prosperity in low income and middle-income countries (LMICs), where most of the world?s poor live (4e de couverture).

Mann, B. S., et al. (2014). "Association between Drug Insurance Cost Sharing Strategies and Outcomes in Patients with Chronic Diseases: A Systematic Review." PLoS One **9**(3): 8 , fig., tabl.
http://www.plosone.org/article/fetchObject.action?uri=info%3Adoi%2F10.1371%2Fjournal.pone.0089168&representation=PDF

Background: Prescription drugs are used in people with hypertension, diabetes, and cardiovascular disease to manage their illness. Patient cost sharing strategies such as copayments and deductibles are often employed to lower expenditures for prescription drug insurance plans, but the impact on health outcomes in these patients is unclear. Objective: To determine the association between drug insurance and patient cost sharing strategies on medication adherence, clinical and economic outcomes in those with chronic diseases (defined herein as diabetes, hypertension, hypercholesterolemia, coronary artery disease, and cerebrovascular disease). Methods: Studies were included if they examined various cost sharing strategies including copayments, coinsurance, fixed copayments, deductibles and maximum out-of-pocket expenditures. Value-based insurance design and reference based pricing studies were excluded. Two reviewers independently identified original intervention studies (randomized controlled trials, interrupted time series, and controlled before-after designs). MEDLINE, EMBASE, Cochrane Library, CINAHL, and relevant reference lists were searched until March 2013. Two reviewers independently assessed studies for inclusion, quality, and extracted data. Eleven studies, assessing the impact of seven policy changes, were included: 2 separate reports of one randomized controlled trial, 4 interrupted time series, and 5 controlled before-after studies. Findings: Outcomes included medication adherence, clinical events (myocardial infarction, stroke, death), quality of life, healthcare utilization, or cost. The heterogeneity among the studies precluded meta-analysis. Few studies reported the impact of cost sharing strategies on mortality, clinical and economic outcomes. The association between patient copayments and medication adherence varied across studies, ranging from no difference to significantly lower adherence, depending on the amount of the copayment. Conclusion: Lowering cost sharing in patients with chronic diseases may improve adherence, but the impact on clinical and economic outcomes is uncertain.

Mulcahy, A. W., et al. (2014). The Cost Savings Potential of Biosimilar Drugs in the United States. Santa-Monica The Rand**:** 15 , tabl., fig.
http://www.rand.org/pubs/perspectives/PE127.html

The U.S. Food and Drug Administration (FDA) is expected to release final regulations outlining lower-cost approval pathway requirements for so-called biosimilar drugs. The introduction of biosimilars is expected to reduce prices, albeit to a lesser degree than small-molecule generics. This Perspective combines prior research and recent data to estimate cost savings in the U.S. market. We predict that biosimilars will lead to a $44.2 billion reduction in direct spending on biologic drugs from 2014 to 2024, or about 4 percent of total biologic spending over the same period, with a range of $13 billion to $66 billion. While our estimate uses recent data and transparent assumptions, we caution that actual savings will hinge on the specifics of the final FDA regulations and on the level of competition.

Nowak, S. A., et al. (2014). "Effects of the Affordable Care Act on Consumer Health Care Spending and Risk of Catastrophic Health Costs." Rand Health Q **3**(4): 3.

This study examines the likely effects of the Affordable Care Act (ACA) on average annual consumer health care spending and the risk of catastrophic medical costs for the United States overall and in two large states that have decided not to expand their Medicaid programs (Texas and Florida). The ACA will have varied impacts on individuals' and families' spending on health care, depending on income level and on estimated 2016 insurance status without the ACA. The authors find that average out-of-pocket spending is expected to decrease for all groups considered in the analysis, although decreases in out-of-pocket spending will be largest for those who would otherwise be uninsured. People who would otherwise be uninsured who transition to the individual market under the ACA will have higher total health care spending on average after implementation of the ACA because they will now incur the cost of health insurance premiums. The authors also find that risk of catastrophic health care spending will decrease for individuals of all income levels for the insurance transitions considered; decreases will be greatest for those at the lowest income levels. Case studies found that in Texas and Florida, Medicaid expansion would substantially reduce out-of-pocket and total health care spending for those with incomes below 100 percent of the federal poverty level, compared with a scenario in which the ACA is implemented without Medicaid expansion. Expansion would reduce the risk of high medical spending for those covered under Medicaid who would remain uninsured without expansion.

OCDE (2014). Health at a Glance - Europe 2014. Paris OCDE**:** 139, ann., graph., tabl.
http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2014_health_glance_eur-2014-en

This third edition of Health at a Glance: Europe presents a set of key indicators related to health status, determinants of health, health care resources and activities, quality of care, access to care, and health expenditure and financing in 35 European countries, including the 28 European Union member states, four candidate countries and three EFTA countries. The selection of indicators is based largely on the European Core Health Indicators (ECHI) shortlist, a set of indicators that has been developed to guide the reporting of health statistics in the European Union. This is complemented by additional indicators on quality of care, access to care and health expenditure, building on the OECD expertise in these areas. Compared with the previous edition, this third edition includes a greater number of ECHI indicators, reflecting progress in the availability of comparable data in the areas of non-medical determinants of health and access to care. It also includes a new chapter dedicated to access to care, including selected indicators on financial access, geographic access and timely access.

Ozgen, N. H., et al. (2014). "Financial catastrophe and poverty impacts of out-of-pocket health payments in Turkey." Eur J Health Econ.
http://www.ncbi.nlm.nih.gov/pubmed/24566703

OBJECTIVE: To determine the prevalence of catastrophic health payments, examine the determinants of catastrophic expenditures, and assess the poverty impact of out-of-pocket (OOP) payments. METHODS: Data came from the 2004 to 2010 Household Budget Survey. Catastrophic health spending was defined by health payments as percentage of household consumption expenditures and capacity to pay at a set of thresholds. The poverty impact was evaluated by poverty head counts and poverty gaps before and after OOP health payments. RESULTS: The percentage of households that catastrophically spent their consumption expenditure and capacity to pay increased from 2004 to 2010, regardless of the threshold used. Households with a share of more than 40 % health spending in both consumption expenditure and capacity to pay accounted for less than 1 % across years. However, when a series of potential confounders were taken into account, the study found statistically significantly increased risk for the lowest threshold and decreased risk for the highest threshold in 2010 relative to the base year. Household income, size, education, senior and under 5-year-old members, health insurance, disabled members, payment for inpatient care and settlement were also statistically significant predictors of catastrophic health spending. Overall, poverty head counts were below 1 %. Poverty gaps reached a maximum of 0.098 %, with an overall increase in 2010 compared to 2004. CONCLUSIONS: Catastrophe and poverty increased from 2004 to 2010. However, given that the realization of some recent policies will affect the financial burden of OOP payments on households, the findings of this study need to be replicated

Poulsen, C. A. (2014). "Introducing out-of-pocket payment for general practice in Denmark: feasibility and support." Health Policy **117**(1): 64-71.

AIMS: The financing of General Practice (GP) is a much-debated topic. In spite of out-of-pocket (OOP) payment for other primary health care provided by self-employed professionals, there is no OOP payment for the use of GP in Denmark. This article aims to explore the arguments, the actors and the decision-making context. METHODS AND MATERIALS: An analysis of the healthcare-policy debate in Parliament and the media from 1990 until September 2012. The materials are parliamentary hearings/discussions and newspaper articles. Kingdon's model on Policy Windows and the Advocacy Coalition framework by Sabatier and Jenkins are used to investigate explanations. RESULTS: The arguments from the proponents are: that OOP payment for GP will reduce pressure on the primary sector; that the current allocation of OOP payment in the sector is historically conditioned; and that resistance towards OOP payment is based on emotions. The main argument from the opponents is that OOP payment will increase social inequality in health. CONCLUSIONS: There is little connection between the attitudes and ideological backgrounds of the political parties. Despite factors such as perceived expert/scientific evidence for OOP payment, changes of government, financial crisis and a market-based reform wave, no government has introduced OOP payment for GP. This article suggests that governmental positions, public- and especially health-professional support are important factors in the decision-making context

Richards, M. R. et Marti, J. (2014). "Heterogeneity in the smoking response to health shocks by out-of-pocket spending risk." Health Econ Policy Law **9**(4): 343-357.

An existing literature demonstrates that adverse changes to health can lead to improvements in health behaviors. Although the exact explanations for these empirical findings are debated, some posit that individuals learn about their true health risks through health shocks. Updated health risk information can then induce changes in health behaviors. While we follow a learning framework, we argue that past work has neglected the role of health insurance and medically related financial risk within this decision making context. Using longitudinal data from 11 European countries, we investigate the impact of a new cardiovascular (CV) health shock on smoking decisions among older adults and examine whether personal exposure to medical spending risk influences the smoking response. We then explore two potential mechanisms for this link: larger updates to health risk beliefs and higher medical expenditures to incentivize behavior change. We find that CV shocks impact the propensity to smoke, with relatively more impact among individuals with high financial risk exposure to medical spending. We also see larger increases in out-of-pocket expenditures following a shock for this group - consistent with the latter mechanism for behavior change

Robinson, S. W., et al. (2014). "An early examination of access to select orphan drugs treating rare diseases in health insurance exchange plans." J Manag Care Spec Pharm **20**(10): 997-1004.

BACKGROUND: Patients with rare diseases often face significant health care access challenges, particularly since the number of available treatment options for rare diseases is limited. The implementation of health insurance exchanges promises improved access to health care. However, when purchasing a plan, patients with rare diseases need to consider multiple factors, such as insurance premium, access to providers, coverage of a specific medication or treatment, tier placement of drug, and out-of-pocket costs. OBJECTIVE: To provide an early snapshot of the exchange plan landscape from the perspective of patients with select rare diseases by evaluating the degree of access to medications in a subset of exchange plans based on coverage, tier placement, associated cost sharing, and utilization management (UM) applied. METHODS: The selection of drugs for this analysis began by identifying rare diseases with FDA-approved treatment options using the National Institutes of Health Office of Rare Diseases' webpage and further identification of a subset of drugs based on select criteria to ensure a varied sample, including the characteristics and prevalence of the condition. The medications were categorized based on whether alternative therapies have FDA approval for the same indication and whether there are comparators based on class or therapeutic area. The list was narrowed to 11 medications across 7 diseases, and the analysis was based on how these drugs are listed in exchange plan outpatient pharmacy benefit formularies. This analysis focused on 84 plans in 15 states with the highest expected exchange enrollment and included a variety of plan types to ensure that variability in the marketplace was represented. To best approximate plans that will have the greatest enrollment, the analysis focused on silver and bronze plan formularies because consumers in this market are expected to be sensitive to premiums. Data on drug coverage, tier placement, cost, and UM were collected from these plans beginning October 1, 2013, with the launch of the open enrollment period. RESULTS: Coverage and use of UM for selected medications vary within and across states. This study found that bronze plans were far less likely than silver plans to cover the 11 products included in this analysis. Results also showed that select drugs identified as the only FDA-approved product indicated for a certain rare disease experienced relatively robust coverage (at least 65% of plans) but often included some form of UM. However, coverage of selected rare disease therapies also is complicated by the fact that plans cover certain products under the medical benefit versus the pharmacy benefit. At the time of this analysis, transparency of medical benefit coverage for these products in exchange plans was limited.Selected medications are most likely to appear on the highest tiers of 4-tier formularies or are not covered at all. Although there are no requirements to designate certain tiers as "specialty tiers," more than 70% of plans in this study use coinsurance for the highest tiers of their formularies. Rates of coinsurance for medications on highest tiers range from 10% to 50% in silver plans and 15% to 50% in bronze plans. Among those plans utilizing copayments rather than coinsurance, ranges of copayments for these select products vary between $20 and $250 per prescription across both silver plans and bronze plans. CONCLUSIONS: This preliminary analysis of access to treatments for patients with select rare diseases revealed the complexities involved for patients with specific needs when selecting a plan with appropriate coverage. For patients with rare diseases, the process of identifying and selecting a plan centers on understanding if and how the plan covers a specific treatment or set of treatments. Access factors will likely vary substantially across plans, as demonstrated by the findings from this analysis. With limited treatment options and the potential for cost sharing and UM barriers, increased data transparency to assist patients in navigating formularies will be a critical step for patients to fully understand their access to needed therapies in each plan.

Saksena, P., et al. (2014). "Inputs for universal health coverage: a methodological contribution to finding proxy indicators for financial hardship due to health expenditure." BMC Health Serv Res **14**: 577.

BACKGROUND: Universal health coverage is high on national health agendas of many countries at the moment. Absence of financial hardship is a key component of universal health coverage and should be monitored regularly. However, relevant household survey data, which is traditionally needed for this analysis is not frequently collected in most countries and in some countries, has not been collected at all. As such, proxy indicators for financial hardship would be very useful. METHODS: We use data from the World Health Survey and use multi-level modeling with national and household level characteristics to see which indicators have a consistent and robust relationship with financial hardship. To strengthen the validity of our findings, we also use different measures of financial hardship. RESULTS: There are several household level characteristics that seem to have a consistent relationship with financial hardship. However there is only one strong candidate for a proxy indicator at the national level- the share of out-of-pocket payments in total health expenditure. Additionally, the Gini coefficient of total household expenditure was also correlated to financial hardship in most of our models. CONCLUSION: The national level indicators related only weakly to the risk of financial hardship. Hence, there should not be an over-reliance on them and collecting good quality household survey data is still a superior option for monitoring financial hardship.

Sanwald, A. et Theurl, E. (2014). What drives out-of pocket health expenditures of private households? Empirical evidence from the Austrian household budget survey. Working Papers in Economics and Statistics ; 2014-04. Innsbruck University of Innsbruck**:** 38 , tabl., graph., fig.
http://eeecon.uibk.ac.at/wopec2/repec/inn/wpaper/2014-04.pdf

Out-of-pocket health expenditures (OOPHE) are a substantial source of health care financing even in health care systems with an established role of prepaid financing. The empirical analysis of OOPHE is challenging, because they are fixed in an interaction with other sources of health care financing. This studye analyzes to what extent a set of socio-economic and socio-demographic covariates of private households in influences the OOPHE-patterns in Austria. Its empirical research strategy is guided by the approach Propper (2000) used to study the demand for private health care in the NHS. The study uses cross-sectional information provided by the Austrian household budget survey 2009/10. It applies a Two-Part Model (Logit/OLS with log-transformed dependent variable or Logit/GLM). It presents results for total OOPHE and for selected OOPHE-subcategories. Overall, it finds mixed results for the different expenditure categories and for the two decision stages. Probability and level of OOPHE increase with the household size and the level of education, while household income shows mixed results on both stages. Private health insurance and OOPHE seem to be complements, at least for total OOPHE and for OOPHE for physician services, while this relationship is insignificant for pharmaceuticals. Different forms of public insurance have an effect on the total OOPHE-level, for physician services and pharmaceuticals on both stages. To some extent the participation decision is influenced in a different way compared to the intensity decision. This is especially true for age, sex, household structure and the status of retirement. It turns out, that the explanatory power of the used variables is low for OOPHE for pharmaceuticals. A splitting up of pharmaceuticals into prescription fees and direct payments gives better insights into the determinants. We conclude: It is necessary to investigate subcategories of OOPHE. It also turns out, that systematic covariates explain only a very small part of the variation in the OOPHE-patterns. Finally, the study also concludes that information on OOPHE from general household budget surveys are of limited value when studying the determinants.

Shigeoka, H. (2014). "The Effect of Patient Cost Sharing on Utilization, Health, and Risk Protection." American Economic Review **104**(7): 2152-2184.
http://search.ebscohost.com/login.aspx?direct=true&db=ecn&AN=1441092&lang=fr&site=ehost-live
http://dx.doi.org/10.1257/aer.104.7.2152

This paper exploits a sharp reduction in patient cost sharing at age 70 in Japan, using a regression discontinuity design to examine its effect on utilization, health, and financial risk arising from out-of-pocket expenditures. Due to the national policy, cost sharing is 60-80 percent lower at age 70 than at age 69. I find that both outpatient and inpatient care are price sensitive among the elderly. While I find little impact on mortality and other health outcomes, the results show that reduced cost sharing is associated with lower out-of-pocket expenditures, especially at the right tail of the distribution.

Shishkin, S., et al. (2014). Out-of-Pocket Payments in the Post-Semashko Health Care System. Higher School of Economics Research Paper No. WP BRP 14/PA/2014. Moscou HSE**:** 36 , tabl., fig.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2427217

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.

Van Den Bosch., K. et Willeme, P. (2014). La signification sociale des soins de santé. Bruxelles Bureau Fédéral du Plan**:** 115 , fig., tabl.
http://www.plan.be/admin/uploaded/201402041408160.INAMI_rapport_final.pdf

Le présent rapport tente de rendre compte de la signification sociale des soins de santé et de l'assurance publique soins de santé en Belgique. Pour ce faire, nous abordons trois questions plus spécifiques. La première est la suivante : de quelle manière les soins de santé ont-ils contribué à améliorer l'état de santé de la population ? Cette question sort en quelque sorte du cadre strict de l'assurance publique soins de santé gérée par l'INAMI. En effet, l'amélioration de la santé n'a pas explicitement été citée comme objectif de la sécurité sociale, ni en 1944/5 ni en 1963. Dans un même temps, il paraît évident que les partenaires sociaux n'ont organisé la protection sociale contre le coût des soins de santé que parce qu'ils partaient (implicitement) du principe que cette protection serait au bénéfice de la santé de la population. Compte tenu de la formidable expansion des soins de santé et des dépenses découlant de l'assurance obligatoire soins de santé après 1963 (voir ci-après), l'on peut légitimement se demander dans quelle mesure les soins de santé ont effectivement contribué à améliorer l'état de santé de la population. Ce rapport montre qu'il n'est pas si évident de répondre à cette question. La deuxième question a trait à la signification économique de la branche des soins de santé. Trop souvent, les soins de santé publics sont considérés comme un coût et un poids économique, alors qu'ils représentent aussi une branche qui propose des services de valeur et qui emploie de nombreux travailleurs. En outre, les soins de santé peuvent être considérés comme un investissement en capital humain qui profite à la fois au bien-être individuel et national. La troisième question qui est posée est de savoir si les soins de santé et l'assurance maladie publique ont contribué à une distribution égalitaire de la santé, une égalité d'accès aux soins de santé et plus généralement une distribution plus égalitaire des ressources et opportunités. En effet, les objectifs explicites du système public de soins de santé et de l'assurance maladie obligatoire étaient l'accès universel aux soins de santé, avec une répartition solidaire des coûts. Un chapitre distinct est consacré aux indemnités de maladie ou d'invalidité. Enfin, le dernier chapitre rassemble les conclusions des différents chapitres. (tiré de l'intro).

Yardim, M. S., et al. (2014). "Financial protection in health in Turkey: the effects of the Health Transformation Programme." Health Policy Plan **29**(2): 177-192.
http://www.ncbi.nlm.nih.gov/pubmed/23411120

Financial protection should be the principal objective of any health system. Commonly used indicators for financial protection are out-of-pocket (OOP) payments as a share of total health expenditure and the amount of households driven into poverty by catastrophic health expenditures (CHEs). In the last decade, OOP health payments consisted of approximately one-fifth of the health finance resources in Turkey. Until the year 2008, Turkish health system covered different public and private financing programmes as well as different types of service provision. After 2008, universal financial coverage became a part of the Health Transformation Programme (HTP). This study aimed to evaluate the financial protection in health in the era of health reforms in Turkey between 2003 and 2009. Household expenditures were derived from nationally representative Turkish Household Budget Surveys (HBSs), 2003, 2006 and 2009. Proportion of households facing CHE and impoverishment are calculated by using the methodology proposed by Ke Xu. Probability of incurring and volume of OOP spending were assessed across the health insurance groups by two-part model approach using logistic and OLS regression methods. Our findings showed that the probability of incurring and volume of OOP spending increased gradually in publicly insured households between 2003 and 2009. However, there was a diminishing trend in CHE in Turkey during the period under consideration. The official data showing an approximately 3-fold increase in per capita health care use since 2003 and our study findings on decreasing CHE in this period can be interpreted as positive impact of HTP. On the other hand, increased household consumption as a share of OOP health payment and the deterioration in the progressivity of OOP spending in this period should be monitored closely

2013

OMS (2013). The European health report 2013: research for universal health coverage. Santé. Copenhague : OMS
http://apps.who.int/iris/bitstream/10665/85761/2/9789240690837_eng.pdf

Universal health coverage, with full access to high-quality services for health promotion, prevention, treatment, rehabilitation, palliation and financial risk protection, cannot be achieved without evidence from research. Research has the power to address a wide range of questions about how we can reach universal coverage, providing answers to improve human health, well-being and development. All nations should be producers of research as well as consumers. The creativity and skills of researchers should be used to strengthen investigations not only in academic centres but also in public health programmes, close to the supply of and demand for health services. Research for universal health coverage requires national and international backing. To make the best use of limited resources, systems are needed to develop national research agendas, to raise funds, to strengthen research capacity, and to make appropriate and effective use of research findings (4e de couverture)

Arsenijevic, J., et al. (2013). "Measuring the catastrophic and impoverishing effect of household health care spending in Serbia." Soc Sci Med **78**: 17-2
5.
http://www.ncbi.nlm.nih.gov/pubmed/23267776

Out-of-pocket patient payments can impose a catastrophic burden on households. This problem may not only affect poor but also wealthy households who need to use health care frequently. The available literature offers no consensus on how to measure poverty and how to measure the effects of out-of-pocket payments on household budgets. The objective of this paper is to contribute to current research in this area by comparing results across different approaches. In particular, the paper examines the catastrophic and impoverishing effects of health care spending in Serbia applying different types of thresholds used in previous research. The application of various approaches allows us to analyze the robustness and convergent validity of the results. We also include the subjective poverty approach in our examination. We use household data from the Serbian Living Standard Measurement Study (LSMS). The Serbian LSMS data were collected in 2007 and consists of 17,375 participants living in 5557 households (sample representative for Serbia). Our results indicate that irrespective of the approach applied, out-of-pocket patient payments have a catastrophic effect on poor households in Serbia. Moreover, households that are above the absolute, relative and subjective poverty lines respectively, after the subtraction of out-of-pocket payments fall below these poverty lines. The probability of catastrophic out-of-pocket patient payments is higher in rural areas, in larger households, and among chronically sick household members (namely, people with diabetes and mental diseases, as well as cardiology diseases in some instances). Perceived health status also appears to be a significant indicator. Policy in Serbia should aim to protect vulnerable groups, especially chronically sick patients and people from rural areas

Atanasova, E., et al. (2013). "Out-of-pocket payments for health care services in Bulgaria: financial burden and barrier to access." The European Journal of Public Health **23**(6): 916-922.
http://eurpub.oxfordjournals.org/content/23/6/916.abstract

Background: In recent years, Bulgaria has increasingly relied on out-of-pocket payments as one of the main sources of health care financing. However, it is largely unknown whether the official patient charges, combined with informal payments, are affordable for the population. Our study aimed to explore the scale of out-of-pocket payments for health care services and their affordability. Methods: Data were collected in two nationally representative surveys, conducted in Bulgaria in 2010 and 2011, using face-to-face interviews based on a standardized questionnaire. To select respondents, a multi-stage random probability method was used. The questionnaire included questions on the out-of-pocket payments for health care services used by the respondent during the preceding 12 months. Results: In total, 75.7% (2010) and 84.0% (2011) of outpatient service users reported to have paid out-of-pocket, with 12.6% (2010) and 9.7% (2011) of users reporting informal payments. Of those who had used inpatient services, 66.5% (2010) and 63.1% (2011) reported to have made out-of-pocket payments, with 31.8% (2010) and 18.3% (2011) reporting to have paid informally. We found large inability to pay indicated by the need to borrow money and/or forego services. Regression analysis showed that the inability to pay is especially pronounced among those with poor health status and chronic diseases and those on low household incomes. Conclusion: The high level of both formal and informal out-of-pocket payments for health care services in Bulgaria poses a considerable burden for households and undermines access to health services for poorer parts of the population

Baicker, K., et al. (2013). "The Oregon experiment--effects of Medicaid on clinical outcomes." N Engl J Med **368**(18): 1713-1722.
http://www.ncbi.nlm.nih.gov/pubmed/23635051

BACKGROUND: Despite the imminent expansion of Medicaid coverage for low-income adults, the effects of expanding coverage are unclear. The 2008 Medicaid expansion in Oregon based on lottery drawings from a waiting list provided an opportunity to evaluate these effects. METHODS: Approximately 2 years after the lottery, we obtained data from 6387 adults who were randomly selected to be able to apply for Medicaid coverage and 5842 adults who were not selected. Measures included blood-pressure, cholesterol, and glycated hemoglobin levels; screening for depression; medication inventories; and self-reported diagnoses, health status, health care utilization, and out-of-pocket spending for such services. We used the random assignment in the lottery to calculate the effect of Medicaid coverage. RESULTS: We found no significant effect of Medicaid coverage on the prevalence or diagnosis of hypertension or high cholesterol levels or on the use of medication for these conditions. Medicaid coverage significantly increased the probability of a diagnosis of diabetes and the use of diabetes medication, but we observed no significant effect on average glycated hemoglobin levels or on the percentage of participants with levels of 6.5% or higher. Medicaid coverage decreased the probability of a positive screening for depression (-9.15 percentage points; 95% confidence interval, -16.70 to -1.60; P=0.02), increased the use of many preventive services, and nearly eliminated catastrophic out-of-pocket medical expenditures. CONCLUSIONS: This randomized, controlled study showed that Medicaid coverage generated no significant improvements in measured physical health outcomes in the first 2 years, but it did increase use of health care services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain.

Bixenstine, P. J., et al. (2013). "Catastrophic Medical Malpractice Payouts in the United States." J Healthc. Qual.
http://www.ncbi.nlm.nih.gov/pubmed/23551334

Catastrophic medical malpractice payouts, $1 million or greater, greatly influence physicians' practice, hospital policy, and discussions of healthcare reform. However, little is known about the specific characteristics and overall cost burden of these payouts. We reviewed all paid malpractice claims nationwide using the National Practitioner Data Bank over a 7-year period (2004-2010) and used multivariate regression to identify risk factors for catastrophic and increased overall payouts. Claims with catastrophic payouts represented 7.9% (6,130/77,621) of all paid claims. Factors most associated with catastrophic payouts were patient age less than 1 year; quadriplegia, brain damage, or lifelong care; and anesthesia allegation group. Compared with court judgments, settlement was associated with decreased odds of a catastrophic payout (odds ratio, 0.31; 95% confidence interval [CI], 0.22-0.42) and lower estimated average payouts ($124,863; 95% CI, $101,509-144,992). A physician's years in practice and previous paid claims history had no effect on the odds of a catastrophic payout. Catastrophic payouts averaged $1.4 billion per year or 0.05% of the National Health Expenditures. Preventing catastrophic malpractice payouts should be only one aspect of comprehensive patient safety and quality improvement strategies. Future studies should evaluate the benefits of targeted interventions based on specific patient safety event characteristics.

Clemans-Cope, L., et al. (2013). "The expansion of Medicaid coverage under the ACA: implications for health care access, use, and spending for vulnerable low-income adults." Inquiry **50**(2): 135-149.

The expansion of Medicaid coverage under the Affordable Care Act offers the potential for significant increases in health care access, use, and spending for vulnerable nonelderly adults who are uninsured. Using pooled data from the Medical Expenditure Panel Survey, this study estimates the potential effects of Medicaid, controlling for individual and local community characteristics. Our findings project significant gains in health care access and use for uninsured adults who enroll in Medicaid coverage and have chronic health conditions and mental health conditions. With that increased use, annual per capita health care spending for those newly insured individuals (excluding out-of-pocket spending) is projected to grow from $2,677 to $6,370 in 2013 dollars, while their out-of-pocket spending would drop by $921. It is expected that these increases in spending would be offset at least in part by reductions in uncompensated care and charity care.

Davis, K., et al. (2013). "Medicare essential: an option to promote better care and curb spending growth." Health Aff. (Millwood.) **32**(5): 900-909.
http://www.ncbi.nlm.nih.gov/pubmed/23650323

Medicare's core benefit design reflects private insurance as of 1965, with separate coverage for hospital and physician services (and now prescription drugs) and no protection against catastrophic costs. Modernizing Medicare's benefit design to offer comprehensive benefits, financial protection, and incentives to choose high-value care could improve coverage and lower beneficiary costs. We describe a new option we call Medicare Essential, which would combine Medicare's hospital, physician, and prescription drug coverage into an integrated benefit with an annual limit on out-of-pocket expenses for covered benefits. Cost sharing would be reduced for enrollees who seek care from high-quality low-cost providers. Out-of-pocket savings from lower premiums and health care costs for a Medicare Essential enrollee could be $173 per month, compared to what an enrollee would pay with traditional Medicare, prescription drug and private supplemental coverage. Financed by a budget-neutral premium, we estimate that this new plan choice could reduce total health spending relative to current projections by $180 billion and reduce employer retiree spending by $90 billion during 2014-23. Given its potential, such an alternative should be a part of the debate over the future of Medicare

Delavande, A., et al. (2013). "Dementia and out-of-pocket spending on health care services." Alzheimers & Dementia **9**(1): 19-29.

Background : High levels of out-of-pocket (OOP) spending for health care may lead patients to forego needed services and medications as well as hamper their ability to pay for other essential goods. Because it leads to disability and the loss of independence, dementia may put patients and their families at risk for high OOP spending, especially for long-term care services. Methods : We used data from the Aging, Demographics, and Memory Study, a nationally representative subsample (n = 743) of the Health and Retirement Study, to determine whether individuals with dementia had higher self-reported OOP spending compared with those with cognitive impairment without dementia and those with normal cognitive function. We also examined the relationship between dementia and utilization of dental care and prescription medications-two types of health care that are frequently paid for OOP. Multivariate and logistic regression models were used to adjust for the influence of potential confounders.

Farbmacher, H. et Winter, J. (2013). "Per-period co-payments and the demand for health care: evidence from survey and claims data." Health Econ **22**(9): 1111-1123.

When health insurance reforms involve non-linear price schedules tied to payment periods (for example, fees levied by quarter or year), the empirical analysis of its effects has to take the within-period time structure of incentives into account. The analysis is further complicated when demand data are obtained from a survey in which the reporting period does not coincide with the payment period. We illustrate these issues using as an example a health care reform in Germany that imposed a per-quarter fee of euro10 for doctor visits and additionally set an out-of-pocket maximum. This co-payment structure results in an effective 'spot' price for a doctor visit that decreases over time within each payment period. Taking this variation into account, we find a substantial reform effect-especially so for young adults. Overall, the number of doctor visits decreased by around 9% in the young population. The probability of visiting a physician in any given quarter decreased by around 4 to 8 percentage points.

Flores, G. et O'Donnell, O. (2013). Catastrophic Medical Expenditure Risk.

Medical expenditure risk can pose a major threat to living standards. We derive decomposable measures of catastrophic medical expenditure risk from reference-dependent utility with loss aversion. We propose a quantile regression based method of estimating risk exposure from cross-section data containing information on the means of financing health payments. We estimate medical expenditure risk in seven Asian countries and find it is highest in Laos and China, and is lowest in Malaysia. Exposure to risk is generally higher for households that have less recourse to self-insurance, lower incomes, wealth and education, and suffer from chronic illness.

Nan-Ping, Y., et al. (2013). "Comparisons of medical utilizations and categorical diagnoses of emergency visits between the elderly with catastrophic illness certificates and those without." BMC Health Serv Res **13**: 152.
http://www.ncbi.nlm.nih.gov/pubmed/23622501

BACKGROUND: In Taiwan, the policy of catastrophic illness certificates has benefited some populations with specific diseases, but its effect on the use of medical services and the sequence of public health has not been examined. As a pilot of a series of studies, focused on emergency department (ED) visits, the present study aimed to compare medical utilization and various diagnostic categories at EDs between the elderly with an identified catastrophic illness and the elderly without. METHODS: A cross-sectional study, based on a large-sample nationwide database (one million of the population, randomly sampled from Taiwan's National Health Insurance Research Database (NHIRD)), was performed in Taiwan. The 2008 insurance records of ambulatory medical services for subjects aged 65 years or more among the above one million of the population were further selected and analyzed. Taiwan's registered catastrophic illness dataset for 2008 was linked in order to identify the target subgroup. RESULTS: The prevalence of certificated catastrophic illness in Taiwan's elderly utilizing ambulatory medical services was 10.16%. On average, 61.62 emergency department (ED) visits/1,000 persons (95% CI: 59.22-64.01) per month was estimated for the elderly Taiwanese with catastrophic illness, which was significantly greater than that for the elderly without a catastrophic illness (mean 33.53, 95% CI: 32.34-34.71). A significantly greater total medical expenditure for emergency care was observed in the catastrophic illness subgroup (US$145.6 +/- 193.5) as compared with the non-catastrophic illness group (US$108.7 +/- 338.0) (p < 0.001). The three most common medical problems diagnosed when visiting EDs were injury/poisoning (14.22%), genitourinary disorders (11.26%) and neoplasm-related morbidity (10.77%) for the elderly population with a catastrophic illness, which differed from those for the elderly without a catastrophic illness. CONCLUSIONS: In Taiwan, the elderly with any certificated catastrophic illness had significantly more ED visits and a higher ED medical cost due to untypical medical complaints

Rezayatmand, R., et al. (2013). "The impact of out-of-pocket payments on prevention and health-related lifestyle: a systematic literature review." The European Journal of Public Health **23**(1): 74-79.
http://eurpub.oxfordjournals.org/content/23/1/74.abstract

Background: Out-of-pocket payments can have a large impact on the demand for healthcare. They can be essential not only to decrease unnecessary service use, but also to encourage the use of particular preventive services provided free of charge or at a lower price. Moreover, out-of-pocket payments may increase the costs of unhealthy behaviour and provide incentives for a healthier lifestyle. Method: This study systematically reviews empirical evidence on the effects of out-of-pocket payments on the use of preventive services and health-related lifestyle. All possible combinations of three key words ƒ_~preventionƒ_T, ƒ_~patient paymentƒ_T and ƒ_~health-related behaviourƒ_T were searched in PUBMED, ECONLITH, ECONPAPER and EMBASE. In total, 47 relevant publications were identified. Results: The results suggest that out-of-pocket payments can create a financial barrier and can decrease the use of preventive services and the uptake of preventive medications. A few studies (with contradicting empirical evidence) address the impact of cost sharing and reduced insurance coverage on a healthier lifestyle. Conclusion: Although the great diversity of study designs (various indicators of out-of-pocket payments and preventive/health-related behaviour) makes it difficult to offer robust policy recommendations, our findings support calls to reconsider how preventive services should be financed. More research is needed to explore the actual impact of cost sharing on different aspects of health-related lifestyles, as well as to explain the role of other relevant determinants that could impact this relationship.

Thiebaut, S. P., et al. (2013). "Ageing, Chronic Conditions and the Evolution of Future Drugs Expenditure: A Five-Year Micro-simulation from 2004 to 2029." Applied Economics **45**(13-15): 1663-1672.

The healthy ageing assumptions may lead to substantial changes in paths of aggregate health care expenditure, notably catastrophic expenditure of people at the end of the life. But clear assessments of involved amounts are not available when we specifically consider ambulatory care (as drug expenditure) generally offered to chronically-ill people. We estimate the effects of epidemiological and life expectancy changes on French health expenditure until 2029 by applying a Markovian micro-simulation model from a nationally representative database. The originality of these simulations holds in using an aggregate indicator of morbidity-mortality, capturing vital risk and making it possible to adapt the quantification of life expectancies by taking into account the presence of severe chronic pathologies. We forecast future national drugs expenditure, under different epidemiological scenarios of chronic morbidity: trend scenario, healthy ageing scenario and medical progress scenario. For the population aged 25+, results predict an increase in reimbursable drug expenditure of between 1.1% and 1.8% (annual growth rate), attributable solely to the ageing population and changes in health status

Tomini, S. M., et al. (2013). "Catastrophic and Impoverishing Effects of Out-of-Pocket Payments for Health Care in Albania: Evidence from Albania Living Standards Measurement Surveys 2002, 2005 and 2008." Health Policy and Planning **28**(4): 419-428.
http://heapol.oxfordjournals.org/content/by/year

The absence of or poorly functioning risk pooling mechanisms and high amounts of out-of-pocket payments for health care expose households to financial risks associated with major illnesses or accidents. The aim of this article is to analyse the extent to which out-of-pocket health spending impoverishes households in Albania. The study augments existing evidence by analysing the dynamics of such payments over different years and the weight that informal payments have in the total out-of-pocket health spending. The data used in the study come from the Albania Living Standards Measurement Survey (ALSMS) for 2002, 2005 and 2008. We measure headcount catastrophic payments using different thresholds and the decomposition of indicators by expenditure quintiles to better understand their effects. We find that out-of-pocket and informal payments have increased in real value throughout the years. Even though their catastrophic effect has gone down (due also to declining trends in absolute poverty), the effect for the poorest expenditure quintiles remains high. Out-of-pocket payments deepen the poverty headcount and also enlarge the poverty gap and again the effect is larger for the poorest quintiles. Future policy interventions should provide better protection mechanisms for the poor by providing exemption criteria or subsidized transport. They should also seek to address the widespread informal payments in the country

van Dijk, C. E., et al. (2013). "Moral hazard and supplier-induced demand: empirical evidence in general practice." Health Econ **22**(3): 340-352.

Changes in cost sharing and remuneration system in the Netherlands in 2006 led to clear changes in financial incentives faced by both consumers and general practitioner (GPs). For privately insured consumers, cost sharing was abolished, whereas those socially insured never faced cost sharing. The separate remuneration systems for socially insured consumers (capitation) and privately insured consumers (fee-for-service) changed to a combined system of capitation and fee-for-service for both groups. Our first hypothesis was that privately insured consumers had a higher increase in patient-initiated GP contact rates compared with socially insured consumers. Our second hypothesis was that socially insured consumers had a higher increase in physician-initiated contact rates. Data were used from electronic medical records from 32 GP-practices and 35336 consumers in 2005-2007. A difference-in-differences approach was applied to study the effect of changes in cost sharing and remuneration system on contact rates. Abolition of cost sharing led to a higher increase in patient-initiated utilisation for privately insured consumers in persons aged 65 and older. Introduction of fee-for-service for socially insured consumers led to a higher increase in physician-initiated utilisation. This was most apparent in persons aged 25 to 54. Differences in the trend in physician-initiated utilisation point to an effect of supplier-induced demand. Differences in patient-initiated utilisation indicate limited evidence for moral hazard.

Wharam, J. F., et al. (2013). "Low-socioeconomic-status enrollees in high-deductible plans reduced high-severity emergency care." Health Aff (Millwood) **32**(8): 1398-1406.

One-third of US workers now have high-deductible health plans, and those numbers are expected to grow in 2014 as implementation of the Affordable Care Act continues. There is concern that high-deductible health plans might cause enrollees of low socioeconomic status to forgo emergency care as a result of burdensome out-of-pocket costs. We analyzed emergency department (ED) visits and hospitalizations over two years among enrollees insured in high-deductible plans through small employers in Massachusetts. We found that plan members of low socioeconomic status experienced 25-30 percent reductions in high-severity ED visits over both years, while hospitalizations declined by 23 percent in year 1 but rose again in year 2. Similar trends were not found among high-deductible plan members of high socioeconomic status. Our findings suggest that plan members of low socioeconomic status at small firms responded inappropriately to high-deductible plans and that initial reductions in high-severity ED visits might have increased the need for subsequent hospitalizations. Policy makers and employers should consider proactive strategies to educate high-deductible plan members about their benefit structures or identify members at higher risk of avoiding needed care. They should also consider implementing means-based deductibles.

Yegian, J. M., et al. (2013). "Engaged patients will need comparative physician-level quality data and information about their out-of-pocket costs." Health Aff (Millwood) **32**(2): 328-337.

For patients to be engaged, they will need meaningful and comparable information about the quality and cost of health care. We conducted a literature review and key-informant interviews, reviewed selected online reporting tools, and found that quality and cost reporting fell into two categories. One emphasizes public reporting of information, supported by philanthropic or government institutions that aim to improve provider quality and efficiency. The other is characterized by proprietary websites that aim to provide personalized, integrated information on cost and quality to support consumers' decision making on providers and services. What consumers seem to want is quality data at the physician level and cost data that reflect their personal out-of-pocket exposure. These needs will be acute under the coverage expansions inherent in the Affordable Care Act. State and federal policy thus should support all-payer claims databases, standards for electronic health records to facilitate sharing of quality data, and a unified approach to presenting information that prioritizes consumers' needs.

Zoidze, A., et al. (2013). "Promoting universal financial protection: health insurance for the poor in Georgia--a case study." Health Res Policy Syst **11**: 45.
http://www.ncbi.nlm.nih.gov/pubmed/24228796

BACKGROUND: The present study focuses on the program "Medical Insurance for the Poor (MIP)" in Georgia. Under this program, the government purchased coverage from private insurance companies for vulnerable households identified through a means testing system, targeting up to 23% of the total population. The benefit package included outpatient and inpatient services with no co-payments, but had only limited outpatient drug benefits. This paper presents the results of the study on the impact of MIP on access to health services and financial protection of the MIP-targeted and general population. METHODS: With a holistic case study design, the study employed a range of quantitative and qualitative methods. The methods included document review and secondary analysis of the data obtained through the nationwide household health expenditure and utilisation surveys 2007-2010 using the difference-in-differences method. RESULTS: The study findings showed that MIP had a positive impact in terms of reduced expenditure for inpatient services and total household health care costs, and there was a higher probability of receiving free outpatient benefits among the MIP-insured. However, MIP insurance had almost no effect on health services utilisation and the households' expenditure on outpatient drugs, including for those with MIP insurance, due to limited drug benefits in the package and a low claims ratio. In summary, the extended MIP coverage and increased financial access provided by the program, most likely due to the exclusion of outpatient drug coverage from the benefit package and possibly due to improper utilisation management by private insurance companies, were not able to reverse adverse effects of economic slow-down and escalating health expenditure. MIP has only cushioned the negative impact for the poorest by decreasing the poor/rich gradient in the rates of catastrophic health expenditure. CONCLUSIONS: The recent governmental decision on major expansion of MIP coverage and inclusion of additional drug benefit will most likely significantly enhance the overall MIP impact and its potential as a viable policy instrument for achieving universal coverage. The Georgian experience presented in this paper may be useful for other low- and middle-income countries that are contemplating ways to ensure universal coverage for their populations

2012

Alvarez-Hernandez, E., et al. (2012). "Catastrophic health expenses and impoverishment of households of patients with rheumatoid arthritis." Reumatol. Clin **8**(4): 168-173.
http://www.ncbi.nlm.nih.gov/pubmed/22704914

BACKGROUND: The cost of certain diseases may lead to catastrophic expenses and impoverishment of households without full financial support by the state and other organizations. OBJECTIVE: To determine the socioeconomic impact of the rheumatoid arthritis (RA) cost in the context of catastrophic expenses and impoverishment. PATIENTS AND METHODS: This is a cohort-nested cross-sectional multicenter study on the cost of RA in Mexican households with partial, full, or private health care coverage. Catastrophic expenses referred to health expenses totaling >30% of the total household income. Impoverishment defined those households that could not afford the Mexican basic food basket (BFB). RESULTS: We included 262 patients with a mean monthly household income (US dollars) of $376 (0-18,890.63). In all, 50.8%, 35.5%, and 13.7% of the patients had partial, full, or private health care coverage, respectively. RA annual cost was $ 5534.8 per patient (65% direct cost, 35% indirect). RA cost caused catastrophic expenses in 46.9% of households, which in the logistic regression analysis were significantly associated with the type of health care coverage (OR 2.7, 95%CI 1.6-4.7) and disease duration (OR 1.024, 95%CI 1.002-1.046). Impoverishment occurred in 66.8% of households and was associated with catastrophic expenses (OR 3.6, 95%CI 1.04-14.1), high health assessment questionnaire scores (OR 4.84 95%CI 1.01-23.3), and low socioeconomic level (OR 4.66, 95%CI 1.37-15.87). CONCLUSION: The cost of RA in Mexican households, particularly those lacking full health coverage leads to catastrophic expenses and impoverishment. These findings could be the same in countries with fragmented health care systems

Athreya, K. B., et al. (2012). "Debt Default and the Insurance of Labor Income Risk." Federal Reserve Bank of Richmond Economic Quarterly **98**(4): 255-307.
http://www.richmondfed.org/publications/research/economic_quarterly/index.cfm

In this article, we evaluate in detail the role of debt forgiveness in altering the transmission of labor income risk in the absence of catastrophic out-of-pocket "expense shocks" used in the literature on consumer default. The experiments we present can be thought of as: "If we insure the out-of-pocket expenses that constitute expenditure shocks, is there still a role of debt relief as a form of insurance against 'pure labor income risk'?" We address this question by studying a range of specifications for households' attitudes toward the intra- and intertemporal properties of income risk alone. Our main finding is that, absent expense shocks, the ability to default very generally hinders the ability of households to protect themselves against labor income risk. Our findings suggest the scope of shocks that debt forgiveness is providing insurance against may be limited, perhaps principally to relatively catastrophic outcomes.

Basar, D., et al. (2012). Out-of-Pocket Health Care Expenditure in Turkey: Analysis of the Household Budget, Sheffield : Uniersity of Sheffield
http://www.shef.ac.uk/polopoly_fs/1.209843!/file/serps_2012020.pdf

This paper analyses the prevalence of ?catastrophic? out-of-pocket health expenditure in Turkey and identifies the factors which are associated with its risk using the Turkish Household Budget Surveys from 2002 to 2008. A sample selection approach based on Sartori (2003) is adopted to allow for the potential selection problem which may arise if poor households choose not to seek health care due to concerns regarding its affordability. The results suggest that poor households are less likely to seek health care as compared to non-poor households and that a negative relationship between poverty and experiencing catastrophic health expenditure remains even after allowing for such selection bias. Our findings, which may assist policy-makers concerned with health care system reforms, also highlight factors such as insurance coverage, which may protect households from the risk of incurring catastrophic health expenditure

DeRigne, L. (2012). "The employment and financial effects on families raising children with special health care needs: an examination of the evidence." J Pediatr Health Care **26**(4): 283-290.

INTRODUCTION: Over 10 million children in the United States have special health care needs (U.S. Department of Health & Human Services, 2008). Parents struggle to afford needed health care and wrestle with the dual responsibilities of caregiving and employment. Researchers from a variety of disciplines, health care, and social science, in particular, are analyzing what variables affect a family's ability to access needed health care while balancing work and caregiving. METHODS: A systematic literature review was conducted on the past 11 years of research that examined insurance status, insurance type, family out-of-pocket expenses, employment outcomes (reductions in hours or stopping work all together), and the role of receiving care in a medical home. RESULTS: It was found that private health insurance, more severe conditions, and specific diagnoses are related to increased expenses and employment changes. It was also found that receiving care in a medical home reduces both. DISCUSSION: It is vital that clinicians and policy makers move forward in expanding the concept of the medical home model as a means to improving the well-being of families raising children with special health care needs.

Davis, K., et al. (2012). "Medicare beneficiaries less likely to experience cost- and access-related problems than adults with private coverage." Health Aff (Millwood) **31**(8): 1866-1875.

The experiences of people covered by Medicare and those with private employer insurance can help inform policy debates over the federal budget deficit, Medicare's affordability, and the expansion of private health insurance under the Affordable Care Act. This article provides evidence that people with employer-sponsored coverage were more likely than Medicare beneficiaries to forgo needed care, experience access problems due to cost, encounter medical bill problems, and be less satisfied with their coverage. Within the subset of beneficiaries who are age sixty-five or older, those enrolled in the private Medicare Advantage program were less likely than those in traditional Medicare to have premiums and out-of-pocket costs exceed 10 percent of their income. But they were also more likely than those in traditional Medicare to rate their insurance poorly and to report cost-related access problems. These results suggest that policy options to shift Medicare beneficiaries into private insurance would need to be attentive to potentially negative insurance experiences, problems obtaining needed care, and difficulties paying medical bills.

Erus, B. et Aktakke, N. (2012). "Impact of healthcare reforms on out-of-pocket health expenditures in Turkey for public insurees." Eur.J Health Econ **13**(3): 337-346.
http://link.springer.com/article/10.1007%2Fs10198-011-0306-2

The Turkish healthcare system has been subject to major reforms since 2003. During the reform process, access to public healthcare providers was eased and private providers were included in the insurance package for public insurees. This study analyzes data on out-of-pocket (OOP) healthcare expenditures to look into the impact of reforms on the size of OOP health expenditures for premium-based public insurees. The study uses Household Budget Surveys that provide a range of individual- and household-level data as well as healthcare expenditures for the years 2003, before the reforms, and 2006, after the reforms. Results show that with the reforms ratio of households with non-zero OOP expenditure has increased. Share and level of OOP expenditures have decreased. The impact varies across income levels. A semi-parametric analysis shows that wealthier individuals benefited more in terms of the decrease in OOP health expenditures.

Finkelstein, A., et al. (2012). "The OregonHealth Insurance Experiment: Evidence from the first year." Q J Econ **127**(3): 1057-1106.

In 2008, a group of uninsured low-income adults in Oregon was selected by lottery to be given the chance to apply for Medicaid. This lottery provides an opportunity to gauge the effects of expanding access to public health insurance on the health care use, financial strain, and health of low-income adults using a randomized controlled design. In the year after random assignment, the treatment group selected by the lottery was about 25 percentage points more likely to have insurance than the control group that was not selected. We find that in this first year, the treatment group had substantively and statistically significantly higher health care utilization (including primary and preventive care as well as hospitalizations), lower out-of-pocket medical expenditures and medical debt (including fewer bills sent to collection), and better self-reported physical and mental health than the control group.

Flores, G. et O'Donnell, O. (2012). Catastrophic Medical Expenditure Risk. Tinbergen : Tinbergen Institute
http://papers.tinbergen.nl/12078.pdf

Medical expenditure risk can pose a major threat to living standards. We derive decomposable measures of catastrophic medical expenditure risk from reference-dependent utility with loss aversion. We propose a quantile regression based method of estimating risk exposure from cross-section data containing information on the means of financing health payments. We estimate medical expenditure risk in seven Asian countries and find it is highest in Laos and China, and is lowest in Malaysia. Exposure to risk is generally higher for households that have less recourse to self-insurance, lower incomes, wealth and education, and suffer from chronic illness.

Geyman, J. P. (2012). "Cost-sharing under consumer-driven health care will not reform U.S. health care." J Law Med Ethics **40**(3): 574-581.

Various kinds of consumer-driven reforms have been attempted over the last 20 years in an effort to rein in soaring costs of health care in the United States. Most are based on a theory of moral hazard, which holds that patients will over-utilize health care services unless they pay enough for them. Although this theory is a basic premise of conventional health insurance, it has been discredited by actual experience over the years. While ineffective in containing costs, increased cost-sharing as a key element of consumer-driven health care (CDHC) leads to restricted access to care, underuse of necessary care, and lower quality and worse outcomes of care. This paper summarizes the three major problems of U.S. health care urgently requiring reform and shows how cost-sharing fails to meet that goal.

Goodridge, D., et al. (2012). "Socioeconomic disparities in home health care service access and utilization: a scoping review." Int J Nurs Stud **49**(10): 1310-1319.

UNLABELLED: Home health care services are expanding at a rapid pace in order to meet the needs of the growing population of older adults and those with chronic illnesses. Because of current restrictions on home health care as an insured service in some countries, individuals may be required to pay for some or all of their home care services out of pocket. These payments may potentially limit access to needed home care services for persons in the lowest socioeconomic strata. Previous research demonstrates a clear socioeconomic gradient in access to acute and primary care services, where those most in need of services are the most disadvantaged and under-serviced. There has been little attention paid thus far, however, to the way in which socioeconomic status may affect the receipt of home health care services. OBJECTIVE: To determine what is known from existing literature about socioeconomic disparities in home health care access and utilization. DESIGN: A scoping review was used to map the extent and nature of the literature in this area. DATA SOURCES: A search of the databases CINAHL, Medline, SocIndex and Sociological Abstracts as well as Dissertations International. REVIEW METHODS: A total of 206 potentially relevant articles were published between 2000 and April 2011. Two reviewers independently reviewed the articles, leaving 15 research articles to be included

in the scoping review. RESULTS: The majority of articles reported secondary analyses of administrative datasets related to utilization of home health care. Several studies examined access and utilization using qualitative approaches. The distinction between professional and supportive home care services was not always clear in the articles. Individual and composite measures of socioeconomic status were reported, with the most frequently used indicator being income. Several studies used more complex composite ecological indicators of socieconomic status. There was general agreement that utilization of home health services favored persons with greater economic disadvantage. Education, rurality and race were less frequently reported. CONCLUSIONS: In contrast to well-documented socioeconomic gradient seen with primary and acute care services, we found general agreement that persons of lower socioeconomic status are favored and not disadvantaged in terms of home health care services.

Hall, J. P. et Moore, J. M. (2012). "The Affordable Care Act's pre-existing condition insurance plan: enrollment, costs, and lessons for reform." Issue Brief (Commonw Fund) **24**: 1-13.

The Pre-Existing Condition Insurance Plan (PCIP) is the temporary, federal high-risk pool created under the Affordable Care Act to provide coverage to uninsured individuals with preexisting conditions until 2014, when exchange coverage becomes avail-able to them. Nearly 78,000 people have enrolled since the program was implemented two years ago. This issue brief compares the PCIP with state-based high-risk pools that existed prior to the Affordable Care Act and considers programmatic differences that may have resulted in lower-than-anticipated enrollment and higher-than-anticipated costs for the PCIP. PCIP coverage, like state high-risk pool coverage, likely remains unaffordable to most lower-income individuals with preexisting conditions, but provides much needed access to care for those able to afford it. Operational costs of these programs are also quite high, making them less than optimal as a means of broader coverage expansion.

Hendryx, M., et al. (2012). "Effects of a cost-sharing policy on disenrollment from a state health insurance program." Soc Work Public Health **27**(7): 671-686.

Subsidized public health insurance programs face financial difficulties and are increasingly implementing policies to pass on greater costs to low-income enrollees. Results of a stratified, random sample of 1,153 enrollees and disenrollees of a state program after introduction of increased cost sharing revealed three main reasons for disenrollment, which varied by enrollee income: finding other coverage, becoming financially ineligible, or dropping coverage as too expensive. Seventeen percent of disenrollees cited cost sharing as a reason for disenrollment. Persons who disenrolled were more likely to be younger adults, male, and have fewer children. Persons who disenrolled reported greater subsequent out-of-pocket costs, more difficulty providing coverage for children, and less access to care than persons who stayed enrolled. Most enrollees stayed enrolled despite the cost sharing increases, and persons who did disenroll left for a variety of reasons, only one of which was cost. Implications for state health insurance policies are discussed.

Hoffman, A. K. et Jackson, H. E. (2012). Retiree Out-of-Pocket Health Care Spending: A Study of Expert Views, Consumer Expectations, and Policy Implications, Santa Monica : The Rand corporation // http://www.rand.org/content/dam/rand/pubs/working_papers/2012/RAND_WR962.pdf

Most retirees in the United States receive Medicare benefits, and most obtain supplemental insurance to help fill the coverage gaps that Medicare leaves, such as for prescription drug expenses. But even with both these types of coverage, they face out-of-pocket expenses for premiums, cost-sharing obligations, and items or services not covered by Medicare or supplemental plans. This study examines whether retirees and near-retirees understand what their likely out-of-pocket health care expenditures might be in retirement. Using the RAND American Life Panel, a representative Internet survey of about 4,000 U.S. households, researchers surveyed Americans age 40?80 on these issues. They found many retirees and near-retirees do not understand the magnitude and variability of their future out-of-pocket health care costs and may be unprepared to finance higher-than-typical expenditures. Women and younger respondents (age 40?60), in particular, were most likely to underestimate their future out-of-pocket health care expenses.

Krutilova, V. et Yaya, S. (2012). "Unexpected impact of changes in out-of-pocket payments for health care on Czech household budgets." Health Policy **107**(2-3): 276-288.
http://www.ncbi.nlm.nih.gov/pubmed/22867940

The Czech Republic is one of the countries that has a relatively low level of private spending on health. As a part of the health care reform package in 2008, some additional out-of-pocket payments were introduced, called 'user (patient) fees'. Furthermore, the government intends to increase some user fees in the following years. There have been serious discussions between proponents and opponents because an increase in out of pocket payments for health care may create financial obstacles for some households and restrict the desirable consumption of health care. The objective of this paper is to determine the impact of changes in out-of-pocket payments on household budgets and provide solution for more just distribution of the burden. Data from the household budget survey regularly collected by the Czech Statistical Office is used. Results showed that the burden of households increased from 2.15% of their net income to 2.63% in 2008 and to 2.55% in 2009 after the implementation of user fees. We noted that the presence of pensioners and elderly in a household was the factor which increased the overall burden the most and led to catastrophic payments.

Long, S. K., et al. (2012). "Coverage, access, and affordability under health reform: learning from the Massachusetts model." Inquiry **49**(4): 303-316.

While the impacts of the Affordable Care Act will vary across the states given their different circumstances, Massachusetts' 2006 reform initiative, the template for national reform, provides a preview of the potential gains in insurance coverage, access to and use of care, and health care affordability for the rest of the nation. Under reform, uninsurance in Massachusetts dropped by more than 50%, due, in part, to an increase in employer-sponsored coverage. Gains in health care access and affordability were widespread, including a 28% decline in unmet need for doctor care and a 38% decline in high out-of-pocket costs.

Luczak, J. et Garcia-Gomez, P. (2012). "Financial burden of drug expenditures in Poland." Health Policy **105**(2-3): 256-264.
http://www.ncbi.nlm.nih.gov/pubmed/22306023

OBJECTIVES: This paper investigates the level of catastrophic out-of-pocket pharmaceutical (OOP) expenditures and their impoverishment effect in Poland. METHODS: We use data from a representative sample of Polish households covering 2000, 2003, 2005, 2007 and 2009. We estimate the incidence and intensity of catastrophic drug expenditure and its impoverishment effects using the methods introduced by Wagstaff and van Doorslaer. We obtain estimates for the full population and for the subsample of retired and chronically ill. RESULTS: The incidence and intensity of catastrophic drug expenditures increased over the years and they are concentrated among the poor. The proportion of households that spent at least 10% of their income on pharmaceuticals reached 18% in 2009. This figure is higher than the evidence found in other countries for total health expenditure. Pharmaceutical expenditures increased poverty rates, and the evidence suggests that the poverty impact of OOP expenditures in the last decade was mainly driven by poor people becoming poorer. The effects are more conspicuous among the retired and chronically ill. CONCLUSIONS: Our findings indicate that OOP pharmaceutical expenditures in Poland are a severe financial burden and that policies aimed at both lowering the price of effective drugs and decreasing consumption of the ineffective ones are needed

Maciejewski, M. L., et al. (2012). "How price responsive is the demand for specialty care?" Health Econ **21**(8): 902-912.

OBJECTIVES: Outpatient visit co-payments have increased in recent years. We estimate the patient response to a price change for specialty care, based on a co-payment increase from $15 to $50 per visit for veterans with hypertension. DESIGN, SETTING, AND PATIENTS: A retrospective cohort of veterans required to pay co-payments was compared with veterans exempt from co-payments whose nonequivalence was reduced via propensity score matching. Specialty care expenditures in 2000-2003 were estimated via a two-part mixed model to account for the correlation of the use and level outcomes over time, and results from this correlated two-part model were compared with an uncorrelated two-part model and a correlated random intercept two-part mixed model. RESULTS: A $35 specialty visit co-payment increase had no impact on the likelihood of seeking specialty care but induced lower specialty expenditures over time among users who were required to pay co-payments. The log ratio of price responsiveness (semi-elasticity) for specialty care increased from -0.25 to -0.31 after the co-payment increase. Estimates were similar across the three models. CONCLUSION: A significant increase in specialty visit co-payments reduced specialty expenditures among patients obtaining medications at the Veterans Affairs medical centers. Longitudinal expenditure analysis may be improved using recent advances in two-part model methods.

Morris, R. (2012). "Using third-party financing to help today's patient pay for treatment and care." J Med Pract Manage **27**(4): 189-191.

Patients walking into your practice today are different than the ones you saw a few years ago. Larger deductibles and out-of-pocket costs may cause many of them to put off recommended treatment. What can you do to ease patients' cost concerns and help them move forward with the care they want and need? Creating a comprehensive financial policy that includes a third-party patient financing program is a good place to start. Here's how to ensure that you select the best program for you.

Nolan, A. et Smith, S. (2012). "The effect of differential eligibility for free GP services on GP utilisation in Ireland." Soc Sci Med **74**(10): 1644-1651.

Internationally, there is extensive empirical evidence that a strong primary care-led health system is associated with improved health outcomes, increased quality of care, decreased health inequalities and lower overall health-care costs. Within primary care, factors influencing access to, and utilisation of, general practitioner (GP) services have been widely examined and this paper focuses on the role of user financial incentives. In particular, user charges for health care have been observed to deter health-care utilisation. Relative to other countries, the Irish health-care system is unusual in that the majority of the population are required to pay out-of-pocket for GP care. However, in 2005 the Irish government extended eligibility for free GP care to a further small subset of the population. Using micro-data from a nationally representative survey of the population in 2007, this paper analyses the impact of differential coverage of free GP services on GP utilisation in Ireland. Results from multivariate regression analysis indicate that GP utilisation is significantly more likely in the context of free GP care, controlling for a range of demographic, socio-economic and health factors. Interpretation of the results for the new category of coverage is complicated by possible pent-up demand and selection effects.

Ridde, V., et al. (2012). "A literature review of the disruptive effects of user fee exemption policies on health systems." BMC Public Health **12**: 289.

BACKGROUND: Several low- and middle-income countries have exempted patients from user fees in certain categories of population or of services. These exemptions are very effective in lifting part of the financial barrier to access to services, but they have been organized within unstable health systems where there are sometimes numerous dysfunctions. The objective of this article is to bring to light the disruptions triggered by exemption policies in health systems of low- and middle-income countries. METHODS: Scoping review of 23 scientific articles. The data were synthesized according to the six essential functions of health systems. RESULTS: The disruptions included specifically: 1) immediate and significant increases in service utilization; 2) perceived heavier workloads for health workers, feelings of being exploited and overworked, and decline in morale; 3) lack of information about free services provided and their reimbursement; 4) unavailability of drugs and delays in the distribution of consumables; 5) unpredictable and insufficient funding, revenue losses for health centres, reimbursement delays; 6) the multiplicity of actors and the difficulty of identifying who is responsible ('no blame' game), and deficiencies in planning and communication. CONCLUSIONS: These disruptive elements give us an idea of what is to be expected if exemption policies do not put in place all the required conditions in terms of preparation, planning and complementary measures. There is a lack of knowledge on the effects of exemptions on all the functions of health systems because so few studies have been carried out from this perspective.

Tinghog, G. et Carlsson, P. (2012). "Individual responsibility for healthcare financing: application of an analytical framework exploring the suitability of private financing of assistive devices." Scand J Public Health **40**(8): 784-794.

OBJECTIVE: To operationalise and apply a conceptual framework for exploring when health services contain characteristics that facilitate individuals' ability to take individual responsibility for health care through out-of-pocket payment. In addition, we investigate if the levels of out-of-pocket payment for assistive devices (ADs) in Sweden are in line with the proposed framework. METHOD: Focus groups were used to operationalise the core concepts of sufficient knowledge, individual autonomy, positive externalities, sufficient demand, affordability, and lifestyle enhancement into a measurable and replicable rationing tool. A selection of 28 ADs were graded separately as having high, medium, or low suitability for private financing according to the measurement scale provided through the operationalised framework. To investigate the actual level of private financing, a questionnaire about the level of out-of-pocket payment for the specific ADs was administered to county councils in Sweden. RESULTS: Concepts were operationalised into three levels indicating possible suitability for private financing. Responses to the questionnaire indicate that financing of ADs in Sweden varies across county councils as regards co-payment, full payment, discretionary payment for certain healthcare consumer groups, and full reimbursement. According to the framework, ADs commonly funded privately were generally considered to be more suitable for private financing. CONCLUSIONS: Sufficient knowledge, individual autonomy, and sufficient demand did not appear to influence why certain ADs were financed out-of-pocket. The level of positive externalities, affordability, and lifestyle enhancement appeared to be somewhat higher for ADs that were financed out-of-pocket, but the differences were small. Affordability seemed to be the most influential concept.

Trottmann, M., et al. (2012). "Supply-side and demand-side cost sharing in deregulated social health insurance: which is more effective?" J Health Econ **31**(1): 231-242.

Microeconomic theory predicts that if patients are fully insured and providers are paid fee-for-service, utilization of medical services exceeds the efficient level ('moral hazard effect'). In Switzerland, both demand-side and supply-side cost sharing have been introduced to mitigate this problem. Analyzing a panel dataset of about 160,000 adults, we find both types of cost sharing to be effective in curtailing the use of medical services. However, when moral hazard mitigation is traded off against risk selection, the minimum-deductible, supply-side cost sharing option ranks first, followed by the medium-deductible demand-side alternative, making the supply-side option somewhat more effective.

Waldman, H. B., et al. (2012). "Many people unable to obtain dental care due to cost." N Y State Dent J **78**(6): 46-48.

While overall spending for dental services appears to be favorable during the period after the last recession, a review of a series of government and private agency reports indicates an increasing proportion of the population is unable to secure needed services due to cost factors. In addition, projections for annual increases in future spending for dental services are lower than for other professional health services.

Watanabe, R. et Hashimoto, H. (2012). "Horizontal inequity in healthcare access under the universal coverage in Japan; 1986-2007." Soc Sci Med **75**(8): 1372-1378.

Universal coverage of healthcare aims at securing access to appropriate healthcare for all at an affordable cost. Since 1961, Japan's national health insurance has provided an equal package of benefits including outpatient, inpatient, dental, and pharmaceutical services. Reduced copayment and other welfare programs are available to the elderly. However, social health insurance may not be a panacea to achieve healthcare for all, especially when facing household impoverishment due to economic stagnation. Using time-series cross-sectional data of a nationally representative survey of Japan, we assessed the degree of inequity in healthcare access in terms of the "equal treatment for equal needs" concept, to identify the impact of changing economic conditions on people's healthcare access. Concentration indices of actual healthcare use (C(M)) and standardized health status as a marker of healthcare needs (C(N)) were obtained. We decomposed C(M) to identify factors contributing to inequalities in healthcare use. Results showed that horizontal inequities in healthcare access in favor of the rich gradually increased over the period with a widening health gap among the poor. The inequality in favor of the rich was specifically observed among people aged 20-64 years, whereas high horizontal equity was achieved among those aged >65 years. Decomposition of C(M) also demonstrated that income and health status were major contributors to widening inequality, which implies that changes in household economic conditions and copayment policy during the study period were responsible for the diminished horizontal equity. Our results suggest that the achievement of horizontal equity through universal coverage should be regarded as an ongoing project that requires continuous redesign of contribution and benefit in the nation's healthcare system.

Weldon, C. B., et al. (2012). "Barriers to the use of personalized medicine in breast cancer." J Oncol Pract **8**(4): e24-31.

PURPOSE: Personalized medicine--the use of genomics and molecular diagnostics to direct care decisions--may improve outcomes by more accurately individualizing treatment to patients. Using qualitative research, we explored care delivery barriers to the use of personalized medicine for patients with breast cancer using examples of BRCA and gene expression profile testing. METHODS: We conducted 51 interviews with multidisciplinary stakeholders in breast cancer care: clinicians (n = 25) from three academic and nine nonacademic organizations, executives (n = 20) from four major private insurers, and patient advocates (n = 6). RESULTS: Barriers were common to the BRCA and gene expression profile tests and were classified under two categories: poor coordination of tests relative to treatment decisions and reimbursement-related disincentives. Perception of specific barriers varied across groups. Difficulty coordinating diagnostics relative to decisions was the most frequent concern by clinicians (60%), but only 35% of payers and 17% of advocates noted this barrier. For 60% of payers, drug- and procedure-based reimbursement was a significant barrier, but only 40% of clinicians and none of the advocates expressed the same concern. The opinion that patient out-of-pocket expenses are a barrier varied significantly between advocates and clinicians (83% v 20%, P < .007), and advocates and payers (83% v 15%, P < .004). Barriers were reported to result in postponement or avoidance of tests, delayed treatment decisions, and proceeding with decisions before test results. CONCLUSION: Poorly coordinated diagnostic testing and the current oncology reimbursement model are barriers to the use of genomic and molecular diagnostic tests in cancer care.

2011

Baji, P., et al. (2011). "User fees for public health care services in Hungary: expectations, experience, and acceptability from the perspectives of different stakeholders." Health Policy **102**(2-3): 255-262.

OBJECTIVE: The introduction of user fees for health care services is a new phenomenon in Central-Eastern European Countries. In Hungary, user fees were first introduced in 2007, but abolished one year later after a referendum. The aim of our study is to describe the experiences and expectations of health system stakeholders in Hungary related to user fees as well as their approval of such fees. METHOD: For our analysis we use both qualitative and quantitative data from focus-group discussions with health care consumers and physicians, and in-depth interviews with policy makers and health insurance representatives. RESULTS: Our findings suggest that the reasons behind the unpopularity of user fees might be (a) the rejection of the objectives of user fees defined by the government, (b) negative personal experiences with user fees, and (c) the general mistrust of the Hungarian population when it comes to the utilization of public resources. CONCLUSION: Successful policy implementation of user fees requires social consensus on the policy objectives, also there should be real improvements in health care provision noticeable for consumers, to assure the fees acceptance.

Bernard, D. S., et al. (2011). "National estimates of out-of-pocket health care expenditure burdens among nonelderly adults with cancer: 2001 to 2008." J Clin Oncol **29**(20): 2821-2826.

PURPOSE: To compare the prevalence of high out-of-pocket burdens among patients with cancer with other chronically ill and well patients, and to examine the sociodemographic characteristics associated with high burdens among patients with cancer. METHODS: The sample included persons 18 to 64 years of age who received treatment for cancer, taken from a nationally representative sample of the US population from the 2001 to 2008 Medical Expenditure Panel Survey. We examined the proportion of persons living in families with high out-of-pocket burdens associated with medical spending, including insurance premiums, relative to income, defining high health care (total) burden as spending more than 20% of income on health care (and premiums). RESULTS: The risk of high burdens is significantly greater for patients with cancer compared with other chronically ill and well patients. We find that 13.4% of patients with cancer had high total burdens, in contrast to 9.7% among those with other chronic conditions and 4.4% among those without chronic conditions. Among nonelderly persons with cancer, the following were associated with higher out-of-pocket burdens: private nongroup insurance, age 55 to 64 years, non-Hispanic black, never married or widowed, one child or no children, unemployed, lower income, lower education level, living in nonmetropolitan statistical areas, and having other chronic conditions. CONCLUSION: High burdens may affect treatment choice and deter patients from getting care. Thus, although a detailed patient-physician discussion of costs of care may not be feasible, we believe that an awareness of out-of-pocket burdens among patients with cancer is useful for clinical oncologists.

Bredenkamp, C., et al. (2011). "Catastrophic and Impoverishing Effects of Health Expenditure: New Evidence from the Western Balkans." Health Policy and Planning **26**(4): 349-356.
http://heapol.oxfordjournals.org/content/by/year

This paper investigates the effect of health-related expenditure on household welfare in Albania, Bosnia and Herzegovina, Montenegro, Serbia and Kosovo, all of which have undertaken major health sector reform. Two methodologies are used: (i) the incidence and intensity of 'catastrophic' health care expenditure, and (ii) the effect of out-of-pocket payments on poverty headcount and poverty gap measures. Data are drawn from the most recent Living Standards and Measurement Surveys, 2000-05. While our analyses are not without their limitations, and the lack of comparability across instruments precludes a direct comparison across countries, there is no doubt that health expenditure contributes substantially to the impoverishment of households--increasing the incidence of poverty and pushing poor households into deeper poverty--in each country. Both the catastrophic and the impoverishing effects of health expenditures are particularly severe in Albania and Kosovo. Transportation expenditure accounts for a large share of total health expenditures, especially in Albania and Serbia. Informal payments are substantial in all countries, and are particularly high in Albania. As countries in the sub-region continue the process of health system reform, an important policy question should be how to protect vulnerable groups from the catastrophic and impoverishing effects of health care expenditure

Cutler, T. W., et al. (2011). "Promoting access and reducing expected out-of-pocket prescription drug costs for vulnerable Medicare beneficiaries: a pharmacist-directed model." Med Care **49**(4): 343-347.

BACKGROUND: The Medicare Part D benefit is complicated and may be costly, especially for vulnerable low-income populations where lack of resources and limited English proficiency may be barriers to optimal plan selection. OBJECTIVES: To identify vulnerable Medicare beneficiaries and lower their expected annual out-of-pocket (OOP) prescription drug costs through one-on-one prescription drug plan counseling by pharmacists and trained pharmacy students. RESEARCH DESIGN: Between October 2008 and January 2010, a cross-sectional study was performed throughout California. Using Medicare's Prescription Drug Plan Finder tool, expected annual OOP costs for each beneficiary's current prescription drug plan were compared with the lowest-cost plan. SUBJECTS: The study sample included vulnerable Medicare beneficiaries with annual incomes </=300% of the Federal Poverty Level. RESULTS: There were 1300 vulnerable beneficiaries who received counseling at 94 outreach events. Only 29% of beneficiaries with a stand-alone Part D prescription drug plan were enrolled in the lowest-cost plan. On the basis of counseling recommendations, 390 beneficiaries changed to the lowest-cost Part D plan on site, reducing their expected OOP costs by 68%. Additionally, 72 beneficiaries were identified as eligible for but not receiving low-income subsidy benefits and 55 received assistance with the online application for the subsidy. CONCLUSIONS: Findings show that targeted outreach by trained pharmacy advocates can identify vulnerable Medicare populations in need of Part D counseling and reduce their expected annual OOP prescription drug costs.

Derkacz, M., et al. (2011). "[Co-payment for public health care services--public opinion survey]." Przegl Epidemiol **65**(2): 363-370.

One of the solutions aimed at improving the functioning of the healthcare system in Poland is to introduce patients' co-payment for public healthcare services. In all countries where the healthcare system is at a high level there already exists a co-payment system and it is regarded by many specialists as a necessary and indispensable condition for the proper functioning of healthcare. The aim of this study was to show respondents' attitudes and opinions regarding the proposal of introduction co-payments as and additional form of financing medical care. The questionnaire survey covered a group of 2,409 persons (50.7% men and 49.3% women). Most respondents, despite the overall rising dissatisfaction with the quality and availability of medical services do not see the need for co-payments. The opinion about the implementation of co-payments. The opinion about the implementation of co-payments depends on many factors, to the most important belong age, education, place of residence and income. More often, the co-payments is in favour of young people in good health condition, who live in big cities, having a university degree and determining their financial situation as good. Before the introduction of co-payment - certain social groups, which would be exempt from additional fees, should be specified. To the highest costs that patients are able to carry belong: paying for a home visit of family doctor or specialist, for surgical procedures, and for complex tests performed during the hospital stay (including computed tomography, magnetic resonance imaging).

Einav, L. et Finkelstein, A. (2011). "Selection in insurance markets: theory and empirics in pictures." J Econ Perspect **25**(1): 115-138.

Government intervention in insurance markets is ubiquitous and the theoretical basis for such intervention, based on classic work from the 1970s, has been the problem of adverse selection. Over the last decade, empirical work on selection in insurance markets has gained considerable momentum. This research finds that adverse selection exists in some insurance markets but not in others. And it has uncovered examples of markets that exhibit "advantageous selection"-a phenomenon not considered by the original theory, and one that has different consequences for equilibrium insurance allocation and optimal public policy than the classical case of adverse selection. Advantageous selection arises when the individuals who are willing to pay the most for insurance are those who are the most risk averse (and so have the lowest expected cost). Indeed, it is natural to think that in many instances individuals who value insurance more may also take action to lower their expected costs: drive more carefully, invest in preventive health care, and so on. Researchers have taken steps toward estimating the welfare consequences of detected selection and of potential public policy interventions. In this essay, we present a graphical framework for analyzing both theoretical and empirical work on selection in insurance markets. This graphical approach provides both a useful and intuitive depiction of the basic theory of selection and its implications for welfare and public policy, as well as a lens through which one can understand the ideas and limitations of existing empirical work on this topic.

Fairman, K. A. et Curtiss, F. R. (2011). "How do seniors respond to 100% cost-sharing for prescription drugs? Quality of the evidence underlying opinions about the Medicare Part D coverage gap." J Manag Care Pharm **17**(5): 382-392.

Popular press coverage of the Medicare Part D coverage gap is based largely on research conducted using retrospective analyses of administrative claims data. These datasets are incomplete because they lack information about methods of obtaining medication that are commonly used by seniors, including free samples, generic drug discount programs, over-the-counter substitution, and patient assistance programs. As a result, evidence about the effects of 100% cost sharing on seniors is limited and suboptimal. Although the current deficit of information about the coverage gap is not entirely unexpected because the Medicare Part D program is relatively new, reliance on claims-based analyses to inform questions that claims data cannot possibly address accurately has tended to mislead and politicize rather than produce constructive policy guidance. Numerous important health policy questions remain unaddressed. These questions are becoming especially important as optimal approaches to providing health care to seniors are the subject of an increasingly vigorous debate.

Fuchs, V. R. (2011). Who shall live ? Health, Economics and social choice, New Jersey : World Scientific Publishing //

Dans cet ouvrage de référence, le professeur américain Victor Fuchs de l'Université de Stanford dresse un état des lieux des forces et des limites de l'économie de la santé, et à partir de sa propre connaissance des institutions sanitaires, il tente d'aider les lecteurs à comprendre les problèmes que rencontrent actuellement les nations à allouer des ressources sanitaires de façon efficiente et équitable. Le texte original de ce livre date de 1974. L'édition de 1998 était augmentée de six contributions complémentaires, qui traitaient du système national d'assurance maladie, de la pauvreté et de la santé aux Etats-Unis. Cette nouvelle édition constitue une mise à jour de l'ensemble de ces problématiques. Elle introduit de nouvelles réflexions, notamment sur l'économie du vieillissement

Gelormino, E., et al. (2011). "The effects of health care reforms on health inequalities: a review and analysis of the European evidence base." Int J Health Serv **41**(2): 209-230.

Health care is widely considered to be an important determinant of health. The health care systems of Western Europe have recently experienced significant reforms, under pressure from economic globalization. Similarly, in Eastern Europe, health care reforms have been undertaken in response to the demands of the new market economy. Both of these changes may influence equality in health outcomes. This article aims to identify the mechanisms through which health care may affect inequalities. The authors conducted a literature review of the effects on health inequalities of European health care reforms. Particular reference was paid to interventions in the fields of financing and pooling, allocation, purchasing, and provision of services. The majority of studies were from Western Europe, and the outcomes most often examined were access to services or income distribution. Overall, the quality of research was poor, confirming the need to develop an appropriate impact assessment methodology. Few studies were related to pooling, allocation, or purchasing. For financing and purchasing, the studies showed that publicly funded universal health care reduces the impact of ill health on income distribution, while insurance systems can increase inequalities in access to care. Out-of-pocket payments increase inequalities in access to care and contribute to impoverishment. Decentralizing health services can lead to geographic inequalities in health care access. Nationalized, publicly funded health care systems are most effective at reducing inequalities in access and reducing the effects on health of income distribution.

Gulley, S. P., et al. (2011). "Ongoing coverage for ongoing care: access, utilization, and out-of-pocket spending among uninsured working-aged adults with chronic health care needs." Am J Public Health **101**(2): 368-375.

OBJECTIVES: We sought to determine how part-year and full-year gaps in health insurance coverage affected working-aged persons with chronic health care needs. METHODS: We conducted multivariate analyses of the 2002-2004 Medical Expenditure Panel Survey to compare access, utilization, and out-of-pocket spending burden among key groups of persons with chronic conditions and disabilities. The results are generalizable to the US community-dwelling population aged 18 to 64 years. RESULTS: Among 92 million adults with chronic conditions, 21% experienced at least 1 month uninsured during the average year (2002-2004). Among the 25 million persons reporting both chronic conditions and disabilities, 23% were uninsured during the average year. These gaps in coverage were associated with significantly higher levels of access problems, lower rates of ambulatory visits and prescription drug use, and higher levels of out-of-pocket spending. CONCLUSIONS: Implementation of health care reform must focus not only on the prevention of chronic conditions and the expansion of insurance coverage but also on the long-term stability of the coverage to be offered.

Knaul, F. M., et al. (2011). "Household catastrophic health expenditures: a comparative analysis of twelve Latin American and Caribbean Countries." Salud Publica Mex **53 Suppl 2**: s85-s95.
http://www.ncbi.nlm.nih.gov/pubmed/21877097

OBJECTIVE: Compare patterns of catastrophic health expenditures in 12 countries in Latin America and the Caribbean. MATERIAL AND METHODS: Prevalence of catastrophic expenses was estimated uniformly at the household level using household surveys. Two types of prevalence indicators were used based on out-of-pocket health expense: a) relative to an international poverty line, and b) relative to the household's ability to pay net of their food basket. Ratios of catastrophic expenditures were estimated across subgroups defined by economic and social variables. RESULTS: The percent of households with catastrophic health expenditures ranged from 1 to 25% in the twelve countries. In general, rural residence, lowest quintile of income, presence of older adults, and lack of health insurance in the household are associated with higher propensity of catastrophic health expenditures. However, there is vast heterogeneity by country. CONCLUSIONS: Cross national studies may serve to examine how health systems contribute to the social protection of Latin American households

Kousky, C. (2011). "Managing Natural Catastrophe Risk: State Insurance Programs in the United States." Review of Environmental Economics and Policy **5**(1): 153-171.
http://reep.oxfordjournals.org/content/by/year

This article surveys state-mandated programs in the United States aimed at providing natural catastrophe insurance to property owners and businesses unable to find policies in the private market. The article provides an overview of ten state programs that offer wind or earthquake coverage and outlines the motivation for establishing such programs. The implications of design and operation decisions, such as pricing strategies and contract options, are discussed, as well as how these programs interact with the private property insurance market. Finally, the article examines whether such programs can handle a truly catastrophic loss year and describes proposals for federal support of these programs

Lagarde, M. et Palmer, N. (2011). "The impact of user fees on access to health services in low- and middle-income countries." Cochrane Database Syst Rev(4): Cd009094.

BACKGROUND: Following an international push for financing reforms, many low- and middle-income countries introduced user fees to raise additional revenue for health systems. User fees are charges levied at the point of use and are supposed to help reduce 'frivolous' consumption of health services, increase quality of services available and, as a result, increase utilisation of services. OBJECTIVES: To assess the effectiveness of introducing, removing or changing user fees to improve access to care in low-and middle-income countries SEARCH STRATEGY: We searched 25 international databases, including the Cochrane Effective Practice and Organisation of Care (EPOC) Group's Trials Register, CENTRAL, MEDLINE and EMBASE. We also searched the websites and online resources of international agencies, organisations and universities to find relevant grey literature. We conducted the original searches between November 2005 and April 2006 and the updated search in CENTRAL (DVD-ROM 2011, Issue 1); MEDLINE In-Process & Other Non-Indexed Citations, Ovid (January 25, 2011); MEDLINE, Ovid (1948 to January Week 2 2011); EMBASE, Ovid (1980 to 2011 Week 03) and EconLit, CSA Illumina (1969 - present) on the 26th of January 2011. SELECTION CRITERIA: We included randomised controlled trials, interrupted time-series studies and controlled before-and-after studies that reported an objective measure of at least one of the following outcomes: healthcare utilisation, health expenditures, or health outcomes. DATA COLLECTION AND ANALYSIS: We re-analysed studies with longitudinal data. We computed price elasticities of demand for health services in controlled before-and-after studies as a standardised measure. Due to the diversity of contexts and outcome measures, we did not perform meta-analysis. Instead, we undertook a narrative summary of evidence. MAIN RESULTS: We included 16 studies out of the 243 identified. Most of the included studies showed methodological weaknesses that hamper the strength and reliability of their findings. When fees were introduced or increased, we found the use of health services decreased significantly in most studies. Two studies found increases in health service use when quality improvements were introduced at the same time as user fees. However, these studies have a high risk of bias. We found no evidence of effects on health outcomes or health expenditure. AUTHORS' CONCLUSIONS: The review suggests that reducing or removing user fees increases the utilisation of certain healthcare services. However, emerging evidence suggests that such a change may have unintended consequences on utilisation of preventive services and service quality. The review also found that introducing or increasing fees can have a negative impact on health services utilisation, although some evidence suggests that when implemented with quality improvements these interventions could be beneficial. Most of the included studies suffered from important methodological weaknesses. More rigorous research is needed to inform debates on the desirability and effects of user fees.

LeMasters, T. et Sambamoorthi, U. (2011). "A national study of out-of-pocket expenditures for mammography screening." J Womens Health (Larchmt) **20**(12): 1775-1783.

OBJECTIVES: To identify variations in screening mammography expenditures, primarily out-of-pocket and total expenditures, of women 40-64 years of age in the United States and factors associated with variations. METHODS: Retrospective analysis of data collected from the 2007 and 2008 Medical Expenditure Panel Survey (MEPS). The sample included 2020 women 40-64 years of age who received one mammogram in 2007 or 2008. Ordinary least squares regression was used to describe relationships among out-of-pocket mammography expenditures, total mammography expenditures, and out-of-pocket mammography expenditures as a percentage of total mammography expenditures and such independent variables as insurance status and type, income, region of the United States, and type of facility where a mammogram was received. RESULTS: The average out-of-pocket expenditure for a mammogram in 2007 or 2008 was $33, representing 14.1% of the total mammogram expenditure ($266). After controlling for demographic and health factors, women who were uninsured, were from the Midwest, and had a mammogram at an office-based facility had greater out-of-pocket mammography expenditures. Women who were uninsured, lived in the South, and received their mammogram at an office-based facility had out-of-pocket mammography expenditures that represented a greater proportion of the total mammography expenditures. CONCLUSIONS: Large variations in out-of-pocket expenditures were observed among women with and without insurance and between insurance types, geographic regions of the United States, and types of facilities where mammograms were received. A higher financial burden of mammography screening among some subgroups of women may act as a barrier to future mammography screening.

Locker, D., et al. (2011). "Income, dental insurance coverage, and financial barriers to dental care among Canadian adults." J Public Health Dent **71**(4): 327-334.

OBJECTIVES: To explore the issue of affordability in dental care by assessing associations between income, dental insurance, and financial barriers to dental care in Canadian adults. METHODS: Data were collection from a national sample of adults 18 years and over using a telephone interview survey based on random digit dialing. Questions were asked about household income and dental insurance coverage along with three questions concerning cost barriers to accessing dental care. These were: "In the past three years...has the cost of dental care been a financial burden to you?...have you delayed or avoided going to a dentist because of the cost?...have you been unable to have all of the treatment recommended by your dentist because of the cost?" RESULTS: The survey was completed by 2,027 people, over half of which (56.0%) were covered by private dental insurance and 4.9 percent by public dental programs. The remainder, 39.1 percent, paid for dental care out-of-pocket. Only 19.3 percent of the lowest income group had private coverage compared with 80.5 percent of the highest income group (P < 0.001). Half (48.2%) responded positively to at least one of the three questions concerning cost barriers, and 14.8 percent responded positively to all three. Low income subjects (P < 0.001) and those without dental insurance (P < 0.001) were most likely to report financial barriers to care. While private dental insurance reduced financial barriers to dental care, it did not entirely eliminate it, particularly for those with low incomes. Those reporting such barriers visited the dentist less frequently and had poorer oral health outcomes after controlling for the effects of income and insurance coverage. CONCLUSIONS: Canadian adults report financial barriers to dental care, especially those of low income. These barriers appear to have negative effects with respect to dental visiting and oral health outcomes. For policy, appropriateness will be key, as clarity needs to be established in terms of what constitutes actual need, and thus which dental services can then be considered a public health response to affordability.

McLeod, L., et al. (2011). "Financial burden of household out-of-pocket expenditures for prescription drugs: cross-sectional analysis based on national survey data." Open Med **5**(1): e1-e9.
http://www.ncbi.nlm.nih.gov/pubmed/22046212

BACKGROUND: Commentaries on the adequacy of insurance coverage for prescription drugs available to Canadians have emphasized differences in the coverage provided by different provincial governments. Less is known about the actual financial burden of prescription drug spending and how this burden varies by province of residence, affluence and source of primary drug coverage. METHODS: We used data from a nationally representative household expenditure survey to analyze the financial burden of prescription drugs. We focused on the drug budget share (defined as the share of the household budget spent on prescription drugs), considering how it varied by province, total household budget and likely primary source of drug insurance coverage (i.e., provincial government plan for senior citizens, social assistance plan or private coverage). We examined both "typical" households (at the median of the distribution of the drug budget share) and households with relatively large shares (in the top 5%). Finally, we estimated the percentage of households with catastrophic drug expenditures (defined as a drug budget share of 10% or more) and the average catastrophic drug expenditures. RESULTS: Senior, social assistance and general population households accounted for 21.1%, 8.9% and 69.9% of the sample of 14,430 respondents to the 2006 Survey of Household Spending, respectively. The median drug budget share in Canada was 1.1% for senior households (range 0.4% [Ontario] to 3.6% [Saskatchewan]) and 0.1% for both social assistance households and general population households, with little appreciable variation across provinces for these latter 2 categories. The 95th percentile drug budget share in Canada was 7.4% for senior households (range 3.5% [Ontario] to 12.7% [Saskatchewan]), 5.4% for social assistance households (range 2.3% [British Columbia] to 13.0% [Prince Edward Island]) and 2.6% for general population households (range 2.1% [Ontario] to 5.4% [Prince Edward Island]). The interprovincial range of the 95th percentile drug budget share was 10.7 percentage points for social assistance households, 9.2 percentage points for senior households and 3.3 percentage points for general population households. INTERPRETATION: For most households, the financial burden of prescription drug expenditures appeared to be relatively small, with little interprovincial variation. However, a small number of households incurred catastrophic drug costs. These households were concentrated in the groups that traditionally benefit from provincial government drug plans. It is likely that some households did not purchase needed prescription drugs because of the expense, so our estimates of the financial burden of catastrophic prescription drug expenditures therefore represent a lower bound

McPake, B., et al. (2011). "Removing user fees: learning from international experience to support the process." Health Policy Plan **26 Suppl 2**: ii104-117.

Removing user fees could improve service coverage and access, in particular among the poorest socio-economic groups, but quick action without prior preparation could lead to unintended effects, including quality deterioration and excessive demands on health workers. This paper illustrates the process needed to make a realistic forecast of the possible resource implications of a well-implemented user fee removal programme and proposes six steps for a successful policy change: (1) analysis of a country's initial position (including user fee level, effectiveness of exemption systems and impact of fee revenues at facility level); (2) estimation of the impact of user fee removal on service utilization; (3) estimation of the additional requirements for human resources, drugs and other inputs, and corresponding financial requirements; (4) mobilization of additional resources (both domestic and external) and development of locally-tailored strategies to compensate for the revenue gap and costs associated with increased utilization; (5) building political commitment for the policy reform; (6) communicating the policy change to all stakeholders. The authors conclude that countries that intend to remove user fees can maximize benefits and avoid potential pitfalls through the utilization of the approach and tools described.

Penfold, R. B., et al. (2011). "Reliability of a patient survey assessing cost-related changes in health care use among high deductible health plan enrollees." BMC Health Serv Res **11**: 133.

BACKGROUND: Recent increases in patient cost-sharing for health care have lent increasing importance to monitoring cost-related changes in health care use. Despite the widespread use of survey questions to measure changes in health care use and related behaviors, scant data exists on the reliability of such questions. METHODS: We administered a cross-sectional survey to a stratified random sample of families in a New England health plan's high deductible health plan (HDHP) with >/= $500 in annualized out-of-pocket expenditures. Enrollees were asked about their knowledge of their plan, information seeking, behavior change associated with having a deductible, experience of delay in care due in part to cost, and hypothetical delay in care due in part to cost. Initial respondents were mailed a follow-up survey within two weeks of each family returning the original survey. We computed several agreement statistics to measure the test-retest reliability for select questions. We also conducted continuity adjusted chi-square, and McNemar tests in both the original and follow-up samples to measure the degree to which our results could be reproduced. Analyses were stratified by self-reported income. RESULTS: The test-retest reliability was moderate for the majority of questions (0.41 - 0.60) and the level of test-retest reliability did not differ substantially across each of the broader domains of questions. The observed proportions of respondents with delayed or foregone pediatric, adult, or any family care were similar when comparing the original and follow-up surveys. In the original survey, respondents in the lower-income group were more likely to delay or forego pediatric care, adult care, or any family care. All of the tests comparing income groups in the follow-up survey produced the same result as in the original survey. CONCLUSIONS: In this population of HDHP beneficiaries, we found that survey questions concerning plan knowledge, information seeking, and delayed or foregone care were moderately reliable. Our results offer reassurance for researchers using survey information to study the effects cost sharing on health care utilization.

Reiss, S. K., et al. (2011). "Effect of switching to a high-deductible health plan on use of chronic medications." Health Serv Res **46**(5): 1382-1401.

OBJECTIVE: To examine whether high-deductible health plans (HDHPs) that exempt prescription drugs from full cost sharing preserve medication use for major chronic illness, compared with traditional HMOs with similar drug cost sharing. DATA SOURCES/STUDY SETTING: We examined 2001-2008 pharmacy claims data of 3,348 continuously enrolled adults in a Massachusetts health plan for 9 months before and 24 months after an employer-mandated switch from a traditional HMO plan to a HDHP, compared with 20,534 contemporaneous matched HMO members. Both study groups faced similar three-tiered drug copayments. We calculated daily medication availability for all prescription drugs and four chronic medication classes: hypoglycemics, lipid-lowering agents, antihypertensives, and chronic obstructive pulmonary disease (COPD)/asthma controllers. STUDY DESIGN: Interrupted time-series with comparison group study design examining monthly level and trend changes in prescription drug utilization. PRINCIPAL FINDINGS: The HDHP and control groups had comparable changes in the level and trend of all drugs after the index date; we detected similar patterns in the use of lipid-lowering agents, antihypertensives, and COPD/asthma controllers. Some evidence suggested a small relative decline in hypoglycemic use among diabetic patients in HDHPs. CONCLUSIONS: Switching to an HDHP that included modest drug copayments did not change medication availability or reduce use of essential medications for three common chronic illnesses.

Steinorth, P. (2011). "Impact of health savings accounts on precautionary savings, demand for health insurance and prevention effort." J Health Econ **30**(2): 458-465.

The paper examines the influence of health savings accounts (HSAs) on optimal savings, insurance demand and prevention effort over the course of a lifetime. This paper adds to the literature by investigating HSAs as both a form of insurance and as saving vehicle in an expected utility framework. Assuming no regulatory constraints on the deductible, we show that individuals voluntarily choose a positive deductible and increase their savings with HSAs. If the government-imposed minimum deductible becomes too great, however, individuals may instead choose to remain in traditional insurance. We determine the effect of HSAs on prevention effort. We find that an increased tax subsidy may worsen moral hazard issues. Assuming partial risk aversion to be less than or equal to one, individuals will either invest less in the health preservation effort and more money in the HSA or vice versa. However, they will never increase both effort and savings simultaneously as was intended when HSAs were introduced.

2010

Barnay, T., et al. (2010). Ageing, chronic conditions and the evolution of future drugs expenditures, Paris : TEPP

The healthy ageing assumptions may lead to substantial changes in paths of aggregate healthcare expenditures, notably catastrophic expenditures of people at the end of the life. But clear assessments of involved amounts are not available when we specifically consider ambulatory care (as drug expenditures) generally offered to chronically-ill people who can remain in this health-status for a long time onward. The Government and Social Security need tools to predict the future cost of health in particular drugs expenditures taking account epidemiological changes on future. This study estimates the evolution in reimbursable outpatient drug expenditures, attributable to age structure and chronic conditions changes, of the French population up to 2029.The healthy ageing assumptions may lead to substantial changes in paths of aggregate healthcare expenditures, notably catastrophic expenditures of people at the end of the life. But clear assessments of involved amounts are not available when we specifically consider ambulatory care (as drug expenditures) generally offered to chronically-ill people who can remain in this health-status for a long time onward. The Government and Social Security need tools to predict the future cost of health in particular drugs expenditures taking account epidemiological changes on future. This study estimates the evolution in reimbursable outpatient drug expenditures, attributable to age structure and chronic conditions changes, of the French population up to 2029.

Bayliss, E. A., et al. (2010). "Characteristics of Medicare Part D beneficiaries who reach the drug benefit threshold in both of the first two years of the Part D benefit." Med Care **48**(3): 267-272.
http://www.ncbi.nlm.nih.gov/pubmed/20125044

BACKGROUND: Medicare Part D beneficiaries who reach the drug benefit threshold (DBT) risk adverse health outcomes. OBJECTIVES: We explore clinical characteristics of beneficiaries who repeatedly reach the DBT during the first 2 years of Medicare Part D and may benefit from proactive identification for medication and care management. RESEARCH DESIGN: Retrospective cohort. SUBJECTS: 25,320 Medicare Advantage beneficiaries of whom 536 reached the DBT in 2006 only, ("2006 only"); 961 reached the DBT in 2006 and 2007 ("both years"); and 23,823 in neither year. MEASURES: We assessed repeatedly reaching the DBT (relative to 2006 only) as a function of demographics, morbidity (specific conditions and overall burden), medication use (specific classes and overall burden), utilization, and use of catastrophic and/or additional pharmacy benefits. RESULTS: Those who reached the DBT in both years had higher morbidity and utilization. In multivariate analyses, they were more likely than the 2006 only group to have one or more of 5 conditions (chronic pulmonary disease, dementia, depression, incontinence, and Parkinson disease), and within these conditions were more likely to use categories of trade-name medications for which there are limited available generic alternatives. CONCLUSIONS: Repeatedly reaching the DBT is a function of the extent and chronicity of disease burden and is characterized by conditions for which there is limited availability of generic medications, and associated common comorbidities. If these findings are confirmed, strategies at practice and policy levels may help such Medicare beneficiaries avoid unnecessary out of pocket expenditures on medications from prematurely reaching the DBT

Cohen, R. A. (2010). "Impact of type of insurance plan on access and utilization of health care services for adults aged 18-64 years with private health insurance: United States, 2007-2008." NCHS Data Brief(28): 1-8.

KEY FINDINGS: Data from the National Health Interview Survey. Almost 18% of adults under age 65 with private health insurance were enrolled in some type of high deductible health plan (HDHP), including 5% who were enrolled in a consumer-directed health plan (CDHP), 2% with a flexible spending account (FSA) for medical expenses, and 12% in a HDHP-only plan. Approximately 17% of adults aged 18-64 years enrolled in an HDHP had unmet medical or prescription drug needs due to cost, compared with 10% among adults aged 18-64 years enrolled in a traditional health plan only (no FSA). Privately insured adults aged 18-64 years with an FSA or health savings account (HSA) were more likely to receive a flu shot or have contact with an eye doctor in the past 12 months than those with neither an FSA nor an HSA.

Corrieri, S., et al. (2010). "Income-, education- and gender-related inequalities in out-of-pocket health-care payments for 65+ patients - a systematic review." International Journal for Equity in Health **9**(20).
http://www.equityhealthj.com/content/9/1/20

In all OECD countries, there is a trend to increasing patients? copayments in order to balance rising overall health-care costs. This systematic review focuses on inequalities concerning the amount of out-of-pocket payments (OOPP) associated with income, education or gender in the Elderly aged 65+. Based on an online search (PubMed), 29 studies providing information on OOPP of 65+ beneficiaries in relation to income, education and gender were reviewed. Low-income individuals pay the highest OOPP in relation to their earnings. Prescription drugs account for the biggest share. A lower educational level is associated with higher OOPP for prescription drugs and a higher probability of insufficient insurance protection. Generally, women face higher OOPP due to their lower income and lower labour participation rate, as well as less employer-sponsored health-care. While most studies found educational and gender inequalities to be associated with income, there might also be effects induced solely by education; for example, an unhealthy lifestyle leading to higher payments for lower-educated people, or exclusively gender-induced effects, like sex-specific illnesses. Based on the considered studies, an explanation for inequalities in OOPP by these factors remains ambiguous.

Dunn, A. (2010). "The value of coverage in the medicare advantage insurance market." J Health Econ **29**(6): 839-855.

This paper examines the impact of coverage on demand for health insurance in the Medicare Advantage (MA) insurance market. Estimating the effects of coverage on demand poses a challenge for researchers who must consider both the hundreds of benefits that affect out-of-pocket costs (OOPC) to consumers, but also the endogeneity of coverage. These problems are addressed in a discrete choice demand model by employing a unique measure of OOPC that considers a consumer's expected payments for a fixed bundle of health services and applying instrumental variable techniques to address potential endogeneity bias. The results of the demand model show that OOPC have a significant effect on consumer surplus and that not instrumenting for OOPC results in a significant underestimate of the value of coverage.

Foundation Rockfeller (2010). Catalyzing Change: The System Reform Costs of Universal Health Coverage. Foundation Rockfeller.
http://www.rockefe erfoundation.org/uploads/files/ebafb89b-2d68-45c0-885e-74d40e8c55d9.pdf

Many countries are beginning to embrace universal health coverage (UHC), defined by the World Health Organization (WHO) as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access ? as a viable financing mechanism. Although models for UHC vary by country, governments are reorganizing national health systems to share health costs more equitably across the population and its life cycle, instead of concentrating the burden on the few who face catastrophic illness in any given year. This timely report addresses a specific question: how much does it cost to shift a health system from being predominantly financed out of pocket toward one that is financed using schemes of universal coverage? Using examples from four countries that have made tremendous strides toward achieving universal coverage, the report puts an approximate price tag on these investments. The conclusions indicate that relatively small early investments can set countries on the path toward universal health coverage. This information should be useful to those involved in planning reform, as well as the development partners that support them

Goedken, A. M., et al. (2010). "Impact of cost sharing on prescription drugs used by Medicare beneficiaries." Res Social Adm Pharm **6**(2): 100-109.

BACKGROUND: Incentive-based prescription drug cost sharing can encourage seniors to use generic medications. Little information exists about prescription drug cost sharing and generic use in employer-sponsored plans after the implementation of Medicare Part D. OBJECTIVES: To compare prescription drug cost sharing across prescription insurance type for Medicare beneficiaries after Medicare Part D, to assess the impact of that cost sharing on the number of medications used, and to examine how generic utilization rates differ before and after Medicare Part D and across the type of insurance. METHODS: This longitudinal study of Medicare beneficiaries aged 65 years and older used Web-based surveys administered in 2005 and 2007 by Harris Interactive((R)) to collect information on prescription drug coverage and medication use. Co-payment plans were categorized as low, medium, or high co-payment plans. Multiple regression was used to assess the impact of co-payment rank on the number of prescription drugs. t-Tests and analysis of variance were used to compare generic use over time and between coverage types. RESULTS: One thousand two hundred twenty and 1024 respondents completed the baseline and follow-up surveys, respectively. Among 3-tier co-payment plans, brand drug co-payments were higher for Part D plans ($26 for preferred brand and $55 for nonpreferred brand) than employer-based plans ($20 for preferred brand and $39 for nonpreferred brand). Co-payment was not a significant predictor for the number of prescription drugs. Generic use was lowest among beneficiaries in employer plans both before and after Part D. In 2007, generic use among beneficiaries with Part D was not significantly different from the generic use for beneficiaries with no drug coverage. CONCLUSIONS: Medicare beneficiaries in Part D had higher cost sharing amounts than those with employer coverage, but higher cost sharing was not significantly linked to lower prescription use. Generic use for Part D beneficiaries was higher than that for beneficiaries with employer coverage but the same as that for beneficiaries without drug coverage.

Heijink, R., et al. (2010). Validity and Comparability of Out-of-pocket Health Expenditure from Household Surveys: A review of the literature and current survey instruments, Genève : OMS
http://www.who.int/health_financing/documents/dp_e_11_01-oop_errors.pdf

Measurement errors have been a persistent concern in survey research. In this study we investigate the current evidence on measurement errors in self-reported household expenditure and health expenditure. We performed a review of the literature on measurement error in healthcare-related surveys. A Pubmed-search was performed and in addition reference tracking was used. In the second part of the study we examined current survey instruments. We collected 90 household surveys, such as household budget surveys, from the International Household Survey Network. We included surveys that were conducted after 1990, with a focus on low-income countries and studied differences in survey design features. The literature review demonstrated that the probability of misreporting increases when the time between interview and event increases. Also, longer and shorter recall periods have generated different outcomes, although the magnitude of this difference varied across populations. Furthermore, respondents reported higher aggregate household spending when more items were used. Respondents may also lose motivation in long-term diaries. Some studies found a relationship between measurement error and respondent characteristics, although results were inconsistent. The review of current household surveys showed a non-negligible variation in design features such as the recall period, the number of disaggregation items and the wording of questions. From reviewing the existing studies and literature we did not find evidence of the optimal survey design features in collecting data on health spending. However, some practical suggestions emerge from the study in terms of question design, recall period and methods of data collection. The study strongly suggests the need for validation studies in order to improve survey instruments and data quality. In the meantime, standardization could improve the comparability across countries and surveys, yet this may discourage the efforts on further exploring the best survey instruments and compromise within-country, over-time comparison efforts.

Marshall, S., et al. (2010). The Risk of Out-of-Pocket Health Care Expenditure at End of Life, Cambridge : NBER
http://papers.nber.org/papers/w16170

There is conflicting evidence on the importance of out-of-pocket medical expenditures as a risk to financial security, particularly at older ages. We revisit this question, focusing on health care spending near the end of life using data from the Health and Retirement Study for the years 1998-2006. We address difficulties with missing values for various categories of expenditures, outliers, and variations across individuals in the length of the reporting period. Spending in the last year of life is estimated to be $11,618 on average, with the 90th percentile equal to $29,335, the 95th percentile $49,907, and the 99th equal to $94,310. These spending measures represent a substantial fraction of liquid wealth for decedents. Total out-of-pocket expenditures are strongly positively related to wealth and weakly related to income. We find evidence for a mechanism by which wealth could plausibly buy health : large expenditures on home modifications, helpers, home health care, and higher-quality nursing homes, which have been shown elsewhere to improve longevity

Mataria, A., et al. (2010). "Catastrophic healthcare payments and impoverishment in the occupied Palestinian territory." Appl. Health Econ Health Policy **8**(6): 393-405.
http://www.ncbi.nlm.nih.gov/pubmed/21043541

BACKGROUND: Financial protection from the risks of ill health has globally recognized importance as a principal performance goal of any health system. This type of financial protection involves minimizing catastrophic payments for healthcare and their associated impoverishing effects. Realization of this performance goal is heavily influenced by factors related to the overall policy environment and sociopolitical context in each country. OBJECTIVES: To examine the incidence and intensity of catastrophic and impoverishing healthcare payments borne by Palestinian households between 1998 and 2007. The incidence and intensity of these effects are examined within the historically unique policy and socioeconomic context of the occupied Palestinian territory. METHODS: A healthcare payment was considered catastrophic if it exceeded 10% of household resources, or 40% of resources net of food expenditures. The impoverishing effect of healthcare was examined by comparing poverty incidence and intensity before and after healthcare payments. The data source was a series of annual expenditure and consumption surveys covering 1998 and 2004-7, and including representative samples of Palestinian households (n = 1231-3098, per year). Total household expenditure was used as a proxy for household level of resources; and the sum of household expenses on a comprehensive list of medical goods and services was used to estimate healthcare payments. RESULTS: While only around 1% of the surveyed households spent >/=40% of their total household expenditures (net of food expenses) on healthcare in 1998, the percentage was almost doubled in 2007. In terms of impoverishing effect, while 11.8% of surveyed households fell into deep poverty in 1998 due to healthcare payments, 12.5% of households entered deep poverty for the same reason in 2006. Over the same period, the monthly amount by which poor households failed to reach the deep poverty line due to healthcare payments increased from $US9.4 to $US12.9. CONCLUSIONS: The inability of the Palestinian healthcare system to protect against the financial risks of ill health could be attributed to the prevailing sociopolitical conditions of the occupied Palestinian territory, and to some intrinsic system characteristics. It is recommended that pro-poor financing schemes be pursued to mitigate the negative impact of the recurrent health shocks affecting Palestinian households.

Mott, D. A., et al. (2010). "Effects of Medicare Part D on drug affordability and use: Are seniors with prior high out-of-pocket drug spending affected more?" Res Social Adm Pharm **6**(2): 90-99.

BACKGROUND: Medicare Part D was expected to have differential impacts on patient drug expenditures and use based on beneficiaries' levels of pre-Part D patient drug spending, but it is unknown whether these projections have borne out. OBJECTIVES: We sought to evaluate whether and how the policy effect of Medicare Part D on drug expenditures and use was modified by levels of pre-Part D drug spending. METHODS: A quasi-experimental, pretest-posttest, nonequivalent control group design was used. Data were obtained from a regional supermarket chain for all prescriptions dispensed between January 1, 2005, and December 31, 2007 (n=1,230,612) to patients aged 60 years and older as of January 1, 2005 (n=51,305) to construct 12-month pre-Part D and post-Part D periods. Annual medication use was measured as the total number of pill days acquired. Annual drug expenditures were measured as total expenditures, patient out-of-pocket expenditures, and the proportion of total expenditures paid out of pocket by the patient. RESULTS: Part D resulted in significant reductions in out-of-pocket spending (17.6%) and significant increases in drug use (4.0%) for individuals in the highest pre-Part D drug-spending group relative to controls. The reduction in out-of-pocket spending for the highest pre-part D spending group was significantly greater compared with the moderate and lowest pre-Part D spending groups. CONCLUSIONS: Our findings suggest that, as expected, Part D facilitated access to medications for patients who previously experienced the greatest costs without adversely increasing use and costs among those with the lowest prior cost.

OMS (2010). Rapport sur la santé dans le monde 2010 : le financement des systèmes de santé. Le chemin vers une couverture universelle. Santé. Paris : OMS.
http://www.who.int/whr/2010/whr10_fr.pdf

Une bonne santé est essentielle au bien-être humain et au développement économique et social durable. Les États membres de l'OMS ont pour objectif de développer leurs systèmes de financement de la santé pour garantir à tous l'utilisation des services de santé et la protection contre les difficultés financières associées à leur paiement. Dans ce rapport, l'Organisation Mondiale de la Santé décrit les mesures que les pays peuvent prendre pour modifier leurs systèmes de financement afin d'atteindre plus rapidement ce but - une couverture universelle - et le maintenir une fois concrétisé. Il se base sur les nouvelles recherches et les leçons tirées de l'expérience des pays. Il fournit aux pays un calendrier d'actions à toutes les étapes du développement et propose à la communauté internationale des moyens lui permettant de mieux soutenir les efforts des pays à faible revenu dans leur objectif de mettre en place la couverture universelle et d'améliorer les résultats sanitaires.

Schoen, C., et al. (2010). "How health insurance design affects access to care and costs, by income, in eleven countries." Health Aff (Millwood) **29**(12): 2323-2334.

This 2010 survey examines the insurance-related experiences of adults in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United States, and the United Kingdom. The countries all have different systems of coverage, ranging from public systems to hybrid systems of public and private insurance, and with varying levels of cost sharing. Overall, the study found significant differences in access, cost burdens, and problems with health insurance that are associated with insurance design. US adults were the most likely to incur high medical expenses, even when insured, and to spend time on insurance paperwork and disputes or to have payments denied. Germans reported spending time on paperwork at rates similar to US rates but were well protected against out-of-pocket spending. Swiss out-of-pocket spending was high, yet few Swiss had access concerns or problems paying bills. For US adults, comprehensive health reforms could lead to improvements in many of these areas, including reducing differences by income observed in the study.

Schreyogg, J. et Grabka, M. M. (2010). "Copayments for ambulatory care in Germany: a natural experiment using a difference-in-difference approach." Eur J Health Econ **11**(3): 331-341.

In response to increasing health expenditures and a high number of physician visits, the German government introduced a copayment for ambulatory care in 2004 for individuals with statutory health insurance (SHI). Because persons with private insurance were exempt from the copayments, this health-care reform can be regarded as a natural experiment. We used a difference-in-difference approach to examine whether the new copayment effectively reduced the overall demand for physician visits and to explore whether it acted as a deterrent to vulnerable groups, such as those with low income or chronic conditions. We found that there was no significant reduction in the number of physician visits among SHI members compared to our control group. At the same time, we did not observe a deterrent effect among vulnerable individuals. Thus, the copayment has failed to reduce the demand for physician visits. It is likely that this result is due to the design of the copayment scheme, as the copayment is low and is paid only for the first physician visit per quarter.

Weale, A. et Clark, S. (2010). "Co-payments in the NHS: an analysis of the normative arguments." Health Econ Policy Law **5**(2): 225-246.

During 2008, some forms of patient co-payments - in particular, patients paying privately for additional medicines as part of an episode of care in the National Health Service - became controversial in political and policy terms in the UK. In response, the UK Government published a report, the Richards' Review, examining the issues. Richards offered a particular policy solution, but also touched on fundamental principles of social value. Using the methods of normative policy analysis, we seek to understand these principles of social value, accepting the Richards' framework according to which the relevant arguments can be grouped under the broad headings of equity and autonomy. None of the arguments on either side are decisive, and, in part, the policy decision turns on uncertain empirical conjectures.

Yardim, M. S., et al. (2010). "Catastrophic health expenditure and impoverishment in Turkey." Health Policy **94**(1): 26-33.
http://www.ncbi.nlm.nih.gov/pubmed/19735960

OBJECTIVES: This study aims to identify the level of catastrophic health expenditure (CHE) in Turkey and, to reveal household factors predicting this outcome. METHODS: CHE is calculated from a national representative data derived from TurkStat, Household Budget Survey, Consumption Expenditures, 2006. The methods introduced by Ke Xu and colleagues are employed for calculations. RESULTS: The proportion of households with CHE is 0.6%. Impoverished households consist 0.4% of total. Average out-of-pocket health payment is 7.36 USD (PPP$-2006) in lowest fifth that is approximately one tenth of the highest fifth (70.18 PPP USD-2006). In the logistic model, probability of facing CHE increases by each unit rise of per capita expenditure. Household head's health insurance is closely related with catastrophe. Rural households face 2.5 times more catastrophe than the urban area residents. Having preschool child in the household is seen as a protective factor for catastrophic expenditure. On the other hand, elderly or disabled person increases risk of catastrophe. CONCLUSIONS: Results indicate that more people in Turkey benefited from risk pooling/health insurance by 2006 and were, therefore, on average, better protected from catastrophic medical expenses, than in many other countries with comparable income levels at that time

Ziller, E. C., et al. (2010). "Access to rural mental health services: service use and out-of-pocket costs." J Rural Health **26**(3): 214-224.

PURPOSE: To examine rural-urban differences in the use of mental health services (mental health and substance abuse office visits, and mental health prescriptions) and in the out-of-pocket costs paid for these services. METHODS: The pooled 2003 and 2004 Medical Expenditure Panel Surveys were used to assess differences in mental health service use by rural and urban residence and average per person mental health expenditures by payer and by service type. FINDINGS: Study findings reveal a complicated pattern of greater need among rural than urban adults for mental health services, lower rural office-based mental health use and higher rural prescription use, and no rural-urban differences in total or out-of-pocket expenditures for mental health services. CONCLUSIONS: These findings raise questions about the appropriateness and quality of mental health services being delivered to rural residents. Lower mental health spending among rural residents is likely explained by lower use of psychotherapy and other office-based services, but it may also be related to these services being delivered by lower-cost providers in rural areas. Findings suggest that an approach focusing on reducing underinsurance for all health services among rural residents may help to reduce unmet mental health needs among the rural privately insured.

Zuvekas, S. H. et Selden, T. M. (2010). "Mental health and family out-of-pocket expenditure burdens." Med Care Res Rev **67**(2): 194-212.
http://www.ncbi.nlm.nih.gov/pubmed/19773590

A growing literature finds that a significant fraction of American families experience high or "catastrophic" burdens of medical spending. Families facing mental health problems may be especially vulnerable to high burdens. This study uses data from the Medical Expenditure Panel Survey to determine the annual and within-year concentration of medical spending and the extent to which mental health treatment contributes to high out-of-pocket burdens among families with and without mental health problems. On average, families incurred 44% of non-mental health and 37% of out-of-pocket mental health treatment expenditures in a single month. Families with one or more members experiencing mental health problems were more likely to have periods of high out-of-pocket spending burdens. However, this study found that mental health treatment itself contributes little to high out-of-pocket spending burdens. Most of the burden was due to other medical conditions and lower average incomes among families with mental health problems

2009

Abul, N. H. et Lamiraud, K. (2009). Catastrophic Health Expenditure and Household Well-Being, Bath : University of Bath
http://opus.bath.ac.uk/15975/1/0309.pdf

According to the catastrophic health expenditure methodology a household is in catastrophe if its health out-of-pocket budget share exceeds a critical threshold. We develop a conceptual framework for addressing three questions in relation to this methodology, namely: 1. Can a budget share be informative about the sign of a change in welfare? 2. Is there a positive association between a household's poverty shortfall and its health out-of-pocket budget share? 3. Does an increase in population coverage of a health insurance scheme always result in a reduction of the prevalence of catastrophic expenditures ?

Butrica, B., et al. (2009). Do Health Problems Reduce Consumption at Older Ages ?, Washington : The Urban Institute //
http://www.urban.org/UploadedPDF/411858_reduce_consumption.pdf

High out-of-pocket health care costs may have serious repercussions for older people and their families. If their incomes are not sufficient to cover these expenses, older adults with health problems may have to deplete their savings, turn to family and friends for financial help, or forgo necessary care. Or they may be forced to reduce their consumption of other goods and services to pay their medical bills. This paper uses data from the Health and Retirement Study (HRS) and the related Consumption and Activities Mail Survey (CAMS) to examine the impact of health problems at older ages on out-of-pocket health care spending and other types of expenditures. The analysis estimates fixed effects models of total out-of-pocket health care spending, out-of-pocket health care spending exclusive of premiums, total spending on all items except health care, and total spending on all items except health care and housing. The models are estimated separately for households ages 65 and older and those ages 51 to 64. The results show that medical conditions increase health spending, particularly for households ages 51 to 64, but that health conditions do not generally reduce non health spending. Medical conditions do, however, reduce non health spending for low-income households ages 51 to 64, suggesting that holes in the health safety net before the Medicare eligibility age force some low-income people to lower their living standards to cover medical expenses

Cavalieri, M. (2009). Geographical patterns of unmet health care needs in Italy. Munich MPRA**:** 26 , tabl., fig.

In recent years, health care reforms and restrained budgets have risen concerns about accessibility to health services, even in countries with universal coverage health systems. Previous studies have explored the issue by using objective event-oriented measures such as those related to utilization of health care. Analyzing access through subjective process-oriented indicators allows to better disentangle the process of seeking care, to investigate self-perceived barriers to health services and to account for differences in individual health care preferences. In this paper, data from the 2006 Italian component of the European Survey on Income and Living Conditions (EU-SILC) are used to explore reasons and predictors of self-reported unmet needs for specialist and/or dental care among adult Italians aged 18 and over. Results reveal different patterns across socio-economic groups and geographical macro-areas. Evidence of income-related inequalities and violations of the horizontal equity principle are also found both at a national and regional level. Policies to address unmet health care needs should adopt a multidimensional approach and be tailored so as to consider such heterogeneities.

Gotsadze, G., et al. (2009). "Household catastrophic health expenditure: evidence from Georgia and its policy implications." BMC Health Serv Res **9**: 69.
http://www.ncbi.nlm.nih.gov/pubmed/19400939

BACKGROUND: To quantify extent of catastrophic household health expenditures, determine factors influencing it and estimate Fairness in Financial Contribution (FFC) index in Georgia to establish the baseline for expected reforms and contribute to the design and fine-tuning of the major reforms in health care financing initiated by the government mid-2007. METHODS: The research is based on the nationally representative Health Care Utilization and Expenditure survey conducted during May-June 2007, prior to preparing for new phase of implementation for the health care financing reforms. Households' catastrophic health expenditures were estimated according to the methodology proposed by WHO--Ke Xu. A logistic regression (logit) model was used to predict probability of catastrophic health expenditure occurrence. RESULTS: In Georgia between 2000 and 2007 access to care for poor has improved slightly and the share of households facing catastrophic health expenditures have seemingly increased from 2.8% in 1999 to 11.7% in 2007. However, this variance may be associated with the methodological differences of the respective surveys from which the analysis were derived. The high level of the catastrophic health expenditure may be associated with the low share of prepayment in national health expenditure, adequate availability of services and a high level of poverty in the country. Major factors determining the financial catastrophe related to ill health were hospitalization, household members with chronic illness and poverty status of the household. The FFC for Georgia appears to have improved since 2004. CONCLUSION: Reducing the prevalence of catastrophic health expenditure is a policy objective of the government, which can be achieved by focusing on increased financial protection offered to poor and expanding government financed benefits for poor and chronically ill by including and expanding inpatient coverage and adding drug benefits. This policy recommendation may also be relevant for other Low and Middle Income countries with similar levels of out of pocket payments and catastrophic health expenditures

Lu, C., et al. (2009). "Limitations of methods for measuring out-of-pocket and catastrophic private health expenditures." Bulletin of the World Health Organization **87**(3).
http://www.who.int/bulletin/volumes/87/3/08-054379.pdf

Cet article a pour objectif d'étudier l'effet du type d'enquête, et en particulier du nombre de postes de dépense examinés et de la période de rappel, sur les estimations des débours directs et des dépenses catastrophiques en faveur de la santé des ménages. Les résultats de deux enquêtes ont été utilisés : l'Enquête sur la santé dans le monde et la Living Standards Measurement Study - ayant interrogé les mêmes personnes à propos de leurs dépenses de santé, mais de manières différentes. Les données provenant de l'Enquête sur la santé dans le monde ont servi à comparer les estimations des débours directs annuels moyens des ménages pour la santé, obtenues par une méthode de mesure ne considérant qu'un poste de dépense et par une méthode prenant en compte huit postes. Cette comparaison a été effectuée en déterminant le rapport de la moyenne obtenue par la première méthode de mesure à celle fournie par la seconde méthode. Nous avons également comparé des estimations des dépenses catastrophiques établies à partir de ces deux méthodes de mesure. Nous avons utilisé des données de la Living Standards Measurement Study pour trois pays (Bulgarie, Jamaïque et Népal), correspondant à différentes périodes de rappel et à un nombre variable de catégories de dépenses, et relevées dans le cadre de divers modules d'enquête, pour comparer les estimations des débours directs annuels moyens obtenues par plusieurs méthodes. Les résultats ont montré que, dans la plupart des pays, un niveau plus faible de désagrégation (c'est-à-dire la prise en compte d'un nombre moindre de postes de dépense) a conduit à une estimation plus basse des dépenses de santé moyennes et une période de rappel plus brève a abouti à une estimation plus élevée. Cependant, lorsque les effets de la désagrégation et de la période de rappel se combinent, il est difficile de prédire quel facteur s'exerce le plus fortement. L'ampleur des débours directs et des dépenses catastrophiques pour la santé des ménages est influencée par le choix de la période de rappel et du nombre de postes de dépense considérés. Il est donc essentiel de définir une méthode pour générer des données valides, fiables et comparables sur les dépenses de santé des privées.

Mitra, S., et al. (2009). Health care expenditures of living with a disability : Total expenditures, out-of-pocket expenses, and burden, 1996 to 2004**:** 1532-1540.

This paper estimates the healthcare expenditures associated with a disability at the individual level and their recent trends. All the analyses accounted for the complex survey design of the MEPS. Between 1996 and 2004, 6% to 9% of individuals in the working age group (21-61 years) were identified as having a disability. Persons with disabilities consistently had higher total health expenditures, OOP and burden compared to their counterparts without disabilities. In 2004, the average total expenditures were estimated at $10,508 for persons with disabilities and at $2,256 for those without disabilities. In a multiple regression framework, persons with disabilities were consistently found to have higher expenditures and OOP between 1996 and 2004. Although expenditures, OOP and burden increased over time, after controlling for demographic, socio-economic, and health status, these three healthcare costs were not found to increase disproportionately for individuals with disability. Over the 1996-2004 period, persons with disabilities are consistently found to have significantly higher health expenditures and OOP compared to their counterparts without disabilities, which may adversely affect their health and standard of living.

November, E. A., et al. (2009). "Individual insurance: health insurers try to tap potential market growth." Res Brief(14): 1-8.

Individual insurance is the only source of health coverage for people without access to employer-sponsored insurance or public insurance. Individual insurance traditionally has been sought by older, sicker individuals who perceive the need for insurance more than younger, healthier people. The attraction of a sicker population to the individual market creates adverse selection, leading insurers to employ medical underwriting--which most states allow--to either avoid those with the greatest health needs or set premiums more reflective of their expected medical use. Recently, however, several factors have prompted insurers to recognize the growth potential of the individual market: a declining proportion of people with employer-sponsored insurance, a sizeable population of younger, healthier people forgoing insurance, and the likelihood that many people receiving subsidies to buy insurance under proposed health insurance reforms would buy individual coverage. Insurers are pursuing several strategies to expand their presence in the individual insurance market, including entering less-regulated markets, developing lower-cost, less-comprehensive products targeting younger, healthy consumers, and attracting consumers through the Internet and other new distribution channels, according to a new study by the Center for Studying Health System Change (HSC). Insurers' strategies in the individual insurance market are unlikely to meet the needs of less-than-healthy people seeking affordable, comprehensive coverage. Congressional health reform proposals, which envision a larger role for the individual market under a sharply different regulatory framework, would likely supersede insurers' current individual market strategies.

Somkotra, T. et Lagrada, L. P. (2009). "Which households are at risk of catastrophic health spending: experience in Thailand after universal coverage." Health Aff. (Millwood.) **28**(3): w467-w478.
http://www.ncbi.nlm.nih.gov/pubmed/19336470

The impact of the universal coverage policy implementation in Thailand is demonstrated by the declining incidence of catastrophic health spending among Thai households-particularly among the poor. The households who remain at risk of catastrophe, as defined here, are better-off households, because of their preference for using private facilities. Others with increased likelihood of incurring catastrophic health expenditures are households with a greater proportion of elderly members, those having a member with a chronic illness or disability, and those having a member who experienced hospitalization. These determinants should prompt policy concerns to protect such households from financial catastrophe.

Vilhjalmsson, R. (2009). "[Out-of-pocket health care expenditures among population groups in Iceland]." Laeknabladid **95**(10): 661-668.

OBJECTIVE: Out-of-pocket health expenditures affect access to health care. The study investigated trends in these expenditures, and whether certain population groups spent more than others. MATERIAL AND METHODS: The data come from two national health surveys among Icelandic adults from 1998 and 2006. The response rate was 69% in the former survey (N=1924), and 60% in the latter (N= 1532). Average household health expenditures and household expenditure burden (expenditures as % of total household income) were compared over time and between groups. RESULTS: Household health expenditures increased by 29% in real terms between 1998 and 2006. The biggest items in 2006 were drugs and dental care. Women, younger and older individuals, the single and divorced, smaller households, the unemployed and non-employed, individuals with low education and income, the chronically ill, and the disabled, had the highest household expenditure burden. Comparison between 1998 and 2006 indicated increased expenditure burden among young people, students, the unemployed, and the least educated, but decreased burden among the elderly, the widowed, and parents of young children. CONCLUSIONS: Household health expenditures differ substantially between groups, suggesting reconsideration of current health insurance policies, especially with regard to disabled, non-employed, low-income, and young individuals.

Zuvekas, S. H. et Meyerhoefer, C. D. (2009). "State variations in the out-of-pocket spending burden for outpatient mental health treatment." Health Aff (Millwood) **28**(3): 713-722.

We examine the potential of mental health/substance abuse (MH/SA) parity laws to reduce the out-of-pocket spending burden for outpatient treatment at the state level by exploring cross-state variations and their causes, as well as the provisions of MH/SA parity laws. We find modest (yet important) variation in out-of-pocket burden across states overall, but-because prescription medications account for two-thirds of out-of-pocket spending and are generally beyond the scope of recently enacted federal parity laws-evidence suggests that those laws will do little to reduce the observed burden or its variation. Other policy measures, designed to expand and improve health insurance coverage or reduce racial/ethnic disparities, could have a more profound impact.

2008

Abul Naga, R. H. et Lamiraud, K. (2008). Catastrophic health expenditure and household well-being.

> According to the catastrophic health expenditure methodology a house-hold is in catastrophe if its health out-of-pocket budget share exceeds a critical threshold. We develop a conceptual framework for addressing three questions in relation to this methodology, namely: 1. Can a budget share be informative about the sign of a change in welfare? 2. Is there a positive association between a household.s poverty shortfall and its health out-of-pocket budget share? 3. Does an increase in population coverage of a health insurance scheme always result in a reduction of the prevalence of catastrophic expenditures?

Finkelstein, A. et McKnight, R. (2008). "What did Medicare do? The initial impact of Medicare on mortality and out of pocket medical spending." Journal of Public Economics **92**(7): 1644-1668.

> We study the impact of the introduction of one of the major pillars of the social insurance system in the United States: the introduction of Medicare in 1965. Our results suggest that, in its first 10 years, the establishment of universal health insurance for the elderly had no discernible impact on elderly mortality. However, we find a substantial reduction in the elderly's exposure to out of pocket medical expenditure risk. Specifically, we estimate that the introduction of Medicare was associated with a 40% decline in out of pocket spending for the top quartile of the out of pocket spending distribution. A stylized expected utility framework suggests that the welfare gains from such reductions in risk exposure alone may be sufficient to cover almost two-fifths of the costs of Medicare. These findings underscore the importance of considering the direct insurance benefits from public health insurance programs, in addition to any indirect benefits from an effect on health.

Flores, G., et al. (2008). "Coping with health-care costs: implications for the measurement of catastrophic expenditures and poverty." Health Econ **17**(12): 1393-1412.
http://www.ncbi.nlm.nih.gov/pubmed/18246595

> In the absence of formal health insurance, we argue that the strategies households adopt to finance health care have important implications for the measurement and interpretation of how health payments impact on consumption and poverty. Given data on source of finance, we propose to (a) approximate the relative impact of health payments on current consumption with a 'coping'-adjusted health expenditure ratio, (b) uncover poverty that is 'hidden' because total household expenditure is inflated by financial coping strategies and (c) identify poverty that is 'transient' because necessary consumption is temporarily sacrificed to pay for health care. Measures that ignore coping strategies not only overstate the risk to current consumption and exaggerate the scale of catastrophic payments but also overlook the long-run burden of health payments. Nationally representative data from India reveal that coping strategies finance as much as three-quarters of the cost of inpatient care. Payments for inpatient care exceed 10% of total household expenditure for around 30% of hospitalized households but less than 4% sacrifice more than 10% of current consumption to accommodate this spending.Ignoring health payments leads to underestimate poverty by 7-8% points among hospitalized households; 80% of this adjustment is hidden poverty due to coping

Naga, R. H. A. et Lamiraud, K. (2008). Catastrophic Health Expenditure and Household Well-Being. Londres : LSE
http://sticerd.lse.ac.uk/dps/darp/darp98.pdf

> According to the catastrophic health expenditure methodology a household is in catastrophe if its health out-of-pocket budget share exceeds a critical threshold. We develop a conceptual framework for addressing three questions in relation to this methodology, namely: 1. Can a budget share be informative about the sign of a change in welfare? 2. Is there a positive association between a household's poverty shortfall and its health out-of-pocket budget share? 3. Does an increase in population coverage of a health insurance scheme always result in a reduction of the prevalence of catastrophic expenditures?

O'Donnell, O., et al. (2008). Analyzing health equity using household survey data : a guide to techniques and

their implementation. Wbi Learning Resources Series. Washington : Banque mondiale**:** 221 , tabl., graph., fig.
http://siteresources.worldbank.org/INTPAH/Resources/Publications/459843-1195594469249/HealthEquityFINAL.pdf

Health equity has become an increasingly popular research topic during the course of the past 25 years. Many factors explain this trend, including a growing demand from policymakers, better and more plentiful household data, and increased computer power. But progress in quantifying and understanding health equities would not have been possible without appropriate analytic techniques. These techniques are the subject of this book. The book includes chapters dealing with data issues and the measurement of the key variables in health equity analysis (Part i), quantitative techniques for interpreting and presenting health equity data (Part ii), and the application of these techniques in the analysis of equity in health care utilization and health care spending (Part iii). The aim of the book is to provide researchers and analysts with a step-by-step practical guide to the measurement of a variety of aspects of health equity, with worked examples and computer code, mostly for the computer.

Wagstaff, A. (2008). Measuring financial protection in health. Wasgington : Banque Mondiale
http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2008/03/12/000158349_20080312140044/Rendered/PDF/wps4554.pdf

Health systems are not just about improving health: good ones also ensure that people are protected from the financial consequences of receiving medical care. Anecdotal evidence suggests health systems often perform badly in this respect, apparently with devastating consequences for households, especially poor ones and near-poor ones. Two principal methods have been used to measure financial protection in health. Both relate a household ' s out-of-pocket spending to a threshold defined in terms of living standards in the absence of the spending: the first defines spending as catastrophic if it exceeds a certain percentage of the living standards measure; the second defines spending as impoverishing if it makes the difference between a household being above and below the poverty line. The paper provides an overview of the methods and issues arising in each case, and presents empirical work in the area of financial protection in health, including the impacts of government policy. The paper also reviews a recent critique of the methods used to measure financial protection.

Willey, V. J., et al. (2008). "Beyond the myths: finding benefit design solutions that address the true costs of high healthcare use." Am J Manag Care **14**(8 Suppl): S252-S263.
http://www.ncbi.nlm.nih.gov/pubmed/18672956

Chronic and severe health problems place an enormous financial burden on individuals, employers, and health plan providers, requiring all to make tough decisions about healthcare. Specialty pharmaceuticals are increasingly attractive treatment options, but employers need tangible ways to incorporate these medications into benefit plans. Benefit managers can take a proactive role in addressing cost and compliance issues, using evidence-based data about true patient costs to develop policies that encourage employees to seek appropriate care. Achieving savings in direct and indirect costs will require more than shifting coverage, which can lead to nonadherence and increase costs elsewhere.

2007

Bloche, M. G. (2007). "Consumer-directed health care and the disadvantaged." Health Aff (Millwood) **26**(5): 1315-1327.

Broad adoption of "consumer-directed health care" would probably widen socioeconomic disparities in care and redistribute wealth in "reverse Robin Hood" fashion, from the working poor and middle classes to the well-off. Racial and ethnic disparities in care would also probably worsen. These effects could be alleviated by adjustments to the consumer-directed paradigm. Possible fixes include more progressive tax subsidies, tiering of cost-sharing schemes to promote high-value care, and reduced cost sharing for the less well-off. These fixes, though, are unlikely to gain traction. If consumer-directed plans achieve market dominance, disparities in care by class and race will probably grow.

Brill, J. V. (2007). "Trends in the prescription drug plans delivering the Medicare Part D prescription drug benefit." Am J Health Syst Pharm **64**(15 Suppl 10): S3-S6.
http://www.ncbi.nlm.nih.gov/pubmed/17646551

PURPOSE: The potential impact of the Democrat-proposed Medicare drug program reform plan; possible Congressional actions in 2007; the standard Medicare prescription drug benefit; the use of low-income subsidies (LIS); and trends in 2006 and 2007 Medicare prescription drug plan (PDP) offerings, coverage, deductibles, premiums, cost-sharing practices, and utilization management strategies are described. SUMMARY: There is evidence that Medicare prices for prescription drugs are considerably higher than federally negotiated prices. Government negotiations with prescription drug manufacturers and a standard federal PDP are among potential Congressional actions in 2007. Seniors' annual out-of-pocket costs for prescription drugs stand to decrease by hundreds of dollars under the proposed Medicare drug program reform plan. Between 2006 and 2007, the number of PDPs offered in the U.S. increased, and the monthly premium increased for most enrollees. In 2006, approximately four million Medicare beneficiaries were projected to have prescription drug spending in the coverage gap (i.e., "doughnut hole") between partial and catastrophic coverage. Most PDPs provided no gap coverage in 2007, and an estimated 10.9 million enrollees were expected to have no gap coverage in 2007. Approximately 3.3 million low income subsidy (LIS) eligible beneficiaries did not receive assistance in 2006. Cost-sharing practices (i.e., tiered copayments for generic, preferred brand, and non-preferred brand drugs and drugs in specialty tiers) varied among PDPs and over time, sometimes as the result of changes in the PDP's negotiated price for the drug, the patent or formulary status of the drug, or the PDP's tier placement of the drug. The use of utilization management strategies, including prior authorization requirements, step-therapy requirements, limits in the quantity of medication dispensed, and specialty tiers for high-cost drugs, to control PDP costs continued or increased between 2006 and 2007. CONCLUSION: The PDPs delivering the Medicare Part D prescription drug benefit have been and continue to be subject to change. High Medicare prices and a lack of gap coverage for enrollees remain concerns that may be addressed by Congressional action in 2007

Duryea, S. (2007). "Defining "catastrophic"." Health Aff. (Millwood.) **26**(6): 1789.
http://www.ncbi.nlm.nih.gov/pubmed/17978402

Ekman, B. (2007). "Catastrophic health payments and health insurance: some counterintuitive evidence from one low-income country." Health Policy **83**(2-3): 304-313.
http://www.ncbi.nlm.nih.gov/pubmed/17379351

OBJECTIVES: The purpose of the study is to quantitatively analyze the role of health insurance in the determinants of catastrophic health payments in a low-income country setting. METHODS: The study uses the most recent publicly available household level data from Zambia collected in 1998 containing detailed information on health care utilization and spending and on other key individual, household, and community factors. An econometric model is estimated by means of multivariate regression. RESULTS: The main results are counterintuitive in that health insurance is not found to provide financial protection against the risk of catastrophic payments; indeed, insurance is found to increase this risk. CONCLUSIONS: Reasons for the findings are discussed using additional available information focusing on the amount of care per illness episode and the type of care provided. The key conclusion is that the true impact of health insurance is an empirical issue depending on several key context factors, including quality assurance and service provision oversight

Geyman, J. P. (2007). "Moral hazard and consumer-driven health care: a fundamentally flawed concept." Int J

Health Serv **37**(2): 333-351.

For more than 30 years, most health care economists in the United States have accepted a conventional theory of health insurance based on the concept of moral hazard: an assumption is made that insured people overuse health care services because they have insurance. The recent trend toward "consumer-driven health care" (CDHC) is advocated by its supporters based on this same premise, assuming that imprudent choices by patients can be avoided if they are held more financially responsible for their health care choices through larger co-payments and deductibles and other restrictions. This article examines how moral hazard-based CDHC plays out in both private plans and public programs. The author identifies seven ways in which this concept fails the public interest, while also failing to control health care costs. Uninsured and underinsured people, now including many in the middle class, underuse essential health care services, resulting in increased morbidity and more preventable hospitalizations and deaths among these groups than their more affluent counterparts. A case is made to reject moral hazard as an organizing rationale for health care, and the author offers some alternative approaches.

Hurley, J., et al. (2007). Publicly Funded Medical Savings Accounts: Expenditures and Distributional Impacts, Hamilton : McMaster University //

This paper presents the findings from simulations of the introduction of publicly funded Medical Savings Accounts in the province of Ontario, Canada. The analysis exploits a unique data set linking population-based health survey information with individual-level information on all physician services and hospital services utilization over a four year period. The analysis provides greater detail than have previous analyses regarding: the distributional impacts of publicly funded MSAs across individuals of differing health statuses, incomes, ages and current expenditures; the impact of differing degrees of risk-adjustment for MSA contributions; and the impact of MSA funding over multiple years, incorporating year-to-year variation in spending at the individual level. In addition, it analyses designs for publicly funded MSAs than existing studies. Government uses information available from period t-1 to allocate its budget for year t between MSA contributions and catastrophic insurance in a manner that is actuarially fair for the public sector: the government first withholds funds equal to expected catastrophic insurance payments under the MSA plan, and then allocates only the balance to individual MSA accounts. The government captures the savings associated with reduced health care utilization under MSAs and we examine deductibles that vary by income rather than current health care expenditures. The impacts on public expenditures under these designs are more modest than existing studies and under plausible assumptions MSAs are predicted to decrease public expenditures. MSAs, however, are predicted to have unavoidable negative distributional consequences with respect to both public expenditures and out-of-pocket spending.

Xu, K., et al. (2007). "Protecting households from catastrophic health spending." Health Aff. (Millwood.) **26**(4): 972-983.
http://www.ncbi.nlm.nih.gov/pubmed/17630440

Many countries rely heavily on patients' out-of-pocket payments to providers to finance their health care systems. This prevents some people from seeking care and results in financial catastrophe and impoverishment for others who do obtain care. Surveys in eighty-nine countries covering 89 percent of the world's population suggest that 150 million people globally suffer financial catastrophe annually because they pay for health services. Prepayment mechanisms protect people from financial catastrophe, but there is no strong evidence that social health insurance systems offer better or worse protection than tax-based systems do

2006

Baicker, K. (2006). "Improving Incentives in Health Care Spending." Business Economics **41**(2): 21-25.
http://www.palgrave-journals.com/be/archive/index.html

Although U.S. economic growth is likely to continue to be robust, the growth of private and public spending on health care presents long-run public policy challenges. To meet these challenges health care resources must be used more efficiently. Currently, there are few incentives to put health care dollars to the highest value use. This is true in both public and private spending. An important element of the problem lies in the tax-preferred treatment given to employer-provided insurance but not to out-of-pocket spending. The resulting bias towards first-dollar insurance coverage means that consumers are insulated from the real costs of the health care that they consume and have little reason to evaluate whether the benefits are greater than those costs. Moreover, they seldom have sufficient price and quality information to make informed decisions. Health Savings Accounts (HSAs) are a promising way to remove the tax-penalty for enrolling in catastrophic insurance and paying for routine care out of pocket. Given the information that they need, consumers would then have more choices and more control, strengthening their role in reducing waste, improving efficiency, and promoting competition. Coupled with other policies, HSAs can be a critical component in moving toward an efficient and equitable health care system.

Barigozzi, F. (2006). "Price vs. quantity in health insurance reimbursement." Int J Health Care Finance Econ **6**(3): 191-213.

While "integrated" systems regulate the quantity of health services, "Bismarckian" systems regulate their price. This paper compares the consumers' allocations implemented within the two reimbursement systems. In the model, illness has a negative impact on labor productivity while public insurance is financed through income tax. Consumers have private information with respect to a parameter which can be interpreted as heterogeneity either in intensity of their preferences for treatment or in the type of illness. The social planner may be constrained to adopt uniform insurance plans, or may be free to choose self selecting plans. The analysis of uniform plans shows that Bismarckian systems dominate integrated systems from the social welfare point of view; whereas the opposite ranking holds with self-selecting plans.

Cecil, W. T., et al. (2006). "Relationship of the use and costs of physician office visits and prescription drugs to travel distance and increases in member cost share." J Manag Care Pharm **12**(8): 665-676.

BACKGROUND: The prescription drug benefit is commonly designed and managed as a stand-alone health insurance product without consideration of how the design of other medical benefits may impact its use. OBJECTIVE: To determine the effects of member cost (copayment/coinsurance) increases on the relationship between the use of physician office visits and the type/tier of prescription medication purchased in a commercially insured population. METHODS: Our research model utilized managed care organization member costshare levels that were changed as part of the annual benefit renewal process to estimate the price.quantity.expenditure relationship between cost sharing and use of physician office visits/prescription drugs by benefit tier. The price.quantity. expenditure relationship was measured across a benefit copayment price change to determine the effect of a price increase on utilization/expenditures. We included the distance from the member.s residence to the physician.s office as a proxy for the time cost of an office visit. The study sample included 44,828 members who were fully insured for the full 12 months of 2002, continued coverage for the full 12 months of 2003, and whose benefit renewal occurred on January 1, 2003. We hypothesize that a relationship exists between office visit use and its expenditures and prescription drug use and its expenditures based on out-of-pocket cost. Hypotheses were tested using a least squares dummy variable regression model across claims records for years 2002 and 2003, containing consecutive yearly records for the same members. The unit of analysis was the member. Demand was estimated by benefit category and copayment tier to provide the study variables, price elasticity of demand, cross-price elasticity of demand, and distance elasticity. Expenditure is net health plan cost after subtraction of member cost share (including copayments, coinsurance, and deductibles). The expenditure categories in this study were pharmacy, medical office visits, and total health care costs. RESULTS: Members with greater travel distance to a primary care physician (PCP) or specialty care physician (SCP) office experienced higher PCP and SCP visit utilization (distance elasticity = 0.164 and

0.202, respectively; P <0.01). Greater travel distance to a PCP was also associated with higher tier-1 prescription use (0.048, P <0.01) as well as higher total plan-paid (0.032, P <0.05) and PCP expenditures (0.141, P <0.01). Greater travel distance to an SCP was associated with higher use of drugs in all 3 pharmacy copayment tiers (0.085, 0.075, and 0.073 for tier 1, tier 2, and tier 3, respectively; P <0.01 for each tier). The price effects of an increase in tier-1 copayments were fewer PCP office visits (-0.118, P <0.01) but more SCP office visits (0.177, P <0.01); SCP visits were also higher with increased tier-3 copayments (0.118, P <0.01). Tier-2 prescription drug use decreased with higher office visit copayments (-0.105, P <0.05). Increased tier-1 copayments were associated with lower expenditures for PCP office visits (-0.146, P <0.05) but higher expenditures for SCP office visits (0.149, P <0.05). While increases in tier-2 copayments were associated with lower PCP (and -0.322, P <0.01) and SCP (-0.453, P <0.01) expenditures, increases in tier-3 copayments were associated with higher PCP (0.495, P <0.01) and SCP (0.197, P <0.05) expenditures. CONCLUSIONS: A relationship exists between physician office visits and prescription drug use based on member cost share and time factors. Increases in office visit copayments were associated with decreased use of drugs in the tier-2 pharmacy benefit category. Increases in tier-2 pharmacy benefit copayment levels were associated with lower PCP/SCP expenditures, but increases in tier-3 pharmacy benefit copayment levels were associated with higher PCP/SCP expenditures. The distance to a physician.s office was directly proportional to the number of office visits. Separation of the management of pharmacy and medical benefits may have significant cost implications for consumers, employers, and health plans. Therefore, optimal management of medical and pharmacy benefits may require a coordinated strategy and tactics.

Johnson, T. J., et al. (2006). "The effects of cost-shifting in the state children's heath insurance program." Am J Public Health **96**(4): 709-715.

OBJECTIVES: Many states are increasing the State Children's Health Insurance Program (SCHIP) cost-sharing requirements to induce reductions in enrollment. We examined the effect of increasing SCHIP premiums on both health care use and cost to the public. METHODS: The net cost to the public of increased cost sharing for SCHIP-insured children in a border community was estimated with multivariate methods. The majority (88%) of children were of Mexican origin. RESULTS: We estimated that a $10 increase in monthly premiums would induce 10% of SCHIP children to disenroll, resulting in a 6% increase in public expenditures. CONCLUSIONS: Families that disenroll from SCHIP and become uninsured typically turn to emergency departments for primary care, which increases total health care expenditures through the use of more expensive services.

McIntyre, D., et al. (2006). "What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts?" Soc Sci Med **62**(4): 858-865.
http://www.ncbi.nlm.nih.gov/pubmed/16099574

This paper presents the findings of a critical review of studies carried out in low- and middle-income countries (LMICs) focusing on the economic consequences for households of illness and health care use. These include household level impacts of direct costs (medical treatment and related financial costs), indirect costs (productive time losses resulting from illness) and subsequent household responses. It highlights that health care financing strategies that place considerable emphasis on out-of-pocket payments can impoverish households. There is growing evidence of households being pushed into poverty or forced into deeper poverty when faced with substantial medical expenses, particularly when combined with a loss of household income due to ill-health. Health sector reforms in LMICs since the late 1980s have particularly focused on promoting user fees for public sector health services and increasing the role of the private for-profit sector in health care provision. This has increasingly placed the burden of paying for health care on individuals experiencing poor health. This trend seems to continue even though some countries and international organisations are considering a shift away from their previous pro-user fee agenda. Research into alternative health care financing strategies and related mechanisms for coping with the direct and indirect costs of illness is urgently required to inform the development of appropriate social policies to improve access to essential health services and break the vicious cycle between illness and poverty.

Michelle, M. (2006). "Can We Say No? The Challenge of Rationing Health Care." Journal of Economic Literature **44**(4): 1049-1054.

Shen, Y. C. et McFeeters, J. (2006). "Out-of-pocket health spending between low-and higher-income populations: who is at risk of having high expenses and high burdens?" Med Care **44**(3): 200-209.

OBJECTIVE: We studied the effects of health insurance, health care needs, and demographic and area characteristics on out-of-pocket health care spending for low and higher income insured populations. MATERIALS AND METHODS: We used the 2002 National Survey of America's Families to analyze out-of-pocket health spending. People were classified into 3 levels of expenses based on their out-of-pocket health care spending and 3 levels of financial burden based on spending as a share of family income. We used a multinomial logit model to estimate the effect of insurance status and other factors on expense and burden levels. RESULTS: Public insurance appears to offer the best financial protection from high out-of-pocket expenses and financial burden for those who are eligible. Families with private nongroup coverage have the highest odds of being in the high-expense and high-burden categories for all incomes. For higher-income families, having a family member in fair or poor health is a significant risk factor for high out-of-pocket expenses and financial burden. Having higher penetration of health maintenance organizations in an area appears to lower the odds of being in the high-burden category for all families. CONCLUSIONS: Health insurance may not prevent people from having high health care spending. Low-income people with serious health needs appear to be financially constrained and spend less on health care relative to higher-income people, and the presence of health maintenance organizations may help reduce out-of-pocket health care spending.

Van Doorslaer, E., et al. (2006). "Effect of payments for health care on poverty estimates in 11 countries in Asia: an analysis of household survey data." Lancet **368**(9544): 1357-1364.
http://www.ncbi.nlm.nih.gov/pubmed/17046468

BACKGROUND: Conventional estimates of poverty do not take account of out-of-pocket payments to finance health care. We aimed to reassess measures of poverty in 11 low-to-middle income countries in Asia by calculating total household resources both with and without out-of-pocket payments for health care. METHODS: We obtained data on payments for health care from nationally representative surveys, and subtracted these payments from total household resources. We then calculated the number of individuals with less than the internationally accepted threshold of absolute poverty (US1 dollar per head per day) after making health payments. We also assessed the effect of health-care payments on the poverty gap--the amount by which household resources fell short of the 1 dollar poverty line in these countries. FINDINGS: Our estimate of the overall prevalence of absolute poverty in these countries was 14% higher than conventional estimates that do not take account of out-of-pocket payments for health care. We calculated that an additional 2.7% of the population under study (78 million people) ended up with less than 1 dollar per day after they had paid for health care. In Bangladesh, China, India, Nepal, and Vietnam, where more than 60% of health-care costs are paid out-of-pocket by households, our estimates of poverty were much higher than conventional figures, ranging from an additional 1.2% of the population in Vietnam to 3.8% in Bangladesh. INTERPRETATION: Out-of-pocket health payments exacerbate poverty. Policies to reduce the number of Asians living on less than 1 dollar per day need to include measures to reduce such payments;

Les restes à charge : un rôle majeur dans le renoncement aux soins

FOCUS

Le renoncement aux soins

Le concept de « renoncement aux soins » (*Unmet health needs* en anglais) est issu de l'enquête Santé et Protection Sociale (ESPS) : 1988-1991, dans laquelle a été introduite une question sur le renoncement aux soins pour des raisons financières. Il n'a pas encore donné lieu à une définition spécifique. Conduite par l'Irdes, l'Enquête Santé Protection Sociale (ESPS) est un outil pluridisciplinaire qui explore les relations entre l'état de santé, l'accès aux services de santé, l'accès à l'assurance publique et privée et le statut économique et social des individus enquêtés. Sa périodicité bisannuelle et sa dimension longitudinale lui permettent de participer à l'évaluation des politiques de santé, de traiter les problématiques d'équité du système de santé publique. De plus, son lien avec les données de prestation de la Sécurité sociale rend possible des analyses fines des déterminants du recours aux soins. Cette enquête a permis un suivi du taux de renoncement sur la période1998-2001. La méthodologie de l'enquête ESPS 2012 a complétement changé en ce qui concerne les questions sur le renoncement aux soins. Il est donc impossible d'obtenir un chiffre comparable à ceux obtenus dans les précédentes enquêtes après cette date (cf QES, n° 198, mai 2014 et Rapport, n° 302, 2014). Selon les résultats de l'Enquête santé protection sociale (ESPS) 2010, 15,4 % de la population de 18 à 64 ans a déclaré renoncer à des soins pour des raisons financières lors des douze derniers mois. Le renoncement à des soins dentaires concerne 10,7 % de la population, ce qui en fait le type de soins le plus concerné après la lunetterie. Ces résultats portent sur un échantillon de 8 000 ménages et 23 000 individus interrogés. Si l'on se reporte aux résultats de l'enquête EHIS-ESPS en 2014[15] - dont la méthodologie est différente - le taux de renoncement se situe à 25 %, ce qui se décline par types de soins de la façon suivante : 45,9 % pour les soins dentaires, 27,5 % pour l'optique, 14,3 % pour les consultations médicales, 12,3 % pour les autres soins et examens.

Une analyse au fil du temps montre que le taux de renoncement à des soins pour des raisons financières en France augmente entre 1998 et 2000. Il chute ensuite fortement de 2000 à 2002 suite à l'instauration de la loi sur la couverture maladie universelle.[16]Il est ensuite en constante augmentation jusqu'en 2014 pour revenir quasiment à son niveau de 2000. Il amorce enfin une décru à partir de 2014. Le Panorama de la santé Europe 2018 de l'OCDE montre aussi que les taux de renoncement aux soins tendent à baisser depuis 2014 dans la plupart des pays européens[17]. Celui de la France, pour diverses raisons (éloignement géographique, délais, financement) est plus faible que la moyenne européenne (2,8% contre 3,3%). Mais si l'on isole les 20% de la population les plus pauvres, la situation française est un peu moins bonne que la moyenne européenne, avec un taux de renoncement de 6,6 % contre 6,4 % en Allemagne, en Espagne ou au Royaume-Uni.

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[15] Celant, N. et Rochereau, T. (2017). L'Enquête santé européenne - Enquête santé et protection sociale (EHIS-ESPS) 2014. Les rapports de l'Irdes ; 566

[16] Instauration de la loi sur la couverture maladie universelle du 27 juillet 1999

[17] OCDE (2018). Health at a glance : Europe 2018. Paris OCDE

Évolution du taux de renoncement aux soins pour raisons financières (en %)

1998	2000	2002	2004	2006	2008	2010
14,3%	15,4%	11,2%	13 %	14,2%	15,4%	15,1%

Source : Enquête ESPS (rapports des années 1998, 2000, 2002, 2006, 2008, 2010, Questions d'économie de la santé, n° 110 pour 2004

ÉTUDES DE L'IRDES

2020

Penneau, A., Pichetti, S. et Espagnacq, M. (2020). "Restes à charge sanitaires des personnes âgées dépendantes à domicile." Gerontologie Et Societe **42**(162): 121-140.
https://www.cairn.info/revue-gerontologie-et-societe-2020-2-page-121.html

> Les personnes âgées dépendantes sont plus souvent confrontées à des dépenses sanitaires élevées. Des dispositifs d'exonération du ticket modérateur (ALD, pension d'invalidité…) leur permettent de réduire leurs restes à charge, mais aucune étude française n'a encore mesuré l'efficacité du système de protection sociale pour ces personnes. Cet article propose une analyse sur les personnes âgées de 60 ans et plus résidant en logement ordinaire. À partir des données de l'enquête Handicap Santé Ménages collectées en 2008, nous classons les assurés en fonction de leur recours à l'aide humaine et analysons les niveaux et la structure de leurs dépenses sanitaires. Malgré une croissance des dépenses avec le niveau de dépendance, le système de protection sociale maintient les restes à charge à un montant moyen de 900 euros annuels quel que soit le niveau de dépendance. Nos résultats montrent également que les postes qui pèsent le plus sur le reste à charge sont bien couverts par les complémentaires. Les inégalités de restes à charge dépendent donc principalement de la capacité des ménages à financer leur assurance complémentaire.

2019

Penneau, A., Pichetti, S. et Espagnacq, M. (2019). Dépenses et restes à charge sanitaires des personnes en situation de handicap avant et après 60 ans. Les rapports de l'Irdes ; 571. Paris IRDES**:** 165.
https://www.irdes.fr/recherche/rapports/571-depenses-de-sante-et-restes-a-charge-sanitaires-des-personnes-en-situation-de-handicap-avant-et-apres-60-ans.pdf

> Les situations de handicap entraînent des coûts supplémentaires pour les ménages concernés. Les coûts sanitaires - soins médicaux et une partie des aides techniques - représentent l'un des principaux postes de dépense des personnes en situation de handicap. L'objectif de ce rapport est de dresser un état des lieux de la prise en charge sanitaire de ces personnes avant et après 60 ans. Deux populations se distinguent, les personnes handicapées reconnues inaptes au travail et les personnes ayant besoin d'aide pour réaliser les activités de la vie quotidienne.

Penneau, A., Pichetti, S. et Espagnacq, M. (2020). "Restes à charge sanitaires des personnes âgées dépendantes à domicile." Gerontologie Et Societe **42**(162): 121-140.
https://www.cairn.info/revue-gerontologie-et-societe-2020-2-page-121.html

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les niveaux et la structure de leurs dépenses sanitaires. Malgré une croissance des dépenses avec le niveau de dépendance, le système de protection sociale maintient les restes à charge à un montant moyen de 900 euros annuels quel que soit le niveau de dépendance. Nos résultats montrent également que les postes qui pèsent le plus sur le reste à charge sont bien couverts par les complémentaires. Les inégalités de restes à charge dépendent donc principalement de la capacité des ménages à financer leur assurance complémentaire.

2018

Penneau, A., Pichetti, S. et Espagnacq, M. (2018). "Le système de protection sociale limite les restes à charge liés aux soins des personnes qui recourent à l'aide humaine." Questions D'Economie de la Sante (Irdes)(233): 1-8.
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/233-le-systeme-de-protection-sociale-limite-les-restes-a-charge-lies-aux-soins-des-personnes-qui-recourent-a-l-aide-humaine.pdf

Les personnes qui recourent à l'aide humaine pour réaliser les activités du quotidien ont souvent des dépenses de santé élevées. Cette aide est en effet fréquemment associée à des pathologies nécessitant une prise en charge sanitaire lourde et à l'achat de dispositifs médicaux coûteux qui peuvent s'accompagner de restes à charge après remboursement par l'assurance maladie obligatoire importants. Pour autant, on ne connaît pas la capacité du système de protection sociale à limiter le niveau de reste à charge pour cette population. A partir des données de l'enquête Handicap Santé Ménages, les profils des personnes âgées de 20 ans et plus recourant à l'aide humaine et qui vivent à domicile sont analysés en termes de caractéristiques sociodémographiques, d'état de santé, de dépenses de santé, d'accès aux dispositifs de protection sociale et de restes à charge. Deux populations sont distinguées, les personnes âgées de plus ou de moins de 60 ans dont les caractéristiques et accès aux droits diffèrent. Les personnes âgées de plus de 20 ans sont 4,4 millions à recourir à cette aide, soit 9 % des plus de 20 ans, et leurs dépenses de santé croissent avec l'intensité de leur recours. Leur reste à charge est le double de celui de la population générale mais ne croît pas avec le degré de recours à l'aide humaine. Et si l'Assurance maladie parvient à lisser les restes à charge moyens liés aux dépenses de santé grâce aux exonérations du ticket modérateur, des restes à charge élevés persistent pour des personnes recourant à l'aide humaine avec des consommations de soins spécifiques tels les orthèses et prothèses ou les hospitalisations en psychiatrie.

2017

Celant, N. et Rochereau, T. (2017). L'Enquête santé européenne - Enquête santé et protection sociale (EHIS-ESPS) 2014. Les rapports de l'Irdes ; 566. Paris IRDES: 282 , tabl.
http://www.irdes.fr/recherche/rapports/566-enquete-sante-europeenne-ehis-enquete-sante-et-protection-sociale-esps-2014.pdf

Conduite par l'Irdes depuis 1988, l'Enquête santé protection sociale (ESPS) est un outil pluridisciplinaire qui explore les relations entre l'état de santé, l'accès aux services de santé, l'accès à l'assurance publique et privée et le statut économique et social des individus enquêtés. En 2014, en collaboration avec la Direction de la recherche, des études, de l'évaluation et des statistiques (Drees), l'enquête ESPS a été le support de l'Enquête santé européenne (European Health Interview Survey-EHIS) qui devient, pour la France, la seule enquête généraliste sur le sujet représentative en population générale. L'année 2014 constitue ainsi la dernière vague du terrain de l'enquête ESPS dont les données de consommation de soins seront collectées et appariées aux données de l'Assurance maladie jusqu'en 2016. Pour la vague 2019 et les suivantes, prévues tous les six ans, la version française d'EHIS intègrera, en plus des questions européennes inscrites dans un règlement Eurostat, des questions spécifiques à la France sur la couverture complémentaire santé. En 2014, ESPS est représentative d'environ 95 % de la population vivant en ménage ordinaire en France. Selon les résultats de l'enquête, près d'une personne sur trois âgée de 15 ans ou plus déclare un état de santé assez bon, mauvais ou très mauvais. Près de 40 % évoquent un problème de santé chronique et un quart une limitation dans les activités du quotidien. Les catégories sociales les plus défavorisées déclarent globalement être en moins bonne santé que les autres. Environ 9 % des femmes et 5 % des hommes souffrent de symptômes dépressifs, ce qui place la France au huitième rang des 26 pays pour lesquels ces données sont disponibles. Concernant la couverture complémentaire santé, près de 5 % des personnes déclarent ne pas en avoir. L'absence de complémentaire santé concerne avant tout les populations les plus précaires, comme les personnes au chômage et celles disposant de faibles revenus. Malgré des dispositifs d'aide existants (Couverture maladie universelle complémentaire (CMU-C) et Aide au paiement d'une complémentaire santé (ACS)), le premier motif de non-recours demeure le coût trop élevé des contrats.

2014

Celant, N., Dourgnon, P., Guillaume, S., et al. (2014). "L'Enquête santé et protection sociale (ESPS) 2012. Premiers résultats." Questions D'Economie de la Sante (Irdes)(198): 6.
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/198-l-enquete-sante-et-protection-sociale-esps-2012-premiers-resultats.pdf

L'enquête santé et protection sociale, menée par l'Irdes tous les deux ans, existe depuis 1988. En 2012, elle a interrogé plus de 8 000 ménages et 23 000 individus sur leur état de santé, leur accès à la complémentaire santé, leur recours ou renoncement aux soins et, à travers des modules spécifiques, sur la fragilité, l'assurance dépendance et les conditions de travail ainsi que sur la couverture vaccinale, les accidents de la vie quotidienne et le don de sang, notamment. Les spécificités de l'enquête comme sa périodicité courte, sa dimension longitudinale et son enrichissement avec des données de l'Assurance maladie, participent d'en faire un outil tant de suivi des politiques publiques que de recherche en sciences sociales. En 2014, l'enquête ESPS est d'ailleurs le support de l'enquête santé européenne EHIS (European Health Interview Survey). Les résultats de l'enquête 2012 présentés dans cette synthèse sont issus d'un rapport (Célant et al., 2014) dans lequel l'intégralité des données chiffrées est accessible en ligne sous forme de tableaux Excel.

Celant, N., Guillaume, S. et Rochereau, T. (2014). Enquête sur la santé et la protection sociale 2012. Les rapports de l'Irdes ; 556. Paris Irdes **:** 302 , tabl.
http://www.irdes.fr/recherche/rapports/556-enquete-sur-la-sante-et-la-protection-sociale-2012.pdf

Conduite par l'Irdes depuis 1988, l'Enquête santé et protection sociale (ESPS) est un outil qui explore à l'échelon national (France métropolitaine) les relations entre l'état de santé, l'accès aux services de santé, l'accès à l'assurance publique et privée et le statut économique et social des individus enquêtés. La périodicité biennale de l'enquête, son lien avec les données de prestations de l'Assurance maladie et sa dimension longitudinale permettent d'alimenter le suivi et l'évaluation des politiques en santé, d'analyser finement les déterminants du recours aux soins et de traiter les problématiques d'équité du système de soins ou de santé publique. En 2012, l'enquête ESPS a interrogé plus de 8 000 ménages et près de 23 000 individus. Le rapport décrit les objectifs ainsi que la méthodologie de l'enquête et présente des travaux de recherche s'appuyant sur de nouvelles questions posées dans ESPS 2012. Sont explorés les déterminants du don du sang, la mesure de la fragilité des personnes âgées dans les enquêtes ESPS et SHARE et les déterminants de la demande d'assurance du risque de dépendance.

2013

Dourgnon, P. (2013). Évaluation des politiques publiques et inégalités sociales d'accès aux services de santé. Paris Université Paris Dauphine, Université Paris-Dauphine. Ecole doctorale de Dauphine. Paris. FRA. **Thèse de doctorat de sciences économiques.:** 160.
http://www.irdes.fr/EspaceEnseignement/ThesesMemoires/ThesePaulDourgnonPolitiquesPubliques.pdf

> En dépit des objectifs énoncés de respect du principe d'équité horizontale, on observe des inégalités sociales dans la consommation de soins des pays dotés de systèmes de santé socialisés. Cette thèse se propose, au travers de quatre études, de contribuer a l'analyse des politiques publiques dans le système de sante, du point de vue de l'équité de recours aux services de santé. L'introduction propose des éléments descriptifs des inégalités sociales de recours aux soins en France ainsi que des principaux mécanismes qui, à l'intérieur du système de santé français, peuvent en être a l'origine. Le premier chapitre étudie les liens entre barrières financières à l'accès aux soins et état de santé. Il montre que le fait de renoncer à des soins pour des raisons financières est associé à un état de santé futur plus détérioré. Le deuxième chapitre propose une analyse de l'interaction médecin-patient et de son rôle dans la formation des inégalités de recours aux soins. Cette thèse étudie les catégorisations opérées par les médecins au sujet de leurs patients en fonction de leurs situations sociales. Elle montre ensuite les relations entre ces catégorisations et les pratiques observées. Un troisième chapitre collige deux études portant sur la réforme du médecin traitant. La première propose une analyse de la réforme et de son contexte, en particulier le rôle des différents acteurs. La seconde propose une étude des conséquences de la réforme sur l'accès financier aux soins de spécialistes.

Rochereau, T. et Azogui-Levy, S. (2013). "La prise en charge du suivi bucco-dentaire des personnes diabétiques est-ellle adaptée ? Exploitation de l'enquête ESPS 2008." Questions D'Economie de la Sante (Irdes)(185): 1-6.
http://www.irdes.fr/Publications/Qes2013/Qes185.pdf

> Le diabète est une pathologie caractérisée par une hyperglycémie chronique résultant d'une déficience de sécrétion d'insuline. Non équilibré, il peut engendrer des complications sévères. La maladie parodontale constitue une des complications du diabète non équilibré. Cette affection bactérienne détruit les tissus qui supportent les dents et provoque leur perte. Or, la prévention des affections dentaires peut avoir un effet bénéfique sur l'équilibre du diabète et la qualité de vie des personnes atteintes. À partir des données de l'Enquête santé et protection sociale (ESPS) 2008, représentative en population générale, nous décrivons les caractéristiques socio-économiques des personnes diabétiques et nous interrogeons sur leurs accès et recours au dentiste.

2012

Despres, C., Renaud, T., Coldefy, M., et al. (2012). Analyse territoriale des obstacles à l'accès aux soins des bénéficiaires de la CMU complémentaire dans les départements de l'Orne et de la Nièvre. Paris Fonds CMU ; Paris Irdes**:** 94.
http://www.cmu.fr/userdocs/Refus_soins_en_milieu_rural.pdf

> Plusieurs tests de discrimination (testing) ont été réalisés par le fonds CMU depuis une dizaine d'années. Ils ont permis de confirmer l'existence de refus de soins de professionnels de santé à l'égard des bénéficiaires de la CMU-C ainsi que de le mesurer sur des territoires géographiques donnés. Cependant, les professionnels testés étaient tous installés en milieu urbain. L'objectif de cette recherche est d'analyser les obstacles à l'accès aux soins des bénéficiaires de la CMU-C et de manière plus large les personnes dans des situations de précarité en milieu rural. Ce nouveau test de discrimination a été réalisé dans deux départements ruraux, la Nièvre et l'Orne. Il permet d'enrichir l'analyse des attitudes des praticiens à l'égard des bénéficiaires de la CMU-C dans un environnement marqué par une faible démographie médicale. Une vingtaine d'entretiens auprès de personnes vivant en milieu rural, dans des situations de vie précaires (dont des bénéficiaires de la CMU-C) ont également été réalisés pour compléter l'analyse quantitative.

Dourgnon, P., Guillaume, S. et Rochereau, T. (2012). Enquête sur la santé et la protection sociale 2010. Rapport Irdes ; 1886. Paris Irdes **:** 232 , tabl., graph., ann.
http://www.irdes.fr/Publications/Rapports2012/rap1886.pdf

Conduite par l'Irdes depuis 1988, l'Enquête santé protection sociale (ESPS) est un outil pluridisciplinaire qui explore les relations entre l'état de santé, l'accès aux services de santé, l'accès à l'assurance publique et privée et le statut économique et social des individus enquêtés. Sa périodicité bisannuelle et sa dimension longitudinale lui permettent de participer à l'évaluation des politiques de santé, de traiter les problématiques d'équité du système de soins ou de santé publique. De plus, son lien avec les données de prestation de la Sécurité sociale rend possible des analyses fines des déterminants du recours aux soins. En 2010, l'enquête ESPS prenant en compte l'évolution des systèmes d'information de l'Assurance maladie a été réalisée sur un échantillon intégralement renouvelé. Plus de 8 000 ménages et près de 23 000 individus ont été interrogés. Après avoir décrit les objectifs et la méthodologie de l'enquête, un article appuyant sur de nouvelles questions posées dans ESPS, concernant la problématique santé-travail, présente des résultats sur l'état de santé des salariés en emplois précaires en 2010.

Dourgnon, P., Jusot, F. et Fantin, R. (2012). Payer peut nuire à votre santé : une étude de l'impact du renoncement financier aux soins sur l'état de santé. Document de travail Irdes ; 47. Paris IRDES**:** 30.
http://www.irdes.fr/EspaceRecherche/DocumentsDeTravail/DT47EtudeImpactRenoncementFinancierSoinsEtatSante.pdf

Cette étude propose d'analyser des déterminants du renoncement aux soins pour raisons financières, puis d'étudier ses conséquences sur l'évolution de l'état de santé quatre ans plus tard à partir des données de l'Enquête santé protection sociale (ESPS). L'analyse des déterminants du renoncement montre le rôle important joué par l'accès à une couverture complémentaire, au côté de celui de la situation sociale présente, passée et anticipée. L'analyse montre ensuite que les difficultés d'accès aux soins contribuent aux inégalités de santé (résumé d'auteur).

Dourgnon, P., Lafortune, G., Chauvin, P., et al. (2012). Le renoncement aux soins. Actes du colloque du 22 novembre 2011, Paris : Drees

La DSS et la DREES ont souhaité explorer cette notion de renoncement aux soins, afin de bien mesurer le phénomène et de mieux comprendre ce qu'il recouvre, d'en connaître les déterminants, et de réfléchir au rôle des politiques publiques pour en limiter l'ampleur. Plusieurs travaux de recherche ont été présentés lors du colloque « Renoncement aux soins » qui s'est tenu à Paris en novembre dernier. La présentation de ces travaux a été suivie par une table ronde donnant la parole aux différents acteurs du système de soins autour d'un débat sur la question suivante : « Comment mieux garantir l'accessibilité financière aux soins ? ». Ce recueil retranscrit les différents exposés de ce colloque ainsi que les débats qui les ont suivis.

2011

Despres, C., Dourgnon, P., Fantin, R., et al. (2011). "Le renoncement aux soins : une approche socio-anthropologique." Questions D'Economie de la Sante (Irdes)(169): 7.
http://www.irdes.fr/Publications/2011/Qes169.pdf

Le concept de renoncement aux soins, utilisé régulièrement dans les enquêtes et de plus en plus mobilisé dans le débat public en France, n'a pas encore fait l'objet d'un travail méthodologique permettant d'analyser le sens que lui donnent les individus interrogés. Si le renoncement aux soins se réfère le plus souvent dans les enquêtes à un renoncement pour raisons financières, une approche socio-anthropologique, à partir d'entretiens non directifs, permet d'analyser plus largement les significations du renoncement pour les individus ainsi que les logiques sociales, économiques et culturelles qui les déterminent. Cette étude montre que le renoncement aux soins, qui peut survenir à tout moment d'un itinéraire thérapeutique, prend deux formes principales : le renoncement-barrière et le renoncement- refus. Dans le premier cas, l'individu fait face à un environnement de contraintes, le plus souvent budgétaires, qui ne lui permet pas d'accéder au soin désiré. Le second cas est l'expression d'un refus qui porte soit sur des soins spécifiques : il s'agit alors d'un acte d'autonomie à l'égard de la médecine dite conventionnelle soit, plus radicalement, sur le fait même de se soigner : il revêt alors un caractère définitif et traduit la perception d'une inutilité des soins. Ces deux formes de renoncement -barrière et refus - sont fréquemment associées : le facteur financier est rarement isolé et se combine à d'autres motifs amenant les individus à renoncer à un soin. Les résultats d'une étude du renoncement aux soins pour raisons financières, s'appuyant sur des travaux économétriques, sont publiés simultanément (Després et al., 2011).

Despres, C., Dourgnon, P., Fantin, R., et al. (2011). "Le renoncement aux soins pour raisons financières : une approche économétrique." Questions D'Economie de la Sante (Irdes)(170): 6.
http://www.irdes.fr/Publications/2011/Qes170.pdf

La France, bien que pourvue d'un système de protection sociale à vocation universelle, connaît des inégalités sociales dans l'accès et l'utilisation des services de santé. L'analyse des déterminants du renoncement aux soins pour raisons financières apporte un nouvel éclairage sur cette question. En 2008, 15,4 % de la population adulte déclare avoir renoncé à des soins médicaux pour des raisons financières au cours des douze derniers mois. Les barrières financières se concentrent sur les soins dentaires (10 % de la population concernée) et, dans une moindre mesure, l'optique (4,1 %) et les consultations de médecins généralistes et spécialistes (3,4 %). Ces difficultés d'accès aux soins sont en partie expliquées par les limites du système de protection sociale. L'absence de couverture complémentaire est un facteur important du renoncement aux soins alors que la CMU-C en facilite l'accès. Néanmoins, cette étude révèle d'autres facteurs de renoncement liés à l'histoire de vie, en particulier la situation sociale passée, présente ainsi que les perspectives d?avenir. Cette étude démontre aussi que les prix pratiqués par les professionnels de santé qui peuvent fixer librement leurs honoraires jouent sur l'accessibilité des soins. Des travaux socio-anthropologiques, publiés simultanément (Desprès et al., 2011), confirment l'intérêt de l?approche par le renoncement financier pour l?étude de l?accès aux services de santé et la pertinence des approches quantitatives multivariées.

Perronnin, M., Pierre, A. et Rochereau, T. (2011). "La complémentaire santé en France en 2008 : une large diffusion mais des inégalités d'accès." Questions D'Economie de la Sante (Irdes)(161): 4.
http://www.irdes.fr/Publications/2011/Qes161.pdf

Dans un contexte de croissance continue des dépenses de santé et d?augmentation récente de la part des dépenses non prises en charge par l'assurance maladie obligatoire, la diffusion de la couverture complémentaire santé représente un enjeu important pour maintenir l'accès aux soins des personnes les plus pauvres et les plus malades. Depuis une trentaine d'années, les pouvoirs publics ont mis en place divers lois et dispositifs visant à favoriser l'accès à la complémentaire santé de l'ensemble de la population. Entre 1980 et 2008, la proportion de personnes couvertes par une complémentaire santé a fortement augmenté, passant de 69 % de la population de France métropolitaine à 94 %. Néanmoins, selon l'enquête santé protection sociale (ESPS), près de 4 millions de personnes restent sans complémentaire santé en France métropolitaine en 2008. Quels sont les différents modes d'accès à la couverture complémentaire santé ? Quelles sont les personnes qui restent en marge de cette couverture ? S'agit-il d'un choix de leur part ou bien persiste-t-il des barrières à l'accès à la complémentaire santé ? Quelles sont les conséquences sur leur accès aux soins et leur état de santé ?

2010

Afrite, A., Bourgueil, Y., Celant, N., et al. (2010). Score Epices : comparaison des résultats dans les échantillons ESPS et Cetaf. Enquête sur la santé et la protection sociale 2008., Paris : IRDES**:** 43-65, tabl., graph.
http://www.irdes.fr/Publications/Rapports2010/rap1800.pdf

Le score Epices est recueilli chaque année auprès d'environ 600 000 personnes qui bénéficient d'un examen périodique de santé (EPS), tous les cinq ans, dans un Centre d'examen de santé (CES) de l'Assurance maladie (près de 6 % de la population affiliée au régime général). Ainsi, en collaboration avec le Cetaf, nous avons pu comparer pour la première fois les données relatives au score Epices dans l'enquête ESPS 2008 à celles recueillies auprès des CES par le Cetaf pour l'année 2007. Les premiers résultats de cette comparaison confirment la reproductibilité du score Epices en population générale et l'apport de ce score en termes de qualification de la précarité sociale comparativement à d'autres outils de mesure existants. Après avoir présenté les deux populations d'étude et comparé les liens entre les valeurs du score Epices et différentes dimensions (sociodémographiques, d'état de santé, de recours aux soins et de comportements à risque), nous analyserons l'apport du score Epices comparativement à celui d'autres outils de mesure comme le revenu ou l'indicateur global de vulnérabilité sociale (Cambois et Jusot, 2006) (résumé d'auteur).

Allonier, C., Dourgnon, P. et Rochereau, T. (2010). Enquête sur la santé et la protection sociale 2008. Rapport Irdes ; 1800. Paris Irdes**:** 258 , tabl., graph., ann.
http://www.irdes.fr/Publications/Rapports2010/rap1800.pdf

L'Enquête santé protection sociale (ESPS) 2008 explore les relations entre l'état de santé, les accès aux services de santé, à l'assurance publique et privée et le statut économique et social des individus enquêtés. Sa périodicité bisannuelle et sa dimension longitudinale permettent de participer à l'évaluation des politiques de santé, de traiter des questions d'équité du système ou de santé publique. De plus, son lien avec les données de prestation de la Sécurité sociale rend possible des analyses fines des déterminants du recours aux soins. En 2008, plus de 8 000 ménages et 22 000 individus ont été interrogés. Après une présentation des objectifs et de la méthodologie de l'enquête, deux nouvelles problématiques sont proposées : l?une sur le renoncement avec un focus sur les CMU-Cistes, l'autre sur une comparaison inédite des données de l'ESPS et du Centre technique d'appui et de formation des centres d'examens de santé (Cetaf) relatives au score Epices qui mesure la précarité et les inégalités de santé. Enfin, des premiers résultats sont fournis sous la forme de tableaux.

Allonier, C., Dourgnon, P., Sermet, C., et al. (2010). La santé des femmes en France. Edition mise à jour, Paris : Dress

À partir de fiches thématiques conjuguant les approches par pathologie et par population, ce recueil dresse un tableau précis de la santé des femmes, en France, en 2008 : données de cadrage, santé sexuelle et reproductive, périnatalité, maladies infectieuses, maladies chroniques et vieillissement, cancers, addictions et toxicomanie, santé mentale, accidents et traumatismes, santé et travail, santé et précarité. Un éclairage particulier est porté sur trois problématiques au c?ur des préoccupations actuelles de santé publique : la périnatalité, la santé sexuelle et reproductive ainsi que les violences subies par les femmes. Au-delà des constats, ce recueil statistique sur l'ensemble des données disponibles dans le champ sanitaire et social se veut aussi un outil d'aide à la décision. Statisticiens, épidémiologistes, médecins, démographes et sociologues... ont apporté leur contribution à cette étude de référence.

Boisguerin, B., Despres, C., Dourgnon, P., et al. (2010). Etudier l'accès aux soins des assurés CMU-C, une approche par le renoncement aux soins. Enquête sur la santé et la protection sociale 2008., Paris : IRDES**:** 31-40, tabl., graph.
http://www.irdes.fr/Publications/Rapports2010/rap1800.pdf

Cette contribution issue de l'Enquête santé protection sociale (ESPS) 2008 préfigure un projet de recherche plus large et comporte quatre parties. D'abord, les auteurs reviennent sur le concept de renoncement aux soins : ce qu'il traduit, ce qu'il apporte à l'analyse de l'accessibilité des services de santé. La deuxième partie, empirique, s'appuie sur les données de l'enquête ESPS 2008 et met en perspective les cinq derniers points d'enquête, depuis 1998. Les facteurs potentiels de renoncement aux soins ainsi que l'évolution au cours du temps du renoncement aux soins y sont analysés. En particulier, les auteurs explorent ce que le renoncement aux soins décrit de l'évolution de l'accès aux services de santé des assurés CMU-C. La troisième partie, méthodologique, précise comment il convient de mesurer des différentiels de renoncement entre CMU-Cistes et autres à partir d'ESPS. Enfin, la quatrième et dernière partie présente les grands axes d?un travail de recherche à venir sur le renoncement.

Kambia-Chopin, B. et Perronnin, M. (2010). "Les franchises ont-elles modifié les comportements d'achats de médicaments ?" Questions D'Economie de la Sante (Irdes)(158): 8.
http://www.irdes.fr/Publications/2010/Qes158.pdf

> Les franchises de 0,5 centimes sur les boîtes de médicaments, mises en place le 1er janvier 2008, avaient notamment pour objectif d'inciter les individus à réguler leur consommation de médicaments. Néanmoins, la somme prélevée par boîte étant la même quels que soient la nature du médicament, le niveau de ressources et l'état de santé des individus, cette charge financière pèse plus fortement sur les individus malades ou à faibles revenus et peut les contraindre à renoncer à des soins utiles. Afin d'apporter un premier éclairage sur ces hypothèses, une analyse a été menée à partir de données déclaratives de l'Enquête santé protection sociale (ESPS) 2008. 12 % des enquêtés déclarent avoir modifié leurs achats de médicaments suite à la mise en place des franchises. Ce comportement est influencé par le niveau de revenu et l'état de santé : la probabilité de déclarer avoir modifié ses achats est de 7 points plus élevée chez les individus gagnant moins de 870 euros par mois, comparés à ceux gagnant plus de 1 167 euros par mois, soit un quasi-doublement de cette probabilité. Elle est plus élevée de 2 points chez les individus souffrant d'une pathologie chronique, comparés aux autres. Une différence similaire est observée entre les individus déclarant un état de santé moyen, mauvais ou très mauvais comparés à ceux qui se déclarent en bonne santé (résumé d'auteur).

2008

Allonier, C., Dourgnon, P. et Rochereau, T. (2008). Enquête sur la Santé et la Protection Sociale 2006. Rapport Irdes ; 1701. Paris Irdes**:** 236 , tabl., graph., ann.

> Depuis 1988, l'Enquête Santé Protection Sociale (ESPS) interroge les Français sur leur état de santé, leur recours aux soins et leur couverture maladie. Par sa fréquence, l'étendue de ses questionnements et sa dimension longitudinale, elle participe à l'évaluation des politiques de santé, au suivi des problèmes de santé publique en population générale et sert de support à la recherche en économie de la santé. En 2006, ESPS a interrogé 8 100 ménages et 22 000 individus. Un suréchantillon de ménages couverts par la Couverture maladie universelle complémentaire a complété l'échantillon habituel, afin de mieux décrire les caractéristiques d'état de santé et d'accès aux soins de cette population. L'enquête 2006 incorpore de nouveaux questionnements. Elle vise en particulier à participer à l'évaluation de la réforme du « médecin traitant » et du parcours de soins coordonnés. Des questions sur la santé respiratoire et l'asthme permettront d'évaluer l'évolution de la maladie, d'étudier ses déterminants sociaux et environnementaux, puis d'évaluer l'adéquation des traitements effectifs avec les normes de bonnes pratiques médicales. Un module sur les conditions de vie dans l'enfance et l'état de santé des parents permettra d'approfondir les travaux menés sur les mécanismes intergénérationnels à l'œuvre dans la construction des inégalités des chances en santé, notamment la transmission des comportements à risque pour la santé.

Kampia Chopin, B., Perronnin, M., Pierre, A., et al. (2008). "La complémentaire santé en France en 2006 : un accès qui reste inégalitaire : résultats de l'Enquête Santé Protection Sociale 2006 (ESPS 2006)." Questions D'Economie de la Sante (Irdes)(132): 4.
http://www.irdes.fr/Publications/Qes/Qes132.pdf

> En 2006, plus de 9 personnes sur 10 déclarent être couvertes par une complémentaire santé en France. Parmi les personnes non couvertes, plus d'une personne sur deux évoque des raisons financières. L'accès à la complémentaire santé reste donc encore difficile et coûteux pour les ménages dont les revenus sont faibles. En effet, ce sont eux qui déclarent les taux de couverture les plus bas. À l'inverse, les ménages ayant les revenus les plus élevés, notamment les cadres, bénéficient d'un accès plus facile à la complémentaire santé du fait de ressources financières plus importantes et d'un accès plus fréquent à la couverture d'entreprise. Pour la première fois, les données de l'enquête Santé Protection Sociale (ESPS) sont exploitées pour calculer le taux d'effort, c'est-à-dire la part de revenu

que les ménages consacrent à la couverture complémentaire. Ce taux d'effort varie de 3 % pour les ménages les plus aisés à 10 % pour les ménages les plus pauvres (exception faite des bénéficiaires de la CMU-C). Pour un taux d'effort trois fois plus élevé, les ménages les plus pauvres bénéficient cependant de contrats offrant en moyenne des garanties inférieures aux contrats des ménages les plus aisés. Par ailleurs, l'absence de couverture complémentaire est un facteur important du renoncement aux soins pour des raisons financières qui concerne, en 2006, 14 % de la population.

Kampia Chopin, B., Perronnin, M., Pierre, A., et al. (2008). Les contrats individuels de complémentaire santé : quel poids dans le budget des ménages ? Enquête sur la Santé et la Protection Sociale 2006., Paris : Irdes **:** 45-55.

Les données recueillies dans l'enquête Santé et Protection Sociale de l? Irdes permettent d'étudier le poids d'un contrat de couverture complémentaire santé dans le budget des ménages. Ce poids, appelé « taux d'effort », n'a pas encore été étudié en population générale sur données françaises. Pourtant, dans un contexte où les dernières réformes de santé tendent à diminuer le rôle de l'assurance obligatoire, il semble important de l'évaluer et de le prendre en considération dans la conduite des politiques publiques. L'accès à la couverture complémentaire santé se fait soit par l'intermédiaire de l'entreprise, soit par une démarche individuelle. Pour étudier le taux d'effort des ménages, nous observons uniquement les personnes qui bénéficient d'un contrat individuel, seules à arbitrer le coût et les bénéfices d'un contrat. En effet, dans le cas des contrats collectifs, l'employeur participe au paiement de la prime à hauteur de 50 % en moyenne. De plus, le salarié ne connaît pas précisément le montant de sa prime, souvent prélevée directement sur sa feuille de paie. Enfin, dans 50 % des cas, la souscription est imposée à l'ensemble des salariés. Avant d'étudier le taux d'effort des ménages ne bénéficiant pas de contrats collectifs, les auteurs commencent par présenter le cadre théorique dans lequel s'inscrit cette étude, ainsi que les différences de revenus et de primes en fonction de la couverture des ménages.

Dourgnon, P., Guillaume, S., Naiditch, M., et al. (2008). Les assurés et le médecin traitant : premier bilan après la réforme. Enquête sur la Santé et la Protection Sociale 2006., Paris : Irdes **:** 37-41.

L'enquête ESPS a notamment pour vocation l'analyse des évolutions du système de santé à travers la description de ses usagers, les assurés, et leur état de santé, couverture santé, accès aux services de soins et expérience dans le système de santé. Sa fréquence bisannuelle permet d'intégrer des questionnements sur les réformes en cours ou en préparation. Ainsi l'enquête 2006 a-t-elle servi de base à l'évaluation de la réforme du parcours de soins coordonnés et du médecin traitant mis en œuvre la même année. Côté usagers, l'évaluation de la réforme peut se décliner en deux étapes. Une première étape en décrit l'implémentation (montée en charge, compréhension, adhésion) et l'impact ressenti à travers l'expérience des assurés, à partir de données déclaratives. Une seconde étape en évalue l'impact sur le recours aux services de santé, et plus particulièrement l'accès au spécialiste, à partir des données d'enquête couplées aux données d'assurance maladie. C'est la première étape qui est présentée dans ce chapitre, qui a fait l'objet d'une publication spécifique dès la mi 2007 (Cf. DOURGNON P., Guillaume S., Naiditch M., Ordonneau C. Les assurés et le médecin traitant : premier bilan après la réforme, Questions d'économie de la santé IRDES n° 124, 2007).

2007

Dourgnon, P., Guillaume, S., Naiditch, M., et al. (2007). "Les assurés et le médecin traitant : premier bilan après la réforme." Questions D'Economie de la Sante (Irdes)(124): 1-4.
http://www.irdes.fr/Publications/Qes/Qes124.pdf

Le dispositif du médecin traitant constitue l'un des éléments centraux de la réforme de l'assurance maladie du 13 août 2004. Bien que non obligatoire, il est encouragé par des incitations financières à partir de janvier 2006. Si son objectif premier est de mieux réguler l'accès aux spécialistes, les promoteurs de la réforme en donnent aussi des justifications plus larges : maîtrise des dépenses de ville, meilleure qualité de la prise en charge médicale, meilleure équité de traitement. L'enquête Santé et Protection Sociale menée en 2006 permet de dresser un premier bilan de l'impact de la réforme, au travers des opinions des assurés.

2006

Allonier, C., Guillaume, S. et Rochereau, T. (2006). "Enquête Santé et protection sociale 2004 : premiers résultats." Questions D'Economie de la Sante (Irdes)(110): 6 , tabl., graph.
http://www.irdes.fr/Publications/Bulletins/QuestEco/pdf/qesnum110.pdf

L'enquête Santé et Protection sociale (ESPS) dresse un tableau de l'état de santé, des soins et de la protection sociale de la population de France métropolitaine selon ses caractéristiques sociales. En 2004, de nouvelles données sur l'état de santé montrent que les femmes sont plus nombreuses que les hommes à ne pas se déclarer en bonne santé. Elles déclarent d'ailleurs plus de maladies que les hommes, mais de moindre gravité. Les hommes, qui ont une espérance de vie plus faible, déclarent plus de maladies graves. Malgré l'existence de la couverture maladie universelle complémentaire, près d'une personne sur 10 déclare encore ne pas avoir de couverture maladie complémentaire et 13 % avoir renoncé à des soins pour des raisons financières au cours des douze derniers mois. Près de la moitié des renoncements concernent les soins dentaires, 18 % les lunettes et 9 % les soins de spécialistes. L'enquête confirme le fort gradient social des statistiques de santé : ce sont les ménages d'ouvriers ou d'employés qui se déclarent en plus mauvais état de santé, qui déclarent le moins bénéficier d'une couverture complémentaire maladie et le plus de renoncements aux soins.

Collet, M., Menahem, G. et Picard, H. (2006). "Logiques de recours aux soins des consultants de centres de soins gratuits : Enquête Précalog 1999-2000." Questions D'Economie de la Sante (Irdes)(113): 8.

Ce document a pour source l'enquête Précalog réalisée par l'Irdes de septembre 1999 à mai 2000 auprès de personnes consultant dans des centres de soins gratuits Cette nouvelle exploration de l'enquête permet d'analyser la diversité des logiques de recours aux soins d'individus en situation de précarité. Elle complète la toute récente étude présentée par Médecins du monde en portant un autre regard sur un échantillon plus large.

Collet, M., Menahem, G. et Picard, H. (2006). Motifs médicaux de recours aux centres de soins gratuits et logiques de recours aux soins des consultants. Rapport Irdes. Paris IRDES**:** 167 , graph., tabl.

Le présent rapport, qui a pour source l'enquête Précalog réalisée par l'Irdes de septembre 1999 à mai 2000, porte sur les motifs et logiques de recours aux soins des consultants de centres de soins gratuits. Il se compose de cinq parties. La première partie présente le champ et les modalités de l'enquête. La deuxième partie expose les motifs de recours aux centres de soins gratuits, puis propose un exercice de comparaison de ces motifs avec ceux des consultations en médecine générale. Les motifs de recours aux soins gratuits sont analysés en fonction des caractéristiques des consultants et des processus de précarisation dans la troisième partie. La quatrième partie se concentre sur l'étude des nombreuses composantes qui interagissent dans la constitution des représentations et des comportements de santé : les relations à la maladie, au corps et aux soins ou encore le rapport entretenu avec les institutions médico-sociales. Enfin, la dernière partie présente les logiques de recours aux soins et leurs déterminants.

2005

Azogui-Levy, S. et Rochereau, T. (2005). "Comportements de recours aux soins et santé bucco-dentaire : exploitation de l'enquête "Santé et protection sociale" 2000." Questions D'Economie de la Sante (Irdes)(94): 8.
http://www.irdes.fr/Publications/Qes/Qes94.pdf

> Un des thèmes de recherche de l'IRDES est le rôle de l'accès aux soins dans la formation des inégalités de santé. Cette question peut s'illustrer de manière spécifique dans le domaine bucco-dentaire, du fait du faible remboursement par l'Assurance-maladie des soins autres que les soins conservateurs. Elle est explorée ici à partir de l'analyse des renoncements aux soins déclarés dans l'enquête santé et protection sociale (ESPS), dont plus de la moitié concerne les soins dentaires.

Lengagne, P. et Perronnin, M. (2005). "Impact des niveaux de garantie des complémentaires santé sur les consommations de soins peu remboursées par l'Assurance maladie : le cas des lunettes et des prothèses dentaires." Questions D'Economie de la Sante (Irdes)(100): 6.
http://www.irdes.fr/Publications/Qes/Qes100.pdf

> Depuis plusieurs années, l'IRDES cherche à évaluer les niveaux de garanties proposés par les contrats de couverture complémentaire santé et à mesurer leur impact sur les consommations de soins. Une étude menée à partir des Enquêtes sur la santé et la protection sociale 2000 et 2002 a permis de décrire les niveaux de garantie optique et dentaire proposés par ces contrats. En associant ces données avec les informations sur les consommations de soins issues de l'Echantillon permanent des assurés sociaux, les auteurs analysent le lien existant entre niveaux de couverture et achats de lunettes et de prothèses dentaires.

2003

Auvray, L., Doussin, A. et Le Fur, P. (2003). "Santé, soins et protection sociale en 2002." Questions D'economie De La Sante (Credes)(78): 8 , graph.
http://www.irdes.fr/Publications/Qes/Qes78.pdf

> Les résultats présentés dans cette synthèse sont issus de l'enquête Santé et Protection sociale (ESPS), menée tous les deux ans par le CREDES, auprès d'environ 20 000 personnes. Cette enquête est représentative des ménages résidant en France (hors collectivités) et dont un des membres est assuré à l'un des trois principaux régimes d'assurance maladie : régime général, régime agricole ou régime des professions indépendantes. Elle permet de faire régulièrement le point sur l'état de santé, le recours aux soins et la couverture maladie selon différentes caractéristiques de la population : âge, sexe, milieu social, niveau de revenu, niveau d'études?Les premiers résultats concernant l'année 2002 sont présentés dans cette synthèse. Un rapport complet comprenant l'ensemble des résultats détaillés est également disponible (Auvray et al., 2003).

Auvray, L., Doussin, A. et Le Fur, P. (2003). Santé, soins et protection sociale en 2002. Rapport Credes. Paris Credes **:** 178 , 166 tabl.

> Pour mieux comprendre l'évolution du comportement de la population face au système de soins et de protection sociale, le CREDES effectue, tous les 2 ans, une enquête auprès d'un échantillon représentatif de ménages. En 2002, 7 339 ménages sont enquêtés, soit environ 21 000 personnes. Dans ce rapport, sont présentés l'ensemble des tableaux de résultats sur la couverture maladie (y compris la couverture maladie universelle), l'état de santé et les consommations médicales des personnes vivant en France selon leurs caractéristiques individuelles : âge, sexe, profession et catégorie professionnelle (PCS), revenu, niveau d'études?Les résultats sont détaillés par type de consommation médicale : recours au médecin, généraliste et spécialiste, recours au dentiste, acquisition de produits pharmaceutiques et hospitalisation.

2001

Auvray, L., Dumesnil, S. et Le Fur, P. (2001). "Santé, soins et protection sociale en 2000." Questions D'economie De La Sante (Credes)(46): 8 , tabl., graph., enc.
http://www.irdes.fr/Publications/Qes/Qes46.pdf

Pour mieux comprendre l'évolution du comportement de la population face au système de soins et de protection sociale, le CREDES effectue, tous les deux ans, une enquête auprès d'un échantillon représentatif de ménages. En 2000, 7074 ménages, soit environ 20 000 personnes ont été enquêtées. Ce document est une synthèse du rapport, ou sont étudiés la couverture maladie, l'état de santé et les consommations médicales des personnes vivant en France. Les différentes consommations analysées sont : le recours au médecin ou au dentiste, l'acquisition de produits pharmaceutiques, l'hospitalisation ainsi que le recours aux pratiques de soins parallèles. Par ailleurs, on relève le point de vue des enquêtés sur le système de santé et son fonctionnement. Différents facteurs agissant sur le comportement des individus sont mis en évidence : l'état de santé et les facteurs de risque associés, l'âge et du sexe, le mode de couverture sociale (notamment la couverture maladie universelle complémentaire), le niveau d'études, l'activité, le milieu social et le type de ménage (résumé d'auteur).

Auvray, L., Dumesnil, S. et Le Fur, P. (2001). Santé, soins et protection sociale en 2000. Enquête sur la santé et la protection sociale. France 2000. Rapport Credes. Paris Credes **:** 2 vol. (194 171), tabl., graph., ann.

Pour mieux comprendre l'évolution du comportement de la population face au système de soins et de protection sociale, le Credes effectue, tous les deux ans, une enquête auprès d'un échantillon représentatif de ménages. En 2000, 7074 ménages, soit environ 20 000 personnes ont été enquêtées. Dans ce rapport, sont étudiés la couverture maladie, l'état de santé et les consommations médicales des personnes vivant en France. Les différentes consommations analysées sont : le recours au médecin ou au dentiste, l'acquisition de produits pharmaceutiques, l'hospitalisation ainsi que le recours aux pratiques de soins parallèles. Par ailleurs, on relève le point de vue des enquêtés sur le système de santé et son fonctionnement. Différents facteurs agissant sur le comportement des individus sont mis en évidence : l'état de santé et les facteurs de risque associés, l'âge et le sexe, le mode de couverture sociale (notamment la couverture maladie universelle complémentaire), le niveau d'études, l'activité, le milieu social et le type de ménage (Résumé d'auteur).

Perronnin, M., Szwarcensztein, K., Couffinhal, A. c., et al. (2001). Généralistes versus spécialistes : une étude de l'influence des couvertures complémentaires santé sur les comportements de consommation à partir de l'enquête Santé et Protection Sociale 1998. Paris Ensa ; Paris : **Mémoire fin 3ème année ensae : année scolaire 2000-2001:** 49 , 45 ann., graph.

Les analyses du risque moral en France ont porté essentiellement sur l'impact de la détention d'une couverture complémentaire sur le volume de soins. Cette étude avait pour objectif d'affiner cette problématique en répondant à la question suivante : les gens mieux assurés dépensent-ils plus ? Et si oui, comment ? Plus précisément, il s'agissait d'identifier et de mesurer un effet quantité, un effet substitution, un effet prix. Dans sa première et seconde partie, ce document présente l'agencement de la couverture obligatoire d'assurance maladie et de la complémentaire santé en France, puis l'enquête Santé et Protection Sociale 1998 qui a été utilisée pour cette étude. La troisième partie présente une estimation d'une demande de soins de spécialiste qui permet d'expliquer de manière pertinente l'effet de la couverture complémentaire. L'analyse porte ensuite sur l'arbitrage entre renoncement à des soins / consommation de soins chez un généralistes / consommation de soins chez un spécialiste qui est issu directement de la structure du système de santé en France où, contrairement à ce qui se passe dans d'autres pays, l'accès au spécialistes est très aisé. En France, le choix se fait directement par les individus. Les médecins généralistes et spécialistes sont donc mis en concurrence. Dans ce cadre, deux modèles de choix ont été mis en place pour comprendre la façon dont les individus prennent leurs décisions de consommation : un modèle à choix séquentiel et un modèle à choix simultanés. C'est le modèle à choix simultanés qui semble plus pertinent pour expliquer cet arbitrage ainsi que le rôle de la couverture complémentaire.

1999

Bocognano, A., Dumesnil, S., Frerot, L., et al. (1999). "Santé, soins et protection sociale en 1998. Enquête sur la santé et la protection sociale. France 1998." Questions D'economie De La Sante (Credes)(24): 6 , tabl., graph., ann.
http://www.irdes.fr/Publications/Qes/Qes24.pdf

> Pour mieux comprendre l'évolution du comportement de la population face au système de soins et de protection sociale, le CREDES effectue chaque année une enquête auprès d'un échantillon représentatif de ménages. En 1998, 7996 ménages , soit environ 23000 personnes ont été enquêtées. Dans ce rapport sont mis en évidence l'influence sur la protection maladie et sur les consommations médicales, de l'état de santé et des facteurs de risque associés, de l'âge et du sexe, du mode de couverture sociale, de l'activité et du milieu social. Les différentes consommations analysées sont : le recours au médecin ou au dentiste, l'acquisition de produits pharmaceutiques, l'hospitalisation ainsi que le recours aux pratiques de soins parallèles. Par ailleurs, on relève le point de vue des enquêtés sur le système de santé et son fonctionnement.

Dumesnil, S., Grandfils, N., Le fur, P., et al. (1999). Santé, soins et protection sociale en 1997. Rapport Credes. Paris Credes **:** 2 vol. (167+134), tabl.

> Pour mieux comprendre l'évolution du comportement de la population face au système de soins et de protection sociale, le CREDES effectue chaque année une enquête auprès d'un échantillon représentatif de ménages. En 1997, 3905 ménages , soit environ 11 500 personnes ont été enquêtées. Dans ce rapport sont mis en évidence l'influence sur la protection maladie et sur les consommations médicales, de l'état de santé et des facteurs de risque associés, de l'âge et du sexe, du mode de couverture sociale, de l'activité et du milieu social. Les différentes consommations analysées sont : le recours au médecin ou au dentiste, l'acquisition de produits pharmaceutiques, l'hospitalisation ainsi que le recours aux pratiques de soins parallèles. Par ailleurs, on relève le point de vue des enquêtés sur le système de santé et son fonctionnement.

Dumesnil, S., Grandfils, N., Le,Fur, P.R. P., et al. (1999). "Santé, soins et protection sociale en 1997." Questions D'economie De La Sante (Credes)(17): 6 , 6 graph.
http://www.irdes.fr/Publications/Qes/Qes17.pdf

> Pour mieux comprendre l'évolution du comportement de la population face au système de soins et de protection sociale, le CREDES effectue chaque année une enquête auprès d'un échantillon représentatif de ménages. En 1997, 3905 ménages , soit environ 11 500 personnes ont été enquêtées. Dans ce rapport sont mis en évidence l'influence sur la protection maladie et sur les consommations médicales, de l'état de santé et des facteurs de risque associés, de l'âge et du sexe, du mode de couverture sociale, de l'activité et du milieu social. Les différentes consommations analysées sont : le recours au médecin ou au dentiste, l'acquisition de produits pharmaceutiques, l'hospitalisation ainsi que le recours aux pratiques de soins parallèles. Par ailleurs, on relève le point de vue des enquêtés sur le système de santé et son fonctionnement.

1998

Dumesnil, S., Grandfils, N., Le Fur, F. U. R. P., et al. (1998). "Santé, soins et protection sociale en 1996." Questions D'economie De La Sante (Credes)(1): 6 , 6 graph., 5 enc.
http://www.irdes.fr/Publications/Qes/Qes01.pdf

> Pour mieux comprendre l'évolution du comportement de la population face au système de soins et de protection sociale, le CREDES effectue chaque année une enquête auprès d'un échantillon représentatif de ménages. En 1996, 4 244 ménages, soit environ 12 000 personnes ont été enquêtées. Dans ce rapport sont mis en évidence l'influence sur la protection maladie et sur les consommations médicales, de l'état de santé et des facteurs de risque associés, de l'âge et du sexe, du mode de couverture sociale, de l'activité et du milieu social. Les différentes consommations analysées sont : le

recours au médecin ou au dentiste, l'acquisition de produits pharmaceutiques, l'hospitalisation ainsi que le recours aux pratiques de soins parallèles. Par ailleurs, on relève le point de vue des enquêtés sur le système de santé et son fonctionnement.

1997

Dumesnil, S., Grandfils, N., Le Fur, P., et al. (1997). Santé, soins et protection sociale en 1996. Rapport Credes. Paris Credes **:** 218 , 269 tabl., 289 graph., ann.

Pour mieux comprendre l'évolution du comportement de la population face au système de soins et de protection sociale, le Credes effectue chaque année une enquête auprès d'un échantillon représentatif de ménages. En 1996, 4 244 ménages, soit environ 12 000 personnes ont été enquêtées. Dans ce rapport sont mis en évidence l'influence sur la protection maladie et sur les consommations médicales, de l'état de santé et des facteurs de risque associés, de l'âge et du sexe, du mode de couverture sociale, de l'activité et du milieu social. Les différentes consommations analysées sont : le recours au médecin ou au dentiste, l'acquisition de produits pharmaceutiques, l'hospitalisation ainsi que le recours aux pratiques de soins parallèles. Par ailleurs, on relève le point de vue des enquêtés sur le système de santé et son fonctionnement.

1996

Grandfils, N., Le Fur, P., Mizrahi, A., et al. (1996). Santé, soins et protection sociale en 1995. Rapport Credes. Paris Credes**:** 168 , 164 tabl., 151 graph.

Pour mieux comprendre l'évolution du comportement de la population face au système de soins et de protection sociale, le CREDES effectue chaque année une enquête auprès d'un échantillon représentatif de ménages. En 1995, 3479 ménages, soit environ 10 000 personnes ont été enquêtées. Dans ce rapport sont mis en évidence l'influence sur la protection maladie et sur les consommations médicales, de l'état de santé et des facteurs de risque associés, de l'âge et du sexe, du mode de couverture sociale, de l'activité et du milieu social. Les différentes consommations analysées sont : le recours au médecin ou au dentiste, l'acquisition de produits pharmaceutiques, l'hospitalisation ainsi que le recours aux pratiques de soins parallèles. Par ailleurs, on relève le point de vue des enquêtés sur le système de santé et son fonctionnement.

1995

Grandfils, N., Le Fur, P., Mizrahi, A., et al. (1995). Santé, soins et protection sociale en 1994. Rapport Credes. Paris Credes**:** 154 , tabl., graph.

Pour mieux comprendre l'évolution du comportement de la population face au système de soins et de protection sociale, le CREDES effectue chaque année une enquête auprès d'un échantillon représentatif de ménages. En 1994,3400 ménages, soit 10 000 personnes ont été enquêtées. Dans ce rapport sont mis en évidence l'influence sur la protection maladie et sur les consommations médicales, de l'état de santé et des facteurs de risque associés, de l'âge et du sexe, du mode de couverture sociale, de l'activité et du milieu social. Les différentes consommations analysées sont : le recours au médecin ou au dentiste, l'acquisition de produits pharmaceutiques, l'hospitalisation ainsi que le recours aux pratiques de soins parallèles. Par ailleurs, on relève le point de vue des enquêtés sur le système de santé et son fonctionnement, notamment, si de trop faibles taux de remboursement les ont entraînés à renoncer à certains soins.

1994

ocognano, A., Grandfils, N., le Fur, P., et al. (1994). Santé, soins et protection sociale en 1993 : enquête sur la santé et la protection sociale - France 1993. Rapport Credes. Paris CREDES**:** 180.

> Quatrième rapport annuel du Centre de Recherche - d'Etude et de Documentation en Economie de la Santé (CREDES), sur l'état de santé, la consommation médicale et la protection sociale des ménages comportant au moins un assuré au Régime général de la Sécurité sociale. Ce document présente les principaux résultats de l'enquête réalisée pendant l'année 1993, "enquête Santé Protection Sociale", menée depuis 1988 en collaboration avec la Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés (CNAMTS). Les informations sont présentées selon les rubriques suivantes : protection sociale, morbidité de la population, séances de médecin et de dentiste, consommation de biens médicaux, biologie, taux d'hospitalisation, questions d'opinion. Des nouvelles rubriques sont analysées cette année : morbidité perçue, soins d'auxiliaires médicaux (infirmiers et kinésithérapeutes), pratiques de soins non conventionnelles.

1993

Bcognano, A., Grandfils, N., Le, Fur, P., et al. (1993). Santé, soins et protection sociale en 1992. Rapport Credes. Paris CREDES**:** 148 , tabl., graph.

> Troisième rapport annuel du Centre de Recherche - d'Etude et de Documentation en Economie de la Santé (CREDES), sur l'état de santé, la consommation médicale et la protection sociale des ménages comportant au moins un assuré au Régime général de la Sécurité Sociale. Ce document présente les principaux résultats de l'enquête réalisée pendant l'année 1992, enquête Santé Protection Sociale, menée depuis 1988 en collaboration avec la Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés (CNAMTS). Les informations sont présentées selon les rubriques suivantes : protection sociale, morbidité de la population, séances de médecin et de dentiste,consommation de biens médicaux, biologie, taux d'hospitalisation, questions d'opinion.

ÉTUDES FRANÇAISES

2020

(2020). Fonds de la Complémentaire Santé Solidaire. Rapport d'activité 2019. Paris Fonds de la Complémentaire Santé Solidaire**:** 150 , tabl., fig.
https://www.complementaire-sante-solidaire.gouv.fr/fichier-utilisateur/fichiers/RA_2019_VF.pdf

> Le Fonds de la Complémentaire santé solidaire assure une mission d'intérêt général : le financement des aides publiques à la couverture complémentaire santé pour les personnes en situation de précarité et l'évaluation de ces aides. Il éclaire les pouvoirs publics en formulant des propositions d'amélioration des dispositifs dans le cadre de ses rapports annuels et des rapports d'évaluation de la loi CMU du 27 juillet 1999 qui lui sont confiés. Cette publication dresse un bilan des avancées dans le domaine de la couverture complémentaire pour l'année 2019.

Arnault, L. et Roy, D. (2020). Allocation personnalisée d'autonomie : en 2017, un bénéficiaire sur deux n'utilise pas l'intégralité du montant d'aide humaine notifié. Paris Drees**:** 6, Tab., graph.
https://drees.solidarites-sante.gouv.fr/

> Fin 2017, 93 % des bénéficiaires de l'allocation personnalisée d'autonomie (APA) à domicile se voient notifier des aides humaines pour accomplir les activités de la vie quotidienne, d'après les remontées individuelles sur l'APA réalisées par la DREES. Elles représentent 87 % des montants totaux notifiés d'APA à domicile. Lorsque le plan d'aide notifié inclut de l'aide humaine, le montant moyen de cette

aide est de 500 euros par mois. À caractéristiques identiques, le montant notifié aux hommes en couple est 54 euros moins élevé que celui proposé aux femmes en couple, et il est inférieur d'environ 130 euros à celui notifié aux bénéficiaires vivant seuls. Près d'un bénéficiaire sur deux (47 %) ne consomme pas l'intégralité du montant d'aide humaine qui lui a été notifiée. Cette proportion est plus élevée de 10 points pour les moins dépendants (GIR 4) que pour les plus dépendants (GIR 1). Parmi ceux qui ne consomment pas la totalité du montant d'aide notifié, un tiers du montant notifié d'aide humaine n'est pas dépensé, en moyenne. Les bénéficiaires aux ressources intermédiaires, pour qui le reste à charge constitue une part importante des ressources, sous-consomment davantage que les autres. C'est également le cas des hommes en couple qui, lorsqu'ils ne consomment pas tout le montant d'aide humaine qui leur est notifié, renoncent aussi à une part plus importante du montant notifié.

Bas, A.-C., Dourgnon, P., Azogui-Levy, S., et al. (2020). "Impact of fees on access to dental care: evidence from France." European Journal of Public Health **30**(6): 1066-1071.
https://doi.org/10.1093/eurpub/ckaa143

For financial reasons, dental prosthetics is one of the major unmet dental healthcare needs [Financial-SUN (F-SUN)]. Private fees for dental prosthetics result in significant out-of-pocket payments for users. This study analyzes the impact of geo-variations in protheses fees on dental F-SUN.Using a nationwide French declarative survey and French National Health Insurance administrative data, we empirically tested the impact of prosthetic fees on dental F-SUN, taking into account several other enabling factors. Our empirical strategy was built on the homogeneous quality of the dental prosthesis selected and used to compute our price index.Unmet dental care needs due to financial issues concern not only the poorest but also people with middle incomes. The major finding is the positive association between dental fees and difficulty in gaining access to dental care when other enabling factors are taken into account (median fee in the highest quintile: OR = 1.35; P value = 0.024; 95% CI 1.04–1.76). People with dental F-SUN are those who have to make a greater financial effort due to a low/middle income or a lack of complementary health insurance. For identical financial reasons, the tendency to give up on healthcare increases as health deteriorates.The results underscore the need for fee regulation regarding dental prosthetics. This is in line with the current French government dental care reform.

Belabbas, A., Despierres, B., Diop, V., et al. (2020). La réforme de la Complémentaire Santé Solidaire : quelles incidences organisationnelles sur les caisses d'assurance maladie ? Saint-Etienne EN3S**:** 139.
http://sco.lt/8i0CBs?_tmc=lubBA12TDUcrEn1fPPwN-DOiHE4WekFZd7BoUZeUKEM&track=1

La réforme de la Complémentaire santé solidaire s'inscrit dans une volonté clairement affichée de lever les freins d'accès à une complémentaire santé pour les publics les plus modestes. Elle a ainsi pour objectif d'améliorer le taux de recours à l'ACS, alors évalué à moins de 50%, en levant les barrières financières d'accès aux soins et en simplifiant les démarches des assurés (disparition de la phase de choix entre trois niveaux de contrats ACS et suppression de la phase de transmission du « chèque ACS »). Dans ce contexte, cette Recherche-Action s'intéresse aux incidences organisationnelles de la mise en place de cette réforme au sein du régime général (principalement les CPAM et les CGSS) et du régime agricole. Le choix de ces deux régimes s'explique par la proportion importante de la population concernée. Plus précisément, l'étude porte sur les modes d'organisation mis en place dans les différentes caisses pour faire face à l'arrivée de la réforme, notamment dans l'optique d'atteindre l'objectif premier d'une hausse du taux de recours à cette prestation et in fine d'améliorer l'accès aux soins. Il s'agit d'examiner comment les différentes caisses se sont adaptées et quelles sont les éventuelles actions et organisations qui ont été mises en place avec des effets positifs. L'un des impacts majeurs de cette réforme concerne la mise en place, pour la perception de la participation financière de la CSSP, d'une fonction de recouvrement, métier inhabituel.

Feral-Pierssens, A.-L., Rives-Lange, C., Matta, J., et al. (2020). "Forgoing health care under universal health insurance: the case of France." Int J Public Health **65**(5): 617-625.
https://doi.org/10.1007/s00038-020-01395-2

> We investigate the reliability of a survey question on forgone healthcare services for financial reasons, based on analysis of actual healthcare use over the 3-year period preceding response to the question. We compare the actual use of different health services by patients who report having forgone health care to those who do not.

FeralGonzalez, L. et Nauze-Fichet, E. (2020). Le non-recours aux prestations sociales - Mise en perspective et données disponibles. Paris Drees**:** 42.
https://drees.solidarites-sante.gouv.fr/

> Ce dossier vise à dresser un panorama des données déjà produites par la DREES sur le non-recours aux prestations sociales et annoncer les travaux prévus pour les prochaines années.

Mignon, D. et Jusot, F. (2020). "Inégalités des chances dans le recours aux soins des jeunes adultes en France." Economie et Statistique(514-515-516): 157-175.
https://www.insee.fr/fr/statistiques/4511689?sommaire=4511714

> Alors que la santé des jeunes adultes est un enjeu reconnu de santé publique en France, moins d'attention est accordée à leur recours aux soins. Cet article s'interroge sur l'existence d'inégalité des chances dans le recours aux soins des jeunes adultes à partir des données de l'Enquête nationale sur les ressources des jeunes (2014). En mobilisant le cadre de la philosophie de la responsabilité, une distinction est faite entre des inégalités « injustes » liées à des circonstances en dehors du contrôle des jeunes et des inégalités « justes » liées à des caractéristiques relevant de leur responsabilité. Des modèles de probabilité linéaire sont mobilisés pour estimer les associations entre les probabilités de non-recours (non-utilisation et renoncement aux soins) et les caractéristiques parentales (assurance complémentaire santé, activité principale, revenu, situation familiale et statut vital) d'une part et celles du jeune (éducation, activité principale, cohabitation, ressources financières, assurance complémentaire santé) d'autre part, traduisant respectivement l'existence d'inégalités injustes et d'inégalités justes. La décomposition de la variance permet de quantifier ces inégalités et suggère que les inégalités injustes sont plus importantes que les inégalités justes.

Pellet, R., Rodolphe, C. et Dergham, M. (2020). "Non-recours au soin des populations précaires." Medecine : De La Medecine Factuelle a Nos Pratiques **16**(8): 354-359.

> Cet article traite du non-recours au soin de populations précaires, déjà sujettes à différents phénomènes de discrimination directe. Il cherche à définir l'expression polymorphe du non-recours et à en expliquer l'origine et sa pérennisation au sein du système de santé.

2019

Jusot, F., Carré, B. et Wittwer, J. (2019). "Réduire les barrières financières à l'accès aux soins." Revue française d'économie **XXXIV**(1): 133-181.
https://www.cairn.info/revue-francaise-d-economie-2019-1-page-133.htm

> En France, le principe d'équité horizontale dans l'accès aux soins est au cœur du pacte de 1945, selon la maxime « De chacun selon ses moyens, à chacun selon ses besoins ». Pour autant, le système d'assurance maladie laisse depuis sa création une part du coût des soins à la charge des patients, afin notamment de les responsabiliser. Toutefois, ces instruments constituent des barrières financières à l'accès aux soins, qui sont autant de sources d'inégalités sociales de recours aux soins. Afin d'améliorer l'équité dans l'accès financier aux soins, diverses politiques ont été mises en œuvre au cours des dernières décennies. Cet article propose d'en tirer les leçons et de dresser le bilan des connaissances sur les inégalités de recours aux soins en France. L'essentiel des dispositifs ont consisté à introduire la gratuité de certains soins ou à réduire le coût de la complémentaire santé pour les ménages les plus modestes. Les évaluations disponibles démontrent l'efficacité de la gratuité, que celle-ci s'applique

aux soins ou à l'assurance, même si elle peut conduire à une moindre qualité perçue ou à des discriminations lorqu'elle est assortie de tarifs plafonnés. La littérature converge également sur l'inefficacité des subventions à l'assurance. Les réformes les plus récentes, non encore évaluées, visent quant à elles à modérer les prix des soins mal couverts par l'assurance maladie. En dépit de ces dispositifs, il subsiste des inégalités de recours aux soins, à besoins de soins donnés, particulièrement importantes pour les soins de spécialistes, les soins dentaires et d'optique et les soins préventifs. La réduction des barrières financières est donc une condition nécessaire mais non suffisante pour atteindre l'équité en santé.

2017

Adam, C. (éd.)., et al. (2017). La santé des populations vulnérables, Paris : Ellipses

« Les hommes naissent et demeurent libres et égaux en droits. Les distinctions sociales ne peuvent être fondées que sur l'utilité commune. » L'article 1er de la Déclaration des droits de l'homme et du citoyen du 26 août 1789 a ensuite été placé en 1791 en tête de la Constitution de la République française. Cependant, depuis la naissance d'un individu, se développent de manifestes inégalités face à la santé et à la maladie qui impactent directement l'espérance de vie, notamment au détriment des personnes aux revenus les plus faibles. La mortalité prématurée évitable touche de façon très discriminante les différentes catégories sociales. Pour les professionnels concernés, agir à cet égard ne relève pas d'une charité où la bonne volonté se substituerait à la compétence. Des savoirs, des savoir-faire et des savoir-être sont indispensables. Ils résultent de nécessaires processus d'apprentissage enrichis par l'expérience.

Caisse Nationale de l'Assurance Maladie des Travailleurs (2017). Agir contre le renoncement aux soins : diagnostic, solutions et déploiement, Paris : Cnamts
http://www.ameli.fr/fileadmin/user_upload/documents/DP_Lutte_contre_le_renoncement_aux_soins_-_VDEF.pdf

L'assurance maladie va progressivement généraliser son dispositif de lutte contre le renoncement aux soins à tout le territoire national Lancé sous forme d'expérimentation depuis novembre 2014 dans une vingtaine de département, ce dispositif intitulé PLANIR (Plan d'accompagnement du non recours, des incompréhensions et des ruptures) va être généralisé à l'ensemble du territoire à travers trois vagues successives du 1er avril 2017 à la mi-2018. Ce dispositif consiste en un accompagnement à 3 niveaux : un bilan exhaustif des droits aux prestations intégrant une explication approfondie de leurs usages; une orientation dans le système de soins ; un accompagnement au montage financier, construit le cas échéant par cofinancement de plusieurs partenaires pour faire face à des restes à charge auxquels la personne, en raison de son « reste pour vivre », ne pourrait faire face.

Observatoire des prix et de la prise en charge de l'optique médicale (2017). Rapport 2016. Paris : Observatoire des Prix et de la Prise en Charge de l'Optique Médicale **:** 68, tab., graph., fig.
https://drees.solidarites-sante.gouv.fr/

En France, 70 % des personnes portent des lunettes ou des lentilles après 20 ans et 96 % déclarent avoir des troubles de la vision après 50 ans. L'accès aux équipements optiques constitue donc un enjeu majeur de santé publique et d'accès aux soins. Le premier rapport de l'Observatoire des prix et de la prise en charge en optique médicale a pour objectif de consolider l'ensemble des données disponibles sur le secteur. Il présente ainsi les indicateurs retenus, leurs caractéristiques et leur disponibilité afin de poser les bases statistiques des prochains rapports. Ce socle sera susceptible d'être enrichi de nouvelles données qui pourront être produites par l'ensemble des participants de l'Observatoire. Il dressera ensuite, à partir de ces indicateurs, une première analyse du secteur.

Polton, D. (2017). "Égalité femmes - hommes en matière de santé et de recours aux soins." Regards(50): 35-45.

Les recherches sur les inégalités sociales de santé se sont développées en France depuis une dizaine d'années, sur l'état de santé des différents groupes sociaux et l'évolution des écarts dans le temps, sur l'accès et le renoncement aux soins, et y compris sur le caractère socialement différencié des réponses du système de soins et des pratiques des professionnels. En revanche, contrairement aux pays anglo-américains et européens, la dimension du genre est souvent négligée dans notre pays dans la recherche en santé publique. Si l'espérance de vie ne résume pas à elle seule l'état de santé, et si les femmes vivent plus longtemps que les hommes, elles se déclarent en plus mauvaise santé et vivent avec plus de maladies, d'incapacités et de situations de dépendance. Ce paradoxe aujourd'hui bien mis en évidence à l'échelle internationale sera développé dans une première partie. On s'attachera ensuite à analyser les différences en termes de recours aux soins, avec là encore un constat nuancé : globalement les femmes apparaissent plus soucieuses de leur santé et consultent plus fréquemment, sans pour autant avoir des dépenses de soins globalement supérieures. Lorsque l'on analyse des pathologies particulières, on constate des inégalités dans les deux sens, souvent liées au fait que la détection et la prise en charge des maladies sont influencées par des stéréotypes de genre qui peuvent induire des différences de traitement.

2016

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.

Ancelot, L., A. et al.. (2016). "Le renoncement aux soins chez les femmes enceintes : une analyse empirique à partir de l'Enquête nationale périnatale." Revue D'Epidemiologie et de Sante Publique **64**(P. S97).

Bras, P. L. (2016). "Les Français moins soignés par leurs généralistes : un virage ambulatoire incantatoire ?" Seve : Les Tribunes De La Sante(50): 67-91.
http://www.cairn.info/revue-les-tribunes-de-la-sante-2016-1.htm

Depuis 2000, les généralistes sont moins nombreux et aspirent à maîtriser leur temps de travail. Les Français reçoivent donc moins de soins de leur part ; cette tendance est appelée à se prolonger. Cette évolution contribue à modérer l'évolution des dépenses. Il est délicat de se prononcer sur ses effets sanitaires mais l'on peut craindre qu'elle n'ait en s'accentuant des effets délétères. Pour autant, cette diminution ne fait pas l'objet de débats publics si ce n'est sous l'angle partiel des « déserts médicaux ». Ainsi des discours publics en appelant à des interventions accrues des médecins de premier recours, notamment pour mettre en œuvre le « virage ambulatoire », peuvent se déployer alors même que ceux-ci sont moins présents auprès de leurs patients. Infléchir cette évolution supposerait des révisions profondes en matière de démographie médicale, d'organisation et de rémunération des soins que ni les pouvoirs publics, ni la profession ne semblent actuellement disposés à entreprendre (résumé de l'auteur).

Chauveaud, C. et Warin, P. (2016). Le non-recours à la Couverture maladie universelle Complémentaire.

Enquête auprès de populations précaires. Grenoble ODENORE: 66.
https://www.cmu.fr/fichier-utilisateur/fichiers/ODENORE_Non-recours_CMUC_2016.pdf

A la suite d'anciens travaux, l'objectif de cette étude est d'examiner à nouveau les raisons du non-recours à la CMU-C. De nombreuses études attestent de la persistance du phénomène de non-recours à une complémentaire santé et de ses incidences sur l'accès aux soins. Pour autant elles n'éclairent pas spécifiquement les raisons du non-recours à la CMU-C en particulier. Elles ne permettent pas de savoir si les personnes sans complémentaire santé seraient éligibles à la CMU-C, ni a fortiori d'expliquer pourquoi les personnes sans complémentaire santé et éligibles à la CMU-C ne recourent pas à ce dispositif. Les explications apportées sur l'absence de complémentaire en général ne donnent pas un aperçu suffisant des raisons particulières du non-recours à la CMU-C. Sans dire que ces explications ne peuvent pas se retrouver lorsque l'on examine spécifiquement le non-recours à la CMU-C, la présente étude cherche à préciser les raisons pour des populations socialement et économiquement précaires, et non pas – comme dans ces autres travaux – pour une population générale d'assurés sociaux (tiré de l'intro).

Fonds CMU (2016). Rapport d'activité 2015 du Fonds de financement de la protection complémentaire de la couverture universelle du risque maladie. Paris Fonds CMU: 132, tabl., fig.
http://www.cmu.fr/rapports_activite.php

La première partie du rapport est consacrée à la thématique du recours aux soins et de l'accès aux droits. Sont présentés dans ce cadre les enseignements du Rapport Charges et Produits de la CNAMTS pour 2016, qui propose pour la première fois une comparaison de l'état de santé et des dépenses annuelles des bénéficiaires de la CMU¬¬ C, de ceux de l'ACS et des autres assurés du régime général. Cette étude confirme que l'état de santé des bénéficiaires de la CMU C et, de manière encore plus marquée, celui des bénéficiaires de l'ACS, est plus dégradé que celui des autres assurés du régime général.

Revil, H. (2016). La Plateforme d'Intervention Départementale pour l'Accès aux Soins et à la Santé (PFIDASS). Regard sur un dispositif expérimental de détection du renoncement aux soins et d'action pour accompagner les personnes à la réalisation de leurs soins. Paris Odenore: 132.
https://odenore.msh-alpes.fr/documents/rapport_accompagnement_pfidass_-_version_revue_et_definitive_-_2016.pdf

La Cnamts expérimente la mise en place d'un dispositif de détection du renoncement en matière de santé et d'action pour accompagner les publics fragiles dans leurs parcours de soins. Ce nouveau dispositif s'articule autour de deux axes : la détection des situations individuelles de renoncement, et leur résolution par la Pfidass, la Plateforme d'intervention départementale pour l'accès aux soins et à la santé, un service dédié de l'assurance-maladie. Ce rapport dresse un état des lieux sur la mise en place de cette plateforme et en évalue la pertinence. Dans quelle mesure un dispositif tel celui de la PFIDASS, surplombé par des enjeux de frontières, de compétences et de professionnalité en interne de la CPAM, ainsi que par des enjeux de positionnement de la caisse par rapport à son environnement et d'orientation stratégique au niveau territorial, répond-il aux besoins de guidance et de soutien financier des personnes en renoncement aux soins et emporte-t-il un changement paradigmatique dans la prise en charge de situations sociales problématiques ?

2015

Barnay, T., et al. (2015). "La santé et les soins : prise en charge, déterminants sociaux, conséquences professionnelles : Introduction générale." Economie et Statistique(475-476): 17-29.
http://www.insee.fr/fr/ffc/docs_ffc/ES475B.pdf

Peu de temps après un numéro spécial déjà consacré à ce thème en 2012, la présente édition d'Économie et Statistique revient sur la question de la santé. Elle rassemble une sélection d'articles issus des 35es Journées des économistes de la santé français (JESF) qui se sont tenues à l'université Paris-Est Créteil en décembre 2013. Ré-aborder ce sujet, à des dates aussi rapprochées, s'explique évidemment par son importance, à la fois sociale et budgétaire, et nous allons y revenir dans un premier temps. Mais le précédent pour la revue ne se limite pas à ce numéro spécial de 2012 : la thématique « santé » y a toujours eu une présence régulière et importante. Après un état des lieux des données disponibles pour éclairer ce thème, on détaillera de quelle façon chacun des articles de ce numéro est allé puiser dans cette masse de données, qu'elles relèvent ou non du strict domaine de la statistique publique, et quels messages ont pu en être tirés (résumé d'auteur).

Bras, P. L. (2015). "La liberté des tarifs médicaux : la victoire des médecins spécialistes." Seve : Les Tribunes De La Sante(48): 73-92.
https://www.cairn.info/revue-les-tribunes-de-la-sante-2015-3.htm

Depuis plus d'un siècle, la liberté tarifaire est l'enjeu d'un conflit entre les médecins et les représentants des assurés. Cet article est consacré au dernier épisode de ce conflit, la négociation engagée sur cette question en 2012 suite à l'engagement pris par le président de la République d'encadrer les dépassements d'honoraires. Il montre que, malgré cet engagement, la négociation s'est conclue par un accord globalement favorable aux médecins spécialistes qui devrait aboutir à un développement des dépassements. Malgré une publicisation de cette question des dépassements, les soutiens limités et diffus dont auraient pu bénéficier les pouvoirs publics ont conduit à privilégier une stratégie visant à éviter un affrontement ouvert avec une fraction du corps médical fortement mobilisée autour de la défense de la liberté tarifaire.

Cohen, L. (2015). Proposition de loi de Mme Laurence Cohen et plusieurs de ses collègues, visant à supprimer les franchises médicales et participations forfaitaires. Paris Sénat**:** 32.
http://www.senat.fr/rap/l14-320/l14-3201.pdf

Le système de santé français repose sur deux piliers : permettre l'accès de tous aux soins et asseoir le financement sur la solidarité entre bien portants et malades. Or l'une des limites à l'accès aux soins est leur coût. Particulièrement visible pour l'appareillage optique ou les soins dentaires, pour lesquels le taux de prise en charge par l'assurance maladie est faible, elle existe également, sous forme de renoncement ou de retard, pour les soins courants. Préserver l'équilibre financier de la sécurité sociale constitue un objectif de valeur constitutionnelle et il importe donc de trouver des ressources correspondant aux besoins de soins. Ce rapport présente les propositions des membres du groupe communiste, républicain et citoyen, préconise une prise en charge intégrale des dépenses de santé par la sécurité sociale. Ils sont donc défavorables à un reste à charge par les malades, même couverts par l'assurance privée. Plusieurs dispositifs existent en effet tendant à faire payer les soins aux personnes auxquelles ils sont prescrits : le ticket modérateur, le forfait hospitalier (1983) et, plus récemment, une participation forfaitaire de 1 euro sur les consultations médicales (2004) et les franchises médicales (2008).Il apparait particulièrement urgent aux auteurs de la proposition de loi de supprimer les deux derniers dispositifs mis en place pour faire financer les soins directement par les usagers.

Cour des Comptes (2015). L'accès aux soins des ménages défavorisés : un bilan en demi-teinte, une action à mieux cibler. Sécurité sociale : Rapport 2015 sur l'application des lois de financement de la Sécurité sociale., Paris : Cour des Comptes**:** 417-448, tabl.

Dans son rapport annuel 2015 sur la Sécurité sociale, la Cour a constaté que la mise en place de la CMU-C et de l'ACS, respectivement en 1999 et 2004,'était imposée sous l'effet du désengagement croissant de l'assurance maladie obligatoire de la prise en charge des dépenses de santé, en dehors des affections de longue durée). Ces dispositifs ont des effets seulement partiels sur l'accès aux soins des ménages défavorisés, l'extension continue de la population potentiellement bénéficiaire s'accompagnant en particulier de la persistance d'un non-recours massif. Compte tenu de l'incidence de l'extension de la population de leurs bénéficiaires potentiels sur leur soutenabilité financière, un ciblage accru de ces dispositifs apparaît devoir être envisagé.

Cour des Comptes (2015). Le fonds de financement de la protection complémentaire de la couverture universelle du risque maladie. Paris Cour des Comptes**:** 15, tabl., carte.

La Cour des comptes rend public, le 3 juin 2015, un rapport sur le fonds de financement de la protection complémentaire de la couverture universelle du risque maladie, demandé par la commission des finances du Sénat en application de l'article 58-2° de la loi organique relatives aux lois de finances. L'enquête porte sur la couverture maladie universelle complémentaire (CMU-C), créée en 1999, et l'aide au paiement d'une complémentaire santé (ACS), instituée en 2004. La Cour examine l'évolution des règles d'éligibilité et du recours effectif à ces dispositifs qui visent à assurer l'accès aux soins des ménages défavorisés, le niveau de la protection qu'ils procurent, ainsi que les risques qui affectent leur gestion et leur soutenabilité financière. Elle formule douze recommandations.

Fonds CMU (2015). Rapport d'activité 2014 du Fonds de financement de la protection complémentaire de la couverture universelle du risque maladie. Paris Fonds CMU**:** 149, tabl., fig.
http://www.cmu.fr/rapports_activite.php

Ce rapport présente l'évolution contrastée des bénéficiaires selon les dispositifs. 2014 a été une année de hausse importante du nombre de bénéficiaires de la CMU-C et, dans une moindre mesure, de l'ACS, malgré la persistance d'un niveau de non-recours significatif. Il constate également la croissance modérée des dépenses.

LMDE (2015). La santé des étudiants : 4e enquête nationale. Premiers résultats. Paris LMDE**:** 12 , tabl.
http://www.lmde.com/securite-sociale-et-sante-des-etudiants/lexpertise-sante-de-la-lmde.html#c10570

Ce dossier de presse rassemble les premiers résultats de la quatrième enquête nationale sur la santé des étudiants, réalisée par de la Mutuelle des Etudiants (LMDE). Les données sont issues de l'Observatoire Expertise et Prévention pour la Santé des Étudiants (EPSE). Il existe peu de données sur la santé des étudiants. La LMDE réalise cette enquête nationale depuis 2005, les précédentes enquêtes ont eu lieu en 2005, 2008 et 2011.Cette 4ème enquête s'est déroulée entre le 1er avril 2014 et le 30 juin 2014 et avait pour but d'identifier, de comprendre les comportements de santé et les habitudes de vie spécifiques des étudiants, et ainsi de mieux cibler les besoins en prévention : consommation d'alcool, accès aux soins, vie affective et sexuelle...

Legal, R. et Vicard, A. (2015). "Renoncement aux soins pour raisons financières." Dossiers Solidarite Et Sante (Drees)(66): 26.

[BDSP. Notice produite par MIN-SANTE 9nqR0xj9. Diffusion soumise à autorisation]. Le renoncement aux soins pour raisons financières est de plus en plus mobilisé pour apprécier l'accessibilité financière aux soins des systèmes de santé. Il est mesuré à l'aide de questions du type : "Au cours des 12 derniers mois, avez-vous renoncé à un soin, pour des raisons financières ?". Cette étude s'appuie sur la vague 2013 du Baromètre d'opinion de la Drees, au sein de laquelle quatre jeux de formulation différents ont été soumis à quatre sous-échantillons de répondants. La valeur du taux de renoncement aux soins pour raisons financières est très sensible à la formulation de la question : les écarts atteignent 15 points selon la formulation utilisée.

ONPES (2015). L'évolution de la pauvreté en France : les nouvelles formes de l'aggravation. Suivi annuel des indicateurs de pauvreté et d'exclusion sociale. Edition 2015. Paris ONPES**:** 30 , tabl.
www.onpes.gouv.fr/IMG/pdf/Rapport_Indicateurs-2015-2.pdf

L'ONPES s'engage, avec ce document, dans la publication annuelle de son tableau de bord de la pauvreté et de l'exclusion sociale. Il informera ainsi périodiquement sur l'évolution de ces phénomènes et tentera de rendre compte du sens de ses évolutions. L'analyse des données disponibles montre comment la crise pèse sur la pauvreté et en complexifie la représentation. Si l'année 2012 marque l'entrée dans une nouvelle phase de croissance économique lente, la reprise

s'essouffle rapidement, alors que le chômage et le sous-emploi s'élargissent. La baisse du taux de pauvreté monétaire constatée en 2012 (13,9 %) n'occulte pas l'aggravation et la persistance de l'exclusion de catégories de population en grande difficulté. À la même date, un Français sur cinq est pauvre monétairement ou en conditions de vie (résumé de l'éditeur).

ONZUS (2015). Observatoire national des zones urbaines sensibles : rapport 2014. Saint Denis ONZUS, ONPV**:** 142 , tabl., graph.
http://www.ville.gouv.fr/IMG/pdf/onzus_synthese_2014.pdf
http://www.ville.gouv.fr/IMG/pdf/onzus_rapport_2014.pdf

Le rapport annuel 2014 de l'Observatoire national des zones urbaines sensibles (ONZUS), qui devient en 2015 l'Observatoire national de la politique de la ville (ONPV) pour accompagner la réforme de la politique de la ville. Il propose une analyse détaillée de la situation en 2013 des quartiers et de leurs habitants bénéficiant des dispositifs de la politique de la ville. Ce rapport retrace une fois encore les différentes facettes des difficultés rencontrées par les quartiers. Certains indicateurs de mesure de la pauvreté signalent ainsi que les écarts se creusent entre les Zus et le reste du territoire, même si les Zus affichent des profils très contrastés. Sur le front de l'emploi, si le taux de chômage semble se stabiliser en Zus en 2013, il reste à un niveau élevé, à plus de 23% de la population active. Les difficultés d'accès à l'emploi frappent prioritairement les jeunes, les immigrés et les personnes d'un faible niveau d'études. Néanmoins, une étude développée dans le rapport montre que même le fait d'être diplômé n'a pas été suffisamment protecteur vis-à-vis de la crise économique pour les résidents des Zus. Enfin, l'état de santé des adultes résidant en Zus continue d'être préoccupant, avec un renoncement aux soins plus élevé et un recours moins fréquent aux médecins spécialistes. Des premières données disponibles sur les nouveaux quartiers prioritaires semblent indiquer qu'ils seraient, sur différents points, encore plus en difficultés que les zones urbaines sensibles. Ce constat méritera d'être étoffé au fur à mesure que l'appareil statistique se mettra en marche pour dresser l'analyse de ces nouveaux territoires, tâche qui sera confiée au nouvel observatoire national de la politique de la ville. L'année 2015 s'ouvre ainsi sur un nouveau défi : apporter rapidement un éclairage aussi riche, fourni et étayé sur la situation des nouveaux quartiers que celui que l'Onzus a porté au cours des dernières années sur les zones urbaines sensibles.

Padieu, Y., et al. (2015). L'inflexion des dépenses de santé dans les pays durement touchés par la crise nuit à l'accès aux soins. France, portrait social. Edition 2015., Paris : Insee**:** 25-36.
http://www.insee.fr/fr/ffc/docs_ffc/FPORSOC15b_EC2_sante.pdf

Depuis les Trente Glorieuses, la part des dépenses de santé dans le produit intérieur brut avait tendance à progresser dans la plupart des pays européens. Toutefois, dans le courant des années 2000, celle-ci s'est quasiment stabilisée dans des pays comme l'Allemagne puis la France. Cette évolution s'est faite sans à-coup majeur grâce au renforcement de la maîtrise de la dépense d'assurance maladie. En revanche, suite à la crise débutée en 2008, les dépenses de santé par habitant ont ralenti, voire diminué, et ce bien plus fortement dans les pays du sud et du nord-ouest de l'Europe, comme la Grèce, le Portugal ou l'Irlande et, dans une moindre mesure, l'Espagne, l'Italie ou le Royaume-Uni. Il est difficile de distinguer l'effet intrinsèque de la crise des conséquences des politiques structurelles de maîtrise de la dépense de santé. Néanmoins, les actions entreprises telles que les coupes budgétaires, la réduction du coût des soins ou bien l'augmentation des franchises, ont contribué à ce retournement de tendance, qui a été particulièrement visible sur le poste médicament. Les difficultés économiques ainsi que les mesures de redressement ont contribué dans certains pays à limiter l'accès aux soins, en raison notamment de l'augmentation du reste à charge des ménages. Une hausse importante du renoncement déclaré pour certains types de soins a de fait été observée dans certains pays durement touchés par la crise comme la Grèce, le Portugal, l'Espagne ou l'Irlande. Si l'espérance de vie n'a diminué dans aucun des pays observés, il n'en va pas toujours de même pour l'espérance de vie en bonne santé : même si le lien de causalité avec la réduction des dépenses de santé n'est à ce stade pas établi, celle-ci a reculé en Grèce et en Italie (résumé d'auteur).

Raynaud, J. et Bailly, A. p. (2015). Inégalités d'accès aux soins : acteurs de santé et territoires, Paris : FBMF ;

Paris : Economica
http://www.economica.fr/livre-inegalites-d-acces-aux-soins,fr,4,9782717867954.cfm

L'accès aux soins est devenu l'une des priorités majeures des Français. Souvent étudié à travers la distance géographique ou les difficultés financières, ce concept relève pourtant de multiples dimensions. La prise en compte des perceptions des acteurs de santé est essentielle pour que les décisions politiques soient en adéquation avec le vécu des acteurs. Ainsi, l'ouvrage présente les concepts et les outils nécessaires pour analyser les perceptions des patients (difficultés pour obtenir une consultation) et des médecins (conditions de travail et solutions pour améliorer l'accès aux soins) afin d'identifier les territoires sur lesquels l'offre de soins est insuffisante. D'autre part, le regroupement pluriprofessionnel et la télémédecine sont étudiés pour déterminer les conditions favorables pour le développement d'une offre de soins durable et de qualité sur les territoires grâce à la coopération entre professionnels de santé. L'auteur replace ainsi la géographie au centre d'une réflexion globale et pluridisciplinaire, intégrant l'aménagement du territoire, la sociologie, l'analyse des politiques de santé et l'organisation des professionnels de santé.

Voynet, D. (2015). Restructuration de la filière visuelle. Rapport IGAS ; Igas 2015-008R. Paris IGAS**:** 80.
http://www.ladocumentationfrancaise.fr/rapports-publics/154000640-restructuration-de-la-filiere-visuelle

[BDSP. Notice produite par MIN-SANTE JmR0x9D9. Diffusion soumise à autorisation]. La filière de santé visuelle est confrontée à d'importants problèmes structurels, liés à la baisse du nombre d'ophtalmologistes, à l'accroissement et au vieillissement de la population, à l'augmentation de la prévalence de certaines pathologies chroniques (cataracte, rétinopathie diabétique, glaucome, DMLA) et à la transformation en profondeur d'une spécialité médico-chirurgicale où les actes techniques ont pris une place prépondérante. Elle se caractérise par d'importantes difficultés d'accès (délais d'attente, fréquence et importance des dépassements d'honoraires), par l'importance des besoins mal ou non couverts (prise en charge des urgences, dépistage des pathologies chez l'enfant, suivi des pathologies chroniques) et par une coordination mal structurée entre les différents professionnels qui la composent.

2014

Bouba-Olga, O. et Vige, M. (2014). Le renoncement aux soins : une analyse empirique à partir de la base SHARE, Poitiers : CRIEF

Cet article propose une analyse empirique du renoncement aux soins à partir d'une base de données originale, jamais utilisée sur ce sujet, l'enquête européenne SHARE. Dans le prolongement de travaux réalisés sur des échantillons plus réduits, il montre que, à côté des contraintes financières, les caractéristiques sociales et les comportements à risque influent fortement sur le renoncement aux soins. Le cumul des déterminants sociaux et des conduites addictives est également très influant. Cette étude observe enfin des différences significatives, notamment entre pays d'Europe du Nord et du Sud, ainsi que pour certains pays de l'Est.

Chaupain-Guillot, S., et al. (2014). "Le renoncement aux soins médicaux et dentaires : une analyse à partir des données de l'enquête SRCV." Economie et Statistique(469-470): 169-197.
http://www.insee.fr/fr/ffc/docs_ffc/ES469H.pdf

D'après les chiffres de la quatrième vague de l'enquête Statistiques sur les ressources et les conditions de vie (SRCV), réalisée par l'Insee en 2007, environ 4 % des personnes de 16 ans et plus ont renoncé au moins une fois, au cours des douze derniers mois, à se rendre chez un médecin alors qu'elles en ressentaient le besoin et près de 7 % se sont abstenues de consulter un dentiste. L'obstacle financier est le motif de renoncement le plus fréquemment cité par les répondants. Cependant, nombreux sont ceux qui mettent en avant des raisons autres que financières. Dans le cas des soins médicaux, le manque de temps et l'attente d'une amélioration sont, en effet, souvent invoqués. Pour le dentaire, c'est la peur des soins qui constitue le second motif de renoncement. L'argument financier est plus souvent mentionné pour ce second type de soins que pour les soins médicaux (dans un cas sur deux, contre un cas sur trois). Sur la courte période 2004-2007, les taux de renoncement aux soins médicaux et dentaires ont peu varié. De même, la part du renoncement pour raisons financières est demeurée assez stable. L'exploitation de la dimension longitudinale de l'enquête SRCV révèle que parmi les personnes ayant renoncé à des soins une année donnée, un assez grand nombre (de l'ordre de 40 % dans le cas des soins dentaires) ont de nouveau été amenées à prendre une telle décision l'année suivante. Ce caractère récurrent est encore plus marqué lorsque le renoncement est motivé par des raisons financières. Les résultats de régressions sur données de panel (2004-2007) montrent, comme on pouvait s'y attendre, que la situation financière du ménage est l'un des principaux facteurs qui interviennent dans la décision de ne pas consulter, aussi bien pour les soins médicaux que pour les soins dentaires. L'âge, l'état de santé, la situation familiale (surtout chez les femmes) et le fait de disposer ou non d'une voiture ont également un impact significatif sur la probabilité de renoncement.

2013

Berchet, C. (2013). "Le recours aux soins en France : une analyse des mécanismes qui génèrent les inégalités de recours aux soins liées à l'immigration." Revue D'Epidemiologie et de Sante Publique : **61S**(3).

À partir des données de l'Enquête sur la santé et la protection sociale (ESPS) réalisée en 2006 et 2008, cette étude s'intéresse aux disparités de recours aux soins entre la population immigrée et la population française. Nous cherchons à mettre en évidence les mécanismes qui génèrent les inégalités de recours aux soins liées à l'immigration en utilisant des techniques de décomposition non linéaire. Les résultats des estimations montrent que les immigrés présentent, à besoins de santé équivalents, un plus faible recours aux médecins généralistes et spécialistes que la population française. L'application des techniques de décomposition non linéaire révèle que la majeure partie du différentiel de recours aux soins entre les immigrés et les Français est liée à une différence de distribution des caractéristiques observables entre les deux populations. En particulier, les inégalités de recours aux généralistes semblent être en premier lieu expliquées par la plus faible couverture santé des immigrés, tandis que leur niveau d'études et de revenu sont les principaux facteurs générant les inégalités de recours aux spécialistes.

Blanchet, N. (2013). Etude aupès d'assurés de la CPAM du Gard sollicitant une aide financière pour des soins dentaires, Grenoble : Odenore
http://odenore.msh-alpes.fr/documents/rapport_definitif_aides_soins_dentaires_cpam_gard.pdf

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

Cercle Santé (2013). Les soins de santé en Europe et aux Etats-Unis. Résultats du baromètre 2013 et évolutions observées depuis 2009. Paris Cercle Santé**:** 84.

Les résultats du 7e baromètre santé d'Europ Assistance-démontrent qu'un Français sur trois dit avoir renoncé ou reporté des soins pour raisons financières en 2013 (contre 27% en 2012), 18% des Européens et 23% des Américains. Les renoncements concernent surtout les soins dentaires (25%), l'achat de lunettes ou de lentilles correctrices (17%), les soins courants (12%), les achats de médicaments (7%) et les soins lourds (7%). Les femmes sont plus concernées que les hommes (41% contre 23%) et les jeunes plus que les personnes âgées (40% des 18-39 ans contre 22% des 60 ans ou plus). Pour couvrir l'augmentation des dépenses de santé, 40% des Français privilégient une hausse de la franchise par acte médical, 32% les impôts et les cotisations obligatoires et 28% un financement par les assurances privées. Ils attribuent une note de 5,1 sur 10 au système de soins et 43% jugent que l'accès aux soins est égalitaire, soit 5 points de plus qu'en 2012.

Despres, C. (2013). "Significations du renoncement aux soins : une analyse anthropologique." Sciences Sociales et Sante : **31**(2).

[BDSP. Notice produite par ORSMIP rHGo8R0x. Diffusion soumise … autorisation]. Le renoncement aux soins, concept récemment introduit dans les enquêtes de l'Institut de recherche et de documentation en économie de la santé (IRDES), constitue aujourd'hui un indicateur d'évaluation des politiques publiques, notamment en termes d'équité, d'accès aux soins. Non définie par les décideurs et les enquêteurs, cette notion fait l'objet de diverses définitions de la part des experts. Cet article vise à les clarifier, puis à analyser les significations attribuées par les non-experts, sujets potentiels des enquêtes, et désignées comme significations profanes. Nous nous sommes appuyés sur des entretiens approfondis en mobilisant les concepts et les méthodes anthropologiques. Les résultats montrent d'abord l'absence du "renoncement aux soins" dans le langage ordinaire. Une fois introduit, il fait l'objet de représentations variées. Nous distinguons deux catégories, le renoncement-refus et le renoncement-barrière, renvoyant à des significations différentes mais articulées entre elles. Ces différentes significations sont mobilisées de manière variable en fonction, notamment, des expériences vécues dans les parcours de soins, des modalités de questionnement, du contexte dé,nonciation. (R.A.)

Jusot, F. (2013). "Les inégalités de recours aux soins : bilan et évolution." Revue D'Epidemiologie et de Sante Publique **61S**(3).
http://www.em-consulte.com/article/824792/article/les-inegalites-de-recours-aux-soins%C2%A0-bilan-et-evol

La réduction des inégalités sociales de santé est aujourd'hui une priorité de santé publique et l'équité d'accès aux soins est une condition nécessaire pour atteindre cet objectif. La compréhension et la mesure des inégalités de consommation de soins sont donc essentielles afin de définir des politiques effectives d'accès aux soins. Après avoir rappelé les différents enjeux de la mesure des inégalités de recours aux soins, cet article propose de dresser le bilan des connaissances sur l'ampleur de ces inégalités en France et dans les pays de l'OCDE, sur leurs causes, et leur évolution. Les résultats des études disponibles en France montrent que les inégalités de recours aux soins ont diminué, en particulier avec l'introduction de la couverture maladie universelle en 2000, bien qu'elles restent significatives. La réduction des inégalités est particulièrement importante pour le recours au médecin généraliste, pour lequel on observe à présent des inégalités en faveur des plus pauvres. Les inégalités restent en revanche très importantes pour le recours aux soins de spécialistes et les soins préventifs, ce qui conduit la France à être l'un des pays d'Europe où les inégalités de recours aux soins sont les plus importantes.

2012

Dourgnon, P., et al. (2012). "Payer nuit gravement à la santé, : une étude de l'impact du renoncement financier aux soins sur l'état de santé,." Economie Publique(28-29).
http://economiepublique.revues.org/8851?file=1

Cette étude propose d'analyser des déterminants du renoncement aux soins pour raisons financières, puis d'étudier ses conséquences sur l'évolution de l'état de santé quatre ans plus tard à partir des données de l'enquête santé protection sociale (ESPS). L'analyse des déterminants du renoncement montre le rôle important joué par l'accès à une couverture complémentaire, au côté de celui de la situation sociale présente, passée et anticipée. L'analyse montre ensuite que les difficultés d'accès aux soins contribuent aux inégalités de santé (Résumé d'auteur).

Dourgnon, P., et al. (2012). Le renoncement aux soins. Actes du colloque du 22 novembre 2011, Paris : Drees https://drees.solidarites-sante.gouv.fr/

La DSS et la DREES ont souhait, explorer cette notion de renoncement aux soins, afin de bien mesurer le phénomène et de mieux comprendre ce qu'il recouvre, d'en connaître les déterminants, et de réfléchir au rôle des politiques publiques pour en limiter l'ampleur. Plusieurs travaux de recherche ont été présentés lors du colloque ® Renoncement aux soins ¯ qui s'est tenu à Paris en novembre dernier. La présentation de ces travaux a été suivie par une table ronde donnant la parole aux différents acteurs du système de soins autour d'un d,bat sur la question suivante : ® Comment mieux garantir l'accessibilité financière aux soins ? ¯. Ce recueil retranscrit les différents exposés de ce colloque ainsi que les débats qui les ont suivis

2011

Brajon, E., et al. (2011). La rotation des bénéficiaires dans le dispositif de la CMU-C. Paris Fonds Cmu**:** 64, annexes.

À la demande du Fonds CMU, un groupe d'étudiants de l'EN3S a mené une étude sur le turn-over des bénéficiaires de la CMU-C auprès de la CPAM de Valence (Drôme). En effet, depuis 2006, plusieurs études (CPAM de l'Allier et de l'Eure-2008) ont été diligentées dans le double objectif de mieux appréhender la population CMU-C, en particulier sous les angles sociologique et de comportement de soins et de mieux cerner le phénomène d'entrée et de sortie de la CMU-C des bénéficiaires. La finalité était d'identifier les éventuels cas de renoncement aux soins et ainsi de réfléchir aux conditions d'une meilleure couverture sociale des populations les plus précaires.

Bremaud, A. (2011). "Inégalité sociale de santé et recul de l'accès aux soins." Cahiers De Sante Publique Et De Protection Sociale (Les): 56-59.

Malgré la performance du système de santé français, les inégalités sociales de santé ont considérablement progressé en France depuis les années 1970, en raison de la crise économique. Cet article étudie les différents facteurs (socio-économiques, socio-culturels) de la dégradation de l'état de santé. Les sources statistiques utilisées sont multiples : données de l'Insee (Institut national des statistiques économiques et sociales), enquête santé et protection sociale de l'Irdes (Institut de recherche et documentation en économie de la santé).

Cercle Santé (2011). Les soins de santé en Europe et aux Etats-Unis. Résultats du baromètre 2011 et évolutions observées depuis 2006. Paris Cercle Santé**:** 20.
http://groupe.europ-assistance.com/fr/actualites/les-resultats-du-5eme-barometre-cercle-sante-europ-assistance-sont-desormais#.WMJ3pn9TAlg
http://groupe.europ-assistance.com/fr/actualites/les-resultats-du-5eme-barometre-cercle-sante-europ-assistance-sont-desormais#.WMJ3pn9TAlg

En octobre 2006, le Groupe Europ Assistance et le Cercle Santé Société lançaient, avec l'institut CSA, un baromètre annuel paneuropéen sur la relation et les pratiques des citoyens européens à l'égard de leurs systèmes de santé. Cette publication présente les chiffres de la sixième vague de l'enquête. Dix pays sont comparés sur sept thèmes. Concernant le jugement des publics sur l'organisation de leur système de santé, CSA note une assez large diversité d'opinion selon les pays, la France (5,0) se retrouvant dans la moyenne haute. Le report des soins est un phénomène contrasté selon les pays et les soins concernés. Si les inégalités d'accès des citoyens aux soins médicaux sont pointées dans la plupart des pays, les scores restent globalement stables, avec un sentiment particulièrement négatif en Pologne, mais aussi en Allemagne, alors qu'en France et aux Etats-Unis la situation est jugée meilleure. On observe que les craintes sur le financement se révèlent relativement moins prégnantes que les problèmes liés à la qualité des soins. A la question : Au cours de l'année écoulée, vous est-il arrivé de renoncer ou de reporter des soins médicaux pour vous ou un membre de votre foyer, en raison des difficultés financières ?, les Polonais sont 36 % à déclarer avoir dû opérer ce choix, les Français 29 % et les Américains 25 %, avec une progression de 6 % en France sur un an et de 18 % par rapport à 2009 ! Les scores sont plus faibles en Italie (19% vs 18%) et même une amorce de baisse en Grande-Bretagne (6% vs 8%) et en Allemagne (15% vs 17%). Parmi les soins reportés ou annulés, ce sont les soins dentaires et les lunettes qui ont été le plus cités dans notre pays (par 26% des répondants), cette proportion étant sensiblement plus forte pour les catégories sociaux-professionnelles les moins favorisées par rapport aux catégories supérieures (28% vs 15%). La majorité des pays sondés porte un jugement favorable sur les professionnels de santé. Avec 59 % d'opinions favorables, les Français sont dans la moyenne, loin derrière les Autrichiens (86 %)., alors que seulement 17 % des Polonais et 29 % des Italiens ont un jugement positif. Sur le thème de la prise en charge de la dépendance, seuls les Autrichiens sont relativement satisfaits. En France, 64 % de la population a une opinion plutôt négative sur ce sujet et 54 % juge l'aide publique pour le maintien à domicile des personnes âgés insatisfaisante.

- *La dernière version de ce baromètre date de 2013 : http://www.europ-assistance.com/sites/default/files/barometre_sante__societe___csa_europ_assistance_2013__rapport_complet.pdf*

Cetaf (2011). Renoncements aux soins des bénéficiaires de la CMU-C : Enquête dans les CES de l'Assurance maladie. Paris Fonds CMU, St Etienne CETAF**:** 44, tabl., annexes.

Les bénéficiaires de la CMU-C doivent normalement accéder aux soins sans participation financière, sauf exigence particulière. En conséquence, le phénomène du renoncement, et plus particulièrement pour raisons financières, a longtemps été considéré comme marginal. Pour autant, les acteurs de terrain, ainsi que les Enquêtes sur la santé et la protection sociale menées par l'IRDES, faisaient régulièrement remonter une information contradictoire. Pour en savoir plus, dans le cadre d'un groupe de travail initié par la Direction de la sécurité sociale, le Fonds CMU a demandé au CETAF (Centre technique d'appui et de formation des centres d'examens de santé) d'effectuer une étude sur le renoncement aux soins des bénéficiaires de la CMU-C. Les CES sont des lieux privilégiés de rencontre et d'observation des bénéficiaires de la CMU-C. En effet, les bénéficiaires de la CMU-C représentent autour de 14% de la population reçue dans les centres d'examens de santé, alors que les bénéficiaires de la CMU-C ne comptent au total que pour 5,8 % de la population française. Près de la moitié des bénéficiaires de la CMU-C a renoncé à au moins un soin aux cours des12 mois précédant l'enquête. Plus d'un tiers des bénéficiaires a renoncé pour des raisons financières et presqu'un quart pour des raisons autres que financières. Toutefois, le bénéfice de la CMU-C fait significativement régresser le renoncement aux soins. On note une différence de plus de 13 points entre le taux de renoncement pour raisons financières pour les personnes bénéficiant de la CMU-C depuis moins d'un an et pour celles qui en bénéficient depuis d'un an. Paradoxalement, un quart des bénéficiaires de la CMU-C a renoncé à au moins un soin pour des raisons financières avant même d'avoir consulté un professionnel de santé, ce qui correspond à plus des deux tiers des renoncements pour raisons financières. Les soins ou produits non remboursés et la demande d'une participation financière sont les principaux motifs de renoncement. Ils concernent essentiellement le dentaire (soins et prothèses), puis les médicaments, l'optique et les consultations de spécialistes. Quand des parents renoncent à des soins pour leurs enfants pour raisons financières, la contrainte porte essentiellement sur les médicaments et l'orthodontie.

Despres, C. et Boisguerin, B. d. (2011). Le renoncement aux soins : des parcours de soins sous contraintes ou une forme d'émancipation ? Le renoncement aux soins. Actes du colloque du 22 novembre 2011., Paris : Drees**:** 67-79.

Ce chapitre présente les résultats d'une étude anthropologique permettant de comprendre les différentes significations de l'expression « renoncement aux soins » telles qu'elles sont perçues par les personnes interrogées dans les enquêtes. Après une brève présentation des objectifs du volet anthropologique de la recherche et des méthodes mises en œuvre, les résultats sont présentés selon deux catégories de sens du renoncement. Cette étude montre que le renoncement aux soins, qui peut survenir à tout moment d'un itinéraire thérapeutique, prend deux formes principales : le renoncement-barrière et le renoncement refus.

Dourgnon, P. et Boisguerin, B. d. (2011). Le renoncement aux soins pour raisons financières, une approche économique. Le renoncement aux soins. Actes du colloque du 22 novembre 2011., Paris : Drees**:** 9-19.
http://social-sante.gouv.fr/IMG/pdf/actes_renoncement_soins_2012.pdf

Ce chapitre s'inscrit dans une approche économique du renoncement aux soins pour raison financière en France et de ses déterminants, à partir des données de l'enquête santé protection sociale (SPS). Après une description des différents types de renoncement pour raisons financières, son évolution de 2000 à 2008 et comment il est distribué selon les différents groupes sociaux, sont étudiés les déterminants du renoncement, en insistant sur les rôles de la situation sociale, de la couverture complémentaire et du prix des soins.

Dourgnon, P., et al. (2011). "Dépense de santé et accès financier aux services de santé : une étude du renoncement aux soins." Serie Statistiques - Document de Travail - Drees(161): 85-96, tabl., graph., fig.
https://drees.solidarites-sante.gouv.fr/

En France, le renoncement aux soins pour raisons financières concerne, en 2008, 15,4 % de la population adulte en ménage ordinaire. Les barrières financières se concentrent sur les soins dentaires, et dans une moindre mesure l'optique et les consultations de médecin. À partir de l'enquête Santé et protection sociale de l'Irdes, qui mesure les déclarations de renoncement aux soins pour raisons financières, et recueille aussi des informations socioéconomiques, sur l'état de santé et la consommation de soins, cette étude analyse les déterminants du renoncement aux soins pour raisons financières.

Fonds CMU (2011). Rapport d'activité 2010 du Fonds de financement de la protection complémentaire de la couverture universelle du risque maladie. Paris Fonds CMU ; Paris La documentation française**:** 104 , ann.
http://www.ladocumentationfrancaise.fr/rapports-publics/114000350/index.shtml

Etablissement public national à caractère administratif créé par l'article 27 de la loi du 27 juillet 1999, le Fonds de financement de la CMU complémentaire a pour mission première de financer le volet complémentaire de la couverture maladie universelle (CMU-C) et d'assurer la gestion de l'aide au paiement d'une complémentaire santé (ACS). Dans son rapport d'activité présenté au titre de l'année 2010, l'établissement revient sur les effets de la crise économique sur le nombre de bénéficiaires, analyse la progression des dépenses de CMU-C et de l'ACS, et fait le point sur les comptes du fonds CMU. La dernière partie du rapport est consacrée aux activités du Fonds, liées à l'analyse de l'application des dispositifs CMU et ACS dans leurs aspects économiques, sanitaires et sociaux (participation à des recherches ou la conduite d'études, etc.).

HCAAM (2011). Mieux évaluer la dépense publique d'assurance maladie : l'ONDAM et la mesure de l'accessibilité financière des soins. Paris HCAAM**:** 182.
https://www.securite-sociale.fr/hcaam

Ce rapport, adopté le 15 décembre 2011, comporte une prise de position sur l'Objectif national des dépenses d'assurance maladie (ONDAM), à partir d'une étude qui aborde l'ensemble des enjeux associés à cet objectif, ainsi que la question des Objectifs régionaux (ORDAM) ;une prise de position sur l'accessibilité financière des soins et la question du "reste à charge" en matière de santé, à partir de données originales produites par le Haut Conseil pour l'avenir de l'assurance maladie. les deux premiers volets du "Tableau de bord " annuel du HCAAM, portant respectivement sur l'accessibilité financière des soins et sur la situation financière de l'assurance maladie. Ce document comprend aussi une note de la Direction de recherche de l'évaluation, des études et des Statistiques (DREES) fera l'objet de compléments. Dès qu'ils seront intégrés, une version définitive du rapport annuel 2011 du HCAAM sera mise en ligne.

ONZUS (2011). L'état de santé des adultes en Zus en 2008. Observatoire national des zones urbaines sensibles : rapport 2011., Paris : La documentation Française**:** 122-139, tabl., graph., fig.
http://www.ville.gouv.fr/IMG/pdf/rapport_onzus_2011.pdf

L'Observatoire national des zones urbaines sensibles (ONZUS) a été créé par la loi d'orientation et de programmation pour la ville et la rénovation urbaine du 1er août 2003. Son objectif est de « mesurer l'évolution des inégalités sociales et des écarts de développement dans chacune des zones urbaines sensibles, de mesurer les moyens spécifiques mis en oeuvre et d'en évaluer les effets par rapport aux objectifs [de la loi du 1er août 2003]. Basé sur les résultats de l'enquête Santé soins et protection sociale (ESPS 2008) de l'Institut de recherche - et documentation en économie de la santé (Irdes), ce chapitre analyse l'état de santé de la population dans les Zus et leur renoncement aux soins.

Ortiz, J. P. et Raynaud, J. (2011). Les obstacles de l'accès aux soins en Languedoc-Roussillon : présentation synthétique des résultats de l'enquête réalisée auprès de 1006 personnes en juin 2011. Montpellier URPS**:** 34 , tabl., graph., fig.

L'Union régionale des professions de santé (URPS) du Languedoc-Roussillon a réalisé une enquête téléphonique en collaboration avec le CSA auprès de 1006 habitants sur les obstacles de l'accès aux soins en Languedoc-Roussillon. Les résultats montrent que la principale difficulté pour consulter un médecin généraliste est le temps d'attente en cabinet (15 %). En ce qui concerne les médecins spécialistes la principale difficulté pour consulter est le délai d'obtention d'un rendez-vous. 11,8% de la population a déclaré avoir renoncé au moins une fois à consulter un médecin généraliste. Ce chiffre s'élève à 23,7% pour un médecin spécialiste. Les 3 spécialités où le renoncement a été le plus fort sont l'ophtalmologie, la dermatologie et la gynéco-obstétrique.

2010

(2010). "Agir pour l'accès de chacun aux soins de qualité." Revue Prescrire(322): 638.

Les obstacles à l'accès à des soins de qualité pour tous sont nombreux et variés, et les inégalités de santé ont tendance à s'aggraver en France et dans le monde. L'amélioration de la santé passe par une réduction des inégalités socio-économiques. Accéder aux soins dépend aussi de la démographie des soignants et de leur répartition sur le territoire, ainsi que de l'organisation des soins et des choix collectifs. Mais à quoi bon lever les obstacles à l'accès aux soins, si les soins ne sont pas de bonne qualité ? Avec des autorisations de mise sur le marché trop laxistes et une pharmacovigilance trop passive, le "marché" du médicament n'est pas assez au service des patients et trop soumis aux influences des firmes. Les politiques de santé sont à courte vue, et certaines dépenses de "santé" sont inutiles, voire nuisibles. La pléthore d'informations de santé est d'intérêt très inégal.

Allonier, C., et al. (2010). La santé des femmes en France. Edition mise à jour, Paris : Drees
https://drees.solidarites-sante.gouv.fr/

À partir de fiches thématiques conjuguant les approches par pathologie et par population, ce recueil dresse un tableau précis de la santé des femmes, en France, en 2008 : données de cadrage, santé sexuelle et reproductive, périnatalité, maladies infectieuses, maladies chroniques et vieillissement, cancers, addictions et toxicomanie, santé mentale, accidents et traumatismes, santé et travail, santé et précarité. Un éclairage particulier est porté sur trois problématiques au coeur des préoccupations actuelles de santé publique : la périnatalité, la santé sexuelle et reproductive ainsi que les violences subies par les femmes. Au-delà des constats, ce recueil statistique sur l'ensemble des données disponibles dans le champ sanitaire et social se veut aussi un outil d'aide à la décision. Statisticiens, épidémiologistes, médecins, démographes et sociologues... ont apporté leur contribution à cette étude de référence.

Cercle Santé (2010). Baromètre sur les principaux débats de santé. Résultats 2010 et évolutions observées depuis 2006. Paris Cercle Santé**:** 15.
http://www.europ-assistance.com/presse/doc_barometres_sante.html

Lancé en octobre 2006 ce baromètre annuel paneuropéen a pour objectif de mesurer et de suivre l'état de l'opinion publique sur les grands débats de santé. Cinq axes prioritaires sont développés à partir des résultats de cette cinquième vague : La qualité des systèmes de santé et leur financement : comment les citoyens évaluent-ils leurs systèmes de santé, quels types de financement privilégient-ils ? La crise et son impact sur la santé : comment les citoyens réagissent-ils ? Quelles sont leurs exigences ? Comment évoluent leurs comportements, notamment en termes de mobilité ? Comment envisagent-ils l'avenir et quelle est leur appréciation de la prévention ? Focus sur la formation et l'information en matière médicale : quel regard les citoyens portent-ils sur le niveau de formation initiale et continue de leurs médecins, tant au plan technique que relationnel et de la communication des informations les concernant entre les différents professionnels; La dépendance et son financement : comment est perçu le « cinquième risque », la prise en charge du vieillissement et des personnes dépendantes; Les nouvelles technologies : quel rôle peuvent-elles jouer par rapport aux pratiques de soins et de suivi traditionnelles ?

Cour des Comptes (2010). Les soins dentaires. La Sécurité sociale : rapport annuel au Parlement., Paris : Cour des comptes**:** 319-350, tabl.

D'après les comptes nationaux de la santé, le montant des dépenses de soins dentaires atteignait, en 2008, 9,65 Md. Elles représentent 5,7 % de la consommation de soins et biens médicaux mais seulement 2,5 % des remboursements de la sécurité sociale. Cet écart qui va croissant traduit un désengagement financier de l'assurance maladie qui a peu d'équivalent dans d'autres secteurs de la santé. Il s'explique principalement par l'importance des dépassements de tarifs qui concernent aujourd'hui près de la moitié des honoraires remboursables. Il faudrait y ajouter un certain nombre d'actes non remboursables, de plus en plus répandus. Aujourd'hui, la sécurité sociale ne prend plus à sa charge que le tiers (34 %) de ces dépenses (contre plus de la moitié en 1980), et en particulier, seulement 18 % des soins prothétiques qui sont les plus coûteux. L'ampleur de ces dépassements explique par ailleurs que les problèmes dentaires représentent à eux seuls, selon les études disponibles, plus de la moitié de tous les cas de renoncements à des soins pour des raisons financières. L'évolution de ce secteur, atypique au sein des dépenses de santé, constitue donc un enjeu majeur de l'accès aux soins en France. Or l'examen effectué par la Cour met en évidence non seulement diverses limites dans la politique sanitaire menée dans ce secteur (I), mais aussi le caractère inadapté de la politique conventionnelle et tarifaire (II).

Fonds CMU (2010). Rapport d'activité 2009 du Fonds de financement de la protection complémentaire de la couverture universelle du risque maladie. Paris Fonds CMU**:** 82, ann.

Ce rapport annuel dresse le profil des bénéficiaires de la CMUC-C au 31 décembre 2009. 4 173 817 personnes bénéficiaient de la CMU-C, un chiffre en légère baisse sur un an, mais qui risque de progresser en 2010 ; En effet, la crise économique amorcée fin 2008 ne produit pas encore ses effets, mais les amortisseurs sociaux liés au risque de perte d'emploi devraient arriver à leur terme courant

2010 pour bon nombre de personnes. Les dépenses de la CMU-C connaissent une évolution modérée. La dépense moyenne par bénéficiaire est ainsi évaluée en 2009 à environ 418 euros par la CNAMTS, soit une augmentation de 2,6 %. Un montant toutefois supérieur au forfait par bénéficiaire attribué aux gestionnaires des contrats (370 euros) qui supportent la différence. Le montant restant à la charge de la CNAMTS, qui gère environ 3 millions de bénéficiaires de CMU-C, s'élève ainsi à 144 millions d'euros. Le nombre de bénéficiaires de la CMU de base a dépassé fin 2009 la barre des 2 millions de personnes, en hausse de 40 % sur un an. Un tiers des bénéficiaires du revenu de solidarité active socle ne ferait pas valoir ses droits à la CMU-C alors qu'ils peuvent y prétendre. Le rapport d'activité souligne par ailleurs la "lente montée en charge" de l'aide à l'acquisition d'une complémentaire santé (ACS), avec un nombre de bénéficiaires qui apparaît stable en 2009 par rapport à 2008 (600 336 personnes fin 2009). Le taux d'utilisation des attestations délivrées par les caisses d'assurance maladie pour l'obtention de l'ACS est très élevé et se situe autour de 80 %. Parmi ses bénéficiaires, 71 % ont fait valoir leurs droits auprès d'une mutuelle, 26 % auprès d'une société d'assurance et 3 % dans un Institut de prévoyance. Les contrats de complémentaire santé que souscrivent les bénéficiaires de l'ACS s'avèrent une nouvelle fois être de qualité limitée, de niveau inférieur à celui des autres contrats individuels. La charge des ménages pour financer annuellement la complémentaire santé reste conséquente et représente la moitié d'un mois de revenus. Les comptes du fonds CMU pour l'année 2009 présentent un résultat positif de 19 millions d'euros.

Hamel, C. et Moisy, M. (2010). L'expérience de la migration, santé perçue et renoncement aux soins. Trajectoires et Origines, enquête sur la diversité des populations en France. Premiers Résultats., Paris : Ined**:** 77-84., tabl., fig.

Si les dimensions du genre et des inégalités de revenu sont de plus en plus systématiquement prises en compte dans les études récentes sur la santé des immigrés, les critères de nationalité, pays de naissance et origine apparaissent souvent manquants, qu'ils soient indisponibles ou non présentés. L'enquête Trajectoires et Origines, de par son objectif premier d'étudier la diversité des populations en France, de par les données quelle renseigne sur le parcours migratoire et les conditions de vie actuelles dans différentes sphères du quotidien et de par la taille de son échantillon, permet d'apporter un éclairage sur la santé des immigrés et natifs d'un DOM. Ce chapitre présente les premiers résultats sur la santé perçue des immigrés et natifs d'un DOM, âgés de 18 à 60 ans, en France. Les natifs d'un DOM sont intégrés aux analyses multivariées au titre de leur expérience d'une grande mobilité géographique et de ses effets possibles sur la santé perçue, à âge identique, les hommes immigrés ont une probabilité supérieure de 30 % de déclarer un état de santé altéré comparés aux hommes de la population majoritaire. Pour les femmes immigrées, cette probabilité s'accroit de 80 %. Être chômeur ou inactif, disposer de faibles revenus et d'un niveau d'études inférieur au baccalauréat apparaissent parmi les facteurs explicatifs les plus significatifs pour expliquer les différences de perception de santé entre immigrés et population majoritaire. Si l'on prend en compte le pays d'origine, ce sont les immigrés de Turquie, du Maghreb et du Portugal qui se déclarent le plus souvent en mauvaise santé. À âge et caractéristiques socio-économiques identiques, les hommes et les femmes immigrés présents sur le territoire métropolitain depuis plus de trente ans se déclarent également en plus mauvaise santé ce qui est compatible avec l'hypothèse souvent émise de l'effet d'une dégradation de l'état de santé sur la terre d'accueil due à une situation sociale plus défavorable.

Henon, D. (2010). La santé des femmes en France. Paris La documentation française **:** 95.
http://lesrapports.ladocumentationfrancaise.fr/BRP/104000510/0000.pdf

La plus grande longévité des femmes est tempérée par des vulnérabilités spécifiques, le développement de comportements à risques et des inégalités d'accès aux soins. L'intégration professionnelle des femmes produit des effets positifs sur leur santé mais les expositions et nuisances liées à de nombreux emplois féminins demeurent largement invisibles car peu étudiées. Sur chacun de ces thèmes, le Conseil cible les efforts à faire pour améliorer la santé des femmes en mettant l'accent sur la prévention et la lutte contre les inégalités sociales pathogènes, toutes actions qui nécessitent une meilleure prise en compte du genre dans la recherche médicale et les politiques de santé publique (résumé d'auteur).

MDM (2010). Rapport 2009 de l'Observatoire de l'Accès aux Soins de la Mission France de Médecins du Monde. Paris MDM**:** 226.
http://www.medecinsdumonde.org/fr/Presse/Dossiers-de-presse/France/L-acces-aux-soins-des-plus-demunis-en-2010

Les centres de Médecins du Monde ne désemplissent pas. En 2009, l'ONG a reçu en consultations plus de 25 800 patients dans ses centres de soins, soit 17 % de plus qu'en 2007. Selon Médecins du Monde, l'augmentation du nombre de patients s'explique par la complexification des démarches administratives (demandes de pièces abusives, durcissement des pratiques, renforcement des contrôles...) qui restreignent l'accès aux soins et découragent les personnes qui y ont droit. Dans son rapport annuel publié à l'occasion de la journée mondiale du refus de la misère, l'observatoire de l'accès aux soins de la mission France constate un doublement des retards aux soins entre 2007 et 2009 de 11 à 22 %, qui entraîne dans de nombreux cas une aggravation de l'état de santé. Autre donnée observée par l'ONG: l'augmentation de 30 % du nombre d'enfants et d'adolescents, qui sont de plus en plus nombreux à être issus des familles de demandeurs d'asiles. Alors que 84 % des personnes reçues n'ont aucune couverture maladie, Médecins du Monde plaide pour l'inclusion de l'aide médicale d'Etat (AME) dans la CMU, afin de créer un seul système de couverture maladie pour toutes les personnes résidant en France et vivant sous le seuil de pauvreté. En effet, divers projets portés par le gouvernement : « Le projet de loi sur l'immigration actuellement en cours de discussion à l'assemblée nationale et le projet de loi de finances viendront aggraver cette situation sils sont votés en l'état (limitations de droits au séjour pour des raisons médicales, restrictions de l'AME). Sans AME, les patients ne pourront faire soigner des pathologies simples qui peuvent dégénérer en complications graves et coûteuses.

2009

Boisguerin, B. (2009). "Quelles caractéristiques sociales et quel recours aux soins pour les bénéficiaires de la CMUC en 2006 ?" Etudes et Resultats (Drees)(675): 6 , tabl., graph.
https://drees.solidarites-sante.gouv.fr/

[BDSP. Notice produite par MIN-SANTE lkFR0xp9. Diffusion soumise à autorisation]. Depuis 2000, date de sa création, les bénéficiaires de la couverture maladie universelle complémentaire (CMUC) conservent les mêmes grandes caractéristiques. Il s'agit d'une population jeune, féminine, au sein de laquelle les ouvriers et les employés, particulièrement ceux exposés au chômage, sont surreprésentés. En 2006, la part relative des familles monoparentales a progressé parmi les bénéficiaires. Ils déclarent un moins bon état de santé que le reste de la population du même âge.

Chaupain-Guillot, S., et al. (2009). Le renoncement aux soins de santé : une analyse à partir de l'enquête SRCV. Emploi et politiques sociales : tome 1. Défis et avenir de la protection sociale., Paris : L'Harmattan**:** 85-96, tabl.

À partir des données de la deuxième vague (2005) de l'enquête Statistiques sur ressources et les conditions de vie (SRSV), volet français de l'EU-SILC, on s'intéresse aux déterminants individuels du renoncement aux soins de santé. L'analyse est menée en opérant une distinction entre les soins médicaux et les soins dentaires.

Degorre, A., et al. (2009). "Sur dix jeunes entrés en 6e en 1995, neuf se déclarent en bonne ou très bonne santé en 2007." Insee Premiere(1261): 4 , 3 tabl., 2 graph.

À 23 ans en moyenne en 2007, neuf jeunes sur dix ont une perception positive de leur état de santé. Les garçons se déclarent en meilleure santé que les filles et semblent peu préoccupés de l'impact des conduites à risque sur leur santé. Près d'un jeune sur deux fume, filles et garçons dans les mêmes proportions. Les filles adoptent moins de comportements à risque en matière d'alcool et sont davantage attentives à leur santé.

Jusot, F. et Wittwer, J. (2009). "L'accès financier aux soins en France : bilan et perspective." Regards Croises Sur L'economie(5): 102-109.
http://www.cairn.info/revue-regards-croises-sur-l-economie-2009-1-p-102.htm

Cet article propose de faire le point sur les barrières financières à l'accès aux soins en France. Après avoir rappelé les déterminants économiques du recours aux soins, la question de l'accessibilité à une complémentaire santé sera discutée. Dans une dernière partie, les réformes récentes visant à améliorer l'accès aux soins seront mises en perspective et un prolongement naturel de ces réformes sera proposé.

Softic, S. et Fontaine, A. (2009). Constat : les difficultés de l'accès aux soins dentaires pour les bénéficiaires des CMU et AME dans 11 villes de France. Rapport d'enquête. Paris Médecins du monde**:** 41.
https://www.medecinsdumonde.org/fr/actualites/publications/2009/04/09/enquete-lacces-aux-soins-dentaires-des-beneficiaires-des-cmu-et-ame-dans-11-villes-de-france

Cette enquête, effectuée dans le cadre d'un stage au sein de la Coordination Mission France de Médecins du Monde, témoigne dans un premier temps du refus à l'accès aux soins dentaires opposé aux bénéficiaires des CMU et AME, puis recense dans un second temps les avis des praticiens sur les causes de ce refus et sur les éventuelles solutions à apporter.

2007

Boisguerin, B. (2007). "Les allocataires des minima sociaux : CMU, état de santé et recours aux soins." Etudes et Resultats (Drees)(603): 8 , tabl., graph.
https://drees.solidarites-sante.gouv.fr/

[BDSP. Notice produite par MIN-SANTE R0xznu1P. Diffusion soumise à autorisation]. Une enquête a été effectuée par la DREES au deuxième trimestre 2006 auprès de personnes allocataires de minima sociaux (RMI, API et ASS) au 31 décembre 2004. A la date de l'enquête, les allocataires toujours présents dans le dispositif bénéficient plus fréquemment de la couverture maladie universelle complémentaire (CMUC) que ceux qui en sont sortis. L'état de santé de ces allocataires est moins bon que celui de la population générale et ils ont plus de problèmes de santé affectant leur travail que les personnes sorties de ces dispositifs.

Le, Pen, C. (2007). "Pour ou contre les franchises médicales." Union Sociale(210): 28-31.

Le gouvernement envisage la création des franchises sur certains actes de soins. D'où un lever de boucliers, du côté de ceux qui craignent que la solidarité s'effrite un peu plus, que les foyers à bas revenus renoncent aux soins... C'est la position du Collectif interassociatif sur la santé. Mais d'autres, comme Claude Le Pen estiment que la gratuité totale laisse filer les dépenses de santé, qu'on peut moduler la franchise en fonction des revenus. Cet article fait le point sur la question.

2006

Azogui-Levy, S., et al. (2006). "État dentaire, recours aux soins et précarité." Revue D'Epidemiologie et de Sante Publique **54**(3): 203-211, tabl., rés.

[BDSP. Notice produite par ORSRA R0xpz0I1. Diffusion soumise à autorisation]. Contexte : Les dispositifs de lutte contre l'exclusion ont permis une meilleure couverture maladie. Cependant, le recours aux soins dentaires reste limité et l'état bucco-dentaire des personnes en situation de précarité problématique. L'analyse de la clientèle d'une consultation hospitalière en odontologie du Groupe Hospitalier Pitié-Salpêtrière a semblé pertinente pour apporter des éclairages sur les besoins de soins de ces populations et les modalités de prise en charge. Cette étude avait pour objectifs d'estimer l'état dentaire et de décrire les caractéristiques sociodémographiques et les besoins de soins dentaires d'une population de consultants à l'hôpital et d'analyser les liens entre précarité et état dentaire. Méthodes : Une enquête transversale a été conduite de février à juin 2003. Un auto-questionnaire et un dossier de prise en charge bucco-dentaire ont été utilisés. Toute personne accueillie prise en charge par le service d'odontologie et suivie pour soins conservateurs et prothétiques était incluse. Nous avons, d'une part, comparé les patients définis comme précaires aux patients non précaires et, d'autre part, les sujets ayant un état dentaire déficient aux sujets sains sur le plan dentaire. Résultats : Un ensemble de 336 questionnaires a été exploité. La population ainsi analysée comportait 2/3 d'hommes et 45% d'étrangers. Plus de la moitié des sujets relevait soit de la couverture maladie universelle (22,8%), soit de l'aide médicale d'État (24,4%), soit était sans couverture sociale (4,3%). La comparaison du groupe patients précaires au groupe patients non précaires a montré des différences significatives sur le plan bucco-dentaire : plus de dents manquantes et non remplacées, plus de problèmes gingivaux, et moins de recours aux soins chez les personnes en situation de précarité. L'analyse multivariée des facteurs liés à l'état dentaire a montré que les principaux facteurs de risque d'un mauvais état dentaire étaient la précarité, l'avancée en âge et la nationalité étrangère. Conclusion : Cette étude souligne l'importance des besoins en soins dentaires dans un contexte de faible prise en charge de leurs coûts par l'Assurance-Maladie et d'insuffisance de structures de soins susceptibles d'accueillir des patients en situation sociale difficile. Elle pose la question de l'organisation de l'offre de soins bucco-dentaires en France.

Bazin, F., et al. (2006). "Déterminants psychosociaux du renoncement aux soins pour raisons financières dans cinq zones urbaines sensibles de la région parisienne en 2001." Sciences Sociales Et Sante **24**(3): 11-31, tabl., fig.

L'accès aux soins est garanti pour tous en France grâce à son système de sécurité sociale. Cependant, les enquêtes nationales sur la santé et la protection sociale de l'IRDES estiment qu'environ une personne interrogée sur cinq déclare avoir déjà renoncé à des soins pour raisons financières. Notre objectif était de montrer que, au-delà des facteurs socio-économiques classiquement étudiés, d'autres facteurs, de l'ordre des conditions de vie, des ruptures et intégrations sociales, des représentations de santé et des caractéristiques psychologiques, sont associés à un tel renoncement. (Résumé d'auteur).

Monteil, J. M. p. et Delafosse, M. p. (2006). La santé des étudiants 2005-2006 : enquête nationale et synthèses régionales. Paris Editions de la vie universitaire**:** 299 , tabl.

Ce rapport de la Mutuelle des Etudiants (LMDE) publie les résultats d'une vaste enquête nationale qu'elle a menée avec l'appui de l'Observatoire expertise et prévention pour la santé des étudiants et de l'Ifop. Intitulé "La santé des étudiants 2005-2006, enquête nationale et études régionales", l'ouvrage se veut un outil d´analyse de l'état de santé général des étudiants. Les questions portaient à la fois sur leurs habitudes de vie, leur rapport aux services de santé, au tabac, aux drogues et à la sexualité. On y apprend que 23 % des étudiants ont renoncé en 2005 à des soins, notamment dentaires et ophtalmologiques, pour des raisons financières. Dans la population générale, ce taux n'est que de 13 %. Le nombre d'étudiants ne disposant pas de complémentaire santé est en hausse à 13 %, contre 7 % en 2002. Ces étudiants qui renoncent à acquérir une complémentaires principalement en raison de son coût (39 % des sondés la jugeant trop chère). Les étudiants, qui ne sont pas couverts consultent moins que les autres, indique LMDE. Les étudiants font surtout appel à la médecine de ville puisque 95 % d'entre eux ont consulté un médecin libéral au cours des douze derniers mois. En revanche, seulement un étudiant sur dix fréquente les centres de santé mutualistes. Les étudiants fument moins en 2005 (22 % de fumeurs réguliers contre 32 % en 2002), mais consomment plus d'alcool. Au chapitre mal-être, cette étude démontre que 15 % des étudiants déclarent avoir eu des idées suicidaires au cours des douze derniers mois.

Raynaud, D. (2006). "La consommation de soins des personnes âgées." Actualite Et Dossier En Sante

Publique(56): 34-38, 33 fig., 31 tab.

A partir des données 2004 de l'échantillon permanent d'assurés sociaux de la Cnamts (EPAS) et de l'enquête santé soins protection sociale de l'Irdes, cet article analyse la consommation médicale des pesonnes âgées selon les variables suivantes : types de soins, âge, couverture complémentaire, renoncement aux soins...

Wauquiez, L. (2006). La santé des étudiants français. Paris Assemblée Nationale**:** 127, ann.

Ce rapport réalisé par la mission parlementaire portant sur la santé des étudiants, créée par la Commission des affaires culturelles, familiales et sociales de l'Assemblée nationale le 5 juillet 2006, dresse un constat alarmant : alimentation peu équilibrée, soins dentaires et optiques négligés, dépression. La santé des étudiants montre des signes de dégradations inquiétantes. Ainsi, "près de 15 % des étudiants ont été amenés à renoncer, faute de moyens, à un soin d'optique ou dentaire". Près de 20 % ne bénéficient pas d'une couverture complémentaire, les primes d'adhésion étant jugées trop onéreuses. Les situations de mal-être se multiplient. Un étudiant sur dix traverse des phases de déprime, près d'un étudiant sur quatre prend des antidépresseurs et le suicide reste la principale cause de mortalité chez les 15-25 ans, avec 11 000 suicides par an. De plus, les services de santé de nos universités sont "indigents" et leurs moyens "dramatiquement faibles" (un médecin pour 10 000 étudiants, pour un budget de 3,4 millions d'euros). Pour faire face à cette dégradation, M. Wauquiez demande "dix mesures prioritaires pour un plan de santé étudiant". Il souhaite notamment le fractionnement du paiement de la cotisation de Sécurité sociale, et la création d'un chèque santé pour améliorer la couverture complémentaire des étudiants en commençant par la mise en place immédiate d'une expérimentation dans 12 départements pilotes. Le rapport réaffirme le rôle des mutuelles étudiantes dans la prise en charge de la santé et recommande l'affiliation de l'ensemble des étudiants au régime étudiant de Sécurité sociale. Il appelle également à créer des maisons de la santé étudiante sur les pôles universitaires. Pour les étudiants inscrits dans les deux premières années d'université, le rapporteur recommande d'instituer le droit à un " paquet santé " (visite médicale "systématique et obligatoire", vaccinations, bilan buccodentaire et d'optique et consultation d'addictologie).

ÉTUDES INTERNATIONALES

2021

Hardin, H. K., Alchami, H., Lee, D., et al. (2021). "Unmet health need and perceived barriers to health care among adolescents living in a rural area." Child Health Care **50**(1): 108-123.

This study investigated the perceived health care needs, unmet health need, and barriers to health care in 224 rural-dwelling adolescents. A cross-sectional, descriptive design was used to survey adolescents attending a public high school in a low-resource, rural Indiana community. One in five adolescents reported an unmet health need. The most common barriers to health care were related to access, apathy, anxiety, and parenting issues. Implications include confidentiality protocols in family healthcare practices, school-based health centers, and intervention research targeting adolescents' communication skills and healthcare consumer skills.

Xu, F., Wheaton, A. G., Liu, Y., et al. (2021). "Higher Prevalence of Health-Risk Factors Among US Adults With Unmet Health Care Needs Due to Cost, 2016." J Public Health Manag Pract **27**(1): E19-e27.

CONTEXT: Adults with unmet health care needs (UHCN) due to cost have fewer opportunities to receive behavioral counseling in clinical settings, which may be associated with a higher likelihood of having health-risk behaviors. OBJECTIVE: This study assessed associations between UHCN and health-risk factors. DESIGN/SETTING: We used 2016 Behavioral Risk Factor Surveillance System data to calculate age-adjusted weighted prevalence of 5 health-risk factors by UHCN and insurance status and to assess the association of UHCN with these factors using multivariable logistic regression. PARTICIPANTS: US adults aged 18 to 64 years who participated in the survey (N = 301 035). MAIN OUTCOME MEASURES: Five health-risk factors: obesity, current cigarette smoking, excessive alcohol use, sleeping less than 7 hours per 24-hour period, and no leisure-time physical activity within the past month. RESULTS: In 2016, among adults aged 18 to 64 years, 11.2% of those with insurance and 40.1% of those without insurance (both age-adjusted) had UHCN. In both study populations, compared with adults with no UHCN, adults reporting UHCN were more likely to be a current cigarette smoker, report excessive alcohol use, and sleep less than 7 hours per 24-hour period. The prevalence of 3 or more health-risk factors was higher among adults with UHCN than among adults without UHCN (adults with insurance: adjusted prevalence ratio = 1.40; 95% confidence interval = 1.33-1.48; adults without insurance: adjusted prevalence ratio = 1.39; 95% confidence interval = 1.27-1.53). CONCLUSIONS: Unmet health care needs was associated with more health-risk factors regardless of insurance status. Addressing cost barriers to behavioral counseling may be one approach to consider when seeking to reduce health-risk behaviors among high-risk populations.

2020

Allan, I. et Ammi, M. (2020). "Evolution of the determinants of unmet health care needs in a universal health care system: Canada, 2001-2014." Health Econ Policy Law: 1-24.

While ensuring adequate access to care is a central concern in countries with universal health care coverage, unmet health care needs remain prevalent. However, subjective unmet health care needs (SUN) can arise from features of a health care system (system reasons) or from health care users' choices or constraints (personal reasons). Furthermore, investigating the evolution of SUN within a health care system has rarely been carried out. We investigate whether health needs, predisposing factors and enabling factors differentially affect SUN for system reasons and SUN for personal reasons, and whether these influences are stable over time, using representative data from the Canadian Community Health Surveys from 2001 to 2014. While SUN slightly decreased overall during our period of observation, the share of SUN for system reasons increased. Some key determinants appear to consistently increase SUN reporting over all our observation periods, in particular being a woman, younger, in poorer health or not having a regular doctor. The distinction between personal and system reasons is important to better understand individual experiences. Notably, women report more SUN for system reasons and less for personal reasons, and reporting system reasons increases with age. Given this stability over time, our results may inform health policymakers on which subpopulations to target to ensure access to health care is universal.

Ancelot, L., Bonnal, L., Depret, M.-H., et al. (2020). "Unmet Need for Health Care during Pregnancy: A French-Romanian Comparison." Applied Economics **52**(12): 1298-1310.

Health inequalities emerge from birth, the early neonatal mortality and infant mortality rates being different between countries. These differences may be related to inequalities in use of health care during pregnancy. The aim of this research is to identify and compare the profiles of women who do not follow pregnancy health care recommendations in two European countries with different health systems and indicators: namely France and Romania. However, health care recommendations for pregnant women are free in the two countries. Firstly, unmet need for health care during pregnancy is observed. Secondly, our results reveal that there is a relationship between perinatal health care abandonment and several forms of inequalities (social, informational and psychological). Thirdly, the much higher probability of forgoing perinatal health care for Romanian women could be associated with financial or informational problems which seems counterintuitive because perinatal health care recommendations are free. Free coverage is too insufficient to ensure the efficiency of the perinatal health care system.

Azar, K. M. J., Petersen, J. P., Shen, Z., et al. (2020). "Serious Mental Illness and Health-Related Factors Associated with Regional Emergency Department Utilization." Popul Health Manag **23**(6): 430-437.

Frequent emergency department (ED) utilization is an indicator of unmet health and social needs, especially among patients with mental and physical health problems. The authors aimed to characterize frequent ED utilizers and drivers of multiple ED use, including presence of serious mental illness (SMI), across 2 large health care systems in Northern California. Using electronic health records and a data-sharing platform, a cross-sectional analysis was conducted of patients aged 18+ years with ≥10 ED visits in 2016. Logistic regression was used to determine factors associated with multiple ED use versus single ED use. Among the 8036 patients who met inclusion criteria, the mean age was 55.9 years (95% CI = 55.5-56.4), 53% were female, 54% were non-Hispanic white, and 38% had any SMI. Overall, 51% of patients were single ED utilizers. Patients ages ≥65 years were less likely to use multiple EDs compared to younger patients (ages 18-23) (OR = 0.3, 95% CI = 0.2-0.4). African Americans exhibited more than 3 times the likelihood of multi-ED use compared to non-Hispanic whites (OR = 3.8, 95% CI = 3.3-4.3). A diagnosis of any SMI (OR = 2.3 [95% CI: 2.1-2.6]), major depressive disorder (OR = 1.3, 95% CI = 1.1-1.4), schizophrenia (OR = 2.1, 95% CI = 1.6-2.6), or suicidal attempts/ideation (OR = 2.7, 95% CI = 2.1-3.6) was significantly associated with increased likelihood of multi-ED use. Findings indicate heterogeneity in regional utilization patterns among frequent ED utilizers, with mental illness increasing the likelihood of multi-ED use.

Breslau, J., Han, B., Lai, J., et al. (2020). "Impact of the Affordable Care Act Medicaid Expansion on Utilization of Mental Health Care." Medical Care **58**(9): 757-762.
https://doi.iorg/10.1097/mlr.0000000000001373

Background: The Affordable Care Act's Medicaid expansions (ME) increased insurance coverage for low-income Americans, among whom unmet need for mental health care is high. Empirical evidence regarding the impact of expanding insurance coverage on use of mental health services among low income and minority populations is lacking. Methods: Data on mental health service use collected between 2007 and 2015 by the Medical Expenditures Panel Survey from nationally representative cross-sectional samples of low income (income<138% of the federal poverty line) adults were analyzed. Use trends among people in states that expanded Medicaid (ME states; n=29,827) were compared with concurrent trends among people in states that did not (non-ME states; n=22,873), with statistical adjustment for demographic characteristics and psychological distress. Results: Annual outpatient visits for mental health conditions increased by 0.513 (0.053–0.974) visits per person, from a baseline rate in ME states of 0.894 visits per person. However, no significant changes were observed in number of mental health related hospital stays, emergency department visits or prescription fills. The increase outpatient visits was limited to Hispanics and non-Hispanic Whites, with no increase in service use observed among non-Hispanic Blacks. There was no apparent increase in the number of users of outpatient mental health care (AOR=0.992, P=0.942) and a marginally significant (P=0.096) increase of 3.144 visits per user. Discussion:

Cree, R. A., Okoro, C. A., Zack, M. M., et al. (2020). "Frequent Mental Distress Among Adults, by Disability Status, Disability Type, and Selected Characteristics - United States, 2018." MMWR Morb Mortal Wkly Rep **69**(36): 1238-1243.

Frequent mental distress, defined as 14 or more self-reported mentally unhealthy days in the past 30 days,* is associated with adverse health behaviors, increased use of health services, mental disorders (e.g., diagnosis of major depressive disorder), chronic diseases, and functional limitations (1). Adults with disabilities more often report depression and anxiety (2), reduced health care access (3), and health-related risk behaviors (4) than do adults without disabilities. CDC analyzed 2018 Behavioral Risk Factor Surveillance System (BRFSS) data to compare the prevalence of frequent mental distress among adults with disabilities with that among adults without disabilities and to identify factors associated with mental distress among those with disabilities. Nationwide, an estimated 17.4 million adults with disabilities reported frequent mental distress; the prevalence of reported mental distress among those with disabilities (32.9%) was 4.6 times that of those without disabilities (7.2%). Among adults with disabilities, those with both cognitive and mobility disabilities most frequently reported mental distress (55.6%). Adults with disabilities who reported adverse health-related characteristics (e.g., cigarette smoking, physical inactivity, insufficient sleep, obesity, or depressive disorders) or an unmet health care need because of cost also reported experiencing more mental distress than did those with disabilities who did not have these characteristics. Adults living below the federal poverty level reported mental distress 70% more often than did adults in higher income households. Among states, age-adjusted prevalence of mental distress among adults with disabilities ranged from 25.2% (Alaska) to 42.9% (New Hampshire). Understanding the prevalence of mental distress among adults with disabilities could help health care providers, public health professionals, and policy makers target interventions and inform programs and policies to ensure receipt of mental health screening, care, and support services to reduce mental distress among adults with disabilities.

Del Puente, F., Riccardi, N., Taramasso, L., et al. (2020). "Migrants and imported disease: Trends of admission in an Italian infectious disease ward during the migration crisis of 2015-2017." BMC Public Health **20**(1): 738.

BACKGROUND: Since 2014, the migrant population residing in Europe has dramatically increased. Migrants' unmet health needs represent a barrier to integration and should be promptly addressed, without stigma, in order to favour resettlement. METHODS: All-cause of admissions in the migrant population at the Infectious Disease Clinic of Policlinico San Martino Hospital in Genoa between 2015 and 2017 were analysed. Patients were classified by duration of residence in Italy according to the Recommendation on Statistics of International Migration, cause of hospitalization, and region of origin. All data were evaluated with SPSS Statistics. RESULTS: Two hundred thirty-five people were admitted, 86 (36.5%) of them residing in Italy for less than 1 year. Except for a significant increase in migrants from Africa, there was no change considering the area of origin, hospitalization reason or by comparing residency in Italy for more or less than 1 year. A considerable number of hospitalizations were related to non-communicable pathologies and latent tuberculosis infection. Residents in Italy for less than 1 year or with active tuberculosis had prolonged hospitalizations, while HIV-infected had shorter hospital stays. CONCLUSIONS: No difference in terms of diagnosis were found between migrants with longer or shorter period of residence in Italy. Adequate outpatient services for the management of communicable diseases could significantly reduce the length of hospitalizations in the migrant population.

Dorney-Smith, S., Schneller, K., Swift, A., et al. (2020). "Meeting the needs of homeless people attending the emergency department." Emerg Nurse **28**(4): 31-39.

Homelessness is on the rise in the UK and, over the past few years, there has been a significant increase in the number of emergency department (ED) attendances and admissions by homeless people. Those attending the ED will often have multiple unmet health, housing and social care needs. While it is not possible to meet all these needs in the ED, emergency nurses should be equipped with the knowledge and skills required to communicate with, refer and signpost patients who are homeless. Under the Homelessness Reduction Act 2017, ED staff have a duty to refer homeless people, with their consent, to local authorities for assistance. This article details the barriers that homeless people may experience when accessing healthcare services and explains how these can be addressed. It also outlines the actions that emergency nurses can take to improve the care of homeless people in the ED at an individual and a systems level.

Fels, M. (2020). "Incentivizing efficient utilization without reducing access: The case against cost-sharing in insurance." Health Economics **29**(7): 827-840.
https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4023

Abstract Cost-sharing is regarded as an important tool to reduce moral hazard in health insurance. Contrary to standard prediction, however, such requirements are found to decrease utilization both of efficient and of inefficient care. I employ a simple model that incorporates two possible explanations—consumer mistakes and limited access—to assess the welfare implications of different insurance designs. I find cost-sharing never to be an optimal solution as it produces two novel inefficiencies by limiting access. An alternative design, relying on bonuses, has no such side effects and achieves the same incentivization. I show how the optimal design can be deduced empirically and discuss possible impediments to its implementation.

Fiorillo, D. (2020). "Reasons for Unmet Needs for Health Care: The Role of Social Capital and Social Support in Some Western EU Countries." Int J Health Econ Manag **20**(1): 79-98.

This paper focuses on the demand side factors that determine access to health care and analyses the issues of unmet needs for health care and the reasons thereof in western EU countries. A probit model is estimated from a sample of the whole population, accounting for the possibility of individual selection in unmet needs for health care (UN) (selection equation). Expanded probit models (including the inverse Mills ratio) are then used on the reasons for unmet needs (RUN) with social capital and social support as determinants and using the European Union Statistics on Income and Living Conditions dataset from 2006. In the RUN equations, the findings show that females, large households, people with low income and financial constraints, the unemployed and those in poor health have a higher probability of declaring unmet needs due to economic costs. Additionally, people in tertiary education, those with high income and the employed have a higher probability of not visiting a doctor when needed due to time constraints. Furthermore, the frequency of contact with friends and the ability to ask for help are correlated with a lower probability of unmet needs due to economic costs, while the frequency of contact with relatives is correlated with a lower probability of unmet needs due to time constraints and distance. However, the ability to ask for help is also correlated with a higher probability of not having medical care due to time constraints and the wait-and-see approach.

Fiori, K. P., Heller, C. G., Rehm, C. D., et al. (2020). "Unmet Social Needs and No-Show Visits in Primary Care in a US Northeastern Urban Health System, 2018–2019." American Journal of Public Health **110**(S2): S242-S250.
https://doi.org/10.2105/AJPH.2020.305717

Objectives. To characterize the association between social needs prevalence and no-show proportion and variation in these associations among specific social needs.Methods. In this study, we used results from a 10-item social needs screener conducted across 19 primary care practices in a large urban health system in Bronx County, New York, between April 2018 and July 2019. We estimated the association between unmet needs and 2-year history of missed appointments from 41?637 patients by using negative binomial regression models.Results. The overall no-show appointment proportion was 26.6%. Adjusted models suggest that patients with 1 or more social needs had a significantly higher no-show proportion (31.5%) than those without any social needs (26.3%), representing an 19.8% increase (P?<?.001). We observed a positive trend (P?<?.001) between the number of reported social needs and the no-show proportion?26.3% for those with no needs, 30.0% for 1 need, 32.1% for 2 needs, and 33.8% for 3 or more needs. The strongest association was for those with health care transportation need as compared with those without (36.0% vs 26.9%).Conclusions. We found unmet social needs to have a significant association with missed primary care appointments with potential implications on cost, quality, and access for health systems.

Fiorillo, D. (2020). "Reasons for unmet needs for health care: the role of social capital and social support in some western EU countries." Int J Health Econ Manag **20**(1): 79-98.
https://doi.org/10.1007/s10754-019-09271-0

This paper focuses on the demand side factors that determine access to health care and analyses the issues of unmet needs for health care and the reasons thereof in western EU countries. A probit model is estimated from a sample of the whole population, accounting for the possibility of individual selection in unmet needs for health care (UN) (selection equation). Expanded probit models (including the inverse Mills ratio) are then used on the reasons for unmet needs (RUN) with social capital and social support as determinants and using the European Union Statistics on Income and Living Conditions dataset from 2006. In the RUN equations, the findings show that females, large households, people with low income and financial constraints, the unemployed and those in poor health have a higher probability of declaring unmet needs due to economic costs. Additionally, people in tertiary education, those with high income and the employed have a higher probability of not visiting a doctor when needed due to time constraints. Furthermore, the frequency of contact with friends and the ability to ask for help are correlated with a lower probability of unmet needs due to economic costs, while the frequency of contact with relatives is correlated with a lower probability of unmet needs due to time constraints and distance. However, the ability to ask for help is also correlated with a higher probability of not having medical care due to time constraints and the wait-and-see approach.

Gaffney, A., White, A., Hawks, L., et al. (2020). "High-Deductible Health Plans and Healthcare Access, Use, and Financial Strain in Those with Chronic Obstructive Pulmonary Disease." Ann Am Thorac Soc **17**(1): 49-56.

Rationale: Medical treatment can improve quality of life and avert exacerbations for those with chronic obstructive pulmonary disease (COPD). High-deductible health plans (HDHPs) can increase exposure to medical costs, and might compromise healthcare access and financial well-being for patients with COPD.Objectives: To examine the association of HDHPs with healthcare access, utilization, and financial strain among individuals with COPD.Methods: We analyzed privately insured adults aged 40-64 years with COPD in the 2011-2017 National Health Interview Survey, which uses Internal Revenue Service-specified thresholds to classify health plans as "high" or "traditional" deductible coverage. We assessed the association between enrollment in an HDHP and indicators of cost-related impediments to care, financial strain, and healthcare utilization, adjusting for potential confounders.Results: Our sample included 803 individuals with an HDHP and 1,334 with a traditional plan. The two groups' demographic and health characteristics were similar. Individuals enrolled in an HDHP more frequently reported delayed or foregone care, cost-related medication nonadherence, medical bill problems, and financial strain. They also more frequently reported out-of-pocket healthcare spending in excess of $5,000 a year. Although the two groups' office visit rates were similar, those enrolled in an HDHP were more likely to report a hospitalization or emergency room visit in the past year.Conclusions: For patients with COPD, enrollment in an HDHP was associated with cost-related barriers to care, financial strain, and more frequent emergency room visits and hospitalizations.

Gross, T., Layton, T. et Prinz, D. (2020). The Liquidity Sensitivity of Healthcare Consumption: Evidence from Social Security Payment. NBER Working Paper Series ; 227977. Cambridge NBER**:** 87.
https://www.nber.org/papers/w27977

Some consumers lack the cash needed to pay for medical care. As a result, they either delay care until they can pay for it or they forgo the care altogether. To test for such a possibility, we study the distribution of monthly Social Security checks among Medicare Part D enrollees. When Social Security checks are distributed, prescription fills increase by 6-12 percent. In that sense, drug consumption of low-income Medicare recipients is "liquidity sensitive." We then study recipients who transition onto a program that eliminates copayments. When those recipients do not face copayments, their drug consumption becomes less liquidity sensitive. That finding implies that, beyond risk protection, generous insurance also provides recipients with the ability to consume healthcare when they need it rather than when they have cash. Further, we find that recipients whose drug consumption is most liquidity sensitive exhibit price elasticities of demand that are twice the size of the average elasticity, suggesting that more-generous insurance causes recipients both to re-time prescription filling and also to start filling prescriptions that they otherwise would not fill. We present a stylized model that uses this finding to call into question the conventional interpretation of demand-response to price as solely inefficient moral hazard.

Hawks, L., Himmelstein, D. U., Woolhandler, S., et al. (2020). "Trends in Unmet Need for Physician and Preventive Services in the United States, 1998-2017." JAMA Intern Med **180**(3): 439-448.

IMPORTANCE: Improvements in insurance coverage and access to care have resulted from the

Affordable Care Act (ACA). However, a focus on short-term pre- to post-ACA changes may distract attention from longer-term trends in unmet health needs, and the problems that persist. OBJECTIVE: To identify changes from 1998 to 2017 in unmet need for physician services among insured and uninsured adults aged 18 to 64 years in the United States. DESIGN, SETTING, AND PARTICIPANTS: Survey study using 20 years of data, from January 1, 1998, to December 31, 2017, from the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System to identify trends in unmet need for physician and preventive services. MAIN OUTCOMES AND MEASURES: The proportion of persons unable to see a physician when needed owing to cost (in the past year), having no routine checkup for those in whom a routine checkup was likely indicated (within 2 years), or failing to receive clinically indicated preventive services (in the recommended timeframe), overall and among subgroups defined by the presence of chronic illnesses and by self-reported health status. We estimated changes over time using logistic regression controlling for age, sex, race, Census region, employment status, and income. RESULTS: Among the adults aged 18 to 64 years in 1998 (n = 117 392) and in 2017 (n = 282 378) who responded to the Centers for Disease Control and Prevention Behavioral Risk Factors Surveillance System (mean age was 39.2 [95% CI, 39.0-39.3]; 50.3% were female; 65.9% were white), uninsurance decreased by 2.1 (95% CI, 1.6-2.5) percentage points (from 16.9% to 14.8%). However, the adjusted proportion unable to see a physician owing to cost increased by 2.7 (95% CI, 2.2-3.8) percentage points overall (from 11.4% to 15.7%, unadjusted); by 5.9 (95% CI, 4.1-7.8) percentage points among the uninsured (32.9% to 39.6%, unadjusted) and 3.6 (95% CI, 3.2-4.0) percentage points among the insured (from 7.1% to 11.5%, unadjusted). The adjusted proportion of persons with chronic medical conditions who were unable to see a physician because of cost also increased for most conditions. For example, an increase in the inability to see a physician because of cost for patients with cardiovascular disease was 5.9% (95% CI, 1.7%-10.1%), for patients with elevated cholesterol was 3.5% (95% CI, 2.5%-4.5%), and for patients with binge drinking was 3.1% (95% CI, 2.3%-3.3%). The adjusted proportion of chronically ill adults receiving checkups did not change. While the adjusted share of people receiving guideline-recommended cholesterol tests (16.8% [95% CI, 16.1%-17.4%]) and flu shots (13.2% [95% CI, 12.7%-13.8%]) increased, the proportion of women receiving mammograms decreased (-6.7% [95% CI, -7.8 to -5.5]). CONCLUSIONS AND RELEVANCE: Despite coverage gains since 1998, most measures of unmet need for physician services have shown no improvement, and financial access to physician services has decreased.

Hogan, A. K., Galligan, M. M., Stack, N. J., et al. (2020). "A Tertiary Care-based Complex Care Program: Improving Care for Children With Medical Complexity." Med Care **58**(11): 958-962.

OBJECTIVE: Children with medical complexity (CMC) have significant health care costs, but they also experience substantial unmet health care needs, hospitalizations, and medical errors. Their parents often report psychosocial stressors and poor care satisfaction. Complex care programs can improve the care for CMC. At our tertiary care institution, we developed a consultative complex care program to improve the quality and cost of care for CMC and to improve the experience of care for patients and families. METHODS: To address the needs of CMC at our institution, we developed the Compass Care Program, a consultative complex care program across inpatient and outpatient settings. Utilization data [hospital admissions per patient month; length of stay per admission; hospital days per patient month; emergency department (ED) visits per patient month; and institutional charges per patient month] and caregiver satisfaction data (obtained via paper survey at outpatient visits) were tracked over the period of participation in the program and compared preenrollment and postenrollment for program participants. RESULTS: Participants had significant decreases in hospital admissions per patient month, length of stay per admission, hospital days per patient month, and charges per patient month following enrollment (P<0.01) without a tandem increase in readmissions within 7 days of discharge. There was no statistically significant difference in ED visits. Caregiver satisfaction scores improved in all domains. CONCLUSION: Participation in a consultative complex care program can improve utilization patterns and cost of care for CMC, as well as experience of care for patients and families.

Iparraguirre, J. L. (2020). "Reductions in Local Government Spending on Community-Based Social Care and Unmet Social Care Needs of Older People in England." Journal of the Economics of Ageing **17**.

This paper investigates whether there is a statistical association between spending per person in community-based adult social care for older people and the probability that an older person has unmet needs. Two definitions of unmet needs are introduced: a) if an individual who had difficulty with one or more ADLs/IADLs did not receive any help at all or if they received help, it did not always meet their need to perform the activity or activities, and b) only considering people who received help. Using two-level and cross-classified panel logistic regressions on data from the English Longitudinal Study of Ageing between 2004/05 and 2012/13, the paper finds that a fall of 29 per cent in expenditure on community-based care for older people per head would lead to an increase of 6.1 per cent or 9.7 percent in the proportion of older people with unmet needs, depending on the definition of unmet needs: contractions in public spending make many older people experience the double plight of having social care needs and not being able to meet them in full. In view of demographic projections--of proportions of older people, of changes in household size and structure, and of geographical residence patterns within family members--unpaid long-term care will lag increasingly behind the needs of the older population; further budgetary reductions are likely to negatively affect particularly older people on low incomes.

Johnson, P. J., Jou, J. et Upchurch, D. M. (2020). "Psychological Distress and Access to Care Among Midlife Women." J Aging Health **32**(5-6): 317-327.

Objective: The objective of this study is to examine unmet health care needs among midlife women (ages 50-64 years) in the United States by level of psychological distress. Method: Using data for a nationally representative sample of midlife women (N = 8,838) from the 2015-2016 National Health Interview Survey, we estimated odds ratios of reasons for delayed care and types of care foregone by level of psychological distress-none, moderate (moderate psychological distress [MPD], and severe (severe psychological distress [SPD]). Findings: More than one in five midlife women had MPD (15.3%) or SPD (5.2%). Women with MPD or SPD had 2 to 5 times higher odds of delayed and 2 to 20 times higher odds of foregone care. Conclusions: Midlife women with psychological distress have poorer health than those with no distress, yet they are less likely to get needed health care. There is a missed window of opportunity to address mental health needs and manage comorbid chronic conditions to facilitate healthy aging.

Kim, J. A., Choi, Y. J., Heo, M. S., et al. (2020). "Team-based primary care program for disabled people and changes in rate of unmet health care needs." Fam Pract.

BACKGROUND: Few studies have been conducted on the application of specific and practical methods, such as interventions, for reducing the unmet health care needs (UHCN) of disabled people. OBJECTIVES: The study aims to evaluate the impact of the team-based primary care program (TPCP) for disabled people on UHCN. METHOD: In 2017, we surveyed 696 disabled people who were enrolled in the TPCP at one of the 11 institutions belonging to the Korea Health Welfare Social Cooperative Federation from 2015 to 2017 to assess their unmet needs before and after enrolment. We conducted a logistic regression analysis before and after the program to evaluate the relationship between participation period and unmet needs after adjusting for physician type, gender, age, drinking, monthly income, disability type, personal assistance services and living alone. RESULT: After using the service, the proportion of disabled people with unmet needs decreased from 42.9% to 20.4% for a medical doctor and 43.6% to 18.6% for a Korean medical (KM) doctor. After adjusting for related factors and stratifying with type of physician, the proportion of disabled people with unmet needs decreased significantly in response to the participation period for the medical doctor-involved program (P-trend < 0.001); this was not observed in the KM counterpart (P-trend = 0.6). CONCLUSION: The TPCP for disabled people provides disease prevention, health care and health promotion activities and is crucial for solving the unmet needs.

Kitching, G. T., Firestone, M., Schei, B., et al. (2020). "Unmet health needs and discrimination by healthcare providers among an Indigenous population in Toronto, Canada." Can J Public Health **111**(1): 40-49.

OBJECTIVES: Inequalities between Indigenous and non-Indigenous peoples in Canada persist. Despite the growth of Indigenous populations in urban settings, information on their health is scarce. The objective of this study is to assess the association between experience of discrimination by healthcare providers and having unmet health needs within the Indigenous population of Toronto. METHODS: The Our Health Counts Toronto (OHCT) database was generated using respondent-driven sampling (RDS) to recruit 917 self-identified Indigenous adults within Toronto for a comprehensive health assessment survey. This cross-sectional study draws on information from 836 OHCT participants with responses to all study variables. Odds ratios and 95% confidence intervals were estimated to examine the relationship between lifetime experience of discrimination by a healthcare provider and having an unmet health need in the 12 months prior to the study. Stratified analysis was conducted to understand how information on access to primary care and socio-demographic factors influenced this relationship. RESULTS: The RDS-adjusted prevalence of discrimination by a healthcare provider was 28.5% (95% CI 20.4-36.5) and of unmet health needs was 27.3% (95% CI 19.1-35.5). Discrimination by a healthcare provider was positively associated with unmet health needs (OR 3.1, 95% CI 1.3-7.3). CONCLUSION: This analysis provides new evidence linking discrimination in healthcare settings to disparities in healthcare access among urban Indigenous people, reinforcing existing recommendations regarding Indigenous cultural safety training for healthcare providers. Our study further demonstrates Our Health Counts methodologies, which employ robust community partnerships and RDS to address gaps in health information for urban Indigenous populations.

Lindly, O. J., Martin, A. J. et Lally, K. (2020). "A Profile of Care Coordination, Missed School Days, and Unmet Needs Among Oregon Children with Special Health Care Needs with Behavioral and Mental Health Conditions." Community Ment Health J **56**(8): 1571-1580.

To inform Oregon's Title V needs assessment activities, we aimed to (1) characterize the state's subpopulation of children with special health care needs (CSHCN) with behavioral and mental health conditions (B/MHC) and (2) determine associations of care coordination with missed school days and unmet needs for this subpopulation. We analyzed 2009-2010 National Survey of Children with Special Health Care Needs data on 736 Oregon CSHCN < 18 years, including 418 CSHCN with B/MHC. Among Oregon CSHCN with B/MHC: 48.9% missed ≥ 4 school days, 25% had ≥ 1 unmet health services need, and 14.8% had ≥ 1 unmet family support services need. Care coordination was associated with lower adjusted odds of ≥ 1 unmet health services need but was not significantly associated with missed school days or unmet family support services need. The approach to identify Oregon CSHCN with B/MHC may be adopted by other states endeavoring to improve health for this vulnerable subpopulation.

Lindström, C., Rosvall, M. et Lindström, M. (2020). "Unmet health-care needs and mortality: A prospective cohort study from southern Sweden." Scand J Public Health **48**(3): 267-274.

Aims: Research on the effect of unmet health-care needs on mortality at follow-up is scarce. This study investigated whether unmet health-care needs in 2008 were associated with a higher risk of mortality during a five-year follow-up period in a population in southern Sweden, and whether the association was stronger for particular subgroups of cause of death. Methods: The 2008 public-health survey in Skåne was used as baseline. The survey included variables such as unmet health-care needs, risk behaviours and social and socio-economic variables, and had 28,198 respondents aged 18-80 years. The study was longitudinal. Mortality data for the period 27 August 2008 (start of the survey) to 31 December 2013 were provided by the National Board on Health and Welfare. Analyses were run using Cox proportional hazard models. Mortality was analysed as the total and in subgroups: cardiovascular disease (CVD), cancer and other causes. Results: In the time period studied, 946 (3.4%) people had died. Unmet health-care needs increased the hazard ratios (HRs) of total mortality after adjusting for age, particularly for people aged 65-80 years (HR=1.53; confidence interval 1.24-1.88). Unmet health-care needs were associated with death due to cancer and other causes but not with CVD. Adjusting for self-rated health attenuated the HRs. For the age group 18-64 years, there was no significant association between unmet health-care needs and mortality. Conclusions: Having unmet health-care needs at baseline was significantly associated with increased mortality for all causes, except CVD, in the following five year-period, particularly for people aged 65-80 years.

Lo-Fo-Wong, D. N. N., de Haes, H., Aaronson, N. K., et al. (2020). "Risk factors of unmet needs among women with breast cancer in the post-treatment phase." Psychooncology **29**(3): 539-549.

OBJECTIVE: Unmet health care needs require additional care resources to achieve optimal patient well-being. In this nationwide study we examined associations between a number of risk factors and unmet needs after treatment among women with breast cancer, while taking into account their health care practices. We expected that more care use would be associated with lower levels of unmet needs. METHODS: A multicenter, prospective, observational design was employed. Women with primary breast cancer completed questionnaires 6 and 15 months post-diagnosis. Medical data were retrieved from medical records. Direct and indirect associations between sociodemographic and clinical risk factors, distress, care use, and unmet needs were investigated with structural equation modeling. RESULTS: Seven hundred forty-six participants completed both questionnaires (response rate 73.7%). The care services received were not negatively associated with the reported levels of unmet needs after treatment. Comorbidity was associated with higher physical and daily living needs. Higher age was associated with higher health system-related and informational needs. Having had chemotherapy and a mastectomy were associated with higher sexuality needs and breast cancer-specific issues, respectively. A higher level of distress was associated with higher levels of unmet need in all domains. CONCLUSIONS: Clinicians may use these results to timely identify which women are at risk of developing specific unmet needs after treatment. Evidence-based, cost-effective (online) interventions that target distress, the most influential risk factor, should be further implemented and disseminated among patients and clinicians.

López-Entrambasaguas, O. M., Martínez-Linares, J. M., Sola-García, M., et al. (2020). "Economic Problems and Loneliness as Factors Related to Subjective Unmet Health Needs in People with Chronic Diseases and Dependency." Int J Environ Res Public Health **17**(8).

Background: The continuous increase of people with chronic diseases is one of the greatest challenges for healthcare systems worldwide. Population growth and life expectancy means that an increasing number of people with chronic diseases and dependency need some kind of assistance to meet their needs. Determining these subjective unmet needs helps to understand the situation of these people. The aim of this study was to explore the perceptions of chronic patients over 65 years of age from the day-care center toward subjective health needs that are not being met by the socio-health system. Methods: Qualitative exploratory-descriptive study. Through convenience sampling, we selected people with chronic diseases and dependency who used day-care centers and met the inclusion criteria. Focus groups were performed. The data were transcribed and a thematic analysis was carried out using Atlas.ti software. Results: The topics resulting from the analysis were classified into dissatisfaction of biological/physiological needs, psychological needs, social needs, and other issues that arose in both groups of participants which referred to the types of needs previously indicated. The issues related to social and psycho-social needs stood out. Conclusions: People with chronic diseases and dependency have their physiological needs covered with the help they receive, but their situation of dependency generates additional costs that worsen their economic situation. However, their greatest need is due to the loneliness they feel and the feeling they have of "being a burden" on their families.

Lublóy, Á. (2020). "Medical crowdfunding in a healthcare system with universal coverage: an exploratory study." BMC Public Health **20**(1): 1672.

BACKGROUND: In recent years, crowdfunding for medical expenses has gained popularity, especially in countries without universal health coverage. Nevertheless, universal coverage does not imply covering all medical costs for everyone. In countries with universal coverage unmet health care needs typically emerge due to financial reasons: the inability to pay the patient co-payments, and additional and experimental therapies not financed by the health insurance fund. This study aims at mapping unmet health care needs manifested in medical crowdfunding campaigns in a country with universal health coverage. METHODS: In this exploratory study we assess unmet health care needs in Germany by investigating 380 medical crowdfunding campaigns launched on Leetchi.com . We combine manual data extraction with text mining tools to identify the most common conditions, diseases and disorders which prompted individuals to launch medical crowdfunding campaigns in Germany. We also assess the type and size of health-related expenses that individuals aim to finance from donations. RESULTS: We find that several conditions frequently listed in crowdfunding campaigns overlap with the most disabling conditions: cancer, mental disorders, musculoskeletal disorders, and neurological disorders. Nevertheless, there is no strong association between the disease burden and the condition which prompted individuals to ask for donations. Although oral health, lipoedema, and genetic disorders and rare diseases are not listed among leading causes of disability worldwide, these conditions frequently prompted individuals to turn to crowdfunding. Unmet needs are the highest for various therapies not financed by the health insurance fund; additional, complementary, and animal-assisted therapies are high on the wish list. Numerous people sought funds to cover the cost of scientifically poorly supported or unsupported therapies. In line with the social drift hypothesis, disability and bad health status being associated with poor socioeconomic status, affected individuals frequently collected donations for their living expenses. CONCLUSIONS: In universal healthcare systems, medical crowdfunding is a viable option to finance alternative, complementary, experimental and scientifically poorly supported therapies not financed by the health insurance fund. Further analysis of the most common diseases and disorders listed in crowdfunding campaigns might provide guidance for national health insurance funds in extending their list of funded medical interventions. The fact of numerous individuals launching crowdfunding campaigns with the same diseases and disorders signals high unmet needs for available but not yet financed treatment. One prominent example of such treatment is liposuction for patients suffering from lipoedema; these treatments were frequently listed in crowdfunding campaigns and might soon be available for patients at the expense of statutory health insurance in Germany.

Maltais, J., Morin, D. et Tassé, M. J. (2020). "Healthcare services utilization among people with intellectual disability and comparison with the general population." J Appl Res Intellect Disabil **33**(3): 552-564.

BACKGROUND: Studies have reported unmet health needs in individuals with intellectual disability (ID). This study illustrated and analysed patterns of healthcare services utilization among people with intellectual disability and compared their use to that of the general population. METHOD: Participants (N = 791, aged 15-82) were mainly recruited through government-financed agencies specializing in services for people with intellectual disabilities in Québec, Canada. Comparisons were possible by using health administrative data. RESULTS: Some services were more used by people with intellectual disability than the general population (general medicine, psychiatry, PSA blood tests), and others were accessed at significantly lower frequencies (optometry, physiotherapy, Pap tests). Similar rates were found for mammography, dentistry and psychology. Inequities were more salient for individuals who had more severe levels of intellectual disability. CONCLUSIONS: Our findings support that the population with intellectual disability would benefit from policies and practices aimed at enhancing the access to healthcare services.

Martínez-Linares, J. M., Andújar-Afán, F. A., Martínez-Yébenes, R., et al. (2020). "A Qualitative View of Homecare Support Workers on Unmet Health Needs of People with Dependency." Int J Environ Res Public Health **17**(9).

BACKGROUND: Longevity and population growth generate an increase in the number of people with dependency, who require homecare assistance to meet their health needs. Homecare support workers provide this care in Spain, and they may have unique insights into the unmet health needs of those receiving homecare assistance. The aim of this study was to determine the unmet health needs of people with dependency based on the perspective of homecare support workers. METHODS: Qualitative exploratory-descriptive study. Through convenience sampling, homecare support workers from a Spanish province were selected, following inclusion and exclusion criteria. Four focus groups, transcription and thematic analyses were performed using Atlas.ti. Coding triangulation was carried out, applying criteria for scientific rigour. RESULTS: The six themes obtained were classified into the material, psychoemotional, socioeconomical and psychosocial needs of people with dependency from the point of view of homecare support workers, along with the contributions of improvements and the need of these professionals for continuous training. CONCLUSIONS: People with dependency need complex technical assistance, materials, psychological attention due to their situation, and more effective assessments of their health and disability status. Homecare support workers perceive themselves to be essential in these assessments. They ask for psychological assistance, due to the emotional burden of their work, and believe this help would contribute to improving the quality of their service. Homecare support workers perceive that they are capable of performing their job, although they believe that some delegated activities are beyond their levels of competency.

McLeod, K. E. et Karim, M. E. (2020). "The relationship between mood disorder diagnosis and experiencing an unmet health-care need in Canada: findings from the 2014 Canadian Community Health Survey." J Ment Health: 1-13.

BACKGROUND: Despite Canada's universal health-care system, millions of Canadians experience unmet health-care needs (UHCN). People with mood disorders may be at higher risk of UHCN due to barriers such as stigma and gaps in health-care services. AIM: We aimed to examine the relationship between having a diagnosed mood disorder and experiencing UHCN using a recent, nationally representative survey. METHODS: Using the 2014 Canadian Community Health Survey, we used multivariate logistic regression to estimate the association between mood disorder and UHCN in the past 12 months, adjusting for sociodemographic variables and health status. RESULTS: Among 52,825 respondents, 11.8% reported UHCN. Respondents with a diagnosed mood disorder were more likely to report UHCN [adjusted odds ratio (OR) 1.61, 95% confidence interval (CI) 1.38, 1.89]. Among respondents with a regular doctor, people with mood disorders were still more likely to report UHCN (OR 1.63, 95% CI 1.38, 1.93). Sensitivity analyses using propensity score and missing data imputation approaches resulted in similar estimates. CONCLUSIONS: Adults diagnosed with a mood disorder are more likely to report UHCN in the past year, even those with a regular doctor. Our findings suggest that barriers beyond physician attachment may impact access to care for people with mood disorders.

Mitrasevic, M., Radovanovic, S., Radevic, S., et al. (2020). "The Unmet Healthcare Needs: Evidence from Serbia." Iran J Public Health **49**(9): 1650-1658.

BACKGROUND: We aimed to determine the socio-economic factors associated with unmet healthcare needs of the population aged 20 and over in Serbia. METHODS: We used data from the 2013 National Health Survey (NHS) of the population of Serbia. We focused only on the data concerning the population aged 20 and over. The final sample thus included 13,765 participants. The logistic regression was used to examine the socio-economic factors associated with unmet health care needs. RESULTS: According to the data obtained in this study, 26.2% of the population aged 20 and over reported unmet health care needs during the previous 12 months. The multivariate analysis shows that significant indicators of unmet healthcare needs include: gender, age, marital status, level of education, financial and employment status. CONCLUSION: Females, the elderly and those with the lowest levels of education and household income, as well as those who are divorced and unemployed are at highest risk of unmet healthcare needs. Different policies and approaches should be taken into consideration when it comes to vulnerable population groups in order to reduce the currently existing gaps to a minimum and provide more equal opportunities for health care to all citizens.

Pétrin, J., Donnelly, C., McColl, M. A., et al. (2020). "Is it worth it?: The experiences of persons with multiple sclerosis as they access health care to manage their condition." Health Expect **23**(5): 1269-1279.

BACKGROUND: People with multiple sclerosis (MS) require complex care throughout life. Canadians with MS are high users of health-care services, yet still report unmet health-care needs and low satisfaction with services received. OBJECTIVE: This study aimed to investigate the health-care access experiences of Ontarians with MS as they manage their condition. DESIGN AND PARTICIPANTS: Interpretive description guided data collection and analysis. Forty-eight people living across seven communities participated. Thirty-eight participated in one of five focus groups; the remaining 10 participated in an individual semi-structured interview. RESULTS: Participants described the experience of accessing care as a decisional process, guided by a form of cost-benefit analysis. The process determined whether seeking conventional health-care services 'is worth it'. Most participants felt that the energy and resources required to access the health-care system outweighed their expected outcomes, based on past experiences. Participants who did not see the benefit of care seeking turned to self-treatment, use of complementary and alternative services, and engaged in patterns of health-care avoidance until a crisis arose. DISCUSSION AND CONCLUSION: Findings suggest that a renewed effort to promote patient-centred care and a biopsychosocial approach may improve the health-care access experiences of persons with MS and reduce service avoidance.

Pianori, D., Maietti, E., Lenzi, J., et al. (2020). "Sociodemographic and health service organizational factors associated with the choice of the private versus public sector for specialty visits: Evidence from a national survey in Italy." PLoS One **15**(5): e0232827.

INTRODUCTION: Although Italy's NHS is funded through general taxation, the private sector plays an important role in health service provision and financing. The aim of this paper was to identify the sociodemographic and health service organizational factors associated with the propensity to seek specialist care in the private sector. MATERIALS AND METHODS: Data were retrieved from the national Istat survey "Health conditions and use of health services" carried out in 2012-2013. We selected adults with a specialty visit in the previous 12 months in the four most frequent medical specialties: ophthalmology, cardiology, obstetrics/gynecology and orthopedics. The study outcome was the choice to use a private service. In order to investigate the determinants of private use, we adopted the socio-behavioral model by Andersen and Newman, making a distinction between sociodemographic and healthcare organizational factors. The associations with the outcome were analyzed using chi-squared test, t-test and multivariable logistic regression analysis. RESULTS AND DISCUSSION: Use of private care varied widely, from 26.3% for cardiology to 53.6% for obstetrics/gynecology. Females, patients with higher educational levels and patients with higher self-reported economic resources sought more frequently private healthcare for all specialties; younger patients and employed patients were more likely to seek private care for ophthalmic conditions. Exemption from copayment for public services reduced more than half the propensity to seek private care. Trust in this healthcare service was the main reason for private users (52.5%) followed by waiting time (26.7%) and physician choice (20.1%). CONCLUSION: The attitude of the population to use private services for specialist visits is linked both to sociodemographic and health services organizational factors: the former are unmodifiable while the latter are susceptible to managerial and health policy actions. In a public-financed, universal coverage system, policy makers may act upon the organizational factors that make private health facilities more attractive in order to reduce private care use.

Ponzio, M., Tacchino, A., Vaccaro, C., et al. (2020). "Unmet needs influence health-related quality of life in people with multiple sclerosis." Mult Scler Relat Disord **38**: 101877.

BACKGROUND: People with MS are a heterogeneous population with varying difficulties and needs that are influenced by the individual experience of the disease, symptoms and disease course. The aim of the present study was to identify factors that influence health-related quality of life in a sample of subjects with MS, specifically health and social care-related needs and demographic and disease characteristics. METHODS: Individuals with a definite diagnosis of MS were identified through MS out-patient clinics and local branches of the Italian MS Society. The EQ-5D-3L utility index was used to describe health profiles and as an overall measure of perceived HRQoL. The number of unmet health and social care-related needs was used to describe the impact of unmet needs on HRQoL. Multiple regression analyses were performed using a hierarchical approach. RESULTS: Data was analyzed from 1013 subjects. Overall, 83% of subjects reported at least one health or social care-related need as being unmet and subjects with a higher number of unmet needs had lower HRQoL ($p < 0.001$). The number of unmet needs was entered at the first step with a statistically significant effect (Cox-Snell R(2) 0.15, BIC 870.9, AIC 851.2). Clinical variables, included in the second step, contributed significantly to explaining the variability between models (Cox-Snell R(2) 0.43, BIC 481.0, AIC 446.6), and the addition of socio-demographic factors further accounted for variability (Cox-Snell R(2), 0.46, BIC 461.0, AIC 402.0). CONCLUSIONS: The study demonstrated that a higher number of both health and social care-related unmet needs predicted lower HRQoL. The health profile of the sample identified all domains of the EQ-5D-3L as being important in determining HRQoL. Data confirms that unmet needs alone are significantly related to reduced HRQoL, although the multifactorial and complex nature of MS makes it a challenge to identify the combination of aspects that fully predict variability in quality of life.

Sackey, D., Jones, M. et Farley, R. (2020). "Reconceptualising specialisation: integrating refugee health in primary care." Aust J Prim Health **26**(6): 452-457.

People from a refugee background have significant unmet health needs including complex physical and psycho-social presentations. They can experience low trust, unfamiliarity with the health system and reliance on family and friends to access care. To address these needs, Australia has specialised refugee health services in each state and territory. The majority of these services transition patients to primary care, but this transition, although necessary, is difficult. Most primary care and specialised health professionals share a high degree of commitment to refugee patients; however, despite best efforts, there are gaps. More integrated health services can start to address gaps and promote continuity of care. A previous study has described 10 principles that are associated with successful integration; this paper references five of those principles (continuum of care, patient focus, geographic coverage, information systems and governance) to describe and map out the outcomes of an integrated model of care designed to deliver specialist refugee health in primary care. The Co-location Model is a partnership between a refugee health service, Primary Health Networks, a settlement agency and general practices. It has the potential to deliver benefits for patients, greater satisfaction for health professionals and gains for the health system.

Sinaiko, A., Gaye, M., Wu, A., et al. (2020). "Variation in out-of-Pocket Spending Among Low-Income Versus High-Income Commercially Insured Patients with Asthma." Health Services Research **55**(S1): 10-11.
https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13335

Research Objective Patient cost-sharing has been increasing over the past two decades, in particular due to high-deductible health plans (HDHP). Asthma is a very common, serious, chronic disease in the United States. We analyzed a large, national sample of asthma patients to provide new evidence on OOP spending overall, across types of asthma care, and variation by patient income. Study Design We used 11 years (2004-2014) of enrollment, claims, and geocoded census tract data on income. Annual OOP costs were measured as the sum of actual patient-paid deductible, coinsurance and copayments on all medical care; spending was adjusted to 2014 dollars using the Medical CPI. Annual asthma OOP spending included OOP payments for asthma services (ie, asthma medications, office and emergency department (ED) visits, and hospitalizations with ICD-9 codes for asthma, spacers for inhalers, asthma nebulizers). Patient income was measured using the census tract income associated with the patient's address, and then, patients were categorized into income quintiles based on the distribution of household income across the United States (eg, not within sample). We report the association of OOP spending with patient income based on linear regression models controlling for patient age, sex, state, morbidity and asthma severity (using the Johns Hopkins ACG system), and year; models were stratified by annual HDHP enrollment. Population Studied All patients ages 4-64 years with asthma (defined as having an asthma ICD-9 diagnosis code for an outpatient or ED visit or hospitalization) in a large, national Commercial and Medicare Advantage claims database (n = 2 018 178). Principal Findings More patients in the lowest-income quintile had a HDHP. Within plan type, levels of spending associated with income quintiles were similar but represented a significantly larger proportion of income for the lowest-income quintile (Table). Conclusions Because patients spent similar amounts of OOP for asthma care, the lowest-income quintile patients experienced greater cost burden. The majority of OOP asthma spending was on asthma medications, but lowest-income quintile patients had greater spending on high acuity care than those in higher income quintiles. Implications for Policy or Practice Efforts should be made to understand whether these differences in cost burden are associated with cost-related underuse of medications or other adverse outcomes to inform policy and insurance benefit design. Primary Funding Source Patient-Centered Outcomes Research Institute.

Smith, S. et Connolly, S. (2020). "Re-thinking Unmet Need for Health Care: Introducing a Dynamic Perspective." Health Economics, Policy and Law **15**(4): 440-457.

There is an increasing interest in assessing unmet need for health care services particularly in European countries. Despite this there has been relatively little analysis of unmet need in the European or wider international setting. It remains a challenge to pin down what types of unmet need can and should be addressed by health care policymakers, and how to go about identifying and quantifying those unmet needs. The objective of this paper is to propose a new way of thinking about unmet need for health care which can in turn guide analysis of unmet need in terms of potential data sources and analytic approaches. Unmet need is shown to be a complex multi-faceted concept that cannot be captured by a single indicator or measurement. To advance the literature in this field, this paper considers what happens to unmet need over time. By introducing a dynamic perspective, three alternative trajectories for health care needs are outlined: non-use of health care, delayed use of health care and sub-optimal use of health care. These trajectories are discussed with a view to improving the focus, and policy applicability, of empirical research in this field.

Sojar, S., Gjelsvik, A., Tsao, H. S., et al. (2020). "Do Unmet Health Needs Drive Pediatric Emergency Department Utilization?: A Population-Based Assessment." Pediatr Emerg Care.

OBJECTIVE: Lack of access to basic health services is thought to increase emergency department (ED) utilization. This study assessed the relationship between unmet health care needs and pediatric ED utilization in the United States. METHODS: The National Survey of Children's Health was used (2016-2017; n = 71,360). Parent/guardians reported number of ED visits and the presence of unmet health needs (medical, dental, mental health, vision, hearing, other) in the last 12 months. Associations were analyzed using multinomial logistic regression modeling and accounted for the weighting and complex survey design of the National Survey of Children's Health. RESULTS: Children with 2 or more unmet health needs had 3.72 times (95% confidence interval, 2.25-6.16) risk of ≥2 ED visits when compared with those with 0 unmet health needs. This risk became nonsignificant when adjusted for race, ethnicity, age, insurance, having asthma, current medication status, health description, number of preventative health visits, and place to go for preventative health (aRR, 1.77; 95% confidence interval, 0.96-3.27). The adjusted association was also nonsignificant for specific types of unmet needs. Race, insurance status, age 0 to 3 years, current medication status, having asthma, ≥2 preventative visits, and poorer health were associated with ≥2 ED visits. CONCLUSIONS: Unmet health needs were not found to be a significant driving force for ED utilization. Other factors were found to be more strongly associated with it. Future studies to understand the perception, motives, and complex interaction of various factors leading to ED use in high-risk populations may optimize care for these children.

Stein, J., Löbner, M., Pabst, A., et al. (2020). "Unmet care needs in the oldest old with social loss experiences: results of a representative survey." BMC Geriatr **20**(1): 416.

BACKGROUND: Loss experiences such as the loss of a spouse, a close relative or significant others become more likely in old age and may be strongly related to specific unmet health care needs. These unmet needs may often remain undetected and undertreated followed by a negative impact on well-being and social role functioning. The present study aims at exploring the relationship between loss experiences and specific unmet care needs in old age. METHODS: As part of the study "Need assessment in the oldest old: application, psychometric examination and establishment of the German version of the Camberwell Assessment of Need for the Elderly (CANE)", the adapted German version of the CANE was used in a population-representative telephone survey in a sample of 988 individuals aged 75+ years. Loss experiences within the last 12 months were assessed within the structured telephone survey. Descriptive and interferential statistical analyses were run in order to examine the association between loss experiences and occurring unmet care needs. RESULTS: Overall, 29.7% of the oldest old reported at least one social loss with other relatives losses being the most frequent (12.5%), followed by non-family losses (10.7%). A significant relationship between loss experiences and a higher number of unmet care needs was observed, especially for close family losses. Other risk factors for unmet care needs were age, marital status, depression, social support and morbidity.

CONCLUSIONS: This study provides, for the first time in Germany, data on the association between loss experiences and unmet needs. These findings may substantially contribute to the development of loss-specific interventions, effective treatment and health care planning for the bereaved elderly.

Stojisavljevic, S., Grabez, M. et Stojanovski, K. (2020). "Unmet Health Needs of Roma Women in the Two Biggest Roma Communities in the Republic of Srpska, Bosnia and Herzegovina." Front Public Health **8**: 30.

Background: Reasons for unmet health needs vary from individual to contextual determinants but are defined as the difference between needed health service and services actually received. Roma experience elevated health issues and challenging social conditions. Objective: The aim of this study was to explore the unmet health needs and potential risk factors among Roma women living in the two biggest Roma communities in the Republic of Srpska. Method: We conducted a health assessment of 183 adult Roma women in the Republic of Srpska. Unmet health needs were observed as the absence of needed medical supervision, despite having chronic conditions. We used logistic regression to assess the degree to which unmet health needs were related to the social determinants and the health status of Roma women. Results: The majority of Roma women were married or were in an unofficial relationship (55.2%), were without schooling (62.8%), and were unemployed (88.5%). The results showed that 94.0% had health insurance, had a health card, and were registered with a family medicine doctor. Sixty percent reported having a chronic disease; however, 68.2% reported that their chronic disease was not medically supervised. Roma women that had less education, those who were unemployed, and those who were divorced or widowed women were more likely to have unmet health needs. Conclusion: Roma women in Bijeljina and Prijedor have unmet health needs due to the circumstances they live in despite the fact that majority of them have health insurance and universal health access is legally guaranteed.

Sundler, A. J., Darcy, L., Råberus, A., et al. (2020). "Unmet health-care needs and human rights-A qualitative analysis of patients' complaints in light of the right to health and health care." Health Expect **23**(3): 614-621.

BACKGROUND: This study focuses on patient complaints from a human rights perspective. Despite the UN Convention on Human Rights being widely recognized, it has not previously been examined in relation to patients' complaints on health care. A human rights perspective and the right to the highest attainable standard of health are a major sustainability challenge in health care today. Previous research points to patients' complaints as a growing concern for health-care organizations, and the handling of this concern can lead to improvement in health-care services. OBJECTIVE: The aim was to analyse patients' complaints on health-care services and to examine expressed needs for health care from a human rights perspective. METHODS: In this descriptive study, a random sample of 170 patient complaints about Swedish health-care services were qualitatively analysed from a human rights perspective. RESULTS: The complaints are described in three themes: the right to available and accessible health-care services, the right to good quality health-care services and the right to dignity and equality in health care. Questions of availability, accessibility, acceptability and quality are highlighted by patients and/or relatives making complaints on health-care services. DISCUSSION AND CONCLUSION: This study emphasizes the human right to health in relation to patient complaints. Findings indicate that this right has been breached in relation to availability, accessibility, acceptability and quality in health-care services. Further debate, education and investigations are necessary to ensure that patients' rights to health and health care not be taken for granted.

Tavares, A. I. et Ferreira, P. L. (2020). "Public satisfaction with health system coverage, empirical evidence from SHARE data." Int J Health Econ Manag **20**(3): 229-249.
https://doi.org/10.1007/s10754-020-09279-x

People's satisfaction with the health system, including the coverage provided, has been a concern for some years now but research into the main explanatory factors is in progress. This work focuses on European countries plus Israel, using the SHARE database to find what determines people's satisfaction with the basic coverage provided by the health system of each country. On top of the usual individual socioeconomic characteristics, other explanatory factors were also considered. These include, at individual level, trust in others, political positioning, and risk aversion; at country level, they include access to specialist care and the type of health system financing. Estimation of an ordered logistic model found that the main predictors for satisfaction with a health system's basic coverage include trust in others, unmet health needs, self-assessed health, free access to specialists, health system financed through social insurance, and out-of-pocket payments. These results provide the basis for possible policies designed to improve people's satisfaction.

Vyas, M. V., Fang, J. et Kapral, M. K. (2020). "Temporal Trends in the Unmet Health Care Needs of Canadian Stroke Survivors." Can J Neurol Sci **47**(2): 176-182.

BACKGROUND: Stroke survivors have higher unmet health care needs than the general population. However, it is unclear whether such needs have changed over time, and whether these have been affected by the introduction of integrated systems of stroke care. METHODS: We used data from the Canadian Community Health Surveys between 2000 and 2014. We developed multivariable log-binomial generalized estimating equations to obtain adjusted risk ratios (aRRs) of unmet health care needs in stroke survivors compared to the general population, and over time. We conducted a difference in differences analysis to determine the association between the implementation of integrated systems of stroke care and unmet health care needs. RESULTS: Data from 350,084 respondents were included in the study; 8072 (2.3%) were stroke survivors. Compared to the general population, stroke survivors were more likely to report unmet health care needs (aRR 1.27; 95% CI, 1.22-1.32). The unmet health care needs reported by stroke survivors were lower after compared to before 2006 (15.8% vs. 31.9%, P < 0.001). After accounting for temporal trends, there was no association between the implementation of integrated systems of stroke care and change in unmet health care needs of stroke survivors. However, this requires cautious interpretation due to limitations in the data available for this study. CONCLUSIONS: Unmet health care needs of stroke survivors have reduced over time but remain higher than the general population. Future research should focus on identifying stroke- and policy-related factors to mitigate disparities in health care access for stroke survivors.

White, J., Morris, H., Cortright, L., et al. (2020). "Concordance of Data on Children's Unmet Health Care Needs Between 2 National Surveys." J Public Health Manag Pract.

OBJECTIVE: We used public data from 2 national surveys to determine how survey mode and questionnaire wording potentially impact estimated prevalence and predictors of children's unmet health care needs. METHODS: Data from 2016-2017 were obtained for the National Health Interview Survey (NHIS), where interviewers ask caregivers about each type of unmet health care need in person, and the National Survey of Children's Health (NSCH), a self-administered questionnaire asking a general question about any unmet health care needs, with subparts about specific types of unmet needs. Weighted proportions and multivariable logistic regression were used to analyze each data set. RESULTS: The weighted proportion of any unmet health care needs was significantly higher in the NHIS (7.5%; 95% confidence interval [CI], 7.0-8.1; N = 17 723) than in the NSCH (3.3%; 95% CI, 2.9-3.7; N = 65 766). When analyzing specific unmet needs, unmet need for dental care was significantly higher according to the NHIS (4.2% vs 1.9% in the NSCH), as was unmet need for vision care (1.7% vs 0.8%). Conversely, estimates of unmet need for medical care were comparable between the surveys (1.4% and 1.0%). On multivariable analysis, predictors of unmet health care needs, such as being uninsured, had effect sizes of similar magnitude in both surveys. CONCLUSION: The NHIS design, asking about each type of unmet need in person, may have been more conducive to identifying the full range of unmet health care needs among children. However, our results did not indicate that this was a source of bias in multivariable regression analysis.

Yegros-Yegros, A., van de Klippe, W., Abad-Garcia, M. F., et al. (2020). "Exploring why global health needs are unmet by research efforts: the potential influences of geography, industry and publication incentives." Health Res Policy Syst **18**(1): 47.

BACKGROUND: It has been well established that research is not addressing health needs in a balanced way - much more research is conducted on diseases with more burden in high-income countries than on those with more burden in lower-income countries. In this study, we explore whether these imbalances persist and inquire about the possible influence of three factors, namely geography, industry and publication incentives. METHODS: We use WHO data on the Global Burden of Disease as a proxy measure of health needs and bibliometric information as a proxy for research efforts. Scientific publications on diseases were collected from MEDLINE using MeSH terms to identify relevant publications. We used Web of Science to collect author affiliations and citation data. We developed a correspondence table between WHO ICD-10 and MeSH descriptors to compare global health needs and research efforts. This correspondence table is available as supplementary material. RESULTS: Research output is heavily concentrated in high-income countries and is mainly focused on their health needs, resulting in a relative lack of attention to diseases in lower income countries. A new finding is that diseases with a similar burden in high- and middle-income countries are also under-researched, both globally and in relation to disease burden in high- and middle-income countries. Global industrial R&D is found to be very similar to the focus of public research. Diseases more prevalent in high-income countries generate ten-fold more research attention than those in low-income countries. We find no discernible preference towards diseases of high-income countries versus those of low-income countries in the top 25% most prestigious journals. However, in middle-income countries, citation rates are substantially lower for diseases most prevalent in low- and middle-income countries. CONCLUSIONS: From a global perspective, the imbalance between research needs and research efforts persists as most of the research effort concentrates on diseases affecting high-income countries. Both pharmaceutical companies and the public sector also tend to focus on diseases with more burden in high-income countries. Our findings indicate that researchers in middle-income countries receive more citations when researching diseases more prevalent in high-income countries, and this may divert the attention of researchers in these countries from diseases more prevalent in their contexts.

2019

Bataineh, H., Devlin, R. A. et Barham, V. (2019). "Unmet health care and health care utilization." Health Economics **28**(4): 529-542.
https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3862

Abstract The objective of this study is to examine the causal effect of health care utilization on unmet health care needs. An IV approach deals with the endogeneity between the use of health care services and unmet health care, using the presence of drug insurance and the number of physicians by health region as instruments. We employ three cycles of the Canadian Community Health Survey confidential master files (2003, 2005, and 2014). We find a robustly negative relationship between health care use and unmet health care needs. One more visit to a medical doctor on average decreases the probability of reporting unmet health care needs by 0.014 points. The effect is negative for the women-only group whereas it is statistically insignificant for men; similarly, the effect is negative for urban dwellers but insignificant for rural ones. Health care use reduces the likelihood of reporting unmet health care. Policies that encourage the use of health care services, like increasing the coverage of public drug insurance and increasing after hours accessibility of physicians, can help reduce the likelihood of unmet health care.

Davin, B., Joutard, X., Paraponaris, A., et al. (2019). "If You Were Me": Proxy Respondents' Biases in Population Health Surveys. Working paper AMSE ; 2019-05. 2019. halshs-02036434**:** 20.
https://halshs.archives-ouvertes.fr/halshs-02036434

Proxy respondents are widely used in population health surveys to maximize response rates. When surveys target frail elderly, the measurement error is expected to be smaller than selection or participation biases. However, in the literature on elderly needs for care, proxy use is most often considered with a dummy variable in which endogeneity with subjects' health status is rarely scrutinised in a robust way. Pitfalls of this choice extend beyond methodological issues. Indeed, the mismeasurement of needs for care with daily activities might lead to irrelevant social policies or to private initiatives that try to address those needs. This paper proposes a comprehensive and tractable strategy supported by various robustness checks to cope with the suspected endogeneity of proxy use to the unobserved health status of subjects in reports of needs for care with activities of daily living. Proxy respondents' subjectivity is found to inflate the needs of the elderly who are replaced or assisted in answering the questionnaire and to deflate the probability of unmet or undermet needs.

Dedania, R. et Gonzales, G. (2019). "Disparities in Access to Health Care Among US-Born and Foreign-Born US Adults by Mental Health Status, 2013–2016." American Journal of Public Health **109**(S3): S221-S227.
https://doi.org/10.2105/AJPH.2019.305149

Objectives. To compare access to care between US-born and foreign-born US adults by mental health status. Methods. We analyzed data on nonelderly adults (n?=?100?428) from the 2013?2016 National Health Interview Survey. We used prevalence estimates and multivariable logistic regression models to compare issues of affordability and accessibility between US-born and foreign-born individuals. Results. Approximately 22.2% of US-born adults and 18.1% of foreign-born adults had symptoms of moderate to severe psychological distress. Compared with US-born adults with no psychological distress, and after adjustment for sociodemographic characteristics, US-born and foreign-born adults with psychological distress were much more likely to report multiple emergency room visits and unmet medical care, mental health care, and prescription medications because of cost. Conclusions. Our study found that adults with moderate to severe psychological distress, regardless of their immigration status, were at greater risk for reporting issues of affordability when accessing health care compared with US-born adults with no psychological distress. Public Health Implications. Health care and mental health reforms should focus on reducing health care costs and establishing innovative efforts to broaden access to care to diverse populations.

Gibson, G., Grignon, M., Hurley, J., et al. (2019). "Here comes the SUN: Self-assessed unmet need, worsening health outcomes, and health care inequity." Health Econ. Ahed of print.

Utilization-based approaches have predominated the measurement of socioeconomic-related inequity in health care. This approach, however, can be misleading when preferences over health and health care are correlated with socioeconomic status, especially when the underlying focus is on equity of access. We examine the potential usefulness of an alternative approach to assessing inequity of access using a direct measure of possible barriers to access-self-reported unmet need (SUN)-which is documented to vary with socioeconomic status and is commonly asked in health surveys. Specifically, as part of an assessment of its external validity, we use Canadian longitudinal health data to test whether self-reported unmet need in one period is associated with a subsequent deterioration in health status in a future period, and find that it is. This suggests that SUN does reflect in part reduced access to needed health care, and therefore may have a role in assessing health system equity as a complement to utilization-based approaches.

Kohlenberger, J., Buber-Ennser, I., Rengs, B., et al. (2019). "Barriers to health care access and service utilization of refugees in Austria: Evidence from a cross-sectional survey." Health Policy(Ahead of print).
http://www.sciencedirect.com/science/article/pii/S0168851018305335

This paper provides evidence on (1) refugees' subjective well-being, (2) their access and barriers to health care utilization and (3) their perception of health care provision in Austria, one of the countries most heavily affected by the European 'refugee crisis.' It is based on primary data from the Refugee Health and Integration Survey (ReHIS), a cross-sectional survey of roughly five hundred Syrian, Iraqi and Afghan refugees. Results indicate that refugees' self-rated health falls below the resident population's, in particular for female and Afghan refugees. Whereas respondents state overall high satisfaction with the Austrian health system, two in ten male and four in ten female refugees report unmet health needs. Most frequently cited barriers include scheduling conflicts, long waiting lists, lack of knowledge about doctors, and language. Although treatment costs were not frequently considered as barriers, consultation of specialist medical services frequently associated with co-payment by patients, in particular dental care, are significantly less often consulted by refugees than by Austrians. Refugees reported comparably high utilization of hospital services, with daycare treatment more common than inpatient stays. We recommend to improve refugees' access to health care in Austria by a) improving the information flow about available treatment, in particular specialists, b) fostering dental health care for refugees, and c) addressing language barriers by providing (web-based) interpretation services.

OCDE (2019). Health at a Glance 2019 : OECD indicators. Paris OCDE**:** 243 , ann., graph., tabl.
https://www.oecd-ilibrary.org/fr/social-issues-migration-health/health-at-a-glance-2019_4dd50c09-en

Health at a Glance compares key indicators for population health and health system performance across OECD members, candidate and partner countries. It highlights how countries differ in terms of the health status and health-seeking behaviour of their citizens; access to and quality of health care; and the resources available for health. Analysis is based on the latest comparable data across 80 indicators, with data coming from official national statistics, unless otherwise stated. Alongside indicator-by-indicator analysis, an overview chapter summarises the comparative performance of countries and major trends, including how much health spending is associated with staffing, access, quality and health outcomes. This edition also includes a special focus on patient-reported outcomes and experiences, with a thematic chapter on measuring what matters for people-centred health systems.

Quintal, C., Lourenço, Ó., Ramos, L. M., et al. (2019). "No unmet needs without needs! Assessing the role of social capital using data from European social survey 2014." Health Policy.

This paper examines the determinants of unmet healthcare needs in Europe. Special emphasis is put on the impact of social capital. Data come from the European Social Survey, 2014. Our study includes 32,868 respondents in 20 countries. Because unmet needs are observed only in those individuals who are exposed to, and recognise, the need of medical care, sample selection can be an issue. To address it, we analyse the data using the bivariate sample selection model. When there is no need, there is no assessment of access to healthcare. Accordingly, in this situation, our model assumes that unmet need is unobserved. The magnitude and statistical significance of the error correlation support our modelling strategy. A high proportion (18.4%) of individuals in need in Europe reported unmet needs. Informal connections seem to mitigate barriers to access as well as trust in other people and institutions, particularly in health services. Financial strain still is a strong predictor of unmet needs. Other vulnerable groups include informal carers, minorities and individuals feeling discriminated. Unmet needs might also arise due to persistent needs of healthcare as it seems to be the case of individuals with lower health status and chronic conditions. A result that merits further research concerns the positive impact of civic engagement on unmet needs.

Ramos, L. M., Quintal, C., Lourenço, Ó., et al. (2019). "Unmet needs across Europe: Disclosing knowledge beyond the ordinary measure." Health Policy **123**(12): 1155-1162.
https://doi.org/10.1016/j.healthpol.2019.09.013

Unmet healthcare needs (or foregone healthcare) is a widely used intermediate indicator to evaluate healthcare systems attainment since it relates to health outcomes, financial risk protection, improved efficiency and responsiveness to the individuals' legitimate expectations. This paper discusses the ordinary measure of this indicator used so far, prevalence of unmet needs in the whole population, based on the level of healthcare needs among the population. The prevalence of needs and the prevalence of unmet needs among those in need are key aspects that have not yet been fully explored when it comes to foregone healthcare. We break down the ordinary measure into prevalence of needs and prevalence of unmet needs among those in need based on data taken from the European Social Survey 2014. Afterwards, we analyse these different measures in a cross-country perspective. We also discuss the link between them and the implicit relative assessment of healthcare systems considering the whole population and the sub-group of the population aged 65 or more. Comparisons across countries show different attainment levels unveiling varying challenges across European countries, depending on the combination of levels of need and levels of unmet needs for those in need.

Smith, S. et Connolly, S. (2019). "Re-thinking unmet need for health care: introducing a dynamic perspective." Health Econ Policy Law: 1-18.

There is an increasing interest in assessing unmet need for health care services particularly in European countries. Despite this there has been relatively little analysis of unmet need in the European or wider international setting. It remains a challenge to pin down what types of unmet need can and should be addressed by health care policymakers, and how to go about identifying and quantifying those unmet needs. The objective of this paper is to propose a new way of thinking about unmet need for health care which can in turn guide analysis of unmet need in terms of potential data sources and analytic approaches. Unmet need is shown to be a complex multi-faceted concept that cannot be captured by a single indicator or measurement. To advance the literature in this field, this paper considers what happens to unmet need over time. By introducing a dynamic perspective, three alternative trajectories for health care needs are outlined: non-use of health care, delayed use of health care and sub-optimal use of health care. These trajectories are discussed with a view to improving the focus, and policy applicability, of empirical research in this field.

2018

Alves, S., Teixeira, L., Azevedo, M. J., et al. (2018). "Unmet needs in Primary Care of older clients with mental health concerns." International Journal for Quality in Health Care **31**(4): 312-318.
https://doi.org/10.1093/intqhc/mzy154

To examine the unmet needs of older clients with perceived mental health problems who attend primary healthcare services.Unmet needs were derived from (i) the health concerns and caregiver network availability provided by a General Practitioner (GPs) and from (ii) a qualitative analysis of an open question about needs completed by informal caregivers (ICs) of those clients.The sample comprised 436 clients with mean age of 75.2 years and 110 ICs with mean age of 56.7 years.Primary healthcare centers in the North of Portugal.The Community Assessment of Risk Instrument—CARI (Clarnette RM, Ryan JP, O'Herlihy E, et al. The community assessment of risk instrument: investigation of inter-rater reliability of an instrument measuring risk of adverse outcomes. J Frailty Aging 2015;4: 80-9; O'Caoimh R, Healy E, Connell EO, et al. The Community Assessment of Risk Tool (CART): investigation of inter-rater reliability for a new instrument measuring risk of adverse outcomes in community dwelling older adults. Irish J Med Sci 2012.) and qualitative data about needs.Several needs were observed in relation to (1) mental state (e.g. cognition, anxiety/depression); (2) functionality (e.g. IADLS, bathing, mobility); (3) medical state (e.g. chronic diseases, vision deficits) and (4) IC ability to meet clients' needs. From the categorical analysis of the ICs' answers, an amount of unmet needs not only health related but also related with referrals and legal issues were found.This study shows a large number of unmet needs of older people. The evaluation of the clients combined with the evaluation of the testimonials of ICs enables the understanding of difficulties of both clients and caregivers, and which needs should be prioritized.

Baeten, R., Spasova, S., Vanhercke, B., et al. (2018). Inequalities in access to healthcare. A study of national policies 2018. Bruxelles Commission européenne**:** 74, tab., graph., fig.
http://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=8152&furtherPubs=yes

The right of everyone to timely access to affordable, preventive and curative care of good quality is one of the key principles of the European Pillar of Social Rights. This report explores inequalities in access to healthcare in 35 European countries. It shows that important inequalities persist, both between and within countries. Large shares of the EU population, in particular vulnerable groups, face multiple hurdles and do not obtain the care they need. National reports are also available at :

https://ec.europa.eu/social/main.jsp?advSearchKey=ESPNhc_2018&mode=advancedSubmit&catId=22&policyArea=0&policyAreaSub=0&country=0&year=0

Communauté Européenne (2018). Benchmarking Access to Healthcare in the EU. Report of the Expert Panel on effective ways of investing in Health (EXPH). Luxembourg Publications Office of the European Union**:** 78 , tabl., fig.

Faced with growing evidence that some groups within European Union Member States have been unable to achieve access to necessary healthcare, the European Union has committed to action to reduce levels of unmet need, most recently as an element of the European Pillar of Social Rights. In response, the Expert Panel on Effective Ways of Investing in Health has been requested to propose a series of quantitative and qualitative benchmarks for assessing progress in reducing unmet need for healthcare and to discuss means by which EU funds or other mechanisms might be used to improve access to healthcare.

Godman, B., Bucsics, A., Vella Bonanno, P., et al. (2018). "Barriers for Access to New Medicines: Searching for the Balance Between Rising Costs and Limited Budgets." Frontiers in Public Health **6**(328).
https://www.frontiersin.org/article/10.3389/fpubh.2018.00328

Introduction: There is continued unmet medical need for new medicines across countries especially for cancer, immunological diseases and orphan diseases. However, there are growing challenges with funding new medicines at ever increasing prices along with funding increased medicine volumes with the growing prevalence of both infectious diseases and non-communicable diseases across countries. This has resulted in the development of new models to better manage the entry of new medicines, new financial models being postulated as well as strategies to improve prescribing efficiency. However, more needs to be done. Consequently, the primary aim of this paper is to consider potential ways to optimise the use of new medicines balancing rising costs with increasing budgetary pressures to stimulate debate especially from a payer perspective. Methods: A narrative review of pharmaceutical policies and implications, as well as possible developments, based on key publications and initiatives known to the co-authors principally from a health authority perspective. Results: A number of initiatives and approaches have been identified including new models to better manage the entry of new medicines based on three pillars (pre-, peri-, and post-launch activities). Within this, we see the growing role of horizon scanning activities starting up to 36 months before launch, managed entry agreements and post launch follow-up. It is also likely there will be greater scrutiny over the effectiveness and value of new cancer medicines given ever increasing prices. This could include establishing minimum effectiveness targets for premium pricing along with re-evaluating prices as more medicines for cancer lose their patent. There will also be a greater involvement of patients especially with orphan diseases. New initiatives could include a greater role of multicriteria decision analysis, as well as looking at the potential for de-linking research and development from commercial activities to enhance affordability. Conclusion: There are a number of ongoing activities across countries to try and fund new valued medicines whilst attaining or maintaining universal healthcare. Such activities will grow with increasing resource pressures and continued unmet need.

OCDE (2018). Health at a glance : Europe 2018. Paris OCDE**:** 221 , ann., graph., tabl.
https://ec.europa.eu/health/state/glance_fr
https://www.oecd.org/health/health-at-a-glance-europe-23056088.htm

Health at a Glance: Europe 2018 presents comparative analyses of the health status of EU citizens and the performance of the health systems of the 28 EU Member States, 5 candidate countries and 3 EFTA countries. It is the first step in the State of Health in the EU cycle of knowledge brokering. This publication has two parts. Part I comprises two thematic chapters, the first focusing on the need for concerted efforts to promote better mental health, the second outlining possible strategies for reducing wasteful spending in health. In Part II, the most recent trends in key indicators of health status, risk factors and health spending are presented, together with a discussion of progress in improving the effectiveness, accessibility and resilience of European health systems.

2017

Aragon, M. J., Chalkley, M. et Goddard, M. (2017). Defining and measuring unmet need to guide healthcare funding: identifying and filling the gaps. CHE Research Paper Series ;141. York University of York**:** 39 ,fig.
https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP141_need_healthcare_funding.pdf

Budget allocations to Clinical Commissioning Groups include adjustments for unmet need for healthcare, but there is a lack of robust evidence to support this. This article describes a literature review with an objective to understand the available evidence regarding unmet need. We developed a conceptual framework for what constitutes ideal evidence that; defines unmet need for a given population, indicates how that need can be met by health care, establishes the barriers to meeting need and provides relevant proxies based on observable measures. Our search focused on recent and empirical UK data and conceptual papers. We found no one article which satisfied all requirements of ideal evidence; the literature was strongest in defining need but weakest in regard to establishing observable proxies of need capable of being used in budget allocations. Our review was limited by its timescale and a vast body of literature, which translated into a limited number of key words for the search. We conclude that further research to inform budget allocation is required and should focus on conditions or services where adverse health outcomes from unmet need are amenable to healthcare interventions and which affect a sizeable proportion of the population.

Ashwood, J. S., Mehrotra, A., Cowling, D., et al. (2017). "Direct-To-Consumer Telehealth May Increase Access To Care But Does Not Decrease Spending." Health Affairs **36**(3): 485-491.
http://content.healthaffairs.org/content/36/3/485.abstract

The use of direct-to-consumer telehealth, in which a patient has access to a physician via telephone or videoconferencing, is growing rapidly. A key attraction of this type of telehealth for health plans and employers is the potential savings involved in replacing physician office and emergency department visits with less expensive virtual visits. However, increased convenience may tap into unmet demand for health care, and new utilization may increase overall health care spending. We used commercial claims data on over 300,000 patients from three years (2011–13) to explore patterns of utilization and spending for acute respiratory illnesses. We estimated that 12 percent of direct-to-consumer telehealth visits replaced visits to other providers, and 88 percent represented new utilization. Net annual spending on acute respiratory illness increased $45 per telehealth user. Direct-to-consumer telehealth may increase access by making care more convenient for certain patients, but it may also increase utilization and health care spending.

Berk, M. L. et Fang, Z. (2017). "Most Americans Have Good Health, Little Unmet Need, And Few Health Care Expenses." Health Aff (Millwood) **36**(4): 742-746.

The distribution of health care expenditures remains highly concentrated, but most Americans use few health care resources and have low out-of-pocket spending. More than 93 percent of "low spenders" (those in the bottom half of the population) believe they have received all needed care in a timely manner. The low spending by the majority of the population has remained almost unchanged during the thirty-seven-year period examined.

Connolly, S. et Wren, M. A. (2017). "Unmet healthcare needs in Ireland: Analysis using the EU-SILC survey." Health Policy **121**(4): 434-441.

The analysis used the 2013 Survey of Income and Living Conditions to examine the extent and causes of unmet need for healthcare services in Ireland. The analysis found that almost four per cent of participants reported an unmet need for medical care. Overall, lower income groups, those with poorer health status and those without free primary care and/or private insurance were more likely to report an unmet healthcare need. The impact of income on the likelihood of reporting an unmet need was particularly strong for those without free primary care and/or private insurance, suggesting a role for the health system in eradicating income based inequalities in unmet need. Factors associated with the healthcare system - cost and waiting lists - accounted for the majority of unmet needs. Those with largely free public healthcare entitlement were more likely than all other eligibility categories to report that their unmet need was due to waiting lists (rather than cost). While not possible to explicitly examine in this analysis, it is probable that unmet need due to cost is picking up on the relatively high out-of-pocket payments for primary care for those who must pay for GP visits; while unmet need due to waiting is identifying the relatively long waiting times within the acute hospital sector for those within the public system.

Detollenaere, J., Hanssens, L., Vyncke, V., et al. (2017). "Do We Reap What We Sow? Exploring the Association between the Strength of European Primary Healthcare Systems and Inequity in Unmet Need." PLoS One **12**(1): e0169274.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5207486/pdf/pone.0169274.pdf

Access to healthcare is inequitably distributed across different socioeconomic groups. Several vulnerable groups experience barriers in accessing healthcare, compared to their more wealthier counterparts. In response to this, many countries use resources to strengthen their primary care (PC) system, because in many European countries PC is the first entry-point to the healthcare system and plays a central role in the coordination of patients through the healthcare system. However it is unclear whether this strengthening of PC leads to less inequity in access to the whole healthcare system. This study investigates the association between strength indicators of PC and inequity in unmet need by merging data from the European Union Statistics on Income and Living Conditions database (2013) and the Primary Healthcare Activity Monitor for Europe (2010). The analyses reveal a significant association between the Gini coefficient for income inequality and inequity in unmet need. When the Gini coefficient of a country is one SD higher, the social inequity in unmet need in that particular country will be 4.960 higher. Furthermore, the accessibility and the workforce development of a country's PC system is inverse associated with the social inequity of unmet need. More specifically, when the access- and workforce development indicator of a country PC system are one standard deviation higher, the inequity in unmet healthcare needs are respectively 2.200 and 4.951 lower. Therefore, policymakers should focus on reducing income inequality to tackle inequity in access, and strengthen PC (by increasing accessibility and better-developing its workforce) as this can influence inequity in unmet need.

Fiorillo, D. (2017). Reasons for unmet needs for health care: the role of social capital and social support in some Western EU countries. Munich MRPA**:** 22.
https://mpra.ub.uni-muenchen.de/82680/

The paper focus on the patient-side factors that determine access to health care and analyzes the issues of unmet needs and reasons for unmet needs for health care in Western EU countries. The paper has two main objectives: First, to study the determinants of unmet health care needs (UN) with a particular hub on social capital and social support; second, to analyze whether social capital and social support are predictors of the reasons for unmet needs (RUN). A probit model is estimated from the whole population sample accounting for the possibility of individual selection in unmet needs for health care (UN) (selection equation). Then expanded probit models (including inverse Mills ratio) are used on the reasons for unmet needs (RUN) with social capital and social support as determinants and using the European Union Statistics on Income and Living Conditions (EU-SILC) dataset carried out in 2006. In UN equation, results indicate higher unmet health care needs for younger, people with tertiary education, low economic situation, unemployed and in poor health status. Moreover, the frequency of visiting relatives and friends and the ability to ask for help are correlated with a lower likelihood of declaring unmet needs, instead volunteering and participation in formal organizations present a higher probability of not visiting a doctor when needed. In RUN equations, findings show that female, large households, people with low economic situation and financial constraints, unemployed and in poor health status have a higher probability of declaring unmet needs due to economic costs. Additionally, people with tertiary education, high income and employed have a higher probability of not visiting a doctor when needed due to time availability. Furthermore, the frequency of contact with friends and the ability to ask for help are related with a lower probability of unmet needs due to economic costs, while the frequency of contact with relatives is related with a lower probability of unmet needs due to time availability and distance. However, the ability to ask for help is also correlated with a higher probability of not having medical care due to time availability and wait and see.

Fjaer, E. L., Stornes, P., Borisova, L. V., et al. (2017). "Subjective perceptions of unmet need for health care in Europe among social groups: Findings from the European social survey (2014) special module on the social determinants of health." Eur J Public Health **27**(suppl_1): 82-89.

Background: Unmet need can be defined as the individually perceived subjective differences between services judged necessary to deal with health problems and the services actually received. This study examines what factors are associated with unmet need, as well as how reasons for unmet need are distributed across socioeconomic and demographic groups in Europe. Multilevel logistic regression models were employed using data from the 7th round of the European Social Survey, on people aged 25-75. Self-reported unmet need measured whether respondents had been unable to get medical consultation or treatment in the last 12 months. Reasons for unmet need were grouped into three categories: availability, accessibility and acceptability. Health status was measured by self-reported health, non-communicable diseases and depressive symptoms. Two-thirds of all unmet need were due waiting lists and appointment availability. Females and young age groups reported more unmet need. We found no educational inequalities, while financial strain was found to be an important factor for all types of unmet need for health care in Europe. All types of health care use and poor health were associated with unmet need. Low physician density and high out-of-pocket payments were found to be associated with unmet need due to availability. Even though health care coverage is universal in many European welfare states, financial strain appeared as a major determinant for European citizens' access to health care. This may suggest that higher income groups are able to bypass waiting lists. European welfare states should, therefore, intensify their efforts in reducing barriers for receiving care.

OCDE (2017). Panorama de la santé 2017. Indicateurs de l'OCDE. Paris OCDE**:** 221 , ann., graph., tabl.
http://www.oecd-ilibrary.org/social-issues-migration-health/panorama-de-la-sante-2017_health_glance-2017-fr

Cette nouvelle édition du Panorama de la santé présente les données comparables les plus récentes pour les principaux indicateurs relatifs à la santé et à la performance des systèmes de santé dans les pays de l'OCDE. Les pays candidats et les principaux pays partenaires (Afrique du Sud, Brésil, Chine, Colombie, Costa Rica, Fédération de Russie, Inde, Indonésie et Lituanie) ont également été inclus dans la mesure du possible. Sauf indication contraire, les données présentées dans cette publication sont tirées des statistiques nationales officielles. Cette édition contient des nouveaux indicateurs, particulièrement dans le domaine des facteurs de risque pour la santé. Elle place aussi une plus grande emphase sur l'analyse des tendances temporelles. Parallèlement à l'analyse par indicateur, cette édition propose des instantanés et une série de tableaux de bord qui résument les performances comparatives des pays, ainsi qu'un chapitre spécial sur les principaux facteurs à l'origine des gains d'espérance de vie.

Osborn, R., Doty, M. M., Moulds, D., et al. (2017). "Older Americans Were Sicker And Faced More Financial Barriers To Health Care Than Counterparts In Other Countries." Health Aff (Millwood): 101377hlthaff20171048.
https://www.ncbi.nlm.nih.gov/pubmed/29140737

High-income countries are grappling with the challenge of caring for aging populations, many of whose members have chronic illnesses and declining capacity to manage activities of daily living. The

2017 Commonwealth Fund International Health Policy Survey of Older Adults in eleven countries showed that US seniors were sicker than their counterparts in other countries and, despite universal coverage under Medicare, faced more financial barriers to health care. The survey's findings also highlight economic hardship and mental health problems that may affect older adults' health, use of care, and outcomes. They show that in some countries, one in five elderly people have unmet needs for social care services-a gap that can undermine health. New to the survey is a focus on the "high-need" elderly (those with multiple chronic conditions or functional limitations), who reported high rates of emergency department use and care coordination failures. Across all eleven countries, many high-need elderly people expressed dissatisfaction with the quality of health care they had received.

Simon, A. E., Fenelon, A., Helms, V., et al. (2017). "HUD Housing Assistance Associated With Lower Uninsurance Rates And Unmet Medical Need." Health Aff (Millwood) **36**(6): 1016-1023.

To investigate whether receiving US Department of Housing and Urban Development (HUD) housing assistance is associated with improved access to health care, we analyzed data on nondisabled adults ages 18-64 who responded to the 2004-12 National Health Interview Survey that were linked with administrative data from HUD for the period 2002-14. To account for potential selection bias, we compared access to care between respondents who were receiving HUD housing assistance at the time of the survey interview (current recipients) and those who received HUD assistance within twenty-four months of completing the survey interview (future recipients). Receiving assistance was associated with lower uninsurance rates: 31.8 percent of current recipients were uninsured, compared to 37.2 percent of future recipients. Rates of unmet need for health care due to cost were similarly lower for current recipients than for future recipients. No effect of receiving assistance was observed on having a usual source of care. These findings provide evidence that supports the effectiveness of housing assistance in improving health care access.

2016

(2016). Health at a Glance 2016 : Europe. Paris OCDE**:** 204, ann., graph., tabl.
http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2016_9789264265592-en;jsessionid=3raq7b06ufflo.x-oecd-live-02

This fourth edition of Health at a Glance: Europe presents key indicators of health and health systems in the 28 EU countries, 5 candidate countries to the EU and 3 EFTA countries. This 2016 edition contains two main new features: two thematic chapters analyse the links between population health and labour market outcomes, and the important challenge of strengthening primary care systems in European countries; and a new chapter on the resilience, efficiency and sustainability of health systems in Europe, in order to align the content of this publication more closely with the 2014 European Commission Communication on effective, accessible and resilient health systems. This publication is the result of a renewed collaboration between the OECD and the European Commission under the broader "State of Health in the EU" initiative, designed to support EU member states in their evidence-based policy making.

- Voir pages 156-157 pour le renoncement aux soins.

Arora, V. S., et al. (2016). "An examination of unmet health needs as perceived by Roma in Central and Eastern Europe." The European Journal of Public Health **26**(5): 737-742.

Background: Roma comprise the largest ethnic minority in Europe, with an estimated population of 10–12 million. Roughly 50–60% of European Roma live in the countries of Central and Eastern Europe. In this study, we set out to quantify and explain disparities in unmet health needs for Roma populations relative to non-Roma populations, using self-reported access to health care. Methods: The United Nations Development Programme/World Bank/European Commission 2011 regional Roma survey was used for this study (12 countries, 8735 Roma and 4572 non-Roma living in same communities), with self-reported unmet health need (did not consult a doctor or health professional when they felt it was necessary in past year) as the primary outcome. Multivariable logistic regressions were performed to study the determinants of unmet health need for Roma populations relative to non-Roma populations. Covariates controlled for included sociodemographic characteristics, economic ability, health status and healthcare access. Results: We found in unadjusted models that Roma throughout Central and Eastern Europe, with the exception of Montenegro, are two to three times more likely to report having an unmet health need in the past 12 months than non-Roma living nearby. These disparities largely remain significant, even after adjusting for gender, age, marital status, employment status, education, number of chronic conditions, health insurance status and geographical proximity to medical providers. Conclusions: Controlling for conventional measures of access to medical care (i.e. geographic access to providers and health insurance) does not eliminate observed disparities in unmet need. Although improving funding and routine access to healthcare services for Roma is important in its own right as a means of increasing inclusion, there is a need for detailed assessments of the barriers that exist in each country, within and outside the health system, coupled with measures to implement existing commitments on Roma rights.%U http://eurpub.oxfordjournals.org/content/eurpub/26/5/737.full.pdf

Brooks-Carthon, J. M., et al. (2016). "Unmet Nursing Care Linked to Rehospitalizations Among Older Black AMI Patients: A Cross-Sectional Study of US Hospitals." Medical Care **54**(5): 457-465.
http://journals.lww.com/lww-medicalcare/Fulltext/2016/05000/Unmet_Nursing_Care_Linked_to_Rehospitalizations.7.aspx

Background: Recent studies suggest that nurses may be unable to complete all aspects of necessary care due to a lack of time. Research is needed to determine whether unmet nursing care contributes to disparities in readmissions for vulnerable populations. Objectives: To examine differences in the relationship between nursing care left undone and acute myocardial infarction readmissions among older black patients compared with older white patients. Research Design: Cross-sectional analysis of multiple datasets, including: 2006 to 2007 administrative discharge data, a survey of registered nurses, and the American Hospital Association Annual Survey. Risk-adjusted logistic regression models were used to estimate the association between care left undone and 30-day readmission. Interactions were used to examine the moderating effect of care left undone on readmission by race. Results: The sample included 69,065 patients in 253 hospitals in California, New Jersey, and Pennsylvania. Older black patients were 18% more likely to experience a readmission after adjusting for patient and hospital characteristics and more likely to be in hospitals where nursing care was often left undone. Black patients were more likely to be readmitted when nurses were unable to talk/comfort patients [odds ratio (OR), 1.09; 95% confidence interval (CI), 1.01–1.19], complete documentation (OR, 1.16; 95% CI, 1.01–1.32), or administer medications in a timely manner (OR, 1.26; 95% CI, 1.09–1.46). Conclusions: Unmet nursing care is associated with readmissions for older black patients following acute myocardial infarction. Investment in nursing resources to improve the delivery of nursing care may decrease disparities in readmission.

Casey, R. (2015). "Disability and unmet health care needs in Canada: A longitudinal analysis." Disabil Health J **8**(2): 173-181.

Background: The rate of unmet health care needs is quite high for the general population in Canada; however, the rate is even higher for the subset of people with disabilities. To date, there is a gap in the research utilizing longitudinal data to measure the unmet health care needs of Canadians. Objective/hypothesis: The purpose of this research is to compare the rate of unmet health care needs of people with disabilities to people without disabilities over 15 years. Methods: Longitudinal data from waves 1 to 8 (1994/95 to 2008/09) of the National Population Health Survey in Canada (NPHS) were analyzed using a growth curve modeling approach. Results: Respondents with disabilities have two to three times the rate of unmet health care needs compared to respondents without disabilities. Unmet health care needs increase over time, and at a faster rate for all disability types except work-related disability. Personal reasons for unmet health care needs decrease over time and there is no significant difference between respondents with disabilities and respondents without disabilities. The opposite was found for structural reasons, which increase over time, and, people with disabilities have higher rates of structural-based unmet health care needs (45% higher) at baseline. Conclusions: The incidence of disability in the population increases over time while at the same time the rate of unmet health care needs are higher for people with disabilities. The combination of these factors suggests that, in the absence of intervention, Canadians can expect more unmet health care needs in the future.

Chaupain-Guillot, S. et Guillot, O. (2015). "Health system characteristics and unmet care needs in Europe: an analysis based on EU-SILC data." Eur J Health Econ **16**(7): 781-796.

Using survey data from the 2009 wave of the European Union Statistics on Income and Living Conditions, this study examines the determinants of unmet needs for medical and dental care in European countries. Special emphasis is put on the impact of health system characteristics. Four factors are taken into account: the density of doctors or dentists, the rules governing access to practitioners, the method of paying primary care physicians, and the amount of out-of-pocket payments. The analysis is carried out using multilevel logistic regression models. Separate regressions are estimated for medical and dental services. The dependent variable is whether respondents reported that, at least once in the last 12 months, they needed care but did not receive it. The estimation results show that the probability of experiencing unmet medical or dental needs varies noticeably across countries. This inter-country variability seems to be partly explained by the differences in the financing of health care. Indeed, a positive link is found between the share of households' out-of-pocket payments in total health expenditure and the probability of unmet needs. The other contextual factors do not seem to play a significant role.

Chen, J. et Dagher, R. (2016). "Gender and Race/Ethnicity Differences in Mental Health Care Use before and during the Great Recession." J Behav Health Serv Res **43**(2): 187-199.

This study examines the changes in health care utilization for mental health disorders among patients who were diagnosed with depressive and/or anxiety disorders during the Great Recession 2007-2009 in the USA. Negative binomial regressions are used to estimate the association of the economic recession and mental health care use for females and males separately. Results show that prescription drug utilization (e.g., antidepressants, psychotropic medications) increased significantly during the economic recession 2007-2009 for both females and males. Physician visits for mental health disorders decreased during the same period. Results show that racial disparities in mental health care might have increased, while ethnic disparities persisted during the Great Recession. Future research should separately examine mental health care utilization by gender and race/ethnicity.

Choi, S. (2016). "Experiencing Unmet Medical Needs or Delayed Care Because of Cost: Foreign-Born Adults in the U.S. by Region of Birth." Int J Health Serv **46**(4): 693-711.

Healthy People 2020 in the United States highlights timely access to necessary health care as a major factor that can reduce health-related disparities. This study examined the prevalence of delaying/missing necessary health care because of cost among foreign-born adults (26+ years old) in the United States by their region of origin, after controlling for geographic clustering at the county and state levels. METHODS: Using the pooled 2007-2011 National Health Interview Survey and linked state/county-level data, this study analyzed data on 61,732 foreign-born adults from nine regions of birth. Three-level multilevel modeling (state > county > individual) was conducted. The age-adjusted percentages of foreign-born adults who delayed/missed necessary health care because of cost varied by region of birth, ranging from 7.0% (Southeast Asia) and 11.9% (Europe) to 15.5% (Mexico/Central America/Caribbean) and 16.7% (the Middle East). However, after controlling for geographic clustering and other individual-level covariates (e.g., insurance), adults from Mexico/Central America/Caribbean were less likely to delay or not receive necessary care compared to their counterparts from all other parts of the world except for those from Asian regions. This study implies that disparities can be reduced if some known risk factors (e.g., insurance) are improved among foreign-born adults.

Christopher, J. R. (2016). "Health Effects of Economic Crises." Health Economics **25**(0): 6-24.

This analysis summarizes prior research and uses national, US state and county-level data from 1976 to 2013 to examine whether the mortality effects of economic crises differ in kind from those of the more typical fluctuations. The tentative conclusion is that economic crises affect mortality rates (and presumably other measures of health) in the same way as less severe downturns – leading to improvements in physical health. The effects of severe national recessions in the USA appear to have a beneficial effect on mortality that is roughly twice as strong as that predicted by the elevated unemployment rates alone, while the higher predicted rate of suicides during typical periods of economic weakness is approximately offset during severe recessions. No consistent pattern is obtained for more localized economic crises occurring at the state level – some estimates suggest larger protective mortality effects while others indicate offsetting deleterious consequences. Copyright © 2016 John Wiley & Sons, Ltd.

Guidi, C. F., et al. (2016). Inequalities by Immigrant Status in Unmet Needs for Healthcare in Europe: The Role of Origin, Nationality and Economic Resources. EUI Working Paper RSCAS 2016/55. San Domenico di Fiesole Robert Schuman Center for Advanced Studies.**:** 19 , tabl. graph.
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2860634

The aim of the research is to assess whether there are inequalities in unmet needs for healthcare between natives and migrants within Europe. We used cross-sectional data from the European Statistics on Income and Living Conditions 2012. Our dependent variables were perceived unmet needs for medical and dental examination or treatment. Our main independent variable is immigrant status, defined using a combination of country of birth and citizenship (nationals born in the country of residence, reference; European Union-born nationals; non-EU born nationals; EU-born foreigners; non EU-born foreigners). The prevalence ratios of unmet needs according to immigrant status are obtained through sex-stratified robust Poisson regression models, sequentially adjusted by age, health status and socio-economic characteristics. The prevalence of medical unmet needs, adjusted by age and health status, is higher in foreign women, both EU-born and non-EU born, but it is no longer significant after the socioeconomic adjustment. For dental unmet needs, the risk is significantly higher for all foreigners, EU and non EU-born, men and women. Once adjusted for socioeconomic variables significant inequalities persist, although diminished, for both EU-born and non-EU-born foreign men and EU-born foreign women. This study contributes to the discussion of adequate access to healthcare systems and adaptation of services for migrants. While inequalities cannot be detected for naturalised immigrants, the higher risk of unmet need affecting foreigners, even within the EU, deserves further attention

Han, K. T., et al. (2016). "Unmet healthcare needs and community health center utilization among the low-income population based on a nationwide community health survey." Health Policy **120**(6): 630-637.
http://dx.doi.org/10.1016/j.healthpol.2016.04.004

The low-income population had higher unmet needs and utilized community health centers (CHC) more frequently compared with the higher income groups. The low-income population visited CHC for primary care and vaccinations. The high-income population visited CHC for incidental purposes.

Israel, S. (2016). "How social policies can improve financial accessibility of healthcare: a multi-level analysis of unmet medical need in European countries." Int J Equity Health **15**: 41.

BACKGROUND: The article explores in how far financial accessibility of healthcare (FAH) is restricted for low-income groups and identifies social protection policies that can supplement health policies in guaranteeing universal access to healthcare. The article is aimed to advance the literature on comparative European social epidemiology by focussing on income-related barriers of healthcare take-up. METHOD: The research is carried out on the basis of multi-level cross-sectional analyses using 2012 EU-SILC data for 30 European countries. The social policy data stems from EU-SILC beneficiary information. RESULTS: It is argued that unmet medical needs are a reality for many individuals within Europe - not only due to direct user fees but also due to indirect costs such as waiting time, travel costs, time not spent working. Moreover, low FAH affects not only the lowest income quintile but also the lower middle income class. The study observes that social allowance increases the purchasing power of both household types, thereby helping them to overcome financial barriers to healthcare uptake. CONCLUSION: Alongside healthcare system reform aimed at improving the pro-poor availability of healthcare facilities and financing, policies directed at improving FAH should aim at providing a minimum income base to the low-income quintile. Moreover, categorical policies should address households exposed to debt which form the key vulnerable group within the low-income classes.

Kim, B. (2016). Inequity in unmet medical need among the European elderly. Discussion Paper Series ; DPS 16.08. Leuven KU Leuven**:** 48.
https://lirias.kuleuven.be/bitstream/123456789/542513/1/DPS1608.pdf

This study evaluates unfair inequality, namely inequality of opportunity (IOp), in access to medical care among the elderly population. I compare the magnitude of IOp across 14 European countries using data from the Survey of Health, Aging and Retirement in Europe (SHARE) collected in 2013. Self-reported unmet medical need caused by cost-related reasons is used as a measure of medical access. Separate models are introduced to accommodate two competing philosophical views (e.g. control and preference approaches) that result in a different definition of the scope of individual responsibility. A joint estimation strategy is applied to take unobserved heterogeneity into account. We find the highest IOp to exist in medical access in EE and IT, and the lowest in AT, CH, SI, NL, SE and DK. However, some results are sensitive to normative assumptions. For instance, EE, IT and DE show greater IOp when it is assumed that individuals are responsible for their decisions made on the basis of genuine preference rather than control. Additional results from a policy simulation suggest that IOp could have been significantly reduced due to educational promotion in many countries, with the exception of EE, NL, SI, SE and DK.

Kling, S., et al. (2016). "Somatic assessments of 120 Swedish children taken into care reveal large unmet health and dental care needs." Acta Paediatr **105**(4): 416-420.

AIM: For decades, non-Nordic countries have consistently reported high rates of somatic health problems among children placed in care by the authorities. This study examined the unmet health and dental care needs of Swedish children in foster and residential care. METHODS: The health of 120 consecutive children aged 0-17 years, who had recently been placed in foster or residential care in one Swedish region, was assessed by an experienced paediatrician using patient records, their medical history and a physical examination. RESULTS: Following the assessments, 51% of the subjects received at least one referral to a specialist or to primary care, either for a previously undetected medical condition or for a follow-up of a previously detected condition noted in their patient records. The study showed that 40% of the girls and 33% of boys were overweight and completed vaccination rates were only 86% for children up to the age of six and 68% for 7- to 17-year-olds. Half of the 7- to 17-year-olds had untreated dental decay. CONCLUSION: Our study revealed a large unmet need for health and dental care interventions among children placed in foster care and residential care and a systematic strategy is required to address those needs.

Prazeres, F. et Santiago, L. (2016). "Relationship between health-related quality of life, perceived family support and unmet health needs in adult patients with multimorbidity attending primary care in Portugal: a multicentre cross-sectional study." Health Qual Life Outcomes **14**(1): 156.

BACKGROUND: Multimorbidity has a high prevalence in the primary care context and it is frequently associated with worse health-related quality of life (HRQoL). Few studies evaluated the variables that could have a potential effect on HRQoL of primary care patients with multimorbidity. The purpose of this study, the first of its kind ever undertaken in Portugal, is to analyse the relationship between multimorbidity, health-related quality of life, perceived family support and unmet health needs in adult patients attending primary care. METHODS: Multicentre, cross-sectional survey conducted among primary care patients with multimorbidity. It included 521 participants (64.1 % females) who met the inclusion criteria. HRQoL was evaluated using the Portuguese Short Form-12 Health Status Questionnaire. The Portuguese Family APGAR was used to measure the perceived family support. A patients' unmet health needs questionnaire was used. The unmet needs for medical, surgical and dental care; prescription medications; mental healthcare or counselling; and eyeglasses or other technical aid was assessed. Descriptive and multivariate analyses were performed. RESULTS: The sample had an overall average of 4.5 chronic health problems. Increased multimorbidity levels were linked to worse health-related quality of life, particularly the physical health. Some variables were confirmed as playing a role on health-related quality of life. Male patients with high monthly incomes and highly functional families had better physical and mental health. High levels of education and the presence of asthma were also associated with better physical health. Contrariwise, elderly patients with high levels of multimorbidity and with osteoarthritis had lower physical health. The majority of the patients did not have unmet health needs. When health needs were stated they were mostly for generalist medical care, dental care, and eyeglasses/other technical aid. Financial insufficiency was the primary reason for not fulfilling their health needs. CONCLUSION: To improve the quality of life of multimorbid patients, within primary care practices and health delivery systems, one should take into special account the sex of the patient, the perceived family support and the self-perceived economic status because of their relationship with both physical and mental health. Limitations and recommendations are discussed.

Salzberg, C. A., et al. (2016). "Health System Performance for the High-Need Patient: A Look at Access to Care and Patient Care Experiences." Issue Brief (Commonw Fund) **27**: 1-12.

Issue: Achieving a high-performing health system will require improving outcomes and reducing costs for high-need, high-cost patients--those who use the most health care services and account for a disproportionately large share of health care spending. Goal: To compare the health care experiences of adults with high needs--those with three or more chronic diseases and a functional limitation in the ability to care for themselves or perform routine daily tasks--to all adults and to those with multiple chronic diseases but no functional limitations. Methods: Analysis of data from the 2009--2011 Medical Expenditure Panel Survey. Key findings: High-need adults were more likely to report having an unmet medical need and less likely to report having good patient-provider communication. High-need adults reported roughly similar ease of obtaining specialist referrals as other adults and greater likelihood of having a medical home. While adults with private health insurance reported the fewest unmet needs overall, privately insured high-need adults reported the greatest difficulties having their needs met. Conclusion: The health care system needs to work better for the highest-need, most-complex patients. This study's findings highlight the importance of tailoring interventions to address their needs.

2015

Casey, R. (2015). "Disability and unmet health care needs in Canada: a longitudinal analysis." Disabil Health J **8**(2): 173-181.

BACKGROUND: The rate of unmet health care needs is quite high for the general population in Canada; however, the rate is even higher for the subset of people with disabilities. To date, there is a gap in the research utilizing longitudinal data to measure the unmet health care needs of Canadians. OBJECTIVE/HYPOTHESIS: The purpose of this research is to compare the rate of unmet health care needs of people with disabilities to people without disabilities over 15 years. METHODS: Longitudinal data from waves 1 to 8 (1994/95 to 2008/09) of the National Population Health Survey in Canada (NPHS) were analyzed using a growth curve modeling approach. RESULTS: Respondents with disabilities have two to three times the rate of unmet health care needs compared to respondents without disabilities. Unmet health care needs increase over time, and at a faster rate for all disability types except work-related disability. Personal reasons for unmet health care needs decrease over time and there is no significant difference between respondents with disabilities and respondents without disabilities. The opposite was found for structural reasons, which increase over time, and, people with disabilities have higher rates of structural-based unmet health care needs (45% higher) at baseline.

CONCLUSIONS: The incidence of disability in the population increases over time while at the same time the rate of unmet health care needs are higher for people with disabilities. The combination of these factors suggests that, in the absence of intervention, Canadians can expect more unmet health care needs in the future.

Chaupain-Guillot, S. et Guillot, O. (2015). "Health system characteristics and unmet care needs in Europe: an analysis based on EU-SILC data." Eur J Health Econ **16**(7): 781-796.

Using survey data from the 2009 wave of the European Union Statistics on Income and Living Conditions, this study examines the determinants of unmet needs for medical and dental care in European countries. Special emphasis is put on the impact of health system characteristics. Four factors are taken into account: the density of doctors or dentists, the rules governing access to practitioners, the method of paying primary care physicians, and the amount of out-of-pocket payments. The analysis is carried out using multilevel logistic regression models. Separate regressions are estimated for medical and dental services. The dependent variable is whether respondents reported that, at least once in the last 12 months, they needed care but did not receive it. The estimation results show that the probability of experiencing unmet medical or dental needs varies noticeably across countries. This inter-country variability seems to be partly explained by the differences in the financing of health care. Indeed, a positive link is found between the share of households' out-of-pocket payments in total health expenditure and the probability of unmet needs. The other contextual factors do not seem to play a significant role.

Cylus, J. et Papanicolas, I. (2015). "An analysis of perceived access to health care in Europe: How universal is universal coverage?" Health Policy **119**(9): 1133-1144.

The objective of this paper is to examine variations in perceptions of access to health care across and within 29 European countries. Using data from the 2008 round of the European Social Survey, we investigate the likelihood of an individual perceiving that they will experience difficulties accessing health care in the next 12 months, should they need it (N=51,835). We find that despite most European countries having mandates for universal health coverage, individuals who are low income, in poor health, lack citizenship in the country where they reside, 20-30 years old, unemployed and/or female have systematically greater odds of feeling unable to access care. Focusing on the role of income, we find that while there is a strong association between low income and perceived access barriers across countries, within many countries, perceptions of difficulties accessing care are not concentrated uniquely among low-income groups. This implies that factors that affect all income groups, such as poor quality care and long waiting times may serve as important barriers to access in these countries. Despite commitments to move towards universal health coverage in Europe, our results suggest that there is still significant heterogeneity among individuals' perceptions of access and important barriers to accessing health care.

Fried, D. A., et al. (2015). "Health and Health Care Service Utilization Among U.S. Veterans Denied VA Service-Connected Disability Compensation: A Review of the Literature." Mil Med **180**(10): 1034-1040.

UNLABELLED: The general consensus in studies of individuals seeking federal disability compensation is that individuals "denied" disability compensation are healthier than those "awarded." In contrast, studies of military veterans seeking U.S. Department of Veterans Affairs (VA) disability compensation suggest that those "denied" ("denied applicants") may be as impaired as those "awarded" ("awarded applicants"), and likely have critical, albeit unmet health care needs. Moreover, although social isolation among U.S. Veterans has received some attention, its broad influence on health and health care consumption among veterans "denied" VA disability compensation is not well understood. OBJECTIVES: To provide a more thorough understanding of "denied" applicants' health, health care utilization, and social conditions. METHODS: We reviewed published reports of health, health care utilization, and social isolation "relevant" to U.S. Veterans "denied" VA disability compensation. Among 122 research items initially reviewed, a total of 47 met our inclusion criteria and are summarized herein. RESULTS: Compared to veterans "awarded" VA disability compensation, those "denied" have poorer health, use less VA health care, and may experience social isolation. CONCLUSIONS: Veterans "denied" VA disability compensation may comprise a vulnerable subgroup of veterans in need of supportive services. Such needs may be addressed through evidence-based targeted outreach programs.

Hargreaves, D. S., et al. (2015). "Unmet Health Care Need in US Adolescents and Adult Health Outcomes." Pediatrics **136**(3): 513-520.

BACKGROUND: Adolescence is a formative period when health care services have a unique opportunity to influence later health outcomes. Unmet health care need in adolescence is known to be associated with poor contemporaneous health outcomes; it is unknown whether it predicts poor adult health outcomes. METHODS: We used nationally representative data from 14 800 subjects who participated in Wave I (mean age: 15.9 years [1994/1995]) and Wave IV (mean age: 29.6 years [2008]) of the National Longitudinal Study of Adolescent to Adult Health. Logistic regression models were used to estimate the association between unmet health care need in adolescence and 5 self-reported measures of adult health (fair/poor general health, functional impairment, time off work/school, depressive symptoms, and suicidal ideation). Models were adjusted for baseline health, insurance category, age, gender, race/ethnicity, household income, and parental education. RESULTS: Unmet health care need was reported by 19.2% of adolescents and predicted worse adult health: fair/poor general health (adjusted odds ratio [aOR]: 1.27 [95% confidence interval (CI): 1.00-1.60]); functional impairment (aOR: 1.52 [95% CI: 1.23-1.87]); depressive symptoms (aOR: 1.36 [95% CI: 1.13-1.64]); and suicidal ideation (aOR: 1.30 [95% CI: 1.03-1.68]). There was no significant association between unmet health care need and time off work/school (aOR: 1.13 [95% CI: 0.93-1.36]). Cost barriers accounted for only 14.8% of unmet health care need. The reason for unmet need was not significantly related to the likelihood of poor adult health outcomes. CONCLUSIONS: Reported unmet health care need in adolescence is common and is an independent predictor of poor adult health. Strategies to reduce unmet adolescent need should address health engagement and care quality, as well as cost barriers to accessing services.

Ponzio, M., et al. (2015). "Unmet care needs of people with a neurological chronic disease: a cross-sectional study in Italy on Multiple Sclerosis." The European Journal of Public Health **25**(5): 775-780.
http://eurpub.oxfordjournals.org/eurpub/25/5/775.full.pdf

Background: Community-based studies are required to accurately describe the supportive services needed by people with multiple sclerosis (MS). Methods: A total of 1205 people with MS participated in a cross-sectional study evaluating their unmet health and social care needs through a questionnaire collecting information used in the study. It was specifically developed by a multi-disciplinary team. Results: Overall, 79% of the responders declared at least one health or social care needs. The most prevalent health care need was the psychological support (27.5%), whereas the transport was the social care need more frequent (over 41%) in our sample. The multivariate analysis highlighted that unmet health care needs depended mainly on clinical factors such as disease stage, influenced by disease duration, and disability degree, whereas the social care needs were related to both clinical and socio-demographic factors. Conclusion: These findings suggest that MS needs significantly change over time during the disease development and to find the best way to personalize PwMS management is crucial. Moreover, more public funding directed at improving the health-related quality of life of people with MS is needed. For this reason, we think that these results will provide important information and baseline data on how to build the national service strategies thereby making healthcare planning more efficient.

Reeves, A., et al. (2015). "The attack on universal health coverage in Europe: recession, austerity and unmet needs." Eur J Public Health **25**(3): 364-365.
http://eurpub.oxfordjournals.org/content/eurpub/25/3/364.full.pdf

Stankuniene, A., et al. (2015). "The prevalence of self-reported underuse of medications due to cost for the elderly: results from seven European urban communities." Bmc Health Services Research **15**(419): 11 ,

tabl.
http://www.biomedcentral.com/1472-6963/15/419

Les auteurs de cette étude européenne ont interviewé 4 467 personnes âgées de 64 à 84 ans en Allemagne, en Grèce, en Italie, en Lituanie, au Portugal, en Espagne et en Suède pour savoir si elles s'abstenaient de prendre des médicaments en raison de leurs coûts. Leurs résultats indiquent que 3,6 % des répondants se sont abstenus d'acheter des médicaments sur ordonnance en raison de leur coût. Le problème était plus répandu en Lituanie (15,7 %).

Terraneo, M. (2015). "Inequities in health care utilization by people aged 50+: Evidence from 12 European countries." Soc Sci Med **126**: 154-163.

The aim of this study is to describe the magnitude of educational inequities in the use of health care services, by people aged 50+, in 12 European countries, controlling for country-level heterogeneity. We consider four services: having seen or talked to 1) a general practitioner (GP) or 2) specialist, 3) having been hospitalized, and 4) having visited a dentist (only for prevention). Data derived from the SHARE (Survey of Health, Ageing and Retirement in Europe) project, a cross-national panel that collects information from individuals aged 50 and over. A Fixed Effects approach is applied, which is a valuable alternative to the application of conventional multilevel models in country-comparative analysis. The main findings of this study confirm that there is substantial educational inequity in the use of health care, although relevant differences arise between services. A clear pro-educated gradient is found for specialists and dentist visits, whereas no evidence of educational disparities was found for GP use. On the other hand, less clear results emerge regarding hospitalizations. However, the analysis shows that micro-level dimensions, i.e. individual needs and predisposing and enabling population characteristics, and macro level factors, i.e. health care system and welfare regime, interact to determine people's use of health services. It can be concluded that people with more education level have more resources (cognitive, communicative, relational) that allow them to make more informed choices and take more effective actions for their health goals, however, the institutional context may modify this relationship.

Tur-Sinai, A., et al. (2015). Forgone visits to the doctor due to cost or lengthy waiting time among older adults in Europe. Ageing in Europe - Supporting Policies for an Inclusive Society., Berlin : Degruyter**:** 291-300.
http://www.degruyter.com/view/product/462442

Close to five per cent of older Europeans forwent a visit to the doctor in the previous year due to its cost. More than six per cent did without such visits because of lengthy waiting time. Forgone healthcare is related to one's sociodemographic background, social networks, health and financial situation. Forgone healthcare is related, first and foremost, to having limited financial means.

Vilaplana Prieto, C. et Jiménez-Martín, S. (2015). "Unmet needs in formal care: kindling the spark for caregiving behavior." Int J Health Econ Manag **15**(2): 153-184.
http://link.springer.com/article/10.1007%2Fs10754-015-9161-5

This paper studies if a situation of formal care unmet needs is a strong motivation for the onset of caregiving behavior, and if becoming caregiving is a compelling argument for leaving current job (in the presence/absence of formal care unmet needs). We use data from the Eurobarometer 67.3 for 18 European countries and estimate a three simultaneous equations model taking into account the potential endogeneity of labor participation and formal care unmet needs and assuming non-zero correlation among the error terms of the three equations. Results show that individuals who anticipate that becoming caregiver can suppose an obstacle for continuing working feel more refractory and are more prone to avoid caregiving responsibilities. Knowing someone with an unmet needs problem increases the probability of becoming caregiver by +19.23 pp (with a maximum of +39.39 pp for difficult access unmet needs) and raises the probability of leaving employment by 5.77 pp. Having to possibility of receiving economic benefits for caregivers encourage more labor market exit as compared to payment of social security contributions during care leaves.

2014

Campbell, D. J. T., et al. (2014). "Obstacles financiers à l'obtention de soins déclarés chez les patients atteints de maladies chroniques d'origine cardiovasculaire." Rapports Sur La Sante **25**(5): 13 , tabl., fig.
http://www.statcan.gc.ca/pub/82-003-x/2014005/article/14005-fra.pdf

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.

Garcia-Gomez, P., et al. (2014). Inequity in long-term care use and unmet need: two sides of the same coin. HEDG Working Paper 14/02. York HEDG**:** 37 , tabl.
http://eprints.lse.ac.uk/55429/

International studies have shown evidence on inequity in use of health services of different kinds, depending on the type of health care service analysed. However, equity in the access to long-term care (LTC) services has received much less attention. We investigate the determinants of several LTC services and the existence of unmet need by the disabled population using unique data from a survey conducted on the disabled population in Spain in 2008. We further measure the level of horizontal inequity using methods based on the Concentration Index, a widely used indicator of income-related inequality in health. At the time of the analysis, only those respondents with the highest dependency level were covered by the recently introduced universal LTC system, which allows us to explore whether inequities remain for this subgroup of the population. In addition, we compare results using self-reported versus a more objective indicator of unmet needs. Evidence suggests that after controlling for a wide set of need variables, there is not an equitable distribution of use and unmet need of LTC services in Spain, with socioeconomic status being an important factor in access to LTC. We find that individuals at the higher end of the income distribution utilize a relatively larger share of formal services (provided by a professional), while intensive informal care (provided by friends and family) is concentrated among the worst-off. In terms of unmet needs for LTC services, their distribution depends on the service considered as well as on whether we focus on subjective or objective measures. Interestingly, for the population covered by the new universal LTC system, inequities in most LTC services and unmet needs remain statistically significant and even increase for certain services, in particular, formal services provided by professionals.

Hauff, A. J. et Secor-Turner, M. (2014). "Homeless health needs: shelter and health service provider perspective." J Community Health Nurs **31**(2): 103-117.

The effects of homelessness on health are well documented, although less is known about the challenges of health care delivery from the perspective of service providers. Using data from a larger health needs assessment, the purpose of this study was to describe homeless health care needs and barriers to access utilizing qualitative data collected from shelter staff (n = 10) and health service staff (n = 14). Shelter staff members described many unmet health needs and barriers to health care access, and discussed needs for other supportive services in the area. Health service providers also described multiple health and service needs, and the need for a recuperative care setting for this population. Although a variety of resources are currently available for homeless health service delivery, barriers to access and gaps in care still exist. Recommendations for program planning are discussed and examined in the context of contributing factors and health care reform.

Herr, M., et al. (2014). "Unmet health care needs of older people: prevalence and predictors in a French cross-sectional survey." Eur J Public Health **24**(5): 808-813.

BACKGROUND: Unmet health care needs are associated with negative health outcomes, yet there is a paucity of data on this problem among older people. OBJECTIVE: To identify unmet health care needs and associated factors among older people in France. METHODS: This is a cross-sectional population study of people aged 70 years or older in which 2350 respondents were interviewed in 2008-10. During a standardized interview, a nurse examined health problems, functional abilities and use of health care resources. Unmet health care needs were defined as situations in which a participant needed health care and did not receive it. RESULTS: The mean age was 83.2 +/- 7.4 years. Almost all participants reporting a chronic disease (98.6%) had consulted a physician in the previous 6 months. Unmet health care needs were found in 23.0% of the sample and mainly consisted of lack of dental care (prevalence of 17.7%), followed by lack of management of visual or hearing impairments (prevalence of 4.4% and 3.1%, respectively). Age was the main factor associated with unmet health care needs [compared with people aged 70-79: odds ratio80-89 years = 2.26 (1.70-3.03), odds ratio90 years and over = 3.85 (2.71-5.45)]. Other associated factors were regular smoking, homebound status, poor socioeconomic conditions, depression, limitations in instrumental activities of daily living and low medical density. CONCLUSION: Unmet health care needs affect almost one-quarter of older people in France. Efforts should be made to improve oral health and develop home care, especially for the oldest-olds

Horner-Johnson, W. et Dobbertin, K. (2014). "Usual source of care and unmet health care needs: interaction of disability with race and ethnicity." Med Care **52**(10 Suppl 3): S40-50.

BACKGROUND: Having a usual source of care (USC) and having unmet health care needs have been found to vary in relation to sociodemographic differences in the US population, including race, ethnicity, and disability status. People in underserved racial and ethnic groups who also have a disability may experience a complex mix of health care advantages and disparities. However, little is known about this intersection. OBJECTIVE: To determine how disability status, combined with membership in an underserved racial or ethnic group, is associated with having a USC and unmet health care needs. METHODS: We conducted multivariate regression analyses of 2002-2010 data from the Medical Expenditure Panel Survey, focused on working age adults (18-64 y). RESULTS: Although most racial and ethnic groups were less likely to have a USC than non-Hispanic whites, people with disabilities were more likely to have a USC; Hispanics with basic activity limitations were the only disability group with elevated odds of lacking a USC. Conversely, disability was strongly associated with unmet health care needs, but we did not find inflated impacts of both having a disability and belonging to an underserved racial or ethnic group. CONCLUSIONS: We found limited evidence of interaction or additive effects of disability and race/ethnicity but did confirm separate disparities for each. Ongoing research is needed to track both disability-related and racial/ethnic disparities, to determine whether increased insurance coverage, provider training, care coordination, and other efforts under the Affordable Care Act lead to reductions in disparities.

Horner-Johnson, W., et al. (2014). "Disparities in health care access and receipt of preventive services by disability type: analysis of the medical expenditure panel survey." Health Serv Res **49**(6): 1980-1999.

OBJECTIVE: To examine differences in access to health care and receipt of clinical preventive services by type of disability among working-age adults with disabilities. DATA SOURCE: Secondary analysis of Medical Expenditure Panel Survey (MEPS) data from 2002 to 2008. STUDY DESIGN: We conducted cross-sectional logistic regression analyses comparing people with different types of disabilities on health insurance status and type; presence of a usual source of health care; delayed or forgone care; and receipt of dental checkups and cancer screening. DATA COLLECTION: We pooled annualized MEPS data files across years. Our analytic sample consisted of adults (18-64 years) with physical, sensory, or cognitive disabilities and nonmissing data for all variables of interest. PRINCIPAL FINDINGS: Individuals with hearing impairment had better health care access and receipt than people with other disability types. People with multiple types of limitations were especially likely to have health care access problems and unmet health care needs. CONCLUSIONS: There are differences in health care access and receipt of preventive care depending on what type of disability people have. More in-depth research is needed to identify specific causes of these disparities and assess interventions to address health care barriers for particular disability groups.

Huang, J., et al. (2014). "Job loss and unmet health care needs in the economic recession: different associations by family income." Am J Public Health **104**(11): e178-183.

OBJECTIVES: We examined heterogeneous associations between job loss and unmet health care needs by family income level in the recent economic recession. METHODS: We conducted logistic regression analyses with the sample from the 2008 Survey of Income and Program Participation (n = 12,658). Dependent variables were 2 dichotomous measures of unmet health care needs in medical and dental services. The primary independent variables were a dummy indicator of job loss during a 2-year period and the family income-to-needs ratio. We used an interaction term between job loss and the family income-to-needs ratio to test the proposed research question. RESULTS: Job loss was significantly associated with the increased risk of unmet health care needs. The proportion with unmet needs was highest for the lowest-income unemployed, but the association between job loss and health hardship was stronger for the middle- and higher-income unemployed. CONCLUSIONS: The unemployed experience health hardship differently by income level. A comprehensive coordination of applications for unemployment and health insurance should be considered to protect the unemployed from health hardship.

Karaca-Mandic, P., et al. (2014). "Family out-of-pocket health care burden and children's unmet needs or delayed health care." Academic Pediatrics **14**(1): 101-108.

OBJECTIVE : To assess the relationship between family members' out-of-pocket (OOP) health care spending and unmet needs or delayed health care due to cost for children with and without special health care needs (SHCN).METHODS : Data come from the Medical Expenditure Panel Survey, 2002-2009, and include 63,462 observations representing 41,748 unique children. The primary outcome was having any unmet needs/delayed care as a result of the cost of medical care, dental care, or prescription drugs. We also examined having unmet needs/delayed care due to cost for each service separately. Key explanatory variables were OOP spending on the index child and OOP spending on other family members. We estimated multivariate instrumental variable models to adjust the results for potential bias from any unobserved factors that might influence both other family OOP costs and the outcome variable.

Kiil, A. et Houlberg, K. (2014). "How does copayment for health care services affect demand, health and redistribution? A systematic review of the empirical evidence from 1990 to 2011." Eur J Health Econ **15**(8): 813-828.

This article reviews the quantitative evidence on the behavioural effects of copayment within the health area across a wide range of countries. The review distinguishes itself from previous similar reviews by having a high degree of transparency for the search strategy used to identify the studies included in the review as well as the criteria for inclusion and by including the most recent literature. Empirical studies were identified by performing searches in EconLit. The literature search identified a total of 47 studies of the behavioural effects of copayment. Considering the demand effects, the majority of the reviewed studies found that copayment reduces the use of prescription medicine, consultations with general practitioners and specialists, and ambulatory care, respectively. The literature found no significant effects of copayment on the prevalence of hospitalisations. The empirical evidence on whether copayment for some services, but not for others, causes substitution from the services that are subject to copayment to the 'free' services rather than lower total use is sparse and mixed. Likewise, the health effects of copayment have only been analysed empirically in a limited number of studies, of which half did not find any significant effects in the short term. Finally, the empirical evidence on the distributional consequences of copayment indicates that individuals with low income and in particular need of care generally reduce their use relatively more than the remaining population in consequence of copayment. Hence, it is clear that copayment involves some important economic and political trade-offs.

Lee, S.-Y., Kim, C.-W., Kang, J.-H., et al. (2015). "Unmet healthcare needs depending on employment status."

Health Policy **119**(7): 899-906.

OBJECTIVES: The purpose of study is to find relevance between unmet healthcare needs and employment status and if factors have relevance to unmet healthcare needs due to "economic burden" and "no time to spare". METHODS: The study conducted a survey of 9163 respondents who said they needed a medical treatment or checkup were asked why the need for care was unmet. RESULTS: 22.9% of the respondents said they did not receive a medical treatment or checkup they needed at least once. The rate of unmet healthcare needs caused by "economic burden" was higher among temporary workers (ORs=2.13), day workers (ORs=1.92). However, the rate of unmet needs due to "no time to spare" was lower for temporary workers (ORs=.58) than for regular workers, studies (ORs=.33), housework (ORs=.26), early retirement (ORs=.19) and disease or injury (ORs=.07). CONCLUSION: Non-regular waged workers were more likely to have an unmet need for healthcare due to "economic burden" than regular waged workers. On the other hand, regular waged workers were less likely to receive necessary healthcare services due to "no time to spare" than non-regular waged workers and economically inactive people.

2013

(2013). "Etat de santé, renoncement aux soins et pauvreté : Enquête sur les revenus et les conditions de vie (SILC) 2011." Actualités OFS Sant,(14).

Les personnes en situation de risque de pauvreté ou de privation matérielle déclarent plus souvent que les autres un état de santé qui n'est pas bon et elles sont plus nombreuses à renoncer à des soins pour des raisons financières. Celles qui renoncent à des soins pour raison financière sont aussi en moins bonne santé. Ces résultats ressortent des données 2011 de l'enquête sur les revenus et les conditions de vie (SILC) des ménages en Suisse [OFS]

Bien, B., et al. (2013). "Disabled older people' use of health and social care services and their unmet care needs in six European countries." The European Journal of Public Health **23**(6): 1032-1038.
http://eurpub.oxfordjournals.org/content/23/6/1032.abstract

Backkground: The national health and social care systems in Europe remain poorly integrated with regard to the care needs of older persons. The present study examined the range of health and social care services used by older people and their unmet care needs, across six European countries. Methods: Family carers of older people were recruited in six countries via a standard protocol. Those providing care for disabled older people (n = 2629) provided data on the older persons' service use over a 6-month period, and their current unmet care needs. An inventory of 21 services common to all six countries was developed. Analyses considered the relationship between older peoples' service use and unmet care needs across countries. Results: Older people in Greece, Italy and Poland used mostly health-oriented services, used fewer services overall and also demonstrated a higher level of unmet care needs when compared with the other countries. Older people in the United Kingdom, Germany and Sweden used a more balanced profile of socio-medical services. A negative relationship was found between the number of different services used and the number of different areas of unmet care needs across countries. Conclusions: Unmet care needs in older people are particularly high in European countries where social service use is low, and where there is a lack of balance in the use of health and social care services. An expansion of social care services in these countries might be the most effective strategy for reducing unmet needs in disabled older people

Cavalieri, M. (2013). "Geographical variation of unmet medical needs in Italy: a multivariate logistic regression analysis." Int J Health Geogr **12**: 27.

BACKGROUND: Unmet health needs should be, in theory, a minor issue in Italy where a publicly funded and universally accessible health system exists. This, however, does not seem to be the case. Moreover, in the last two decades responsibilities for health care have been progressively decentralized to regional governments, which have differently organized health service delivery within their territories. Regional decision-making has affected the use of health care services, further increasing the existing geographical disparities in the access to care across the country. This study aims at comparing self-perceived unmet needs across Italian regions and assessing how the reported reasons - grouped into the categories of availability, accessibility and acceptability - vary geographically. METHODS: Data from the 2006 Italian component of the European Union Statistics on Income and Living Conditions are employed to explore reasons and predictors of self-reported unmet medical needs among 45,175 Italian respondents aged 18 and over. Multivariate logistic regression models are used to determine adjusted rates for overall unmet medical needs and for each of the three categories of reasons. RESULTS: Results show that, overall, 6.9% of the Italian population stated having experienced at least one unmet medical need during the last 12 months. The unadjusted rates vary markedly across regions, thus resulting in a clear-cut north-south divide (4.6% in the North-East vs. 10.6% in the South). Among those reporting unmet medical needs, the leading reason was problems of accessibility related to cost or transportation (45.5%), followed by acceptability (26.4%) and availability due to the presence of too long waiting lists (21.4%). In the South, more than one out of two individuals with an unmet need refrained from seeing a physician due to economic reasons. In the northern regions, working and family responsibilities contribute relatively more to the underutilization of medical services. Logistic regression results suggest that some population groups are more vulnerable than others to experiencing unmet health needs and to reporting some categories of reasons. Adjusting for the predictors resulted in very few changes in the rank order of macro-area rates. CONCLUSIONS: Policies to address unmet health care needs should adopt a multidimensional approach and be tailored so as to consider such geographical heterogeneities.

Fronstin, P. (2013). "Use of Health Care Services and Access Issues by Type of Health Plan: Findings from the EBRI/MGA Consumer Engagement in Health Care Survey." Ebri Notes **34**(6).
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2286764

This paper examines the impact of plan type, medical homes, and income on use of health care services. It also examines differences in the use of health services within the CDHP population. Data from the 2005-2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey and the 2008-2012 EBRI/MGA Consumer Engagement in Health Care Survey are used for the analysis. In 2012, 26-40 percent of respondents reported some type of access-to-health-care issue for either themselves or family members. Individuals in consumer-driven health plans (CDHPs) and high-deductible health plans (HDHPs) were more likely than individuals with traditional coverage to report access issues. Findings from the survey indicate that individuals in HDHPs were more likely than individuals with traditional coverage to report that they or family members did not fill prescriptions or skipped doses to make the medication last longer or that they delayed or avoided getting health care due to cost. Overall, 40 percent of those in an HDHP reported some type of access issue, compared with 26 percent among those with traditional coverage. Nearly 4 in 10 (38 percent) of those with a CDHP reported some type of access issue, statistically higher than those with traditional coverage. Individuals in households with less than $50,000 in annual income were more likely than those in households with $50,000 or more in annual income to report access issues. Very few differences in access issues were found by whether employers contributed to the account, but access issues were found by the level of contribution. Length of time with the account had an impact on access issues, with 2012 being the first year where it was found that more years with the account were more likely to be associated with access issues. Overall, individuals in HDHPs and CDHPs were more likely than those with traditional coverage to report access issues, both for those with and without medical homes

Fulda, K. G., et al. (2013). "Do unmet needs differ geographically for children with special health care needs?" Matern Child Health J **17**(3): 505-511.

The purpose of this study was to identify geographic differences in health indicators for children with special health care needs (CSHCN). It was hypothesized that geographic differences in unmet health care needs exist among CSHCN by region in the United States. Data were obtained from the National

Survey of Children with Special Health Care Needs, 2005-2006. Nine variables representing unmet needs were analyzed by geographic region. The region with the highest percent of unmet needs was identified for each service. Logistic regression was utilized to determine differences by region after controlling for age, gender, ethnicity, race, federal poverty level, relationship of responder to child, insurance status, severity of condition, and size of household. A total of 40,723 CSHCN were represented. Crude analysis demonstrated that the greatest unmet need for routine preventive care, specialist care, prescription medications, physical/occupational/speech therapy, mental health care, and genetic counseling occurred in the West. The greatest unmet need for preventive dental care, respite care, and vision care occurred in the South. Significant differences between regions remained for six of the nine services after controlling for potential confounders. Geographic differences in unmet health care needs exist for CSHCN. Further delving into these differences provides valuable information for program and policy planning and development. Meeting the needs of CSHCN is important to reduce cost burden and improve quality of life for the affected child and care providers.

Henning-Smith, C., et al. (2013). "Delayed and unmet need for medical care among publicly insured adults with disabilities." Medical Care **51**(11): 1015-1019.

BACKGROUND : While Medicaid is an important source of insurance coverage for persons with disabilities, barriers remain to accessing care for this population. OBJECTIVES : This study addresses 3 research questions: (1) do adults with disabilities experience greater unmet need/delayed care?; (2) do barriers related to cost, providers, or structure vary by disability status?; and (3) do barriers mediate the relationship between disability and access to care? RESEARCH DESIGN : Data were obtained from a 2008 stratified random sample of Minnesota Health Care Program's nonelderly adult enrollees (n=1880). The survey was administered by mail, with a telephone follow-up for nonresponders. MEASURES : Disability is defined by self-report. Access to care is measured by reported delayed and unmet need for medical care within the past year. Respondents were asked about their experiences with a variety of cost-related, provider-related, and structural barriers to care. RESULTS : Respondents with a disability were more likely to experience delayed (40%) and unmet need (23%) for medical care than persons without disabilities (24% and 10%, respectively). Persons with disabilities also reported multiple barriers to health care, especially structural barriers, such as making a timely appointment and accessing transportation (74% vs. 59%). The greater likelihood of facing a structural barrier partially explained increased risk of delayed or unmet care among adults with disabilities. CONCLUSIONS : Disparities in access to health care based on disability status remain even for persons who have insurance. These disparities deserve further research and policy attention to better address the particular needs of this population.

Jusot, F. (2013). "[Inequalities in access to care and their evolution: A review]." Rev Epidemiol Sante Publique **61 Suppl 3**: S163-S169.

Tackling health inequalities is one of the main public health goals, and equity of access to care is a necessary condition to achieve this objective. Analyzing and assessing inequalities in health care use is therefore essential in order to enlighten public health policies. This article proposes a review on inequalities in access to care in France and OECD countries, their causes and their evolution. During the last decades, inequalities in health care expenditure have decreased in France with diffusion of complementary insurance, due in particular to the CMU-C implementation in 2000, but they are still significant. The reduction of inequalities is particularly important for GP use, for which we observe now pro-poor inequities. However, there are persistent and important inequalities in access to specialist care, as well as in preventive care. Therefore, France is still one of the European countries with the highest level of inequities in access to care

Pappa, E., et al. (2013). "Investigating unmet health needs in primary health care services in a representative sample of the Greek population." Int J Environ Res Public Health **10**(5): 2017-2027.

Unmet health care needs are determined as the difference between the services judged necessary and the services actually received, and stem from barriers related to accessibility, availability and acceptability. This study aims to examine the prevalence of unmet needs and to identify the socioeconomic and health status factors that are associated with unmet needs. A cross-sectional study was conducted in Greece in 2010 and involved data from 1,000 consenting subjects (>18 years old). Multiple binary logistic regression analysis was applied to investigate the predictors of unmet needs and to determine the relation between the socio-demographic characteristics and the accessibility, availability and acceptability barriers. Ninety nine participants (9.9%) reported unmet health needs during the 12 months prior to the research. The most frequently self-reported reasons were cost and lack of time. Youth, parenthood, physician consultations, and poor mental health increased the likelihood of unmet needs. Women were less likely to report accessibility and availability than acceptability barriers. Educational differences were evident and individuals with primary and secondary education were associated with significantly more accessibility and availability barriers compared with those with tertiary education. Unmet health needs pose a significant challenge to the health care system, especially given the difficult current financial situation in Greece. It is believed that unmet health needs will continue to increase, which will widen inequalities in health and health care access.

Ronksley, P. E., et al. (2013). "Association between perceived unmet health care needs and risk of adverse health outcomes among patients with chronic medical conditions." Open Med **7**(1): e21-30.

BACKGROUND: Adults with chronic medical conditions are more likely to report unmet health care needs. Whether unmet health care needs are associated with an increased risk of adverse health outcomes is unclear. METHODS: Adults with at least one self-reported chronic condition (arthritis, chronic obstructive pulmonary disease, diabetes mellitus, heart disease, hypertension, mood disorder, stroke) from the 2001 and 2003 cycles of the Canadian Community Health Survey were linked to national hospitalization data. Participants were followed from the date of their survey until March 31, 2005, for the primary outcomes of all-cause and cause-specific admission to hospital. Secondary outcomes included length of stay, 30-day and 1-year all-cause readmission to hospital, and in-hospital death. Negative binomial regression models were used to estimate the association between unmet health care needs, admission to hospital, and length of stay, with adjustment for socio-demographic variables, health behaviours, and health status. Logistic regression was used to estimate the association between unmet needs, readmission, and in-hospital death. Further analyses were conducted by type of unmet need. RESULTS: Of the 51 932 adults with self-reported chronic disease, 15.5% reported an unmet health care need. Participants with unmet health care needs had a risk of all-cause admission to hospital similar to that of patients with no unmet needs (adjusted rate ratio [RR] 1.04, 95% confidence interval [CI] 0.94-1.15). When stratified by type of need, participants who reported issues of limited resource availability had a slightly higher risk of hospital admission (RR 1.18, 95% CI 1.09-1.28). There was no association between unmet needs and length of stay, readmission, or in-hospital death. INTERPRETATION: Overall, unmet health care needs were not associated with an increased risk of admission to hospital among those with chronic conditions. However, certain types of unmet needs may be associated with higher or lower risk. Whether unmet needs are associated with other measures of resource use remains to be determined.

Vikum, E., et al. (2013). "Socio-economic inequalities in Norwegian health care utilization over 3 decades: the HUNT Study." The European Journal of Public Health **23**(6): 1003-1010.

Background: The aim of this study was to investigate socio-economic inequalities in health care utilization from the 1980s and through the last 3 decades in a Norwegian county population. Methods: Altogether, 166 758 observations of 97 251 individuals during surveys in 1984â€“86 (83% eligible responses), 1995â€“97 (51% eligible responses) and 2006â€“08 (50% eligible responses) of the total population of adults (â‰¥20 years) from Nord-Tr+¸ndelag county in Norway were included. Health care utilization was measured as at least one visit to general practitioner (GP), hospital outpatient services and inpatient care in the past year. Socio-economy was measured by both education and income and rescaled to measure relative indexes of inequality (RII). Relative and absolute inequalities were estimated from multilevel logistic regression. Estimates were adjusted for age, sex, municipality size and self-reported health. Results: GP utilization was higher among individuals with higher education in 1984â€“86. Among men the RII was 0.54 (CI: 0.48â€“0.62), and among women RII was 0.67 (CI: 0.58â€“0.77). In 2006â€“08, the corresponding RII was 1.31 (CI: 1.13â€“1.52) for men and 1.00 (CI: 0.85â€“1.18) for women, indicating higher or equal GP utilization among those with lower education, respectively. The corresponding RIIs for outpatient consultations were 0.58 (CI: 0.49â€“0.68) for men and 0.40 (CI: 0.34â€“0.46) for women in 1984â€“86, and 0.53 (CI: 0.46â€“0.62) for men and 0.47 (CI: 0.41â€“0.53) for women in 2006â€“08. Conclusion: Through the last 3 decades, the previous socio-economic differences in GP utilization have diminished. Despite this, highly educated people were more prone to utilize hospital outpatient consultations throughout the period 1984â€“2008

2012

Kossioni, A. E. (2012). "Is Europe prepared to meet the oral health needs of older people?" Gerodontology **29**(2): e1230-1240.

OBJECTIVE: To discuss the preparedness of the social and health care systems and the health workforce in Europe to manage the increasing general and oral health care needs of older adults. BACKGROUND AND DISCUSSION: There are large inequalities across European countries and regions in the demographic, socioeconomic and health status of the elderly. The ageing of the population and the economic crisis put at risk the existing social and health care systems and are expected to further widen the existing inequalities. Despite the increase in funding for the general health care, public funding for dental care has reduced, limiting the access for the disadvantaged elderly. Dental care is isolated from health care policies and funding. At the same time there is a significant shortage of adequately trained personnel in the care of the elderly and a shortage of training opportunities particularly at a postgraduate and continuing education level. CONCLUSION: Immediate action is needed and appropriate strategies need to be implemented. Oral health prevention, delivery policies and funding should be integrated within the general health care system. Clinical protocols and guidelines need to be developed on the oral care of the elderly. Interdisciplinary training in the care of the elderly needs to be implemented for all health care workers (dentists, physicians, nurses, health care aids, social workers) at all education levels to enhance comprehensive care.

Ronksley, P. E., et al. (2012). "Association between chronic conditions and perceived unmet health care needs." Open Med **6**(2): e48-58.

BACKGROUND: Although effective treatments exist, many Canadians with chronic medical conditions do not receive the full care they require, possibly as a consequence of limited accessibility or availability. A commonly used indicator of inadequate access to or availability of care is the perception of unmet health care needs. The objective of this study was therefore to determine the association between chronic conditions and perceived unmet health care needs. METHODS: We extracted data for adult respondents from the combined 2001, 2003 and 2005 cross-sectional cycles of the Canadian Community Health Survey. Multivariate logistic regression was used to estimate the association between 7 high-prevalence and high-impact chronic conditions (arthritis, chronic obstructive pulmonary disease/emphysema, diabetes, heart disease, hypertension, mood disorder and stroke) and perceived unmet health care needs in the prior 12 months, adjusting for sociodemographic variables, health behaviours, health status and survey cycle. RESULTS: Of the 360 105 adult respondents, 12.2% reported an unmet health care need. Compared with those without chronic conditions, respondents with at least one condition were more likely to report an unmet need (adjusted odds ratio [OR] 1.51, 95% confidence interval [CI] 1.45-1.59). Those with mood disorders were almost twice as likely to report an unmet need (OR 1.94, 95% CI 1.78-2.12), while those with diabetes or hypertension were less likely to report an unmet need (diabetes OR 0.85, 95% CI 0.76-0.94; hypertension OR 0.96, 95% CI 0.89-1.04). Furthermore, the likelihood of an unmet need increased with the number of chronic conditions (OR 1.71, 95% CI 1.56-1.88 for 3 or more conditions). Respondents with chronic conditions were more likely than those without to report an unmet need related to resource availability (OR 1.14, 95% CI 1.06-1.22). INTERPRETATION: Adults with chronic medical conditions are more likely to report an unmet health care need, and the likelihood increases with an increasing number of conditions. Whether these unmet needs are associated with worse outcomes, and whether interventions targeted to address these needs may improve outcomes for Canadians with chronic disease, remain to be determined.

Waldman, H. B., et al. (2012). "Many people unable to obtain dental care due to cost." N Y State Dent J **78**(6): 46-48.

While overall spending for dental services appears to be favorable during the period after the last recession, a review of a series of government and private agency reports indicates an increasing proportion of the population is unable to secure needed services due to cost factors. In addition, projections for annual increases in future spending for dental services are lower than for other professional health services.

Walsh, B., et al. (2012). "The role of private medical insurance in socio-economic inequalities in cancer screening uptake in ireland." Health Econ **21**(10): 1250-1256.
http://onlinelibrary.wiley.com/doi/10.1002/hec.1784/abstract

Screening is seen by many as a key element in cancer control strategies. Differences in uptake of screening related to socio-economic status exist and may contribute to differences in morbidity and mortality across socio-economic groups. Although a number of factors are likely to underlie differential uptake, differential access to subsequent diagnostic tests and/or treatment may have a pivotal role. This study examines differences in the uptake of cancer screening in Ireland related to socio-economic status. Data were extracted from SLAN 2007 concerning uptake of breast, cervical, colorectal and prostate cancer screening in the preceding 12 months. Concentration indices were calculated and decomposed. Particular emphasis was placed in the decomposition upon the impact of private health insurance, evidenced in other work to impact on access to care within the mixed public-private Irish health system. This study found that significant differences related to socio-economic status exist with respect to uptake of cancer screening and that the main determinant of difference for breast, colorectal and prostate cancer screening was possession of private insurance. This may have profound implications for the design of cancer control strategies in countries where private insurance has a significant role, even where screening services are publicly funded and population based. Copyright (c) 2011 John Wiley & Sons, Ltd

Wisk, L. E. et Witt, W. P. (2012). "Predictors of delayed or forgone needed health care for families with children." Pediatrics **130**(6): 1027-1037.

BACKGROUND: We sought to determine how health care-related financial burden, childhood activity limitations, health insurance, and other access-related factors predict delayed or forgone care for families with children, using a nationally representative, population-based sample. METHODS: Our sample included families with children aged 0 to 17 years whose family was interviewed about their health care expenditures in 1 of 7 panels of the 2001 to 2008 Medial Expenditure Panel Survey (N = 14 138). Financial burden was defined as (1) the sum of out-of-pocket health service expenditures during the first survey year and (2) that sum divided by adjusted family income. Delayed or forgone care was defined as self-report of delayed or forgone medical care or prescription medications for the reference parent or child during the second survey year. RESULTS: Financial burden, discordant insurance, and having a child with an activity limitation were some of the strongest predictors of delayed or forgone care. Additionally, significant health insurance and income-related disparities exist in the experience of delayed or forgone care. CONCLUSIONS: Children and their families are delaying or forgoing needed care due to health care-related financial burden. Policies are needed to effectively reduce financial burden and improve the concordance of insurance between parents and children because this may reduce the frequency of unmet need among families. Moreover, reducing the occurrence of delayed or forgone care may improve health outcomes by increasing the opportunity to receive timely and preventive care.

2011

(2011). Migrants in an irregular situation: Access to healthcare in 10 European Union Member States. Vienne European Union Agency for Fundamental Rights**:** 64 , tabl., annexes.
http://fra.europa.eu/fraWebsite/attachments/FRA-2011-fundamental-rights-for-irregular-migrants-healthcare_EN.pdf

Migrants in an irregular situation in the European Union (EU), namely those who do not fulfil conditions for entry, stay or residence, often suffer from specific health risks, such as those resulting from exploitative working conditions or precarious housing. As EU Member States, faced with an ageing population and the repercussions of a global economic crisis, struggle to contain public health expenditure, the right to health for all ? regardless of legal status ? must remain a key concern. This report of the European Union Agency for Fundamental Rights (FRA) documents the legal, economic and practical obstacles that migrants in an irregular situation face in accessing healthcare in 10 EU Member States and proposes a number of ways to improve this access. The FRA found in particular that the risk of detection and deportation prevents migrants in an irregular situation from seeking healthcare, even in those countries where it is legally available, and suggests, among other improvements, disconnecting healthcare from immigration control policies.

Hurley, J., et al. (2011). The Relationship between Self-reported Unmet Need for Health Care and Health Care Utilization. RDC Research Paper ; 23. Hamilton McMaster Research Data Centre**:** 35 , tabl., fig.
http://socserv.mcmaster.ca/rdc/RDCwp23.pdf

This study builds on the work of Allin, Grignon, and Le Grand (2008) to investigate the relationship between self-reported unmet need and a variety of measures of health care utilization. It exploits a linked Ontario Canadian Community Health Survey-administrative data that includes individual-level information on self-reported unmet needs and a person?s actual use of physician and hospital services, which permits a number of improvements over existing research. It measures utilization using the dollar value of services received, which: provides a more accurate measure of volume of care obtained (because it is not subject to recall error and because it adjusts for the nature of the services received); allows us to combine general practitioner, specialist physician services and hospital services to examine the relationship between unmet need and total service use; and allows us to study both inpatient services and day procedures, the latter of which constitute an increasing proportion of hospital utilization (CIHI 2007).

Setia, M. S., et al. (2011). "Access to health-care in Canadian immigrants: a longitudinal study of the National Population Health Survey." Health Soc Care Community **19**(1): 70-79.

Immigrants often lose their health advantage as they start adapting to the ways of the new society. Having access to care when it is needed is one way that individuals can maintain their health. We assessed the healthcare access in Canadian immigrants and the socioeconomic factors associated with access over a 12-year period. We compared two measures of healthcare access (having a regular doctor and reporting an unmet healthcare need in the past 12 months) among immigrants and Canadian-born men and women, aged more than 18 years. We applied a logistic random effects model to evaluate these outcomes separately, in 3081 males and 4187 females from the National Population Health Survey (1994-2006). Adjusting for all covariates, immigrant men and women (white and non-white) had similar odds of having a regular doctor than the Canadian-born individuals (white immigrants: males OR: 1.32, 95% C.I.: 0.89-1.94, females OR: 1.14, 95% C.I.: 0.78-1.66; non-white immigrants: males OR: 1.28, 95% C.I.: 0.73-2.23, females OR: 1.23, 95% C.I.: 0.64-2.36). Interestingly, non-white immigrant women had significantly fewer unmet health needs (OR: 0.32, 95% C.I.: 0.17-0.59). Among immigrants, time since immigration was associated with having access to a regular doctor (OR per year: 1.02, 95% C.I.: 1.00-1.04). Visible minority female immigrants were least likely to report an unmet healthcare need. In general, there is little evidence that immigrants have worse access to health-care than the Canadian-born population.

2010

Allin, S., et al. (2010). "Subjective unmet need and utilization of health care services in Canada : what are the equity implications ?" Social Science & Medicine **70**(3): 465-472.

This study aimed to evaluate whether subjective assessments of unmet need may complement conventional methods of measuring socioeconomic inequity in health care utilization. This study draws on the 2003 Canadian Community Health Survey to develop a conceptual framework for understanding how unmet need arises, to empirically assess the association between utilization and the different types of unmet need (due to waiting times, barriers and personal reasons), and to investigate the effect of adjusting for unmet need on estimates of income-related inequity. The study?s findings suggest that a disaggregated approach to analyzing unmet need is required, since the three different subgroups of unmet need that we identify in Canada have different associations with utilization, along with different equity implications. People who report unmet need due to waiting times use more health services than would be expected based on their observable characteristics. However, there is no consistent pattern of utilization among people who report unmet need due to access barriers, or for reasons related to personal choice. Estimates of inequity remain unchanged when we incorporate information on unmet need in the analysis. Subjective assessments of unmet need, namely those that relate to barriers to access, provide additional policy-relevant information that can be used to complement conventional methods of measuring inequity, to better understand inequity, and to guide policy action.

Baggett, T. P., et al. (2010). "The unmet health care needs of homeless adults: a national study." Am J Public Health **100**(7): 1326-1333.

OBJECTIVES: We assessed the prevalence and predictors of past-year unmet needs for 5 types of health care services in a national sample of homeless adults. METHODS: We analyzed data from 966 adult respondents to the 2003 Health Care for the Homeless User Survey, a sample representing more than 436,000 individuals nationally. Using multivariable logistic regression, we determined the independent predictors of each type of unmet need. RESULTS: Seventy-three percent of the respondents reported at least one unmet health need, including an inability to obtain needed medical or surgical care (32%), prescription medications (36%), mental health care (21%), eyeglasses (41%), and dental care (41%). In multivariable analyses, significant predictors of unmet needs included food insufficiency, out-of-home placement as a minor, vision impairment, and lack of health insurance. Individuals who had been employed in the past year were more likely than those who had not to be uninsured and to have unmet needs for medical care and prescription medications. CONCLUSIONS: This national sample of homeless adults reported substantial unmet needs for multiple types of health care. Expansion of health insurance may improve health care access for homeless adults, but addressing the unique challenges inherent to homelessness will also be required.

2009

Allin, S. et Masseria, C. (2009). Unmet need as an indicator of access to health care in Europe : Research Note, Londres : LSE

Ensuring adequate and fair access to health care is a priority objective for European governments. This short paper discusses the measurement, distribution and policy implications of one indicator of access to health care: self-reported unmet need or foregone care. Two international surveys : EU-SILC and SHARE, include questions on unmet need and foregone care respectively, and therefore provide an opportunity for drawing comparisons on access to health care. It appears that, overall, people who report unmet need tend to be in worse health and with lower income. However, from a policy perspective, it is important to separate the causes of unmet need into those that are more relevant to policymakers from those that reflect individuals? preferences and tastes, to view this indicator alongside other access measures such as health care contacts, distance to facilities, waiting times and supply characteristics, and to examine long-term trends in reporting unmet need and health outcomes.

Bryant, T., et al. (2009). "Unmet healthcare need, gender, and health inequalities in Canada." Health Policy **91**(1): 24-32.

Unmet healthcare need should be rare in nations with a universally accessible publicly funded healthcare system such as Canada. This however is not the case. This study examines the extent to which predictors of such need are consistent with various paradigmatic approaches (e.g., structural-critical, social capital, social support, and lifestyle) that consider such issues. Analyses of data from a probability sample of 2536 urban residents in British Columbia specified the relationship of unmet need with socioeconomic issues such as income, gender, and housing tenure, community issues such as social networks and social support, and traditional lifestyle or behavioural risk factors. The structural-critical model concerned with socio-demographics provided the most parsimonious explanation for having an unmet healthcare need. Consistent with a structural-critical approach, gender was found to be a reliable predictor of having an unmet health need in each of the models tested. Increasing federal transfers to healthcare and providing childcare and other community supports that are of special value for women may help to reduce unmet healthcare need.

Glazier, R. H. et Sibley, L. M. (2009). "Reasons for Self-Reported Unmet Healthcare Needs in Canada: A Population-Based Provincial Comparison." Healthcare Policy **5**(1): 87-101+ annexes, tabl.

Cette étude compare la perception de la population face aux besoins non comblés et évalue la variation des raisons qui mènent à cette perception- n (raisons liées à des problèmes de disponibilité, d'accessibilité et d'acceptabilité), entre les provinces canadiennes. Cette étude transversale s'appuie sur les données de l'Enquête sur la santé dans les collectivités canadiennes (2.1) effectuée en 2003. En général, 11,7 pour cent des répondants perçoivent avoir eu des besoins non comblés au cours des 12 mois précédents l'enquête. Les taux provinciaux ajustés varient entre 13,3 pour cent au Manitoba et 7,8 pour cent à l'Île-du-Prince-Édouard- . Parmi les besoins non comblés déclarés, les raisons principalement invoquées sont liées aux problèmes de disponibilité des services (54,9 pour cent), suivi de l'acceptabilité (42,8 pour cent) et de l'accessibilité en raison des coûts de transport (12,7 pour cent). Les besoins non comblés attribués à la disponibilité sont plus susceptibles d'avoir lieu au Québec, à Terre-Neuve et au Manitoba tandis que pour l'Alberta et la Colombie-Britannique, ce sont les besoins non comblés attribués à l'accessibilité qui sont le plus invoqués. Les résidents de la Colombie-Britannique, de la Saskatchewan et du Manitoba sont plus susceptibles d'invoquer des problèmes liés à l'acceptabilité. Les raisons invoquées pour signaler des besoins non comblés varient entre les provinces, et chacune d'entre elles a ses propres répercussions sur les politiques.

Guend, H. et Tesseron, A. L. (2009). Unmet needs for primary care in the context of a universal healthcare system. The case of Quebec. Inédits / Working Papers; 2009-04. Montréal INRS**:** 18 , tabl.

Même sous un régime d'assurance universelle, certaines personnes éprouvent des difficultés à accéder aux soins de santé primaires. Cette recherche identifie les facteurs individuels et sociaux qui contribuent à ces difficultés au Québec. Nous développons trois modèles de regressions logistiques pour tester la signifiance des associations des variables explicatives à la variable expliquée, par référence au modèle comportemental de l'accès aux soins de santé. La variable dépendante est dichotomique et rend compte de l'auto-déclaration concernant les besoins non comblés. Les résultats suggèrent que l'insatisfaction des besoins en soins de santé est associée aux variables relatives au besoin plutôt qu'aux variables relatives aux caractéristiques pré-disposantes ou à celles liées aux ressources. Le facteur géographique est aussi insignifiant sauf pour la région socio-sanitaire de Québec.

Levesque, J. F., et al. (2009). Unmet health care needs: a reflection of the accessibility of primary services?, Montréal : Agence de la santé et des services sociaux

In this thematic pamphlet, we present some results of a study entitled Accessibilité et continuité des services de santé -Une étude sur la première ligne au Québec(1), conducted in 2005 among more than 9000 people in Montréal and Montérégie. Our goal is to provide information concerning unmet health care needs and to analyse the initial implications. The concept of unmet needs refers to the difference between health services deemed necessary to treat a particular health problem and services actually received(2). A person who perceived the need to receive medical services?whether information from a health professional or a therapeutic procedure?but who has not obtained these services has unmet health care needs. To a certain extent, this reflects the lack of access to health services. The hypotheses raised in this document will be the subject of more thorough analyses, the results of which will be published at a later date. The first section gives an overall description of the phenomenon of unmet needs: its scope, the profile of individuals reporting having unmet needs, the nature of health problems for which unmet needs are reported, and the outcome for persons who are not obtaining services. We then examine the factors associated with experiencing unmet needs, and we conclude with a discussion on aspects related to health services organization.

2008

Communauté Européenne (2008). Quality in and Equality of Access to Healthcare Services. Bruxelles Commission européenne**:** 359 , tabl., ann.

This study reviews barriers of access to health care that persist in European Union countries and presents an analysis of what policies countries have adopted to mitigate these barriers. It has a focus on the situation of migrants, older people with functional limitations, and people with mental disorders. What are the barriers to accessing high quality health care for people at risk of social exclusion? What are the interdependencies between poverty, social exclusion and problems of accessing health care? What policies have EU Member States put in place to improve access and quality of health care for vulnerable groups of the population? The study is based on eight country reports: Finland, Germany, Greece, the Netherlands, Poland, Romania, Spain, and the United Kingdom. This was complemented with findings from the literature and European comparisons. Ensuring equitable access to high-quality healthcare constitutes a key challenge for health systems throughout Europe. Despite differences in health system size, structure and financing, evidence suggests that across Europe particular sections of the population are disproportionately affected by barriers to accessing healthcare. Studies have also shown that difficulties in accessing healthcare are compounded by poverty and social exclusion, and that poverty and social exclusion compound difficulties in accessing healthcare.

Vassiliou, A. (2008). "Research and innovation in pharmaceuticals : covering unmets needs." Eurohealth **14**(4): 1-3.

This text is an edited version of a speech given at the Sixth Biennial Health and Pharmaceuticals ummit. Innovation and Value in Health and Pharmaceutical Care, held in Athens, Greece on 24 November 2008.

2007

Ngui, E. M. et Flores, G. (2007). "Unmet needs for specialty, dental, mental, and allied health care among children with special health care needs: are there racial/ethnic disparities?" J Health Care Poor Underserved **18**(4): 931-949.

We examined racial/ethnic disparities in unmet specialty, dental, mental, and allied health care needs among children with special health care needs (CSHCN) using data on 38,866 children in the National

Survey of CSHCN. Compared with White CSHCN, Black CSHCN had significantly greater unmet specialty (9.6% vs. 6.7%), dental (16% vs. 8.7%), and mental (27% vs. 17%) health care needs. Hispanic CSHCN had greater unmet dental care needs (15.8% vs. 8.7%). Black females had greater unmet mental health care needs than other groups (41% vs. 13-20%). Most disparities disappeared after multivariate adjustment. Significant risk factors for unmet health care needs included uninsurance, having no personal doctor/nurse, poverty, and condition stability and severity. Eliminating unmet specialty, dental, and mental health care needs for all CSHCN, and especially minority CSHCN, may require greater efforts to reduce poverty and increase insurance coverage among CSHCN, better mental health care assessment of Black female CSHCN, and ensuring all CSHCN have a medical home.

2006

Sommers, A. S. (2006). "Access to Health Insurance, Barriers to Care, and Service Use among Adults with Disabilities." Inquiry **43**(4): 393-405.
http://www.inquiryjournalonline.org/loi/inqr

No studies to date have examined access to insurance coverage or medical care for a broadly defined population of uninsured nonelderly adults with disabilities. This analysis uses the 2002 National Survey of America's Families to examine access to coverage, access to care, and service use for a large sample of adults with disabilities, with a focus on the uninsured. All disabled groups reported unmet need and service use greater than their nondisabled counterparts with the same insured status. Access to coverage was most problematic for low-income adults with work limitations but no other indication of disability, with over one-third uninsured. This group deserves greater policy attention.

Les effets de la crise économique sur l'accès aux soins : un facteur aggravant

ÉTUDES FRANÇAISES

2019

Médecins du Monde (2019). Observatoire de l'accès aux droits et aux soins dans les programmes de Médecins du Monde en France : rapport 2018. Paris Médecins du Monde**:** 128.
https://www.medecinsdumonde.org/fr/actualites/presse/2019/10/15/19e-rapport-de-lacces-aux-soins-de-medecins-du-monde

L' Observatoire de l'accès aux soins de Médecins du Monde est un outil essentiel de connaissance des populations rencontrées par les équipes de Médecins du Monde permettant de faire le lien entre leurs conditions de vie, leur environnement, leurs droits et leurs problèmes de santé, d'observer les discriminations dans l'accès aux soins, les dysfonctionnements des dispositifs, mais aussi les expériences positives. Il contribue à enrichir la connaissance des populations vulnérables en France, par ailleurs largement ignorées par les statistiques officielles françaises de santé publique : les données portent sur un nombre important de personnes sans domicile fixe ou vivant avec un statut administratif précaire sur le territoire. Au travers de ces programmes d'intervention en France, le rapport de l'année 2018 fait le même constat que celui des années précédentes : la grande majorité des personnes, qu'elle soit bénéficiaire de l'AME ou demandeuse d'asile, que nous accueillons et soignons dans nos centres d'accueil, de soin et d'orientation (CASO) se trouve physiquement et psychologiquement épuisée et nécessite une prise en charge médicale immédiate. Parmi elles, 85,7 % n'ont aucune couverture maladie.

2018

Médecins du Monde (2018). Observatoire de l'accès aux soins de la mission France de Médecins du Monde : rapport 2018. Paris Médecins du Monde**:** 134, tabl., annexes.
https://www.medecinsdumonde.org/fr/file/112170/download?token=j3Oln1XI

> À l'occasion de la Journée mondiale du refus de la misère, le 17 octobre, Médecins du Monde (MdM) publie son 18e rapport annuel sur l'accès aux droits et aux soins des plus démunis en France. 18e rapport annuel, 18e constat implacable et persistant tiré de nos actions : le non-accès aux droits et à la santé en France contribue à exclure de plus en plus de personnes précaires du système de santé. Sur les bases de données objectives, ce rapport témoigne des obstacles et des dysfonctionnements croissants dans l'accès aux soins et aux droits de ces personnes.

2017

Batifoulier, P., Da Silva, N. et Math, A. (2017). "Crise et réformes au prisme de la santé." Revue De L'ires(91-92): 245.
http://www.ires-fr.org/publications-de-l-ires/itemlist/category/287-n-91-92

> La santé est un besoin fondamental et universel dont la satisfaction conditionne de façon cruciale le bien-être des populations. Elle occupe de ce fait une place centrale dans l'étude des problèmes économiques et sociaux et constitue un étalon majeur d'évaluation des transformations de la société. Les contributions rassemblées dans ce numéro spécial s'inscrivent dans cette démarche en analysant certaines de ces transformations à l'aune de leurs effets sur la santé des populations. Dans un contexte marqué par diverses formes de « privatisation » du secteur de la santé, ces contributions mettent en lumière les conséquences souvent négatives des politiques publiques, à la fois sur l'état de santé des populations mais aussi sur les conditions de travail du personnel soignant.

Cusset, P. Y. (2017). Les déterminants de long terme des dépenses de santé en France. Document de travail ; 2017-07. Paris France Stratégie**:** 68 , tab., graph., fig.
http://www.strategie.gouv.fr/document-de-travail/determinants-de-long-terme-depenses-de-sante-france

> Depuis les années 1950, la France consacre une part croissante de ses ressources aux dépenses de soins. Ainsi, la consommation de soins et biens médicaux (CSBM)[1] est passée de 2,6 à 8,9 points de PIB entre 1950 et 2015. La croissance des dépenses a été très forte en début de période, au moment où se constituait l'infrastructure sanitaire et se développait l'assurance maladie. Elle est plus faible depuis la fin des années 1980. Par ailleurs, depuis les années 1970, on assiste à un mouvement de convergence des niveaux de dépenses de santé parmi les pays les plus développés, les États-Unis faisant toutefois figure d'exception. Le document de travail rappelle d'abord quels sont les grands facteurs de croissance des dépenses de santé, en s'appuyant sur une somme de travaux réalisés sur cette question. Il discute ensuite les principales projections de long terme des dépenses de santé réalisées pour la France, en présentant leur méthodologie, leurs résultats et leurs limites.

Da Silva, N. (2017). "L'impact des conditions macroéconomiques sur l'état de santé." Revue De L'ires(91-92): 49-75.
http://www.ires-fr.org/publications-de-l-ires/itemlist/category/287-n-91-92

> La réponse principale à la violente crise économique commencée en 2007 a été la mise en place et le renforcement de politiques de rigueur dans de nombreux pays. Or, les difficultés économiques marquent les corps et les vies de celles et ceux qui en souffrent. Dans ce contexte, mener une politique d'austérité ou de relance peut avoir des effets différenciés sur la santé de la population. Cet article a pour objectif de proposer un état de l'art sur la relation ambiguë entre conditions macroéconomiques et santé – est-ce la crise économique ou l'austérité qui détériore l'état de santé ? Si les travaux des économistes ont tendance à montrer que la crise économique est bonne pour la santé, une littérature plus récente issue de l'épidémiologie démontre qu'en cas de fluctuation

économique la réponse politique est déterminante : quand la relance peut sauver des vies, l'austérité tue (résumé de l'éditeur).

Lang, T., Gremy, I. et Visier, L. (2017). "Crise économique et santé. Dossier." Actualite Et Dossier En Sante Publique(99): 8-52.

[BDSP. Notice produite par EHESP m8mR0xFJ. Diffusion soumise à autorisation]. Les crises économiques affectent particulièrement les populations démunies et leur santé. Elles entraînent une diminution des budgets consacrés à la protection sociale, à l'éducation et au logement, ce qui a des conséquences sur certains déterminants de santé et renforce les inégalités sociales de santé. Les études conduites dans plusieurs pays, et notamment en Grèce, montrent des impacts complexes à court terme. L'objectif des articles de ce numéro est de faire le point sur l'effet sur la santé des politiques en temps de crise. Le "modèle social français" a-t-il permis d'amortir les effets de la crise ? Et, surtout, quelles composantes les diverses politiques publiques ont eu un impact, positif ou aggravant ? L'objectif est aussi de réfléchir à l'effet de la crise et des politiques qu'elle suscite pour les Français dans quelques décennies.

Malard, L., Chastang, J. F. et Niedhammer, I. (2017). "Évolution des comportements et indicateurs de santé mentale entre 2006 et 2010 dans la population au travail en France." Revue D'Epidemiologie et de Sante Publique **65**(4): 309-320.

Les répercussions de la crise économique de 2008 sur la santé mentale de la population sont encore mal connues, en particulier dans la population au travail. Pourtant la santé mentale au travail est un enjeu important par ses coûts et ses conséquences substantiels. L'objectif était d'évaluer l'évolution de la prévalence de comportements et d'indicateurs de santé mentale dans la population au travail en France entre 2006 et 2010, et d'étudier les évolutions différentielles selon l'âge, l'origine, la profession, le secteur d'activité, le secteur public/privé, le statut indépendant/salarié et le type de contrat. L'enquête Santé et itinéraire professionnel (SIP) est une enquête prospective représentative de la population générale française, et parmi les individus interrogés, 5600 étaient en emploi en 2006 et en 2010. Les comportements et les indicateurs de santé mentale étudiés étaient la consommation d'alcool à risque, le tabagisme, les problèmes du sommeil (troubles du sommeil et/ou durée de sommeil insuffisante), la prise de psychotropes (antidépresseurs, anxiolytiques et/ou hypnotiques), et la mauvaise santé perçue. Des équations d'estimation généralisées ont été utilisées pour étudier les évolutions, les analyses étaient ajustées sur l'âge, puis des covariables (âge, origine, profession, secteur d'activité, secteur public/privé, statut indépendant/salarié et type de contrat) ont été introduites séparément pour évaluer les évolutions différentielles. Dans la population au travail en France, des augmentations de la prévalence de la consommation d'alcool à risque chez les femmes, des problèmes de sommeil chez les hommes, et de tabagisme, de la durée de sommeil insuffisante et de la mauvaise santé perçue pour les deux genres ont été observées entre 2006 et 2010. Quelques évolutions différentielles ont été mises en évidence, en particulier au détriment des plus jeunes et des personnes en contrat permanent. En conclusion, les politiques de prévention devraient considérer que les prévalences des comportements et des indicateurs de mauvaise santé mentale peuvent avoir augmenté en période de crise économique, en particulier pour certains sous-groupes de la population au travail tels que les plus jeunes et les personnes en contrat permanent. Ces évolutions pourraient laisser présager une augmentation future des pathologies mentales.

Math, A. (2017). "Les effets des politiques d'austérité sur les dépenses et services publics de santé en Europe." Revue De L'ires(91-92): 17-47, fig.

Cet article analyse l'évolution des politiques et des dépenses de santé depuis la grande récession (2008-2009) dans les pays européens. Dans un premier temps, l'article analyse les modalités des réformes et des mesures prises dans le secteur de la santé, en particulier depuis le tournant de l'austérité débuté en 2010, qu'il s'agisse de mesures visant à diminuer directement le volume et le prix des soins au moyen d'une limitation des emplois et des rémunérations dans le secteur de la santé ou à travers des réformes plus « structurelles ». La compression des dépenses publiques de santé a été d'autant plus forte que les mesures ont porté sur le facteur travail. Dans un second temps, l'article documente et analyse l'évolution des dépenses de santé. Si la croissance des dépenses (totales et publiques) de santé a été très peu altérée durant la récession de 2008-2009, une rupture est intervenue dans tous les pays après 2009 (l'Allemagne faisant exception). Certains pays « périphériques » ont connu une baisse des dépenses de santé sans équivalent dans l'histoire contemporaine. L'article conclut sur les limites des politiques d'austérité appliquées au champ de la santé, non pas tant au regard de leurs effets sur le soin ou la situation sanitaire, mais au regard même de leur objectif de réduction des déficits publics. Les travaux montrent que les restrictions opérées dans les dépenses publiques de santé, mais aussi celles en matière d'éducation et de protection sociale, ont des effets récessifs désastreux et s'avèrent inefficaces, ou moins efficaces que des réductions d'autres dépenses publiques.

Médecins du Monde (2017). Observatoire de l'accès aux droits et aux soins de la mission France de Médecins du Monde : rapport 2016. Paris Médecins du Monde**:** 136, annexes.
http://www.medecinsdumonde.org/fr/actualites/publications/2017/10/13/rapport-de-lobservatoire-de-lacces-aux-droits-et-aux-soins-de-la-mission-france-2016

L'Observatoire de l'accès aux soins de Médecins du Monde est un outil essentiel de connaissance des populations rencontrées par les équipes de Médecins du Monde permettant de faire le lien entre leurs conditions de vie, leur environnement, leurs droits et leurs problèmes de santé, d'observer les discriminations dans l'accès aux soins, les dysfonctionnements des dispositifs, mais aussi les expériences positives. Il contribue à enrichir la connaissance des populations vulnérables en France, par ailleurs largement ignorées par les statistiques officielles françaises de santé publique : les données portent sur un nombre important de personnes sans domicile fixe ou vivant avec un statut administratif précaire sur le territoire. Au travers de ces programmes d'intervention en France, le rapport de l'année 2016 fait le constat des difficultés rencontrées par les personnes précaires pour faire valoir leurs droits et leurs accès aux soins. Dans un nouveau rapport, l'Observatoire de Médecins du Monde critique « une gestion désastreuse de l'accueil des migrants par les autorités françaises ». L'Observatoire dénonce une dégradation des conditions d'accueil des demandeurs d'asile ainsi qu'un non-respect du droit à la protection pour les mineurs nonaccompagnés. Le rapport fait plus généralement état de difficultés d'accès aux soins pour les personnes en situation de précarité, liées notamment à la complexité des démarches et à la remise en cause de l'AME. Il souligne que les personnes en situation de grande précarité présentent des problèmes de santé particuliers liés à leurs conditions de vie, notamment des troubles psychologiques. Il indique également des difficultés d'accès à la prévention et aux dépistages dans les populations précaires, qui engagent de larges problématiques de santé publique.

Médecins du Monde (2017). Synthèse du rapport de l'Observatoire 2017. Les laissés pour compte : l'échec de la couverture santé universelle en Europe. Paris Médecins du Monde**:** 136 , annexes.
http://www.medecinsdumonde.org/fr/actualites/publications/2017/11/08/synthese-rapport-de-lobservatoire-2017

Le Rapport de l'Observatoire de Médecins du Monde décrit la situation actuelle de ceux et celles qui passent entre les mailles du filet des systèmes de santé européens et appelle les parties prenantes aux niveaux international, européen et national à faire de la couverture santé universelle une priorité. Le rapport 2017 pointe sur les oubliés de cette couverture maladie universelle.

Meneton, P., Plessz, M., Courtin, E., et al. (2017). "Le chômage : un problème de santé publique majeur." Revue De L'ires(91-92): 141-154.
http://www.ires-fr.org/publications-de-l-ires/itemlist/category/287-n-91-92

Les études disponibles dans plusieurs pays et les quelques données obtenues récemment en France suggèrent que les conséquences du chômage sur la santé vont bien au-delà de l'augmentation de la fréquence des suicides. L'incidence des pathologies chroniques, maladies cardio-vasculaires et cancers en premier lieu, semble également fortement augmentée chez les chômeurs par rapport aux travailleurs. Les mécanismes par lesquels le chômage est susceptible de dégrader l'état de santé sur le long terme sont encore à éclaircir : exposition accrue à des facteurs de risque comportementaux, accès réduit au système de soins, effets organiques plus directs sont autant de pistes possibles. D'ores et déjà, il serait souhaitable que le corps médical soit sensibilisé sur les risques encourus par les chômeurs afin de les aider à les réduire autant que faire se peut.

Rey, S. et Roussel, R. (2017). "Accès aux soins dans les pays touchés par la crise économique. In : Crise économique et santé." Actualite Et Dossier En Sante Publique(99): A compléter.
http://www.hcsp.fr/explore.cgi/Adsp?clef=156

Visier, L., Gremy, I. et Zoia, G. (2017). "L'impact de la crise sur le bien-être et la santé du nouveau-né, du nourrisson et de l'enfant." Actualite Et Dossier En Sante Publique(99): 12-17.

[BDSP. Notice produite par EHESP p7k99R0x. Diffusion soumise à autorisation]. En France, comme dans d'autres pays européens, les jeunes actifs, leurs familles et leurs enfants ont particulièrement été touchés. Une analyse des effets sanitaires de la crise doit tenir compte, en plus des déterminants sociaux usuels, des politiques sociales déployées dans les pays, de leur capacité à amortir la crise et des populations qu'elles visent. Les études socio-économiques convergent pour montrer l'impact négatif de la crise sur la famille et les enfants.

2016

(2016). Crise économique, santé et inégalités sociales de santé. Collection Avis et rapports. Paris La documentation française**:** 104.

Les crises économiques affectent particulièrement les populations les plus socialement démunies. De plus, les restrictions budgétaires qui s'en suivent entraînent souvent une diminution des budgets consacrés à la protection sociale. Ce rapport a pour but d'identifier des pistes d'action, de surveillance et de recherche pour limiter les effets de la crise économique sur la santé et éviter un impact négatif de mesures politiques de gestion de crise. Il livre ici ses recommandations aux pouvoirs publics.

Médecins du Monde (2016). Observatoire de l'accès aux soins de la mission France de Médecins du Monde : rapport 2015. Paris Médecins du Monde**:** 152, annexes.

L'Observatoire de l'accès aux soins de Médecins du Monde est un outil essentiel de connaissance des populations rencontrées par les équipes de Médecins du Monde permettant de faire le lien entre leurs conditions de vie, leur environnement, leurs droits et leurs problèmes de santé, d'observer les discriminations dans l'accès aux soins, les dysfonctionnements des dispositifs, mais aussi les expériences positives. Il contribue à enrichir la connaissance des populations vulnérables en France, par ailleurs largement ignorées par les statistiques officielles françaises de santé publique : les données portent sur un nombre important de personnes sans domicile fixe ou vivant avec un statut administratif précaire sur le territoire. A l'occasion de la Journée mondiale du refus de la misère, le 17 octobre 2016, Médecins du Monde a publié son 16e rapport de l'observatoire de l'accès aux droits et aux soins des plus démunis en France. Un rapport qui témoigne des difficultés persistantes rencontrées par ces personnes pour accéder à leurs droits et se faire soigner. Cette année, elle constate que les politiques publiques sont bien en-deçà des enjeux actuels. De plus, l'année 2015 a été marquée par de nombreuses réformes (loi de santé, loi immigration, loi asile, réforme PUMa....) qui sont venues modifier en profondeur le contexte législatif français en matière d'accueil et d'intégration des étrangers en particulier et qui ont fortement mobilisé les équipes de MdM.

2012

Vigneron, E. (2012). "[Territorial and social healthcare inequalities in France]." Bull Acad Natl Med **196**(4-5):

939-952.

Geographic analyses of health-related issues have a long tradition in France, and have often consisted of observational studies conducted by practitioners themselves. Such geographic approaches were gradually abandoned during the 20th century as the pace of clinical progress increased. The few healthcare studies conducted by geographers have had little impact among the medical community. However, our studies show that geographic inequalities in health still persist. During the last 10 years or so, the social and economic crisis has dangerously accentuated health inequalities at every level In France, where equality is supposed to be the watchword of the entire healthcare system, this situation is particularly regrettable. Access to care decreases with distance from medical services. With the increasing urban and suburban concentration of the population, public healthcare policy must focus on finding solutions for people living in remote areas or too poor to access medical care. Geographic analyses of healthcare organization can help to make medical care available for all, especially those who need it most.

ÉTUDES INTERNATIONALES

2020

Zavras, D. (2020). "Studying Healthcare Affordability during an Economic Recession: The Case of Greece." Int J Environ Res Public Health **17**(21).

The significant deterioration of economic prosperity in Greece during the economic crisis decreased patients' ability to pay. Thus, the objective of this study is to determine the factors affecting healthcare affordability in Greece during an economic recession. This study used data from the European Union Statistics on Income and Living Conditions (EU-SILC) 2016. The sample consisted of 18,255 households. Healthcare affordability was regressed on geographic characteristics as well as several variables that refer to the households' financial condition. Region of residence, ability to make ends meet, and capacity to cope with unexpected financial expenses were found to be statistically significant. Using sample sizes of 1000 and 1096 adults, respectively, the European Quality of Life Surveys (EQLS) of 2007 and 2016 were also used as data sources. Economic crisis was expressed with a dummy variable: (1) 0: 2007, and (2) 1: 2016. Difficulty in responding to healthcare costs was regressed on survey year and several demographic, socioeconomic, and health characteristics, revealing that individuals were more likely to face difficulties in responding to healthcare costs during the economic crisis. These results confirm the mechanism on the basis of which economic crises affect healthcare access: primarily through the effects of demand-side barriers.

2019

Artabe, A. et Sigüenza, W. (2019). "The effects of the economic recession on spending on private health insurance in Spain." Int J Health Econ Manag **19**(2): 155-191.
https://doi.org/10.1007/s10754-018-9251-2

The paper seeks to analyse the evolution of expenditure on private health insurance (PHI) in Spain. We consider the factors that influence PHI demand and level of spending before and during the economic recession, along with identifying the effect of the recession on these factors. The data is obtained from the Spanish Family Budget Survey (SFBS) for 2006 and 2012. Due to the data structure and the demand function, the analysis is performed using a sample selection model in order to avoid sample selection bias. We estimate three models: a pre-recession model (2006), a model for the recession period (2012) and a third one covering both periods (2006 and 2012) and where we include a dummy variable that establishes the effect of the economic recession. The results show that the effect of the economic recession on PHI demand is not significant, but it is on the level of spending.

Bellido, H., Olmos, L. et Román-Aso, J. A. (2019). "Do political factors influence public health expenditures? Evidence pre- and post-great recession." The European Journal of Health Economics **20**(3): 455-474.
https://doi.org/10.1007/s10198-018-1010-2

This paper analyses whether government ideology and other political- and electoral-related factors influence country-level public healthcare expenditures, focussing on the impact of the Great Recession on that relationship. We test this hypothesis for the OECD countries in 1970–2016. Our results reveal the presence of a partisan effect, left-wing governments being more likely to raise public expenditures in the health sector. We also find that coalitions increase these expenditures, whilst minority governments and those with a high presence in the lower house decrease them. Meanwhile, the opportunistic behaviour of incumbents related to the timing of elections is not supported by our results. The percentage of public expenditures over total health expenditures is also examined, obtaining similar results regarding the partisan effect. However, the onset of the Great Recession has altered these relationships, neutralizing the impact of political factors.

Birody, J., Doyle, O. et Kelleher, C. (2019). The Effect of the Great Recession on Health: A Longitudinal Study of Irish Mothers 2001-2011. UCD Centre for Economic Research Working Paper Series; WP19/18. Dublin University College Dublin, School of Economics**:** 41.
http://d.repec.org/n?u=RePEc:ucn:wpaper:201918&r=lab

The relationship between recessions and health is mixed, with some evidence from the most recent financial crisis finding a positive effect on heath behaviours. This study uses longitudinal data spanning the periods before, during and after the Irish crisis of 2008, to test the impact of economic expansion and contraction on mothers physical and mental health and health behaviours. Three waves of data from the Irish Lifeways Cohort Study for the period 2001-2011, and local area employment rates from the Irish Census, are used to capture the impact of the recession on health, independent of individual employment status. The results from fixed effect linear probability models demonstrate that increases in the local unemployment rate are associated with significant increases in the probability of mothers reporting poor self-rated health and poor mental well-being. Yet the association between local area unemployment and health behaviours is mostly positive, with higher unemployment reducing the probability of being obese and tobacco consumption. The relationship with physical activity is more ambiguous. These results are largely consistent with the US literature, which is predominantly based on working men, thus demonstrating the universal impact of recessions on health.

Curtis, S., Pearce, J., Cherrie, M., et al. (2019). "Changing labour market conditions during the 'great recession' and mental health in Scotland 2007–2011: an example using the Scottish Longitudinal Study and data for local areas in Scotland." Social Science & Medicine **227**: 1-9.

This paper reports research exploring how trends in local labour market conditions during the period 2007–2011 (early stages of the 'great recession') relate to reported mental illness for individuals. It contributes to research on spatio-temporal variation in the wider determinants of health, exploring how the lifecourse of places relates to socio-geographical inequalities in health outcomes for individuals. This study also contributes to the renewed research focus on the links between labour market trends and population health, prompted by the recent global economic recession. We report research using the Scottish Longitudinal Study (SLS), a 5.3% representative sample of the Scottish population, derived from census data (https://sls.lscs.ac.uk/). In Scotland, (2011) census data include self-reported mental health. SLS data were combined with non-disclosive information from other sources, including spatio-temporal trends in labour market conditions (calculated using trajectory modelling) in the 32 local authority areas in Scotland. We show that, for groups of local authorities in Scotland over the period 2007–2011, trends in employment varied. These geographically variable trends in employment rates were associated with inequalities in self-reported mental health across the country, after controlling for a number of other individual and neighbourhood risk factors. For residents of regions that had experienced relatively high and stable levels of employment the odds ratio for reporting a mental illness was significantly lower than for the 'reference group', living in areas with persistently low employment rates. In areas where employment declined markedly from higher levels, the odds ratio was similar to the reference group. The findings emphasise how changes in local economic conditions may influence people's health and wellbeing independently of their own employment status. We conclude that, during the recent recession, the economic life course of places across Scotland has been associated with individual mental health outcomes.

Martin, A. B., Hartman, M., Washington, B., et al. (2019). "National Health Care Spending In 2017: Growth Slows To Post-Great Recession Rates; Share Of GDP Stabilizes." Health Aff (Millwood) **38**(1): 101377hlthaff201805085.

Total nominal US health care spending increased 3.9 percent to $3.5 trillion in 2017, slowing from growth of 4.8 percent in 2016. The rate of growth in 2017 was similar to the increases between 2008 and 2013, which preceded the faster growth experienced during 2014-15-a period that was marked by insurance coverage expansion and large increases in prescription drug spending. Slower growth in health care spending in 2017 was mainly attributable to the use and intensity of goods and services, particularly for hospital care, physician and clinical services, and retail prescription drugs. Nearly all major sources of insurance and sponsors of health care experienced slower growth in 2017. On a per capita basis, spending on health care increased 3.2 percent and reached $10,739 in 2017. The share of gross domestic product devoted to health care spending was 17.9 percent in 2017, similar to the share in 2016.

Mazeikaite, G., O'Donoghue, C. et Sologon, D. M. (2019). "The Great Recession, financial strain and self-assessed health in Ireland." The European Journal of Health Economics **20**(4): 579-596.
https://doi.org/10.1007/s10198-018-1019-6

In this paper, we study the effects of the 2008 economic crisis on general health in one of the most severely affected EU economies—Ireland. We examine the relationship between compositional changes in demographic and socio-economic factors, such as education, income, and financial strain, and changes in the prevalence of poor self-assessed health over a 5-year period (2008–2013). We apply a generalised Oaxaca–Blinder decomposition approach for non-linear regression models proposed by Fairlie (1999, 2005). Results show that the increased financial strain explained the largest part of the increase in poor health in the Irish population and different sub-groups. Changes in the economic activity status and population structure also had a significant positive effect. The expansion of education had a significant negative effect, preventing further increases in poor health. Wealthier and better educated individuals experienced larger relative increases in poor health, which led to reduced socio-economic health inequalities.

Rizzi, D., Simionato, C. et Zantomio, F. (2019). Older people health and access to healthcare. A retrospective look at inequality dynamics over the past decade. No. 26/WP/2019. Venice University Ca' Foscari of Venice**:** 27 ,tabl., fig.
https://econpapers.repec.org/paper/venwpaper/2019_3a26.htm

The past decade of austerity measures has severely hit Public Healthcare provision in Italy, entailing significant reductions in per-capita expenditure, particularly in Regions put under 'Healthcare Budget Recovery Plans', mostly in the South of the country. Building on data on individuals aged 50 or older drawn from the Survey of Health, Ageing and Retirement in Europe, we compute time- and area-specific Concentration and Horizontal Inequity indexes, to assess the evolution of inequity in older people health and healthcare access (i.e. GP contacts and specialists' visits) across Italian macro-areas since the Great Recession onset. Results show that in the North, while health has been improving on average, income-related inequality in health has increased; in the South, while on average health has not improved, the concentration of bad health among the income-poor has decreased. Sizeable inequity in access to specialists' visits emerges throughout the country, and generally worsened since before the crisis onset. Evidence overall suggests that in the South, along the crisis, under worsened income conditions and Public Healthcare budget cuts, poorer older individuals might have substituted specialised care with increased family doctors' visits.

2018

Barnay, T. et Jusot, F. (2018). Travail et santé, Paris : Les Presses de Sciences Po

Si la pénibilité du travail contribue à dégrader la santé, les études montrent aussi que l'emploi la préserve en favorisant notamment l'accès aux soins. Les relations entre état de santé des individus et marché du travail ont fait l'objet de nombreux débats et d'une abondante législation. Les dispositions actuelles, fondées sur une logique de compensation et de réparation, ne prennent pas assez en compte la complexité de ces interactions, encore accrue par le vieillissement de la population, l'allongement et la précarisation des trajectoires professionnelles. Face au risque santé s'impose la nécessité de plus de prévention et de sécurisation des parcours (4è de couv.)

Cima, J. et Almeida, A. S. (2018). Health Expenditure, GDP Growth and the Financial Crisis: A Panel Data Analysis for OECD European Countries. Porto Universidade do Porto**:** 19 , tabl.
http://wps.fep.up.pt/wps/wp602.pdf

This study analyses the dynamics of Gross Domestic Product and health expenditure for 25 OECD European countries from 1993 to 2015. The novelty of this work is in the joint evaluation of the impact of the Great Recession of the XXI century and the post-crisis period on the growth dynamics of both variables. We estimate a Vector Error Correction model with countries' fixed effects, and amongst other findings, we conclude that the growth dynamics of health expenditure did not change significantly during the crisis. We perform additional assessments with a third variable related to the population's health status that show there was a higher rate of people reporting poor health during the crisis and in the following periods, and the health status is caused by GDP rather than health spending. Moreover, we decompose the analysis by health financing scheme, and we observe that countries mostly financed by compulsory health insurance scheme had a worsened health status even though there was no decrease in the growth of health expenditure. These findings are a relevant contribution to the comprehensive and recent literature about the impact of the financial crisis on health. We show there was no direct impact of the Great Recession on the process that determines health expenditure growth, and that a possible deterioration in health during the recession goes beyond the effect on health spending of economic growth.

Coveney, M., Garcia-Gomez, P., Van Doorslaer, E., et al. (2018). Every crisis has a silver lining? Unravelling the pro-cyclical pattern of health inequalities by income. Tinbergen Institute Discussion Paper ; 2018-066/V. Rotterdam Tinbergen Institute**:** 46 , tabl., fig., annexes.
https://ideas.repec.org/p/tin/wpaper/20180066.html

It is well known that income and health are positively associated. Much less is known about the strength of this association in times of growth and recession. We develop a novel decomposition method that focuses on isolating the roles played by government transfers versus market transfers on changes in income-related health inequality (IRHI) in Europe. Using European Union Survey of Income and Living Conditions (EU-SILC) panel data for 7 EU countries from 2004 to 2013, we decompose the changes in IRHI while focusing on possible effects of the 2008 financial crisis. We find that such inequalities rise in good economic times and fall in bad economic times. This pattern can largely be explained by the relative stickiness of old age pension benefits compared to the market incomes of younger groups. Austerity measures are associated with a weakening of the IRHI reducing effect of government transfers.

Kuka, E. (2018). Quantifying the Benefits of Social Insurance: Unemployment Insurance and Health. NBER Working Paper Series ; n° 24766. Cambridge NBER**:** 55 , tabl., fig.
http://papers.nber.org/papers/W24766

While the Unemployment Insurance (UI) program is one of the largest safety net program in the U.S., research on its benefits is limited. This paper exploits plausibly exogenous changes in state UI laws to empirically estimate whether UI generosity mitigates any of the previously documented negative health effects of job loss. The results show higher UI generosity increases health insurance coverage and utilization, and leads to improved self-reported health. Moreover, these effects are stronger during periods of high unemployment rates. Finally, I find no effects on risky behaviors nor on health conditions.

Liang, L.-L. et Tussing, A. D. (2018). "The cyclicality of government health expenditure and its effects on population health." Health Policy.

Scholars have raised concerns that cutbacks on government health expenditure (GHE) during recessions may jeopardise population health. The present research investigates the extent to which population health outcomes are affected by responses of GHE to business cycles, i.e., cyclicality of GHE. We estimate GHE cyclicality by regressing detrended GHE on detrended gross domestic product (GDP). Our analysis of data for 1995 through 2014 from 135 developing countries shows that mean cyclicality is 0.61, or that a one percent deviation from the GDP trend is positively correlated with a 0.61 percent deviation from the GHE trend. Further, countries in which GHE is less procyclical appear to have shorter life expectancies and higher adult mortality rates. These results suggest that reducing procyclicality of GHE by protecting GHE in bad times may generate substantial health gains. Importantly, our results show that increasing the weight of social security funds in health budgets, and improving institutional quality, can be critical to breaking the procyclical pattern of GHE.

Perotti, R. (2018). The Human Side of Austerity: Health Spending and Outcomes During the Greek Crisis. NBER Working Paper Series ; n° 24909. Cambridge NBER**:** 61,tabl.,fig.,ann.
http://papers.nber.org/papers/W24909

The Greek crisis was the most severe in postwar Europe; its budget cuts were the deepest. Among the components of the budget, health spending was hit particularly hard, declining by more than one third in just five years. This paper has two goals: establish the facts about health inputs, outputs and outcomes during the Greek crisis, and explore the connection between budget cuts and health outcomes. Health spending and inputs were very high in Greece before the crisis: in several dimensions, even after the budget cuts were implemented health spending and inputs were still at or near the top of the European countries; in other cases they merely went back to the European average. Nevertheless, budget cuts so deep and so sudden are unlikely to merely cut into inefficiencies and overcapacities. I highlight several areas in which a comparative quantitative analysis suggests that budget cuts might have had an appreciable effects on the health of the population.

Van Den Berg, J., Paul, A. et Reinhold, S. (2018). Economic Conditions, Parental Employment and Health of Newborns. IZA Discussion paper ; 11338. Bonn IZA**:** 56 , tabl., fig.
http://ftp.iza.org/dp11338.pdf

We examine whether economic downturns are beneficial to health outcomes of newborn infants in developed countries. For this we use merged population-wide registers on health and economic and demographic variables, including the national medical birth register and intergenerational link registers from Sweden covering 1992–2004. We take a rigorous econometric approach that exploits regional variation in unemployment and compares babies born to the same parents so as to deal with possible selective fertility based on labor market conditions. We find that downturns are beneficial; for example, a one-percentage-point increase in the unemployment rate during pregnancy reduces the probability of having a birth weight less than 1,500 grams or of dying within 28 days of birth by 10–15%. Effects are larger in low socio-economic status households. Health improvements cannot be attributed to the parents' own employment status. The results suggest pathways through stress and air pollution.

2017

Alessie, R., Angelini, V., Mierau, J. O., et al. (2017). Economic Conditions at Birth and Cardiovascular Disease Risk in Adulthood:Evidence from New Cohorts. Working paper ; 10810. Bonn IZA**:** 29 , tabl., fig.
http://ftp.iza.org/dp10810.pdf

Most of the literature that exploits business cycle variation at birth to study long-run effects of economic conditions on health later in life is based on pre-1940 birth cohorts. They were born in times where social safety nets were largely absent and they grew up in societies with relatively low female labor force participation. We complement the evidence from this literature by exploiting post-1950 regional business cycle variations in the Netherlands to study effects on cardiovascular disease (CVD) risk in adulthood, by gender. We operationalize CVD risk by constructing the Systematic COronary Risk Evaluation (SCORE) index from an extensive set of biomarkers. The data are from a large cohort study covering socio-economic, biological and health data from over 75k individuals aged between 18 and 63. We conclude that women born in adverse economic conditions experience higher CVD risk.

Antonova, L., Bucher-Koenen, T. et Mazzonna, F. (2017). "Long-term health consequences of recessions during working years." Soc Sci Med **187**: 134-143.

Economic crises may have severe consequences for population health. We investigate the long-term effects of macroeconomic crises experienced during prime working age (20-50) on health outcomes later in life using SHARE data (Survey of Health Aging and Retirement in Europe) from eleven European countries. Analyses are based on the first two waves of SHARE data collected in 2004 and 2006 (N = 22,886) and retrospective life history data from SHARELIFE collected in 2008 (N = 13,732). Experiencing a severe crisis in which GDP dropped by at least 1% significantly reduces health later in life. Specifically, respondents hit by such a shock rate their subjective health as worse, are more likely to suffer from chronic diseases and mobility limitations, and have lower grip strength. The effects are twice as large among low-educated respondents. A deeper analysis of critical periods in life reveals that respondents' health is more affected by crises experienced later in the career (between age 41 and 50). The labor market patterns show that these people drop out of the labor force. While men retire early, women are more likely to become home makers. In line with the literature on the negative consequences of retirement on health, this suggests that early retirement in times of economic crises might be detrimental to health.

Axelrad, H. et Sabbath;, E. L. (2017). "The impact of the 2008 recession on the health of older workers: data from 13 European countries. ." European Journal of Public Health **27**(4): 647-652.

Background: Fluctuations in the national economy shape labour market opportunities and outcomes, which in turn influence the health conditions of older workers. This study examined whether overall economic shifts during the 2008 recession was associated with four health indicators among older workers. Method: Data came from 4917 respondents (16 090 contacts) aged 50–70 in 13 European countries (Austria, Belgium, Czech Republic, Denmark, France, Germany, Israel, Italy, Netherlands, Poland, Spain, Sweden, Switzerland) participating in the Survey of Health, Ageing and Retirement in Europe. Health and employment assessments from 2004–13 were linked to annual data on fluctuations in Gross Domestic Product (GDP) per capita, life expectancy and unemployment rates for each country. Using fixed effects models, we assessed the recession's implications on four individual health outcomes: body mass index (BMI), drinking alcohol, depression and general health, while isolating cyclical variation within countries and individual changes over time. Results: Overall economic shifts had an effect on older workers: decreases in GDP were associated with a decline in average BMI, consumption of alcohol and deterioration in self-rated health; country-level unemployment rate had no effect on health outcomes, while life expectancy at birth was significant but not consistently across models. Being employed or retired were associated with fewer depressive symptoms and better self-rated health. Conclusions: Overall economic shifts during recessions affect certain health outcomes of older workers, and better health conditions together with being employed or retired may limit the negative health consequences of a recession.

Basu, S., Carney, M. A. et Kenworthy, N. J. (2017). "Ten years after the financial crisis: The long reach of

austerity and its global impacts on health." Soc Sci Med **187**: 203-207.

Bhandari, R., Kasim, A., Warren, J., et al. (2017). "Geographical inequalities in health in a time of austerity: Baseline findings from the Stockton-on-Tees cohort study." Health Place **48**: 111-122.

Stockton-on-Tees has the highest geographical inequalities in health in England with the life expectancy at birth gap between the most and deprived neighbourhoods standing at over 17 years for men and 11 years for women. In this study, we provide the first detailed empirical examination of this geographical health divide by: estimating the gap in physical and general health (as measured by EQ. 5D, EQ. 5D-VAS and SF8PCS) between the most and least deprived areas; using a novel statistical technique to examining the causal role of compositional and contextual factors and their interaction; and doing so in a time of economic recession and austerity. Using a stratified random sampling technique, individual-level survey data was combined with secondary data sources and analysed using multi-level models with 95% confidence intervals obtained from nonparametric bootstrapping. The main findings indicate that there is a significant gap in health between the two areas, and that compositional level material factors, contextual factors and their interaction appear to be the major explanations of this gap. Contrary to the dominant policy discourse in this area, individual behavioural and psychosocial factors did not make a significant contribution towards explaining health inequalities in the study area. The findings are discussed in relation to geographical theories of health inequalities and the context of austerity.

Bosque-Prous, M., Kunst, A. E., Brugal, M. T., et al. (2017). "Changes in alcohol consumption in the 50- to 64-year-old European economically active population during an economic crisis." Eur J Public Health.

Background: The aim was to compare alcohol drinking patterns in economically active people aged 50-64 years before the last economic crisis (2006) and during the crisis (2013). Cross-sectional study with data from 25 479 economically active people aged 50-64 years resident in 11 European countries who participated in wave 2 or wave 5 of the SHARE project (2006 and 2013). The outcome variables were hazardous drinking, abstention in previous 3 months and the weekly average number of drinks per drinker. The prevalence ratios of hazardous drinking and abstention, comparing the prevalence in 2013 vs. 2006, were estimated with Poisson regression models with robust variance, and the changes in the number of drinks per week with Poisson regression models. The prevalence of hazardous drinking decreased among both men (PR = 0.75; 95%CI = 0.63-0.92) and women (PR = 0.91; 95%CI = 0.72-1.15), although the latter decrease was smaller and not statistically significant. The proportion of abstainers increased among both men (PR = 1.11; 95%CI = 0.99-1.29) and women (PR = 1.18; 95%CI = 1.07-1.30), although the former increase was smaller and not statistically significant. The weekly average number of drinks per drinker decreased in men and women. The decreases in consumption were larger in Italy and Spain. From 2006 to 2013, the amount of alcohol consumed by late working age drinkers decreased in Europe, with more pronounced declines in the countries hardest hit by the economic crisis.

Buffel, V., Missinne, S. et Bracke, P. (2017). "The social norm of unemployment in relation to mental health and medical care use: the role of regional unemployment levels and of displaced workers." Work, employment and society **31**(3): 501-521.
http://journals.sagepub.com/doi/abs/10.1177/0950017016631442

The relationships between unemployment, mental health (care) and medication use among 50–65 year-old men (N = 11,789) and women (N = 15,118) are studied in Europe. Inspired by the social norm theory of unemployment, the relevance of regional unemployment levels and workplace closure are explored, using multilevel analyses of data from the Survey of Health, Ageing and Retirement. In line with the social norm theory, the results show that – only for men – displaced workers are less depressed and use less medication than the non-displaced unemployed. However, they report more depressive symptoms than the employed, which supports the causal effect of unemployment on mental health. Non-displaced unemployed men are also more likely to consume medication than the displaced unemployed. In addition, using regional unemployment as a proxy for the social norm of unemployment can be questioned when studying mental health effects, as it seems to be a stronger measurement of labour market conditions than of the social norm of unemployment, especially during a recession.

Costa-Font, J., Frank, R. et Swartz, K. (2017). Access to Long-Term Care After a Wealth Shock: Evidence from the Housing Bubble and Burst. NBER Working Paper Series ; n° 23781. Cambridge NBER**:** 34 ,fig., tabl., annexes.
http://www.nber.org/papers/w23781

Home equity is the primary self-funding mechanism for long term services and supports (LTSS). Using data from the relevant waves of the Health and Retirement Study (1996-2010), we exploit the exogenous variation in the form of wealth shocks resulting from the value of housing assets, to examine the effect of wealth on use of home health, unpaid help and nursing home care by older adults. We find a significant increase in the use of paid home health care and unpaid informal care but no effect on nursing home care access. We conduct a placebo test on individuals who do not own property; their use of LTSS was not affected by the housing wealth changes. The findings suggest that a wealth shock exerts a positive and significant effect on the uptake of home health and some effect on unpaid care but no significant effect on nursing home care.

Johnston, D. W., Shields, M. A. et Suziedelyte, A. (2017). World Commodity Prices, Job Security and Health: Evidence from the Mining Industry. Iza Dp ; 11251. Bonn IZA**:** 42 , tab., graph., fig.
http://ftp.iza.org/dp11251.pdf

A lack of job security is an increasingly prevalent characteristic of modern labour markets, and there is evidence that recent financial crises have exacerbated this issue. In this paper, we assess how exogenous changes in the macroeconomic environment affect workers' perceived job security, and the impact of job security on measures of mental and physical health. To identify these effects, we exploit variation in world commodity prices over the period 2001–15, and analyse 15 waves of individual-level panel data that includes unusually detailed classifications of mining workers. We find that commodity price movements drive changes in perceived job security, which in turn significantly and substantively affects the mental health of workers. In contrast, we find no effects on physical health. Our results imply that the estimated welfare costs of recessions are substantially larger when the effects of job insecurity on the health of workers is considered.

Lopez-Valcarcel, B. G. et Barber, P. (2017). "Economic Crisis, Austerity Policies, Health and Fairness: Lessons Learned in Spain." Appl Health Econ Health Policy **15**(1): 13-21.

This paper reviews economic and medical research publications to determine the extent to which the measures applied in Spain to control public health spending following the economic and financial crisis that began in 2008 have affected healthcare utilization, health and fairness within the public healthcare system. The majority of the studies examined focus on the most controversial cutbacks that came into force in mid-2012. The conclusions drawn, in general, are inconclusive. The consequences of this new policy of healthcare austerity are apparent in terms of access to the system, but no systematic effects on the health of the general population are reported. Studies based on indicators of premature mortality, avoidable mortality or self-perceived health have not found clear negative effects of the crisis on public health. The increased demands for co-payment provoked a short-term cutback in the consumption of medicines, but this effect faded after 12-18 months. No deterioration in the health of immigrants after the onset of the crisis was unambiguously detected. The impact of the recession on the general population in terms of diseases associated with mental health is well documented; however, the high levels of unemployment are identified as direct causes. Therefore, social policies rather than measures affecting the healthcare system would be primarily responsible. In addition, some health problems have a clear social dimension, which seems to have become more acute during the crisis, affecting in particular the most vulnerable population groups and the most disadvantaged social classes, thus widening the inequality gap.

Math, A. (2017). "L'impact des conditions macroéconomiques sur l'état de santé." Revue De L'ires(91-92): 49-75, tab.

La réponse principale à la violente crise économique commencée en 2007 a été la mise en place et le renforcement de politiques de rigueur dans de nombreux pays. Or, les difficultés économiques marquent les corps et les vies de celles et ceux qui en souffrent. Dans ce contexte, mener une politique d'austérité ou de relance peut avoir des effets différenciés sur la santé de la population. Cet article a pour objectif de proposer un état de l'art sur la relation ambiguë entre conditions macroéconomiques et santé – est-ce la crise économique ou l'austérité qui détériore l'état de santé ? Si les travaux des économistes ont tendance à montrer que la crise économique est bonne pour la santé, une littérature plus récente issue de l'épidémiologie démontre qu'en cas de fluctuation économique la réponse politique est déterminante : quand la relance peut sauver des vies, l'austérité tue.

Reibling, N., Beckfield, J., Huijts, T., et al. (2017). "Depressed during the depression: has the economic crisis affected mental health inequalities in Europe? Findings from the European Social Survey (2014) special module on the determinants of health." Eur J Public Health **27**(suppl_1): 47-54.

Background: Economic crises constitute a shock to societies with potentially harmful effects to the mental health status of the population, including depressive symptoms, and existing health inequalities. With recent data from the European Social Survey (2006-14), this study investigates how the economic recession in Europe starting in 2007 has affected health inequalities in 21 European nations. Depressive feelings were measured with the CES-D eight-item depression scale. We tested for measurement invariance across different socio-economic groups. Overall, depressive feelings have decreased between 2006 and 2014 except for Cyprus and Spain. Inequalities between persons whose household income depends mainly on public benefits and those who do not have decreased, while the development of depressive feelings was less favorable among the precariously employed and the inactive than among the persons employed with an unlimited work contract. There are no robust effects of the crisis measure on health inequalities. Negative implications for mental health (in terms of depressive feelings) have been limited to some of the most strongly affected countries, while in the majority of Europe persons have felt less depressed over the course of the recession. Health inequalities have persisted in most countries during this time with little influence of the recession. Particular attention should be paid to the mental health of the inactive and the precariously employed.

Rivera, B., Casal, B. et Currais, L. (2017). "Crisis, suicide and labour productivity losses in Spain." Eur J Health Econ **18**(1): 83-96.
http://link.springer.com/article/10.1007%2Fs10198-015-0760-3

OBJECTIVES: Suicide became the first cause of death between the ages of 15 and 44 in Spain in the year 2013. Moreover, the suicide rate in Spain went up by more than 9 % with respect to the previous year. This increase could be related to the serious economic recession that Spain has been experiencing in recent years. In this sense, there is a lack of evidence to help assess to what extent these suicides have a social cost in terms of losses in human capital. Firstly, this article examines the relationship between the variables related to the economic cycle and the suicide rates in the 17 Spanish regions. Secondly, an estimate is made of the losses in labour productivity owing to these suicides. METHODOLOGY: In this article, panel data models are used to consider different variables related to the economic cycle. Demographic variables and the suicide rates for regions across Spain from 2002 to 2013 also come into play. The present and future production costs owing to premature death from suicide are calculated using a human capital model. These costs are valued from the gross salary that an individual no longer receives in the future at the very moment he or she leaves the labour market. RESULTS: The results provide a strong indication that a decrease in economic growth and an increase in unemployment negatively affect suicide rates. Due to suicide, 38,038 potential years of working life were lost in 2013. This has an estimated cost of over 565 million euros. CONCLUSIONS: The economic crisis endured by Spain in recent years has played a role in the higher suicide rates one can observe from the data in official statistics. From a social perspective, suicide is a public health problem with far-reaching consequences.

Sarti, S., Terraneo, M. et Tognetti Bordogna, M. (2017). "Poverty and private health expenditures in Italian households during the recent crisis." Health Policy **121**(3): 307-314.

The global financial crisis that began in 2008 had an overall effect on the health behaviours of Italian households. Aggregate private health expenditures have decreased while the citizens have increasingly been asked to share health costs. The reduction of households' health expenditure could have serious consequences for health, especially if it concerns the most vulnerable people. The aim of this paper is to analyse the relation between poverty and household health expenditure, considering regional and social group variations. The data used stem from the "Family Expenditure Survey" collected by the Italian Statistical Institute (ISTAT) from 1997 to 2013. Results of multivariate analysis controlling for potential socio-demographic confounders show that the propensity to spend for poor families is decreased in the last years compared to not poor households. Meanwhile, among the households who spend, the average expenditure in euro seems to have been more stable over time. This is an alarming signal for the health of the most vulnerable households. These conditions could result in a gradual deterioration of health in poor families, which is likely to increase the burden on health systems in future. Hence, at this moment public intervention does not seem able to alleviate this situation.

Sirven, N. et Barnay, T. (2017). "Expectations, loss aversion and retirement decisions in the context of the 2009 crisis in Europe." International Journal of Manpower **38**(1): 25-44.
http://www.emeraldinsight.com/doi/abs/10.1108/IJM-02-2016-0041

Purpose The purpose of this paper is to estimate a reduced form model of expectations-based reference-dependent preferences to explain job retention of older workers in Europe in the context of the 2009 economic crisis. Design/methodology/approach Using individual micro-economic longitudinal data from the Survey of Health, Ageing, and Retirement in Europe between 2006 and 2011, the authors derive a measure of “good, bad or no surprise” from workers’ anticipated evolution of their standard of living five years from 2006 (reference point) and from a comparison of their capacity to make ends meet between 2006 and 2011. Findings The authors find that the probability to remain on the labour market in 2011 is significantly higher for individuals who experienced a lower than expected standard of living. The effect of a “bad surprise” on job retention is larger than the effect of a “good surprise” once netted out from the effects of expectations at baseline, change in consumption utility, and the usual life-cycle determinants on job retention of older workers. Originality/value The authors interpret this result as an evidence of loss aversion in the case the reference point is based on individuals’ expectations. The authors also find that loss aversion is more common among men, risk-averse individuals and those with a higher perceived life expectancy.

Strumpf, E. C., Charters, T. J., Harper, S., et al. (2017). "Did the Great Recession affect mortality rates in the metropolitan United States? Effects on mortality by age, gender and cause of death." Soc Sci Med **189**: 11-16.

OBJECTIVES: Mortality rates generally decline during economic recessions in high-income countries, however gaps remain in our understanding of the underlying mechanisms. This study estimates the impacts of increases in unemployment rates on both all-cause and cause-specific mortality across U.S. metropolitan regions during the Great Recession. METHODS: We estimate the effects of economic conditions during the recent and severe recessionary period on mortality, including differences by age and gender subgroups, using fixed effects regression models. We identify a plausibly causal effect by isolating the impacts of within-metropolitan area changes in unemployment rates and controlling for common temporal trends. We aggregated vital statistics, population, and unemployment data at the area-month-year-age-gender-race level, yielding 527,040 observations across 366 metropolitan areas, 2005-2010. RESULTS: We estimate that a one percentage point increase in the metropolitan area unemployment rate was associated with a decrease in all-cause mortality of 3.95 deaths per 100,000 person years (95%CI -6.80 to -1.10), or 0.5%. Estimated reductions in cardiovascular disease mortality contributed 60% of the overall effect and were more pronounced among women. Motor vehicle accident mortality declined with unemployment increases, especially for men and those under age 65, as did legal intervention and homicide mortality, particularly for men and adults ages 25-64. We find suggestive evidence that increases in metropolitan area unemployment increased accidental drug poisoning deaths for both men and women ages 25-64. CONCLUSIONS: Our finding that all-cause mortality decreased during the Great Recession is consistent with previous studies. Some categories of cause-specific mortality, notably cardiovascular disease, also follow this pattern, and are more pronounced for certain gender and age groups. Our study also suggests that the recent recession contributed to the growth in deaths from overdoses of prescription drugs in working-age adults in metropolitan areas. Additional research investigating the mechanisms underlying the health consequences of macroeconomic conditions is warranted.

Tapia Granados, J. A. et Ionides, E. L. (2017). "Population health and the economy: Mortality and the Great Recession in Europe." Health Econ **26**(12): e219-e235.

We analyze the evolution of mortality-based health indicators in 27 European countries before and after the start of the Great Recession. We find that in the countries where the crisis has been particularly severe, mortality reductions in 2007-2010 were considerably bigger than in 2004-2007. Panel models adjusted for space-invariant and time-invariant factors show that an increase of 1 percentage point in the national unemployment rate is associated with a reduction of 0.5% (p < .001) in the rate of age-adjusted mortality. The pattern of mortality oscillating procyclically is found for total and sex-specific mortality, cause-specific mortality due to major causes of death, and mortality for ages 30-44 and 75 and over, but not for ages 0-14. Suicides appear increasing when the economy decelerates-countercyclically-but the evidence is weak. Results are robust to using different weights in the regression, applying nonlinear methods for detrending, expanding the sample, and using as business cycle indicator gross domestic product per capita or employment-to-population ratios rather than the unemployment rate. We conclude that in the European experience of the past 20 years, recessions, on average, have beneficial short-term effects on mortality of the adult population.

Tavares, A. I. et Zantomio, F. (2017). Inequity in healthcare use among older people after 2008: The case of Southern European Countries. Working paper ; 17/06. Londres University of York**:** 25 , tabl.
http://www.york.ac.uk/economics/postgrad/herc/hedg/wps/

Despite the sizeable cuts in public healthcare spending, part of the austerity measures recently undertaken in Southern European countries, little attention has been devoted to monitoring distributional aspects of healthcare usage. This study aims at measuring socioeconomic inequities in primary and secondary healthcare experienced some time after the crisis onset in Italy, Spain and Portugal. The analysis, based on data drawn from the Survey of Health, Ageing and Retirement in Europe (SHARE), focuses on older people, who generally face significantly higher healthcare needs, and whose health appeared to have worsened in the aftermath of the crisis. The Horizontal Inequity indexes reveal remarkable socioeconomic inequities in older people's access to secondary healthcare in all three countries. In Portugal, the one country facing most severe healthcare budget cuts and where user charges apply also to GP visits, even access to primary care exhibits a significant pro-rich concentration. If reducing inequities in older people's access to healthcare remains a policy objective, austerity measures maybe pulling the Olive belt countries further away from achieving it.

Wang, C., Wang, H. et Halliday, T. (2017). Health and Health Inequality during the Great Recession: Evidence from the PSID. Working paper ; 10808. Bonn IZA**:** 32 , tabl., fig.
http://ftp.iza.org/dp10808.pdf

We estimate the impact of the Great Recession of 2007–2009 on health outcomes in the United States. We show that a one percentage point increase in the unemployment rate resulted in a 7.8–8.8 percent increase in reports of poor health. Mental health was also adversely impacted and reports of chronic drinking increased. These effects were concentrated among those with strong labor force attachments. Whites, the less educated, and women were the most impacted demographic groups.

Wouters, O. J. et McKee, M. (2017). "Private Financing of Health Care in Times of Economic Crisis: a Review of the Evidence." Global Policy **8**: 23-29.
http://dx.doi.org/10.1111/1758-5899.12211

Many high-income countries have cut public health care spending since the global economic downturn in 2008. In some cases these cuts have been accompanied by calls to expand private financing to improve the efficiency of health systems. In low and middle-income countries seeking to increase access to health care, it is sometimes suggested that private financing is more effective than public financing because of weak state institutions and bureaucratic shortcomings. In this paper, we review the theoretical and empirical evidence on private financing in terms of cost, efficiency, equity and financial protection. We consider private health insurance, medical savings accounts and user charges in high, middle and low-income countries. The theoretical and empirical evidence reveals major market failures in the health sector. It is unlikely that private financing generates better results than public financing. Still, as private financing options are heterogeneous, it is possible that a particular form might play a beneficial role in a specific setting. Given the current state of knowledge, however, any calls to increase private financing must be accompanied by robust evidence, such as real world pilot studies.

2016

Brall, C., et al. (2016). "The Economic Crisis and Its Ethical Relevance for Public Health in Europe - an Analysis in the Perspective of the Capability Approach." Cent Eur J Public Health **24**(1): 3-8.

Policy responses to the economic crisis have manifest consequences to European population health and health systems. The aim of this article is to assess, by using the capability approach advanced by Sen, the ethical dimension of trade-offs made in health policy due to austerity measures. From a capability approach point of view, austerity measures such as reducing resources for health care, further deregulating the health care market or moving towards privatisation are ethically challenging since they limit opportunities and capabilities for individuals of a population. Public policies should thus aim to guarantee sufficient capabilities (options to access health care and possibilities to make healthy choices) for its populations. Prioritising those in need is a notion the capability approach particularly focuses on in its goal of supporting those with the least capabilities.

Burke, S. A., et al. (2016). "From universal health insurance to universal healthcare? The shifting health policy landscape in Ireland since the economic crisis." Health Policy **120**(3): 235-240.

Ireland experienced one of the most severe economic crises of any OECD country. In 2011, a new government came to power amidst unprecedented health budget cuts. Despite a retrenchment in the ability of health resources to meet growing need, the government promised a universal, single-tiered health system, with access based solely on medical need. Key to this was introducing universal free GP care by 2015 and Universal Health Insurance from 2016 onwards. Delays in delivering universal access and a new health minister in 2014 resulted in a shift in language from 'universal health insurance' to 'universal healthcare'. During 2014 and 2015, there was an absence of clarity on what government meant by universal healthcare and divergence in policy measures from their initial intent of universalism. Despite the rhetoric of universal healthcare, years of austerity resulted in poorer access to essential healthcare and little extension of population coverage. The Irish health system is at a critical juncture in 2015, veering between a potential path to universal healthcare and a system, overwhelmed by years of austerity, which maintains the status quo. This papers assesses the gap between policy intent and practice and the difficulties in implementing major health system reform especially while emerging from an economic crisis.

Heras-Mosteiro, J., et al. (2016). "Health Care Austerity Measures in Times of Crisis: The Perspectives of Primary

Health Care Physicians in Madrid, Spain." International Journal of Health Services **46**(2): 283-299.

The current financial crisis has seen severe austerity measures imposed on the Spanish health care system, including reduced public spending, copayments, salary reductions, and reduced services for undocumented migrants. However, the impacts have not been well-documented. We present findings from a qualitative study that explores the perceptions of primary health care physicians in Madrid, Spain. This article discusses the effects of austerity measures implemented in the public health care system and their potential impacts on access and utilization of primary health care services. This is the first study, to our knowledge, exploring the health care experiences during the financial crisis of general practitioners in Madrid, Spain. The majority of participating physicians disapproved of austerity measures implemented in Spain. The findings of this study suggest that undocumented migrants should regain access to health care services; copayments should be minimized and removed for patients with low incomes; and health care professionals should receive additional help to avoid burnout. Failure to implement these measures could result in the quality of health care further deteriorating and could potentially have long-term negative consequences on population health.

Jiménez-Martín, S., et al. (2016). "Interactions between Private Health and Long-term Care Insurance and the Effects of the Crisis: Evidence for Spain." Health Economics **25**(0): 159-179.

This paper analyzes the reasons for the scarce development of the private long-term care insurance market in Spain, and its relationship with health insurance. We are also interested in the effects the crisis has had both on the evolution of the demand for long-term care insurance and on the existence of regional disparities. We estimate bivariate probit models with endogenous variables using Spanish data from the Survey on Health and Retirement in Europe. Our results confirm that individuals wishing to purchase long-term care insurance are, in a sense, forced to subscribe a health insurance policy. In spite of this restriction in the supply of long-term care insurance contracts, we find its demand has grown in recent years, which we attribute to the budget cuts affecting the implementation of Spain's System of Autonomy and Attention to Dependent People. Regional differences in its implementation, as well as the varying effects the crisis has had across Spanish regions, lead to the existence of a crowding-in effect in the demand for long-term care insurance in those regions where co-payment is based on income and wealth, those that have a lower percentage of public long-term care beneficiaries, or those with a smaller share of cash benefits over total public benefits. Copyright © 2016 John Wiley & Sons, Ltd.

Karanikolos, M., et al. (2016). "Access to care in the Baltic States: did crisis have an impact?" The European Journal of Public Health **26**(2): 236-241.

Background: In 2009, brief but deep economic crisis profoundly affected the three Baltic States: Estonia, Latvia and Lithuania. In response, all three countries adopted severe austerity measures with the shared goal of containing rising deficits, but employing different methods. Aims: In this article, we analyze the impact of the economic crisis and post-crisis austerity measures on health systems and access to medical services in the three countries. Methods: We use the EU-SILC data to analyze trends in unmet medical need in 2005–2012, and apply log-binomial regression to calculate the risk of unmet medical need in the pre- and post- crisis period. Results: Between 2009 and 2012 unmet need has increased significantly in Latvia (OR: 1.24, 95% confidence interval (CI): 1.15–1.34) and Estonia (OR: 1.98, 95% CI: 1.72–2.27), but not Lithuania (OR: 0.84. 95% CI: 0.69–1.04). The main drivers of increased unmet need were inability to afford care in Latvia and long waiting lists in Estonia. Conclusion: The impact of the crisis on access to care in the three countries varied, as did the austerity measures affecting their health systems. Estonia and Latvia experienced worsening access to care, largely exacerbating already existing barriers. The example of Lithuania suggests that deterioration in access is not inevitable, once health policies prioritise maintenance and availability of existing services, or if there is room for reducing existing inefficiencies. Moreover, better financial preparedness of health systems in Estonia and Lithuania achieved some protection of the population from increasing unmet need due to the rising cost of medical care.

Karanikolos, M., et al. (2016). "Effects of the Global Financial Crisis on Health in High-Income Oecd Countries: A Narrative Review." International Journal of Health Services **46**(2): 208-240.

A growing body of evidence documents how economic crises impact aspects of health across countries and over time. We performed a systematic narrative review of the health effects of the latest economic crisis based on studies of high-income countries. Papers published between January 2009 and July 2015 were selected based on review of titles and abstracts, followed by a full text review conducted by two independent reviewers. Ultimately, 122 studies were selected and their findings summarized. The review finds that the 2008 financial crisis had negative effects on mental health, including suicide, and to a varying extent on some non-communicable and communicable diseases and access to care. Although unhealthy behaviors such as hazardous drinking and tobacco use appeared to decline during the crisis, there have been increases in some groups, typically those already at greatest risk. The health impact was greatest in countries that suffered the largest economic impact of the crisis or prolonged austerity. The Great Recessions in high-income countries have had mixed impacts on health. They tend to be worse when economic impacts are more severe, prolonged austerity measures are implemented, and there are pre-existing problems of substance use among vulnerable groups.

Karanikolos, M. et Kentikelenis, A. (2016). "Health inequalities after austerity in Greece." Int J Equity Health **15**: 83.

Since the beginning of economic crisis, Greece has been experiencing unprecedented levels of unemployment and profound cuts to public budgets. Health and welfare sectors were subject to severe austerity measures, which have endangered provision of as well as access to services, potentially widening health inequality gap. European Union Statistics on Income and Living Conditions data show that the proportion of individuals on low incomes reporting unmet medical need due to cost doubled from 7 % in 2008 to 13.9 % in 2013, while the relative gap in access to care between the richest and poorest population groups increased almost ten-fold. In addition, austerity cuts have affected other vulnerable groups, such as undocumented migrants and injecting drug users. Steps have been taken in attempt to mitigate the impact of the austerity, however addressing the growing health inequality gap will require persistent effort of the country's leadership for years to come.

Legido-Quigley, H., et al. (2016). "Effects of the financial crisis and Troika austerity measures on health and health care access in Portugal." Health Policy **120**(7): 833-839.

Although Portugal has been deeply affected by the global financial crisis, the impact of the recession and subsequent austerity on health and to health care has attracted relatively little attention. We used several sources of data including the European Union Statistics for Income and Living Conditions (EU-SILC) which tracks unmet medical need during the recession and before and after the Troika's austerity package. Our results show that the odds of respondents reporting having an unmet medical need more than doubled between 2010 and 2012 (OR=2.41, 95% CI 2.01-2.89), with the greatest impact on those in employment, followed by the unemployed, retired, and other economically inactive groups. The reasons for not seeking care involved a combination of factors, with a 68% higher odds of citing financial barriers (OR=1.68, 95% CI 1.32-2.12), more than twice the odds of citing waiting times and inability to take time off work or family responsibilities (OR 2.18, 95% CI 1.20-3.98), and a large increase of reporting delaying care in the hope that the problem would resolve on its own (OR=13.98, 95% CI 6.51-30.02). Individual-level studies from Portugal also suggest that co-payments at primary and hospital level are having a negative effect on the most vulnerable living in disadvantaged areas, and that health care professionals have concerns about the impact of recession and subsequent austerity measures on the quality of care provided. The Portuguese government no longer needs external assistance, but these findings suggest that measures are now needed to mitigate the damage incurred by the crisis and austerity.

Max, C., et al. (2016). "Health Disparities by Income in Spain Before and After the Economic Crisis." Health Economics **25**(0): 141-158.

Little is known about how health disparities by income change during times of economic crisis. We apply a decomposition method to unravel the contributions of income growth, income inequality and differential income mobility across socio-demographic groups to changes in health disparities by income in Spain using longitudinal data from the Survey of Income and Living Conditionsfor the period 2004–2012. We find a modest rise in health inequality by income in Spain in the 5 years of economic growth prior to the start of the crisis in 2008, but a sharp fall after 2008. The drop mainly derives from the fact that loss of employment and earnings has disproportionately affected the incomes of the younger and healthier groups rather than the (mainly stable pension) incomes of the groups over 65 years. This suggests that unequal distribution of income protection by age may reduce health inequality in the short run after an economic recession. Copyright © 2016 John Wiley & Sons, Ltd.

Palladino, R., et al. (2016). "The Great Recession And Increased Cost Sharing In European Health Systems." Health Affairs **35**(7): 1204-1213.

European health systems are increasingly adopting cost-sharing models, potentially increasing out-of-pocket expenditures for patients who use health care services or buy medications. Government policies that increase patient cost sharing are responding to incremental growth in cost pressures from aging populations and the need to invest in new health technologies, as well as to general constraints on public expenditures resulting from the Great Recession (2007–09). We used data from the Survey of Health, Ageing and Retirement in Europe to examine changes from 2006–07 to 2013 in out-of-pocket expenditures among people ages fifty and older in eleven European countries. Our results identify increases both in the proportion of older European citizens who incurred out-of-pocket expenditures and in mean out-of-pocket expenditures over this period. We also identified a significant increase over time in the percentage of people who incurred catastrophic health expenditures (greater than 30 percent of the household income) in the Czech Republic, Italy, and Spain. Poorer populations were less likely than those in the highest income quintile to incur an out-of-pocket expenditure and reported lower mean out-of-pocket expenditures, which suggests that measures are in place to provide poorer groups with some financial protection. These findings indicate the substantial weakening of financial protection for people ages fifty and older in European health systems after the Great Recession.

Reeves, A., et al. (2016). "Public pensions and unmet medical need among older people: cross-national analysis of 16 European countries, 2004–2010." Journal of Epidemiology and Community Health **0**: 7.

Background Since the onset of the Great Recession in Europe, unmet need for medical care has been increasing, especially in persons aged 65 or older. It is possible that public pensions buffer access to healthcare in older persons during times of economic crisis, but to our knowledge, this has not been tested empirically in Europe. Methods We integrated panel data on 16 European countries for years 2004–2010 with indicators of public pension, unemployment insurance and sickness insurance entitlement from the Comparative Welfare Entitlements Dataset and unmet need (due to cost) prevalence rates from EuroStat 2014 edition. Using country-level fixed-effects regression models, we evaluate whether greater public pension entitlement, which helps reduce old-age poverty, reduces the prevalence of unmet medical need in older persons and whether it reduces inequalities in unmet medical need across the income distribution. Results We found that each 1-unit increase in public pension entitlement is associated with a 1.11 percentage-point decline in unmet medical need due to cost among over 65s (95% CI -0.55 to -1.66). This association is strongest for the lowest income quintile (1.65 percentage points, 95% CI -1.19 to -2.10). Importantly, we found consistent evidence that out-of-pocket payments were linked with greater unmet needs, but that this association was mitigated by greater public pension entitlement (ß=-1.21 percentage points, 95% CI -0.37 to -2.06). Conclusions Greater public pension entitlement plays a crucial role in reducing inequalities in unmet medical need among older persons, especially in healthcare systems which rely heavily on out-of-pocket payments.

2015

Buffel, V., et al. (2015). "Employment status and mental health care use in times of economic contraction: a repeated cross-sectional study in Europe, using a three-level model." Int J Equity Health **14**: 29.

INTRODUCTION: Framed within the recent economic crisis, in this study we investigate the medical mental health care use of the unemployed compared with that of the employed in Europe, and whether the relationship between employment status and mental health care use varies across macro-economic conditions. We examine whether the macro-economic context and changes therein are related to mental health care use, via their impact on mental health, or more directly, irrespective of mental health. METHODS: We use data from three waves of the Eurobarometer (2002, 2005/2006, and 2010), which has a repeated cross-sectional and cross-national design. Linear and logistic multilevel regression analyses are performed with mental health, contacting a general practitioner, and contacting a psychiatrist for mental health problems as dependent variables. The multilevel design has three levels (the individual, the period-country, and the country), which allows us to estimate both longitudinal and cross-sectional macro-effects. The macro-economic context and changes therein are assessed using national unemployment rates and growth rates in Gross Domestic Product (GDP). RESULTS: The mean unemployment rate is negatively related to mental health, although for women, this effect only applies to the employed. Among women, no relationship is found between changes in the macro-economic context and mental health. The unemployment rate, and changes in both the unemployment rate and the real GDP growth rate, are associated with men's care use, regardless of their mental health, whereas this does not hold for women. In countries with an increase in the unemployment rate, both unemployed and employed men tend to medicalize their problems more by contacting a general practitioner, irrespective of their mental health, while the likelihood of contacting a psychiatrist is lower among employed men. CONCLUSIONS: Our findings stress the importance of taking the macro-economic context and changes therein into account when studying the mental health care use of unemployed people compared with the employed, in particular among men. Moreover, it is important to make the distinction between primary and specialized medical care use, as the impact of macro-economic conditions is dependent on the type of care, which also applies when controlling for mental health.

Cawley, J., et al. (2015). "The impact of the macroeconomy on health insurance coverage: evidence from the great recession." Health Econ **24**(2): 206-223.

This paper investigates the impact of the macroeconomy on the health insurance coverage of Americans using panel data from the Survey of Income and Program Participation for 2004-2010, a period that includes the Great Recession of 2007-2009. We find that a one percentage point increase in the state unemployment rate is associated with a 1.67 percentage point (2.12%) reduction in the probability that men have health insurance; this effect is strongest among college-educated, white, and older (50-64 years old) men. For women and children, health insurance coverage is not significantly correlated with the unemployment rate, which may be the result of public health insurance acting as a social safety net. Compared with the previous recession, the health insurance coverage of men is more sensitive to the unemployment rate, which may be due to the nature of the Great Recession. Copyright (c) 2013 John Wiley & Sons, Ltd.

Fortes, P. A., et al. (2015). "Economic crisis and counter-reform of universal health care systems: Spanish case." Rev Saude Publica **49**: 34.

The economic crisis that has been affecting Europe in the 21st century has modified social protection systems in the countries that adopted, in the 20th century, universal health care system models, such as Spain. This communication presents some recent transformations, which were caused by changes in Spanish law. Those changes relate to the access to health care services, mainly in regards to the provision of care to foreigners, to financial contribution from users for health care services, and to pharmaceutical assistance. In crisis situations, reforms are observed to follow a trend which restricts rights and deepens social inequalities.

Kert, S., et al. (2015). "A cross-sectional study of socio-demographic factors associated with patient access to primary care in Slovenia." Int J Equity Health **14**(1): 39.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4411768/pdf/12939_2015_Article_166.pdf

INTRODUCTION: Primary care (PC) is the provision of universally accessible, integrated, person-centred, comprehensive health and community services. Professionals active in primary care teams include family physicians and general practitioners (FP/GPs). There is concern in Slovenia that the current economic crisis might change the nature of PC services. Access, one of the most basic requirements of general practice, is universal in Slovenia, which is one of the smallest European countries; under national law, compulsory health insurance is mandatory for its citizens. Our study examined access to PC in Slovenia during a time of economic crisis as experienced and perceived by patients between 2011 and 2012, and investigated socio-demographic factors affecting access to PC in Slovenia. METHODS: Data were collected as a part of a larger international study entitled Quality and Costs of Primary Care in Europe (QUALICOPC) that took place during a period of eight months in 2011 and 2012. 219 general practices were included; in each, the aim was to evaluate 10 patients. Dependent variables covered five aspects of access to PC: communicational, cultural, financial, geographical and organizational. 15 socio-demographic factors were investigated as independent variables. Descriptive statistics, factor analysis and multilevel analysis were applied. RESULTS: There were 1,962 patients in the final sample, with a response rate of 89.6%. The factors with the most positive effect on access to PC were financial and cultural; the most negative effects were caused by organizational problems. Financial difficulties were not a significant socio-demographic factor. Greater frequency of visits improves patients' perception of communicational and cultural access. Deteriorating health conditions are expected to lower perceived geographical access. Patients born outside Slovenia perceived better organizational access than patients born in Slovenia. CONCLUSIONS: Universal medical insurance in Slovenia protects most patients from PC inaccessibility. However, problems perceived by patients may indicate the need for changes in the organization of PC.

Maresso, A. (éd.), et al. (2015). Economic crise, health systems and health in Europe : country experience, Copenhague : : Bureau Régional de l'Europe
http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/economic-crisis,-health-systems-and-health-in-europe-country-experiences

The financial and economic crisis has had a visible but varied impact on many health systems in Europe, eliciting a wide range of responses from governments faced with increased financial and other pressures. This book maps health system responses by country, providing a detailed analysis of policy changes in nine countries and shorter overviews of policy responses in 47 countries. It draws on a large study involving over one hundred health system experts and academic researchers across Europe. Focusing on policy responses in three areas – public funding of the health system, health coverage and health service planning, purchasing and delivery – this book gives policymakers, researchers and others valuable, systematic information about national contexts of particular interest to them, ranging from countries operating under the fiscal and structural conditions of international bailout agreements to those that, while less severely affected by the crisis, still have had to operate in a climate of diminished public sector spending since 2008. Along with a companion volume that analyses the impact of the crisis across countries, this book is part of a wider initiative to monitor the effects of the crisis on health systems and health, to identify those policies most likely to sustain the performance of health systems facing fiscal pressure and to gain insight into the political economy of implementing reforms in a crisis (résumé des éditeurs).

Peiró, S. et Maynard, A. S. (2015). "Variations in health care delivery within the European Union." The European Journal of Public Health **25**(suppl 1): 1-2.
http://eurpub.oxfordjournals.org/eurpub/25/suppl_1/1.full.pdf
http://eurpub.oxfordjournals.org/content/eurpub/25/suppl_1/1.full.pdf

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Biomédica de la Comunidad Valenciana (FISABIO), Valencia, Spain2 Red de Investigación en Servicios de Salud en Enfermedades Crónicas (REDISSEC), Valencia, Spain3 Department of Health Sciences, University of York, York, UKCorrespondence: Salvador Peiró, FISABIO, Valencia, Spain, Tel: +34 961 925 916, Fax: +34 961 925 703, e-mail: peiro_bor{at}gva.esHealth care systems over troubled water European Union (EU) healthcare systems, whether they are National Health Services or Social Insurance systems, are going through difficult times. Governments, the healthcare community and the public are increasingly concerned about the growth of health spending and the sustainability of their healthcare systems. The current economic crisis—the most intense, comprehensive and long lasting in post-war Europe—with its corollary of tax revenue falling, increased social needs and financial failure of the States, has contributed decisively to accentuate this concern, and placed health spending (along other items of social spending) as a critical aspect of the policies to control public sector deficits. While some of the contemporary concerns are directly related to the current economic crisis the recession has exerabated pre-existing problems. The pressures on all healthcare systems are familiar but resistant to resolution. First, there have been changes in morbidity patterns with the emergence of chronicity and multi-morbidities as the main drivers of healthcare utilization in developed countries. Disease is now evolving into a continuum of exacerbations and relapses leading to long-term functional impairment. These new morbidity patterns require changes in existing organizational structures and the integration of fragmented healthcare delivery systems. Unfortunately an evidence base to facilitate such innovation is absent. Second, the acceleration of technological change (in preventive, diagnostic, therapeutic, surgical, biological, imaging and other technologies), with a very rapid incorporation of new drugs, tests and devices into routine clinical practice has fuelled expenditure inflation. These new technologies sometimes involve significant clinical innovations (although not always cost-effectively) and, in other cases, the 'innovation' is limited to increased in prices (rather than to improved clinical outcomes). The combination of new drugs and technologies …

Perelman, J., et al. (2015). "The Great Recession in Portugal: Impact on hospital care use." Health Policy **119**(3): 307-315.
http://www.healthpolicyjrnl.com/article/S0168-8510(14)00349-2/abstract

The Great Recession started in Portugal in 2009, coupled with severe austerity. This study examines its impact on hospital care utilization, interpreted as caused by demand-side effects (related to variations in population income and health) and supply-side effects (related to hospitals' tighter budgets and reduced capacity). The database included all in-patient stays at all Portuguese NHS hospitals over the 2001-2012 period (n=17.7 millions). We analyzed changes in discharge rates, casemix index, and length of stay (LOS), using a before-after methodology. We additionally measured the association of health care indicators to unemployment. A 3.2% higher rate of discharges was observed after 2009. Urgent stays increased by 2.5%, while elective in-patient stays decreased by 1.4% after 2011. The LOS was 2.8% shorter after the crisis onset, essentially driven by the 4.5% decrease among non-elective stays. A one percentage point increase in unemployment rate was associated to a 0.4% increase in total volume, a 2.3% decrease in day cases, and a 0.1% decrease in LOS. The increase in total and urgent cases may reflect delayed out-patient care and health deterioration; the reduced volume of elective stays possibly signal a reduced capacity; finally, the shorter stays may indicate either efficiency-enhancing measures or reduced quality.

Tapia Granados, J. A. et Rodriguez, J. M. (2015). "Health, economic crisis, and austerity: A comparison of Greece, Finland and Iceland." Health Policy **119**(7): 941-953.

Reports have attributed a public health tragedy in Greece to the Great Recession and the subsequent application of austerity programs. It is also claimed that the comparison of Greece with Iceland and Finland-where austerity policies were not applied-reveals the harmful effect of austerity on health and that by protecting spending in health and social budgets, governments can offset the harmful effects of economic crises on health. We use data on life expectancy, mortality rates, incidence of infectious diseases, rates of vaccination, self-reported health and other measures to examine the evolution of population health and health services performance in Greece, Finland and Iceland since 1990-2011 or 2012-the most recent years for which data are available. We find that in the three countries most indicators of population health continued improving after the Great Recession started. In terms of population health and performance of the health care system, in the period after 2007 for which data are available, Greece did as good as Iceland and Finland. The evidence does not support the claim that there is a health crisis in Greece. On the basis of the extant evidence, claims of a public health tragedy in Greece seem overly exaggerated.

Towne, S. D., Jr., et al. (2015). "Differences in the Effects of the Great Recession on Health Outcomes among Minority Working-Age Adults." J Racial Ethn Health Disparities **2**(1): 43-52.

INTRODUCTION: We examined the effects of the Great Recession (December 2007-June 2009) among vulnerable adults who may be at high risk of poor health and low access to health care. METHODS: Our primary outcomes of interest were self-reported health status (fair/poor versus good/very good/excellent), and foregoing needed health care due to cost in the past 12 months. RESULTS: Racial and ethnic minorities, except Asians, experienced higher rates of poor/fair health and higher rates of forgone medical care than did White adults. Hispanic and AIAN adults experienced differential effects of the Great Recession, as compared to White adults. CONCLUSIONS: Understanding how vulnerable populations react in times of economic flux will enable policy makers to identify strategies/policies to lessen the burden experienced by vulnerable adults.

2014

Baumbach, A. et Gulis, G. (2014). "Impact of financial crisis on selected health outcomes in Europe." Eur J Public Health **24**(3): 399-403.

BACKGROUND: A number of health outcomes were affected by previous financial crises, e.g. suicides, homicides and transport accident mortality. Aim of this study was to analyse the effects of the current financial crisis on selected health outcomes at population level in Europe. METHODS: A mixed approach of ecologic and time trend design was applied, including correlation analysis. For eight countries, data on the economic situation (unemployment rate and economic growth) and health indicators (overall mortality, suicide and transport accident mortality) was drawn from EUROSTAT database for 2000-10. Spearman's rank correlation was applied to analyse the influence of social protection on the association between exposure and outcome variables. RESULTS: The financial crisis had no visible effect on overall mortality in any of the eight countries until 2010. Transport accident mortality decreased in all eight countries, in the range of 18% in Portugal to 52% in Slovenia. In contrast, suicide mortality increased in Germany (+5.3%), Portugal (+5.2%), Czech Republic (+7.6%), Slovakia (+22.7%) and Poland (+19.3%). The effect of unemployment on suicide is higher in countries with lower social spending (Spearman's r = -0.83). DISCUSSION: Clear cause-effect relations could not be established owing to the ecological study design and issues concerning data availability. However, there are clear changes in suicide and transport accident mortality after onset of the crisis, and findings are consistent with previous work. As part of this work, a comprehensive framework was developed, which can be applied to analyse health effects of financial crises in more detail

Chauvin, P., et al. (2014). L'accès aux soins des plus précaires dans une Europe en crise sociale. Le cas des femmes enceintes et des enfants. Paris MDM**:** 38 , tabl., fig.
http://www.medecinsdumonde.org/Publications/Les-Rapports/A-l-international/Rapport-sur-l-acces-aux-soins-des-plus-precaires-dans-une-Europe-en-crise

Dans ce rapport, le réseau international de Médecins du Monde présente les chiffres clés des données 2013 recueillies au cours de 29 400 consultations dans quelques-uns de ses centres d'accès aux soins (dans 25 villes de huit pays européens : Allemagne, Belgique, Espagne, France, Grèce, Pays-Bas, Royaume-Uni, Suisse) :2/3 des femmes enceintes n'ont pas eu accès aux soins prénataux avant de consulter dans les centres de MdM. Parmi celles qui avaient accès aux soins prénataux, 43 % avaient été suivies trop tardivement. Seul un mineur sur deux, au mieux, est vacciné contre le tétanos, l'hépatite B, la rougeole ou la coqueluche. Dans certains pays, ce taux est inférieur à 30 %, ce qui est bien en-deçà des taux de couverture vaccinale de la population générale, qui se situent autour de 90 %. Seules 2% des personnes citent la santé personnelle comme motif de migration, réfutant ainsi l'idée reçue que les mécanismes de protection sociale représentent un facteur d'attraction pour les migrants. 76 % des personnes interrogées ont rapporté avoir vécu au moins une expérience de violence. Près de 20 % des violences ont été subies en Europe.

Fanourgiakis, J. et Kanoupakis, E. (2014). "Catastrophic healthcare expenditure during economic recession in the field of cardiovascular disease." Expert Rev Pharmacoecon Outcomes Res **14**(1): 5-8.
http://www.ncbi.nlm.nih.gov/pubmed/24308449

Economic crisis drives many governments into drastic spending cuts in order to minimize their healthcare costs, resulting in an increase of out-of-pocket payment. This causes mainly the most vulnerable social groups, not only in poor countries, to lose their access to quality care and their ability to pay, and leads them in to catastrophic healthcare expenditures. Questions about whether health spending can be catastrophic rise across nations where there is an income reduction, unemployment and serious or chronic illness. Cardiovascular disease is the number one cause of death today. The first cost-of-illness study, which estimated the costs of cardiovascular disease in the EU in 2003, found them to be euro169 billion a year, while the most recent, in 2009, estimated them at nearly euro196 billion a year. Financial protection measures must be taken by governments in order to protect their citizens, particularly the most vulnerable ones

Simou, E. et Koutsogeorgou, E. (2014). "Effects of the economic crisis on health and healthcare in Greece in the literature from 2009 to 2013: A systematic review." Health Policy **115**(2-3): 111-119.

BACKGROUND: Due to the current economic crisis in Greece, effects on health and healthcare have been reported. The aim of this study was to present a systematic overview of the consequences that the financial crisis has had for health and healthcare in Greece. METHODS: Systematic literature review was conducted in order to identify articles that were published from January 2009 to March 2013 and explicitly referred to the effects of economic crisis on health or healthcare, in Greece. Data extraction and synthesis was performed with the use of thematic analysis. FINDINGS: Thirty-nine studies were considered for further analyses. Various existing and potential relevant effects were identified, including reductions in public health expenditure and changes in healthcare services and the pharmaceutical market, with an increasing number of admissions in public healthcare sector, and efficiency and organizational-related issues being evident, overall. Indications were found for post-crisis deterioration of public health with increasing rates of mental health, suicides, and epidemics, and deterioration of self-rated health. CONCLUSION: The recent efforts to reform the Greek National Health System have been focusing mainly on short-term effects by reducing expenditure, while the measures imposed seem to have dubious long-term consequences for Greek public health and healthcare

Thomson, S. (éd.), et al. (2014). Health system responses to financial pressures in Ireland. Policy options in an international context, Copenhague : OMS Bureau régional de l'Europe
http://www.euro.who.int/__data/assets/pdf_file/0006/260088/Health-system-responses-to-financial-pressures-in-Ireland.pdf

Ireland's recent financial and economic crisis – one of the most severe in the European Union – led to unprecedented reductions in levels of public spending. Public spending on the health sector fell particularly sharply. How did the Irish health system respond to the financial pressure created by the crisis? What were the options available to health policymakers as they sought to adapt to a lower level of public financing? How did the policy changes introduced affect the health system's performance? These are some of the questions this book addresses. Originally commissioned by the Department of Health in Ireland, the book draws on international experience to assess and reflect on the challenges the health system has faced as a result of the crisis, to review underlying structural issues in the health sector and to identify priority areas for improving efficiency, quality and equitable access to health care. The book will be of interest to policy-makers and researchers in Ireland and other countries who want to understand the short- and longer term implications of sharp reductions in public spending on health (4ème de couv.)

Vazquez, M. L., et al. (2014). "[The impact of the economic crisis on the health and healthcare of the immigrant population. SESPAS report 2014]." Gac Sanit **28 Suppl 1**: 142-146.

Despite the economic crisis, the immigrant population of Spain continues to be high, with 5.7 million persons (11.4%). This population, whose health needs are similar to those of the general population, is more vulnerable due to their exposure to worse social determinants (living and working conditions together with a higher risk of exclusion from social services). In this article, we analyze how the economic crisis affects or can affect the health of the immigrant population in Spain by examining distinct population-specific or institutional factors that influence the effects of the crisis and the available data. The available evidence is limited, but several effects can be identified: firstly, some social determinants, such as higher unemployment rates and worse working conditions, have deteriorated, which can be expected to lead to a worsening of health status. These consequences have already been described for mental health or have been estimated for infectious diseases. Secondly, political decisions have had a direct impact, excluding-with some exceptions-undocumented immigrants from the right to health care. Finally, the lower priority given to adapting health services to the specific characteristics of the immigrant population (most of whom are documented) together with the introduction of new barriers, has hampered or will hamper access to health care. As a result, the economic crisis can be expected to have a greater impact on the immigrant population.

2013

Antonanzas, F. (2013). "The impact of the economic downturn on healthcare in Spain: consequences and alternatives." Expert Review of Pharmacoeconomics & Outcomes Research **13**(4): 433-439.
http://dx.doi.org/10.1586/14737167.2013.815418

In Spain, the economic downturn has caused big changes in most of the public policies, where healthcare system is the one which is deeply affected too. The objective of the paper is to review some of the recent changes achieved in the system, and to discuss about providing some alternative ideas to the implemented policies. The existing universal coverage previous to the crisis, as acknowledged by the law, has changed last year and the new figure of 'insured person' has been introduced into the system. These persons are now the only ones eligible to receive healthcare under the public coverage. New co-payments have been introduced for drugs, and retired persons must also pay a 10% co-payment (which was 0% before) at the chemist office. Healthcare institutions have also implemented several policies to manage tough budget constraints. Some regions have privatized healthcare management of some hospitals (as Madrid) to control budget and presumably to obtain a higher efficiency. Different initiatives dealing with human resources and external purchases are also presented in this paper to mostly achieve budget control. The majority of the changes have been pure budget cuts and a reorganization of the system and institutions is still needed.

Ifanti, A. A., et al. (2013). "Financial crisis and austerity measures in Greece: Their impact on health promotion policies and public health care." Health policy (Amsterdam, Netherlands) **113**(1-2): 8-12.

This review study explores the available data relating to the impact of financial crisis and subsequently applied austerity measures on the health care, social services and health promotion policies in Greece. It is evident that Greece is affected more than any other European country by the financial crisis. Unemployment, job insecurity, income reduction, poverty and increase of mental disorders are among the most serious consequences of crisis in the socioeconomic life. The health system is particularly affected by the severe austerity measures. The drastic curtailing of government spending has significantly affected the structure and functioning of public hospitals that cope with understaffing, deficits, drug shortage and basic medical supplies. Moreover, health promotion policies are constrained, inhibiting thus the relevant initiatives toward disease prevention and health promotion education practices. Overall, the current economic situation in Greece and its impact on real life and health care is quite concerning. Policy makers should not disregard the implications that austerity and fiscal policies have on the health sector. Greater attention is needed in order to ensure that individuals would continue getting public health care and having access to preventive and social support services. To face the economic hardship, policy makers are expected to implement human-centered approaches, safeguarding the human dignity and the moral values

Karaca-Mandic, P., et al. (2013). "Recession led to a decline in out-of-pocket spending for children with special health care needs." Health Aff (Millwood) **32**(6): 1054-1062.

The 2007-09 recession led to an overall slowing in health care spending growth, but it is unclear whether the slowed spending growth had different impacts on adults and children. Although most children are healthy, forgoing routine health care could have long-term adverse implications for public health. Furthermore, children with special health care needs are at risk of adverse outcomes if they do not receive adequate care. Focusing on privately insured families with children, we investigated how out-of-pocket spending trends changed before and during the recession. Medical Expenditure Panel Survey data from the period 2001-09 revealed that the recession did not affect out-of-pocket spending for most children, but it led to a decline in spending for children with special needs, who had much higher out-of-pocket spending at baseline. Adults had significantly lower out-of-pocket spending during the recession, which suggests that parents may reduce their own medical care in difficult economic times to meet their children's health care needs.

Kondilis, E., et al. (2013). "Economic Crisis, Restrictive Policies, and the Population's Health and Health Care: The Greek Case." American Journal of Public Health **103**(6): 973-979.
http://dx.doi.org/10.2105/AJPH.2012.301126

2012

Browne, A. J., et al. (2012). "Closing the health equity gap: evidence-based strategies for primary health care organizations." International Journal for Equity in Health: 1-29.
http://www.equityhealthj.com/content/pdf/1475-9276-11-59.pdf

International evidence shows that enhancement of primary health care (PHC) services for disadvantaged populations is essential to reducing health and health care inequities. However, little is known about how to enhance equity at the organizational level within the PHC sector. Drawing on research conducted at two PHC Centres in Canada whose explicit mandates are to provide services to marginalized populations, the purpose of this paper is to discuss the key dimensions of equity-oriented services to guide PHC organizations, and strategies for operationalizing equity-orie- nted PHC services, particularly for marginalized populations.T he PHC Centres are located in two cities within urban neighborhoods recognized as among the poorest in Canada. Using a mixed methods ethnographic design, data were collected through intensive immersion in the Centres, and included: in-depth interviews with a total of 114 participants (73 patients; 41 staff), over 900 hours of participant observation, and an analysis of key organizational documents, which shed light on the policy and funding environments. Through our analysis, we identified four key dimensions of equity-oriented PHC services: inequity-responsive care; trauma-informed care; contextually-tailored care; and culturally competent care. The operationalization of these key dimensions are identified as 10 strategies that intersect to optimize the effectiveness of PHC services, particularly through improvements in the quality of care, an improved 'fit' between people's needs and services, enhanced trust and engagement by patients, and a shift from crisis-oriented care to continuity of care. Using illustrative examples from the data, these strategies are discussed to illuminate their relevance at three inter-related levels: organizational, clinical programming, and at the level of patient-provider interactions

Burstrom, B., et al. (2012). "Delayed and differential effects of the economic crisis in Sweden in the 1990s on

health-related exclusion from the labour market: a health equity assessment." Soc Sci.Med **75**(12): 2431-2436.

Many OECD countries are currently experiencing economic crisis and introducing counter-measures with unknown effects. To learn from previous experience, we explored whether there were delayed or differential effects of the Swedish recession in the 1990s and the government's response to it for people with limiting longstanding illness or disability (LLSI) from different socioeconomic groups (SEGs), by policy analysis and secondary data analysis of the Swedish Survey of Living Conditions (ULF) from 1978 to 2005. The government policy response involved cutting public expenditure, privatising some services and measures to boost private sector employment. There was a decline in overall employment rates from the early 1990s, particularly among men and women with LLSI and in lower SEGs. Public sector employment declined from 53 to 40 percent among women and from 23 to 14 percent among men. Private sector employment increased modestly for women (from 31 percent to 37 percent), and stayed stable at 59-60 percent among men. Following economic recovery, employment rates continued to decline among men and women with LLSI from manual SEGs, while the employment levels increased among most healthy men and women. There was a concomitant increase in rates of LLSI, sickness absence and rates of disability pension particularly among women in lower SEGs. Conclusion: The policy response to the 1990s economic crisis in Sweden had differential consequences, hitting the employment of women in the public sector, especially women with both LLSI and low socioeconomic status. The observed increase in disability pension rates, particularly among women with LLSI in lower SEGs, may be a delayed effect of the policy response to the economic crisis

Kaplan, G. A. (2012). "Economic crises: some thoughts on why, when and where they (might) matter for health--a tale of three countries." Soc Sci Med **74**(5): 643-646.

Economic crises can have important effects on a wide variety of determinants of individual and population health, and these effects may be played out over the life course. However, social and economic policies have the potential to mitigate at least some of the potential negative health effects of economic crises, and the substantial variation in these policies across countries suggests that the impact of economic crises may vary between countries. We know much less about this than we need to. Only with expanded efforts to provide a true accounting of the health costs of economic crises, and of the ways in which social and economic policies can reduce these costs, can we prepare ourselves to protect population health when the next economic crises happen, which they surely will.

Nuti, S., et al. (2012). "Healthcare resources and expenditure in financial crisis: scenarios and managerial strategies." J Matern Fetal Neonatal Med **25 Suppl 4**: 48-51.

OBJECTIVE: What are the implications of financial crisis on healthcare expenditure? This paper explores different approaches applied across European countries focusing on the role that managerial tools may have in coping with this challenge. METHOD: The paper reports the results of recent studies on responses to financial crisis from European countries and which are the techniques they had applied to reallocate resources. RESULTS: Although resources scarcity, some governments did not reduce the healthcare expenditure because they believe in its focal role on the economic development and on maintaining social cohesion and protection of vulnerable people. Other countries decided a strong reduction of costs which often has affected services delivered. In both cases authors suggest to avoid across-the-board cuts in favor of approach involving priority setting. CONCLUSION: The public sector has assumed new responsibilities following the global crisis and the rising demand for social services. Some countries shifted the healthcare costs from the public purse to private households undermining the survival of the health system and the universal coverage. A way to avoid this risk is based on the ability to share discussion about where to cut and where to reallocate resources.

Les effets de la crise sanitaire liée à la Covid-19 sur l'accès aux soins : une aggravation des inégalités sociales

FOCUS

La crise sanitaire liée à l'épidémie du Covid-19 et ses conséquences économiques soulèvent deux enjeux majeurs en termes d'inégalités sociales. D'une part, l'exposition au risque de contamination ainsi que le risque de développer des formes graves et de décéder sont inégalement réparties dans la population. D'autre part, la crise du Covid-19 vient ajouter un mécanisme supplémentaire et nouveau dans sa nature et son ampleur dans l'histoire des épidémies : les inégalités face au confinement. Des travaux antérieurs sur de précédentes pandémies comme la grippe espagnole ou la grippe H1N1, ou d'autres maladies infectieuses comme la tuberculose ou la rougeole, insistaient déjà sur l'importance de la prise en compte des différents facteurs d'inégalités sociales afin de mieux maîtriser l'impact différentiel des prochaines pandémies[18]. Les mécanismes, qui se retrouvent dans la crise du Covid-19, sont à la fois une exposition différentielle face au virus, une plus grande fragilité face aux maladies infectieuses ou à ses complications, ainsi qu'un accès inégal aux soins. Le cumul des inégalités face à l'épidémie et face au confinement font ainsi de la crise sanitaire actuelle un fort révélateur d'inégalités sociales. Enfin, la crise économique risque à son tour de creuser les inégalités, avec des conséquences probables à long terme.[19]

ÉTUDES FRANÇAISES

2021

Gandre, C., Espagnacq, M., Coldefy, M., et al. (2021). "Détresse psychologique pendant le premier confinement lié à la Covid-19 : des facteurs de vulnérabilité spécifiques aux personnes vivant avec une maladie chronique ou un handicap." Questions D'Economie de la Sante (Irdes)(255): 8p.
https://www.irdes.fr/recherche/questions-d-economie-de-la-sante/255-detresse-psychologique-pendant-le-premier-confinement-lie-a-la-covid-19.pdf

L'impact sur la santé mentale de la crise sanitaire et du premier confinement liés à la pandémie de Covid-19 en France a été objectivé par des enquêtes en population générale qui ont souligné le sur-risque de survenue de détresse psychologique chez les personnes vivant avec une maladie chronique ou un handicap. Mais les données issues de telles enquêtes ne permettent pas d'étudier avec précision la situation de ces populations spécifiques, du fait de leurs faibles effectifs parmi les répondants. Pour pallier ce manque d'informations et mieux comprendre les mécanismes impliqués, le choix a été fait de recourir à une enquête par internet diffusée par un réseau social et des associations de personnes vivant avec une maladie chronique ou un handicap. Malgré des facteurs de vulnérabilité communs à la population générale, la survenue de détresse psychologique au cours du confinement chez ces personnes s'avère également liée à des problématiques qui leur sont propres : difficultés à appliquer les mesures sanitaires, fait de penser ne pas être pris en charge comme les autres en cas d'infection par la Covid-19, arrêt ou diminution du suivi médical ou médico-social habituel pendant le confinement. Nos résultats soulignent ainsi l'importance de prendre en compte les besoins spécifiques des personnes vivant avec une maladie chronique ou un handicap dans le cadre de la réitération des politiques de confinement, d'autant que l'impact de la plupart des facteurs de vulnérabilité qui leur sont propres semble pouvoir être modéré par des politiques adaptées.

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[18] Quinn S.C., Kumar S. (2014) Health inequalities and infectious disease epidemics: a challenge for global health security, *Biosecur Bioterror*, 12(5):263-273..

[19] Dubost, C., Pollack, C. et Rey, S. (2020). Les inégalités sociales face à l'épidémie de Covid-19 - État des lieux et perspectives. Paris Drees**:** 42.

Or, Z., Gandre, C., Durand-Zaleski, I., et al. (2021). France's Response to the Covid-19 Pandemic: between a Rock and a Hard Place. Document de travail Irdes ; 83. Paris Irdes**:** 19.
https://www.irdes.fr/english/working-papers/083-france-s-response-to-the-covid-19-pandemic-between-a-rock-and-a-hard-place.pdf

France is one of the European countries hardest hit by the Covid-19 pandemic. The pandemic brought into light structural weaknesses of the health system, including its governance and decision making process, but also provoked changes that helped to improve its resilience. We analyse the French experience of Covid-19 in 2020 by critically reviewing major policy measures implemented during the first two waves of the pandemic. France has struggled to find the right balance between the rock of economic and social damage caused by containment measures and the hard alternative of a rapidly spreading pandemic. The response to the first wave, including a full lockdown, was an emergency response that revealed the low level of preparedness for pandemics and the overly hospital-centred provision of health care in France. During the second wave, this response evolved into a more level strategy trying to reconcile health needs in a broader perspective integrating socio-economic considerations, but without fully managing to put in place an effective health strategy. We conclude that to achieve the right balance, France will have to strengthen health system capacity and improve the cooperation between actors at central and local levels with greater participatory decision-making that takes into account local-level realities and the diversity of needs.

2020

Barthel, J., Guilhembet, N., Elbaum, M., et al. (2020). "La crise sanitaire et ses conséquences sur la protection sociale : dossier spécial." Regards **57**: 13-44.
https://www.cairn.info/revue-regards-2020-1.htm

Trois articles composent ce dossier spécial consacré à la crise sanitaire et ses conséquences sur la protection sociale : La notion actuelle de durée du travail peut-elle résister au coronavirus ? Le deuxième article se penche sur le rôle de la protection sociale durant la crise sanitaire. Enfin, le dernier article examine les mesures d'adaptation de la protection sociale liées à la crise de la Covid-19.

Dubost, C., Pollack, C. et Rey, S. (2020). Les inégalités sociales face à l'épidémie de Covid-19 - État des lieux et perspectives. Paris Drees**:** 42.
https://drees.solidarites-sante.gouv.fr/publications/les-dossiers-de-la-drees/les-inegalites-sociales-face-lepidemie-de-covid-19-etat-des

La crise sanitaire liée à l'épidémie du Covid-19 et ses conséquences économiques soulèvent deux enjeux majeurs en termes d'inégalités sociales. D'une part, l'exposition au risque de contamination ainsi que le risque de développer des formes graves et de décéder sont inégalement réparties dans la population. Le prix Nobel d'économie Joseph Stiglitz le rappelle : « Covid is not an equal opportunity killer » (Stiglitz, 2020). D'autre part, la crise du Covid-19 vient ajouter un mécanisme supplémentaire et nouveau dans sa nature et son ampleur dans l'histoire des épidémies : les inégalités face au confinement. Des travaux antérieurs sur de précédentes pandémies comme la grippe espagnole ou la grippe H1N1, ou d'autres maladies infectieuses comme la tuberculose ou la rougeole, insistaient déjà sur l'importance de la prise en compte des différents facteurs d'inégalités sociales afin de mieux maîtriser l'impact différentiel des prochaines pandémies (Quinn, 2014). Les mécanismes, qui se retrouvent dans la crise du Covid-19, sont à la fois une exposition différentielle face au virus, une plus grande fragilité face aux maladies infectieuses ou à ses complications, ainsi qu'un accès inégal aux soins. Le cumul des inégalités face à l'épidémie et face au confinement font ainsi de la crise sanitaire actuelle un fort révélateur d'inégalités sociales. Enfin, la crise économique risque à son tour de creuser les inégalités, avec des conséquences probables à long terme. Ces inégalités font l'objet de nombreuses alertes dans les médias ou par le biais du monde associatif ou de comités d'experts.

L'analyse du sujet nécessite une approche transversale, reliant des travaux épidémiologiques, géographiques, démographiques et économiques aux analyses et mesures des inégalités en sciences sociales. L'objectif de ce dossier est de faire un premier état des lieux des inégalités sociales dans cette crise sanitaire, de présenter les facteurs d'inégalités sociales actuellement identifiés à partir de la littérature française et internationale et de les documenter et les quantifier si possible dans le contexte français. Après avoir présenté les inégalités sociales face au virus, qui se révèlent par des inégalités face à l'exposition, à ses facteurs aggravants, et dans sa prise en charge, il présente les inégalités sociales face au confinement. Le cumul de ces inégalités permet enfin de dresser un premier tableau des populations particulièrement vulnérables, et d'identifier des pistes pour des analyses ultérieures.

Gandre, C., Coldefy, M. et Rochereau, T. c. (2020). "Les inégalités face au risque de détresse psychologique pendant le confinement. Premiers résultats de l'enquête COCLICO du 3 au 14 avril 2020." Questions D'Economie de la Sante (Irdes)(249): 8.
https://www.irdes.fr/recherche/questions-d-economie-de-la-sante/249-les-inegalites-face-au-risque-de-detresse-psychologique-pendant-le-confinement-premiers-resultats-enquete-coclico.pdf

La France fait face à une crise sanitaire sans précédent, liée à l'épidémie de Covid-19, qui a conduit à la mise en place d'un confinement obligatoire à domicile pour toute la population. Or, cette mesure n'est pas sans impact potentiel sur la santé, en particulier la santé mentale. Cette étude a pour objectif de déterminer l'ampleur de la survenue de détresse psychologique dans la population française au cours des premières phases du confinement, et d'en identifier les facteurs associés afin de repérer des populations vulnérables nécessitant un soutien. Une première vague d'enquête internet a été diffusée entre le 3 et le 14 avril 2020 en mobilisant un échantillon de personnes de 18 ans ou plus, représentatives de la population française vivant en ménage ordinaire en France métropolitaine. La survenue d'une détresse psychologique est observée chez un tiers des répondants. Si le fait d'être exposé au virus en constitue un facteur de risque, les conditions et conséquences du confinement semblent jouer le rôle le plus marqué. Certains segments de la population particulièrement à risque ont été identifiés, notamment les femmes, les personnes vivant avec une maladie chronique, celles bénéficiant d'un faible soutien social, celles confinées dans des logements sur-occupés et celles dont la situation financière s'est dégradée. Ces résultats encouragent le développement d'actions ciblées à destination de ces populations, que ce soit pour favoriser leur accès aux soins de santé mentale ou pour modérer l'impact social et économique de nouvelles mesures de confinement si elles devaient être reproduites.

Revil, H., Blanchoz, J. M., Olm, C., et al. (2020). Renoncer à se soigner pendant le confinement, Paris : Odenore ; Paris : Cnam
https://www.ameli.fr/paris/medecin/actualites/etude-odenore-pres-de-2-personnes-sur-3-ont-renonce-se-soigner-pendant-le-premier-confinement

L'observatoire des non-recours aux droits et services (Odenore) et l'Assurance Maladie ont lancé une enquête afin d'estimer l'ampleur, la nature, les causes et conséquences des non-réalisations de soins pendant la première période de confinement. Les premiers résultats de l'enquête montrent que 60 % des personnes interrogées disent ne pas avoir réalisé à leur initiative, pendant le premier confinement, au moins un soin dont elles avaient besoin. Parmi les personnes qui n'ont pas consulté de médecin généraliste pendant le 1er confinement malgré un besoin, une nette majorité (68 %) dit avoir consulté à l'issue du 1er confinement. Il ressort de cette étude un renoncement «définitif» assez faible (entre 2 % et 7 % selon le type de besoin de soins). La plupart des personnes qui n'ont toujours pas réalisé la consultation ou l'acte au moment de l'enquête garde l'intention de le faire.

ÉTUDES INTERNATIONALES

2021

Berkowitz, S. A. et Basu, S. (2021). "Unmet Social Needs And Worse Mental Health After Expiration Of COVID-19 Federal Pandemic Unemployment Compensation." Health Aff (Millwood) **40**(3): 426-434.

Federal Pandemic Unemployment Compensation (FPUC) provided unemployment insurance beneficiaries an extra $600 a week during the unprecedented economic downturn during the coronavirus disease 2019 (COVID-19) pandemic, but it initially expired in July 2020. We applied difference-in-differences models to nationally representative data from the Census Bureau's Household Pulse Survey to examine changes in unmet health-related social needs and mental health among unemployment insurance beneficiaries before and after initial expiration of FPUC. The initial expiration was associated with a 10.79-percentage-point increase in risk for self-reported missed housing payments. Further, risk for food insufficiency, depressive symptoms, and anxiety symptoms also increased among households that reported receiving unemployment insurance benefits, relative to the period when FPUC was in effect. As further unemployment insurance reform is debated, policy makers should recognize the potential health impact of unemployment insurance.

Kotwal, A. A., Holt-Lunstad, J., Newmark, R. L., et al. (2021). "Social Isolation and Loneliness Among San Francisco Bay Area Older Adults During the COVID-19 Shelter-in-Place Orders." J Am Geriatr Soc **69**(1): 20-29.

BACKGROUND/OBJECTIVES: Physical distancing during the COVID-19 pandemic may have unintended, detrimental effects on social isolation and loneliness among older adults. Our objectives were to investigate (1) experiences of social isolation and loneliness during shelter-in-place orders, and (2) unmet health needs related to changes in social interactions. DESIGN: Mixed-methods longitudinal phone-based survey administered every 2 weeks. SETTING: Two community sites and an academic geriatrics outpatient clinical practice. PARTICIPANTS: A total of 151 community-dwelling older adults. MEASUREMENTS: We measured social isolation using a six-item modified Duke Social Support Index, social interaction subscale, that included assessments of video-based and Internet-based socializing. Measures of loneliness included self-reported worsened loneliness due to the COVID-19 pandemic and loneliness severity based on the three-item University of California, Los Angeles (UCLA) Loneliness Scale. Participants were invited to share open-ended comments about their social experiences. RESULTS: Participants were on average aged 75 years (standard deviation = 10), 50% had hearing or vision impairment, 64% lived alone, and 26% had difficulty bathing. Participants reported social isolation in 40% of interviews, 76% reported minimal video-based socializing, and 42% minimal Internet-based socializing. Socially isolated participants reported difficulty finding help with functional needs including bathing (20% vs 55%; P = .04). More than half (54%) of the participants reported worsened loneliness due to COVID-19 that was associated with worsened depression (62% vs 9%; P < .001) and anxiety (57% vs 9%; P < .001). Rates of loneliness improved on average by time since shelter-in-place orders (4-6 weeks: 46% vs 13-15 weeks: 27%; P = .009), however, loneliness persisted or worsened for a subgroup of participants. Open-ended responses revealed challenges faced by the subgroup experiencing persistent loneliness including poor emotional coping and discomfort with new technologies. CONCLUSION: Many older adults are adjusting to COVID-19 restrictions since the start of shelter-in-place orders. Additional steps are critically needed to address the psychological suffering and unmet medical needs of those with persistent loneliness or barriers to technology-based social interaction.

Machado, S. et Goldenberg, S. (2021). "Sharpening our public health lens: advancing im/migrant health equity during COVID-19 and beyond." Int J Equity Health **20**(1): 57.

BACKGROUND: Differential impacts of the COVID-19 pandemic have brought deeply rooted inequities to the forefront, where increasing evidence has shown that racialized immigrant and migrant (im/migrant) populations face a disproportionate burden of COVID-19. Im/migrant communities may be worst affected by lockdowns and restrictive measures, face less opportunity to physically distance or stay home sick within 'essential' jobs, and experience severe barriers to healthcare. Insufficient attention to experiences of racialized im/migrants in current pandemic responses globally highlights an urgent need to more fulsomely address unmet health needs through an anti-racist, equity-oriented lens. This commentary aims to highlight the need for public health and clinical training, research, and policy to thoughtfully prioritize im/migrant health equity during and beyond the COVID-19 pandemic. MAIN TEXT: Global pandemic responses have neglected im/migrants by continuing to ignore or insufficiently address inequities, exacerbating COVID transmission, xenophobia, and occupational injustice. Deaths, illness, stress, and other negative outcomes of the overlapping epidemics of COVID-19 and structural racism disproportionately borne by racialized im/migrants suggest the urgent need for action. As evidence mounts about how im/migrants have been left behind in times of crises, we need enhanced focus on health equity within COVID-19 research and interventions, including research that examines and pursues structural interventions necessary to mitigate these impacts, and that identifies patterns and harms of xenophobic policy, structural racism, and white supremacy in shaping im/migrant health outcomes. We must also strengthen anti-racist and equity-oriented curriculum within health education, and ensure sufficient attention to the needs of im/migrant communities within public health, clinical, and research training. CONCLUSION: The COVID-19 pandemic has exacerbated and rendered more visible the deeply rooted health and social inequities faced by racialized im/migrants across diverse settings. We argue for a greater emphasis on equity-focused and anti-racist im/migrant health research, interventions, and training. Policymakers and practitioners must ensure that healthcare policies and practices do not exacerbate inequities, and instead meaningfully address unmet needs of communities, including racialized im/migrants. Ethical and respectful community engagement, commitment and collaboration with global, national, and local communities, policymakers, academics, and educators, as well as accountability across sectors, is critical.

2020

Agarwal, S. D. et Sommers, B. D. (2020). "Insurance Coverage after Job Loss — The Importance of the ACA during the Covid-Associated Recession." New England Journal of Medicine **383**(17): 1603-1606.
https://doi.org/10.1056/NEJMp2023312

Ahn, S. et Koh, K. (2020). Changes in Healthcare Utilization, Spending, and Perceived Health during COVID–19: A Longitudinal Study from Singapore. Séoul Université de Corée**:** 37.
https://privpapers.ssrn.com/sol3/papers.cfm?abstract_id=3669090&

> The outbreak of the novel coronavirus (COVID–19) has challenged the capacity of healthcare systems around the world and can potentially compromise healthcare utilization and health outcomes among non-COVID–19 patients. However, the empirical evidence regarding changes in healthcare utilization, healthcare spending, and health status among non-COVID–19 patients is limited. This aim of this study is to examine the associations of the COVID-19 pandemic with healthcare utilization, out-of-pocket medical costs, and perceived health status in Singapore. A retrospective observational study using a difference-in-differences method that examines changes in healthcare utilization, healthcare spending, and perceived health status before and during the outbreak of COVID-19 of the same individuals using monthly individual-level panel survey data.

Arthi, V. et Parman, J. (2020). Disease, Downturns, and Wellbeing: Economic History and the Long-Run Impacts of COVID-19. NBER Working Paper Series ; 27805. Cambridge NBER**:** 30 , fig., tab.
https://www.nber.org/papers/w27805

> How might COVID-19 affect human capital and wellbeing in the long run? The COVID-19 pandemic has already imposed a heavy human cost—taken together, this public health crisis and its attendant economic downturn appear poised to dwarf the scope, scale, and disruptiveness of most modern pandemics. What evidence we do have about other modern pandemics is largely limited to short-run impacts. Consequently, recent experience can do little to help us anticipate and respond to COVID-19's potential long-run impact on individuals over decades and even generations. History, however, offers a solution. Historical crises offer closer analogues to COVID-19 in each of its key dimensions—as a global pandemic, as a global recession—and offer the runway necessary to study the life-course and intergenerational outcomes. In this paper, we review the evidence on the long-run effects on health, labor, and human capital of both historical pandemics (with a focus on the 1918 Influenza Pandemic) and historical recessions (with a focus on the Great Depression). We conclude by discussing how past

crises can inform our approach to COVID-19—helping tell us what to look for, what to prepare for, and what data we ought to collect now.

Bhatt, A. (2020). "Real-world data in COVID-19 pandemic: An essential unmet health-care need." Perspect Clin Res **11**(3): 103-105.

Brian, Z. et Weintraub, J. A. (2020). "Oral Health and COVID-19: Increasing the Need for Prevention and Access." Prev Chronic Dis **17**: E82.

Populations disproportionately affected by coronavirus disease 2019 (COVID-19) are also at higher risk for oral diseases and experience oral health and oral health care disparities at higher rates. COVID-19 has led to closure and reduced hours of dental practices except for emergency and urgent services, limiting routine care and prevention. Dental care includes aerosol-generating procedures that can increase viral transmission. The pandemic offers an opportunity for the dental profession to shift more toward nonaerosolizing, prevention-centric approaches to care and away from surgical interventions. Regulatory barrier changes to oral health care access during the pandemic could have a favorable impact if sustained into the future.

Chivers, B. R., Garad, R. M., Boyle, J. A., et al. (2020). "Perinatal Distress During COVID-19: Thematic Analysis of an Online Parenting Forum." J Med Internet Res **22**(9): e22002.

BACKGROUND: The COVID-19 global pandemic has impacted the whole of society, requiring rapid implementation of individual-, population-, and system-level public health responses to contain and reduce the spread of infection. Women in the perinatal period (pregnant, birthing, and postpartum) have unique and timely needs for directives on health, safety, and risk aversion during periods of isolation and physical distancing for themselves, their child or children, and other family members. In addition, they are a vulnerable group at increased risk of psychological distress that may be exacerbated in the context of social support deprivation and a high-risk external environment. OBJECTIVE: The aim of this study is to examine the public discourse of a perinatal cohort to understand unmet health information and support needs, and the impacts on mothering identity and social dynamics in the context of COVID-19. METHODS: A leading Australian online support forum for women pre- through to postbirth was used to interrogate all posts related to COVID-19 from January 27 to May 12, 2020, inclusive. Key search terms included "COVID," "corona," and "pandemic." A three-phase analysis was conducted, including thematic analysis, sentiment analysis, and word frequency calculations. RESULTS: The search yielded 960 posts, of which 831 were included in our analysis. The qualitative thematic analysis demonstrated reasonable understanding, interpretation, and application of relevant restrictions in place, with five emerging themes identified. These were (1) heightened distress related to a high-risk external environment; (2) despair and anticipatory grief due to deprivation of social and family support, and bonding rituals; (3) altered family and support relationships; (4) guilt-tampered happiness; and (5) family future postponed. Sentiment analysis revealed that the content was predominantly negative (very negative: n=537 and moderately negative: n=443 compared to very positive: n=236 and moderately positive: n=340). Negative words were frequently used in the 831 posts with associated derivatives including "worried" (n=165, 19.9%), "risk" (n=143, 17.2%), "anxiety" (n=98, 11.8%), "concerns" (n=74, 8.8%), and "stress" (n=69, 8.3%). CONCLUSIONS: Women in the perinatal period are uniquely impacted by the current pandemic. General information on COVID-19 safe behaviors did not meet the particular needs of this cohort. The lack of nuanced and timely information may exacerbate the risk of psychological and psychosocial distress in this vulnerable, high-risk group. State and federal public health departments need to provide a central repository of information that is targeted, consistent, accessible, timely, and reassuring. Compensatory social and emotional support should be considered, using alternative measures to mitigate the risk of mental health disorders in this cohort.

Dudine, P., Hellwig, K. P. et Jahan, S. (2020). A Framework for Estimating Health Spending in Response to COVID-19. IMF Working Paper; 20/145. International Monetary Fund**:** 43.
http://d.repec.org/n?u=RePEc:imf:imfwpa:2020/145&r=hea

> We estimate the additional health spending necessary to treat COVID-19 patients. We expand a Susceptible Infected Recovered model to project the number of people requiring hospitalization, use information about healthcare costs by country, and make assumptions about capacity constraints in the health sector. Without social distancing and lockdowns, countries would need to expand health systems ten-fold, on average, to assist all COVID-19 patients in need of hospitalization. Under capacity constraints, effective social distancing and quarantine reduce the additional health spending from a range of $0.6–1 trillion globally to $130–231 billion, and the fatality rate from 1.2 to 0.2 percent, on average.

Giannopoulou, I. et Tsobanoglou, G. O. (2020). "COVID-19 pandemic: challenges and opportunities for the Greek health care system." Ir J Psychol Med **37**(3): 226-230.

> After coming out of the state debt crisis, Greece is facing yet another crisis - that of the COVID-19 pandemic. The key challenges facing the organizational structure and function of the Greek public health system in order to meet the populations' health needs are discussed. Social distancing, through imposed national lockdown very early in the pandemic, has been a key emergency public health measure that has saved lives. However, the system needs to enhance its capacity, through strengthening primary health and social support care, to be able to meet existing unmet health needs, the impact of the pandemic on mental health, as well as to tackle future new waves of outbreak. The related changes in health service provisions in response to the COVID-19 pandemic call for developing new models and novel approaches for delivering effective mental health services.

Iyanda, A. E., Adeleke, R., Lu, Y., et al. (2020). "A retrospective cross-national examination of COVID-19 outbreak in 175 countries: a multiscale geographically weighted regression analysis (January 11-June 28, 2020)." J Infect Public Health **13**(10): 1438-1445.

> OBJECTIVE: This study retrospectively examined the health and social determinants of the COVID-19 outbreak in 175 countries from a spatial epidemiological approach. METHODS: We used spatial analysis to examine the cross-national determinants of confirmed cases of COVID-19 based on the World Health Organization official COVID-19 data and the World Bank Indicators of Interest to the COVID-19 outbreak. All models controlled for COVID-19 government measures. RESULTS: The percentage of the population age between 15-64 years (Age15-64), percentage smokers (SmokTot.), and out-of-pocket expenditure (OOPExp) significantly explained global variation in the current COVID-19 outbreak in 175 countries. The percentage population age group 15-64 and out of pocket expenditure were positively associated with COVID-19. Conversely, the percentage of the total population who smoke was inversely associated with COVID-19 at the global level. CONCLUSIONS: This study is timely and could serve as a potential geospatial guide to developing public health and epidemiological surveillance programs for the outbreak in multiple countries. Removal of catastrophic medical expenditure, smoking cessation, and observing public health guidelines will not only reduce illness related to COVID-19 but also prevent unecessary deaths.

Kumar, N. (2020). "COVID 19 era: a beginning of upsurge in unwanted pregnancies, unmet need for contraception and other women related issues." Eur J Contracept Reprod Health Care **25**(4): 323-325.

> The Novel Coronavirus disease that was first identified in Wuhan city of China in December 2019 has emerged as one of the fastest spreading pandemics all over the world affecting millions of people and causing millions of deaths worldwide. In an attempt to control its spread, countries have imposed local and national lockdowns, affecting many healthcare services, especially sexual and reproductive health services which are actually essential and lifesaving. In near future this will result in a large number of grave consequences including increased unmet need for modern contraceptives, unintended pregnancies, increased unsafe abortions, maternal and neonatal deaths and other harmful practices like female genital mutilation and child marriages in developing countries. The present short review focusses on such issues which will be dramatically increased depending on the duration of lockdowns and the time for which the sexual and reproductive health services will remain halted. It also reflects

the need for considering reproductive health services as essential, allowing the people to avail these services without any fear and hence, saving many more lives which will be lost not due to coronavirus infection. Methodology: The data was searched from various governmental and non-governmental organisation sites including the World Health Organisation, United Nations, United Nations Population Fund, Guttmacher Institute and many PubMed indexed journals.

Leira, E. C., Russman, A. N., Biller, J., et al. (2020). "Preserving stroke care during the COVID-19 pandemic: Potential issues and solutions." Neurology **95**(3): 124-133.

The coronavirus 2019 (COVID-19) pandemic requires drastic changes in allocation of resources, which can affect the delivery of stroke care, and many providers are seeking guidance. As caregivers, we are guided by 3 distinct principles that will occasionally conflict during the pandemic: (1) we must ensure the best care for those stricken with COVID-19, (2) we must provide excellent care and advocacy for patients with cerebrovascular disease and their families, and (3) we must advocate for the safety of health care personnel managing patients with stroke, with particular attention to those most vulnerable, including trainees. This descriptive review by a diverse group of experts in stroke care aims to provide advice by specifically addressing the potential impact of this pandemic on (1) the quality of the stroke care delivered, (2) ethical considerations in stroke care, (3) safety and logistic issues for providers of patients with stroke, and (4) stroke research. Our recommendations on these issues represent our best opinions given the available information, but are subject to revision as the situation related to the COVID-19 pandemic continues to evolve. We expect that ongoing emergent research will offer additional insights that will provide evidence that could prompt the modification or removal of some of these recommendations.

Mackey, K., Ayers, C. K., Kondo, K. K., et al. (2020). "Racial and Ethnic Disparities in COVID-19-Related Infections, Hospitalizations, and Deaths : A Systematic Review." Ann Intern Med.

BACKGROUND: Data suggest that the effects of coronavirus disease 2019 (COVID-19) differ among U.S. racial/ethnic groups. PURPOSE: To evaluate racial/ethnic disparities in severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection rates and COVID-19 outcomes, factors contributing to disparities, and interventions to reduce them. (PROSPERO: CRD42020187078). DATA SOURCES: English-language articles in MEDLINE, PsycINFO, CINAHL, Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, and Scopus, searched from inception through 31 August 2020. Gray literature sources were searched through 2 November 2020. STUDY SELECTION: Observational studies examining SARS-CoV-2 infections, hospitalizations, or deaths by race/ethnicity in U.S. settings. DATA EXTRACTION: Single-reviewer abstraction confirmed by a second reviewer; independent dual-reviewer assessment of quality and strength of evidence. DATA SYNTHESIS: 37 mostly fair-quality cohort and cross-sectional studies, 15 mostly good-quality ecological studies, and data from the Centers for Disease Control and Prevention and APM Research Lab were included. African American/Black and Hispanic populations experience disproportionately higher rates of SARS-CoV-2 infection, hospitalization, and COVID-19-related mortality compared with non-Hispanic White populations, but not higher case-fatality rates (mostly reported as in-hospital mortality) (moderate- to high-strength evidence). Asian populations experience similar outcomes to non-Hispanic White populations (low-strength evidence). Outcomes for other racial/ethnic groups have been insufficiently studied. Health care access and exposure factors may underlie the observed disparities more than susceptibility due to comorbid conditions (low-strength evidence). LIMITATIONS: Selection bias, missing race/ethnicity data, and incomplete outcome assessments in cohort and cross-sectional studies must be considered. In addition, adjustment for key demographic covariates was lacking in ecological studies. CONCLUSION: African American/Black and Hispanic populations experience disproportionately higher rates of SARS-CoV-2 infection and COVID-19-related mortality but similar rates of case fatality. Differences in health care access and exposure risk may be driving higher infection and mortality rates. PRIMARY FUNDING SOURCE: Department of Veterans Affairs, Veterans Health Administration, Health Services Research & Development.

Nath, S., Mishra, B. R., Padhy, S. K., et al. (2020). "Meeting the Unmet Mental Health Needs during COVID-19: Where Does Telemedicine Stands during These Times in India?" Psychiatr Danub **32**(3-4): 594-595.

Nezafat Maldonado, B. M., Collins, J., Blundell, H. J., et al. (2020). "Engaging the vulnerable: A rapid review of public health communication aimed at migrants during the COVID-19 pandemic in Europe." J Migr Health **1**: 100004.

> BACKGROUND: The World Health Organization recommends national risk communications tools targeting migrant communities to contain the spread of COVID-19. Within Europe, migrants are often left behind in healthcare due to structural barriers driven by hostile environment measures. This study aimed to assess inclusion of migrants in COVID-19 prevention measures by evaluating if governmental risk communications are available in common migrant languages across Europe. METHODS: A rapid review was performed in June 2020 to understand the availability of government produced risk communications across Council of Europe member states, namely: COVID-19 health communications, migrant-specific guidelines and COVID-19 helplines. RESULTS: 96% (45/47) of countries sampled had online government COVID-19 advice. 30% (15/47) issued information in their official language(s), whilst 64% (30/47) of countries delivered information in additional languages. 48% (23/47) translated information into at least one migrant language. However, information on testing or healthcare entitlements in common migrant languages was only found in 6% (3/47). Half (53%; 25/47) of the countries with COVID-19 helpline offered information in at least one alternative language.No government produced risk communications on disease prevention targeting people in refugee camps or informal settlements. CONCLUSIONS: There are clear gaps in the availability of translated COVID-19 risk communications across Europe, excluding migrants from the COVID-19 response. Governments must reflect on the inclusion of migrants within their COVID-19 response and seek to engage vulnerable communities. Governments should urgently partner with non-governmental organizations who already play a key role in addressing unmet health needs.

Ray, K. N., Ettinger, A. K., Dwarakanath, N., et al. (2020). "Rapid-Cycle Community Assessment of Health-Related Social Needs of Children and Families During Coronavirus Disease 2019." Acad Pediatr.

> OBJECTIVE: To identify unmet health and social resource needs during a county-wide coronavirus disease 19 (COVID-19) stay-at-home order and phased re-opening in Western Pennsylvania. METHODS: With public health, social service, and community partners connected through an ongoing academic-community collaborative, we developed and fielded a weekly repeated cross-sectional electronic survey assessing usage of and unmet need for health and social service resources. Using 10 weeks of surveys (April 3-June 11, 2020) by Allegheny County residents, we examined variation in responses by week and by sociodemographic characteristics using chi-square tests. We shared written reports weekly and discussed emerging trends with community partners. RESULTS: Participants ranged from 229 to 1001 per week. Unmet need for at least 1 health or health-related social need resource varied by week, ranging from 55% (95% confidence interval [CI] 50%-59%) of participants in week 2 to 43% (95% CI 37%-49%) of participants in week 9 (P = .006). Increased use of at least 1 resource ranged from 53% (95% CI 47%-58%) of participants in week 3 to 36% (95% CI 31%-42%) in week 9 (P < .001). Unmet need for food and financial assistance peaked early during the stay-at-home order, while unmet need for mental health care rose later. Unmet need for food assistance varied significantly by race and ethnicity and by household prepandemic income. CONCLUSIONS: Over half of families with children reported unmet health or social service needs during the first month of a county-wide COVID-19 stay-at-home order. Unmet needs varied with race, ethnicity, and income and with duration of the stay-at-home order.

Sangnam, A., Seonghoon, K. et Kanghyock, K. (2020). Changes in Healthcare Utilization, Spending, and Perceived Health during COVID–19: A Longitudinal Study from Singapore. IZA Discussion Paper ; 13715. Bonn IZA**:** 33.
http://ftp.iza.org/dp13715.pdf

The COVID–19 pandemic has challenged the capacity of healthcare systems around the world and can potentially compromise healthcare utilization and health outcomes among non-COVID–19 patients. Using monthly panel data of nationally representative middle-aged and older Singaporeans, we examined the associations of the pandemic with healthcare utilization, out-of-pocket medical costs, and perceived health. At its peak, doctor visits decreased by 30% and out-of-pocket medical spending decreased by 23%, mostly driven by reductions in inpatient and outpatient care. Although there were little changes in self-reported health and sleep quality, COVID–19 increased depressive symptoms by 4%. We argue that it is imperative to monitor COVID–19's long-term health effects among non-COVID–19 patients since our findings indicated delayed healthcare and worsened mental health during the outbreak.

Ressources électroniques

Sites de l'OCDE et de la Communauté européenne

- Health at a glance Europe 2020/ Panorama de la santé 2020

Données sur les restes à charge et le renoncement aux soins (voir chapitres 5 et 7).

Voir aussi la base de données des indicateurs : https://www.oecd.org/health/health-at-a-glance-europe-23056088.htm

- Can you afford to pay for health care ; Avril 2019.

Site de l'OMS Europe

- Can people afford to pay for health care 2019.
- Out-of-pocket payments for health, particularly for medicines, are unaffordable for many in Europe ; Avril 2019.

Portail documentaire des Pays- de-la- Loire

- Bibliographie sur le renoncement aux soins ; Novembre 2019.

Site de l'Irdes

- Bibliographie sur les inégalités sociales de santé ; Avril 2016.