counterfactual was combined with cost of illness data to estimate the generic cost-effectiveness of prevention and medical care for the selected disease clusters. RESULTS: The total increase in disability-adjusted life expectancy due to prevention and medical care was 5.3 years: 1.7 years for infectious diseases, 0.6 years for cancers, and 3.1 years for cardiovascular diseases. This increase was larger for females than for males: 6.3 years and 4.3 years, respectively. The increase can be disentangled into an increase in life expectancy of 3.9 years and 1.4 decrease in years lived with disability. The average costs per DALY gained were 2,000 euro for cardiovascular disease, 3,400 euro for infectious diseases, and 16,000 euro for cancers. CONCLUSION: For the selected disease clusters, the average cost-effectiveness of health care is far below current acceptable thresholds. We assessed the likely health contribution of sociocultural and socioeconomic factors as opposed to health care with help of the best available knowledge, but many questions remain unanswered.

OBJECTIVES: To evaluate the impact of discontinuity in health insurance on resource utilization. METHODS: We used the Medical Expenditure Panel Survey (MEPS) for years 2000–2004 for this study. MEPS provides monthly insurance status and resource utilization. Additionally, MEPS contains detailed demographic, socioeconomic and health status information. We estimated the number of transitions for an individual using monthly insurance data. We estimated resource utilization using the total number of inpatient hospitalizations, emergency room visits, outpatient visits, and total number of prescriptions. Number of inpatient hospitalization and emergency room visits were modeled using zero-inflated negative binomial models, while outpatient visits and prescription drugs were modeled using negative binomial models. RESULTS: Our sample has 35,779 individuals, of whom 10,754 had one transition into or out of Medicaid and 2,448 had more than one transition. We find that individuals with multiple transitions tend to have 46% more hospitalizations and use the emergency room 13% more. However, these individuals have 37% lower prescription drug utilization and 12% less outpatient physician visits relative to those who are continuously insured by Medicaid. CONCLUSION: Utilization of emergency and inpatient services were significantly higher, while use of outpatient care and prescription drugs was significantly lower for beneficiaries with interruption in Medicaid coverage. These findings point to the need for further research to assess the impact of churning in this population.

OBJECTIVES: This study was conducted to clarify the relationship between lifestyle-related diseases and medical expenses after 10 years of metabolic syndrome. METHODS: The subjects of analysis were 2165 people who were randomly selected from a population insured by the government-managed health insurance. The test results of 1993 were used to divide the subjects of analysis into the following 4 groups, and the diseases and medical expenses of each group were examined for 2003. Group 1 contained individuals who did not have metabolic syndrome in 1993. Group 2 contained individuals who did not have metabolic syndrome in 1993 but developed metabolic syndrome in 2003. Group 3 contained individuals who had metabolic syndrome in 1993 and did not develop it in 2003. Group 4 contained individuals who had metabolic syndrome in 1993 and developed it in 2003. RESULTS: Our sample has 35,779 individuals, of whom 10,754 had one transition into or out of Medicaid and 2,448 had more than one transition. We find that individuals with multiple transitions tend to have 46% more hospitalizations and use the emergency room 13% more. However, these individuals have 37% lower prescription drug utilization and 12% less outpatient physician visits relative to those who are continuously insured by Medicaid. CONCLUSION: Utilization of emergency and inpatient services were significantly higher, while use of outpatient care and prescription drugs was significantly lower for beneficiaries with interruption in Medicaid coverage. These findings point to the need for further research to assess the impact of churning in this population.

OBJECTIVES: In September 2006, the National Statistical Service of Greece revised the system of National Accounts. In this framework, significant increases took place in the data describing the pharmaceutical market, the overall picture of which has completely changed. The study aims to present these changes, as well as highlight some remarkable (or even questionable) characteristics of the revision. METHODS: Data from official sources relating to pharmaceuticals’ production, external trade, expenditure and sales were collected and analyzed, in an effort to synthesize the overall picture of the pharmaceutical market and provide a comparative instrument for the revised data. RESULTS: Under the new data, the pharmaceutical market bears two significant changes: a) private pharmaceutical expenditure accounts for 47.5% of total expenditure—against 22% which was the case before the revision, and b) data on the demand side appear to exceed supply-side data—the latter including parallel imports. The disproportional rise in pharmaceutical expenditure (58% on average for the years 2000–2005) led to an increase in pharmacists’ share to both health care expenditure and GDP. Moreover, the increase was totally attributable to a shift in private pharmaceutical expenditure—which was tripled—whereas public expenditure remained at the before-the-revision levels. However, such an increase contravenes both the fact that pharmaceuticals in Greece are mainly reimbursed by Social Insurance and the fact that the pharmaceutical market is heavily regulated and—in general—“hidden economy” phenomena do not exist. Furthermore, the increase is not supported by the results of the 2005 Household Budget Survey. CONCLUSION: The revised data raise questions on the relationship of public-private pharmaceutical expenditure and supply-demand market data, and entail the risk of leading to irrational decision making for both policy makers and pharmaceutical companies.