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Sommaire

Assurance maladie – Health insurance

Arentz C., Eekhoff J., Kochskamper S. (2012). Private health insurance: a role model for European health systems. *European Journal of Health Economics (The),* 13 (5) : 615-621.
Abstract: European health care systems will face major challenges in the near future. Demographic change and technological progress induce rising costs. In order to deal with these developments and to preserve the current level of health care provision, health care systems need to be highly efficient. Yet existing health care systems show a lot of inefficiencies that result in waste of scarce resources. Therefore, improvements in performance are necessary. In this article, the authors argue that a change in financing health care accompanied by the liberalisation of the market for health care service providers offers a promising solution. We develop a market-based model for financing health care and show how it can be put into practice without generating additional costs for society while meeting social equity criteria

Stephen T.P., Roger F. (2013). Microsimulation of Private Health Insurance and Medicaid Take-Up Following the U.S. Supreme Court Decision Upholding the Affordable Care Act. *Health Services Research,* 48 (2) : 826-849.
http://ejournals.ebsco.com/direct.asp?ArticleID=4A8B810FE6D20889126D

Sarah T., Reinhard B., Luca C., Wynand v.d., V, Carine V.d., V (2013). Statutory health insurance competition in Europe: A four-country comparison. *Health Policy,* 109 (3) : 209-225.
Abstract: This paper explores the goals and implementation of reforms introducing choice of and competition among insurers providing statutory health coverage in Belgium, Germany, the Netherlands and Switzerland. In theory, health insurance competition can enhance efficiency in health care administration and delivery only if people have free choice of insurer (consumer mobility), if insurers do not have incentives to select risks, and if insurers are able to influence health service quality and costs. In practice, reforms in the four countries have not always prioritised efficiency and implementation has varied. Differences in policy goals explain some but not all of the differences in implementation. Despite significant investment in risk adjustment, incentives for risk selection remain and consumer mobility is not evenly distributed across the population. Better risk adjustment might make it easier for older and less healthy people to change insurer. Policy makers could also do more to prevent insurers from linking the sale of statutory and voluntary health insurance, particularly where take-up of voluntary coverage is widespread. Collective negotiation between insurers and providers in Belgium, Germany and Switzerland curbs insurers' ability to influence health care quality and costs. Nevertheless, while insurers in the Netherlands have good access to efficiency-enhancing tools, data and capacity constraints and resistance from stakeholders limit the extent to which tools are used. The experience of these countries offers an important lesson to other countries: it is not straightforward to put in place the conditions under which health insurance competition can enhance efficiency. Policy makers should not, therefore, underestimate the challenges involved
http://ejournals.ebsco.com/direct.asp?ArticleID=4D5C8A8D7D47F212E4A3

Economie de la santé – Health economics

Pammolli F., Riccaboni M., Magazzini L. (2012). The sustainability of European health care systems: beyond income and aging. *European Journal of Health Economics (The),* 13 (5) : 623-634.
Abstract: During the last 30 years, health care expenditure (HCE) has been growing much more rapidly than GDP in OECD countries. In this paper, we review the determinants of HCE dynamics in Europe, taking into account the role of income, aging population, technological progress, female labor participation and public budgetary variables. We show that HCE is a multifaceted phenomenon where demographic, social, economic, technological and institutional factors all play an important role. The comparison of total, public and private HCE reveals an imbalance of European welfare toward the care of the elderly. European Governments should increasingly rely on pluralistic systems to balance sustainability and access and equilibrate the distribution of resources across the functions of the public welfare system

Benning T.M., Dellaert B.G.C. (2013). Paying more for faster care? Individuals' attitude toward price-based priority access in health care. *Social Science & Medicine,* (Ahead of print) :
Abstract: Increased competition in the health care sector has led hospitals and other health care institutions to experiment with new access allocation policies that move away from traditional expert based allocation of care to price-based priority access (i.e., the option to pay more for faster care). To date, little is known about individuals' attitude toward price-based priority access and the evaluation process underlying this attitude. This paper addresses the role of individuals' evaluations of collective health outcomes as an important driver of their attitude toward (price-based) allocation policies in health care. The authors investigate how individuals evaluate price-based priority access by means of scenario-based survey data collected in a representative sample from the Dutch population (NÂ =Â 1464). They find that (a) offering individuals the opportunity to pay for faster care negatively affects their evaluations of both the total and distributional collective health outcome achieved, (b) however, when health care supply is not restricted (i.e., when treatment can be offered outside versus within the regular working hours of the hospital) offering price-based priority access affects total collective health outcome evaluations positively instead of negatively, but it does not change distributional collective health outcome evaluations. Furthermore, (c) the type of health care treatment (i.e., life saving liver transplantation treatment vs. life improving cosmetic ear correction treatment â€“ priced at the same level to the individual) moderates the effect of collective health outcome evaluations on individuals' attitude toward allocation policies. For policy makers and hospital managers the results presented in this article are helpful because they provide a better understanding of what drives individuals' preferences for health care allocation policies. In particular, the results show that policies based on the €œpaying more for faster careâ€• principle are more attractive to the general public when treatment takes place outside the regular working hours of a hospital
http://www.sciencedirect.com/science/article/pii/S0277953613000750

Ekaterini P., Theologos P. (2013). Cross state disparities in US health care expenditures. *Health Economics,* 22 (4) : 451-465.
Abstract: This study examines the degree of convergence in health care expenditures among the US states from 1980 to 2004. Our results suggest that the US states form two clubs with specific geographical characteristics that converge to different equilibria. We also extend our analysis to investigate the cross-state disparities in nine major components of health expenditures. Our findings provide evidence for full convergence for only two components, namely ‘physician and other professional services’ and ‘home health care’. However, for the remaining components, we can still identify various convergence clubs. Copyright © 2012 John Wiley & Sons, Ltd
http://ejournals.ebsco.com/direct.asp?ArticleID=4CD580B6EAE4E26E55DC

Mark A., Zane G. (2013). Lessons from Game Theory about Healthcare System Price Inflation. *Applied Health Economics and Health Policy,* 11 (1) : 45-51.
Abstract: Game theory is useful for identifying conditions under which individual stakeholders in a collective action problem interact in ways that are more cooperative and in the best interest of the collective. The literature applying game theory to healthcare markets predicts that when providers set prices for services autonomously and in a noncooperative fashion, the market will be susceptible to ongoing price inflation. We compare the traditional fee-for-service pricing framework with an alternative framework involving modified doctor, hospital and insurer pricing and incentive strategies. While the fee-for-service framework generally allows providers to set prices autonomously, the alternative framework constrains providers to interact more cooperatively. We use community-level provider and insurer data to compare provider and insurer costs and patient wellness under the traditional and modified pricing frameworks. The alternative pricing framework assumes (i) providers agree to manage all outpatient claims; (ii) the insurer agrees to manage all inpatient clams; and (iii) insurance premiums are tied to patients' healthy behaviours. Consistent with game theory predictions, the more cooperative alternative pricing framework benefits all parties by producing substantially lower administrative costs along with higher profit margins for the providers and the insurer. With insurance premiums tied to consumers' risk-reducing behaviours, the cost of insurance likewise decreases for both the consumer and the insurer
http://ejournals.ebsco.com/direct.asp?ArticleID=4536AC0FB40E22A03015

Etat de santé / Health status

Kamimoto L., Euler G.L., Lu P.J., Reingold A., Hadler J., Gershman K., Farley M., Terebuh P., Ryan P., Lynfield R., Albanese B., Thomas A., Craig A.S., Schaffner W., Finelli L., Bresee J., Singleton J.A. (2012). Seasonal Influenza Morbidity Estimates Obtained From Telephone Surveys, 2007. In :*American Journal of Public Health,* 103 (4) : 755-763.
Objectives. We assessed telephone surveys as a novel surveillance method, comparing data obtained by telephone with existing national influenza surveillance systems, and evaluated the utility of telephone surveys. Methods. We used the 2007 Behavioral Risk Factor Surveillance System (BRFSS) and the 2007 National Immunization Survey-Adult (NIS-Adult) to estimate the incidence of influenza-like illness (ILI), medically attended ILI, provider-diagnosed influenza, influenza testing, and treatment of influenza with antiviral medications during the 2006-2007 influenza season. Results. With the January-May BRFSS, among persons aged 18 years and older, the cumulative incidence of seasonal ILI and provider-diagnosed influenza was 37.9 and 5.7 adults per 100 persons, respectively. Monthly medically attended ILI and provider-diagnosed influenza among adults were temporally associated with influenza activity, as documented by national surveillance. With the NIS-Adult survey data, estimated provider-diagnosed influenza, influenza testing, and antiviral treatment were 2.8%, 1.4%, and 0.6%, respectively. Conclusions. Our telephone interview-based estimates of influenza morbidity were consistent with those from national influenza surveillance systems. Telephone surveys may provide an alternative method by which population-based influenza morbidity information can be gathered.
http://dx.doi.org/10.2105/AJPH.2012.300799

Géographie de la santé / Geography of health

Stefan F., Harald T. (2013). Federal state differentials in the efficiency of health production in Germany: an artifact of spatial dependence? *The European Journal of Health Economics,* 14 (1) : 21-39.
Abstract: Due to regional competition and patient migration, the efficiency of healthcare provision at

the regional level is subject to spatial dependence. We address this issue by applying a spatial autoregressive model to longitudinal data from Germany at the district ('Kreis') level. The empirical model is specified to explain efficiency scores, which we derive through non-parametric order-m efficiency analysis of regional health production. The focus is on the role of health policy of federal states ('Bundesländer') for district efficiency. Regression results reveal significant spatial spillover effects. Notably, accounting for spatial dependence does not decrease but increases the estimated effect of federal states on district efficiency. It appears that genuinely more efficient states are less affected by positive efficiency spillovers, so that taking into account spatial dependence clarifies the importance of health policy at the state level. Due to regional competition and patient migration, the efficiency of healthcare provision at the regional level is subject to spatial dependence. We address this issue by applying a spatial autoregressive model to longitudinal data from Germany at the district ('Kreis') level. The empirical model is specified to explain efficiency scores, which we derive through non-parametric order-m efficiency analysis of regional health production. The focus is on the role of health policy of federal states ('Bundesländer') for district efficiency. Regression results reveal significant spatial spillover effects. Notably, accounting for spatial dependence does not decrease but increases the estimated effect of federal states on district efficiency. It appears that genuinely more efficient states are less affected by positive efficiency spillovers, so that taking into account spatial dependence clarifies the importance of health policy at the state level
http://ejournals.ebsco.com/direct.asp?ArticleID=4F0DAFA6152CBD86CDD5

Ngamini Ngui A., Cohen A.A., Courteau J., Lesage A., Fleury M.J.e., Grégoire 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,* 20 (0) : 66-74.
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

Hôpital / Hospitals

Pirson M., Schenker L., Martins D., Duong D., Chalé J., Leclercq P. (2013). What can we learn from international comparisons of costs by DRG? *The European Journal of Health Economics,* 14 (1) : 67-73.
Abstract: The objective of this study was to compare costs data by diagnosis related group (DRG) between Belgium and Switzerland. Our hypotheses were that differences between countries can probably be explained by methodological differences in cost calculations, by differences in medical practices and by differences in cost structures within the two countries. Classifications of DRG used in the two countries differ (AP-DRGs version 1.7 in Switzerland and APR-DRGs version 15.0 in Belgium). The first step of this study was to transform Belgian summaries into Swiss AP-DRGs. Belgian and Swiss data were calculated with a clinical costing methodology (full costing). Belgian and Swiss costs were converted into US$ PPP (purchasing power parity) in order to neutralize differences in purchasing power between countries. The results of this study showed higher costs in Switzerland despite standardization of cost data according to PPP. The difference is not explained by the case-mix index because this was similar for inliers between the two countries. The length of stay (LOS) was also quite similar for inliers between the two countries. The case-mix index was, however, higher for high outliers in Belgium, as reflected in a higher LOS for these patients. Higher costs in Switzerland are thus probably explained mainly by the higher number of agency staff by service in this country or because of differences in medical practices. It is possible to make international comparisons but only if

there is standardization of the case-mix between countries and only if comparable accountancy methodologies are used. Harmonization of DRGs groups, nomenclature and accountancy is thus required
http://ejournals.ebsco.com/direct.asp?ArticleID=4D1FA6E0B78BC6418F6D

Engin Y., Denis R. (2013). The influence of social deprivation on length of hospitalisation. *The European Journal of Health Economics,* 14 (2) : 243-252.
Abstract: The implementation of activity-based payment system named T2A—tarification à l'activité—in 2004 profoundly modified the financing of French hospitals. Presently applied to activities concerning medicine, surgery and obstetrics, the pricing for these activities was developed using the National Costs Study. The considerable differences observed between costs in the private sector and those in the public sector are in part justified, by the latter, by caring for patients with social deprivation. The goal of this study is to measure the influence of social deprivation on the length of hospitalisation. A survey on inpatient social deprivation was carried out from November to December 2008 by the French Ministry of Health (Department of Research, Study, Evaluation and Statistics—DREES, and technical agency of Hospital information—ATIH). Four dimensions of social deprivation were taken into consideration after a previous qualitative study: social isolation, quality of housing, level of income and access to rights. The sample is based on 27 hospitals, including public and private (for-profit and not-for-profit), representing 57,175 stays, 6,800 of which were patients with social deprivation. After multivariate analyses adjusted for age, severity of illness and DRG, we found that there was a longer length of stay for inpatients with social deprivation (+16%), and in particular for patients living in social isolation (+17%) and for patients with inadequate housing (+17%). The impact of low income on the length of stay is less important. However, low income associated with inadequate housing significantly increases lengths of stay (+24%).The implementation of activity-based payment system named T2A—tarification à l'activité—in 2004 profoundly modified the financing of French hospitals. Presently applied to activities concerning medicine, surgery and obstetrics, the pricing for these activities was developed using the National Costs Study. The considerable differences observed between costs in the private sector and those in the public sector are in part justified, by the latter, by caring for patients with social deprivation. The goal of this study is to measure the influence of social deprivation on the length of hospitalisation. A survey on inpatient social deprivation was carried out from November to December 2008 by the French Ministry of Health (Department of Research, Study, Evaluation and Statistics—DREES, and technical agency of Hospital information—ATIH). Four dimensions of social deprivation were taken into consideration after a previous qualitative study: social isolation, quality of housing, level of income and access to rights. The sample is based on 27 hospitals, including public and private (for-profit and not-for-profit), representing 57,175 stays, 6,800 of which were patients with social deprivation. After multivariate analyses adjusted for age, severity of illness and DRG, we found that there was a longer length of stay for inpatients with social deprivation (+16%), and in particular for patients living in social isolation (+17%) and for patients with inadequate housing (+17%). The impact of low income on the length of stay is less important. However, low income associated with inadequate housing significantly increases lengths of stay (+24%)
http://ejournals.ebsco.com/direct.asp?ArticleID=4C94804296603731358A

Navid G., Andrew J.E., Erika G.M. (2013). Practice Variation, Bias, and Experiential Learning in Cesarean Delivery: A Data-Based System Dynamics Approach. *Health Services Research,* 48 (2) : 713-734.
http://ejournals.ebsco.com/direct.asp?ArticleID=49F18F605D5B0FEE5175

Richard C.L., Konetzka R.T., Amol S.Navathe, Jingsan Z., Wei C., Kevin V. (2013). The Impact of Profitability of Hospital Admissions on Mortality. *Health Services Research,* 48 (2) : 792-809.
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Matthias V. (2013). Improving patient-level costing in the English and the German 'DRG' system. *Health Policy,* 109 (3) : 290-300.
Abstract: The purpose of this paper is to develop ways to improve patient-level cost apportioning (PLCA) in the English and German inpatient 'DRG' cost accounting systems, to support regulators in improving costing schemes, and to give clinicians and hospital management sophisticated tools to measure and link their management
http://ejournals.ebsco.com/direct.asp?ArticleID=4CE2A794A940218C8841

Andreas S., Volker U. (2013). Consolidation and concentration in the German hospital market: The two sides of the coin. *Health Policy,* 109 (3) : 301-310.
Abstract: In many countries, policy makers try to increase quality and efficiency in the hospital sector by fostering competition. The German hospital market is a good example of this approach and the challenges that come with it. We focus on market concentration which is both a result of and a potential threat to more competition
http://ejournals.ebsco.com/direct.asp?ArticleID=43308C4FC16266EEF2F1

Inégalités sociales de santé / Social inequalities of health

Vigneron E. (2012). Inégalités de santé, inégalités de soins dans les territoires français. *Bulletin de L'Académie Nationale de Médecine,* 196 (4-5) : 939-952.
Abstract: Au cours de l'histoire, l'approche territoriale des questions de santé a occupé une place importante. Souvent conduite par les médecins eux-mêmes sous la forme d'observations, cette approche s'est progressivement effacée au cours du XXe siècle en raison du progrès clinique et en dépit de la poursuite de travaux de recherche. Pourtant, les inégalités territoriales de santé se sont maintenues et récemment approfondies en relation avec la crise sociale et économique. Cette situation est d'autant plus sensible en France, que l'égalité de traitement est la règle sur laquelle repose l'organisation du système de santé. La distance d'accès est un facteur important du renoncement aux soins. La concentration de la population dans les grandes aires urbaines et péri-urbaines implique d'apporter des solutions à la prise en charge de ceux qui en demeurent éloigner, géographiquement ou socialement. Le système de santé a pour justification d'aider ainsi la médecine à mieux s'exercer au profit de tous et d'abord de ceux qui en ont le plus besoin.

Lang T., Jusot F., Visier L., Menvielle G., Lombrail P. (2012). Réduire la consommation de tabac : comment prendre en compte les inégalités sociales de santé ? *Actualité et Dossier en Santé Publique,* (81) : 44-46.
Abstract: Malgré les politiques menées, le tabagisme a augmenté dans les catégories sociales modestes. Des mesures prenant en compte les déterminants sociaux doivent être envisagées

Laia P., Albert E., Maica R., Katia B.R., Pasarín M.I., Carme B. (2013). Trends in social class inequalities in the use of health care services within the Spanish National Health System, 1993–2006. *The European Journal of Health Economics,* 14 (2) : 211-219.
Abstract: The aim of this study was to analyse the trends and socio-economic inequalities in the use of health care services in Spain between 1993 and 2006.A study of trends was performed using data from six Spanish National Health Surveys (1993, 1995, 1997, 2001, 2003 and 2006). Sample sizes were 21,061; 6,396; 6,396; 21,066; 21,650 and 29,478, respectively. The following dependent variables were analysed: having visited a general practitioner (GP) or specialist in the previous 2 weeks, having visited a dentist within the previous 3 months and having visited a gynaecologist, having used the emergency services or having been hospitalised in the previous year. The main independent variable was social class, classified as manual or non-manual occupation. For each service, age-standardised proportions of use were calculated by survey year, sex and social class, and indices of relative (RII) and absolute (SII) inequality were computed. Trend tests were applied.An increase in the proportion of use was observed for all services, particularly emergency services. Individuals from manual classes were more likely to visit the GP and emergency services than those from non-manual classes. Conversely, those from non-manual classes were more likely to use specialised services. This trend was most notable for dentist visits. Social inequalities did not change significantly during the study period. Despite the increase in the use of health care services, the relationship between social class and the use of these services has remained stable throughout the study period. Achieving equity in the use of specialised care services is still a challenge for universal health care systems
http://ejournals.ebsco.com/direct.asp?ArticleID=45FA984924698BECFDE3

Luca G., Ponzo M., Andrés A.R. (2013). Health care utilization by immigrants in Italy. In : International Journal of Health Care Finance and Economics. *Int J Health Care Finance Econ,* 13 (1) : 1-31.
http://dx.doi.org/10.1007/s10754-012-9119-9

Muennig P., Cohen A.K., Palmer A., Zhu W. (2013). The relationship between five different measures of structural social capital, medical examination outcomes, and mortality. *Social Science & Medicine,* 85 (0) : 18-26.
Abstract Higher social capital is associated with improved mental and physical health and reduced risk of premature mortality. We explored the relationship between five measures of structural social capital and 1) intermediate health outcomes (elevated C-reactive protein, cholesterol, blood pressure, and serum fibrinogen) and 2) distal outcomes (cardiovascular and all cause mortality). We did so using the National Health and Nutrition Examination Survey III 1988–1994 linked to the National Death Index with mortality follow-up through 2006. We employed ordinary least squares regression for the intermediate outcomes, seemingly unrelated regression (SUR) to consider combined effects, and Cox proportionate hazards models for mortality outcomes. We then performed extensive sensitivity analyses, exploring the contribution of various variables and reverse causality. We find that our measures of social capital did not predict statistically significant changes in the laboratory biomarkers we study. Nevertheless, belonging to organizations or attending church >12 times per year were associated with reduced all cause mortality (hazard ratio [HR] = 0.81, 95% confidence interval [CI] = 0.70–0.93 and HR = 0.72, 95% CI = 0.60–0.86, respectively). In SUR analyses, however, combined laboratory values were significant for all measures of social capital we study with the exception of visits to neighbors. This suggests that some forms of structural social capital improve survival through small changes in multiple measures of biological risk factors rather than moderate or large changes in any one measure.
http://www.sciencedirect.com/science/article/pii/S0277953613000804

Cook B.L., Doksum T., Chen C.n., Carle A., Alegrla M. (2013). The role of provider supply and organization in reducing racial/ethnic disparities in mental health care in the U.S. *Social Science & Medicine,* (Ahead of print) :
Abstract: Racial and ethnic disparities in mental health care access in the United States are well documented. Prior studies highlight the importance of individual and community factors such as health insurance coverage, language and cultural barriers, and socioeconomic differences, though these factors fail to explain the extent of measured disparities. A critical factor in mental health care access is a local area's organization and supply of mental health care providers. However, it is unclear how geographic differences in provider organization and supply impact racial/ethnic disparities. The present study is the first analysis of a nationally representative U.S. sample to identify contextual factors (county-level provider organization and supply, as well as socioeconomic characteristics) associated with use of mental health care services and how these factors differ across racial/ethnic groups. Hierarchical logistic models were used to examine racial/ethnic differences in the association of county-level provider organization (health maintenance organization (HMO) penetration) and supply (density of specialty mental health providers and existence of a community mental health center) with any use of mental health services and specialty mental health services. Models controlled for individual- and county-level socio-demographic and mental health characteristics. Increased county-level supply of mental health care providers was significantly associated with greater use of any mental health services and any specialty care, and these positive associations were greater for Latinos and African-Americans compared to non-Latino Whites. Expanding the mental health care workforce holds promise for reducing racial/ethnic disparities in mental health care access.

Policymakers should consider that increasing the management of mental health care may not only decrease expenditures, but also provide a potential lever for reducing mental health care disparities between social groups
http://www.sciencedirect.com/science/article/pii/S0277953613000798

Kim I.H., Carrasco C., Muntaner C., McKenzie K., Noh S. (2013). Ethnicity and Postmigration Health Trajectory in New Immigrants to Canada. In : *American Journal of*

Public Health, 103 (4) : e96-e104.
Abstract: Objectives. In this prospective cohort study, we examined the trajectory of general health during the first 4 years after new immigrants? arrival in Canada. We focused on the change in self-rated health trajectories and their gender and ethnic disparities. Methods. Data were derived from the Longitudinal Survey of Immigrants to Canada and were collected between April 2001 and November 2005 by Statistics Canada. We used weighted samples of 3309 men and 3351 women aged between 20 and 59 years. Results. At arrival, only 3.5% of new immigrants rated their general health as poor. Significant and steady increases in poor health were revealed during the following 4 years, especially among ethnic minorities and women. Specifically, we found a higher risk of poor health among West Asian and Chinese men and among South Asian and Chinese women than among their European counterparts. Conclusions. Newly arrived immigrants are extremely healthy, but the health advantage dissipates rapidly during the initial years of settlement in Canada. Women and minority ethnic groups may be more vulnerable to social changes and postmigration settlement
Objectives. In this prospective cohort study, we examined the trajectory of general health during the first 4 years after new immigrants? arrival in Canada. We focused on the change in self-rated health trajectories and their gender and ethnic disparities. Methods. Data were derived from the Longitudinal Survey of Immigrants to Canada and were collected between April 2001 and November 2005 by Statistics Canada. We used weighted samples of 3309 men and 3351 women aged between 20 and 59 years. Results. At arrival, only 3.5% of new immigrants rated their general health as poor. Significant and steady increases in poor health were revealed during the following 4 years, especially among ethnic minorities and women. Specifically, we found a higher risk of poor health among West Asian and Chinese men and among South Asian and Chinese women than among their European counterparts. Conclusions. Newly arrived immigrants are extremely healthy, but the health advantage dissipates rapidly during the initial years of settlement in Canada. Women and minority ethnic groups may be more vulnerable to social changes and postmigration settlement
http://dx.doi.org/10.2105/AJPH.2012.301185

Asada Y., Yoshida Y., Whipp A.M. (2013). Summarizing social disparities in health.

Milbank Q, 91 (1) : 5-36.
Abstract: CONTEXT: Reporting on health disparities is fundamental for meeting the goal of reducing health disparities. One often overlooked challenge is determining the best way to report those disparities associated with multiple attributes such as income, education, sex, and race/ethnicity. This article proposes an analytical approach to summarizing social disparities in health, and we demonstrate its empirical application by comparing the degrees and patterns of health disparities in all fifty states and the District of Columbia (DC). METHODS: We used the 2009 American Community Survey, and our measure of health was functional limitation. For each state and DC, we calculated the overall disparity and attribute-specific disparities for income, education, sex, and race/ethnicity in functional limitation. Along with the state rankings of these health disparities, we developed health disparity profiles according to the attribute making the largest contribution to overall disparity in each state. FINDINGS: Our results show a general lack of consistency in the rankings of overall and attribute-specific disparities in functional limitation across the states. Wyoming has the smallest overall disparity and West Virginia the largest. In each of the four attribute-specific health disparity rankings, however, most of the best- and worst-performing states in regard to overall health disparity are not consistently good or bad. Our analysis suggests the following three disparity profiles across states: (1) the largest contribution from race/ethnicity (thirty-four states), (2) roughly equal contributions of race/ethnicity and socioeconomic factor(s) (ten states), and (3) the largest contribution from socioeconomic factor(s) (seven states). CONCLUSIONS: Our proposed approach offers policy-relevant health disparity information in a comparable and interpretable manner, and currently publicly available data support its application. We hope this approach will spark discussion regarding how best to systematically track health disparities across communities or within a community over time in relation to the health disparity goal of Healthy People 2020

Guido E. (2013). A dual Atkinson measure of socioeconomic inequality of health. *Health Economics,* 22 (4) : 466-479.

Abstract: The Atkinson index of income inequality is based on a comparison of the average income with the equivalent income, where the equivalent income is defined as the level of income that, if given to everyone, would generate the same social welfare as the existing distribution of income. This paper explores the possibility of extending this approach to the measurement of socioeconomic inequality of health. It assumes a social evaluation function that depends upon two variables: socioeconomic status

as well as health status. With a general form of this function, an Atkinson measure is derived, which gives exactly the same result when applied to the socioeconomic variable and when applied to the health variable. The paper examines the properties of the index and suggests various extensions.
http://ejournals.ebsco.com/direct.asp?ArticleID=4E0F94252650029D9B66

Médicaments / Pharmaceuticals

Ungier V. (2013). Les 25 nouvelles molécules de 2012. *Moniteur des Pharmacies et des Laboratoires (Le),* (2971) : -19p.
Abstract: Cet article dresse un bilan des innovations dans le domaine du médicament en France pour l'année 2012. A la différence de l'année 2011 particulièrement pauvre, l'année 2012 se distingue par la mise sur le marché de 25 nouveaux principes actifs

Vega A. (2013). Les prescripteurs en médecine générale. *Pratiques : les Cahiers de la Médecine Utopique,* (60) : 88-91.
Abstract: L'objectif de cet article est de dresser un profil des petits prescripteurs de médicaments en France. Une étude qualitative réalisée en 2009-2010 souligne l'importance des motivations à devenir praticien et des modes d'organisation de l'exercice médical

Jaume P. (2012). Do Higher-Priced Generic Medicines Enjoy a Competitive Advantage Under Reference Pricing? *Applied Health Economics and Health Policy,* 10 (6) : 441-451.
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. 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
http://ejournals.ebsco.com/direct.asp?ArticleID=43518055207739 46D489

Baumgartel C., Godman B., Malmstrom R.E., Andersen M., Abdu S., Bennie M., Bishop I., Buckhardt T., Fahmy S., Furst J., Garuoliene K., Herholz H., Kalaba M., Koskinen H., Laius O., Lonsdale J., Malinowska K., Schwabe U., Sermet C. (2012), et al. What lessons can be learned from the launch of generic clopidogrel ? *Gabi Journals : Generics and Biosimilars Initiative Journal,* 1 (2) : 58-68.

Godman B., Abuelkhair M., Vitry A., Abdu S., Bennie M., Bishop I., Fahmy S., Garuoliene K., Herholz H., Martin A., Malmstrom R.E., Jan S., Schwabe U., Sermet C. (2012), et al. Payers endorse generics to enhance prescribing efficiency : impact and future implications, a case history approach. *Gabi Journals : Generics and Biosimilars Initiative Journal,* 1 (2) : 69-83.

Frank L. (2013). The impact of new (orphan) drug approvals on premature mortality from rare diseases in the United States and France, 1999–2007. *The European Journal of Health Economics,* 14 (1) : 41-56.
Abstract: This paper investigates the impact of the introduction of new orphan drugs on premature mortality from rare diseases using longitudinal, disease-level data obtained from a number of major databases. The analysis is performed using data from two countries: the United States (during the period 1999–2006) and France (during the period 2000–2007). For both countries, we estimate models using two alternative definitions of premature mortality, several alternative criteria for inclusion in the set of rare diseases, and several values of the potential lag between new drug approvals and premature mortality reduction. Both the United States and French estimates indicate that, overall, premature mortality from rare diseases is unrelated to the cumulative number of drugs approved 0–2 years earlier but is significantly inversely related to the cumulative number of drugs approved 3–4 years earlier. This delay is not surprising, since most patients probably do not have access to a drug

until several years after it has been launched. Although the estimates for the two countries are qualitatively similar, the estimated magnitudes of the US coefficients are about four times as large as the magnitudes of the French coefficients. This may be partly due to greater errors in measuring dates of drug introduction in France. Also, access to new drugs may be more restricted in France than it is in the United States. Our estimates indicate that, in the United States, potential years of life lost to rare diseases before age 65 (PYLL65) declined at an average annual rate of 3.3% and that, in the absence of lagged new drug approvals, PYLL65 would have increase data rate of 0.9%. Since the US population aged 0–64 was increasing at the rate of 1.0% per year, this means that PYLL65 per person under 65 would have remained approximately constant. The reduction in the US growth rate of PYLL65 attributable to lagged new drug approvals was 4.2%. In France, PYLL65 declined at an average annual rate of 1.8%. The estimates imply that, in the absence of lagged new drug approvals, it would have declined at a rate of 0.6%. The reduction in the French growth rate of PYLL65 attributable to lagged new drug approvals was 1.1%. Earlier access to orphan drugs could result in earlier reductions in premature mortality from rare diseases. This paper investigates the impact of the introduction of new orphan drugs on premature mortality from rare diseases using longitudinal, disease-level data obtained from a number of major databases. The analysis is performed using data from two countries: the United States (during the period 1999–2006) and France (during the period 2000–2007). For both countries, we estimate models using two alternative definitions of premature mortality, several alternative criteria for inclusion in the set of rare diseases, and several values of the potential lag between new drug approvals and premature mortality reduction. Both the United States and French estimates indicate that, overall, premature mortality from rare diseases is unrelated to the cumulative number of drugs approved 0–2 years earlier but is significantly inversely related to the cumulative number of drugs approved 3–4 years earlier. This delay is not surprising, since most patients probably do not have access to a drug until several years after it has been launched. Although the estimates for the two countries are qualitatively similar, the estimated magnitudes of the US coefficients are about four times as large as the magnitudes of the French coefficients. This may be partly due to greater errors in measuring dates of drug introduction in France. Also, access to new drugs may be more restricted in France than it is in the United States. Our estimates indicate that, in the United States, potential years of life lost to rare diseases before age 65 (PYLL65) declined at an average annual rate of 3.3% and that, in the absence of lagged new drug approvals, PYLL65 would have increase data rate of 0.9%. Since the US population aged 0–64 was increasing at the rate of 1.0% per year, this means that PYLL65 per person under 65 would have remained approximately constant. The reduction in the US growth rate of PYLL65 attributable to lagged new drug approvals was 4.2%. In France, PYLL65 declined at an average annual rate of 1.8%. The estimates imply that, in the absence of lagged new drug approvals, it would have declined at a rate of 0.6%. The reduction in the French growth rate of PYLL65 attributable to lagged new drug approvals was 1.1%. Earlier access to orphan drugs could result in earlier reductions in premature mortality from rare diseases
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Natalie C., Minjung P. (2013). The impact of health insurance mandates on drug innovation: evidence from the United States. *The European Journal of Health Economics,* 14 (2) : 323-344.

Abstract: An important health policy issue is the low rate of patient enrollment into clinical trials, which may slow down the process of clinical trials and discourage their supply, leading to delays in innovative life-saving drug treatments reaching the general population. In the US, patients' cost of participating in a clinical trial is considered to be a major barrier to patient enrollment. In order to reduce this barrier, some states in the US have implemented policies requiring health insurers to cover routine care costs for patients enrolled in clinical trials. This paper evaluates empirically how effective these policies were in increasing the supply of clinical trials and speeding up their completion, using data on cancer clinical trials initiated in the US between 2001 and 2007. Our analysis indicates that the policies did not lead to an increased supply in the number of clinical trials conducted in mandate states compared to non-mandate states. However, we find some evidence that once clinical trials are initiated, they are more likely to finish their patient recruitment in a timely manner in mandate states than in non-mandate states. As a result, the overall length to completion was significantly shorter in mandate states than in non-mandate states for cancer clinical trials in certain phases. The findings hint at the possibility that these policies might encourage drug innovation in the long run. An important health policy issue is the low rate of patient enrollment into clinical trials, which may slow down the process of clinical trials and discourage their supply, leading to delays in innovative life-saving drug treatments reaching the general population. In the US, patients' cost of participating in a clinical trial is

considered to be a major barrier to patient enrollment. In order to reduce this barrier, some states in the US have implemented policies requiring health insurers to cover routine care costs for patients enrolled in clinical trials. This paper evaluates empirically how effective these policies were in increasing the supply of clinical trials and speeding up their completion, using data on cancer clinical trials initiated in the US between 2001 and 2007. Our analysis indicates that the policies did not lead to an increased supply in the number of clinical trials conducted in mandate states compared to non-mandate states. However, we find some evidence that once clinical trials are initiated, they are more likely to finish their patient recruitment in a timely manner in mandate states than in non-mandate states. As a result, the overall length to completion was significantly shorter in mandate states than in non-mandate states for cancer clinical trials in certain phases. The findings hint at the possibility that these policies might encourage drug innovation in the long run
http://ejournals.ebsco.com/direct.asp?ArticleID=4EFD811ECE4952313739

Shen G., Bin H., Hai Z. (2013). Impact of parallel trade on pharmaceutical firm's profits: rise or fall?

The European Journal of Health Economics, 14 (2) : 345-355.
Abstract: Most existing studies on parallel trade conclude that it reduces pharmaceutical firms' profits. One special feature of the pharmaceutical industry is the presence of price regulation in most countries. Taking into account the impact of parallel trade on the regulated pharmaceutical prices [Pecorino, P.: J. Health Econ. 21, 699–708 (2002)] shows that a pharmaceutical firm's profit is greater in the presence of parallel trade. The present paper relaxes the assumption on identical demands among countries, and takes into account transaction costs. The results of our model show that a firm's profits may increase or decrease in the presence of parallel trade, depending on its bargaining power in the price negotiation and market size of the drug. Changes in social welfare due to the transition to parallel trade regime are also considered. Most existing studies on parallel trade conclude that it reduces pharmaceutical firms' profits. One special feature of the pharmaceutical industry is the presence of price regulation in most countries. Taking into account the impact of parallel trade on the regulated pharmaceutical prices [Pecorino, P.: J. Health Econ. 21, 699–708 (2002)] shows that a pharmaceutical firm's profit is greater in the presence of parallel trade. The present paper relaxes the assumption on identical demands among countries, and takes into account transaction costs. The results of our model show that a firm's profits may increase or decrease in the presence of parallel trade, depending on its bargaining power in the price negotiation and market size of the drug. Changes in social welfare due to the transition to parallel trade regime are also considered
http://ejournals.ebsco.com/direct.asp?ArticleID=46C7BCA0FBAC943227FC

Anca M.C., Daniel K.B., John E.Walker (2013). Medical regulation and health outcomes: the effect of physician examination requirement.

Health Economics, 22 (4) : 393-409.
Abstract: This article investigates the effect on health outcomes of the regulation prohibiting physicians from prescribing drugs without a prior physical examination. This requirement could improve health by reducing illegal access to prescription drugs. However, it reduces access to health care by making it more difficult for patients and physicians to use many forms of telemedicine. Thus, this regulation generates a trade-off between access and safety. Using matching techniques, we find that the physician examination requirement leads to an increase of 1% in mortality rates from disease, the equivalent of 8.5 more deaths per 100,000 people, and a decrease of 6.7% in injury mortality, the equivalent of 2.5 deaths per 100,000 people. The magnitude of these effects is larger in rural areas and in areas with low physician density and is accompanied by an 18% increase in the number of days lost each month to illness. Copyright © 2012 John Wiley & Sons, Ltd
http://ejournals.ebsco.com/direct.asp?ArticleID=4848B4425BFE2D1C1C8E

Marissa K., Connor E. (2013). The geography of antidepressant, antipsychotic, and stimulant utilization in the United States.

Health & Place, 20 (3) : 32-38.
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 60% of prescriptions written in the United States, we find that use of antidepressants in three digit postal codes ranged from less than 1% of residents to more than 40% 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://ejournals.ebsco.com/direct.asp?ArticleID=4891AAED06D1D7754375

Cornelia H., Leonie S., Reinhard B. (2013). Structural changes in the German pharmaceutical market: Price setting mechanisms based on the early benefit evaluation. *Health Policy,* 109 (3) : 263-269.
Abstract: In the past, free price setting mechanisms in Germany led to high prices of patented pharmaceuticals and to increasing expenditures in the pharmaceutical sector. In order to control patented pharmaceutical prices and to curb increasing pharmaceutical spending, the Act for Restructuring the Pharmaceutical Market in Statutory Health Insurance (AMNOG) came into effect on 1st January 2011. In a structured dossier, pharmaceutical manufacturers have to demonstrate the additional therapeutic benefit of the newly approved pharmaceutical compared to its appropriate comparator. According to the level of additional benefit, pharmaceuticals will be subject to price negotiations between the Federal Association of Statutory Health Insurance Funds and the pharmaceutical company concerned (or assigned to a reference price group in case of no additional benefit). Therefore, the health care reform is a first step to decision making based on “value for money”. The process of price setting based on early benefit evaluation has an impact on the German as well as the European pharmaceutical markets. Therefore, these structural changes in Germany are of importance for pricing decisions in many European countries both from a political point of view and for strategic planning for pharmaceutical manufacturers, which may have an effect on insured patients’ access to pharmaceuticals
http://ejournals.ebsco.com/direct.asp?ArticleID=42A1A9B2D99E91625BBD

Brian G., Lars G. (2013). A New Reimbursement System for Innovative Pharmaceuticals Combining Value-Based and Free Market Pricing. *Applied Health Economics and Health Policy,* 11 (1) : 79-82.
http://ejournals.ebsco.com/direct.asp?ArticleID=4635ABBAA7C59DE61574

Ulf P., Johanna S., Billie P. (2013). Authors’ Reply to Godman and Gustafsson: “A New Reimbursement System for Innovative Pharmaceuticals Combining Value-Based and Free Market Pricing”. *Applied Health Economics and Health Policy,* 11 (1) : 83-84.
http://ejournals.ebsco.com/direct.asp?ArticleID=40F3AA8778CAC92A15B4

Méthodologie – Statistique / Methodology – Statistics

Julie C., Gérard P. (2013). Valuing EQ-5D using Time Trade-Off in France. *The European Journal of Health Economics,* 14 (1) : 57-66.
Abstract: While a French language version of the EQ-5D exists, to date, there has been no French value set to accompany it. The objective of our study was then to derive the French TTO value set of the EQ-5D.A total of 452 respondents aged over 18 were recruited who were representative of the French population with regard to age, gender, and socio-professional group. The direct valuation of 24 health states was first obtained by Time Trade-Off (TTO), and the negative TTO values were bounded using the monotonic transformation. Several alternative model specifications were investigated to estimate the values for all 243 states in the EQ-5D descriptive system. Only the best fitting model is presented in this paper. The analysis was conducted at an individual level to make the maximum use of the available data, and we estimated mixed models with random intercept. Models were compared through the Akaike information criterion (AIC), the mean absolute error (MAE), and the Pearson correlation coefficient between the observed and the predicted values of each model. After exclusion, 443 respondents took part in the study. The best fitting model included the same variables as the N3-model used in UK. This study provides the French value set of the EQ-5D based on the stated preferences of the French general public facilitating cost-effectiveness analysis
http://ejournals.ebsco.com/direct.asp?ArticleID=4DF38AA6436ECCBB4452

Robert K. (2013). The Grossman model after 40 years: a reply to Peter Zweifel. *The European Journal of Health Economics,* 14 (2) : 357-360.
http://ejournals.ebsco.com/direct.asp?ArticleID=4AA4968BF30AB0D03DED

Peter Z. (2013). The Grossman model after 40 years: response to Robert Kaestner. *The European Journal of Health Economics,* 14 (2) : 361-362.
http://ejournals.ebsco.com/direct.asp?ArticleID=43CD88583194CDE56086

Jean M.A. (2013). Using Microsimulation Models to Inform U.S. Health Policy Making. *Health Services Research,* 48 (2) : 686-695.
http://ejournals.ebsco.com/direct.asp?ArticleID=41478A51F39ADF424382

Andrew M.R., Yuhua B. (2013). Profiling Provider Outcome Quality for Pay-for-Performance in the Presence of Missing Data: A Simulation Approach. *Health Services Research,* 48 (2) : 810-825.
http://ejournals.ebsco.com/direct.asp?ArticleID=4DC1B84664DB79684F82

Noemi K., Richard G., Sadique M.Z. (2013). Statistical methods for cost effectiveness analyses that use observational data: a critical appraisal tool and review of current practice. *Health Economics,* 22 (4) : 486-500.
Abstract: Many cost-effectiveness analyses (CEAs) use data from observational studies. Statistical methods can only address selection bias if they make plausible assumptions. No quality assessment tool is available for appraising CEAs that use observational studies. We developed a new checklist to assess statistical methods for addressing selection bias in CEAs that use observational data
http://ejournals.ebsco.com/direct.asp?ArticleID=4E409B9679B4980C5CD4

Prévention santé / Health prevention

Marti J. (2012). Assessing preferences for improved smoking cessation medications: a discrete choice experiment. *European Journal of Health Economics (The),* 13 (5) : 533-548.
Abstract: The use of smoking cessation medications can considerably enhance the long-term abstinence rate at a reasonable cost, but only a small proportion of quitters seek medical assistance. The objective of this study was to evaluate the factors that influence the decision to use such treatments and the willingness-to-pay of smokers for improved cessation drugs. A discrete choice experiment was conducted amongst smokers in the French-speaking part of Switzerland. Choice sets consisted of two hypothetical medications described via five attributes (price, efficacy, possibility of minor side effects, attenuation of weight gain and availability) and an opt-out option. Various discrete choice models were estimated to analyse both the factors that influence treatment choice and those that influence the overall propensity to use a smoking cessation medication- . The results indicate that smokers are willing to pay for higher efficacy, less-frequent side effects and prevention of weight gain. Whether the drug is available over-the-counter or on medical prescription is of secondary importance. In addition, we show that there are several individual-specific factors influencing the decision to use such medications, including education level. Results also indicate substantial preference heterogeneity. This study shows that there is a potential demand for improved cessation medications. Broader usage could be reached through lower out-of-pocket price and greater efficacy. Secondary aspects such as side effects and weight gain should also be taken into consideration

Jan O., Ole R., Knut S. (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) : 407-415.
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. 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 http://ejournals.ebsco.com/direct.asp?ArticleID=4E738C956AE73F70A7A0

Prévision – Evaluation / Prevision - Evaluation

Haji Ali Afzali H., Karnon J., Grazy J. (2012). A proposed model for economic evaluations of major depressive disorder. *European Journal of Health Economics (The),* 13 (4) : 501-510.

Abstract: In countries like UK and Australia, the comparability of model-based analyses is an essential aspect of reimbursement decisions for new pharmaceuticals, medical services and technologies. Within disease areas, the use of models with alternative structures, type of modelling techniques and/or data sources for common parameters reduces the comparability of evaluations of alternative technologies for the same condition. The aim of this paper is to propose a decision analytic model to evaluate long-term costs and benefits of alternative management options in patients with depression. The structure of the proposed model is based on the natural history of depression and includes clinical events that are important from both clinical and economic perspectives. Considering its greater flexibility with respect to handling time, discrete event simulation (DES) is an appropriate simulation platform for modelling studies of depression. We argue that the proposed model can be used as a reference model in model-based studies of depression improving the quality and comparability of studies

Ananth K., Robert L., Anuraag K., Sonja S., Denis G. (2012). Inclusion of Compliance and Persistence in Economic Models. *Applied Health Economics and Health Policy,* 10 (6) : 365-379.

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. 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
http://ejournals.ebsco.com/direct.asp?ArticleID=4DDB804B3A70419F0843

Sebastian G. (2013). An analysis of the influence of framework aspects on the study design of health economic modeling evaluations.

The European Journal of Health Economics, 14 (2) : 221-230.

Abstract: Research and practical guidelines have many implications for how to structure a health economic study. A major focus in recent decades has been the quality of health economic research. In practice, the factors influencing a study design are not limited to the quest for quality. Moreover, the framework of the study is important. This research addresses three major questions related to these framework aspects. First, we want to know whether the design of health economic studies has changed over time. Second, we want to know how the subject of a study, whether it is a process or product innovation, influences the parameters of the study design. Third, one of the most important questions we will answer is whether and how the study's source of funding has an impact on the design of the research. To answer these questions, a total of 234 health economic studies were analyzed using a correspondence analysis and a logistic regression analysis. All three categories of framework factors have an influence on the aspects of the study design. Health economic studies have evolved over time, leading to the use of more advanced methods like complex sensitivity analyses. Additionally, the patient's point of view has increased in importance. The evaluation of product innovations has focused more on utility concepts. On the other hand, the source of funding may influence only a few aspects of the study design, such as the use of evaluation methods, the source of data, and the use of certain utility measures. The most important trends in health care, such as the emphasis on the patients' point of view, become increasingly established in health economic evaluations with the passage of time. Although methodological challenges remain, modern information and communication technologies provide a basis for increasing the complexity and quality of health economic studies if used frequently. Research and practical guidelines have many implications for how to structure a health economic study. A major focus in recent decades has been the quality of health economic research. In practice, the factors influencing a study design are not limited to the quest for quality. Moreover, the framework of the study is important. This research addresses three major questions related to these framework aspects. First, we want to know whether the design of health economic studies has changed over time. Second, we want to know how the subject of a study, whether it is a process or product innovation, influences the parameters of the study design. Third, one of the most important questions we will answer is whether and how the study's source of funding has an impact on the design of the research. To answer these questions, a total of 234 health economic studies were analyzed using a correspondence analysis and a logistic regression analysis. All three categories of framework factors have an influence on the aspects of the study design. Health economic studies have evolved over time, leading to the use of more advanced methods like complex sensitivity analyses. Additionally, the patient's point of view has increased in importance. The evaluation of product innovations has focused more on utility concepts. On the other hand, the source of funding may influence only a few aspects of the study design, such as the use of evaluation methods, the source of data, and the use of certain utility measures. The most important trends in health care, such as the emphasis on the patients' point of view, become increasingly established in health economic evaluations with the passage of time. Although methodological challenges remain, modern information and communication technologies provide a basis for increasing the complexity and quality of health economic studies if used frequently
http://ejournals.ebsco.com/direct.asp?ArticleID=44749D6BFD0EBF586494

Soins de santé primaires / Primary health care

Salem G., Rican S., Vaillant Z. et al. (2013). Déserts médicaux : où est le problème ?
Pratiques : les Cahiers de la Médecine Utopique, (60) : 1-82.
Pourquoi certains territoires sont-ils désertés par les médecins ? Si ceux-ci n'ont jamais été aussi nombreux, ils sont peu désireux de s'installer dans des zones où les services publics disparaissent peu à peu et où les conditions d'exercice se sont dégradées. De plus, les jeunes professionnels ne veulent pas travailler seuls, ni travailler trop. Le libéralisme médical auquel s'accrochent certains médecins est incapable de résoudre les inégalités géographiques d'accès aux soins qui se cumulent souvent, pour les patients, avec les inégalités financières liées à l'augmentation des restes à charge : dépassements d'honoraires, taxes et franchises diverses... Il est aussi un frein pour s'atteler aux questions d'inégalités sociales de santé : on meurt plus tôt et on vit en moins bonne santé dans certaines régions. Des professionnels racontent comment ils essaient de travailler « autrement ». La question du champ d'intervention de la médecine est posée. Des chercheurs rendent compte de leurs travaux sur ces questions. Ensemble, ils tracent les contours de ce que pourrait être une véritable politique de santé publique qui serait en capacité de répondre, en amont du soin, aux problèmes de santé de la population.

Schieber A.C., Kelly-Irving M., Delpierre C., Lepage B., Bensafi A., Afrite A., Pascal J., Cases C., Lombrail P., Lang T. (2013). Is perceived social distance between the patient and the general practitioner related to their disagreement on patient's health status ?
Patient Education and Counseling, 91 (1) : 97-104.

Saurina C., Vall-Ilosera L. (2012). Factors determining access to and use of primary health care services in the Girona Health Region (Spain). *European Journal of Health Economics (The),* 13 (4) : 419-427.
Abstract: Increased population flowing from abroad has generated an intense debate regarding the economic consequences of migration in public services such as health, where new and specific demands are being created. This new demand for health care gives rise to the need to identify those factors which influence the user's decision to contact the health services and those which determine the quantity of services consumed. The aim of this study is to identify which variables affect these two stages of the use of such services in the Girona Health Region (RSG), where immigrant population represents 21.96% of the total population. Specification of a Hurdle model with a count response variable related to primary health care service visits in the RSG for 2006. The study data is based on a sample of users (immigrants and natives) taken from the population assigned to primary health care services in eight Basic Health Areas (ABS) of the RSG. Contacting primary health care services is associated with variables that ought to affect use of health care such as chronic illness and taking prescribed medication as well as being aged between 46 and 55. Using primary health care services once makes users more likely to make further visits. The number of visits is related not only with variables that ought affect use of health care but also with variables that ought not to affect use of health care such as working without a contract, living in rented accommodation, or being unemployed. Additionally, if we consider the birthplace of the user, we observe the same pattern, with different directions and intensities, depending on the origin of the patient. For example, a higher likelihood of first contact is shown in Eastern Europeans, South Americans, and North Africans that suffer from cholesterol. A higher attendance is observed in natives and Eastern Europeans that take prescribed medication as well as natives, Eastern Europeans, and North Africans living in rented accommodation. On the other hand, working without a contract supposes a higher attendance in natives but a lower attendance in Eastern Europeans and sub-Saharan Africans. We do not detect any socioeconomic barriers associated with making a first contact with primary health services for the users analyzed. However, we do note evidence of horizontal inequity in terms of attending health services, related to variables that ought to affect use of health care as well as socioeconomic factors (variables that ought not to affect use of health care). The user's origin is an important key in detecting different intensities of access and regular visits to primary health care services

Jurges H., Pohl V. (2012). Medical guidelines, physician density, and quality of care: evidence from German Share data. *European Journal of Health Economics (The),* 13 (5) : 635-

649.
Abstract: This issue uses German SHARE data to study the relationship between district general practitioner density and the quality of preventive care provided to older adults. It measures physician quality of care as the degree of adherence to medical guidelines (for the management of risk factors for cardiovascular disease and the prevention of falls) as reported by patients. Contrary to theoretical expectations, we find only weak and insignificant effects of physician density on quality of care. The results shed doubt on the notion that increasing physician supply will increase the quality of care provided in Germany's present health care system

Daphne K., Philipa M., Tiziana L., Eugenia K., Olga S. (2012). Understanding the Oversupply of Physicians in Greece: The Role of Human Resources Planning, Financing Policy, and Physician Power. *International Journal of Health Services,* 42 (4) : 719-738.
Abstract: Planning of the workforce has emerged as a critical issue in European health policy, as the need for human resources for health is changing in light of demographic, epidemiological, and socio-cultural trends and patterns of supply and demand in service provision. Greece represents a country with an oversupply of physicians, having the highest concentration of physicians among European Union countries. The study aims to analyze the factors influencing the high number of physicians in Greece and make policy recommendations. The analysis was conducted through international literature review and database searches. Neither the demography of the physician population in terms of age, gender composition, and geographic dispersion, nor the epidemiology of the Greek population, can explain the relatively high number of physicians in Greece. Despite the physician surplus, Greece faces serious geographical inequities regarding the distribution of physicians. There are also imbalances within the specialist category, with certain specialists (e.g., cardiologists) being in oversupply compared to other European countries, while others (e.g., general practitioners) remain weakly represented. Inadequate planning of human resources for health, inadequate health financing policy regarding primary care, gatekeeping mechanisms, and medical power constitute the primary themes explaining the trends of physicians' population in Greece
http://ejournals.ebsco.com/direct.asp?ArticleID=47C0864D1FCF3C060C9C

Frank E. (2013). Key issues in the design of pay for performance programs. *The European Journal of Health Economics,* 14 (1) : 117-131.
Abstract: Pay for performance (P4P) is increasingly being used to stimulate healthcare providers to improve their performance. However, evidence on P4P effectiveness remains inconclusive. Flaws in program design may have contributed to this limited success. Based on a synthesis of relevant theoretical and empirical literature, this paper discusses key issues in P4P-program design. The analysis reveals that designing a fair and effective program is a complex undertaking. The following tentative conclusions are made: (1) performance is ideally defined broadly, provided that the set of measures remains comprehensible, (2) concerns that P4P encourages "selection" and "teaching to the test" should not be dismissed, (3) sophisticated risk adjustment is important, especially in outcome and resource use measures, (4) involving providers in program design is vital, (5) on balance, group incentives are preferred over individual incentives, (6) whether to use rewards or penalties is context-dependent, (7) payouts should be frequent and low-powered, (8) absolute targets are generally preferred over relative targets, (9) multiple targets are preferred over single targets, and (10) P4P should be a permanent component of provider compensation and is ideally "decoupled" form base payments. However, the design of P4P programs should be tailored to the specific setting of implementation, and empirical research is needed to confirm the conclusions. Pay for performance (P4P) is increasingly being used to stimulate healthcare providers to improve their performance. However, evidence on P4P effectiveness remains inconclusive. Flaws in program design may have contributed to this limited success. Based on a synthesis of relevant theoretical and empirical literature, this paper discusses key issues in P4P-program design. The analysis reveals that designing a fair and effective program is a complex undertaking. The following tentative conclusions are made: (1) performance is ideally defined broadly, provided that the set of measures remains comprehensible, (2) concerns that P4P encourages "selection" and "teaching to the test" should not be dismissed, (3) sophisticated risk adjustment is important, especially in outcome and resource use measures, (4) involving providers in program design is vital, (5) on balance, group incentives are preferred over individual incentives, (6) whether to use rewards or penalties is context-dependent, (7) payouts should be frequent and low-powered, (8) absolute targets are generally preferred over relative targets, (9) multiple targets are preferred over single targets, and (10) P4P should be a permanent component of

provider compensation and is ideally “decoupled” form base payments. However, the design of P4P programs should be tailored to the specific setting of implementation, and empirical research is needed to confirm the conclusions
http://ejournals.ebsco.com/direct.asp?ArticleID=48DAAE89614097FACD1F

Kim O., Dorte G., Torben S., Troels K., Peter V., Andrew S. (2013). Organisational determinants of production and efficiency in general practice: a population-based study. *The European Journal of Health Economics,* 14 (2) : 267-276.
Abstract: Shortage of general practitioners (GPs) and an increased political focus on primary care have enforced the interest in efficiency analysis in the Danish primary care sector. This paper assesses the association between organisational factors of general practices and production and efficiency.We assume that production and efficiency can be modelled using a behavioural production function. We apply the Battese and Coelli (Empir Econ 20:325–332, 1995) estimator to accomplish a decomposition of exogenous variables to determine the production frontier and variables determining the individual GPs distance to this frontier. Two different measures of practice outputs (number of office visits and total production) were applied and the results compared.The results indicate that nurses do not substitute GPs in the production. The production function exhibited constant returns to scale. The mean level of efficiency was between 0.79 and 0.84, and list size was the most important determinant of variation in efficiency levels.Nurses are currently undertaking other tasks than GPs, and larger practices do not lead to increased production per GP. However, a relative increase in list size increased the efficiency. This indicates that organisational changes aiming to increase capacity in general practice should be carefully designed and tested
http://ejournals.ebsco.com/direct.asp?ArticleID=44928C1811B26AEC0688

Pouvourville G.d. (2013). Paying for performance. *European Journal of Health Economics (The),* 14 (1) : 1-4.

Carole R.G., David I.A., Fabian D. (2013). Opportunities and Challenges in Supply-Side Simulation: Physician-Based Models. *Health Services Research,* 48 (2) : 696-712.
http://ejournals.ebsco.com/direct.asp?ArticleID=46DD8E35D85A64205E7E

Systèmes de santé / Health care systems

Nilgun Y., Veli Y., Zehra O. (2013). Is health care a luxury or a necessity or both? Evidence from Turkey. *The European Journal of Health Economics,* 14 (1) : 5-10.
Abstract: This study investigates the effect of per capita income on per capita health expenditures in Turkey over the period 1975–2007 by using ARDL bounds test approach to the cointegration considering both demand and supply side variables. Since we reject the null hypothesis that there is no cointegration among the series, we estimate long run and short run elasticities. The results show that while income has no effect on health expenditures in the long run, it is a necessity good in the short run that is a 1% increase in per capita income creates an 0.75% increase in per capita health expenditures. On the other hand, by examining the coefficient of demand and supply side variables, we found that average length of stay and number of physicians has negative effect, percentage of older people has positive effect and infant mortality rate has no effect on health expenditures in both short and long runs. This study investigates the effect of per capita income on per capita health expenditures in Turkey over the period 1975–2007 by using ARDL bounds test approach to the cointegration considering both demand and supply side variables. Since we reject the null hypothesis that there is no cointegration among the series, we estimate long run and short run elasticities. The results show that while income has no effect on health expenditures in the long run, it is a necessity good in the short run that is a 1% increase in per capita income creates an 0.75% increase in per capita health expenditures. On the other hand, by examining the coefficient of demand and supply side variables, we found that average length of stay and number of physicians has negative effect, percentage of older people has positive effect and infant mortality rate has no effect on health

expenditures in both short and long runs
http://ejournals.ebsco.com/direct.asp?ArticleID=4C74875032C4CDA7E574

Mihajlo J. (2013). Resource allocation strategies in Southeastern European health policy. *The European Journal of Health Economics,* 14 (2) : 153-159.

Abstract: The past 23 years of post-socialist restructuring of health system funding and management patterns has brought many changes to small Balkan markets, putting them under increasing pressure to keep pace with advancing globalization. Socioeconomic inequalities in healthcare access are still growing across the region. This uneven development is marked by the substantial difficulties encountered by local governments in delivering medical services to broad sectors of the population. This paper presents the results of a systematic review of the following evidence: published reports on health system reforms in the region commissioned by WHO, IMF, World Bank, OECD, European Commission; all available published evidence on health economics, funding, reimbursement in world/local languages since 1989 indexed at Medline, Excerpta Medica and Google Scholar; in depth analysis of official website data on medical care financing related legislation among key public institutions such as national Ministries of health, Health Insurance Funds, Professional Associations were applicable, in local languages; correspondence with key opinion leaders in the field in their respective communities. Contributors were asked to answer a particular set of questions related to the issue, thus enlightening fresh legislative developments and hidden patterns of policy maker's behavior. Cost awareness is slowly expanding in regional management, academic and industrial establishment. The study provides an exact and comprehensive description of its current extent and legislative framework. Western Balkans policy makers would profit substantially from health-economics-based decision-making to cope with increasing difficulties in funding and delivering medical care in emerging markets with a rapidly growing demand for health services. The past 23 years of post-socialist restructuring of health system funding and management patterns has brought many changes to small Balkan markets, putting them under increasing pressure to keep pace with advancing globalization. Socioeconomic inequalities in healthcare access are still growing across the region. This uneven development is marked by the substantial difficulties encountered by local governments in delivering medical services to broad sectors of the population. This paper presents the results of a systematic review of the following evidence: published reports on health system reforms in the region commissioned by WHO, IMF, World Bank, OECD, European Commission; all available published evidence on health economics, funding, reimbursement in world/local languages since 1989 indexed at Medline, Excerpta Medica and Google Scholar; in depth analysis of official website data on medical care financing related legislation among key public institutions such as national Ministries of health, Health Insurance Funds, Professional Associations were applicable, in local languages; correspondence with key opinion leaders in the field in their respective communities. Contributors were asked to answer a particular set of questions related to the issue, thus enlightening fresh legislative developments and hidden patterns of policy maker's behavior. Cost awareness is slowly expanding in regional management, academic and industrial establishment. The study provides an exact and comprehensive description of its current extent and legislative framework. Western Balkans policy makers would profit substantially from health-economics-based decision-making to cope with increasing difficulties in funding and delivering medical care in emerging markets with a rapidly growing demand for health services
http://ejournals.ebsco.com/direct.asp?ArticleID=4C079D567C50CFC73138

Sharon H., Yossi H., Tzahit S. (2013). Determinants of healthcare system's efficiency in OECD countries. *The European Journal of Health Economics,* 14 (2) : 253-265.

Abstract: Firstly, to compare healthcare systems' efficiency (HSE) using two models: one incorporating mostly inputs that are considered to be within the discretionary control of the healthcare system (i.e., physicians' density, inpatient bed density, and health expenditure), and another, including mostly inputs beyond healthcare systems' control (i.e., GDP, fruit and vegetables consumption, and health expenditure). Secondly, analyze whether institutional arrangements, population behavior, and socioeconomic or environmental determinants are associated with HSE. Data envelopment analysis (DEA) was utilized to calculate OECD countries' HSE. Life expectancy and infant survival rate were considered as outputs in both models. Healthcare systems' rankings according to the super-efficiency and the cross-efficiency ranking methods were used to analyze determinants associated with efficiency.(1) Healthcare systems in nine countries with large and stable economies were defined as efficient in model I, but were found to be inefficient in model II; (2) Gatekeeping and the presence of multiple insurers were associated with a lower efficiency; and (3) The association between

socioeconomic and environmental indicators was found to be ambiguous. Countries striving to improve their HSE should aim to impact population behavior and welfare rather than only ensure adequate medical care. In addition, they may consider avoiding specific institutional arrangements, namely gatekeeping and the presence of multiple insurers. Finally, the ambiguous association found between socioeconomic and environmental indicators, and a country's HSE necessitates caution when interpreting different ranking techniques in a cross-country efficiency evaluation and needs further exploration
http://ejournals.ebsco.com/direct.asp?ArticleID=4F749F5A990E5B6BB6B0

Jan A.O., Jeff R. (2013). Preferences for the normative basis of health care priority setting: some evidence from two countries.

Health Economics, 22 (4) : 480-485.
Abstract: The present paper concerns the criteria people would prefer for prioritising health programmes. It differs from most empirical studies as subjects were not asked about their personal preferences for programmes per se. Rather, they were asked about the principles that should guide the choice of programmes. Four different principles were framed as arguments for alternative programmes. The results from population surveys in Australia and Norway suggest that people are least supportive of the principle that decision makers should follow the stated preferences of the public. Rather, respondents expressed more support for decisions based upon health maximisation, equality and urgency. Copyright © 2012 John Wiley & Sons, Ltd
http://ejournals.ebsco.com/direct.asp?ArticleID=4C0CAA655B8A244FCD1A

Wynand P.M.M., Konstantin B., Florian B., Erik S., F.T.(Erik) Schut, Amir S., Juergen W. (2013). Preconditions for efficiency and affordability in competitive healthcare markets: Are they fulfilled in Belgium, Germany, Israel, the Netherlands and Switzerland?

Health Policy, 109 (3) : 226-245.
Abstract: From the mid-1990s several countries have introduced elements of regulated competition in healthcare. The aim of this paper is to identify the most important preconditions for achieving efficiency and affordability under regulated competition in healthcare, and to indicate to what extent these preconditions are fulfilled in Belgium, Germany, Israel, the Netherlands and Switzerland. These experiences can be worthwhile for other countries (considering) implementing regulated competition (e.g. Australia, Czech Republic, Ireland, Russia, Slovakia, US)
http://ejournals.ebsco.com/direct.asp?ArticleID=4129AD681F4E9DB0BB08

Dirk G., Klaus-Dirk H. (2013). The German Central Health Fund—Recent developments in health care financing in Germany.

Health Policy, 109 (3) : 246-252.
Abstract: In 2009, Germany's Statutory Health Insurance System underwent a major financing reform. A uniform contribution rate set by government was introduced. Sickness funds retain only limited autonomy in charging additional premiums. A dynamic subsidy from general revenue was introduced. The aims of the reform were: (1) intensifying competition, (2) gearing competition towards quality and efficiency, and (3) increasing financial sustainability. This article describes the reform, presents the experiences made, and evaluates whether the policy aims have been met
http://ejournals.ebsco.com/direct.asp?ArticleID=44249A91E3B5888904E6

Travail et santé / Health at work

Oliva-Moreno J. (2012). Loss of labour productivity caused by disease and health problems: what is the magnitude of its effect on Spain's economy.

European Journal of Health Economics (The), 13 (5) : 605-614.
Abstract: The aim of this study is to estimate the economic impact of the non-medical costs of diseases and accidents in Spain. Its main premise sustains the idea that in addition to the number of deaths, the loss of quality of life and the pain suffered by patients and their family members as a result of diseases and accidents, there are other indicators that provide us with a better understanding of their socioeconomic impact. Our analysis provides estimates of the loss of labour productivity in Spain as a result of health problems in 2005. The main finding suggests an estimated loss amounting to over

37,969 millions euros, of which 9,136 millions euros are due to premature deaths, 18,577 millions to permanent disability and 10,255 millions to temporary disability. The loss in labour productivity due to accidents and health problems was estimated to a figure equivalent to nearly 4.2% of the Gross Domestic Product of Spain in 2005. This study underscores the strong economic impact of non-medical costs of diseases. In addition, it stresses the need for better information systems for collecting data that is relevant to the topic at hand

Vieillissement / Ageing

Sundmacher L., Jimenez M.S., Villaplana P.C. (2012). The trade-off between formal and informal care in Spain. *European Journal of Health Economics (The),* 13 (4) : 461-490.

Abstract: Understanding the factors that determine the type and amount of formal care is important for predicting use in the future and developing long-term policy. In this context, we jointly analyze the provision of care at both the extensive (choice of care) and the intensive margin (number of hours of care received). In particular, we estimate and test, for the first time in this area of research, a sample selection model with the particularities that the first step is a multinomial logit model and the hours of care is an interval variable. Our results support the complementary and task-specific models which evidence has been found in other countries. Furthermore, we obtain evidence of substitution between formal and informal care for the male, young, married and unmarried subsamples. Regarding the hours of care, we find significant biases in predicted hours of care when sample selection is not taken into account. For the whole sample, the average bias is 2.77% for total hours and 3.23% for formal care hours. However, biases can be much larger (up to 10–15%), depending on the subsample and the type of care considered

John C., Brenda G., Eamon O.S. (2013). The welfare implications of disability for older people in Ireland. *The European Journal of Health Economics,* 14 (2) : 171-183.

Abstract: Recent data analysed for Ireland suggest a strong link between disability status and household poverty, while there exists substantial evidence to suggest that disability is highly prevalent among persons of older age. Within this context, this paper estimates the welfare implications of disability for older people in Ireland. We define and estimate models of the private costs borne by households with older persons who have a disability in Ireland, both in general and by severity of illness or condition. Our modelling framework is based on the standard of living approach to estimating the cost of disability. The model quantifies the extra costs of living associated with disability and is estimated by comparing the standard of living of households with and without disabled members at a given income, controlling for other sources of variation. The analysis suggests that the estimated economic cost of disability for older people in Ireland is significant and varies by severity of disability, as well as by household type. The results also suggest that the cost of disability increases in proportionate terms as the number of people in the household decreases. Our results are important when considering the effectiveness of policies that aim to address the economic problems associated with disability for older people, suggesting that current policy in Ireland does not go far enough. They indicate that older people face a double jeopardy through age and disability, which is not reflected in official poverty rates and support the case for the introduction of disability-adjusted poverty payments.Recent data analysed for Ireland suggest a strong link between disability status and household poverty, while there exists substantial evidence to suggest that disability is highly prevalent among persons of older age. Within this context, this paper estimates the welfare implications of disability for older people in Ireland. We define and estimate models of the private costs borne by households with older persons who have a disability in Ireland, both in general and by severity of illness or condition. Our modelling framework is based on the standard of living approach to estimating the cost of disability. The model quantifies the extra costs of living associated with disability and is estimated by comparing the standard of living of households with and without disabled members at a given income, controlling for other sources of variation. The analysis suggests that the estimated economic cost of disability for older people in Ireland is significant and varies by severity of disability, as well as by household type. The results also suggest that the cost of disability increases in proportionate terms as the number of people in the household decreases. Our results are important when considering the effectiveness of policies that aim to address the economic problems associated

with disability for older people, suggesting that current policy in Ireland does not go far enough. They indicate that older people face a double jeopardy through age and disability, which is not reflected in official poverty rates and support the case for the introduction of disability-adjusted poverty payments
http://ejournals.ebsco.com/direct.asp?ArticleID=4BCC8C2E1921B9219561

Jacobs J.C., Lilly M.B., Ng C., Coyte P.C. (2013). 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,* 81 (0) : 102-109.
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

Jerome J.F., Sally C.S., Laura P.D., Kimberley H.G., Christopher A.B., Daniel J.C., Timothy S.Carey, Joseph S.Rossi, Brett C.S. (2013). Resource Use Trajectories for Aged Medicare Beneficiaries with Complex Coronary Conditions. *Health Services Research,* 48 (2) : 753-772.
http://ejournals.ebsco.com/direct.asp?ArticleID=416A9D13CAE58DF52282

John P.A., David B.M., Sean R.L., Rahul M., Young K.D., Angelique C., Robert E. (2013). Simulating the Impact of Long-Term Care Policy on Family Eldercare Hours. *Health Services Research,* 48 (2) : 773-791.
http://ejournals.ebsco.com/direct.asp?ArticleID=41C381938AEAF9416637

Alan M., Paul N. (2013). Geographies of the impact of retirement on health in the United Kingdom. *Health & Place,* 20 (3) : 1-12.
Abstract: This paper explores how the impact of retirement on self-assessed illness varies spatially across the UK. Curves of age-specific limiting long term illness rates reveal a ‘retirement kink'—where the rise in illness rates with age slows or declines at retirement age indicating possible health improvement after retirement. The kink is negligible in the affluent South East and most prominent in the coalfield and former industrial districts. It is likely that the kink is attributable to hidden unemployment and health-related selective migration but additionally that in certain areas retirement is associated with improvements in self-assessed health
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