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DOC VEILLE : veille bibliographique en économie de la santé

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Assurance maladie

Johar M., Jones G., Keane M.P., Savage E., Stavrunova O. (2013). Discrimination in a universal health system: Explaining socioeconomic waiting time gaps. *Journal of Health Economics*, 32 (1) : 181-194.

Abstract: One of the core goals of a universal health care system is to eliminate discrimination on the basis of socioeconomic status. We test for discrimination using patient waiting times for non-emergency treatment in public hospitals. Waiting time should reflect patients' clinical need with priority given to more urgent cases. Using data from Australia, we find evidence of prioritisation of the most socioeconomically advantaged patients at all quantiles of the waiting time distribution. These patients also benefit from variation in supply endowments. These results challenge the universal health system's core principle of equitable treatment.

<http://www.sciencedirect.com/science/article/pii/S0167629612001208>

Economie de la santé

Dakin H., Wordsworth S. (2013). Cost-minimisation analysis versus cost-effectiveness analysis, revisited. *Health Econ*, 22 (1) : 22-34.

Abstract: We aim to establish whether it is ever appropriate to conduct cost-minimisation analysis (CMA) rather than cost-effectiveness analysis. We perform a literature review to examine how the use of CMA has changed since Briggs & O'Brien announced its death in 2001. Examples of simulated and trial data are presented: firstly to illustrate the advantages and disadvantages of CMA in the context of non-inferiority trials and those finding no significant difference in efficacy and secondly to assess whether CMA gives biased results. We show that CMA is still used and will bias measures of uncertainty, causing overestimation or underestimation of the value of information and the probability that treatment is cost-effective. Although bias will be negligible for non-inferiority studies comparing treatments that differ enormously in cost, it is generally necessary to collect and analyse data on costs and efficacy (including utilities) to assess this bias. Cost-effectiveness analysis (including evaluation of the joint distribution of costs and benefits) is almost always required to avoid biased estimation of uncertainty. The remit of CMA in trial-based economic evaluation is therefore even narrower than previously thought, suggesting that CMA is not only dead but should also be buried. Copyright (c) 2011 John Wiley & Sons, Ltd PM:22109960

Géographie de la santé

King M., Essick C. (2013). The Geography of Antidepressant, Antipsychotic, and Stimulant Utilization in the United States. *Health & Place*, (In press) :

Abstract: This paper analyzes local and regional geographic variability in the use of antidepressant, antipsychotic and stimulant medications in the United States. Using a data set that covers sixty percent of prescriptions written in the United States, we find that use of antidepressants in three digit postal codes ranged from less than one percent of residents to more than forty percent

residents. Stimulant and antipsychotic use exhibited similar levels of local geographic variability. A Kulldorf Spatial Scan identified clusters of elevated use of antidepressants (RR 1.46; $p < 0.001$), antipsychotics (RR 1.42; $p < 0.001$), and stimulants (RR 1.77; $p < 0.001$). Using a multilevel model, we find that access to health care, insurance coverage and pharmaceutical marketing efforts explain much of the geographic variation in use.

<http://www.sciencedirect.com/science/article/pii/S1353829212002067>

Bojke C., Castelli A., Street A., Ward P., Laudicella M. (2013). Regional variation in the productivity of the English National Health Service. *Health Economics*, 22 (2) : 194-211.

Abstract: Variation in the provision of health care has long been a policy concern. We adapt the framework for productivity measurement used in the National Accounts, making it applicable for sub-national comparisons using cross-sectional data. We assess the productivity of the National Health Service (NHS) across regions of England, termed Strategic Health Authorities (SHAs). Productivity is calculated by comparing the total amount of healthcare output to total inputs for each region, standardised to the national average. Healthcare output comprises 6500 different categories, capturing the number and type of NHS patients treated and the quality of care received. Healthcare inputs include NHS and agency staff, supplies, equipment and capital. We find that productivity varies from 5% above to 6% below the national average. Productivity is highest in South West SHA and lowest in East Midlands, South Central and Yorkshire and The Humber SHAs. We estimate that if all regions were as productive as the most productive region in England, the NHS could treat the same number of patients with £3.2bn fewer resources each year. The methods developed lend themselves to investigate variations in productivity in other types of healthcare organisations and health systems. Copyright © 2012 John Wiley & Sons, Ltd <http://dx.doi.org/10.1002/hec.2794>

Hôpital

Hockenberry J.M., Burgess J.F., Jr., Glasgow J., Vaughan-Sarrazin M., Kaboli P.J. (2013). Cost of Readmission: Can the Veterans Health Administration (VHA) Experience Inform National Payment Policy? *Med Care*, 51 (1) : 13-19.

Abstract: CONTEXT:: Scrutiny of hospital readmissions has led to the development and implementation of policies targeted at reducing readmission rates. OBJECTIVE:: To assess whether historic hospital readmission rates predict risk-adjusted patient readmission and to measure the costs of readmission, thus informing reimbursement policies under consideration by non-Veterans Health Administration payers. DESIGN, SETTINGS, AND PARTICIPANTS:: Multivariable hospital-fixed effects regression analyses of patients admitted to 129 Veterans Health Administration hospitals between 2005 and 2009 for 3 common conditions, acute myocardial infarction (AMI), community-acquired pneumonia (CAP), and congestive heart failure (CHF). MAIN OUTCOME MEASURES:: We examined whether previous hospital readmission rates predicted risk-adjusted readmission or 30-day episode cost of care for subsequent patients. We then examined the 30-day inpatient hospitalization episode cost differences between those who had a readmission in the episode and those who did not. RESULTS:: Hospital readmission rates in the previous quarter are not predictive of individual patient risk-adjusted readmission or of patients' inpatient hospitalization episode cost in the subsequent quarter. Relative to those who were not readmitted within 30 days of index visit discharge, readmitted patients had 30-day episode costs that were 53.3% ($P < 0.001$), 82.8% ($P < 0.001$), and 79.8% ($P < 0.001$) higher for AMI, CAP, and CHF hospitalization episodes, respectively. CONCLUSIONS:: Previous hospital readmission rates are poor predictors of readmission for future individual patients, therefore, policies using these measures to guide subsequent reimbursement are problematic for hospitals that are financially constrained. Our findings indicate current diagnosis

related group payments would need to be raised by 10.0% for AMI, 11.5% for CAP, and 16.6% for CHF if these are to become 30-day bundled payments. PM:22683595

Mehrotra A., Sloss E.M., Hussey P.S., Adams J.L., Lovejoy S., Soohoo N.F. (2013). Evaluation of centers of excellence program for knee and hip replacement. *Med Care*, 51 (1) : 28-36.

Abstract: BACKGROUND: : Medicare and private plans are encouraging individuals to seek care at hospitals that are designated as centers of excellence. Few evaluations of such programs have been conducted. This study examines a large national initiative that designated hospitals as centers of excellence for knee and hip replacement. OBJECTIVE: : Comparison of outcomes and costs associated with knee and hip replacement at designated hospitals and other hospitals. RESEARCH DESIGN: : Retrospective claims analysis of approximately 54 million enrollees. STUDY POPULATION: : Individuals with insurance from one of the sponsors of this centers of excellence program who underwent a primary knee or hip replacement in 2007-2009. OUTCOMES: : Primary outcomes were any complication within 30 days of discharge and costs within 90 days after the procedure. RESULTS: : A total of 80,931 patients had a knee replacement and 39,532 patients had a hip replacement of which 52.2% and 56.5%, respectively, were performed at a designated hospital. Designated hospitals had a larger number of beds and were more likely to be an academic center. Patients with a knee replacement at designated hospitals did not have a statistically significantly lower overall complication rate with an odds ratio of 0.90 (P=0.08). Patients with hip replacement treated at designated hospitals had a statistically significant lower risk of complications with an odds ratio of 0.80 (P=0.002). There was no significant difference in 90-day costs for either procedure. CONCLUSIONS: : Hospitals designated as joint replacement centers of excellence had lower rates of complications for hip replacement, but there was no statistically significant difference for knee replacement. It is important to validate the criteria used to designate centers of excellence. PM:23222470

Rosen A.K., Loveland S., Shin M., Shwartz M., Hanchate A., Chen Q., Kaafarani H.M., Borzecki A. (2013). Examining the Impact of the AHRQ Patient Safety Indicators (PSIs) on the Veterans Health Administration: The Case of Readmissions. *Med Care*, 51 (1) : 37-44.

Abstract: BACKGROUND:: By focusing primarily on outcomes in the inpatient setting one may overlook serious adverse events that may occur after discharge (eg, readmissions, mortality) as well as opportunities for improving outpatient care. OBJECTIVE:: Our overall objective was to examine whether experiencing an Agency for Healthcare Research and Quality Patient Safety Indicator (PSI) event in an index medical or surgical hospitalization increased the likelihood of readmission. METHODS:: We applied the Agency for Healthcare Research and Quality PSI software (version 4.1.a) to 2003-2007 Veterans Health Administration inpatient discharge data to generate risk-adjusted PSI rates for 9 individual PSIs and 4 aggregate PSI measures: any PSI event and composite PSIs reflecting "Technical Care," "Continuity of Care," and both surgical and medical care (Mixed). We estimated separate logistic regression models to predict the likelihood of 30-day readmission for individual PSIs, any PSI event, and the 3 composites, adjusting for age, sex, comorbidities, and the occurrence of other PSI(s). RESULTS:: The odds of readmission were 23% higher for index hospitalizations with any PSI event compared with those with no event [confidence interval (CI), 1.19-1.26], and ranged from 22% higher for Iatrogenic Pneumothorax (CI, 1.03-1.45) to 61% higher for Postoperative Wound Dehiscence (CI, 1.27-2.05). For the composites, the odds of readmission ranged from 15% higher for the Technical Care composite (CI, 1.08-1.22) to 37% higher for the Continuity of Care composite (CI, 1.26-1.50). CONCLUSIONS:: Our results suggest that interventions that focus on minimizing preventable inpatient safety events as well as improving coordination of care between and across settings may decrease the likelihood of readmission. PM:23032358

McHugh M.D., Ma C. (2013). Hospital nursing and 30-day readmissions among medicare patients with heart failure, acute myocardial infarction, and pneumonia. *Med Care*, 51 (1) : 52-59.

Abstract: BACKGROUND: : Provisions of the Affordable Care Act that increase hospitals' financial

accountability for preventable readmissions have heightened interest in identifying system-level interventions to reduce readmissions. OBJECTIVES: : To determine the relationship between hospital nursing; that is, nurse work environment, nurse staffing levels, and nurse education, and 30-day readmissions among Medicare patients with heart failure, acute myocardial infarction, and pneumonia. METHOD AND DESIGN: : Analysis of linked data from California, New Jersey, and Pennsylvania that included information on the organization of hospital nursing (ie, work environment, patient-to-nurse ratios, and proportion of nurses holding a BSN degree) from a survey of nurses, as well as patient discharge data, and American Hospital Association Annual Survey data. Robust logistic regression was used to estimate the relationship between nursing factors and 30-day readmission. RESULTS: : Nearly 1 quarter of heart failure index admissions [23.3% (n=39,954)], 19.1% (n=12,131) of myocardial infarction admissions, and 17.8% (n=25,169) of pneumonia admissions were readmitted within 30 days. Each additional patient per nurse in the average nurse's workload was associated with a 7% higher odds of readmission for heart failure [odds ratio (OR)=1.07; confidence interval CI, 1.05-1.09], 6% for pneumonia patients (OR=1.06; CI, 1.03-1.09), and 9% for myocardial infarction patients (OR=1.09; CI, 1.05-1.13). Care in a hospital with a good versus poor work environment was associated with odds of readmission that were 7% lower for heart failure (OR=0.93; CI, 0.89-0.97), 6% lower for myocardial infarction (OR=0.94; CI, 0.88-0.98), and 10% lower for pneumonia (OR=0.90; CI, 0.85-0.96) patients. CONCLUSIONS: : Improving nurses' work environments and staffing may be effective interventions for preventing readmissions. PM:23151591

Li Y., Cai X., Mukamel D.B., Cram P. (2013). Impact of Length of Stay After Coronary Bypass Surgery on Short-term Readmission Rate: An Instrumental Variable Analysis. *Med Care*, 51 (1) : 45-51.

Abstract: OBJECTIVE: : To determine the effect of postoperative length of stay (LOS) on 30-day readmission after coronary artery bypass surgery. DATA SOURCES/STUDY SETTING: : We analyzed a final database consisting of Medicare claims of a cohort (N=157,070) of all fee-for-service beneficiaries undergoing bypass surgery during 2007-2008, the American Hospital Association annual survey file, and the rural urban commuting area file. STUDY DESIGN: : We regressed the probability of 30-day readmission on postoperative LOS using (1) a (naive) logit model that controlled for observed patient and hospital covariates only; and (2) a residual inclusion instrumental variable (IV) logit model that further controlled for unobserved confounding. The IV was defined using a measure of the hospital's risk-adjusted LOS for patients admitted for gastrointestinal hemorrhage. PRINCIPAL FINDINGS: : The naive logit model predicted that a 1-day reduction in median postoperative LOS (ie, from a median of 6-5 d) lowered the 30-day readmission rate by 2 percentage points. The IV model predicted that a 1-day reduction in median postoperative LOS increased 30-day readmission rate by 3 percentage points. CONCLUSIONS: : The findings indicate that a reduction in postoperative LOS is associated with an increased risk for 30-day readmission among Medicare patients undergoing bypass surgery, after both observed and unobserved confounding effects are corrected. PM:23032357

Siciliani L., Sivey P., Street A. (2013). Differences in length for hip replacement between public hospitals, specialised treatment centres and private providers, selection or efficiency ? *Health Economics*, 22 (2) : 234-242.

Abstract: We investigate differences in patients a length of stay between National Health Service (NHS) public hospitals, specialised public treatment centres and private treatment centres that provide elective (non-emergency) hip replacement to publicly funded patients. We find that the specialised public treatment centres and private treatment centres have, on average, respectively 18% and 40% shorter length of stay compared with NHS public hospitals, even after controlling for differences in age, gender, number and type of diagnoses, deprivation and regional variation. Therefore, we interpret such differences as because of efficiency as opposed to selection of less complex patients. Quantile regression suggests that the proportional differences between different provider types are larger at the higher conditional quantiles of length of stay. Copyright © 2012 John Wiley & Sons, Ltd <http://dx.doi.org/10.1002/hec.1826>

Polyzos N., Karanikas H., Thireos E., Kastanioti C., Kontodimopoulos N. (2013). Reforming reimbursement of public hospitals in Greece during the economic crisis: Implementation of a DRG system. *Health Policy*, Volume 109, Issue 1, Pages 14-22. Abstract: Until recently, in-patient NHS hospital care in Greece was reimbursed via an anachronistic and under-priced retrospective per diem system, which has been held primarily responsible for continuous budget deficits. The purpose of this paper is to present the efforts of the Ministry of Health (MoH) to implement a new DRG-based payment system. As in many countries, the decision was to adopt a patient classification from abroad and to refine it for use in Greece with national data. Pricing was achieved with a combination of activity-based costing with data from selected Greek hospitals, and "imported" cost weights. Data collection, IT support and monitoring are provided via ESY.net, a web-based facility developed and implemented by the MoH. After an initial pilot testing of the classification in 20 hospitals, complete DRG reimbursement data was reported by 113 hospitals (85% of total) for the fourth quarter of 2011. The recorded monthly increase in patient discharges billed with the new system and in revenue implies increasing adaptability by the hospitals. However, the unfavorable inlier vs. outlier distribution of discharges and revenue observed in some health regions signifies the need for corrective actions. The importance of this reimbursement reform is discussed in light of the current crisis faced by the Greek economy. There is yet much to be done and many projects are currently in progress to support this effort; however the first cost containment results are encouraging.
<http://linkinghub.elsevier.com/retrieve/pii/S0168851012002758?showall=true>

Inégalités sociales de santé

Tampubolon G., Subramanian S.V., Kawachi I. (2013). **Neighbourhood social capital and individual self-rated health in wales.** *Health Econ*, 22 (1) : 14-21.

Abstract: Although neighbourhood social capital can be beneficial for individual health, supporting evidence in the UK is scant. We aim to find the net effect of neighbourhood social capital and deprivation on individual health beyond sociodemographic composition of neighbourhood. We propose a multilevel path analytic model of health to delineate complex pathways involving neighbourhoods (measured as local super output area) and individuals. Analysis of the most recent data containing independent measures of neighbourhood social capital shows that neighbourhood social capital appears to be associated with benefits in some aspects of individual health in the Welsh setting. The improvement stands beyond individual determinants and neighbourhood deprivation. Social scientists and public health officials have reason to continue focusing on the neighbourhoods as well as the individuals to improve the health of the population. Copyright (c) 2011 John Wiley & Sons, LtdPM:22114035

Lazar A., Silber J. (2013). On the cardinal measurement of health inequality when only ordinal information is available on individual health status. *Health Econ*, 22 (1) : 106-113.

Abstract: This paper suggests new indices of health inequality which may be used when only ordinal information is available on individual health status. We borrow ideas from the literature on the measurement of occupational or residential segregation and show that indices of ordinal segregation which have been recently proposed may be also applied to the measurement of health inequality. We also prove that these indices satisfy four axioms introduced to measure inequality with ordered response health data so that the new indices presented in this paper are consistent with the inequality ordering proposed by Allison and Foster. We also suggest an extension of the family of indices proposed by Abul Naga and Yalcin. Copyright (c) 2011 John Wiley & Sons, LtdPM:22144048

Cohen A.K., Rehkopf D.H., Deardorff J., Abrams B. (2013). Education and obesity at age 40 among American adults. *Social Science & Medicine*, 78 (0) : 34-41.

Abstract: Although many have studied the association between educational attainment and obesity, studies to date have not fully examined prior common causes and possible interactions by race/ethnicity or gender. It is also not clear if the relationship between actual educational attainment and obesity is independent of the role of aspired educational attainment or expected educational attainment. The authors use generalized linear log link models to examine the association between educational attainment at age 25 and obesity (BMI ≥ 30) at age 40 in the USA's National Longitudinal Survey of Youth 1979 cohort, adjusting for demographics, confounders, and mediators. Race/ethnicity but not gender interacted with educational attainment. In a complete case analysis, after adjusting for socioeconomic covariates from childhood, adolescence, and adulthood, among whites only, college graduates were less likely than high school graduates to be obese (RR = 0.69, 95%CI: 0.57, 0.83). The risk ratio remained similar in two sensitivity analyses when the authors adjusted for educational aspirations and educational expectations and analyzed a multiply imputed dataset to address missingness. This more nuanced understanding of the role of education after controlling for a thorough set of confounders and mediators helps advance the study of social determinants of health and risk factors for obesity.

<http://www.sciencedirect.com/science/article/pii/S0277953612007836>

Bilger M., Carrieri V. (2013). Health in the cities: When the neighborhood matters more than income. *Journal of Health Economics*, 32 (1) : 1-11.

Abstract: Using a rich Italian cross-sectional dataset, we estimate the effect of a neighborhood problems aggregate (including pollution, crime, and noise) on self-assessed health, presence of chronic conditions and limitations in daily activities. We address the self-selection of the residents in their neighborhoods, as well as the possible endogeneity of income with respect to health, through instrumental variable methods and several endogeneity tests. The main novelty is the sound estimation of the neighborhood effect on health using observational data, which has the advantage of providing general results that are not dependent on any experimental design. This allows us to fully compare the neighborhood effect with the traditional socioeconomic determinants of health. Our main findings are that low quality neighborhoods are strongly health damaging. This effect is comparable to the primary/upper secondary education health differential and is even higher than the impact that poor economic circumstances have on health.

<http://www.sciencedirect.com/science/article/pii/S0167629612001531>

Médicaments

Puig-Junoy J. (2012). Do Higher-Priced Generic Medicines Enjoy a Competitive Advantage Under Reference Pricing? *Applied Health Economics and Health Policy*, 10 (6) :

Abstract: Background: In many countries with generic reference pricing, generic producers and distributors compete by means of undisclosed discounts offered to pharmacies in order to reduce acquisition costs and to induce them to dispense their generic to patients in preference over others. Objective: The objective of this article is to test the hypothesis that under prevailing reference pricing systems for generic medicines, those medicines sold at a higher consumer price may enjoy a competitive advantage. Method: Real transaction prices for 179 generic medicines acquired by pharmacies in Spain have been used to calculate the discount rate on acquisition versus reimbursed costs to pharmacies. Two empirical hypotheses are tested: the discount rate at which pharmacies acquire generic medicines is higher for those pharmaceutical presentations for which there are more generic competitors; and, the discount rate at which pharmacies acquire generic medicines is higher

for those pharmaceutical forms for which the consumer price has declined less in relation to the consumer price of the brand drug before generic entry (higher-priced generic medicines). Results: An average discount rate of 39.3% on acquisition versus reimbursed costs to pharmacies has been observed. The magnitude of the discount positively depends on the number of competitors in the market. The higher the ratio of the consumer price of the generic to that of the brand drug prior to generic entry (i.e. the smaller the price reduction of the generic in relation to the brand drug), the larger the discount rate. Conclusions: Under reference pricing there is intense price competition among generic firms in the form of unusually high discounts to pharmacies on official ex-factory prices reimbursed to pharmacies. However, this effect is highly distorting because it favours those medicines with a higher relative price in relation to the brand price before generic entry. Springer International Publishing Switzerland 2012.

http://adisonline.com/healthconomics/Fulltext/2012/11000/Do_Higher_Priced_Generic_Medicines_Enjoy_a.9.aspx

Cabrales A., Jimenez-Martan S. (2013). The determinants of pricing in pharmaceuticals : are us prices really so high ? *Health Economics*, 10 janvier.

Abstract: This paper studies price determination in pharmaceutical markets using data for 25 countries, 6 years, and a comprehensive list of products from the MIDAS IMS database. A key finding is that the USA has prices that are not significantly higher than those of countries with similar income levels, especially those that are highly regulated. More importantly, price differences to the US levels increase for branded, world top selling, or innovative products, and decrease, regardless of the level of regulation for mature or widely diffused molecules. Because prices for top selling molecules may be easier to perceive and recollect and more important for companies, they may bias the public discussion about international price differences. Copyright © 2013 John Wiley & Sons Ltd.

<http://dx.doi.org/10.1002/hec.2887>

Dowd B., Feldman R., Nersesian W.I.L.L. (2013). Setting pay targets : do poor performers give up ? *Health Economics*, 22 (2) : 168-179.

Abstract: We examine the effect of a health plan's pay for performance incentives on the percentage of outpatient drug prescriptions that are filled with generic rather than brand-name drugs in physicians' practices in an established physician network – the generic prescription rate (GPR). The financial reward was based on the performance of the entire network, but the network implemented rewards at the practice level. Practice-level rewards were awarded on an all-or-nothing basis if the GPR met or exceeded specialty-specific targets that increased each year. Although that design gave the practices a strong incentive to meet the target, practices performing far below the target might – give up –, costing the network its reward. Using a partial adjustment model, we estimate that in the absence of pay for performance, the average equilibrium value of GPR was 58.3%. We estimate that GPR would be maximized if the target were set at 77%. The GPR-maximizing target would induce an improvement in average GPR from 58.3% to 65.8% or 7.5 percentage points. When the target is set above 80%, practices with equilibrium GPR below 58.3% will – give up – in the sense that they will not improve relative to their equilibrium value. Copyright © 2012 John Wiley & Sons, Ltd. <http://dx.doi.org/10.1002/hec.2773>

Jena A.B., Philipson T.J. (2013). Endogenous cost-effectiveness analysis and health care technology adoption. *Journal of Health Economics*, 32 (1) : 172-180.

Abstract: Increased health care spending has placed pressure on public and private payers to prioritize spending. Cost-effectiveness (CE) analysis is the main tool used by payers to prioritize coverage of new therapies. We argue that reimbursement based on CE is subject to a form of the – Lucas critique – ; the goals of CE policies may not materialize when firms affected by the policies respond optimally to them. For instance, because – costs – in CE analysis reflect prices

set optimally by firms rather than production costs, observed CE levels will depend on how firm pricing responds to CE policies. Observed CE is therefore endogenous. When CE is endogenously determined, policies aimed at lowering spending and improving overall CE may paradoxically raise spending and lead to the adoption of more resource-costly treatments. We empirically illustrate whether this may occur using data on public coverage decisions in the United Kingdom.

<http://www.sciencedirect.com/science/article/pii/S0167629612001555>

Méthodologie

Jurges H., Winter J. (2013). Are anchoring vignettes ratings sensitive to vignette age and sex? *Health Econ*, 22 (1) : 1-13.

Abstract: Anchoring vignettes are commonly used to study and correct for differential item functioning and response bias in subjective survey questions. Self-assessed health status is a leading example. A crucial assumption of the vignette methodology is 'vignette equivalence': The health status of the person described in the vignette must be perceived by all respondents in the same way. We use data from a survey experiment conducted with a sample of almost 5000 older Americans to validate this assumption. We find weak evidence that respondents' vignette ratings may be sensitive to the sex and, for older respondents, also to the age (implied by the first name) of the person described in the vignette. Our findings suggest that vignette equivalence may not hold, at least if the potentially subtle connotations of vignette persons' names are not fully controlled. Copyright (c) 2011 John Wiley & Sons, LtdPM:22083845

Kim H.J., Fredriksen-Goldsen K.I. (2013). Nonresponse to a question on self-identified sexual orientation in a public health survey and its relationship to race and ethnicity. *Am J Public Health*, 103 (1) : 67-69.

Abstract: We examined whether nonresponse to the survey question on self-identified sexual orientation was associated with race and ethnicity, utilizing Washington State Behavioral Risk Factor Surveillance System data. The results of adjusted multinomial logistic regression indicated that the nonresponse rates of Asian Americans, Hispanics, and African Americans are higher than those of non-Hispanic Whites. Innovative ways of measuring sexual orientation to reduce racially and ethnically driven bias need to be developed and integrated into public health surveys. PM:23153153

Costa-Font J., McGuire A., Stanley T. (2013). Publication selection in health policy research: The winner's curse hypothesis. *Health Policy*. 2013 Jan;109(1):78-87 (pp. 78-87).

Abstract: There is a widely discussed problem of publication bias in medical and health services research. Where quantitative effects form the basis of a publication a 'winner's curse' curse may apply. This phenomenon may occur as prospective authors of research papers compete by reporting 'more extreme and spectacular results' in order to increase the chances of their paper being accepted for publication. This paper examines this phenomenon using quantitative findings on income and price elasticities as reported in health economics research. We find robust statistical evidence that higher-impact journals preferentially report larger empirical estimates of these elasticities. That is, we find robust evidence of a winner's curse hypothesis contributing to the existence of publication bias found in both the income and the price elasticities of health care and drugs, as well as value of life research.

<http://linkinghub.elsevier.com/retrieve/pii/S0168851012002965?showall=true>

Politique de santé

Kammer A., Niehues J., Peichl A. (2012). Welfare regimes and welfare state outcomes in Europe. *Journal of European Social Policy*, 22 (5) : 455-471.

Abstract: Welfare state typologies are generally based on the institutional design of welfare policies. In this paper we analyse whether such typologies also persist when they are applied to effective redistributive outcomes of welfare states' tax and transfer policies. In contrast to the widespread use of macro indicators, our empirical analysis relies on internationally comparable microdata in order to account for the distribution of resources across households. We perform a hierarchical cluster analysis and check whether the classical typology for Western European welfare states reproduces the typical patterns when it comes to effective economic outcomes. We find that the established welfare regimes not only differ in their welfare state institutions as is known, but also in their economic outcomes. In particular, we identify the social-democratic, conservative, liberal and southern welfare regimes. Belgium and the Netherlands emerge as hybrid cases lying between the social-democratic and conservative model.

<http://esp.sagepub.com/content/22/5/455.abstract>

Prévention

Olsen J.A., RÅgeberg O.J., Stavem K., Faculty of Medicine (2012). What Explains Willingness to Pay for Smoking-Cessation Treatments -Addiction Level, Quit-Rate Effectiveness or the Opening Bid? *Applied Health Economics and Health Policy*, 10 (6) :

Abstract: Background: Several countries have now passed laws that place limitations on where smokers may smoke. A range of smoking-cessation treatments have become available, many of which have documented increased quit rates. Population surveys show that most smokers wish to quit, and most nonsmokers would prefer to reduce the prevalence of smoking in society. The strengths of these preferences, however, as measured by their willingness to pay (WTP), have not yet been investigated. Objective: This study aims to identify variables that explain variations in people's answers to WTP questions on smoking-cessation treatments. Methods: A representative sample of the Norwegian population was asked their WTP in terms of an earmarked contribution to a public smokingcessation programme. A sub-group of daily smokers was, in addition, asked about their WTP for a hypothetical treatment that would remove their urge to smoke. The impact of variation in the question format (different opening bids) on stated WTP was compared with that of factors suggested by economic theory, such as quit-rate effectiveness, degree of addiction as measured by the 12-item Cigarette Dependence Scale (CDS-12), and degree of peer group influence as measured by the proportion of one's friends who smoke. Results: In both programmes, the most important determinant for explaining variations in WTP was the size of the opening bid. Differences in quit-rate effectiveness did not matter for people's WTP for the smoking-cessation programme. Addiction, and having a small proportion of friends who smoke, were positively associated with smokers' WTP to quit smoking. Conclusion: Variations in WTP were influenced more by how the question was framed in terms of differences in opening bids, than by variables reflecting the quality (effectiveness) and need (addiction level) for the good in question. While the WTP method is theoretically attractive, the findings that outcomes in terms of different quit rates did not affect WTP, and that WTP answers can be manipulated by the chosen opening bid, should raise further doubts on the ability of this method to provide valid and reliable answers that reflect true preferences for health and healthcare. Springer International Publishing Switzerland

http://adisonline.com/healthconomics/Fulltext/2012/11000/What_Explains_Willingness_to_Pay_for.6.aspx

Prévision – Evaluation

Kadambi A., Leipold R.J., Kansal A.R., Sorensen S., Getsios D. (2012). Inclusion of Compliance and Persistence in Economic Models. *Applied Health Economics and Health Policy*, 10 (6) :

Abstract: Economic models are developed to provide decision makers with information related to the real-world effectiveness of therapeutics, screening and diagnostic regimens. Although compliance with these regimens often has a significant impact on real-world clinical outcomes and costs, compliance and persistence have historically been addressed in a relatively superficial fashion in economic models. In this review, we present a discussion of the current state of economic modelling as it relates to the consideration of compliance and persistence. We discuss the challenges associated with the inclusion of compliance and persistence in economic models and provide an in-depth review of recent modelling literature that considers compliance or persistence, including a brief summary of previous reviews on this topic and a survey of published models from 2005 to 2012. We review the recent literature in detail, providing a therapeutic-area-specific discussion of the approaches and conclusions drawn from the inclusion of compliance or persistence in economic models. In virtually all publications, variation of model parameters related to compliance and persistence was shown to have a significant impact on predictions of economic outcomes. Growing recognition of the importance of compliance and persistence in the context of economic evaluations has led to an increasing number of economic models that consider these factors, as well as the use of more sophisticated modelling techniques such as individual simulations that provide an avenue for more rigorous consideration of compliance and persistence than is possible with more traditional methods. However, we note areas of continuing concern cited by previous reviews, including inconsistent definitions, documentation and tenuous assumptions required to estimate the effect of compliance and persistence. Finally, we discuss potential means to surmount these challenges via more focused efforts to collect compliance and persistence data. Springer International Publishing Switzerland 2012

http://adisonline.com/healthconomics/Fulltext/2012/11000/Inclusion_of_Compliance_and_Persistence_in.3.aspx

Psychiatrie

Ngamini Ngui A., Cohen A.A., Courteau J., Lesage A., Fleury M.J.e., Gragoire J.P., Moisan J., Vanasse A. (2013). Does elapsed time between first diagnosis of schizophrenia and migration between health territories vary by place of residence? A survival analysis approach. *Health & Place*, (In press) :

Abstract: Migration of patients with schizophrenia might influence health care access and utilization. However, the time between diagnosis and migration of these patients has not yet been explored. We studied the first migration between health territories of 6873 patients newly diagnosed with schizophrenia in Quebec in 2001, aiming to describe the pattern of migration and assess the influence of the place of residence on migration. Between 2001 and 2007, 34.5% of patients migrated between health territories; those living in metropolitan areas were more likely to migrate than others but tended to remain in metropolitan areas. Migrant patients were also more likely to

stay in or migrate to the most socially or materially deprived territories.

<http://www.sciencedirect.com/science/article/pii/S1353829212002092>

Soins de santé primaires

Aysola J., Bitton A., Zaslavsky A.M., Ayanian J.Z. (2013). Quality and equity of primary care with patient-centered medical homes: results from a national survey. *Med Care*, 51 (1) : 68-77.

Abstract: BACKGROUND: : The patient-centered medical home (PCMH) model has gained support, but the impact of this model on the quality and equity of care merits further evaluation. OBJECTIVE: : To determine if PCMHs are associated with improved quality and equity in pediatric primary care. RESEARCH DESIGN: : Using the 2007/2008 National Survey of Children's Health, a nationally representative survey of parents/guardians of children (age, 0-17 y), we evaluated the association of PCMHs with 10 quality-of-care measures using multivariable regression models, adjusting for demographic and socioeconomic covariates. For quality indicators that were significantly associated with medical homes, we determined if this association differed by race/ethnicity. RESULTS: : Compared with children without medical homes, those with medical homes had significantly better adjusted rates for 6 of 10 quality measures (all $P \leq 0.02$), such as obtaining a developmental history [adjusted rates % (SE): 41.7 (1.3) vs. 52.0 (1.1), $P < 0.001$]. Having a medical home was associated with better adjusted rates of receiving a developmental history exam for both white and black children, but the disparity between these groups was not significantly narrowed [difference in risk differences (SE): 0.9 (4.3) for whites vs. blacks; $P = 0.83$]. CONCLUSIONS: : Our results underscore the benefits of the medical home model for children while highlighting areas for improvement, such as narrowing disparities. Our findings also emphasize the key role of patient experience measures in the evaluation of medical homes. PM:23047125

Mohr D.C., Benzer J.K., Young G.J. (2013). Provider workload and quality of care in primary care settings: moderating role of relational climate. *Med Care*, 51 (1) : 108-114.

Abstract: Primary care providers are increasingly under pressure to do more with fewer resources. We examined the effect of workload on patients' experiences of quality of care, measured through approximately 44,000 patient experience surveys in a sample of 222 primary care clinics in the Veterans Health Administration. We tested the extent to which relational climate, a measure of teamwork, moderated the relationship between workload and patient ratings of quality of care. Our outcome measures included patient complaints, time spent with provider, and overall visit quality. Workload was negatively associated with patients' quality of care ratings and relational climate moderated the relation between workload and quality of care ratings. Patients seen in clinics with higher workload and greater relational climate reported better care compared with patients in clinics with higher workload but lower relational climate. Findings highlight the importance of relational climate as an important teamwork factor when managing and developing clinic policies, practices, and procedures in resource-constrained settings. PM:23222471

Paplluste K., Kasiulevičius V., Veide S., Kringos D.S., Boerma W., Lember M. (2013). Primary care in Baltic countries: A comparison of progress and present systems. *Health Policy*, Volume 109, Issue 2, Pages 122-130

Abstract: This study aims to compare the organisation of primary care (PC) systems in Estonia, Latvia and Lithuania, focusing on the structure and process of service delivery, and to discuss the suitability of the PHAMEU instrument for international comparison of PC systems. The data were collected in the framework of PHAMEU project during 2009-2010. The selected indicators were used to describe and compare the structure and process of PC in Estonia, Latvia and Lithuania. The results

showed that the coordination of PC services, legislative framework, service delivery, quality requirements and PC financing principles are rather similar in all three Baltic countries. Population coverage for PC services, cost sharing for some services, and the employment status of family doctors differs by country. The PHAMEU instrument was most applicable for the description and comparison of the structure of PC and some aspects of the process. Information about patient outcome and quality of care was neither available nor reliable enough. The development of PC systems in Baltic countries has been rather similar, but some aspects also differ between the countries. Use of a standardized instrument allows for international comparison, but assumes standardised data collection procedures in comparable countries.

<http://linkinghub.elsevier.com/retrieve/pii/S0168851012002242?showall=true>

Systèmes de santé

Buchmueller T.C., Grazier K., Hirth R.A., Okeke E.N. (2013). The price sensitivity of medicare beneficiaries: a regression discontinuity approach. *Health Econ*, 22 (1) : 35-51.

Abstract: We use 4 years of data from the retiree health benefits program of the University of Michigan to estimate the effect of price on the health plan choices of Medicare beneficiaries. During the period of our analysis, changes in the University's premium contribution rules led to substantial price changes. A key feature of this 'natural experiment' is that individuals who had retired before a certain date were exempted from having to pay any premium contributions. This 'grandfathering' creates quasi-experimental variation that is ideal for estimating the effect of price. Using regression discontinuity methods, we compare the plan choices of individuals who retired just after the grandfathering cutoff date and were therefore exposed to significant price changes to the choices of a 'control group' of individuals who retired just before that date and therefore did not experience the price changes. The results indicate a statistically significant effect of price, with a \$10 increase in monthly premium contributions leading to a 2 to 3 percentage point decrease in a plan's market share. Copyright (c) 2012 John Wiley & Sons, LtdPM:22278904

Vandoros S., Stargardt T. (2013). Reforms in the Greek pharmaceutical market during the financial crisis. *Health Policy*, Volume 109, Issue 1, pp. 1-6.

Abstract: Following the financial crisis of 2008, Greece has been facing severe fiscal problems associated with high public debt and deficit. Given their significant contribution to public sector expenditure, part of the effort to reduce public expenditure has involved a focus on pharmaceutical markets. Our aim is to provide an overview of recent policy changes in the Greek pharmaceutical market as a response to the crisis. We also discuss other potential measures that can be implemented. The recommendations are relevant to European countries facing debt crises, but also to any other country, as improving efficiency makes funds available to be used on other interventions. In 2010 and 2011, following the debt crisis and the agreement with the IMF, EU and ECB, the Greek government introduced several policy measures aimed at cost-containment. These changes included (a) price cuts, (b) the re-introduction of a positive list, (c) changes in the profit margins of pharmacies and wholesalers, and (d) tenders for hospital drugs. As a result, public drug expenditure decreased from $\hat{\alpha}$, -5.09 billion in 2009 to $\hat{\alpha}$, -4.25 billion in 2010 and $\hat{\alpha}$, -4.10 billion in 2011. As the need to cut expenditure becomes more urgent, seeking efficiency is possibly the only option for countries that do not wish to compromise quality of healthcare and public health. However, efficiency and cost containment are not only about introducing new policies, but also about the enforcement of existing laws and fighting corruption

<http://linkinghub.elsevier.com/retrieve/pii/S0168851012002254?showall=true>

Heinemann S., Leiber S., GreÄ S. (2013). Managed competition in the Netherlands. A qualitative study. Health Policy, Volume 109, Issue 2, Pages 113-121.

Abstract: In 2006, the Health Insurance Act changed Dutch health insurance by implementing managed competition, whereby the health insurance market is strongly regulated by the government. The aim of the study is to investigate key stakeholders'™ opinions about effects of recent changes in Dutch healthcare policy, focussing upon three important requirements for successful managed competition: risk-adjustment, consumer choice and instruments for managed care. Expert interviews with 12 key stakeholders were performed (October/November 2009), transcribed and analyzed in a four-step qualitative process. The Dutch risk-adjustment scheme is very advanced but incentives for health insurers to select risks remain. The Health Insurance Act has given insurers new incentives to focus upon consumer needs and preferences, whereby large group contracts have replaced individual consumer choice with collective decision-making. Managed care concepts are slow in developing. Patient organizations and insurers report taking part in such efforts, but other stakeholders do not perceive that progress has been made. The pre-requisites for successful managed competition in the Netherlands are not yet entirely in place: risk-adjustment schemes cannot yet counteract all incentives to select risks, consumer preferences are just beginning to influence insurer policies and managed care elements are currently in the development stage
<http://linkinghub.elsevier.com/retrieve/pii/S0168851012002485?showall=true>

Travail et sant 

Vieillessement

Jacobs J.C., Lilly M.B., Ng C., Coyte P.C. (213). The fiscal impact of informal caregiving to home care recipients in Canada: How the intensity of care influences costs and benefits to government. *Social Science & Medicine*, (In press) :

Abstract: The objective of this study was to estimate the annual costs and consequences of unpaid caregiving by Canadians from a government perspective. We estimated these costs both at the individual and population levels for caregivers aged 45 and older. We conducted a cost-benefit analysis where we considered the costs of unpaid caregiving to be potential losses in income tax revenues and changes in social assistance payments and the potential benefit of reduced paid care expenditures. Our costing methods were based on multivariate analyses using the 2007 General Social Survey, a cross-sectional survey of 23,404 individuals. We determined the differential probability of employment, wages, and hours worked by caregivers of varying intensity versus non-caregivers. We also used multivariate analysis to determine how receiving different intensities of unpaid care impacted both the probability of receiving paid care and the weekly hours of paid care received. At the lowest intensities of caregiving, there was a net benefit to government from caregiving, at both the individual and population levels. At the population level, the net benefit to government was estimated to be \$4.4 billion for caregivers providing less than five hours of weekly care. At the highest intensity of caregiving, there was a net cost to government of \$641 million. Our overall findings were robust to a number of changes applied in our sensitivity analysis. We found that the factor with the greatest impact on cost was the probability of labour force participation. As the biggest cost driver appears to be the higher likelihood of intense caregivers dropping out of the labour force, government policies that enable intense caregivers to balance caregiving with employment may help to mitigate these losses.

<http://www.sciencedirect.com/science/article/pii/S0277953612008386>

Van Houtven C., Thorpe J.M., Chestnutt D., Molloy M., Boling J.C., Davis L.L. (2013). Do Nurse-Led Skill Training Interventions Affect Informal Caregivers Out-of-Pocket Expenditures?

The Gerontologist, 53 (1) : 60-70.

Abstract: Purpose of the Study: This paper is a report of a study of the Assistance, Support, and Self-health Initiated through Skill Training (ASSIST) randomized control trial. The aim of this paper is to understand whether participating in ASSIST significantly changed the out-of-pocket (OOP) costs for family caregivers of Alzheimer's disease (AD) or Parkinson's disease (PD) patients. Design and Methods: Secondary analysis of randomized control trial data, calculating average treatment effects of the intervention on OOP costs. Enrollment in the ASSIST trial occurred between 2002 and 2007 at 2 sites: Durham, North Carolina, and Birmingham, Alabama. We profile OOP costs for caregivers who participated in the ASSIST study and use 2-part expenditure models to examine the average treatment effect of the intervention on caregiver OOP expenditures. Results: ASSIST-trained AD and PD caregivers reported monthly OOP expenditures that averaged \$500-\$600. The intervention increased the likelihood of caregivers spending any money OOP by 26 percentage points over usual care, but the intervention did not significantly increase overall OOP costs. Implications: The ASSIST intervention was effective and inexpensive to the caregiver in direct monetary outlays; thus, there are minimal unintended consequences of the trial on caregiver financial well-being.

<http://gerontologist.oxfordjournals.org/content/53/1/60.abstract>

Cramm J.M., van Dijk H.M., Nieboer A.P. (2013). The Importance of Neighborhood Social Cohesion and Social Capital for the Well Being of Older Adults in the Community. *The Gerontologist*, 53 (1) : 142-152.

Abstract: Purpose of the Study: We aimed to investigate whether social capital (obtaining support through indirect ties such as from neighbors) and social cohesion (interdependencies among neighbors) within neighborhoods positively affect the well being of older adults. Design and Methods: This cross-sectional study included 945 of 1,440 (66% response rate) independently living older adults (aged 65-70 years) in Rotterdam. We fitted a hierarchical random effects model to account for the hierarchical structure of the study design: 945 older adults (Level 1) nested in 72 neighborhoods (Level 2). Results: Univariate analyses showed that being born in the Netherlands, house ownership, education, income, social capital of individuals, neighborhood security, neighborhood services, neighborhood social capital, and neighborhood social cohesion were significantly related to the well being of older adults. Multilevel analyses showed that social capital of individuals, neighborhood services, neighborhood social capital, and neighborhood social cohesion predicted the well being of older adults. Single and poor older adults reported lower well being than did better off and married older adults. However, the effects of marital status and income were mediated by neighborhood services, social capital, and social cohesion. Neighborhood services, social capital, and social cohesion may act as buffer against the adverse effects of being single and poor on the well being of older adults. Implications: The results of this study support the importance of social capital of individuals, as well as social capital within the neighborhood and social cohesion within the neighborhood for well being of older adults. The well being of older adults may also be enhanced through the improvement of quality of neighborhood services.

<http://gerontologist.oxfordjournals.org/content/53/1/142.abstract>

Van Houtven C., Coe N.B., Skira M.M. (2013). The effect of informal care on work and wages. *Journal of Health Economics*, 32 (1) : 240-252.

Abstract: Cross-sectional evidence in the United States finds that informal caregivers have less attachment to the labor force. The causal mechanism is unclear: do children who work less become informal caregivers, or are children who become caregivers working less? Using longitudinal data from the Health and Retirement Study, we identify the relationship between informal care and work in the United States, both on the intensive and extensive margins, and examine wage effects. We control for time-invariant individual heterogeneity; rule out or control for endogeneity; examine

effects for men and women separately; and analyze heterogeneous effects by task and intensity. We find modest decreases—2.4 percentage points—in the likelihood of working for male caregivers providing personal care. Female chore caregivers, meanwhile, are more likely to be retired. For female care providers who remain working, we find evidence that they decrease work by 3–10 hours per week and face a 3 percent lower wage than non-caregivers. We find little effect of caregiving on working men's hours or wages. These estimates suggest that the opportunity costs to informal care providers are important to consider when making policy recommendations about the design and funding of public long-term care programs.