

Veille scientifique en économie de la santé

Watch on Health Economics Literature

Mars 2024 / March 2024

Assurance maladie	<i>Health Insurance</i>
E-santé – Technologies médicales	<i>E-Health-Medical Technologies</i>
Économie de la santé	<i>Health Economics</i>
Environnement et santé	<i>Environmental Health</i>
État de santé	<i>Health Status</i>
Géographie de la santé	<i>Geography of Health</i>
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Vieillesse	<i>Aging</i>

Présentation

Cette publication mensuelle, réalisée par les documentalistes de l'Irdes, rassemble de façon thématique les résultats de la veille documentaire sur les systèmes et les politiques de santé ainsi que sur l'économie de la santé : articles, littérature grise, ouvrages, rapports...

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Presentation

Produced by the IRDES Information Centre, this publication presents each month a theme-sorted selection of recently published peer-reviewed journal articles, grey literature, books and reports related to Health Policy, Health Systems and Health Economics.

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Health Insurance**► Using Enrollment Records to Evaluate Self-Reports of Monthly Coverage in the Redesigned Current Population Survey Health Insurance Module**PASCALE J., *et al.*

2024

Health Services Research : 1-12.<https://doi.org/10.1111/1475-6773.14285>

Objective To evaluate the veracity of self-reports of month-level health insurance coverage in the Current Population Survey Annual Social and Economic Supplement (CPS). **Data Sources and Study Setting** The CHIME (Comparing Health Insurance Measurement Error) study used health insurance enrollment records from a large regional Midwest insurer as sample for primary data collection in spring 2015. **Study Design** A sample of individuals enrolled in a range of public and private coverage types (including Medicaid and marketplace) was administered the CPS health insurance module, which included questions about month-level coverage, by type, over a 17–18-month time span. Survey data was then matched to enrollment records covering that same time frame, and concordance between the records and self-reports was assessed. **Data Collection/Extraction Methods** Sample was drawn by the insurer’s informatics specialists and Census Bureau interviewers conducted the survey. Following data collection, updated enrollment records were matched to the survey data to produce a person-level file of coverage by type at the month-level. **Principal Findings** For 91% of the overall sample, coverage status and type were reported accurately for at least 75% of observed months. Results varied somewhat by stability of coverage. Among those who were continuously covered throughout the 17–18 month observation period (which comprised 64% of the overall sample), that level of reporting accuracy was observed for 94% of the sample; for those who had censored spells (34% of the overall sample), the figure was 87%; and among those with gaps and/or changes according to the records (2% of the overall sample), for 82% of the group at least 75% of months were reported accurately. **Conclusions** Findings suggest that reporting accuracy of month-level coverage in the CPS is high and that the survey could become a valuable new data source for studying the dynamics of coverage, including the Medicaid unwinding.

► Scope and Incentives For Risk Selection in Health Insurance Markets with Regulated Competition: A Conceptual Framework and International ComparisonVAN KLEEF R. C., *et al.*

2024

**Medical Care Research and Review:
10775587231222584.**<https://doi.org/10.1177/10775587231222584>

In health insurance markets with regulated competition, regulators face the challenge of preventing risk selection. This paper provides a framework for analyzing the scope (i.e., potential actions by insurers and consumers) and incentives for risk selection in such markets. Our approach consists of three steps. First, we describe four types of risk selection: (a) selection by consumers in and out of the market, (b) selection by consumers between high- and low-value plans, (c) selection by insurers via plan design, and (d) selection by insurers via other channels such as marketing, customer service, and supplementary insurance. In a second step, we develop a conceptual framework of how regulation and features of health insurance markets affect the scope and incentives for risk selection along these four dimensions. In a third step, we use this framework to compare nine health insurance markets with regulated competition in Australia, Europe, Israel, and the United States.

► **If You Build It, They May Not Come: Understanding Factors Influencing Use of a Community Resource Referral Technology**

FICHTENBERG C., *et al.*

2024

Health Services Research 59(S1): e14234.

<https://doi.org/10.1111/1475-6773.14234>

Objective Identify factors affecting the use of a community resource referral platform among local community-based organizations (CBOs) and test strategies to increase platform use. Data Sources and Study Setting Data sources included platform usage data and semi-structured interviews. The study took place in a small city in the Northeastern United States from 2020 to 2022. Study Design We analyzed platform data and conducted interviews with local organizations and organizations in other communities to understand barriers to CBOs' use of the referral platform and identify strategies that might increase use. We then tested 4 strategies and assessed impacts via time trend analysis of platform usage and qualitative interviews. Data Collection/Extraction Methods Platform usage data were obtained from the platform. Semi-structured interviews were conducted with staff and leaders of 36 local CBOs and 9 external organizations. Principal Findings Four years after launch, platform use remained relatively low. None of the tested strategies (data insight reports, a referral hub, tailored training, and a communication campaign) noticeably increased platform use. The main barrier to the use of the platform was the lack of perceived usefulness, mostly because existing processes for identifying resources and referring clients worked well enough and because many organizations were already required to use a client management or referral tool. Additional barriers included the lack of comfort with and, in some cases, active dislike of e-referrals, and lack of comfort with technology tools overall. Organizations that were most likely to find the platform useful and to use it were those that provided referrals for a wide range of needs and whose staff were not already familiar with local resources. Conclusions Organizations seeking to implement referral platforms should not assume that local CBOs will automatically take up these platforms. For these platforms to succeed, much more attention

needs to be paid to ensuring the platforms provide value to the CBOs they seek to engage.

► **Telemedicine Could Reduce the Role of Family Physicians to Case Managers**

KANNAI R. ET RICE A.

2024

The Annals of Family Medicine 22(1): 63-64.

<https://doi.org/10.1370/afm.3049>

The COVID-19 pandemic led to the widespread and continuing use of telemedicine in primary care. Despite telemedicine's benefits, it threatens to reduce the role of family physician to that of gatekeeper and case manager, nullifying decades of experience and medical intuition that is more difficult to develop and apply virtually. Additionally, many values of family medicine have eroded during this global process. The narrative presents 3 vignettes that illustrate different ways in which we contend with this complex issue. The challenges presented by telemedicine require us to re-examine our professional and personal values such as maintaining the centrality of the therapeutic relationship with patients. The greatest concern, however, relates to the future of the profession and the ability of new family doctors to overcome the challenges of telemedicine in an increasingly digital world.

► **Jusqu'où la santé numérique va-t-elle transformer l'organisation des soins ?**

MINVIELLE E.

2024

Bulletin de l'Académie Nationale de Médecine. [In press]

<https://doi.org/10.1016/j.banm.2023.10.004>

► **La crise de l'offre de soins peut-elle être amortie par la téléconsultation territoriale ? Premiers enseignements pour la Normandie**

VIDAL P. ET LE HIR S.

2023

Géographie, économie, société 25(4): 567-598.

<https://www.cairn.info/revue-geographie-economie-societe-2023-4-page-567.htm>

Depuis 2018 et sur un rythme toujours plus élevé, se déploient, au sein du territoire national et à l'initiative du privé, des bornes et cabines de téléconsultation médicales disposées dans des lieux facilement accessibles au public, principalement des pharmacies. Ces dispositifs sont développés par des entreprises privées issues de la dynamique French Tech sur le double argument de lutte contre la désertification médicale et d'anticipation du vieillissement de la population, partant de l'hypothèse que l'avancée en âge entraînera de fait des besoins accrus en offre de soins sur le territoire national. Sur fond de discours contre le délaissement du territoire, avec l'assentiment et parfois la participation active des acteurs publics locaux, les bornes et cabines de téléconsultation privées se déploient à grande vitesse. Elles s'inscrivent dans le courant du « solutionnisme technologique » et se présentent ainsi comme un remède à la crise du secteur sanitaire et social qui ne cesse de s'aggraver sur l'ensemble du territoire national. Le cas de la Normandie est envisagé montrant que le déploiement en cours témoigne d'un réel dynamisme dans les zones de fragilité médicale, mais esquivent pour le moment les territoires les plus durement touchés par la pénurie de médecins normands. L'article conclut sur un premier retour d'usage montrant in fine que ces dispositifs sont surtout appréciés par leur capacité à répondre aux urgences médicales et au suivi récurrent d'une patientèle qui ne vit pourtant pas toujours en zone de désertification médicale.

► **Stakeholders' Preferences For the Design and Delivery of Virtual Care Services: A Systematic Review of Discrete Choice Experiments**

VO L. K., *et al.*

2024

Social Science & Medicine 340: 116459.

<https://www.sciencedirect.com/science/article/pii/S027795362300816X>

This systematic review aimed to synthesise evidence from discrete choice experiments (DCEs) eliciting preferences for virtual models of care, as well as to assess the quality of those DCEs and compare the relative preferences for different stakeholder groups. Articles were included if published between January 2010 and December 2022. Data were synthesised narratively, and attributes were assessed for frequency, significance, and relative importance using a semi-quantitative approach. Overall, 21 studies were included encompassing a wide range of virtual care modalities, with the most common setting being virtual consultations for outpatient management of chronic conditions. A total of 135 attributes were identified and thematically classified into six categories: service delivery, service quality, technical aspects, monetary aspects, health provider characteristics and health consumer characteristics. Attributes related to service delivery were most frequently reported but less highly ranked. Service costs were consistently significant across all studies where they appeared, indicating their importance to the respondents. All studies examining health providers' preferences reported either system performance or professional endorsement attributes to be the most important. Substantial heterogeneity in attribute selection and preference outcomes were observed across studies reporting on health consumers' preferences, suggesting that the consideration of local context is important in the design and delivery of person-centred virtual care services. In general, the experimental design and analysis methods of included studies were clearly reported and justified. An improvement was observed in the quality of DCE design and analysis in recent years, particularly in the attribute development process. Given the continued growth in the use of DCEs within healthcare settings, further research is needed to develop a standardised approach for quantitatively synthesising DCE findings. There is also a need for further research on preferences for virtual care in post-pandemic contexts, where emerging evidence suggests that preferences may differ to those observed in pre-pandemic times.

Health Economics

► **Physician Responses to Insurance Benefit Restrictions: The case of Ophthalmology**

ABIONA O., *et al.*

2024

Health Economics 1-18

<https://doi.org/10.1002/hec.4799>

This study examines the impact of social insurance benefit restrictions on physician behaviour, using ophthalmologists as a case study. We examine whether ophthalmologists use their market power to alter their fees and rebates across services to compensate for potential policy-induced income losses. The results show that ophthalmologists substantially reduced their fees and rebates for services directly targeted by the benefit restriction compared to other medical specialists' fees and rebates. There is also some evidence that they increased their fees for services that were not targeted. High-fee charging ophthalmologists exhibited larger fee and rebate responses while the low-fee charging group raise their rebates to match the reference price provided by the policy environment.

► **Deductible Imputation in Administrative Medical Claims Datasets**

CLIFF B. Q., *et al.*

2024

Health Services Research [Ahead of pub]

<https://doi.org/10.1111/1475-6773.14278>

Objective To validate imputation methods used to infer plan-level deductibles and determine which enrollees are in high-deductible health plans (HDHPs) in administrative claims datasets. **Data Sources and Study Setting** 2017 medical and pharmaceutical claims from OptumLabs Data Warehouse for US individuals <65 continuously enrolled in an employer-sponsored plan. **Data** include enrollee and plan characteristics, deductible spending, plan spending, and actual plan-level deductibles. **Study Design** We impute plan deductibles using four methods: (1) parametric prediction using individual-level spending; (2) parametric prediction with imputation and plan characteristics; (3) highest plan-specific mode of individual annual deductible spending; and (4) deductible spending at the 80th per-

centile among individuals meeting their deductible. We compare deductibles' levels and categories for imputed versus actual deductibles. **Data Collection/Extraction Methods** Not applicable. **Principal Findings** All methods had a positive predictive value (PPV) for determining high- versus low-deductible plans of $\geq 87\%$; negative predictive values (NPV) were lower. The method imputing plan-specific deductible spending modes was most accurate and least computationally intensive (PPV: 95%; NPV: 91%). This method also best correlated with actual deductible levels; 69% of imputed deductibles were within \$250 of the true deductible. **Conclusions** In the absence of plan structure data, imputing plan-specific modes of individual annual deductible spending best correlates with true deductibles and best predicts enrollees in HDHPs.

► **Financement et fonctionnement du monde associatif : la marchandisation et ses conséquences**

COTTIN-MARX S., *et al.*

2023

Revue Française des Affaires Sociales 234(4).

<https://www.cairn.info/revue-francaise-des-affaires-sociales-2023-4.htm>

► **Immigration, Policies of Integration and Healthcare Expenditure: A Longitudinal Analysis of the INHS (2002-2018)**

D'ANDREAMATTEO A., *et al.*

2023

Health Policy: 104960 [Ahead of pub]

<https://doi.org/10.1016/j.healthpol.2023.104960>

Background : Immigration has become a structural phenomenon in Italy, a country reputed as being 'immigrant-friendly'. The increase in the proportion of immigrants has led to increasing efforts to design and implement health policies throughout the country while controlling public spending. **Method** : Being interested in both the cross-sectional and time series dimensions of analysis, we used a PVAR (Panel Vector Autoregression) model, which combines the VAR technique with panel data models, to estimate the impact

of regular immigration on health expenditure. Findings Our results confirm that an increase in the share of regular immigrants in the total population decreases the amount of aggregate public health expenditure. Conclusion : Despite the intense activity by Italian governments on social and health integration policies for immigrants, policymakers may focus more on the implementation of national policies at regional and local levels, on their costs and with a specific focus on undocumented immigrants.

► **National Health Care Spending in 2022: Growth Similar to Prepandemic Rates**

HARTMAN M., *et al.*

2023

[Health Affairs 43\(1\): 6-17.](#)

<https://doi.org/10.1377/hlthaff.2023.01360>

Health care spending in the US grew 4.1 percent to reach \$4.5 trillion in 2022, which was still a faster rate of growth than the increase of 3.2 percent in 2021 but was much slower than the rate of 10.6 percent seen in 2020. In 2022, strong Medicaid and private health insurance spending growth, including a turnaround in the net cost of insurance, was somewhat offset by continued declines in federal spending associated with the COVID-19 pandemic. The insured share of the population reached a historic high of 92.0 percent in 2022 as enrollment in private health insurance increased at a faster rate relative to 2021 and Medicaid enrollment continued to experience strong growth. The share of the economy accounted for by the health sector was 17.3 percent in 2022, which was down from a peak of 19.5 percent in 2020 but was more consistent with the average share of 17.5 percent during 2016-19.

► **Why Higher Copayments For Opioids Did Not Reduce Use Among Medicare Beneficiaries**

JOYCE G., *et al.*

2024

[Health Economics 33\(3\): 466-481.](#)

<https://doi.org/10.1002/heh.4779>

To examine whether higher cost-sharing deterred prescription opioid use. Medicare Part D claims from 2007 to 2016 for a 20% random sample of Medicare enrollees. We obtain estimates of the effect of cost-sharing on prescription opioid use using ordinary least squares and instrumental variables methods. In both, we exploit

the variation (change) in cost-sharing within plans over time for a sample of beneficiaries who remain in the same plan. Focusing on changes in cost-sharing within a plan for a constant sample of beneficiaries mitigates potential bias from plan selection and using a constant set of weights derived from use in year (t) eliminates changes in the cost-sharing indexes due to (endogenous) consumer choice in year (t+1). Part D plans adopted benefit changes designed to reduce opioid use, including moving opioids to higher cost-sharing tiers. Increasing plan copayments for hydrocodone or oxycodone was associated with reductions in plan-paid claims and offsetting increases in cash claims. Widespread availability of low-cost generics combined with the anti-clawback provision in Part D mediated the effect of higher cost sharing to curb opioid use. As plans moved generic opioids to higher cost-sharing tiers, beneficiaries simply paid cash prices and aggregate use remained largely unchanged. The anti-clawback provision in Part D, intended to protect beneficiaries from price gouging, limited plans' ability to constrain opioid use through typical demand-side measures such as increased cost-sharing.

► **(No) Time to Be Healthy: Optimal Policy with Time and Monetary Investments in Health**

KLIMAVICIUTE J.

2024

[Health Economics 33\(3\): 410-431.](#)

<https://doi.org/10.1002/heh.4765>

Time is often an important ingredient of a healthy lifestyle. Starting from this observation, this paper studies optimal public policy concerned with promoting healthy choices taking into account both monetary and time investments in health. Individuals tend to underestimate the importance of their health while making decisions, which makes their investments too low compared to the first-best. While the decentralization of the first-best requires personalized subsidies on both time and monetary investments, this may be problematic due to informational issues. In a second-best world where individual productivities and time investments are publicly unobservable, whereas monetary investments are observable in an anonymous way, the paper considers a policy with a non-linear income tax and a linear subsidy on monetary health investments. If there are no incentive concerns, all other things equal, monetary investments complementary (substitutable) to time investments should be subsidized more (less) than

those independent of time use. The addition of incentive concerns demonstrates that optimal subsidization of monetary health investments is less straightforward than one might think. Overall, the time ingredient in the production of health does play a role in the optimal policy design, affecting not only the subsidy on monetary health investments but also the income taxation.

► **Association Between Changes in Prices and Out-Of-Pocket Costs For Brand-Name Clinician-Administered Drugs**

LALANI H. S., *et al.*

2024

Health Services Research n/a(n/a). [Ahead of Pub]

<https://doi.org/10.1111/1475-6773.14279>

Objective To determine whether annual changes in prices for clinician-administered drugs are associated with changes in patient out-of-pocket costs. **Data Sources and Study Setting** National commercial claims database, 2009 to 2018. **Study Design** In a serial, cross-sectional study, we calculated the annual percent change in manufacturer list prices and net prices after rebates. We used two-part generalized linear models to assess the relationship between annual changes in price with (1) the percentage of individuals incurring any out-of-pocket costs and (2) the percent change in median non-zero out-of-pocket costs. **Data Collection/Extraction Methods** We created annual cohorts of privately insured individuals who used one of 52 brand-name clinician-administered drugs. **Principal Findings** List prices increased 4.4%/yr (interquartile range [IQR], 1.1% to 6.0%) and net prices 3.3%/yr (IQR, 0.3% to 5.5%). The median percentage of patients with any out-of-pocket costs increased from 38% in 2009 to 48% in 2018, and median non-zero annual out-of-pocket costs increased by 9.6%/yr (IQR, 4.1% to 15.4%). There was no association between changes in prices and out-of-pocket costs for individual drugs. **Conclusions** From 2009 to 2018, prices and out-of-pocket costs for brand-name clinician-administered drugs increased, but these were not directly related for individual drugs. This may be due to changes to insurance benefit design and private insurer drug reimbursement rates.

► **Public Reporting and Consumer Demand in the Home Health Sector**

LI J.

2024

Medical Care Research and Review 0(0): [Ahead of Pub]

<https://doi.org/10.1177/10775587231221852>

Health care report cards improve information and are a crucial part of health care reform of the federal government of the United States. I exploit a natural experiment in the home health sector to assess whether a higher rating under the star ratings program affects patient choice. Higher rated agencies increased their market share by 1.4% or 0.25 (95% confidence interval: [-0.63, 1.12]) percentage points, a practically and statistically insignificant amount. I find no evidence of heterogeneous effects across the rating distribution or over time. I also find precise null effects among consumers expected to be more responsive, including community-entry patients and patients in competitive markets with more options and star types. Agencies may have modestly impeded consumer choice by engaging in some patient selection behaviors, although the evidence is only weakly suggestive. The star ratings are unlikely to improve home health quality despite continued policymaker interest.

► **Cost-Effectiveness Analysis of Vaccines For COVID-19 According to Sex, Comorbidity and Socioeconomic Status: A Population Study**

MAR J., *et al.*

2024

Pharmacoeconomics 42(2): 219-229.

<https://doi.org/10.1007/s40273-023-01326-y>

Coronavirus disease 2019 (COVID-19) vaccines are extremely effective in preventing severe disease, but their real-world cost effectiveness is still an open question. We present an analysis of the cost-effectiveness and economic impact of the initial phase of the COVID-19 vaccination rollout in the Basque Country, Spain.

► **Universal Health Coverage in the Context of Population Ageing: Catastrophic Health Expenditure and Unmet Need For Healthcare**

OKAMOTO S., *et al.*

2024

Health Economics Review 14(1): 8.

<https://doi.org/10.1186/s13561-023-00475-2>

Universal health coverage means that all people can access essential health services without incurring financial hardship. Even in countries with good service coverage and financial protection, the progress towards universal health coverage may decelerate or be limited with respect to the growing older population. This study investigates the incidence/prevalence, determinants, and consequences of catastrophic health expenditure (CHE) and unmet need for healthcare and assesses the potential heterogeneity between younger (≤ 64 years) and older people (65 years \leq).

► **Systematic Review of the Relative Social Value of Child and Adult Health**

PEASGOOD T., *et al.*

2024

Pharmacoeconomics 42(2): 177-198.

<https://doi.org/10.1007/s40273-023-01327-x>

We aimed to synthesise knowledge on the relative social value of child and adult health. Quantitative and qualitative studies that evaluated the willingness of the public to prioritise treatments for children over adults were included. A search to September 2023 was undertaken. Completeness of reporting was assessed using a checklist derived from Johnston et al. Findings were tabulated by study type (matching/person trade-off, discrete choice experiment, willingness to pay, opinion survey or qualitative). Evidence in favour of children was considered in total, by length or quality of life, methodology and respondent characteristics.

► **The Causal Effect of a Health Treatment on Beliefs, Stated Preferences and Memories**

PRATI A. ET SAUCET C.

2024

Journal of Health Economics: 94: 102864.

<https://doi.org/10.1016/j.jhealeco.2024.102864>

The paper estimates the causal effect of a health treatment on patients' beliefs, preferences and memories about the treatment. It exploits a natural experiment which occurred in the United Kingdom during the COVID-19 vaccination campaign. UK residents could choose to opt into the vaccination program, but not which vaccine they received. The assignment to a vaccine offered little objective information for learning about its qualities, but triggered strong psychological demand for reassuring beliefs. We surveyed a sample of UK residents about their beliefs on the different COVID-19 vaccines before and after receiving their jab. Before vaccination, individuals exhibit similar prior beliefs and stated preferences about the different vaccines. After vaccination, however, they update their beliefs overly optimistically about the safety and effectiveness of the vaccine they received, state that they would have chosen it if they could, and have distorted memories about their past beliefs. These results cannot be explained by conventional experience effects. At the aggregated level, they show that random assignment to a health treatment predicts a polarization of opinions about its quality. At the individual level, these findings provide evidence in line with the predictions of motivated beliefs and over-inference from weak signals in a real-world health setting.

► **Exploring Health Preference Heterogeneity in the UK: Using the Online Elicitation of Personal Utility Functions Approach to Construct EQ-5d-5l Value Functions on Societal, Group and Individual Level**

SCHNEIDER P., *et al.*

2024

Health Economics n/a(n/a).

<https://doi.org/10.1002/heco.4805>

A new method has recently been developed for valuing health states, called 'Online elicitation of Personal Utility Functions' (OPUF). In contrast to established methods, such as time trade-off or discrete choice experiments, OPUF does not require hundreds of

respondents, but allows estimating utility functions for small groups and even at the individual level. In this study, we used OPUF to elicit EQ-5D-5L health state preferences from a (not representative) sample of the UK general population, and then compared utility functions on the societal-, group-, and individual level. A demo version of the survey is available at: <https://eq5d5l.me>. Data from 874 respondents were included in the analysis. For each respondent, we constructed a personal EQ-5D-5L value set. These personal value sets predicted respondents' choices in three hold-out discrete choice tasks with an accuracy of 78%. Overall, preferences varied greatly between individuals. However, PERMANOVA analysis showed that demographic characteristics explained only a small proportion of the variability between subgroups. While OPUF is still under development, it has important strengths: it can be used to construct value sets for patient reported outcome instruments such as EQ-5D-5L, while also allowing examination of underlying preferences in an unprecedented level of detail. In the future, OPUF could be used to complement existing methods, allow-

ing valuation studies in smaller samples, and providing more detailed insights into the heterogeneity of preferences across subgroups.

► **Research Trends in Contemporary Health Economics: A Scientometric Analysis on Collective Content of Specialty Journals**

ZWACK C. C., *et al.*
2024

Health Economics Review 14(1): 6.
<https://doi.org/10.1186/s13561-023-00471-6>

Health economics is a thriving sub-discipline of economics. Applied health economics research is considered essential in the health care sector and is used extensively by public policy makers. For scholars, it is important to understand the history and status of health economics—when it emerged, the rate of research output, trending topics, and its temporal evolution—to ensure clarity and direction when formulating research questions.

Environmental Health

► **Toward a Climate-Ready Health Care System: Institutional Motivators and Workforce Engagement**

DRESSER C., *et al.*
2024

The Milbank Quarterly n/a(n/a).
<https://doi.org/10.1111/1468-0009.12687>

Policy Points The US health care system faces mounting pressure to reduce greenhouse gas emissions and adapt to the impacts of climate change; motivated institutions and an engaged health care workforce are essential to the development, implementation, and maintenance of a climate-ready US health care system. Health care workers have numerous profession-specific and role-specific opportunities to address the causes and impacts of climate change. Policies must address institutional barriers to change and create incentives aligned with climate readiness goals. Institutions and individuals can support climate readiness by integrating content on the health care impli-

cations of climate change into educational curricula.

► **Effects of Socioeconomic Status and Greenspace on Respiratory Emergency Department Visits Under Short-Term Temperature Variations: An Age-Stratified Case Time-Series Study**

LIU S. ET HO H. C.
2024

Social Science & Medicine: 343 :116613.
<https://doi.org/10.1016/j.socscimed.2024.116613>

Introduction Neighborhood socioeconomic status (SES) and greenspace can affect respiratory health. However, it is unclear whether effects of neighborhood SES and greenspace on respiratory health still exist regardless of temperature variations. Methods This paper conducted a two-stage, age-stratified case time-series study. The first goal is to examine the associations between two temperature metrics (daily

mean temperature [DMT] and diurnal temperature range [DTR]) and respiratory emergency department (ED) visits among four age groups in New York City. The second goal is to evaluate whether neighborhood SES and greenspace would be determinants of respiratory ED visits independent from temperature varying factors. A distributed lag nonlinear model was applied on ED data from 135 zip codes (October 2016 - February 2020). Results Our first-stage analysis indicated that older adults aged 65+ had higher risks of ED visit (RR=2.78, 95% eCI: 2.41, 3.22; with 7 days of lag) on days with low DMT (-10°C), followed by adults aged 18-64 (RR=2.48, 95% eCI: 2.32, 2.65), children and youth aged 5-17 (RR=1.38, 95% eCI: 1.24, 1.53), and young children aged 0-4 (RR=1.04, 95% eCI: 0.96, 1.13). However, no excess respiratory ED visits were observed on days with high DMT (30°C). Higher

DTR was associated with higher risks, with children and youth more susceptible when DTR was high (DTR 20°C; RR=5.70, 95% eCI: 3.42, 9.49; with 7 days of lag). The second-stage analysis indicated neighborhood SES and greenspace had significant associations with respiratory ED visits regardless of temperature variations. Specifically, Higher income and greenspace exposure were negatively associated with ED visits among all age groups. Conclusions Neighborhood SES and greenspace could affect respiratory morbidity regardless of weather conditions. Daily temperature variations accelerated the short-term risk among population subgroups under different weather conditions (e.g., higher risk of days with low DMT among older adults, higher risk of days with high DTR among children and youth aged 5-17), which could create co-effects with neighborhood SES and greenspace on respiratory health.

État de santé

Health Status

► Wealth Redistribution to Extend Longevity in the US

HIMMELSTEIN K. E. W., *et al.*

2024

[JAMA Internal Medicine.](#)

<https://doi.org/10.1001/jamainternmed.2023.7975>

The US is unique among wealthy countries in its degree of wealth inequality and its poor health outcomes. Wealth is known to be positively associated with longevity, but little is known about whether wealth redistribution might extend longevity. To examine the association between wealth and longevity and estimate the changes in longevity that could occur with simulated wealth distributions that were perfectly equal, similar to that observed in Japan (among the most equitable of Organisation for Economic Co-operation and Development [OECD] countries), generated by minimum inheritance proposals, and produced by baby bonds proposals. This longitudinal cohort study analyzed the association between wealth and survival among participants in the Health and Retirement Study (1992-2018), a nationally representative panel study of middle-aged and older (≥50 years) community-dwelling, noninstitutionalized US adults. The data analysis was performed between November 15, 2022, and

September 24, 2023. Household wealth on study entry, calculated as the sum of all assets minus the value of debts and classified into deciles. Weibull survival models were used to estimate the association between per-person wealth decile and survival, adjusting for age, sex, marital status, household size, and race and ethnicity. Changes in longevity that might occur under alternative wealth distributions were then estimated. The sample included 35 164 participants (mean [SE] age at study entry, 59.1 [0.1] years; 50.1% female and 49.9% male [weighted]). The hazard of death generally decreased with increasing wealth, wherein participants in the highest wealth decile had a hazard ratio of 0.59 for death (95% CI, 0.53-0.66) compared with those in the lowest decile, corresponding to a 13.5-year difference in survival. A simulated wealth distribution of perfect equality would increase population wide median longevity by 2.2 years (95% CI, 2.2-2.3 years), fully closing the mortality gap between the US and the OECD average. A simulated minimum inheritance proposal would increase population wide median longevity by 1.7 years; a simulated wealth distribution similar to Japan's would increase median longevity by 1.2 years; and a simulated baby bonds proposal would increase population wide median longevity by 1.0 year. findings suggest that wealth inequality in the US is associated

with significant inequities in survival. Wealth redistribution policies may substantially reduce those inequities and increase population longevity.

► **Cancer Burden Among Adolescents and Young Adults in Relation to Childhood Adversity: A Nationwide Life-Course Cohort Study of 1.2 Million Individuals**

ROD N. H., *et al.*

2023

The Lancet Regional Health - Europe 27: 100588.

<https://doi.org/10.1016/j.lanepe.2023.100588>

Summary Background Childhood adversity such as poverty, loss of a parent, and dysfunctional family dynamics may be associated with exposure to environmental and behavioral hazards, interfere with normal biological functions, and affect cancer care and outcomes. To explore this hypothesis, we assessed the cancer burden among young men and women exposed to adversity during childhood. Methods We undertook a population-based study using Danish nationwide register data on childhood adversity and cancer outcomes. Children who were alive and resident in Denmark until their 16th birthday were followed into young adulthood (16–38 years). Group-based multi-trajectory modelling was used to categorize individuals into five distinct groups: low adversity, early material deprivation, persistent material deprivation, loss/threat of loss, and high adversity. We assessed the association with overall cancer incidence, mortality, and five-year case fatality; and cancer specific outcomes for the four most common cancers in this age group in sex-stratified survival analyses. Findings 1,281,334 individuals born between Jan 1, 1980, and Dec 31, 2001, were followed up until Dec 31, 2018, capturing 8229 incident cancer cases and 662 cancer deaths. Compared to low adversity, women who experienced persistent material deprivation carried a slightly lower risk of overall cancer (hazard ratio (HR) 0.90; 95% CI 0.82; 0.99), particularly due to malignant melanoma and brain and central nervous system cancers, while women who experienced high adversity carried a higher risk of breast cancer (HR 1.71; 95% CI 1.09; 2.70) and cervical cancer incidence (HR 1.82; 95% CI 1.18; 2.83). While there was no clear association between childhood adversity and cancer incidence in men, those men who had experienced persistent material deprivation (HR 1.72; 95% CI 1.29; 2.31) or high adversity (HR 2.27; 95% CI 1.38; 3.72) carried a disproportionate burden of cancer mortality during adolescence or young adulthood compared to men

in the low adversity group. Interpretation Childhood adversity is associated with a lower risk of some subtypes of cancer and a higher risk of others, particular in women. Persistent deprivation and adversity are also associated with a higher risk of adverse cancer outcomes for men. These findings may relate to a combination of biological susceptibility, health behaviors and treatment-related factors. Funding None.

► **The Direct and Spillover Effects of Diabetes Diagnosis on Lifestyle Behaviours**

THOMAS R. L. ET MENTZAKIS E.

2024

Health Economics n/a(n/a).

<https://doi.org/10.1002/hec.4803>

Using blood sample data we exploit an arbitrary cut-off of diabetes risk and through a fuzzy regression kink design we estimate the effect of a diabetes diagnosis on own and partner health-related behaviours. Diabetes diagnosis increases the probability of exercising, both for those diagnosed with diabetes and their partner. We also conduct mediation analysis which suggests that joint household participation is the channel behind this effect. Our results have significant implications for the understanding of the channels that induce behavioural change, and household decision making, as well as, for the evaluation of diabetes related policies.

► **Neighborhoods and Health: Interventions at the Neighborhood Level Could Help Advance Health Equity**

ARCAYA M. C., *et al.*

2024

Health Affairs 43(2): 156-163.

<https://doi.org/10.1377/hlthaff.2023.01037>

Housing is tied to neighborhoods. Therefore, to understand how housing affects health and health equity, the role of neighborhood environments must be considered. This article is a critical review of the relationship between neighborhoods and health. We discuss inequality among US neighborhoods and the roots of that inequality. We then explore the ways in which neighborhood environments may shape health, review the evidence about these effects, and discuss policy responses. Many studies document an association between neighborhoods and physical and mental health, and a few studies suggest that some of these relationships are causal. Thus, the evidence suggests that interventions at the neighborhood scale can potentially help advance health equity. Further research on the long-term impacts of neighborhoods on health and more rigorous studies of the impact of particular neighborhood interventions are needed. To advance health equity, policy makers also need to better understand the institutional arrangements and social policies that have created neighborhood inequality and pursue innovative approaches to changing them.

► **Determinants of Disparities of Diabetes-Related Hospitalization Rates in Florida: A Retrospective Ecological Study Using a Multiscale Geographically Weighted Regression Approach**

LORD J. ET ODOI A.

2024

International Journal of Health Geographics 23(1): 1.

<https://doi.org/10.1186/s12942-023-00360-5>

Early diagnosis, control of blood glucose levels and cardiovascular risk factors, and regular screening are essential to prevent or delay complications of diabetes. However, most adults with diabetes do not meet recommended targets, and some populations have disproportionately high rates of potentially preventable diabetes-related hospitalizations. Understanding the factors that contribute to geographic disparities can guide resource allocation and help ensure that future interventions are designed to meet the specific needs of these communities. Therefore, the objectives of this study were (1) to identify determinants of diabetes-related hospitalization rates at the ZIP code tabulation area (ZCTA) level in Florida, and (2) assess if the strengths of these relationships vary by geographic location and at different spatial scales.

Disability

► **Health Care Management Adequacy Among French Persons with Severe Profound Intellectual and Multiple Disabilities: A Longitudinal Study**

BAUMSTARCK K., *et al.*

2024

BMC Health Services Research 24(1): 99.

<https://doi.org/10.1186/s12913-024-10552-9>

The care organization of persons with profound intellectual and multiple disabilities (PIMD) varies by country according to the health care system. This study used a large sample of French individuals with severe PIMD/polyhandicap to assess: 1) the adequacy of care setting over a 5-year period and 2) health care consumption.

► **A Comparison of Factors Associated with Unmet Healthcare Needs in People with Disabilities Before and After COVID-19: A Nationally Representative Population-Based Study**

LEE S., *et al.*

2024

BMC Health Services Research 24(1): 134.

<https://doi.org/10.1186/s12913-024-10579-y>

People with disabilities, who require numerous healthcare services, are vulnerable to unmet healthcare needs. This study aimed to investigate and identify the factors that influence unmet healthcare needs among people with disabilities and to compare these factors before and after the COVID-19 pandemic in South Korea.

► **The Association of Disability Conditions with Access to Minimally Invasive General Surgery**

RAFAQAT W., *et al.*

2024

Disability and Health Journal: 101586.

<https://doi.org/10.1016/j.dhjo.2024.101586>

Background Despite the high prevalence of disability conditions in the US, their association with access to minimally invasive surgery (MIS) remains under-char-

acterized. Objective To understand the association of disability conditions with rates of MIS and describe nationwide temporal trends in MIS in patients with disability conditions. Methods We conducted a retrospective cohort study using the Nationwide Readmission Database (2016–2019). We included patients ≥ 18 years undergoing general surgery procedures. Our primary outcome was the impact of disability conditions on the rate of MIS. We performed 1:1 propensity matching, comparing patients with disability conditions with those without and adjusting for patient, procedure, and hospital characteristics. We performed a subgroup analysis among patients < 65 years and with patients with each type of disability. We evaluated temporal trends of MIS in patients with disabilities. We identified predictors of undergoing MIS using mixed effects regression analysis. Results In the propensity-matched comparison, a lower proportion of patients with disabilities had MIS. In the sub-group analyses, the rate of MIS was significantly lower in patients below 65 years with disabilities and among patients with motor and intellectual impairments. There was an increasing trend in the proportion of patients with disabilities undergoing MIS ($p < 0.005$). The regression analysis confirmed that the presence of a disability was associated with decreased odds of undergoing MIS. Conclusions This study characterizes the negative association of disability conditions with access to MIS. As the healthcare landscape evolves, considerations on how to equitably share new treatment modalities with a wide range of patient populations are necessary.

► **Medicare, Medicaid, and Dual Enrollment For Adults with Intellectual and Developmental Disabilities**

RUBENSTEIN E., *et al.*

2024

Health Services Research 1-10

<https://doi.org/10.1016/j.dhjo.2024.101586>

Objective Given high rates of un- and underemployment among disabled people, adults with intellectual and developmental disabilities rely on Medicaid, Medicare, or both to pay for healthcare. Many disabled adults are Medicare eligible before the age of 65 but little is known as to why some receive Medicare ser-

vices while others do not. We described the duration of Medicare enrollment for adults with intellectual and developmental disabilities in 2019 and then compared demographics by enrollment type (Medicare-only, Medicaid-only, dual-enrolled). Additionally, we examined the percent in each enrollment type by state, and differences in enrollment type for those with Down syndrome. Data Sources and Study Setting 2019 Medicare and Medicaid claims data for all adults (≥ 18 years) in the US with claim codes for intellectual disability, Down syndrome, or autism at any time between 2011 and 2019. Study Design Administrative claims cohort. Data Collection and Abstraction Methods Data were from the Transformed Medicaid Statistical Information System Analytic Files and Medicare Beneficiary Summary files. Principle Findings In 2019, Medicare

insured 582,868 adults with identified intellectual disability, autism, or Down syndrome. Of 582,868 Medicare beneficiaries, 149,172 were Medicare only and 433,396 were dual-enrolled. Most Medicare enrollees were enrolled as child dependents (61.5%) Medicaid-only enrollees ($N = 819,256$) were less likely to be white non-Hispanic (58.5% white non-Hispanic vs. 72.9% white non-Hispanic in dual-enrolled), more likely to be Hispanic (19.6% Hispanic vs. 9.2% Hispanic in dual-enrolled) and were younger (mean 34.2 years vs. 50.5 years dual-enrolled). Conclusion There is heterogeneity in public insurance enrollment which is associated with state and disability type. Action is needed to ensure all are insured in the program that works for their healthcare needs.

Hôpital

Hospital

► **Separating the Wheat From the Chaff: How to Measure Hospital Quality in Routine Data?**

BILGER J., *et al.*
2024

Health Services Research 1-10.
<https://doi.org/10.1111/1475-6773.14282>

Objective To measure hospital quality based on routine data available in many health care systems including the United States, Germany, the United Kingdom, Scandinavia, and Switzerland. **Data Sources and Study Setting** We use the Swiss Medical Statistics of Hospitals, an administrative hospital dataset of all inpatient stays in acute care hospitals in Switzerland for the years 2017–2019. **Study Design** We study hospital quality based on quality indicators used by leading agencies in five countries (the United States, the United Kingdom, Germany, Austria, and Switzerland) for two high-volume elective procedures: inguinal hernia repair and hip replacement surgery. We assess how least absolute shrinkage and selection operator (LASSO), a supervised machine learning technique for variable selection, and Mundlak corrections that account for unobserved heterogeneity between hospitals can be used to improve risk adjustment and correct for imbalances in patient risks across hospitals. **Data Collection/Extraction**

Methods The Swiss Federal Statistical Office collects annual data on all acute care inpatient stays including basic socio-demographic patient attributes and case-level diagnosis and procedure codes. **Principal Findings** We find that LASSO-selected and Mundlak-corrected hospital random effects logit models outperform common practice logistic regression models used for risk adjustment. Besides the more favorable statistical properties, they have superior in- and out-of-sample explanatory power. Moreover, we find that Mundlak-corrected logits and the more complex LASSO-selected models identify the same hospitals as high or low-quality offering public health authorities a valuable alternative to standard logistic regression models. Our analysis shows that hospitals vary considerably in the quality they provide to patients. **Conclusion** We find that routine hospital data can be used to measure clinically relevant quality indicators that help patients make informed hospital choices.

► **Hospital Outpatient Department Billing Is a Poor Indicator of Primary Care Practice Integration with Hospital Systems**

CHATRATH S., *et al.*

2024

Health Services Research n/a(n/a).

<https://doi.org/10.1111/1475-6773.14284>

Objective To test the reliability of Medicare claims in measuring vertical integration. We assess the accuracy of a commonly used measure of integration, primary care physician (PCP) practices billing Medicare as a hospital outpatient department (HOPD) in claims. **Data Sources and Study Setting** Medicare fee-for-service claims, IQVIA, and CPC+ practice surveys for this study. **Study Design** We compare measures of integration from Medicare claims to self-reported indicators of integration from IQVIA and a survey of CPC+ participating practice sites. **Data Collection/Extraction Methods** We measure integration by using site-of-service billing in the 100% sample of Medicare Carrier claims from 2017-2020. In the IQVIA SK SK this gap persists in 2018-2019. **Conclusion** Measuring physician-hospital vertical integration accurately is integral to determining consolidation. The overwhelming majority of PCP practice sites not billing as an HOPD may reflect Medicare regulatory changes that have reduced the financial incentives for doing so. These findings have implications for researchers that study the growth in PCP-hospital integration in health care markets.

► **Does the Opening of an Emergency Department Influence Hospital Admissions? Evidence From French Private Hospitals**

DORMONT B. ET DOTTIN A.

2024

Social Science & Medicine 340: 116380.

<https://doi.org/10.1016/j.socscimed.2023.116380>

Although operating an emergency department (ED) can influence general admission activity of hospitals, most articles that analyze hospital care ignore the potential spillover of emergency activity. In this paper, we examine the consequences of a French reform that encouraged the creation of EDs within private-for-profit (PFP) hospitals in order to decrease congestion in EDs. We use administrative panel data on 365 French PFP hospitals observed between 2002 and 2012. Specifications including hospital fixed-effects are estimated to examine the impact of an ED opening on

private hospitals' admission activity, namely inpatient and day-care admissions (ED visits are excluded, but patients admitted following an ED visit are included). We control for shocks that can impact demand for care in hospitals, and we estimate yearly changes before and after the opening. We find that an ED opening is followed by an increase in the number and proportion of inpatient admissions, and by an increase in the length of inpatient stays. A transitory increase in the bed occupancy rate is also observed. In many countries, public and private hospitals compete to some extent. The former provide a public service, while the latter are profit-maximizers that are allowed to specialize in profitable activities. They generally focus on day-care admissions. We provide empirical evidence that private hospitals experience a significant change in the composition of their admissions when they start providing emergency care. Opening an ED creates a new non-selective entryway to private hospitals, resulting in admissions of inpatients with health problems that are more severe. Hence, involving PFP hospitals in the provision of emergency care is likely to make the structure of admissions of private hospitals closer to that of public hospitals.

► **Facteurs organisationnels et États émergents : étude de la collaboration interprofessionnelle hospitalière**

ECKENSCHWILLER M., *et al.*

2023

Journal de gestion et d'économie de la santé 2(2): 98-113.

<https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2023-2-page-98.htm>

Le domaine hospitalier français subit de nombreuses évolutions (financières, structurelles, organisationnelles, humaines, etc.) et ses acteurs doivent déployer de grandes capacités d'adaptation pour faire face aux défis d'aujourd'hui et de demain. La collaboration interprofessionnelle (CIP) est un levier majeur pour répondre aux difficultés que rencontrent les hôpitaux mais les mécanismes de sa mise en œuvre sont encore flous. Après avoir précisé l'intérêt de la collaboration interprofessionnelle au sein des hôpitaux (concernant 3 niveaux, ceux des patients, des professionnels et de l'organisation), nous proposons dans cet article, fondé sur une recension des écrits, de répondre aux objectifs suivants : clarifier la notion d'état émergent et identifier les principaux états émergents de la collaboration interprofessionnelle (la confiance, la cohésion, la

reconnaissance mutuelle, la volonté à collaborer et le leadership); identifier les facteurs organisationnels propres aux hôpitaux en interaction avec ces états émergents dans le secteur hospitalier; comprendre les effets de ces interactions. Cette étude nous permet ainsi de mettre en perspective de nombreuses interactions entre l'organisation et les facteurs émergents mais aussi d'éclairer cette émergence compte-tenu des spécificités du secteur de la santé. Les liens identifiés sont nombreux, leur enchevêtrement et les interactions sont complexes. La contextualisation de l'analyse au secteur hospitalier fait quant à elle apparaître des questionnements spécifiques à ce domaine. Le travail de recherche pourra ensuite s'orienter, à travers une étude complémentaire, vers une mise en perspective de l'analyse de la littérature avec des éléments d'enquête empirique.

► **Impacts of Norway's Extended Free Choice Reform on Waiting Times and Hospital Visits**

GE G., *et al.*

2024

[Health Economics n/a\(n/a\).](#)

<https://doi.org/10.1002/he.4801>

Norway's extended free choice (EFC) reform extends the patient's choice of publicly funded hospitals for treatment to authorized private institutions (EFC providers). We study the effects of the reform on waiting times, number of visits, and patients' Charlson Comorbidity Index scores in public hospitals. We use a difference-in-differences model to compare changes over time for public hospitals with and without EFC providers in the catchment area. Focusing on five prevalent somatic services, we find that the EFC reform did not exert pressure on public hospitals to stimulate shorter waiting times and more visits. Moreover, we do not find that the sum of public and private visits increased. When we compare patient comorbidity between public hospitals and EFC providers, we find that for non-invasive diagnostic services, patient comorbidity is lower in EFC providers. For surgical services, we detect no difference in patient comorbidities between public and EFC providers.

► **How Do Hospitals Respond to Payment Unbundling For Diagnostic Imaging of Suspected Cancer Patients?**

HAYES H., *et al.*

2024

[Health Economics n/a\(n/a\).](#)

<https://doi.org/10.1002/he.4804>

Payments for some diagnostic scans undertaken in outpatient settings were unbundled from Diagnosis Related Group based payments in England in April 2013 to address under-provision. Unbundled scans attracted additional payments of between £45 and £748 directly following the reform. We examined the effect on utilization of these scans for patients with suspected cancer. We also explored whether any detected effects represented real increases in use of scans or better coding of activity. We applied difference-in-differences regression to patient-level data from Hospital Episodes Statistics for 180 NHS hospital Trusts in England, between April 2010 and March 2018. We also explored heterogeneity in recorded use of scans before and after the unbundling at hospital Trust-level. Use of scans increased by 0.137 scans per patient following unbundling, a 134% relative increase. This increased annual national provider payments by £79.2 million. Over 15% of scans recorded after the unbundling were at providers that previously recorded no scans, suggesting some of the observed increase in activity reflected previous under-coding. Hospitals recorded substantial increases in diagnostic imaging for suspected cancer in response to payment unbundling. Results suggest that the reform also encouraged improvements in recording, so the real increase in testing is likely lower than detected.

► **Racial and Ethnic Disparities in Emergency Department Transfers to Public Hospitals**

HSUAN C., *et al.*

2024

[Health Services Research n/a\(n/a\).](#)

<https://doi.org/10.1111/1475-6773.14276>

Objective To examine racial/ethnic differences in emergency department (ED) transfers to public hospitals and factors explaining these differences. Data Sources and Study Setting ED and inpatient data from the Healthcare Cost and Utilization Project for Florida (2010–2019); American Hospital Association Annual Survey (2009–2018). Study Design Logistic regression

examined race/ethnicity and payer on the likelihood of transfer to a public hospital among transferred ED patients. The base model was controlled for patient and hospital characteristics and year fixed effects. Models II and III added urbanicity and hospital referral region (HRR), respectively. Model IV used hospital fixed effects, which compares patients within the same hospital. Models V and VI stratified Model IV by payer and condition, respectively. Conditions were classified as emergency care sensitive conditions (ECSCs), where transfer is protocolized, and non-ECSCs. We reported marginal effects at the means. Data Collection/Extraction Methods We examined 1,265,588 adult ED patients transferred from 187 hospitals. Principal Findings Black patients were more likely to be transferred to public hospitals compared with White patients in all models except ECSC patients within the same initial hospital (except trauma). Black patients were 0.5–1.3 percentage points (pp) more likely to be transferred to public hospitals than White patients in the same hospital with the same payer. In the base model, Hispanic patients were more likely to be transferred to public hospitals compared with White patients, but this difference reversed after controlling for HRR. Hispanic patients were –0.6 pp to –1.2 pp less likely to be transferred to public hospitals than White patients in the same hospital with the same payer. Conclusions Large population-level differences in whether ED patients of different races/ethnicities were transferred to public hospitals were largely explained by hospital market and the initial hospital, suggesting that they may play a larger role in explaining differences in transfer to public hospitals, compared with other external factors.

► **Urgence et tri des malades. La production de files d'attente socialement stratifiées pour l'accès aux soins d'urgence**

MOREL S.

2023

Actes de la recherche en sciences sociales 250(5): 100-117.

<https://www.cairn.info/revue-actes-de-la-recherche-en-sciences-sociales-2023-5-page-100.htm>

La littérature sociologique consacrée à l'hôpital, et plus particulièrement aux services d'urgences, a depuis longtemps documenté l'existence d'un tri des patient-es, qui a pour fonction de les faire attendre ou non, en vue de les inclure vers la filière de soins appropriée à leur état. À partir d'une relecture de journaux de terrain au prisme d'une sociologie politique de

l'attente, nous proposons ici d'appréhender les filières de soins comme autant de files d'attente pour l'accès aux soins d'urgence, mais également de penser le tri comme un dispositif de gouvernement de/par l'attente. Nous montrerons ainsi que ce dispositif produit des files d'attente différentes et socialement stratifiées ayant chacune sa politique du tri dont les contours se définissent dans sa relation avec les autres. Une statistique « armée » par l'ethnographie révèle que les disparités repérées sont le signe d'une qualité de soin variée selon les files d'attente, celle-ci étant appréciée à l'aune du temps d'attente. Sa mesure ethnographique permet de dévoiler in fine l'existence d'un accès aux soins d'urgence à plusieurs « vitesses sociales ».

► **Differential Impact of Hospital and Community Factors on Breadth and Depth of Hospital Population Health Partnerships**

PURO N., *et al.*

2024

Health Services Research 59(S1): e14238.

<https://doi.org/10.1111/1475-6773.14238>

Objective The aim was to identify hospital and county characteristics associated with variation in breadth and depth of hospital partnerships with a broad range of organizations to improve population health. Data Sources The American Hospital Association Annual Survey provided data on hospital partnerships to improve population health for the years 2017–2019. Design The study adopts the dimensional publicness theory and social capital framework to examine hospital and county characteristics that facilitate hospital population health partnerships. The two dependent variables were number of local community organizations that hospitals partner with (breadth) and level of engagement with the partners (depth) to improve population health. The independent variables include three dimensions of publicness: Regulative, Normative and Cultural-cognitive measured by various hospital factors and presence of social capital present at county level. Covariates in the multivariate analysis included hospital factors such as bed-size and system membership. Methods We used hierarchical linear regression models to assess various hospital and county factors associated with breadth and depth of hospital-community partnerships, adjusting for covariates. Principal Findings Nonprofit and public hospitals provided a greater breadth (coefficient, 1.61; SE, 0.11; $p < 0.001$ and coefficient, 0.95; SE, 0.14; $p < 0.001$) and

depth (coefficient, 0.26, SE, 0.04; $p < 0.001$ & coefficient, 0.13; SE, 0.05; $p < 0.05$) of partnerships than their for-profit counterparts, partially supporting regulative dimension of publicness. At a county level, we found community social capital positively associated with breadth of partnerships (coefficient, 0.13; SE, 0.08; $p < 0.001$). Conclusions An environment that promotes collaboration between hospitals and organizations

to improve population health may impact the health of the community by identifying health needs of the community, targeting social determinants of health, or by addressing patient social needs. However, findings suggest that publicness dimensions at an organizational level, which involves a culture of public value, maybe more important than county factors to achieve community building through partnerships.

Inégalités de santé

Health inequalities

► **Socioeconomic Disparities in Mammography Screening in the United States From 2012 to 2020**

ANDO M., *et al.*

2024

Social Science & Medicine 340: 116443.

<https://doi.org/10.1016/j.socscimed.2023.116443>

The potential impact of the COVID-19 pandemic on socioeconomic disparities in mammography uptake remain poorly understood. We used repeated cross-sectional data from the 2012, 2014, 2016, 2018, and 2020 waves of the Behavioral Risk Factor Surveillance System, focusing on the U.S. women aged 50–74 years and investigated the relationships of educational attainment, employment status, and household income with a missed mammogram in the past two years. We ran Poisson regression analyses accounting for survey weights. The sample numbers were 139,761 in 2012, 137,916 in 2014, 140,000 in 2016, 116,756 in 2018, and 102,774 in 2020, respectively. Women with the lower educational attainment and lower household incomes reported higher proportions of missed mammography screening. Self-employed women were most likely to miss a mammogram. Accounting for other covariates, there was an increase in the adjusted prevalence ratio (PR) of missed mammography from 2018 to 2020 (pre-pandemic versus post pandemic onset) for self-employed women compared to women in waged work. Non-Hispanic Black women who were self-employed (PR = 0.28, 95% CI: 0.16, 0.51) and employed for wages (PR = 0.58, 95% CI: 0.47, 0.73) were at lower risks of missing a mammogram compared to non-Hispanic White women in the same categories. The findings suggest that disparities for mammography uptake wid-

ened after the pandemic onset, especially for employment status, which varied by race/ethnicity.

► **Effects of Education on Adult Mortality: A Global Systematic Review and Meta-Analysis**

BALAJ M., *et al.*

2024

The Lancet Public Health.

[https://doi.org/10.1016/S2468-2667\(23\)00306-7](https://doi.org/10.1016/S2468-2667(23)00306-7)

The positive effect of education on reducing all-cause adult mortality is known; however, the relative magnitude of this effect has not been systematically quantified. The aim of our study was to estimate the reduction in all-cause adult mortality associated with each year of schooling at a global level.

► **Les déterminants du renoncement aux soins pour raisons financières en France : une revue systématique**

BLANCO-CAZEAUX I.

2023

Journal de Gestion et d'Économie de la santé 2(2): 132-153.

<https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2023-2-page-132.htm>

Afin d'étudier les inégalités d'accès aux soins, la littérature internationale utilise souvent la notion d'unmet healthcare needs tandis que les travaux français reposent sur celle de renoncement aux soins, et particulièrement sur ses raisons financières. Il apparaît

intéressant de dresser un bilan sur les déterminants du renoncement aux soins pour raisons financières (RSRF) afin d'identifier les populations les plus vulnérables. Pour remplir cet objectif, l'article opère une revue systématique selon les critères définis par la méthode PRISMA 2020. Quatre moteurs de recherche ont été interrogés : Pubmed, Scopus, Cairn et Google Scholar. Les différents moteurs de recherche ont permis d'identifier 544 publications. Après le processus de sélection, 20 articles constituent le corpus final de la revue systématique. Il apparaît que le RSRF est impacté par des facteurs à la fois économiques (revenu, précarité, exposition au reste à charge...) mais également non-économiques (caractéristiques sociales, démographiques et sanitaires). La littérature sur les déterminants du RSRF en France est relativement riche et parvient à définir un consensus scientifique sur un certain nombre de caractéristiques surexposant au RSRF. Celle-ci pourrait néanmoins être améliorée par des études prenant en compte davantage de dimensions de l'accès aux soins et en ajoutant une composante temporelle afin d'améliorer les estimations.

► **Unmet Needs and the Effect of Healthcare System Generosity on Prevention Activity – a Multilevel Analysis**

BRAMMLI-GREENBERG S. ET HOVAV B.

2024

Social Science & Medicine 340: 116473.

<https://doi.org/10.1016/j.socscimed.2023.116473>

Introduction Maintaining a healthy lifestyle and obtaining preventive care (hereafter, prevention-activity) usually have an inverse association with poverty status and unmet needs. We seek to estimate the extent to which the effect of individual unmet needs status on prevention-activity is moderated by the generosity of the healthcare system. **Materials and methods** Two datasets were combined: Pre-Covid Wave-8 (2019–2020) of the Survey of Health, Ageing and Retirement in Europe (SHARE, Release 8.0.0), with 46,500 individuals aged 50+ from 27 countries (26 European countries and Israel) and 12 healthcare generosity variables obtained from the OECD Health Statistics Library. An econometric two-level model was used in three sequentially models. **Outcome variables** included five prevention-activities align over a continuum (sports, smoking, flu vaccinations, mammography, and colon cancer screening) and unmet needs status, defined as the lack of resources necessary to meet basic human and medical needs. **Results** We found that unmet needs

at the individual level had a significant negative fixed effect in all of the prevention-activity models including a healthy lifestyle, primary prevention and secondary prevention. Sources of intra-country variation were social/public insurance, health expenditure and number of nurses, which have had a significant and positive effect on an individual's prevention-activities (except years of smoking). Nonetheless, the gaps in generous countries between people reporting on unmet need and others were larger or similar to those in less generous countries, suggesting that disparities increase with the generosity of the health system. **Conclusions** The study provides insight into the effect of health system generosity on socioeconomic inequalities in healthy lifestyle and prevention care. Our findings suggest that the state has an important and decisive role to play in ensuring that prevention services are accessible to the entire population, particularly those reporting unmet needs.

► **Exploring How Health Equity Is Addressed in Accountable Communities Of/For Health (ACHs)**

BULTEMA S., *et al.*

2024

Health Services Research 59(S1): e14258.

<https://doi.org/10.1111/1475-6773.14258>

Objective To explore how Accountable Communities of/for Health (ACHs), a type of health-focused multisector collaborative, are developing strategies to address health equity with diverse partners. **Data Sources and Study Setting** Interview and focus group participants were recruited from a purposive sample of 22 ACH participant organizations in Washington (n = 9 ACHs) and California (n = 13 ACH). **Study Design** Interview and focus group data were thematized using constant comparison analysis. **Data Collection** Interviews were conducted to learn how each ACH's system context, collaboration processes, and goals influence its progress toward health equity. **Focus groups** were conducted to gain a deeper understanding of how local context and power dynamics influence an ACH's ability to make progress toward health equity. There were 22 focus group participants and 65 interview participants. **Principal Findings** Results indicate that ACHs advance health equity across the social-ecological spectrum of health with approaches targeting the individual, community, and societal levels. **Specific approaches** used by ACHs to collaboratively address health equity include providing equity education to

participating organizations and community groups; including diverse community voices in collaborative decision-making; changing practices in their participant's daily operations; improving existing services and developing new services; and actively promoting a culture of keeping equity at the center of ACH efforts. Conclusions This study identifies strategies for advancing health equity in multisector collaboratives. ACHs in Washington and California are devoting resources to ensure health equity is central to their work. The numerous approaches ACHs use to advance health equity are important to ensure everyone can reach their full health potential. While current literature argues that multisector health initiatives are integral for advancing health equity, there is a lack of research on how these initiatives advance equity in practice. Thus, this paper provides generalizable strategies that can be further investigated to optimize progress toward health equity.

► **The Influence of Parents' and Partner's Education on Own Health Behaviours**

CHEN G., *et al.*

2024

Social Science & Medicine 343: 116581.

<https://doi.org/10.1016/j.socscimed.2024.116581>

The link between educational attainment and multiple health behaviours has been explained in various ways. This paper provides new insights into the social patterning in health behaviours by investigating the influence of parents' and partners' educational attainments on a composite indicator that integrates the four commonly studied lifestyle behaviours (smoking, alcohol, physical activity and BMI). Two key outcome indicators of interests were created to reflect both ends of the "healthy – unhealthy spectrum". Data was drawn from The Tromsø Study, conducted in 2015/16 (N = 21,083, aged 40–93 years). We controlled for two indicators of early life human capital and one personality trait variable. Partners' education attainments are relatively more important for avoiding unhealthy behaviour than choosing healthy behaviour; on the contrary, parents' education is more important for healthy behaviour. Heterogeneity by sex and age was also evident. The influences of partner's education on widening the socioeconomic contrasts in health behaviours were much stronger in the younger (40–59 years) age group. In conclusion, our results support the hypothesis that own health behaviour is affected by the educational attainments of our 'nearest and dearest' (i.e. spouse,

mother, and father), net of own education. This study facilitates a better understanding of education-health behaviours nexus from a life course perspective and supports the importance of family-based interventions to improve healthy behaviours.

► **How, When, and Why Is Social Class Linked to Mental Health and Wellbeing? A Systematic Meta-Review**

DOUGALL I., *et al.*

2024

Social Science & Medicine 343: 116542.

<https://doi.org/10.1016/j.socscimed.2023.116542>

Rationale Meta-reviews synthesising research on social class and mental health and wellbeing are currently limited and focused on specific facets of social class (e.g., social capital) or mental health and wellbeing (e.g., mental health disorders), and none sought to identify mechanisms in this relationship. Objectives The present meta-review sought to (1) assess the overall relationship between social class and mental health and wellbeing, (2) determine the mechanisms that act in this relationship, and (3) evaluate the strength of evidence available. Methods The protocol was prospectively registered on PROSPERO (CRD42021214731). We systematically searched twelve databases in September 2022 and identified 149 eligible reviews from 38,257 records screened. Quality of evidence was assessed with the JBI levels of evidence and risk of bias with the ROBIS tool. Results A large but low-quality evidence base points to class-based inequalities in mental health and wellbeing, with the strongest available evidence linking lower social positions to an increased risk of depression. In terms of different facets of stratification, the best available evidence suggests that deprivation (e.g., poverty), socioeconomic status, income, and subjective social status are consequential for individuals' mental health and wellbeing. However, high-quality evidence for the roles of education, occupation, other economic resources (e.g., wealth), and social capital is currently limited. Most reviews employed individual-level measures (e.g., income), as opposed to interpersonal- (e.g., social capital) or community-level (e.g., neighbourhood deprivation) measures. Considering mechanisms, we found some evidence for mediation via subjective social status, sense of control, and experiences of stress and trauma. There was also some evidence that higher socioeconomic status can provide a buffer for neighbourhood deprivation, lower social capital, and lower

subjective social status. Conclusions Future research employing experimental or quasi-experimental methods, and systematic reviews with a low risk of bias, are necessary to advance this area of research.

► **Application of Life Course Trajectory Methods to Public Health Data: A Comparison of Sequence Analysis and Group-Based Multi-Trajectory Modeling For Modelling Childhood Adversity Trajectories**

ELSENBURG L. K., *et al.*

2024

Social Science & Medicine 340: 116449.

<https://doi.org/10.1016/j.socscimed.2023.116449>

There is increasing awareness of the importance of modelling life course trajectories to unravel how social, economic and health factors relate to health over time. Different methods have been developed and applied in public health to classify individuals into groups based on characteristics of their life course. However, the application and results of different methods are rarely compared. We compared the application and results of two methods to classify life course trajectories of individuals, i.e. sequence analysis and group-based multi-trajectory modeling (GBTM), using public health data. We used high-resolution Danish nationwide register data on 926,160 individuals born between 1987 and 2001, including information on the yearly occurrence of 7 childhood adversities in 2 dimensions (i.e. family poverty and family dynamics). We constructed childhood adversity trajectories from 0 to 15 years by applying (1) sequence analysis using optimal matching and cluster analysis using Ward's method and (2) GBTM using logistic and zero-inflated Poisson regressions. We identified 2 to 8 cluster solutions using both methods and determined the optimal solution for both methods. Both methods generated a low adversity, a poverty, and a consistent or high adversity cluster. The 5-cluster solution using sequence analysis additionally included a household psychiatric illness and a late adversity cluster. The 4-group solution using GBTM additionally included a moderate adversity cluster. Compared with the solution obtained through sequence analysis, the solution obtained through GBTM contained fewer individuals in the low adversity cluster and more in the other clusters. We find that the two methods generate qualitatively similar solutions, but the quantitative distributions of children over the groups are different. The method of choice depends on the type of data availa-

ble and the research question of interest. We provide a comprehensive overview of important considerations and benefits and drawbacks of both methods.

► **The Effects of Education on Mortality: Evidence Using College Expansions**

FLETCHER J. ET NOGHANIBEHAMBARI H.

2024

Health Economics 33(3): 541-575.

<https://doi.org/10.1002/hec.4787>

This paper explores the long-run health benefits of education for longevity. Using mortality data from the Social Security Administration (1988–2005) linked to geographic locations in the 1940-census data, we exploit changes in college availability across cohorts in local areas. Our treatment on the treated calculations suggest increases in longevity between 1.3 and 2.7 years. Some further analyses suggest the results are not driven by pre-trends, endogenous migration, and other time-varying local confounders. This paper adds to the literature on the health and social benefits of education.

► **Mortal Systemic Exclusion Yielded Steep Mortality-Rate Increases in People Experiencing Homelessness, 2011–20**

FOWLE M. Z. ET ROUTHIER G.

2024

Health Affairs 43(2): 226-233.

<https://doi.org/10.1377/hlthaff.2023.01039>

The number and percentage of people in the US dying while homeless has increased in recent years. However, information about the causes of death most prevalent among this population, and about how cause-specific mortality rates may be shifting over time, has been limited to locally specific data. Using a unique data set of 22,143 homeless decedents in twenty-two localities across ten states and Washington, D.C., from the period 2011–2020, we found large increases in all-cause and cause-specific homeless mortality rates. The largest increases in cause-specific homeless mortality rates in the ten-year period were for deaths related to drug and alcohol overdose, diabetes, infection, cancer, homicide, and traffic injury. We discuss implications of these results and posit that people experiencing homelessness are systematically excluded from the life-affirming institutions of housing and health care, in an example of mortal systemic exclusion. The find-

ings have important implications for existing local and federal policy approaches to homelessness.

► **Investigating Health Services For Sexual and Gender Minorities in France: A Qualitative Study Protocol**

GIRARD G., *et al.*

2023

BMJ Open 13(4): e068716.

<https://doi.org/10.1136/bmjopen-2022-068716>

Introduction Discrimination and structural violence experienced by sexual and gender minorities are the source of social inequalities in health. The last decade has been marked by major developments in the provision of sexual health services for these minorities in France. This paper presents the research protocol of the Services for Minorities-Lesbian Gays Bisexuals Transgender Intersex+ (SeSAM- LGBTI+) study, which aims to document the health, social and professional challenges in the organisation of current health services for sexual and gender minorities in France. Methods and analysis The SeSAM- LGBTI+ study relies on a multidisciplinary qualitative study. It has two objectives : (1) to analyse the history of the development of LGBTI+ health services in France, through interviews with key informants and rights activists and through a study of archives and (2) to study the functioning and challenges of a sample of health services currently offered to LGBTI+ people in France, through a multiple case study, using a multilevel and multisited ethnography. The study will rely on approximately 100 interviews. The analysis will be based on an inductive and iterative approach, combining socio-historical data and the cross-sectional analysis of the case studies. Ethics and dissemination The study protocol has undergone a peer review by the Institut de Recherche En santé Publique's scientific committee and has been approved by the research ethical committee of Aix-Marseille University (registration number : 2022-05-12-010). The project has received funding from December 2021 to November 2024. The results of the research will be disseminated from 2023 onwards to researchers, health professionals and community health organisations.

► **Two Generations Later: New Evidence on Health Equalisation in Youth**

KLOCKE A. ET STADTMÜLLER S.

2024

Social Science & Medicine 342: 116522.

<https://doi.org/10.1016/j.socscimed.2023.116522>

In the 1990s, Patrick West argued that, in contrast to childhood and adulthood, youth was characterised by relative social equality in health. This equalisation hypothesis has since been empirically tested several times, but with inconclusive results. The objective of the present study was to provide an up-to-date contribution to the question of health equalisation in youth by drawing on data from the German longitudinal study Health Behaviour and Injuries at School Age (GUS). The target population of GUS comprised students who were in 5th grade at German public secondary schools in the school year 2014/15. Over 10,000 students from randomly selected schools participated in the initial survey wave and were followed up in annual surveys until 10th grade. As GUS included a variety of health-related variables as well as indicators for family affluence, we could examine how social inequalities affected the health and health behaviour of young people with increasing age. Our study goes beyond previous research in two ways. First, from a youth and health sociology perspective, we present reasons why we expect an increase in socially determined health inequalities in the present youth generation. Second, we fully exploit the potential of our panel data, and thus arrive at very reliable results. For self-rated general health, as well as for numerous mental health and health behaviour items, our data show that health inequalities emerged or increased during the observation period (ages 10–16 years). Despite some indications of equalisation, especially for the consumption of unhealthy food and beverages, most of our results contradict West's equalisation hypothesis and suggest that social inequalities play an increasing role in health disparities among youth in the process of growing up.

► **Child Health and Its Effect on Adult Social Capital Accumulation**

LEBENBAUM M., *et al.*

2024

Health Economics n/a(n/a).

<https://doi.org/10.1002/hec.4792>

Although studies have demonstrated important effects of poor health in childhood on stocks of human and health capital, little research has tested economic theories to investigate the effect of child health on social capital in adulthood. Studies on the influence of child health on adult social capital are mixed and have not used sibling fixed effects models to account for unmeasured family and genetic characteristics, that are likely to be important. Using the Add-Health sample, health in childhood was assessed as self-rated health, the occurrence of a physical health condition or mental health condition, while social capital in adulthood was measured as volunteering, religious service attendance, team sports participation, number of friends, social isolation, and social support. We used sibling fixed effects models, which attenuated several associations to non-significance. In sibling fixed effects models there was significant positive effects of greater self-rated health on participation in team sports and social support, and negative effect of mental health in childhood on social isolation in adulthood. These results suggest that children with poor health require additional supports to build and maintain their stock of social capital and highlight further potential benefits to efforts that address poor child health.

► **The Impact of Socioeconomic Status on Health Practices Via Health Lifestyles: Results of Qualitative Interviews with Americans From Diverse Socioeconomic Backgrounds**

MCCOY C. A., *et al.*

2024

Social Science & Medicine: 344 :116618.

<https://doi.org/10.1016/j.socscimed.2024.116618>

We performed 55 qualitative interviews with Americans from diverse socioeconomic backgrounds from a small city in the Northeast to better understand the complex process through which socioeconomic status (SES) influences the health practices persons carry out. We argue that SES not only influences health practices directly, but also via shaping interviewees' health lifestyles. We describe four connected ways that SES

shapes interviewees' health lifestyles: (a) the impact of physical and mental illness on how much time, energy, and resources can be devoted to health; (b) the impact of social connections on opportunities to engage in healthy practices; (c) variation in interviewees' sense of control over health and health practices; and (d) how intentional and planned out interviewees' health lifestyles are. Although explored previously, the aim of this study is to examine how these elements come together to form into distinct styles of health shaped by the socio-economic background of our respondents.

► **Social Inequalities and the COVID-19 Pandemic**

SORCI G.

2024

Social Science & Medicine 340: 116484.

<https://doi.org/10.1016/j.socscimed.2023.116484>

Social inequality has been identified as an important determinant of the outcome of infectious diseases and the recent SARS-CoV-2 pandemic has vividly reminded us that there are no "equal opportunity infectors". In a recent article, Chakrabarty et al. (2023) reported the finding of a cross-country comparison of COVID-19 cases and social deprivation, using up-to-date statistical modelling. These results add to the extensive evidence showing that vulnerable populations are consistently at higher risk of contracting the infection and to suffer from more severe symptoms, whatever the spatial scale used (from the country to the neighborhood). Spatial clustering of socially deprived groups, preexisting pathologies and hotspots of COVID-19 cases and deaths indicate that the SARS-CoV-2 should be seen as a syndemic, where both the infection dynamics and the outcome of the disease strongly depend on the three-way interaction between the virus, preexisting pathologies, and the socioeconomic environment.

Pharmaceuticals**► A Framework For the Fair Pricing of Medicines**

PAULDEN M.

2024

PharmacoEconomics 42(2): 145-164.<https://doi.org/10.1007/s40273-023-01325-z>

As high-cost medicines put increasing pressure on public health care budgets, the need to identify 'fair' prices for medicines has never been greater. This paper proposes a framework, built upon fundamental economic principles, that allows for the consideration of 'fair' prices for medicines. The framework incorporates key considerations from conventional supply-side and demand-side approaches for specifying a cost-effectiveness 'threshold', including the health opportunity cost borne by other patients (k) and society's willingness to pay for marginal improvements in population health (k). The costs incurred by manufacturers in developing and supplying new medicines are also considered, as are the incentives for manufacturers to strategically price up to any common price per unit of benefit (cost-effectiveness 'threshold') specified by the payer. The framework finds that, at any 'fair' price, a medicine's dynamically calculated incremental cost-effectiveness ratio (ICER) lies below k . When pricing medicines collectively, the framework finds that a common price below k is required to maximize population health (consumer surplus) or to maximize total welfare (consumer and producer surplus). This framework has important policy implications for payers who wish to improve population health outcomes from constrained health care budgets. In particular, existing approaches to 'value-based pricing' should be reconsidered to ensure that patients receive a 'fair' share of the resulting economic surplus.

► Achieving Dynamic Efficiency in Pharmaceutical Innovation: Identifying the Optimal Share of Value and Payments RequiredWOODS B., *et al.*

2024

Health Economics n/a(n/a).<https://doi.org/10.1002/hec.4795>

It has been argued that cost-effectiveness analysis of branded pharmaceuticals only considers static efficiency, neglects dynamic effects and undermines incentives for socially valuable innovation. We present a framework for designing pharmaceutical pricing policy to achieve dynamic efficiency. We develop a coherent framework that identifies the long-term static and dynamic benefits and costs of offering manufacturers different levels of reward. The share of value that would maximise long-term population health depends on how the quantity and quality of innovation responds to payment. Using evidence of the response of innovation to payment, the optimal share of value of new pharmaceuticals to offer to manufacturers is roughly 20% (range: 6%–51%). Reanalysis of a sample of NICE technology appraisals suggests that, in most cases, the share of value offered to manufacturers and the price premium paid by the English NHS were too high. In the UK, application of optimal shares would offer considerable benefits under both a public health objective and a broader view of social welfare. We illustrate how an optimal share of value can be delivered through a range of payment mechanisms including indirect price regulation via the use of different approval norms by an HTA body.

Methodology- Statistics

► Addressing the Distributional Consequences of Spillovers in Health Economic Evaluation: A Prioritarian Approach

HENRY E. ET CULLINAN J.

2024

Health Economics n/a(n/a).

<https://doi.org/10.1002/hec.4796>

Health spillovers arise when an individual's serious illness affects those close to them emotionally, psychologically, and/or physically. As a result, healthcare interventions that improve the lives of patients may also confer wider health benefits. However, contrary to widespread calls for health spillovers to be included in health economic evaluation, others have argued this could have adverse distributional consequences and equity implications. This paper presents a novel approach to spillover inclusion in health economic evaluation using a "prioritarian transformation" of health gains that allows these equity concerns to be addressed. Affording greater weight to the incremental change in patient outcomes when incorporating carer/family health spillovers into resource allocation decisions, the method provides a feasible means of moderating the distributional impact of spillover inclusion. It also introduces a normative, theoretical perspective to a largely empirical extant literature and, as such, its axiomatic basis is examined. Finally, an illustrative example of the approach is presented to demonstrate its application.

► Menu Choice Stated Preference Tasks to Capture Demand Complementarity in Health

HUYNH E., *et al.*

2024

Social Science & Medicine: 116636.

<https://doi.org/10.1016/j.socscimed.2024.116636>

Health programs/services are often bundled, allowing for both substitution and complementarity. We adapt Discrete Choice Experiments to capture bundling, with application to a case study of exercise and nutrition; complementarity arises due to the goal of improving health. Our contributions are (1) to present a menu-

based choice experiment to explore bundling; (2) to analyse the menu-based data using an extension of the choice set generation model (GenL) to account for correlations between bundles and component singles. A nationally representative sample of 333 Australians chose between a nutrition program only; exercise program only; both nutrition and exercise programs; or their status quo. Overall, we show that by incorporating the menu choice task and introducing the combined alternative, we capture a significant portion of the population seeking both exercise and nutrition components. We estimate a latent class GenL model, and identify two latent classes: Class 1 preferred to choose programs on offer, and Class 2 was more price sensitive and had a stronger preference for staying with their status quo. We show in the post-estimation analysis that heterogeneity in preferences translates into heterogeneity in the way alternatives are bundled, indicating that the combined offering is appealing to specific classes of individuals who prefer bundling. By implementing the menu choice task, researchers and policymakers can effectively identify, cater to and influence the demand for combined exercise and nutrition options, leading to more targeted and impactful interventions in promoting healthier lifestyle choices.

► Social Determinants of Health As a Framework to Identify and Assess Cross-Sector Funding Opportunities

LEONARD M., *et al.*

2024

Health Services Research 59(S1): e14235.

<https://doi.org/10.1111/1475-6773.14235>

Objective To present a content analysis and method for applying a social determinants of health (SDOH) analytical framework to legislation. Data Sources and Study Setting Secondary data include 215 sections of the American Rescue Plan Act of 2021 (ARPA) and related information from federal government websites (e.g., press releases, notices of funding announcements, and funding tables). Study Design Researchers conducted a qualitative content analysis of legislative text, recording all sections, appropriations, allocations, and administrators. Using an SDOH analytical framework defined by Healthy People 2030, researchers coded

each section, appropriation, and allocation within the legislation. Data Collection/Extraction Methods Researchers reviewed all ARPA sections, appropriations, and allocations separately, resulting in 328 entries. Descriptive characteristics were calculated using Tableau and Microsoft Excel. Researchers coded each appropriation or allocation using definitions and key words presented in the SDOH analytical framework. Principal Findings Applying an SDOH analytical framework to the legislation's funding amounts reveals an overlap of investment opportunities that cross-sector initiatives can leverage. This overlap is seen primarily in two ways: (1) specific allocations and appropriations that can be used to meet multiple SDOH goals and (2) federal administrators receiving money that can be categorized according to multiple SDOHs. For example, approximately 99% of tracked ARPA funds can be used to support one or more SDOHs. Thirty-five appropriations or allocations can support programs categorized for more than one SDOH category. Eight

departments received funds that could be designated for two or more SDOHs. All five SDOH categories can potentially receive funding from 3 to 11 federal administrators. Conclusions Using an SDOH analytical framework is an innovative approach to conceptualizing and synthesizing the contents of complex legislation. This approach demonstrates funding patterns across SDOH that can encourage cross-sector collaborations. Future content analysis of legislation can employ this SDOH framework to demonstrate cross-sector initiative funding opportunities.

► **Theories, Models and Frameworks For Health Systems Integration. A Scoping Review**

PIQUER-MARTINEZ C., *et al.*

2024

[Health Policy 141: 104997.](#)

<https://doi.org/10.1016/j.healthpol.2024.104997>

Politique de santé

Health Policy

► **Organizational and Community Resilience For COVID-19 and Beyond: Leveraging a System For Health and Social Services Integration**

FLEMING M. D., *et al.*

2024

[Health Services Research 59\(S1\): e14250.](#)

<https://doi.org/10.1111/1475-6773.14250>

Objective To examine how a preexisting initiative to align health care, public health, and social services influenced COVID-19 pandemic response. **Data Sources and Study Setting** In-depth interviews with administrators and frontline staff in health care, public health, and social services in Contra Costa County, California from October, 2020, to May, 2021. **Study Design** Qualitative, semi-structured interviews examined how COVID-19 response used resources developed for system alignment prior to the pandemic. **Data Collection** We interviewed 31 informants including 14 managers in public health, health care, or social services and 17 social needs case managers who coordinated services across these sectors on behalf of patients. An induc-

tive-deductive qualitative coding approach was used to systematically identify recurrent themes. **Principal Findings** We identified four distinct components of the county's system alignment capabilities that supported COVID-19 response, including (1) an organizational culture of adaptability fostered through earlier system alignment efforts, which included the ability and willingness to rapidly implement new organizational processes, (2) trusting relationships among organizations based on prior, positive experiences of cross-sector collaboration, (3) capacity to monitor population health of historically marginalized community members, including information infrastructures, data analytics, and population monitoring and outreach, and (4) frontline staff with flexible skills to support health and social care who had built relationships with the highest risk community members. **Conclusions** Prior investments in aligning systems provided unanticipated benefits for organizational and community resilience during the COVID-19 pandemic. Our results illustrate a pathway for investment in system alignment efforts that build capacity within organizations and relationships between organizations to enhance resilience to crisis.

Our findings suggest the usefulness of an integrated concept of organizational and community resilience that understands the resilience of systems of care as a vital resource for community resilience during crisis.

► **Estimating the Population Effectiveness of Interventions Against COVID-19 in France: A Modelling Study**

GANSER I., *et al.*

2024

Epidemics 46: 100744.

<https://doi.org/10.1016/j.epidem.2024.100744>

Background Non-pharmaceutical interventions (NPIs) and vaccines have been widely used to manage the COVID-19 pandemic. However, uncertainty persists regarding the effectiveness of these interventions due to data quality issues, methodological challenges, and differing contextual factors. Accurate estimation of their effects is crucial for future epidemic preparedness. Methods To address this, we developed a population-based mechanistic model that includes the impact of NPIs and vaccines on SARS-CoV-2 transmission and hospitalization rates. Our statistical approach estimated all parameters in one step, accurately propagating uncertainty. We fitted the model to comprehensive epidemiological data in France from March 2020 to October 2021. With the same model, we simulated scenarios of vaccine rollout. Results The first lockdown was the most effective, reducing transmission by 84% (95% confidence interval (CI) 83–85). Subsequent lockdowns had diminished effectiveness (reduction of 74% (69–77) and 11% (9–18), respectively). A 6 pm curfew was more effective than one at 8 pm (68% (66–69) vs. 48% (45–49) reduction), while school closures reduced transmission by 15% (12–18). In a scenario without vaccines before November 2021, we predicted 159,000 or 168% (95% prediction interval (PI) 70–315) more deaths and 1,488,000 or 300% (133–492) more hospitalizations. If a vaccine had been available after 100 days, over 71,000 deaths (16,507–204,249) and 384,000 (88,579–1,020,386) hospitalizations could have been averted. Conclusion Our results highlight the substantial impact of NPIs, including lockdowns and curfews, in controlling the COVID-19 pandemic. We also demonstrate the value of the 100 days objective of the Coalition for Epidemic Preparedness Innovations (CEPI) initiative for vaccine availability.

► **Revising the Logic Model Behind Health Care's Social Care Investments**

GOTTLIEB L. M., *et al.*

2024

The Milbank Quarterly n/a(n/a).

<https://doi.org/10.1111/1468-0009.12690>

This article summarizes recent evidence on how increased awareness of patients' social conditions in the health care sector may influence health and health care utilization outcomes. Using this evidence, we propose a more expansive logic model to explain the impacts of social care programs and inform future social care program investments and evaluations.

► **A Global Comparative Analysis of the Inclusion of Priority Setting in National COVID-19 Pandemic Plans: A Reflection on the Methods and the Accessibility of the Plans**

KAPIRIRI L., *et al.*

2024

Health Policy: 141 :105011.

<https://doi.org/10.1016/j.healthpol.2024.105011>

Background Despite the swift governments' response to the COVID-19 pandemic, there remains a paucity of literature assessing the degree to which; priority setting (PS) was included in the pandemic plans and the pandemic plans were publicly accessible. This paper reflects on the methods employed in a global comparative analysis of the degree to which countries integrated PS into their COVID-19 pandemic plans based on Kafiriri & Martin's framework. We also assessed if the accessibility of the plans was related to the country's transparency index. Methods Through a three stage search strategy, we accessed and reviewed 86 national COVID-19 pandemic plans (and 11 Canadian provinces and territories). Secondary analysis assessed any alignment between the readily accessible plans and the country's transparency index. Results and conclusion 71 national plans were readily accessible while 43 were not. There were no systematic differences between the countries whose plans were readily available and those whose plans were 'missing'. However, most of the countries with 'missing' plans tended to have a low transparency index. The framework was adapted to the pandemic context by adding a parameter on the need to plan for continuity of priority routine services. While document review may be the most feasible and appropriate approach to conduct-

ing policy analysis during health emergencies, interviews and follow up document review would assess policy implementation.

► **How Did European Countries Set Health Priorities in Response to the COVID-19 Threat? A Comparative Document Analysis of 24 Pandemic Preparedness Plans Across the EURO Region**

WILLIAMS I., *et al.*

2024

Health Policy 141 : 104998.

<https://doi.org/10.1016/j.healthpol.2024.104998>

The COVID-19 pandemic has forced governments across the world to consider how to prioritise the allocation of scarce resources. There are many tools and frameworks that have been designed to assist with the challenges of priority setting in health care. The purpose of this study was to examine the extent to

which formal priority setting was evident in the pandemic plans produced by countries in the World Health Organisation's EURO region, during the first wave of the COVID-19 pandemic. This compliments analysis of similar plans produced in other regions of the world. Twenty four pandemic preparedness plans were obtained that had been published between March and September 2020. For data extraction, we applied a framework for identifying and assessing the elements of good priority setting to each plan, before conducting comparative analysis across the sample. Our findings suggest that while some pre-requisites for effective priority setting were present in many cases – including political commitment and a recognition of the need for allocation decisions – many other hallmarks were less evident, such as explicit ethical criteria, decision making frameworks, and engagement processes. This study provides a unique insight into the role of priority setting in the European response to the onset of the COVID-19 pandemic.

Prévention

Prevention

► **Use of and Barriers to Adopting Standardized Social Risk Screening Tools in Federally Qualified Health Centers During the First Year of the COVID-19 Pandemic**

GIRON N. C., *et al.*

2024

Health Services Research 59(S1): e14232.

<https://doi.org/10.1111/1475-6773.14232>

Objective To describe the national rate of social risk factor screening adoption among federally qualified health centers (FQHCs), examine organizational factors associated with social risk screening adoption, and identify barriers to utilizing a standardized screening tool in 2020. **Data Source** 2020 Uniform Data System, a 100% sample of all US FQHCs (N = 1375). **Study Design** We used multivariable linear probability models to assess the association between social risk screening adoption and key FQHC characteristics. We used descriptive statistics to describe variations in screening tool types and barriers to utiliz-

ing standardized tools. We thematically categorized open-ended responses about tools and barriers. **Data Collection** None. **Principal Findings** In 2020, 68.9% of FQHCs screened patients for any social risk factors. Characteristics associated with a greater likelihood of screening adoption included having high proportions of patients best served in a language other than English (18.8 percentage point [PP] increase, 95% CI: 6.0, 31.6) and being larger in size (10.3 PP increase, 95% CI: 0.7, 20.0). Having higher proportions of uninsured patients (14.2 PP decrease, 95% CI: -25.5, -0.3) and participating in Medicaid-managed care contracts (7.3 PP decrease, 95% CI: -14.2, -0.3) were associated with lower screening likelihood. Among screening FQHCs, the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) was the most common tool (47.1%). Among non-screening FQHCs, common barriers to using a standardized tool included lack of staff training to discuss social issues (25.2%), inability to include screening in patient intake (21.7%), and lack of funding for addressing social needs (19.2%). **Conclusions** Though most FQHCs screened for social

risk factors in 2020, various barriers have prevented nearly 1 in 3 FQHCs from adopting a screening tool. Policies that provide FQHCs with resources to support

training and workflow changes may increase screening uptake and facilitate engagement with other sectors.

Psychiatry

► **How Gender and Low Mental Health Literacy Are Related to Unmet Need For Mental Healthcare: A Cross-Sectional Population-Based Study in Sweden**

BLOM S., *et al.*

2024

Archives of Public Health 82(1): 12.

<https://doi.org/10.1186/s13690-023-01228-7>

Men are more likely to have unmet need for mental healthcare than women. However, an under-investigated aspect of the gender difference is the role of mental health literacy. This study investigated how combinations of gender and mental health literacy were related to two indicators of unmet need: not perceiving a need for mental healthcare despite poor mental health, and refraining from seeking mental healthcare.

► **Mental Health Care Provision in Community Health Centers and Hospital Emergency Department Utilization**

CAREY K. ET COLE M. B. .

2024

Health Services Research n/a(n/a).

<https://doi.org/10.1111/1475-6773.14283>

Objectives To examine whether community health centers (CHCs) are effective in offsetting mental health emergency department (ED) visits. **Data Sources and Study Setting** The HRSA Uniform Data System and the HCUP State ED Databases for Florida patients during 2012–2019. **Study Design** We identified CHC-year-specific service areas using patient origin zip codes. We then estimated panel data models for number of ED mental health visits per capita in a CHC's service area. Models measured CHC mental health utilization as number of visits, unique patients, and intensity (vis-

its per patient). **Principal Findings** CHC mental health utilization increased approximately 100% during 2012–2019. Increased CHC mental health provision was associated with small reductions in ED mental health utilization. An annual increase of 1000 CHC mental health care visits (5%) was associated with 0.44% fewer ED mental health care visits ($p = 0.153$), and an increase of 1000 CHC mental health care patients (15%) with 1.9% fewer ED mental health care visits ($p = 0.123$). An increase of 1 annual mental health visit per patient was associated with 16% fewer ED mental health care visits ($p = 0.011$). **Conclusions** Results suggest that mental health provision in CHCs may reduce reliance on hospital EDs, albeit minimally. Policies that promote alignment of services between CHCs and local hospitals may accelerate this effect.

► **The Cumulative Effects of Stigma-Related Stress: Chronic Stigma-Related Stress Exposure Exacerbates Daily Associations Between Enacted Stigma and Anxious/Depressed Affect**

DYAR C.

2024

Social Science & Medicine: 344 : 116604.

<https://doi.org/10.1016/j.socscimed.2024.116604>

Purpose Sexual and gender minority individuals are at elevated risk for mood and anxiety disorders compared to heterosexual and cisgender individuals. Ecological momentary assessments studies have implicated experiences of enacted stigma (i.e., biased treatment) by linking these experiences with elevations in anxious and depressed affect. The current study utilizes a theory from the broader stress and affect literature to determine whether chronic enacted stigma exposure amplifies individuals' negative affective reactions to experiences of enacted stigma at the daily level. **Methods** We used data from a 30-day ecological

momentary assessment study with 429 sexual minority women and gender diverse sexual minorities assigned female at birth (SMWGD) living in the US in 2020–21 to determine whether concurrent and prospective event-level associations between enacted stigma, anxious/depressed affect, and perceived coping efficacy were moderated by chronic enacted stigma exposure. Results demonstrate that individuals with moderate to high chronic stigma exposure experience larger increases in anxious/depressed affect and larger decreases in perceived coping efficacy following daily experiences of enacted stigma. Further, these effects of daily stigma on anxious/depressed affect persist for longer among individuals with high chronic stigma exposure. Interestingly, chronic stigma exposure did not moderate associations between daily general stressors (i.e., those unrelated to identity) and affect or perceived coping efficacy, suggesting that these effects are specific to stigma-related stressors. Conclusions These results help to advance our understanding of both long-term and daily effects of exposure to enacted stigma, highlighting the potentially profound cumulative effects of stigma exposure and the need to intervene in this cycle.

► **‘Housing First’ Increased Psychiatric Care Office Visits and Prescriptions While Reducing Emergency Visits**

HANSON D. ET GILLESPIE S.

2024

[Health Affairs: 10.1377/hlthaff.2023.01041.](https://doi.org/10.1377/hlthaff.2023.01041)

<https://doi.org/10.1377/hlthaff.2023.01041>

Housing First is an approach to ending homelessness that recognizes permanent housing as a platform for stability and engagement in health services. As part of a randomized controlled trial to test the effects of permanent supportive housing with the Housing First approach in Denver, Colorado, we analyzed the intervention’s impact on health care use, Medicaid enrollment, and mortality among people experiencing chronic homelessness who had frequent arrests and jail stays. Two years after assignment to the Housing First intervention, participants had an average of eight more office-based visits for psychiatric diagnoses, three more prescription medications, and six fewer emergency department visits than the control group. Although enrollment in Medicaid increased over the course of the study for both the intervention group and the control group, the intervention group was 5 percentage points less likely to be enrolled in Medicaid.

Supportive housing had no significant impact on mortality. When considering pathways to scale up supportive housing, policy makers should recognize the potential of Housing First to facilitate the use of office-based psychiatric care and medications in a population with many health care needs.

► **Factors Associated with Death, Hospitalization, Resignation, and Sick Leave From Work Among Patients with Schizophrenia in Japan: A Nested Case–Control Study Using a Large Claims Database**

INADA K., *et al.*

2024

[BMC Psychiatry 24\(1\): 22.](https://doi.org/10.1186/s12888-023-05474-5)

<https://doi.org/10.1186/s12888-023-05474-5>

Premature mortality, frequent relapse that easily leads to hospitalization, and discontinuous employment are key challenges for the treatment of schizophrenia. We evaluated risk factors for important clinical outcomes (death, hospitalization, resignation, and sick leave from work) in patients with schizophrenia in Japan.

► **Social Mobility and Mental Health: A Systematic Review and Meta-Analysis**

ISLAM S. ET JAFFEE S. R.

2024

[Social Science & Medicine 340: 116340.](https://doi.org/10.1016/j.socscimed.2023.116340)

<https://doi.org/10.1016/j.socscimed.2023.116340>

Socioeconomic status (SES) is a robust correlate of mental health, and emerging research indicates that life course trajectories of SES (i.e., social mobility) may be more predictive for health outcomes than point-in-time SES assessments. This paper presents five primary meta-analyses to determine how mental health differs between social mobility groups. We conducted a systematic review of PsycINFO, Web of Science, and PubMed for studies of social mobility and mental health. We used random-effects multilevel meta-analyses to compare mental health problems between individuals who experienced upward mobility, downward mobility, stable high SES, and stable low SES. We included data from 21 studies and 157,763 unique participants yielding 105 effect sizes. Upwardly mobile participants experienced more mental health problems than stable high SES participants ($d = 0.11$), fewer mental health problems than stable low SES participants ($d = -0.24$),

and fewer mental health problems than downwardly mobile participants ($d = -0.17$). Downwardly mobile individuals experienced more mental health problems than stable high SES participants ($d = 0.26$) and fewer mental health problems than stable low SES participants ($d = -0.10$). Subgroup analyses revealed that the magnitude of effects did not differ by continent of study, type of generational mobility (intergenerational vs. intragenerational), or SES indicator. Meta-regressions with continuous moderators (age, gender, race, study quality) were also non-significant. Taken together, these results indicate that both upwardly and downwardly mobile individuals experience more mental health problems than those who are persistently advantaged, and they both experience fewer mental health problems than those who are persistently disadvantaged. Our findings suggest that while current SES has a stronger association with adult mental health than childhood SES, it is important to also consider the impact of early life and prior generation SES to account for lingering effects of early disadvantage.

► **Does Biological Age Mediate the Relationship Between Childhood Adversity and Depression? Insights From the Detroit Neighborhood Health Study**

MARTINEZ R. A. M., *et al.*

2024

Social Science & Medicine 340: 116440.

<https://doi.org/10.1016/j.socscimed.2023.116440>

The link between childhood adversity and adulthood depression is well-established; however, the underlying mechanisms are still being explored. Recent research suggests biological age may mediate the relationship between childhood adversity and depression in later life. This study examines if biological age mediates the relationship between childhood adversity and depression symptoms using an expanded set of biological age measures in an urban population-based cohort. Data from waves 1–3 of the Detroit Neighborhood Health Study (DNHS) were used in this analysis. Questions about abuse during childhood were coded to form a childhood adversity score similar to the Adverse Childhood Experience measure. Multiple dimensions of biological age, defined as latent variables, were considered, including systemic biological age (GrimAge, PhenoAge), epigenetic age (Horvath, SkinBlood), and immune age (cytomegalovirus, herpes simplex virus type 1, C-reactive protein, interleukin-6). Depression symptoms, modeled as a latent variable, were captured

through the Patient Health Questionnaire-9 (PHQ-9). Models were adjusted for age, gender, race, parent education, and past depressive symptoms. Total and direct effects of childhood adversity on depression symptoms and indirect effects mediated by biological age were estimated. For total and direct effects, we observed a dose-dependent relationship between cumulative childhood adversity and depression symptoms, with emotional abuse being particularly influential. However, contrary to prior studies, in this sample, we found few direct effects of childhood adversity on biological age or biological age on depression symptoms and no evidence of mediation through the measures of biological age considered in this study. Further research is needed to understand how childhood maltreatment experiences are embodied to influence health and wellness.

► **Assessing the “Healthy Immigrant Effect” in Mental Health: Intra- and Inter-Cohort Trends in Mood And/Or Anxiety Disorders**

MASON J., *et al.*

2024

Social Science & Medicine 340: 116367.

<https://doi.org/10.1016/j.socscimed.2023.116367>

Background The healthy immigrant effect implies that, at the time of immigration, new immigrants are typically healthier than the Canadian-born population. Furthermore, this health advantage fades the longer cohorts of immigrants remain in the host country. **Methods** Most studies assessing the healthy immigrant effect rely on strong, untestable assumptions to extract unique effects for length of stay (LOS) (i.e., how long an immigrant has been in a host country), period (i.e., year of observation), and cohort (i.e., year of immigration). Rather than attempting to parse out separate effects for LOS, period, and cohort, we adopt a descriptive, cohort-centric approach to study immigrant mental health, which examines intra- and inter-cohort trends, that is, joint LOS-period and cohort-period parameters, respectively. While intra-cohort trends show how immigrants’ mental health change with LOS across periods, inter-cohort trends reveal how the mental health of successive cohorts of immigrants differ across time periods. To provide a thorough assessment of the healthy immigrant effect, we use both survey and administrative data on cohorts of Canadian immigrants from 2003 to 2013. **Results** The survey data reveal that mental health declines steeply (i.e., there is an increase in mood and/or anxiety disorders) within and across

immigrant cohorts, while the administrative data show little overall change in mental health care utilization within and across cohorts. The divergent results may reflect issues related to barriers in access to mental health services because the administrative data, which are based on health care utilization, do not capture the increase in mental disorders seen in the survey data. Conclusion This study highlights the benefit of a cohort-based approach to assess the healthy immigrant effect as it pertains to mental health as well as the importance of using different types of data, which may be measuring different aspects of immigrant mental health and health care utilization.

► **Subjective Quality of Life and Schizophrenia: Results From a Large Cohort Study Based in Chinese Primary Care**

MIGLIORINI C., *et al.*

2024

BMC Psychiatry 24(1): 86.

<https://doi.org/10.1186/s12888-024-05558-w>

Much confusion exists between health-related QoL (HRQoL) scales and subjective QoL (SQoL) scales. One

method to avoid confusion is use of a single question that asks What is your quality of life? or similar. This study explored the relationship between biopsychosocial factors and high SQoL, SQoL stability, and factors associated with improving SQoL.

► **Changes in Patient Care Through Flexible and Integrated Treatment Programs in German Psychiatric Hospitals: Meta-Analyses Based on a Series of Controlled Claims-Based Cohort Studies**

NEUMANN A., *et al.*

2024

BMC Psychiatry 24(1): 74.

<https://doi.org/10.1186/s12888-024-05500-0>

Global treatment budgets, i.e. predefined budgets for patients treated in hospital independent of the setting within the hospital, together with flexible and integrated treatment (FIT) have been introduced in some German psychiatric hospitals since 2013. We investigated pooled changes in inpatient, day-care, outpatient treatment, and continuity of care for patients with mental disorders in 12 FIT-hospitals.

Sociologie de la santé

Sociology of Health

► **Social Identity and Health-Related Behavior: A Systematic Review and Meta-Analysis**

DE HOOG N. ET PAT-EL R.

2024

Social Science & Medicine: 116629.

<https://doi.org/10.1016/j.socscimed.2024.116629>

This paper examined the relationship between social identity and health-related behavior, exploring whether social identities are associated with multiple health-related behaviors or only specific ones, and whether this association varies on the type of social identity, the type of social identity measures or the expected relationship between identity and behavior. In a systematic review and meta-analysis we assessed whether the pattern of findings can be explained by

the social identity approach. An extensive literature search was conducted in several databases including EBSCO-host and PubMed, using elaborate search terms related to social identity and health-related behavior. This resulted in 10728 potential articles, with 115 articles (with 248 effect sizes from 133 independent samples, N = 112.112) included in the meta-analysis. We found a small but positive overall association between social identification and health-related behavior, which was present for actual behavior, as well as for intention and attitudes. This association was stronger for health-related social identities, positive health-related behaviors, when the expected relationship was positive and when indirect social identity measures were used. However, not all findings could be explained by the social identity approach, indicating a need for further research to better understand the relationship

between social identity and health-related behavior, in order to more effectively incorporate social identity into health interventions.

► **Social Connectedness, Functional Capacity, and Longevity: A Focus on Positive Relations with Others**

FRIEDMAN E., *et al.*

2024

Social Science & Medicine 340: 116419.

<https://doi.org/10.1016/j.socscimed.2023.116419>

Rationale A large literature links social connectedness to health, but there is growing recognition of considerable nuance in the ways social connectedness is defined, assessed, and associated with health. **Objective** This study centers on positive relations with others – a measure derived from philosophical notions of the components of a “good life” – and the extent to which it predicts functional limitations and mortality using data from the national, longitudinal Mid-Life in the United States (MIDUS) study. We also assess whether these associations are independent of two common measures of social connectedness: social integration and social support. **Methods** Data on social connectedness came from the first wave of MIDUS (1994–1996), self-reported functional limitations were from the first (MIDUS 1) and third (MIDUS 3; 2013–2014) waves, and mortality data through 2022 were obtained from the National Death Index. **Results** Linear regression analyses showed that higher scores on positive relations with others predicted significantly less increase in functional limitations over time, and logistic regression models showed reduced probability of onset of functional limitations between MIDUS 1 and MIDUS 3 in those scoring higher on positive relations with others. Mortality was also significantly lower in those with higher scores on positive relations with others. All models adjusted for demographic and health characteristics, and all associations were robust to the inclusion of social integration and social support in the models. **Conclusions** These results show that positive relations with others, a component of a well-lived life that describes sustained investment in social relationships that are mutual and trusting, is associated with two key health outcomes in aging adults: functional limitations and longevity. That these associations are independent of social integration and social support suggests a unique role for this formulation of social connectedness in the health of aging adults.

► **Impacts For Health and Care Workers of Covid-19 and Other Public Health Emergencies of International Concern: Living Systematic Review, Meta-Analysis and Policy Recommendations**

FRONTEIRA I., *et al.*

2024

Human Resources for Health 22(1): 10.

<https://doi.org/10.1186/s12960-024-00892-2>

Health and care workers (HCW) faced the double burden of the SARS-CoV-2 pandemic: as members of a society affected by a public health emergency and as HWC who experienced fear of becoming infected and of infecting others, stigma, violence, increased workloads, changes in scope of practice, among others. To understand the short and long-term impacts in terms of the COVID-19 pandemic and other public health emergencies of international concern (PHEICs) on HCW and relevant interventions to address them, we designed and conducted a living systematic review (LSR).

► **A Longitudinal Study of Perceived Social Position and Health-Related Quality of Life**

GUGUSHVILI A. ET JAROSZ E.

2024

Social Science & Medicine 340: 116446.

<https://doi.org/10.1016/j.socscimed.2023.116446>

Background A large body of evidence suggests that there is a social gradient in the association between perceived social position and various health outcomes. Yet only a fraction of this research uses longitudinal data, and these studies usually rely on two data points in time, consider a single health outcome measure, overlook non-linear effects of perceived social position, and come almost exclusively from the Western welfare democracies. **Methods** Using data for 1921 individuals from three waves (2008, 2013, 2018) of the Polish Panel Survey (POLPAN), we fit between- and within-individuals hybrid-effects models with cluster-robust standard errors to investigate the association between one’s perceived social position (self-placement on a socioeconomic hierarchy scale varying 1 to 10) and subsequent health-related quality of life (HRQoL) measured using the Nottingham Health Profile (NHP) and its six components. **Results** We find that the association between perceived social position and health-related quality of life is larger when estimated between individuals than within individuals, yet

in fixed- and hybrid-effects models perceived social position remains significantly and negatively linked with both the aggregated NHP measure as well as with its components such as emotional reaction, physical abilities, sleep, and social isolation. We also identify that starting to perceive oneself at the lower end of the social hierarchy is associated with a deteriorating health-related quality of life but a change at the top of the perceived social hierarchy is not linked with an improvement in NHP scores. Conclusions We provide new evidence on the significant and non-linear links between perceived social position and health-related quality of life and highlight possible pathways linking these two aspects of individuals' lives.

► **There but Not Really Involved:
The Meanings of Loneliness For People
with Chronic Illness**

LEWIS S., *et al.*

2024

Social Science & Medicine 343: 116596.

<https://doi.org/10.1016/j.socscimed.2024.116596>

Loneliness is one of the most pressing and rapidly growing contemporary social challenges around the world. Yet we still lack a good understanding of how loneliness is constituted and experienced by those most affected. We conducted semi-structured interviews with 40 people with chronic illness who were experiencing loneliness to explore what loneliness means to them and how it impacts in their daily lives. Drawing on ideas around liquidity and performativity, we identified the relational, temporal and social layers of loneliness. Our analysis revealed the interconnectedness of chronic illness and loneliness in participants' daily lives, as well as how chronic illness shifts temporal orientation, and transforms interpersonal relationships and relationship with self, contributing to the experiences of loneliness. Though participants described the many social conditions that restricted their opportunities for social participation, giving them a sense of being left behind and spectating the social life of others, a rhetoric of loneliness as a problem and responsibility of the individual was still prominent. A narrative of the need to perform social connection emerged in the absence of meaningful social bonds with others. We argue that normative ideals of wellness and positivity circulating in chronic illness communities and society more broadly are implicated in the experience of loneliness for people with chronic conditions. We conclude by considering how more expan-

sive representations of how to live well with chronic illness may be important in reducing personal and collective loneliness.

► **The Impact of Social Media Influencers
on Health Outcomes: Systematic Review**

POWELL J. ET PRING T.

2024

Social Science & Medicine 340: 116472.

<https://doi.org/10.1016/j.socscimed.2023.116472>

A fast emerging area of public health interest is the potential role of social media influencers in spreading health information and affecting health behaviour. The aim of this research was to systematically synthesise evidence on the impact of social media influencers on health outcomes. A systematic search of six databases (Medline, Embase, PsycINFO, CINAHL, Science Citation Index and Sociology Collection) was conducted in October 2021, with an update search in January 2023. Two reviewers independently screened titles and abstracts. We included interventional study designs which examined the effect of social media influencer as the primary or only exposure on a quantified health outcome. We used narrative synthesis to summarise the characteristics and main findings of studies within each of four main topic areas. We assessed quality using a critical appraisal checklist for quasi-experimental studies. We identified twelve studies across four areas that met the inclusion criteria: children's dietary behaviour (n = 5), body image dissatisfaction (n = 4), influenza and COVID-19 (n = 2), and social comparison and anxiety (n = 1). Influencer marketing of unhealthy foods had a statistically significant effect on increasing children's immediate energy intake, but no effect was found for influencer promotion of vegetables. When an unhealthy food is marketed by an influencer of unhealthy appearance, this led to an increased preference for healthy snacks. Exposure to idealised influencer body imagery had statistically significant negative impacts on body image and mood. Anxiety caused by viewing idealised portrayals of motherhood was the same whether or not the portrayal was by an influencer. Public health campaigns harnessing influencers to promote hygiene habits in the context of COVID-19 and influenza showed some positive changes in health behaviours. Most of the published studies are of poor methodological quality with poor generalisability and statistical weaknesses. We conclude that social media influencers have both negative and positive impacts on health outcomes, with negative impacts seen consist-

ently in studies of body image dissatisfaction. Further research is needed to harness the potential positive health impact of social media influencers, while mitigating against harmful effects.

► **Le VIH au long cours : voilements et dévoilements à l'épreuve du temps**

YVON S., *et al.*

2023

Sciences sociales et santé 41(3): 37-62.

<https://www.cairn.info/revue-sciences-sociales-et-sante-2023-3-page-37.htm>

Cet article propose une analyse sociologique de l'expérience des personnes vivant avec le VIH après 60 ans et ayant un parcours migratoire, au prisme de leurs pratiques de gestion de l'information concernant leur diagnostic. Il s'appuie sur une enquête par entretiens auprès de 23 personnes vivant en région parisienne.

La gestion de l'information ne se réduit pas à des choix délibérés et ponctuels entre « dire » et « ne pas dire » : les pratiques de voilement et de dévoilement du diagnostic incluent des situations ténues et intermédiaires, encastrées dans des contextes relationnels et matériels, prises dans des rapports sociaux et façonnées par les économies morales locales qui entourent l'infection au VIH. Cette recherche révèle le vif décalage entre les avancées thérapeutiques majeures et l'inertie de représentations négatives au sujet du VIH. Pris dans des tensions entre normalisation et stigmatisation, les personnes vivant avec le VIH maintiennent un fort contrôle de l'information, malgré la longue durée, la banalisation et l'intransmissibilité de l'infection. Cependant l'avancée en âge, modifiant les anticipations, notamment résidentielles, et ouvrant la perspective de mobiliser des solidarités familiales, fait bouger les lignes du contrôle de l'information et révèle de discrètes transformations du rapport à l'infection VIH.

Soins de santé primaires

Primary Health care

► **Catalyzing Alignment and Systems Transformation Through Cross-Sector Partnerships: Findings From the California Accountable Communities For Health Initiative**

ANGUS L., *et al.*

2024

Health Services Research 59(S1): e14236.

<https://doi.org/10.1111/1475-6773.14236>

Objectives To describe the impact of Accountable Communities of Health (ACHs) on organizational and community partnerships and explore how ACHs contribute to systems change. Data Sources and Study Setting The California Accountable Communities of Health Initiative (CACHI) was a 5-year, \$17 M investment in community health transformation in 13 ACH sites. Data sources include two surveys, key informant interviews, small group conversations, and ACH meeting observations and document review. Study Design This was a mixed-methods, observational study. Surveys conducted in 2021 and 2022 focused on ACH progress in building organizational and com-

munity partnerships and ACH impact on partners and systems, respectively. Interviews and small group conversations were conducted toward the end of the CACHI grant period and designed to complement the surveys. Data Collection Survey respondents included ACH backbone agency staff and partner organization representatives (n = 141 in 2021 and 88 in 2022). Semi structured individual interviews and group conversations were conducted with 40 ACH backbone staff and partners. Documents were collected via grant reporting and directly from ACH staff. Data were analyzed descriptively and thematically. Principal Findings ACHs appear to have supported organizational partnerships and collaboration. Seventy-six percent of survey respondents reported that their ACH had strengthened organizations' ability to work together and 65% reported developing new or deepened connections. While ACH participants reported a better understanding of community needs and priorities, progress on community relationships, and greater attention to equity and racial justice, many saw room for improvement on meaningful community engagement. Systems changes and precursors of systems change observed

across ACH sites included strengthened partnerships, enhanced knowledge, increased capacity, more collaborative ways of working, and new funding streams. **Conclusions** The ACH model is effective at strengthening organizational partnerships and catalyzing other systems changes and precursors including enhanced knowledge, increased capacity, more collaborative ways of working, and new funding.

► **What Can We Learn From General Practitioners Who Left Spain? A Mixed Methods International Study**

CALDERÓN-LARRAÑAGA S., *et al.*
2024

Human Resources for Health 22(1): 9.
<https://doi.org/10.1186/s12960-023-00888-4>

International mobility of health workforce affects the performance of health systems and has major relevance in human resources for health policy and planning. To date, there has been little research exploring the reasons why general practitioners (GPs) migrate. This mixed methods study aimed to investigate the reasons why Spain-trained GPs migrate and develop GP retention and recruitment health policy recommendations relevant to Spanish primary care.

► **Cross-Sector Collaboration Practitioners Weigh-In on This Special Issue**

ELLIS W., *et al.*
2024

Health Services Research 59(S1): e14267.
<https://doi.org/10.1111/1475-6773.14267>

► **A Mixed Methods Evaluation of a Quality Improvement Model to Optimize Perinatal and Primary Care in the Community Health Setting**

GEMKOW J. W., *et al.*
2024

The Annals of Family Medicine 22(1): 37-44.
<https://doi.org/10.1111/1475-6773.14267>

PURPOSE Many maternal deaths occur beyond the acute birth encounter. There are opportunities for improving maternal health outcomes through facilitated quality improvement efforts in community settings, particularly in the postpartum period. We used

a mixed methods approach to evaluate a collaborative quality improvement (QI) model in 6 Chicago Federally Qualified Health Centers (FQHCs) that implemented workflows optimizing care continuity in the extended postpartum period for high-risk prenatal patients. **METHODS** The Quality Improvement Learning Collaborative focused on the implementation of a registry of high-risk prenatal patients to link them to primary care and was implemented in 2021; study data were collected in 2021-2022. We conducted a quantitative evaluation of FQHC-reported aggregate structure, process, and outcomes data at baseline (2020) and monthly. (2021). Qualitative analysis of semistructured interviews of participating FQHC staff focused on the experience of participating in the collaborative. **RESULTS** At baseline, none of the 6 participating FQHCs had integrated workflows connecting high-risk prenatal patients to primary care; by the end of implementation of the QI intervention, such workflows had been implemented at 19 sites across all 6 FQHCs, and 54 staff were trained in using these workflows. The share of high-risk patients transitioned to primary care within 6 months of delivery significantly increased from 25% at baseline to 72% by the end of implementation. Qualitative analysis of interviews with 11 key informants revealed buy-in, intervention flexibility, and collaboration as facilitators of successful engagement, and staffing and data infrastructure as participation barriers. **CONCLUSIONS** Our findings show that a flexible and collaborative QI approach in the FQHC setting can help optimize care delivery. Future evaluations should incorporate the patient experience and patient-level data for comprehensive analysis.

► **A Novel Application of Interrupted Time Series Analysis to Identify the Impact of a Primary Health Care Reform on Intersectional Inequities in Avoidable Hospitalizations in the Adult Swedish Population**

GUSTAFSSON P. E., *et al.*
2024

Social Science & Medicine 343: 116589.
<https://doi.org/10.1016/j.socscimed.2024.116589>

Primary health care (PHC) systems are a crucial instrument for achieving equitable population health, but there is little evidence of how PHC reforms impact equities in population health. In 2010, Sweden implemented a reform that promoted marketization and privatization of PHC. The present study uses a novel inte-

gration of intersectionality-informed and evaluative epidemiological analytical frameworks to disentangle the impact of the 2010 Swedish PHC reform on intersectional inequities in avoidable hospitalizations. The study population comprised the total Swedish population aged 18–85 years across 2001–2017, in total 129 million annual observations, for whom register data on sociodemographics and hospitalizations due to ambulatory care sensitive conditions were retrieved. Multilevel Analysis of Individual Heterogeneity and Discriminatory Analyses (MAIHDA) were run for the pre-reform (2001–2009) and post-reform (2010–2017) periods to provide a mapping of inequities. In addition, random effects estimates reflecting the discriminatory accuracy of intersectional strata were extracted from a series MAIHDA runs per year 2001–2017. The estimates were re-analyzed by Interrupted Time Series Analysis (ITSA), in order to identify the impact of the reform on measures of intersectional inequity in avoidable hospitalizations. The results point to a complex reconfiguration of social inequities following the reform. While the post-reform period showed a reduction in overall rates of avoidable hospitalizations and in age disparities, socioeconomic inequities in avoidable hospitalizations, as well as the importance of interactions between complex social positions, both increased. Socioeconomically disadvantaged groups born in the Nordic countries seem to have benefited the least from the reform. The study supports a greater attention to the potentially complex consequences that health reforms can have on inequities in health and health care, which may not be immediately apparent in conventional evaluations of either population-average outcomes, or by simple evaluations of equity impacts. Methodological approaches for evaluation of complex inequity impacts need further development.

► **Heterogeneity in Physician's Job Preferences in a Dual Practice Context – Evidence From a DCE**

PESTANA J., *et al.*

2024

Social Science & Medicine 343: 116551.

<https://doi.org/10.1016/j.socscimed.2023.116551>

Many countries are facing challenges in recruiting and retaining physicians, particularly in regions where the public and private sectors compete for doctors. Understanding the factors influencing physicians' job choices can help inform policies aimed at attracting and retaining this valuable workforce. This study aims

to elicit the strength of physicians' preferences regarding various job-related aspects, including earnings, time flexibility, discussion of clinical cases, frequency of facilities and equipment updates, training opportunities and autonomy in decision making. To achieve this, a Discrete Choice Experiment (DCE) was administered to 697 physicians. Each participant completed a series of eight choice tasks, where they had to choose between two hypothetical jobs differing in these attributes with levels mirroring positions in the public and private sectors in Portugal. The resulting choices were analysed using mixed logit, generalized multinomial logit and latent classes models to account for diverse unobserved variations in physicians' preferences and to explore preference heterogeneity across different observable characteristics. Jobs that offered more autonomy and training opportunities were strongly preferred, as physicians would require additional compensation to work with reduced autonomy (equivalent to 28.62% of gross income) or less frequent training (equivalent to 22.75%). This study also shows that the ranking of the job characteristics is similar between physicians working exclusively in the public sector and those engaged in dual practice. Nevertheless, public sector physicians place more emphasis on the availability of frequent training possibilities and frequent updates of facilities and equipment compared to their counterparts in dual practice. These findings contribute to existing knowledge by highlighting the significance of non-monetary attributes and shedding light on the preferences of physicians across various employment scenarios. They offer valuable insights for policy development aimed at influencing physicians' allocation of time between sectors.

► **A Comparison of Social Prescribing Approaches Across Twelve High-Income Countries**

SCARPETTI G., *et al.*

2024

Health Policy: 104992.

<https://doi.org/10.1016/j.healthpol.2024.104992>

Background Social prescribing connects patients with community resources to improve their health and well-being. It is gaining momentum globally due to its potential for addressing non-medical causes of illness while building on existing resources and enhancing overall health at a relatively low cost. The COVID-19 pandemic further underscored the need for policy interventions to address health-related social issues

such as loneliness and isolation. Aim This paper presents evidence of the conceptualisation and implementation of social prescribing schemes in twelve countries: Australia, Austria, Canada, England, Finland, Germany, Portugal, the Slovak Republic, Slovenia, the Netherlands, the United States and Wales. Methods Twelve countries were identified through the Health Systems and Policy Monitor (HSPM) network and the EuroHealthNet Partnership. Information was collected through a twelve open-ended question survey based on a conceptual model inspired by the WHO's Health System Framework. Results We found that social prescribing can take different forms, and the scale of implementation also varies significantly. Robust evidence on impact is scarce and highly context-specific, with some indications of cost-effectiveness and positive impact on well-being. Conclusions This paper provides insights into social prescribing in various contexts and may guide countries interested in holistically tackling health-related social factors and strengthening community-based care. Policies can support a more seamless integration of social prescribing into existing care, improve collaboration among sectors and training programs for health and social care professionals.

► **Evaluating Engagement with Equity in Canadian Provincial and Territorial Primary Care Policies: Results of a Jurisdictional Scan**

SPENCER S., *et al.*

2024

[Health Policy 140: 104994.](#)

<https://doi.org/10.1016/j.healthpol.2024.104994>

Equitable access to primary care is essential to achieving more equitable health outcomes, yet evidence suggests that structurally marginalized populations are less likely to have benefited from varied primary care reforms in Canada. Our objective is to determine how equity is incorporated in public primary care policy and strategy documents across Canada. We conducted string term and snowball searches for provincial/territorial primary care policy documents published between 01 January 2018 and 30 June 2022, extracted the policy objective, and applied a rubric to evaluate each document's engagement with equity. We performed content analysis of the documents which acknowledged inequities and articulated a related policy response. Of the 224 identified documents that discussed primary care policy: 63 (28 %) identified one or more structurally marginalized group(s) expe-

riencing inequities related to primary care, 64 (29 %) identified a structurally marginalized group and articulated a policy response, and 16 (7 %) articulated a detailed policy response to address inequities. Even where policy responses were articulated, in most cases these did not directly address the acknowledged inequities. The absence of measurable goals, meaningful community consultation, and tenuous connections between the policy response and inequities mentioned may help explain persistent inequities in primary care across Canada.

► **Effects of Extending Residencies on the Supply and Quality of Family Medicine Practitioners; Difference-In-Differences Evidence From the Implementation of Mandatory Family Medicine Residencies in Canada**

STROBEL S.

2024

[Health Economics 33\(3\): 393-409.](#)

<https://doi.org/10.1002/hec.4782>

I examine the impacts of extending residency training programs on the supply and quality of physicians practicing primary care. I leverage mandated extended residency lengths for primary care practitioners that were rolled out over 20 years in Canada on a province-by-province basis. I compare these primary care specialties to other specialties that did not change residency length (first difference) before and after the policy implementation (second difference) to assess how physician supply evolved in response. To examine quality outcomes, I use a set of scraped data and repeat this difference-in-differences identification strategy for complaints resulting in censure against physicians in Ontario. I find declines in the number of primary care providers by 5% for up to 9 years after the policy change. These changes are particularly pronounced in new graduates and younger physicians, suggesting that the policy change dissuaded these physicians from entering primary care residencies. I find no impacts on quality of physicians as measured by public censure of physicians. This suggests that extending primary care training caused declines in physician supply without improvement in the quality of these physicians. This has implications for current plans to extend residency training programs.

► **Les mutations de la médecine de premier recours**

TABUTEAU D., *et al.*
2023

Sève : Les Tribunes de la santé : (4)

Les articles réunis dans ce numéro visent à apporter un éclairage pluridisciplinaire sur les mutations de la médecine de premier recours.

► **Changes in Cross-Sector Collaboration Between Nurse Home Visitors and Community Providers in the United States: A Panel Survey Analysis**

WILLIAMS V. N., *et al.*
2024

Health Services Research 59(S1): e14242.

<https://doi.org/10.1111/1475-6773.14242>

Objective Assess changes in cross-sector collaboration between Nurse-Family Partnership (NFP) nurse home visitors and community providers in the United States. **Data Sources and Study Setting** We collected primary data via internet-based surveys of all NFP nursing supervisors in the United States in 2018, 2020, and 2021. **Study Design** We conducted a panel survey to measure changes in cross-sector collaboration between NFP nurses and 10 provider types in healthcare and social services. We assessed relational coordination using the

validated seven item Relational Coordination Scale and structural integration using four items adapted from the Interagency Collaboration Activities Scale. Responses over time were compared using one-way analysis of variances (ANOVAs) and pairwise t-tests. We used the Kruskal–Wallis rank test to assess differences in collaboration by implementing agency type. **Data Collection** All nursing supervisors from NFP implementing agencies in the United States were eligible for the study. Survey implementation was conducted using Qualtrics and administered to all eligible participants (N = 370 [2018], 383 [2020], 414 [2021]). Email reminders were sent every 7–10 days, followed by a final telephone outreach. **Principal Findings** The response rate was 71% in 2018, 83% in 2020, and 74% in 2021. Relational coordination scores were calculated as a mean of the seven items and ranged from 1 to 5 (not at all to completely); integration scores were calculated as a sum of the four items and ranged from 4 to 20, where higher scores indicated greater sharing of resources. Coordination with women’s care increased from 2018 to 2020 (M = 3.39 vs. 3.57; $p < 0.01$); while coordination (M = 3.23 vs. 3.01; $p < 0.05$) and integration (M = 6.50 vs. 5.28 vs. 5.43; $p < 0.01$) with parenting programs decreased. **Conclusions** Changes to cross-sector collaboration varied by provider type, likely due to the delivery of NFP and other services via telehealth during the COVID-19 pandemic. There is an opportunity to improve cross-sector collaboration in home visiting to better address family needs.

Systèmes de santé

Health systems

► **The Role of Health and Health Systems in Promoting Social Capital, Political Participation and Peace: A Narrative Review**

DE LUCA G. D. ET LIN X.
2024

Health Policy: 105009.

<https://doi.org/10.1016/j.healthpol.2024.105009>

High levels of violence and insecurity are highly detrimental for societies. United Nations Sustainable Development Goal 16 is advocating for peaceful, accountable and inclusive institutions as one power-

ful channel to foster global development. Investing in health and health policies can potentially contribute achieving these objectives. After providing a conceptual framework, this article reviews the existing literature on the evidence of the role of health and health systems in promoting social capital and trust, political engagement and participation, and peace that closely relate to the objectives of Sustainable Development Goal 16. We provide evidence of a systematically positive impact of better physical and mental health on social capital, and on political participation, both contributing to the sustainability of inclusive democratic institutions. We also document that health and

health systems can help supporting peace, both via the reduction of social inequality and grievances, and by reducing the disruptive effects of epidemic shocks. Overall, the study provides evidence that health and health systems can generate co-benefits outside the health domain by promoting social capital, political participation and peace.

► **Contributing to Health System Resilience During Pandemics Via Purchasing and Supply Strategies: An Exploratory System Dynamics Approach**

GÖTZ P., *et al.*

2024

BMC Health Services Research 24(1): 130.

<https://doi.org/10.1186/s12913-023-10487-7>

Health systems worldwide struggled to obtain sufficient personal protective equipment (PPE) and ventilators during the COVID-19 pandemic due to global supply chain disruptions. Our study's aim was to create a proof-of-concept model that would simulate the effects of supply strategies under various scenarios, to ultimately help decision-makers decide on alternative supply strategies for future similar health system related crises.

► **The Policy and Politics of Healthcare Corporatisation: The Case of the English NHS**

SHEAFF R., *et al.*

2024

Social Science & Medicine 342: 116505.

<https://doi.org/10.1016/j.socscimed.2023.116505>

Rationale Few accounts of healthcare corporatisation examine the effects of the 2008 financial crisis. New Politics of the Welfare State (NPWS) theories recognise the relevance of crises but give more attention to programmatic than systemic (structural) retrenchment, and little to healthcare corporatisation. Objective To examine what changes the 2008 financial crisis produced in the pattern of healthcare corporatisation, and the implications for NPWS theories. Methods Using administrative data from the English NHS during 1995–2019 we formulated a multi-dimensional index of corporatisation, tested its validity, and used it to analyse longitudinally how the financial crisis affected the balance between the responsabilization of management and re-commodification (introduction of mar-

ket-like practices) in provider corporatisation. Results The financial crisis influenced NHS corporatisation through the fiscal austerity with which governments responded. The re-commodification of NHS providers stalled but not the responsabilization of NHS managers. Conclusions The corporatisation of NHS providers faltered after the financial crisis. These findings corroborate parts of NPWS theory but also reveal scope for further elaborating its accounts of systemic retrenchment in health systems.

► **Financing COVID-19-Related Health Care Costs in the Dutch Competitive Health System During 2020 and 2021: Overall Experiences and Policy Recommendations For Improving Health System Resilience**

SCHUT F. T., *et al.*

2024

Health Policy: 141 :104969.

<https://doi.org/10.1016/j.healthpol.2023.104969>

The Dutch health system is based on the principles of managed (or regulated) competition, meaning that competing risk bearing insurers and providers negotiate contracts on the price, quantity and quality of care. The COVID-19 pandemic caused a huge external shock to the health system which potentially distorted the conditions required for fair competition. Therefore, an important question is to what extent was the competitive Dutch health system resilient to the financial shock caused by the pandemic? Overall, the Dutch competitive health system proved to be sufficiently flexible and resilient at absorbing the financial shock caused by the COVID-19 pandemic in 2020 and 2021 due to an effective combination of regulatory and self-regulatory measures. However, based on the overall experiences in the Netherlands, from the health policy perspective improvements are needed aimed at (i) refining the catastrophic costs clause included in the Health Insurance Act, (ii) reducing the vulnerability of the Dutch risk equalisation system to distortions due to unforeseen catastrophic health care costs, and (iii) establishing more equal financial risk sharing between health insurers and health care providers. These improvements are also relevant for other countries with a health system based on the principles of managed (or regulated) competition.

Occupational Health

► Dimensions juridiques de l'employabilité sanitaire

DEL SOL M. ET GINON A.-S.

2023

Sciences sociales et santé 41(3): 29-35.

<https://www.cairn.info/revue-sciences-sociales-et-sante-2023-3-page-29.htm>

► Le travail de santé des chômeurs : une approche qualitative

LHUILIER D., *et al.*

2023

Sciences sociales et santé 41(3): 5-28.

<https://www.cairn.info/revue-sciences-sociales-et-sante-2023-3-page-5.htm>

Faire face à une problématique de santé durant le chômage est à la fois déterminé par les relations entre trajectoires de santé et de travail et par le travail de santé réalisé au chômage, i.e. l'activité dans ses versants factuel et subjectif que les chômeurs déploient dans leurs sphères de vie familiale, sociale et personnelle pour recouvrer un bien-être psychique, physique et social ou en redéfinir les normes. Notre recherche qualitative, conduite auprès de chômeurs, s'est composée d'entretiens approfondis et d'animations sur plusieurs mois de groupes d'échange entre pairs afin d'explorer les diverses formes possibles d'un travail de santé ainsi que les facteurs qui en favorisent ou en rendent difficile la réalisation. Nous tentons d'en saisir les fonctionnalités en termes de finalité et d'effet évolutif sur la santé éprouvée, sur les significations qui lui sont attribuées et sur le rapport santé/travail qui détermine la représentation de l'avenir et les conditions psychiques et sociales de construction d'un projet professionnel.

► Travail et emploi dans un centre hospitalier de dépistage et vaccination : aux marges de la réponse à la pandémie de COVID-19

RICHARD Z., *et al.*

2023

Revue Française des Affaires Sociales 234(4): 339-358.

<https://www.cairn.info/revue-francaise-des-affaires-sociales-2023-4-page-339.htm>

Dès mars 2020, les hôpitaux publics ont constitué l'épicentre de la réponse à l'épidémie de COVID-19 en France. Malgré la situation critique de services publics hospitaliers saturés, des interventions de santé publique de contrôle de l'épidémie ont été déployées dans certains hôpitaux. À partir d'une enquête ethnographique menée dans un centre de dépistage et de vaccination COVID-19 d'un hôpital de Seine-Saint-Denis, cette contribution s'attache à analyser les enjeux associés à la mise en flexibilité de l'hôpital pour les travailleurs évoluant aux marges de la réponse à la pandémie. Les auteurs mettent en lumière la façon dont la mise en œuvre du dépistage et de la vaccination a reposé sur de jeunes travailleurs marginalisés dans les hiérarchies sociales et hospitalières. Pour eux, le contexte pandémique a représenté une opportunité d'emploi et de travail ambivalente, à la fois sécurisante et précarisante. Ils ont accédé à un espace de moindre souffrance au travail dans ses dimensions physique, mentale et sociale. Ils ont aussi été confrontés à une importante instabilité et imprévisibilité, mettant en exergue les inégalités (re)produites par une institution publique hospitalière dégradée.

► **COVID-19 Lockdowns and Working Women’s Mental Health: Does Motherhood and Size of Workplace Matter? A Comparative Analysis Using Understanding Society**

WILSON J., *et al.*

2024

Social Science & Medicine 340: 116418.

<https://doi.org/10.1016/j.socscimed.2023.116418>

The COVID-19 pandemic had detrimental and unequal repercussions on mental health. To date there is little evidence exploring how motherhood and workplace size moderates this relationship for working women. This study aimed to estimate changes in working women’s mental health at the start of each UK lockdown and estimate the effect of motherhood and workplace size on mental health. We used Understanding Society data from women in paid employment, who participated in at least: one pre-COVID-19 Wave (9 or 10/11) and one COVID-19 lockdown wave (Lockdown 1: April 2020, Lockdown 2: November 2020, Lockdown 3: January 2021). Primary outcome was probable psychological distress (i.e., score ≥ 4 in the General Health Questionnaire-12 (GHQ-12)). In Model 1, exposure was motherhood (binary), interacting with a variable that split time in the pre-pandemic and lockdown peri-

ods. In Model 2, workplace size (Micro:1–24, Medium: 25–199, Large: More than 200 employees) was added as an exposure (3-way interaction) to investigate moderation effects. We fitted mixed-effects logistic regression models, adjusting for age, ethnicity, UK country of residence, cohabitation, educational qualifications, working hours, furlough, subjective financial difficulty and previous health condition. In the adjusted Model 1, pre-pandemic, odds of GHQ-12 caseness were lower for mothers compared to non-mothers (OR:0.89 95%CI:0.77,1.03). However post-pandemic compared to pre-pandemic, odds for mothers were higher than non-mothers, especially during lockdown 3 (Non-mothers: OR:1.93 95%CI:1.69,2.20; Mothers: OR:2.87 95%CI:2.36,3.49). In Model 2, workplace size did not modify the relationship. Pre-pandemic, there was no difference in the odds of GHQ-12 caseness by workplace size; however, the differences observed in Lockdown 3 between non-mothers and mothers, are mainly attributed to differences in medium-sized enterprises (Non-mothers: OR:1.95 95%CI:1.53,2.48; Mothers: OR:3.56 95%CI:2.54,4.99). Future policies should be designed to facilitate the working lives of mothers, but especially for medium-sized enterprises as extreme uncertainty appears to affect these employees more.

Vieillessement

Aging

► **La marchandisation, un processus aux multiples facettes. Enseignements à partir du secteur de l’aide à domicile en France**

ARTIS A. ET GALLOIS F.

2023

Revue Française des Affaires Sociales 234(4): 47-69.

<https://www.cairn.info/revue-francaise-des-affaires-sociales-2023-4-page-47.htm>

L’usage de la notion de marchandisation est souvent flou et multiforme. Cet article cherche à mieux spécifier la marchandisation en construisant et opérationnalisant une grille d’analyse prolongeant les travaux de K. Polanyi et d’A. Ebner. Il s’appuie sur l’analyse de l’aide à domicile en France, un secteur initialement

constitué d’associations et organisations publiques. Cela permet de démontrer que la marchandisation est un processus progressif qui prend plusieurs dimensions cumulatives qui sont la commodification, c’est-à-dire la transformation en marchandise associée à l’introduction d’échanges monétaires, la privatisation, avec l’entrée d’agents privés ayant un objectif d’accumulation, et la marchandisation associée à l’introduction de règles de marchés.

► **Higher Levels of State Funding For Home- and Community-Based Services Linked to Better State Performances in Long-Term Services and Supports**

CHENG Z., *et al.*

2024

Health Services Research [Ahead of pub]

<https://doi.org/10.1111/1475-6773.14288>

Objective To examine the relationship between the level of state funding for Home- and Community-Based Services (HCBS) and state overall and dimension-specific performances in Long-Term Services and Supports (LTSS). **Data Sources and Study Setting** We employed state-level secondary data from the Medicaid LTSS Annual Expenditures Reports, the American Association of Retired Persons (AARP) State Scorecards, the U.S. Census, and Federal Reserve Economic data, spanning the timeframe of 2010-2020. **Study Design** Overall state LTSS rankings, along with dimension-specific rankings, were modeled separately against state Medicaid spending on HCBS relative to total Medicaid spending on LTSS. All models were adjusted for state covariates, secular trend, and state fixed effects. **Data Collection/Extraction Methods** The study sample included all 50 states and the District of Columbia. However, California, Delaware, Illinois, and Virginia were excluded from FY2019 due to missing data on Medicaid HCBS expenditures. **Principal Findings** Every 10 percentage-point increase in the proportion of Medicaid LTSS spending to HCBS demonstrated 2.05 points improvement (95% confidence interval [CI]: -3.88 to 0.22, $p = 0.03$) in rankings for state overall LTSS system performance, 2.92 points improvement (95% CI: -4.87 to 0.98, $p < 0.01$) in rankings for the Choice of Setting and Provider dimension, as well as 1.73 points (95% CI: -3.14 to 0.32, $p = 0.02$) ranking improvement in the dimension of Effective Transitions.

► **Nursing Home Staffing: Share of Immigrant Certified Nursing Assistants Grew As US-Born Staff Numbers Fell, 2010–21**

JUN H. ET GRABOWSKI D. C.

2024

Health Affairs 43(1): 108-117.

<https://doi.org/10.1377/hlthaff.2023.00881>

Nursing homes have long faced a shortage of direct care workers, a problem that was magnified during the COVID-19 pandemic. Using nationally representative

data from three sources, we found that much of the certified nursing assistant (CNA) workforce in US nursing homes is filled by immigrant labor. The number of native-born CNAs has been declining rapidly since the mid-2010s, whereas the number of foreign-born CNAs has remained relatively constant. During the first two years of the COVID-19 pandemic, the share of immigrant CNAs employed by nursing homes surged, which can be explained by a simultaneous drop in the share of native-born staff. Staffing shortages observed during the pandemic would have been worse if not for foreign-born CNAs remaining in the workforce. However, the share of foreign-born CNAs varied considerably across states, from less than 1 percent in West Virginia to more than 70 percent in Hawaii. In an analysis of prepandemic data, we found that nursing homes in regions with a higher share of immigrant CNAs were associated with more direct care staff hours per resident day and better nursing home quality performance. With the growing demand for long-term care, creating pathways for job-seeking immigrants to fill the gaps in direct care will be crucial to meeting future staffing needs.

► **The Value of Healthy Ageing: Estimating the Economic Value of Health Using Time Use Data**

SANTOS J. V. ET CYLUS J.

2024

Social Science & Medicine 340: 116451.

<https://doi.org/10.1016/j.socscimed.2023.116451>

Introduction Economic arguments in favour of investing in health and health care are important for policy making, yet demonstrating the potential economic gains associated with health at older ages can be empirically challenging due to older peoples' limited attachment to the labour market. **Methods** We develop a novel method to quantify the economic value of health through time use data. Using data on people aged 65 years-old and older from the United Kingdom Time Use Survey (UKTUS) 2014–15, we apply survey-weighted generalized linear models to predict the time spent in non-market productive activities conditional on characteristics including age and self-perceived health. We weight these estimates of predicted minutes spent in each activity using household satellite accounts to quantify the monetary value of time spent engaging in non-market productive activities according to health status and simulate the monetary impact of health gains at older ages. **Results** Both age

and self-perceived health status were associated with minutes spent in many non-market productive activities. Summing the monetized predictions of minutes spent across all types of activities indicates that being in “very good” instead of “very bad” self-perceived health is associated with an additional production of 439£, 629£ and 598£ (in real 2015 GBP) per month for an average individual aged 65 to 74 years-old, 75 to 84 years-old and 85 years-old and older, respectively. Using our simulation model, if 10% of older people in “very bad” health in the United Kingdom were to transition to “very good” health it could lead to an increase of up to 278£ million through the production of non-market activities. Conclusions Health at older ages creates considerable economic value which is not observed using standard national accounting measures. Our method to quantify the monetary value of health can be adapted to other settings to make the economic case for investing in healthy ageing.

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