| Accident insurance, 68 | non-parametric estimation, |
|---|--------------------------------------|
| ADF test, 331, 332 | 148-150 |
| Administrative data, 285–300 | parametric estimation, 150-151 |
| ex-ante assessments, 288 | results, 157-164, 169-174 |
| ex-post assessments, 288-292 | Antibiotic consumption, 314–315 |
| health care services, assessment | Artefactual field experiments, 4 |
| of, 286–288 | Assortative matching, 181 |
| hospital efficiency measurement, | Atomistic fallacy, 296 |
| methods of, 292–294 | Attribute non-attendance (ANA), |
| relative efficiency assessment, | 93–96 |
| methods of, 294–297 | Average treatment effect (ATE), |
| Adopted children, effect of health | 2, 61 |
| endowment at birth of, | , |
| 183 | Bayesian information criterion |
| Adverse selection, 23–25, 34, 47, | (BIC), 90, 368 |
| 48, 51 | Bayesian methods, 89, 314, 318 |
| Affordable Care Act, 65 | Behavioral data linking, 5 |
| Agency for Healthcare Research | Behavioral econometrics, 3, 8 |
| and Quality (AHRQ), | applications to health, |
| 290, 292, 293 | 14–15 |
| Agglomeration, 318–320 | choice under risk, 11 |
| Aikaike information criterion | econometrics, 12–14 |
| (AIC), 90, 368 | experimental design and tests, 12 |
| Ambulatory Care Sensitive | general framework, 10 |
| Conditions (ACSC), | identification problem, 10 |
| 312, 319 Anchoring vignettes, 145–166, | individual discounting, 11–12 |
| 169–174 | Behavioral experiments in health, |
| data, 151–157 | 3–6 |
| objective measures of | Behavioral insights teams, 2 |
| mobility, 153–154 | Belief elicitation, 27–28 |
| self-reported mobility, | Benefit package, 27 |
| 152–153 | Body mass index (BMI), 108, |
| socio-demographic variables, | 313–314 |
| 154–155 | Bootstrapping, 121 |
| study design, 155–157 | Bureau of Labor Statistics (BLS), 68 |
| 50daj de51511, 155 157 | Dareau of Euror Statistics (BES), 00 |

| Canadian Institute for Health | Corrected ordinary least squares |
|------------------------------------|------------------------------------|
| information (CIHI), 290, | (COLS), 292 |
| 293, 299 | Cost-effectiveness analysis (CEA), |
| Canadian Patient Experiences | 6, 119-141 |
| Survey, 292 | case study, 130-140 |
| Caps on contingency fees, 242 | incremental cost-effectiveness |
| Caps on damages, 242 | ratio, 120-122 |
| Causal effects, 57 | incremental net benefit, |
| Certainty equivalent (CE) | 122-123 |
| method, 8 | net benefit regression |
| Certificate of merit, 242 | framework, 124–141 |
| Child's health endowment at birth, | seemingly unrelated regression, |
| parental investments to, | critique of, 126–127 |
| 175–193, 197–199 | Cost-utility analysis (CUA), 6 |
| conceptual framework, 178-179 | Cox Proportional Hazard (PH) |
| data and sample selection, | model, 208–211 |
| 184-185 | Cross-country comparison |
| econometric strategy, 179-183 | anchoring vignettes, 151–164, |
| estimation results, 186–193 | 169–174 |
| Chilling effect, 109 | healthcare expenditures, |
| Choice architecture, 2 | 327–344, 349–358 |
| Choice under risk, 11 | Cross-sectional dependence of |
| Clinical governance, 290 | healthcare expenditures, |
| Cobb Douglas production | 331–334, 341–343 |
| function, 293 | * |
| Column-by-column approach, | Cross-sectionally augmented |
| 364-365 | distributed lag (CS-DL), |
| Commission for Health | 334 G W 111 (CW) 260 260 |
| Improvement (CHI), 290 | Cross-Validation (CV), 368–369 |
| Common Correlated Effects | Cultural assimilation, 107–109 |
| (CCE), 312, 315, 334 | D . 1 |
| Common Correlated Effects Mean | Database of State Tort Law |
| Group (CCE MG) | Reforms (DSTLR), |
| estimator, 316 | 249—251 |
| Common Correlated Effects | Data envelopment analysis (DEA) |
| Pooled (CCEP) | 292 |
| estimation, 315–316 | Defensive medicine |
| Compound hierarchical ordered | empirical analysis, 244-247 |
| probit model. See | liability pressure and, 253-254 |
| Hierarchical ordered | negative, 236–237 |
| probit (HOPIT) model | positive, 236 |
| Conditional autoregressive (CAR) | Delta method, 122 |
| model, 360, 362 | Demand of health care services, |
| Contagious presenteeism, 67 | immigration and, |
| Conventional lab experiments, 4 | 110-111 |
| | |

| Diagnosis-related groups (DRG), | English Care Quality Commission, |
|------------------------------------|------------------------------------|
| 263-267, 274-275, 278, | 292 |
| 289, 291, 299 | Enterprise liability, 237 |
| Difference-in-Difference-in- | Episode splitting, 209 |
| Difference (DDD), 59, 65 | Equality-constrained latent class |
| Disability insurance (DI), 69–70 | (EC-LC) model, 94, 95 |
| Discrete choice methods, in health | Equation-by-equation estimation, |
| economics, 85–96 | 134-136 |
| attribute non-attendance, 93-96 | Ethiopia |
| multinomial logit and mixed | subjective expectations of |
| logit models, 86-91 | medical expenditures and |
| scale heterogeneity, 91–92 | insurance, 23–52 |
| willingness to pay space, in | Évaluation des pratiques (EPP), |
| estimation of, 92–93 | 290 |
| Domain-Specific Risk-Taking scale | Ex-ante assessments, 288 |
| (DOSPERT), 7 | Expectation-Maximisation (EM) |
| Drug expenditure, insurance | algorithm, 90, 370, 371 |
| coverage on, 202 | Expectations, of medical |
| Drug innovation, 203, 205 | expenditures and |
| Duration models, 201–228 | insurance, 23–52 |
| | Expected Utility Theory (EUT), |
| Ecological fallacy, 296 | 8-9 |
| Econometric strategy | Expenditure externality hypothesis |
| parental investments to child's | 317 |
| health endowment at | Experimental design, 12 |
| birth, 179–183 | Experimental tests, 12 |
| Effectiveness, 289 | Experimenter demand effects, 4 |
| Efficiency, 289 | Ex-post assessments, 288–292 |
| hospital, 292–294 | Extended Bayesian Information |
| relative, 294–297 | Criterion (EBIC), 368 |
| Emergency department (ED) visits, | Extended Cox Model, 209 |
| geographical accessibility | |
| to, 318 | Face validity, 35–42 |
| Empirical models of hospital | Failure of R&D process, |
| competition, 267–271 | 204-210 |
| Endogeneity | estimation strategy, 208–209 |
| of child health, 176, 177, 179, | hazard function, 205–208 |
| 180, 188, 192, 193 | time-varying characteristics and |
| hospital's quality competition, | effects, 209–210 |
| 267–271 | Father's birth endowment, 181 |
| immigration and health, 113 | FMOLS (Fully Modified OLS) |
| Endogenous attribute attendance | estimation, 339–341 |
| (EAA) model, 94–95 | Forecast expenditure, 24 |
| mixed, 95–96 | Framed field experiments, 4 |

| Gamble tradeoff (GTO) method, 8 | in spatial econometrics, |
|-----------------------------------|---|
| Gamma Pseudo Maximum | 362-363 |
| Likelihood (GPML), 26, | Great Migration, 106 |
| 42, 44 | , |
| Gauss-Hermite quadrature, 370, | Hansen-Sargan test, 178 |
| 371 | Hausman's test, 311 |
| Gaussian graphical models, 360, | Haute Autorité de Santé (HAS), |
| 361-362 | 290 |
| Generalised Linear Model (GLM), | Hawthorne effects, 4 |
| 26, 42, 311 | Hazard function, of R&D process, |
| Generalised-multinomial logit | 205–208 |
| model (G-MNL), 91, 92 | Health, defined, 61 |
| Generalized Cross-Validation, 368 | Healthcare Costs and Utilization |
| Generalized Method of Moments | Project (HCUP), 290 |
| (GMM), 127–129, | Healthcare expenditures (HCE), |
| 140-141, 306, 321 | cross-country modeling |
| relationship with SUR and | of, 315–318, 327–344, |
| OLS, 129–130 | 349–358 |
| German Socioeconomic Panel | data and variables, 334–335 |
| (SOEP), 111, 112 | panel ARDL modeling studies, |
| Gesundheitsberichterstattung des | 327–329, 331, 335–339, |
| Bundes (GBE), 290 | 349–351 349–351 |
| Gibbs sampling, 371 | study methodology, 331–334 |
| Granger causality test, 340 | technology effects on, 329–330 |
| Graphical discrete choice models, | unit root tests, 335–339 |
| 370-371 | Healthcare services, assessment of, |
| Graphical LASSO (GLASSO), | 286–288 |
| 321, 360, 366, 367, 372 | Health insurance. <i>See</i> Insurance |
| Graphical modeling, for large | Health of migrants, 101–114 |
| network inference, | Health outcomes, 285–300 |
| 359-373 | Health resources, allocation of, |
| applications of, 371–373 | 315–318 |
| discrete random variables | Health selectivity, 107 |
| graphical discrete choice | Healthy immigrant effect, 103, 110 |
| models, 370–371 | Heart attack survival rate and |
| Ising graphical model, | expenditure, 313 |
| 369–370 | Herfindahl-Hirschman Index |
| estimation, 363–369 | |
| column-by-column approach, | (HHI), 268–271, 319 |
| 364–365 | Heteroskedasticity-autocorrelation consistent (HAC) |
| model selection, 367–369 | |
| penalized log-likelihood | estimator, 313 |
| approach, 365–367 | Hierarchical ordered probit |
| Gaussian graphical models, | (HOPIT) model, |
| 361-362 | 146–148, 154, 157, 165 |

| cross-country comparison, 158, | Immunisation decisions, 183 |
|----------------------------------|--------------------------------------|
| 163, 164, 169–170 | Incentive-compatible (IC) tests, 8 |
| health equation, 151 | Income elasticity, 329, 335, 339 |
| reporting behavior, 150–151, | Incremental cost-effectiveness ratio |
| 156 | (ICER), 120–122, 123 |
| HIV prevalence, 314 | Incremental net benefit (INB), |
| Hospital competition on quality, | 122-123, 140-141 |
| 263-279, 318-320 | Individual discounting, 11–12 |
| DRG tariffs and, 274-275 | Information technology, 330 |
| empirical models of, 267–271 | Inpatient hospital admissions, |
| non-profit hospitals, 275-278 | 312-313 |
| spatial approach to, 271–273 | Institutional accreditation, 287 |
| Hospital discharge chart (HDC), | Instrumental variables (IV), 60, |
| 286 | 176, 178, 180, 183, 242, |
| Hospital efficiency measurement, | 248, 269, 277, 306, 311 |
| methods of, 292-294 | Insurance |
| Hospital mergers, 273–274 | accident, 68 |
| | coverage |
| Identification problem, 10 | on drug expenditure, 202 |
| Immigration and health, 101–114 | for immigrants, 109 |
| administrative records, 104-105 | disability, 69–70 |
| cultural assimilation and | health, subjective expectations |
| language skills, 107–109 | of, 23-52 |
| demand of health care services, | long-term care, 70–71 |
| 110-111 | sick leave, 66–67 |
| health insurance coverage, 109 | statutory pension, 71–72 |
| health of those left behind, 113 | unemployment, 71 |
| health selectivity, 107 | Insurance market choices, 7 |
| healthy immigrant effect, 103, | Intent-to-treat (ITT), 60 |
| 110 | Interactive fixed effects estimator |
| immigration policy, 107 | (IFE), 334 |
| natural and quasi-natural | Intergenerational mobility, 178, |
| experiments, 105–107 | 181 |
| selection and regression toward | Intrahousehold resource |
| the mean, modeling, 104 | allocation, 178 |
| supply of health care services, | Irrelevant alternatives (IIA) |
| 112 | property, 88, 89 |
| visa status, 107 | Ising graphical model, 369–370 |
| working conditions and | ISO-9000 certification, 288 |
| work-related risks, | - 4 |
| 111-112 | John Henry effects, 5 |
| Immigration and Refugee | Joint and several liability (JSL) |
| Protection Act of 2002, | rule, 242, 249, 250 |
| 107 | Joint Commission on |
| Immigration policy, 107 | Accreditation of |

| Healthcare Organizations | existing evidence and |
|------------------------------------|-----------------------------------|
| (JCAHO), 287 | limitations, 242–252 |
| Joint Commission on | future research, 255–257 |
| Accreditation of | liability pressure, 252–255 |
| Hospitals, 287 | theoretical expectations, |
| | 238-240 |
| Key performance indicators (KPI), | Likert scale, 7 |
| 289 | Lind, James, 3 |
| Kolmogorov-Smirnov (KS) test, | Local Average Treatment Effect |
| 155-156 | (LATE), 59, 61, 72 |
| Kulback-Leibler divergence, 368 | Long-term care insurance, 70–71 |
| Lab-field experiments, 5 | Market structure, impact on price |
| Labor market, immigration effect | reaction function, |
| on, 111 | 318-319 |
| Language skills, 107–109 | Markov chain Monte Carlo |
| Large network inference, graphical | algorithm, 366 |
| modeling techniques for, | Maximum Likelihood Estimation |
| 359-373 | (MLE), 8, 306, 311, 321 |
| applications of, 371–373 | Mean group (MG) estimator, |
| discrete random variables | 332-333 |
| graphical discrete choice | Medicaid, 64–66, 109 |
| models, 370–371 | Medical expenditure, 23–52 |
| Ising graphical model, | Medical malpractice, 235–257 |
| 369-370 | empirical analysis, 240-241, |
| estimation, 363–369 | 244—247 |
| column-by-column approach, | existing evidence and |
| 364-365 | limitations, 242–252 |
| model selection, 367–369 | future research, 255–257 |
| penalized log-likelihood | liability pressure, 252–255 |
| approach, 365–367 | theoretical expectations, |
| Gaussian graphical models, | 238-240 |
| 361-362 | Medicare, 65, 274 |
| in spatial econometrics, | Part B program, 106 |
| 362-363 | Medicare Current Beneficiary |
| Latent class (LC) model, 89, 90 | Survey, 70 |
| Least Absolute Shrinkage and | Mental health expenditures, |
| Selection Operator | 316-317 |
| (LASSO), 321, 360, 364, | Mental health outcomes, 314 |
| 365, 372 | Metropolis-Hastings algorithm, |
| Liability and medical decisions, | 371 |
| 236-241, 249, 251, 255 | Microeconometrics, 59, 60 |
| empirical analysis, 240-241, | "Minimum Standards for |
| 244—247 | Hospitals" program 287 |

| MIXED EAA (MEAA) model, | Objective nearth measures, 62–63 |
|-----------------------------------|-----------------------------------|
| 95-96 | Occupational Safety and Health |
| Mixed logit (MXT) model, | Administration (OSHA), |
| 88-91, 92 | 68 |
| Mixed proportional hazard | OECD countries, healthcare |
| (MPH) model, 207–208, | expenditures in, |
| 209 | 327-344, 349-358 |
| Monte Carlo integration, | Offset effects, 65 |
| 370, 371 | Ontario Hospital Association, 290 |
| Moral hazard, 24, 46, 57 | Ordinary Least Squares (OLS) |
| Mortality of deprivation, 313 | estimation, 125, 126, 144, |
| Mother's labour supply, effect of | 186–190, 192, 193, 272, |
| child health at birth on, | 292, 309, 313 |
| | |
| 176, 178, 180–181 | FMOLS (Fully Modified OLS) |
| Multicollinearity, 86 | estimation, 339 |
| Multinomial logit (MNT) model, | relationship with SUR and |
| 86–88 | GMM, 129–130 |
| generalised, 91, 92 | Oregon Health Insurance |
| hospital's quality competition, | Experiment, 64–65 |
| 268 | ORYX program, 290 |
| Multiple price list (MPL) method, | Out-of-pocket (OOP) payments, |
| 8, 9 | 46, 47 |
| | Outpatient expenditure, 28 |
| National Health Interview Survey, | Outpatient hospital admissions, |
| 107-109 | 312-313 |
| National Health Service (NHS), 2, | Overuse of treatments, 237, 238, |
| 110, 290 | 240-241 |
| Natural field experiments, 4, 5 | |
| Neighbourhood, effect on health, | Pain and suffering (P&S), 242, |
| 313-314 | 249-251 |
| Net benefit regression framework | Panel ARDL modeling, 327–329, |
| (NBRF) | 331, 349–351 |
| to cost-effectiveness analysis, | long-and short-run estimation |
| 124-141 | of healthcare expenditure |
| criticisms of, 125-126 | with, 335-339, 352-357 |
| New Chemical Entities (NCEs), | Panel cointegration tests, 339, |
| 202 | 341-354, 358 |
| Newton-Raphson algorithm, 370 | Parametric estimation |
| No fault system, 237 | anchoring vignettes, 150-151 |
| Non-parametric estimation | Parental investments to child's |
| anchoring vignettes, | health endowment at |
| 148–150 | birth, 175–193, 197–199 |
| R&D hazard function, 207 | conceptual framework, 178–179 |
| Non-profit hospitals, quality of, | data and sample selection, |
| 275–278 | 184–185 |
| | |

| econometric strategy, 179-183 | equation-by-equation |
|--------------------------------------|-----------------------------------|
| estimation results, 186–193 | estimation, 134–136 |
| Partial Likelihood method, 209, | estimation strategies, 132-134 |
| 210 | simultaneous equations |
| Patents, 329–330 | estimation, 137–138 |
| Patient satisfaction, 289–290 | Prospective payment systems |
| Peer review, 290 | (PPS), 291, 299 |
| Penalized log-likelihood approach, | Public Health England, 2 |
| 365-367 | Public health expenditures, 316, |
| computational costs of, 367 | 317 |
| Personal Responsibility and Work | |
| Opportunity | Quality Adjusted Life Years |
| Reconciliation Act of | (QALY), 6 |
| 1996, 109 | Quality-related life measures, 63 |
| Pharmaceutical R&D, 201–228 | Quasi difference-in-difference |
| determinants of, 214-225 | (DiD) model, 269–270 |
| failure, 204–210 | Quasi-experimental design, 147 |
| estimation strategy, 208–209 | Quasi-maximum likelihood |
| hazard function, 205–208 | estimator (QMLE), 334 |
| time-varying characteristics | QUIC algorithm, 367 |
| and effects, 209–210 | , |
| measures of innovation, | RAND Health Insurance |
| 223-225 | Experiment (RAND |
| nature of, 203-204 | HIE), 63–64 |
| productivity, 202 | Randomized controlled trials |
| successful transition to next | (RCTs), 1–6 |
| stage, 210-225 | bias in, 5 |
| control, 212–213 | types of, $4-5$ |
| estimation strategy, 212 | Random utility models, 87 |
| Phillips-Perron (PP) test, 331, 332, | Reduced-form methods, 59–61, |
| 335 | 69, 71 |
| Piano nazionale esiti (PNE), 291 | Regional malpractice liability |
| Pooled mean group (PMG) | funds, 237 |
| estimator, 333 | Regression analysis, 306 |
| Predictive value of expectations, | Regression Discontinuity (RD), 59 |
| 42-46 | Regression Kink (RK), 59 |
| Pretrial screening, 242 | Rehabilitation, 66–67 |
| Probability equivalent (PE) | Relative efficiency assessment, |
| method, 8 | methods of, 294-297 |
| Program in Assertive Community | Reporting heterogeneity, 146-148, |
| Treatment, 130–140 | 156, 165 |
| background of data, 131-132 | Research and development (R&D) |
| background of study, 130-131 | expenditure, 330 |
| characterizing uncertainty, | in pharmaceutical industry, |
| 138-140 | 201-228 |

| control, 212-213 | Sick leave insurance, 66–67 |
|---------------------------------------|-----------------------------------|
| determinants of, 214-222 | Simultaneous equations |
| estimation strategy, 212 | estimation, 137–138 |
| failure, 204–210 | Smoothly clipped absolute |
| measures of innovation, | deviation (SCAD) |
| 223-225 | penalty, 366, 368 |
| nature of, 203-204 | Social insurance, 57–73 |
| productivity, 202 | accident insurance (workers |
| successful transition to next | compensation), 68 |
| stage, 210–225 | disability insurance, 69–70 |
| Response consistency, 147 | health econometric evidence |
| Revealed preference (RP) data, 86 | empirical methods, 59-61 |
| Reverse causality, 273 | objective health measures, |
| Risk adjustment, 290, 295, 298 | 62-63 |
| Risk aversion, 47 | quality-related life measures, |
| Risk preferences, 6–7 | 63 |
| Risk-taking measurement, 7–9 | subjective self-reported health |
| CADAD 11 207 215 | measures, 62 |
| SARAR model, 306, 315 | long-term care insurance, 70–71 |
| SARMA (spatial lag and moving | Oregon health insurance |
| average model) model, | experiment, 64-65 |
| 317 | RAND Health Insurance |
| SAR-Seemingly Unrelated | Experiment (RAND |
| Regression (SUR) model, 312, 317, 320 | HIE), $63-64$ |
| Scale-based self-assessed approach, | sick leave insurance and |
| 7–8 | rehabilitation, 66–67 |
| Scale heterogeneity, 91–92 | statutory pension insurance, |
| Scale of reference bias, 62 | 71-72 |
| Schedules damages, 252 | unemployment insurance, 71 |
| Seemingly unrelated regression | Social Security Administration, |
| (SUR) | 106 |
| critique in cost-effectiveness | Social Services Performance |
| analysis, 126–127 | Rating (SSPR), 317 |
| relationship with GMM and | Socio-Economic Panel Study |
| OLŜ, 129–130 | (SOEP), 63, 70 |
| Self-reported mobility (SRM), | Spatial approach to hospital |
| empirical assessment of, | competition, 271–273 |
| 145–166, 169–174 | Spatial autoregressive model, 360 |
| SEM-GMM model, 313 | Spatial dependence, 305–307, 311, |
| Semi-parametric models | 314, 316–318 |
| R&D hazard function, 207-208 | Spatial Durbin lag model, 306, |
| SEM-SUR panel model, 312 | 317, 320 |
| SF-12, 298 | Spatial econometrics, graphical |
| SF-36, 298 | models in, 362–363 |

| Spatial error model (SEM), 306, | face validity and formation of |
|---|-------------------------------------|
| 310, 314, 316 | expectations |
| Spatial health econometrics (SHE), | household-specific mean, |
| 305–322 | predictors of, 35–41 |
| health care expenditures, | revisions to expectations, |
| 315–318 | 41–42 |
| health needs, 314 | forecasts and realizations, |
| health outcomes, risk factors | comparison of |
| and health needs, | expected and realized |
| 312–315 | expenditures, correlation |
| health resources, allocation of, | between, 34–35 |
| 315–318 | forecast medical expenditure |
| hospital competition and | distributions, moments |
| agglomeration, 318–320 | of, 32–34 |
| risk factors, 313 | medical expenditure data, |
| spatial models, 309–312 | 28-29 |
| spatial weights, 307–309 | predictive value of expectations, |
| Spatial lag autoregressive model | 42-46 |
| (SAR), 306, 310–314, | sampling design, 26–27 |
| 316, 319, 362 | validity of |
| Spatial lag operator, 309 | distribution of responses, |
| Spatial models, 309–312 | 31-32 |
| Spatial panel data model, | illogical responses, 30–31 |
| 310–311, 316 | response rates, 29–30 |
| Spatial weight matrix, 307, 308 | Subjective self-reported health |
| Spatial weights, 307–309 | measures, 62 |
| Standard Gamble (SG) method, 6 | Supply of health care services, |
| Standard Gamble (3G) method, 6 Standardization, 295 | immigration and, 112 |
| State dependent reporting bias, 62 | Survey of Health, Ageing and |
| Status of limitations, 242 | Retirement in Europe |
| | (SHARE), 145, 148, 151, |
| Statutory pension insurance, 71–72 | 153, 154, 165 |
| Stochastic dominance, 156, | Synthetic Control Group Method |
| 158–160, 170–174 | (SCGM), 59, 60 |
| Stochastic frontier approach | T 100 00 11 0T 1 |
| | Tariffs, effect on quality, 274–275 |
| (SFA), 292, 293 Structural methods, 60, 61, 67, 70 | Taylor approximation, 122 |
| | Technology, effects on healthcare |
| Subjective probability, of medical | expenditures, 329–330 |
| expenditures and | Temporary Disability Insurance, 67 |
| insurance, 23–52 | TIGER, 369 |
| belief elicitation, 27–28 | Time preferences, 6–7 |
| expectations influence on | measurement of, 9–10 |
| insurance decision, | Time Trade Off (TTO) method, 6 |
| 46 - 50 | Tort reforms, 242, 243, 248 |

Trade-off approach, 8
Transportation costs, 265, 266
Treatment selection, medical
liability effects on, 241
Truncated Normal distribution,
371
Truven Health Analytics, 290
Two-stage least square estimation
(2SLS), 186–193

Ufficio federale per la sanità
pubblica (UFSP), 290
Underuse of treatments, 237, 238,
240–241
Unemployment insurance (UI), 71
UNI-EN-ISO-9000 certification,
288
United Kingdom (UK)
Cabinet Office, 3
Nudge Unit, 2
Department of Health, 2

Labor Force Survey, 112

United States (US)
Earned Income Credit, 59
Health and Retirement
Survey, 8
Social Security Notch, 59
Unit root tests, 335–339

Vignette equivalence, 147 Virtual experiments, 5 Visa status, 107 VISION-2000 version, 288

Westerlund ECM test, for panel cointegration, 341–343
Willingness to pay (WTP), 87–88 space, in estimation of, 91–93
Workers compensation (WC), 68
Workhorse models, 86–91
Working conditions, immigration effect on, 111–112
Work-related risks, immigration effect on, 111–112